VA - Medicaid State Plan

CMS-10434 OMB 0938-1188

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

Package Header

Package ID	VA2018MS0008O	**SPA ID**	VA-18-0011
Submission Type	Official	**Initial Submission Date**	7/23/2018
Approval Date	10/9/2018	**Effective Date**	11/1/2018
Superseded SPA ID	VA-13-0012 System-Derived		

A. Single State Agency

1. State Name: Virginia

☐ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Department of Medical Assistance Services

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

☐ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
AG Certification_Single State Agency_Attachment 1	7/5/2018 9:37 AM EDT	PDF

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

◉ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

○ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

Package Header

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	System-Derived		

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

Package Header

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	System-Derived		

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- a. The Medicaid agency
- b. Delegated governmental agency
  - i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - iii. Other

2. The entity or entities that conduct determinations of eligibility based on age, blindness, and disability are:

- a. The Medicaid agency
- b. Delegated governmental agency
  - i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - iii. The Social Security Administration determines Medicaid eligibility for SSI beneficiaries
  - iv. Other

3. Assurances:

- a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

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B. Fair Hearings (including any delegations)

☐ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

☐ The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☐ a. Medicaid agency

☐ d. Delegated governmental agency

☐ i. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ ii. An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

(1) Name of entity:

HHS Appeals Entity

(2) The Medicaid agency has established a review process whereby it reviews appeals decisions made by the Exchange or Exchange appeals entity, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes

◉ No

2. The state must assure the following with respect to delegations of authority to conduct fair hearings regarding eligibility based on applicable modified adjusted gross income (MAGI):

☐ a. There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ b. When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

☐ c. The Medicaid agency does not delegate authority to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

☐ d. The delegated entity is capable of performing the delegated functions.

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☐ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

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C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | VA2019MS0007O | VA-19-0016

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Package ID	VA2019MS0007O	**SPA ID**	VA-19-0016
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	System-Derived		

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- (•) a. A stand-alone agency, separate from every other state agency
- ( ) b. Also the Title IV-A (TANF) agency
- ( ) c. Also the state health department
- ( ) d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Title IV-A Agency, the State Department of Social Services, maintains the Virginia Case Management System (VaCMS); the eligibility determination system implemented to evaluate and enroll eligible members directly into the MMIS.

A contractor vendor is responsible for operating the Medicaid call center, Cover Virginia, and for data entry of MAGI application information into the VaCMS system, the state's eligibility system. The Eligibility and Enrollment division in the Department of Medical Assistance Services oversees the contracted vendor.

b. Fair Hearings (including expedited fair hearings)

The Appeals Division within the State Medicaid agency provides a process by which clients and providers can appeal adverse decisions made by the Agency or its contractors. The Appeals Division has separate units that handle client appeals and provider appeals.

The FADS and Formal Appeals team oversees and manages the formal appeals process and reviews the formal appeals decisions issued by DMAS.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

The Health Care Services Division focuses on the development, implementation, and administration of managed care, pharmacy, and quality assurance services provided to eligible Medicaid recipients.

The Integrated Care Division is responsible for ensuring individuals with complex care needs receive comprehensive care coordination, ensuring access to appropriate quality care that supports the highest possible level of health outcomes. The Division leads the development and implementation of necessary regulations, policies and procedures to promote the most effective and efficient care in the least restrictive environments.

The Division of Aging and Disability Services develops, implements and administers programs designed to improve the lives of the elderly and persons with disabilities. The Division analyzes, develops and promulgates long-term care regulations, policies and procedures, designs and conducts long-term care studies, provides policy and operational support for the long-term care programs of the Agency and develops new home-and-community-based waivers.

The Medical Support Unit is housed within the Office of the Chief Medical Officer and is a federally required critical component of the Medicaid Program. It ensures that medical consultation is available to Agency programs and to Agency administration, as well as to assure that peer review is available to enrolled providers.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

The Policy Planning and Innovation Division with the State Medicaid Agency provides program and policy support to include planning and innovation efforts in response to state and federal laws and other requirements, agency priorities, industry best practices and stakeholder inputs.

The Eligibility and Enrollment Division establishes and maintains the program rules related to financial and non-financial eligibility for the Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) programs in accordance with federal guidelines.

The Behavioral Health Division reviews the use of existing behavioral health services, reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of Developmental Disabilities reviews the use of services for individuals with developmental disabilities, reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of Community Living reviews the use of the CCC Plus Waiver as well as both consumer-directed and agency-directed services within the home and community based waivers. The Office reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The COMPASS Division provides policy analysis and guidance related to the Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency (COMPASS) 1115 Waiver program.

The Office of Quality and Population Health focuses on developing, analyzing, reporting, and improving quality measures and outcomes of health care provided to Medicaid members.

e. Administration, including budget, legal counsel

The Department of Medical Assistance Services (DMAS) is operated under the direct supervision of the Director of DMAS who is appointed by the Governor. The Director executes the Department's multi-billion dollar biennium budget, plans and implements medical services through a network of health providers, and represents DMAS with other governmental entities. The principal assistant is the Deputy Director who assists the Director in all aspects of Medicaid planning, development, evaluation and the daily operation of all program functions, in addition to supervising the Support Services Unit.

The Budget Division is responsible for developing and managing the Agency's budget, submitting the Agency's budget to the Department of Planning and Budget (the Agency responsible for managing the entire state government budget) and the federal Centers for Medicare and Medicaid Services.

The Federal Reporting Division is in charge of managing the federal reports that are sent to CMS for financial management.

The Internal Audit Division independently examines and evaluates the ongoing control processes of the Agency and provides counsel and recommendations for improvement whenever such opportunities are identified. The objective of the Division is to provide reasonable assurance to management, within economic limitations and subject to the availability of staff.

The Procurement and Contract Management Division directs the Agency procurement activities and directs the development of Requests for Proposals (RFP) and Invitations for Bids (IFB), contract preparation, solicitation evaluation processes, contractor selection and contract performance reporting.

f. Financial management, including processing of provider claims and other health care financing

The Fiscal Division provides accounting, reporting, and financial management services to the Agency. The accounting functions are in compliance with relevant laws, regulations, fiscal policies and procedures, and professional standards. The Division develops and operates financial systems with sufficient internal control to provide accurate, timely, and meaningful financial and operating information to all interested parties and to protect the Department against theft and other types of loss. The Division is responsible for financial reporting, disbursement, cash management, third party liability, purchasing and support operations, and financial system administration. The Controller performs general administrative functions; develops and maintains fiscal policies and procedures; develops and implements and uses major automated systems; and provides overall planning and guidance for the Division.

The Program Operations Division provides services for medical evaluation of services including an eligibility and enrollment component, payment processing, customer services, and provider training. The Payment Processing Unit within the Program Operations Division evaluates, processes, and adjudicates claims and payments for various providers in specific benefit programs.

The Provider Reimbursement Division (PRD) is responsible for determining the payments for participating providers in Virginia's Department of Medical Assistance Services, including calculating, reviewing, and updating Medicaid capitation and provider payment rates. In addition, PRD calculates and administers supplemental payments to hospitals, nursing care facilities and physicians. An important part of this work includes the settlement and auditing of institutional providers' cost reports and utilizing both regulatory and market information to determine appropriate and allowable payments.

The Office of Value Based Purchasing serves as an Agency expert in the development and implementation of value-based payment policy.

g. Systems administration, including MMIS, eligibility systems

The Information Management Division (IM) is responsible for the development, implementation, and maintenance of all computer software systems within the Agency as well as the procurement, maintenance, and operation of computer equipment. Much of the work is performed in tandem with Agency's fiscal agent. Under DMAS' direction, the fiscal agent designs, develops, and maintains the Agency's Medicaid Management Information System (MMIS).

The Title IV-A Agency, the State Department of Social Services, maintains the Virginia Case Management System (VaCMS); the eligibility determination system implemented to evaluate and enroll eligible members directly into the MMIS.

A contractor vendor is responsible for operating the Medicaid call center, Cover Virginia, and for data entry of MAGI application information into the VaCMS system, the state's eligibility system. The Eligibility and Enrollment division in the Department of Medical Assistance Services oversees the contracted vendor.

The Office of Enterprise and Project Management is responsible for the implementation of agency information technology and program related projects.

h. Other functions, e.g., TPL, utilization management (optional)

The Office of Communications, Legislation and Administration liaisons with Virginia Legislators, Congressmen, providers, clients, other State Agencies, Associations, stakeholders, the general public and every division within the agency.

The Office of Data Analytics provide a structured analytics environment that assures data integrity, data consistency, well documented research, and repeatability.

The Program Integrity Division has responsibility for three units: Recipient Audit Unit, External Provider Audit and Policy Unit, and the Prior Authorization and Utilization Review (PAUR) Unit. The Recipient Audit Unit investigates referrals of fraudulent activity and abuse by Medicaid and FAMIS enrollees. The External Provider Audit and Policy unit oversees a wide variety of audit contracts in addition to providing policy analysis and expertise related to program integrity issues. The PAUR Unit conducts provider audits and also oversees a contractor that provides medical staff who review requests for service authorization and determine if the service is medically necessary under DMAS policy.

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
Organizational Chart 1-7-2020	1/14/2020 9:42 AM EST	

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | VA2019MS0007O | VA-19-0016

Package Header

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B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
Single state agency under Title IV-A (TANF)	The Title IV-A agency (State Department of Social Services or DSS) determines eligibility for Title XIX services, including eligibility under MAGI. Eligibility determinations are performed by staff supervised by the State DSS and administered by county and city departments of social services. The duties of the State DSS are as follows: certification by local social services agency superintendents/directors of current public assistance recipients and foster care children of the local social services department, acceptance of applications for medical assistance under Title XIX by the local department of social services of the city or county in which the applicant resides, or by State employees located in designated institutions. This includes determination of initial eligibility, certification of applicants found eligible, recertification on basis of periodic reviews of eligibility, and notification to the Department of Medical Assistance Services and to the applicant/recipient of the initial eligibility decision and any subsequent change in eligibility status. The State DSS is responsible for supervising the local departments of social services in the performance of the eligibility determination function. DMAS oversees the performance of these functions and retains all policy-making and decision-making authority as set forth in 42 CFR 431.10(e).
An Exchange that is a government agency	The Federally Facilitated Marketplace (FFM) will conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the FFM. The FFM will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost-sharing (if applicable), or assigning a benefit package. These functions will be performed by the single state agency.
An Exchange appeals entity	The HHS appeals entity will conduct Medicaid fair hearings for individuals whose Medicaid eligibility has been determined and found ineligible for Medicaid by the Federally-facilitated Marketplace (FFM). These will be individuals whose income eligibility is determined based on MAGI income methodology.

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E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

(•) Yes
( ) No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Department for Aging and Rehabilitative Services	The Department for Aging and Rehabilitative Services (DARS) coordinates and provides Medicaid services and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.
Department for the Blind and Vision Impaired	The Department for the Blind and Vision Impaired (DBVI) coordinates and provides services, to include Medicaid services, to assist citizens who are blind, deaf and blind, or vision impaired in achieving their maximum level of employment, education, and personal independence.
The Department of Health Professions	The Department of Health Professions (DHP) is responsible for the licensure and regulation of healthcare practitioners across 80 professions. Health regulatory boards issue permits and licenses to facilities, to include Medicaid facilities, such as pharmacies.
Department of Behavioral Health and Developmental Services	The Department of Behavioral Health and Developmental Services (DBHDS) licenses services that provide treatment, training, support and habilitation to individuals who have mental illness, developmental disabilities or

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
	substance abuse disorders, to individuals receiving services under the Medicaid DD Waiver, or to individuals receiving services in residential facilities for individuals with brain injuries.

Organization and Administration

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F. Additional information (optional)

Medicaid State Plan Administration

Organization

Single State Agency Assurances

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

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A. Assurances

- [ ] 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [ ] 2. All requirements of 42 CFR 431.10 are met.
- [ ] 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- [ ] 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- [ ] 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- [ ] 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2017MS0002O | VA-17-0021

Package Header

Package ID	VA2017MS0002O	**SPA ID**	VA-17-0021
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Superseded SPA ID	N/A		

The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. §435.603):

A. Financial Eligibility Methodologies

☐ The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §435.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

○ SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

◉ State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

☐ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. §435.602.

D. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

Package Header

Package ID VA2018MS0006O
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Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☐	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☐	☐	○	CONVERTED
Pregnant Women		☐	☐	○	CONVERTED
Deemed Newborns		☐	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☐	☐	○	NEW
Former Foster Care Children		☐	☐	○	APPROVED
Transitional Medical Assistance		☐	☐	○	NEW
Extended Medicaid due to Spousal Support Collections		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Aged, Blind and Disabled Individuals in 209(b) States		☐	☐	○	NEW
Individuals Receiving Mandatory State Supplements		☐	☐	○	NEW
Individuals Who Are Essential Spouses		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Institutionalized Individuals Continuously Eligible Since 1973		☐	☐	○	NEW
Blind or Disabled Individuals Eligible in 1973		☐	☐	○	NEW
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972		☐	☐	○	NEW
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977		☐	☐	○	NEW
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI		☐	☐	○	NEW
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security		☐	☐	○	NEW
Working Disabled under 1619(b)		☐	☐	○	NEW
Disabled Adult Children		☐	☐	○	NEW
Qualified Medicare Beneficiaries		☐	☐	○	NEW
Qualified Disabled and Working Individuals		☐	☐	○	NEW
Specified Low Income Medicare Beneficiaries		☐	☐	○	NEW
Qualifying Individuals		☐	☐	○	NEW

Mandatory Eligibility Groups

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B. The state elects the Adult Group, described at 42 CFR 435.119.

(•) Yes ( ) No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group		☐	☐	○	APPROVED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | VA2017MS0002O | VA-17-0021

Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and foster care when they turned age 18 or aged out of foster care.

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The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group

B. Individuals Covered

1. The state covers individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) and were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act.

2. Additionally, the state covers individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

- [ ] a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
- [ ] b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
- [ ] c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

Former Foster Care Children

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C. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Adult Group

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

Not Started | In Progress | Complete

Package Header

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Superseded SPA ID	N/A		

The state covers the Adult Group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have attained age 19 but not age 65

2. Are not pregnant

3. Are not entitled to or enrolled for Part A or B Medicare benefits

4. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

5. Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The amount of the income standard for this group is 133% FPL.

D. Coverage of Dependent Children

Parents or caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

- ○ 1. Under age 19, or
- ◉ 2. A higher age of children, if any covered under the Reasonable Classifications of Children eligibility group (42 CFR 435.222) on March 23, 2010:
  - ○ a. Under age 20
  - ◉ b. Under age 21

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

Package Header

Package ID VA2018MS0006O
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E. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

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SPA ID VA-18-0004
Submission Type Official
Initial Submission Date 6/8/2018
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Superseded SPA ID VA-17-0021
System-Derived

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21		☐	☐	○	CONVERTED
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	NEW
Optional Targeted Low Income Children		☐	☐	○	NEW
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Certain Individuals Needing Treatment		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
for Breast or Cervical Cancer					
Individuals Eligible for Family Planning Services		☐	☐	○	CONVERTED
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash		☐	☐	○	NEW
Individuals Eligible for Cash except for Institutionalization		☐	☐	○	NEW
Individuals Receiving Home and Community Based Services under Institutional Rules		☐	☐	●	NEW
Optional State Supplement Beneficiaries-209(b) States,and SSI Criteria States without 1616 Agreements		☐	☐	○	NEW
Institutionalized Individuals Eligible under a Special Income Level		☐	☐	●	NEW
Individuals participating in a PACE Program under Institutional Rules		☐	☐	○	NEW
Individuals Receiving Hospice Care		☐	☐	○	NEW
Qualified Disabled Children under Age 19		☐	☐	○	NEW
Poverty Level Aged or Disabled		☐	☐	●	NEW
Work Incentives Eligibility Group		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Ticket to Work Basic Group		☐	☐	○	NEW
Ticket to Work Medical Improvements Group		☐	☐	○	NEW
Family Opportunity Act Children with Disabilities		☐	☐	○	NEW
Individuals Eligible for Home and Community-Based Services		☐	☐	○	NEW
Individuals Eligible for Home and Community-Based Services - Special Income Level		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

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B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	NEW
Medically Needy Children under Age 18		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Blind or Disabled Individuals Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Children Age 18 through 20		☐	☐	○	NEW
Medically Needy Parents and Other Caretakers		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Aged, Blind or Disabled		☐	☐	●	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

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	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

Package Header

Package ID	VA2020MS0001O	**SPA ID**	VA-21-0005
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Approval Date	4/16/2021	**Effective Date**	4/1/2021
Superseded SPA ID	VA-13-0014		
	User-Entered		

☐ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens who meet all other Medicaid eligibility requirements under the state plan, consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

A. Citizens, Nationals and Eligible Non-Citizens

The state provides Medicaid eligibility to otherwise eligible individuals:

1. Who are citizens or nationals of the United States; or

2. Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641) or who are non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility, subject to the requirements at 8 U.S.C. §1612(b)(2), and are not restricted by section 403 of PRWORA (8 U.S.C. §1613); or who are non-citizens whose eligibility is required by 8 U.S.C. 1612(b)(2)(E) and (F); and

3. Who have declared themselves to be citizens or nationals of the United States, or non-citizens having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, 911, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

a. The agency provides for an extension of the reasonable opportunity period for non-citizens if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

◉ Yes

○ No

☐ b. When a reasonable opportunity period is provided, the agency furnishes benefits to otherwise eligible individuals on the following date:

The date benefits are furnished is:

◉ i. The date of the application containing the declaration of citizenship or immigration status.

○ ii. The first day of the month of application.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

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B. Optional Coverage of Qualified Non-Citizens

The state provides Medicaid coverage to all otherwise-eligible Qualified Non-Citizens whose eligibility is not restricted by section 403 of PRWORA (8 U.S.C. §1613).

- ○ Yes
- ◉ No

Indicate which requirements apply:

1. The state requires Lawful Permanent Residents to have 40 qualifying work quarters under Title II of the Social Security Act.

- ○ Yes
- ◉ No

2. The state limits eligibility to 7 years for the following non-citizens:

a. Non-citizens admitted to the U.S. as a refugee under section 207 of the Immigration and Nationality Act (INA)

b. Non-citizens granted asylum under section 208 of the INA

c. Non-citizens whose deportation is withheld under section 243(h) or 241(b)(3) of the INA

d. Non-citizens granted status as a Cuban-Haitian Entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980

e. Non-citizens admitted to the U.S. as Amerasian immigrants

f. Non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility

- ◉ Yes
- ○ No

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

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C. Coverage of Lawfully Residing Individuals

The state elects the option to provide Medicaid coverage to otherwise eligible individuals, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

(•) Yes
( ) No

[ ] 1. Pregnant women

[ ] 2. Individuals under a specified age:

( ) a. Individuals under age 21
( ) b. Individuals under age 20
(•) c. Individuals under age 19

3. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

4. An individual is considered to be lawfully present in the United States if he or she is:

a. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

b. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

c. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

d. A non-citizen who belongs to one of the following classes:

i. Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

ii. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

iii. Granted employment authorization under 8 CFR 274a.12(c);

iv. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

v. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

vi. Granted Deferred Action status;

vii. Granted an administrative stay of removal under 8 CFR 241;

viii.Beneficiary of approved visa petition who has a pending application for adjustment of status;

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture who:

i. Has been granted employment authorization; or

ii. Is under the age of 14 and has had an application pending for at least 180 days;

f. Has been granted withholding of removal under the Convention Against Torture;

g. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);

h. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

i. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

j. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (a) through (i) of this definition.

☐ k. Other

Description:

Description: Exceptions: • Individuals granted an administrative stay of removal under 8 CFR 241, described under C.4.d.vii., above, are not considered to be lawfully present; • Individuals granted employment authorization under 8 CFR 274a.12(c)(35) and (c)(36), described under paragraph C.4.d.iii, are not considered to be lawfully present unless they have an immigration status considered lawfully present under paragraph 4.a. through i.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

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	User-Entered		

D. Emergency Coverage

☐ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the Social Security Act and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

1. Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613(a)

2. Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

3. Qualified non-citizens for whom the state has elected to limit coverage, in accordance with 8 U.S.C. 1612(b)(2)(A), as amended, or (B).

E. Additional Information (optional)

Medicaid State Plan Eligibility

General Eligibility Requirements

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID	VA2022MS0001O	**SPA ID**	VA-22-0001
Submission Type	Official	**Initial Submission Date**	8/25/2022
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	System-Derived		

A. MAGI Paper Application

The state uses the following paper application(s) for individuals applying for coverage based on the applicable modified adjusted gross income (MAGI) standard.

○ 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

◉ 2. One or more alternative single, streamlined applications developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary

Name

Standard Application and Single Page Supplement

The paper application(s) has been uploaded.

Document Name ↓	Date Created ↓	
English Application Single Page Supplement 12_22_22	12/22/2022 5:10 PM EST	
English MAGI Standard Application 122222	12/22/2022 5:10 PM EST	

☐ 3. One or more alternative applications used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID	VA2022MS0001O	**SPA ID**	VA-22-0001
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	System-Derived		

B. MAGI Online Application

The state uses the following online application(s) for individuals applying for coverage based on the applicable MAGI standard.

- ○ 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- ◉ 2. One or more alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary

Name

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Screenshots or other documentation of the online application(s) has been uploaded.

Document Name	Date Created	
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- ☐ 3. One or more alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single application used only for insurance affordability programs to individuals seeking assistance only through such programs
- ☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

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	System-Derived		

C. Basis Other than MAGI - Paper Application

The state uses the following paper application(s) for individuals applying for coverage on a basis other than the applicable MAGI standard:

☐ 1. The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

The supplemental form(s) used to collect additional information has been uploaded.

Name	Date Created	
APPENDIX E Medically Needy Application English	6/7/2022 12:50 PM EDT	
ABD-LTC_Supplement	6/7/2022 12:53 PM EDT	
Appendix F English	10/11/2022 11:45 AM EDT	
English MAGI Standard Application 122222	12/22/2022 5:12 PM EST	
English Application Single Page Supplement 12_22_22	12/22/2022 5:12 PM EST	

1 – 5 of 5

☐ 2. One or more applications designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary

☐ 3. One or more applications used to apply for multiple human service programs

☐ 4. Other alternative applications

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

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D. Other than MAGI - Online Application

The state uses the following online application(s) for individuals applying for coverage who may be eligible on a basis other than the applicable MAGI standard:

☐ 1. The single, streamlined application developed by the Secretary or one of the alternate online forms developed by the state and approved by the Secretary, and supplemental online forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

Screenshots or other documentation of the online form(s) used to the collect additional information have been uploaded

Name	Date Created	
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☐ 2. One or more application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary

☐ 3. One or more application used to apply for multiple human service programs

☐ 4. Other alternative applications

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID VA2018MS0007O
SPA ID VA-18-0010
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Superseded SPA ID VA-14-0007
User-Entered

The state provides Medicaid services to individuals during a presumptive eligibility period following a determination by a qualified entity.

Presumptive eligibility covered in the state plan includes:

Eligibility Groups

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility for Children under Age 19	☐	☐	○	NEW
Parents and Other Caretaker Relatives - Presumptive Eligibility	☐	☐	○	NEW
Presumptive Eligibility for Pregnant Women	☐	☐	○	NEW
Adult Group - Presumptive Eligibility	☐	☐	○	NEW
Individuals above 133% FPL under Age 65 - Presumptive Eligibility	☐	☐	○	NEW
Individuals Eligible for Family Planning Services - Presumptive Eligibility	☐	☐	○	NEW
Former Foster Care Children - Presumptive Eligibility	☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer - Presumptive Eligibility	☐	☐	○	NEW

Hospitals

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility by Hospitals	☐	☐	○	APPROVED

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

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Superseded SPA ID	VA-14-0007		
	User-Entered		

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID	VA2018MS0007O	**SPA ID**	VA-18-0010
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Superseded SPA ID	VA-14-0007		
	System-Derived		

☐ The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☐ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◉ Yes ○ No

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

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Superseded SPA ID	VA-14-0007		
	System-Derived		

B. Eligibility Groups or Populations Included

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

(●) Yes ( ) No

☐ 9. Other Medicaid state plan eligibility groups:

☐ 10. Demonstration populations covered under section 1115

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

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Superseded SPA ID	VA-14-0007		
	System-Derived		

C. Standards for Participating Hospitals

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

(●) Yes ( ) No

[ ] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Percentage of individuals submitting a regular application:

85.00%

[ ] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Percentage of individuals found eligible for Medicaid

70.00%

D. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. Periods of presumptive eligibility are limited as follows:

(●) a. No more than one period within a calendar year.

( ) b. No more than one period within two calendar years.

( ) c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

( ) d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) e. Other reasonable limitation:

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

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Package ID VA2018MS0007O
SPA ID VA-18-0010
Submission Type Official
Initial Submission Date 6/22/2018
Approval Date 12/17/2018
Effective Date 1/1/2019
Superseded SPA ID VA-14-0007
System-Derived

E. Application for Presumptive Eligibility

☐ 1. The state uses a standardized screening process for determining presumptive eligibility.

☐ 2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

☐ 3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

☐ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Name	Date Created	
HPE Update BRD v0.5 (1) _12.3.2018	12/14/2018 9:50 AM EST	

F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

2. Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

◉ a. A reasonable estimate of MAGI-based income is used to determine household income.

○ b. Gross income is used to determine household size.

○ c. Other income methodology

☐ 3. State residency

☐ 4. Citizenship, status as a national, or satisfactory immigration status

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

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G. Qualified Entity Requirements

☐ 1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.

2. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
S21 HPE Training with 40 quarter reference 12.11.18.Revisedpptx	12/14/2018 9:53 AM EST	
Immigration Status dropdown menus expanded_12.11.2018	12/14/2018 9:55 AM EST	

H. Additional Information (optional)

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