Cheryl Roberts
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October 1, 2025

Virginia Medical Assistance Eligibility Manual Transmittal
DMAS-36

The following acronyms are contained in this letter:

- DJJ – Department of Juvenile Justice
- DMAS – Department of Medical Assistance Services
- LDSS – Local Department of Social Services
- MA – Medical Assistance
- OTIP – Office on Trafficking in Persons
- PDPM - Patient-Driven Payment Model
- RUG Rate – Resource Utilization Group
- SAVE – Systematic Alien Verification for Entitlements
- TN – Transmittal

TN #DMAS-36 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after October 1, 2025.

The following changes are contained in TN #DMAS-36:

Changed Sections	Changes
Subchapter M0120.100	Clarifies that a face-to-face or telephone interview is not required but may be requested by the applicant or benefits worker. An application for MA must be signed to be valid. Paper forms must bear the written (not typed) signature of the applicant or an individual authorized to apply on their behalf. Applications submitted electronically or through the approved telephonic process at Cover Virginia or the Virginia Insurance Marketplace meet the signature requirement.
Subchapter M0130.500 F.	After making required efforts to contact the applicant or client, if the applicant does not respond or contact the agency within 45 days of the date of application (30 days for a change), deny the application or close the case. See M0130.400 and M1520.200.
Subchapter M0220.100 & Appendix 1; Appendix 2	Verification of U.S. citizenship by a state vital statistics agency or SAVE is stand-alone evidence of citizenship. Separate proof of identity is not required. Clarified that "Letter of Eligibility" applies to children and "Letter of Certification" to adults. The source of the letter of eligibility is the Office on Trafficking in Persons (OTIP).
Subchapter M0280.500 A.; D.	Removes "nursing facility" from public institutions list. Clarifies that a child who is incarcerated in a DJJ facility is considered to be temporarily absent from the home.

Subchapter M0310.111 D. Appendix 1	Clarifies that a child continues to meet the Individuals Under Age 21 covered group as long as he is under the supervision of the LDSS or DJJ, including during a trial visit in the child's own home. Removes the 6 month provision; if a Medicaid renewal is due during the trial home visit of any duration, continue to treat the child as a foster care or DJJ child. Update DDS contact numbers and address.
Subchapter M1460 and M1470	Update RUG rate to PDPM (Patient-Driven Payment Model) rate.
M1470.230	Add language that dental services not provided by a Medicaid provider or covered by Medicaid are allowable deductions from patient pay.
M1520.20	Clarifies that the reconsideration period starts with the termination of coverage for failure to renew versus the month after renewal month.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration and
Coverage

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Page 1
TN #DMAS-35	7/1/25	Pages 2 and 5
TN #DMAS-30	1/1/24	Page 17
TN #DMAS-25	10/1/22	Page 7
TN #DMAS-23	4/1/22	Pages 9, 10, 16, 17, 19
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

M0120.000 Medical Assistance Application

M0120.100 Applying for Medical Assistance

A. Right to Apply

An individual cannot be refused the right to complete an application for medical assistance (MA) for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face *or telephone* interview is not required *but may be requested by the applicant or benefits worker*.

B. Signed Application Required

An application for MA must be signed to be valid. Paper forms must bear the *written (not typed)* signature of the applicant or an individual authorized to apply on *their* behalf. Applications submitted electronically or through the approved telephonic process *at Cover Virginia or the Virginia Insurance Marketplace* meet the signature requirement.

1. Unsigned Application

A paper application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

2. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. For paper applications, return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

If an electronic application does not bear a valid signature, the agency must obtain a valid signature from the applicant or his authorized representative for the case record. The signature page of a paper application form can be used.

M0120.150 When An Application Is Required

A. New Application Required

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

B. Application NOT Required

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. An application is not needed for a child turning age one when the child was deemed to be eligible based on the mother's enrollment at the time of birth. A renewal following the procedures in M1520 must be completed when the child turns one. Act on the enrollment of a deemed newborn *within seven days* when the birth is reported to the local DSS office or to DMAS.

Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to,

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Page 15
TN #DMAS-35	7/1/25	Pages 1, 9, 10 and 15
TN #DMAS-34	1/1/25	Page 9
TN #DMAS-33	10/1/24	TOC, Pages 1, 6, 6a, 12-14 Page 15 is added.
TN #DMAS-32	7/1/24	Pages 9 and 10
TN #DMAS-29	10/1/23	Page 12
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

M0130.500 Returned Mail

A. General Principle

This policy pertains to all information mailed to the applicant at intake, changes or renewals. Generally, there are three types of recipient mail that could be returned to the Medicaid agency:
(1) mail with an in-state forwarding address;
(2) mail with an out-of-state forwarding address; and
(3) mail that does not include a forwarding address.

Workers must confirm whether the address information on the piece of returned mail is complete and consistent with the address information the agency has on file. The front of the returned mail should be scanned into the case record and all actions to contact the client must be documented.

B. Returned Mail With Complete Information

Compare the address provided to existing records. If an error is discovered (i.e., missing or incorrect apartment number, etc.), make any necessary corrections and resend the information. If the subsequent mailing to the correct address is not returned, no additional contact is required. The address should be updated in VaCMS and no other action is required. If the subsequent mailing is returned, proceed as indicated below based on whether the returned mail has a forwarding address.

C. Returned Mail with no Forwarding Addres

The worker must attempt to contact the recipient through two other methods, including phone, text, email, or alternate addresses [including attempting to contact the Authorized representative (AR)]. If only one other method is available, a contact attempt must be made. If no other methods are available, the condition will be met if it has satisfied the up-to-date contact information.

D. Returned Mail with Forwarding Address

Sending the VCL or other mail to the new address will represent one contact method. One other method of contact, if available, is required to satisfy the returned mail condition. If mail is not returned from the forwarding address, the returned mail condition no longer applies because the original mailing has been completed and is no longer considered to be returned. The address should be updated in VaCMS and no other action is required.

E. Mail Returned from Authorized Representative

Returned mail from the AR should also be *investigated*. If the address appears correct and no other methods (phone, text, email or alternate addresses) are *available,* the client should be informed.

F. Lack of Alternative Contact Information

If after complying with the conditions described above, the only contact information available is the address in the individual's case record, and the LDSS does not have or cannot find a phone number, email address or other means to contact the individual, no further efforts to contact the individual are necessary. *If the applicant does not respond or contact the agency within 45 days of the date of application (30 days for a change), deny the application or close the case. See M0130.400 and M1520.200.*

G. Documentation

The case narrative must contain documentation of all methods used for contact attempts. To ensure applicants are able to complete the application process, the worker should ensure that if they successfully contact an individual after receiving returned mail, the recipient receives any necessary verification requests at their correct address and has sufficient time to return the information and complete the application process.

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Page 3; Appendix 1, page 1; Appendix 2, pages 1 and 2
TN #DMAS-35	7/1/25	Pages 4, 4a, 4b and 20
TN #DMAS-33	10/1/24	Pages 14e, 22
TN #DMAS-32	7/1/24	Pages 1, 4-5, 6a; Appendix 1, page 5 Appendix 4, page 2 Appendix 5, page 1
TN #DMAS-30	1/1/24	Page 3; Appendix 4, page 1
TN #DMAS-27	4/1/23	Page 17 Appendix 4, page 1 Appendix 5, page 1
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

a. All foster care children and IV-E Adoption Assistance children;

b. Individuals born to mothers who were eligible for MA in any state on the date of the individuals' birth;

c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

d. Verification of U.S. citizenship by a state vital statistics agency or SAVE is stand-alone evidence of citizenship. Separate proof of identity is not required.

When an individual loses an exception status and his C&I has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for MA for himself, is NOT required to verify his or her C&I.

3. Verification Required One Time

Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.

4. Enroll Under Good Faith Effort

If an individual meets all other eligibility requirements and declares that he is a citizen, he is to be enrolled under a good faith effort. **Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.**

If the applicant meets all other eligibility requirements:

- Approve the application and enroll the applicant in MA, AND
- Specify on the Notice that the individual may have to provide documentation of C&I if it cannot be obtained by other means, OR
- Include the Reasonable Opportunity Insert, available at https://fusion.dss.virginia.gov/Portals/[bp]/Files/Medical%20Assistance%20Guidance/medicaid_reasonable_opportunity_insertrev_03-09-10.pdf?ver=2019-06-04-151050-230 with the Notice.

The individual remains eligible for MA while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification. **Children enrolled under good faith effort are not eligible for 12 months of continuous eligibility**.

D. Procedures for Documenting C&I

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a monthly exchange of data between the Medicaid Management Information System

Citizenship & Identity Procedures

Workers are to use the following procedures when citizenship and identity verification is required to determine the individual's continued eligibility.

A. Documents Establishing U.S. Citizenship and Identity

1. Documents that Verify Citizenship and Identity

Both U.S. Citizenship and identity are verified by a:

- U.S. Passport,
- Certificate of Naturalization, or
- Certificate of U. S. Citizenship
- *Verification from a state vital statistics agency or SAVE.*

Documentary evidence issued by a federally recognized Indian tribe which identifies the tribe that issued the document, identifies the individual by name and confirms membership, enrollment or affiliation with the tribe (tribal enrollment card, certificate of degree of Indian blood, Tribal census. document, documents on Tribal letterhead)If the individual presents one of these documents, he has verified his citizenship and identity. **Photocopies of original documents are acceptable.**

2. Documents that Verify Identity

a. Documents

The agency must accept any of the documents listed below as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color or address. **Photocopies of original documents are acceptable.**

- Identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(l), except a driver's license issued by a Canadian government authority
- Driver's license issued by a State or Territory
- School identification card
- U.S. military card or draft record
- Identification card issued by the Federal, State or local government
- Military dependent's identification card
- U.S. Coast Guard Merchant Mariner's card
- For children under age 19, a clinic, doctor, hospital or school record, including preschool or daycare records

Sample Letter of Certification for Victims of a Severe Form of Trafficking

[Used For Adults]

HHS Tracking Number

(Address)

CERTIFICATION LETTER

Dear _____:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000. Your certification date is _. Certification does not confer immigration status.

With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/
Acting
Director
Office of Refugee Resettlement

Sample Letter of Eligibility for Victims of a Severe Form of Trafficking

[Used For Children Under Age 18 Years]

HHS Tracking Number

(Address)

Dear _____:

This letter confirms that pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

Your initial eligibility date is _____. This letter does not confer immigration status.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/
Acting
Director
Office on Trafficking in Persons (OTIP)

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Pages 6 and 7
TN #DMAS-32	7/1/24	Page 7
TN #DMAS-20	7/1/21	Table of Contents Page 1 Appendix 2 was added.
TN #DMAS-19	4/1/21	Pages 3, 4 Appendix 1 Page 4a was added.
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

M0280.300 INMATE OF A PUBLIC INSTITUTION

A. Policy

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 and considered incarcerated until permanent release, bail, probation or parole. An offender sentenced to the Community Corrections Alternative Program (CCAP) *is* confined in a DOC facility *is* not considered released, and *is* not a parolee or probationer.

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

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

A public residential facility that does not meet the definition of a "publicly operated community residence" in section M0280.100 above, is an "ineligible public institution."

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:

C. Incarcerated Adults

Offenders can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer.

Offenders include:

- individuals under the authority of the Department of Corrections (DOC)
- 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. For a juvenile in a facility, refer to M0280.300.D below and Appendix 1.

An offender who transfers temporarily to a halfway house, residential re-entry center (RRC), 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. Note: some drug or alcohol rehabilitation centers may be referred to as a "halfway house"; the eligibility worker should confirm the individual is not an inmate or incarcerated.

Once an incarcerated individual who is enrolled in Medicaid is released from the correctional facility, he may be eligible for all benefits available under the Medicaid covered group he meets.

D. Juveniles in Detention

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.

1. Held for Care, Protection or Best Interest

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 Medical Insurance Security (FAMIS) coverage. *A child who is incarcerated in a Department of Juvenile Justice Facility is considered to be temporarily absent from home.*

2. Held for Criminal Activity

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 at Juvenile-Detention-Centers-and-Homes-Contacts.pdf (virginia.gov). Because this list is subject to change, consult the list whenever eligibility must be evaluated for a juvenile who is reportedly in a detention center.

If the juvenile goes to a non-secure group home, he can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

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

A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a "Non-IV-E Foster Care" child for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for and receive Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

3. Non-IV-E Children in Another State's Custody

A child in the custody of another state's social services agency who is not receiving IV-E foster care maintenance or SSI payments, does NOT meet the Virginia residency requirement for Medicaid (M0230) and is not eligible for Virginia Medicaid UNLESS the child has been placed with and is residing in Virginia with a parent or care-taker relative.

4. Trial Home Visits

A foster care or DJJ child continues to meet the foster care definition (either IV-E or non-IV-E) when placed by the agency in the child's own home for a trial period, if the child continues to be in the agency's custody or remains the financial responsibility of DJJ or the court. *If a* Medicaid *renewal is due* during the trial home visit, *continue to treat the child as a foster care or DJJ child.*

M0310.116 HOSPICE

A. Definition

"Hospice" is a covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility, including a nursing facility.

1. Hospice Care

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

Disability Determination Services (DDS) Contact Information

Send ALL expedited and non-expedited disability referrals to the DDS Central District Office.

DDS *Central* District Office	Hearing Contacts
Central District Office Disability Determination Services 9960 Mayland Drive. Suite 200 *Henrico*, Virginia 23233 Phone: *855-445-3938* FAX: 804-*527*-4523 Operations Manager: Talya Brown Professional Relations Officer: Bonita Jones District Director: Elliot Duncan	Primary Contact for Scheduling a hearing: Bonita Jones (804) 367-4707 Backup: Shawnelle Martin 804-367-3292

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Pages 2, 17, 41, 42, 44, 46
TN #DMAS-34	1/1/25	Pages 3, 29, 35 Page 26a is added
TN #DMAS-33	10/1/24	Pages 4, 23, 24
TN #DMAS-32	7/1/24	Page 4a
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

3. Carry-over Expenses

Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.

4. Certification Period

The certification period is the period of time over which an application or redetermination is valid.

5. Current Payments

Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

6. Income Determination Period

The income determination period is the budget period; for all LTC cases, the budget period is one month.

7. LTC Case

A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.

8. Lump Sum Payment

Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.

Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.

9. MAGI Adults

Effective January 1, 2019, MAGI Adults is the CN covered group of individuals between the ages of 19 and 64 with household income at or below 138% of the Federal Poverty Level (FPL) and who are not entitled to or receiving Medicare.

10. Medicaid Rate

The Medicaid rate is a monthly rate which is calculated:

- for a facility, by multiplying the individual's daily *Patient-Driven Payment Model (PDPM)* code amount by the number of days in the month. A patient's *PDPM* code amount is based on his room and board and ancillary services. The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's *PDPM* code amount must be obtained by contacting the facility;

  NOTE: When projecting the facility's monthly Medicaid rate, the daily *PDPM* code amount is multiplied by 31 days. *Use of the PDPM is effective as of 10/1/2025.*

- for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.

C. Determine MN Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less Than or Equal to MN Income Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

4. Spenddown--Facility Patients

The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. For MN patients, the nursing facility must be contacted to obtain the *PDPM* code amount.

a. Spenddown Liability Less Than or Equal to the Individual's Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, determine spenddown eligibility by projecting the facility's costs at the individual's Medicaid rate for the month. Spenddown balance after deducting projected costs at the individual's Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than the Individual's Medicaid Rate

When the spenddown liability is **more than** the individual's Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 Medically Needy Spenddown Enrollment and Post-eligibility Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the *individual's* Medicaid rate.

2. individuals with a spenddown liability greater than the *individual's* Medicaid rate.

The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. The nursing facility must be contacted to obtain the *PDPM* code amount whenever a daily facility cost of care is needed to determine eligibility and patient pay for medically needy individuals.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the Medicaid rate.

Applications for individuals who are placed on spenddown are valid for 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

1. ABD MN Groups

a. Start with the gross monthly income for the ABD MN income determination found in section M1460.410 C.

b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.

c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.

2. F&C MN Groups

a. Start with the gross monthly income for the F&C MN income determination found in section M1460.410 C.

b. If the individual has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the individual has child support income, subtract the $50 child support exclusion. See section M0730.400.

a. The remainder is the MN monthly countable income.

d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

C. Determine the Individual's Projected Medicaid Rate

The individual's projected monthly Medicaid rate is the daily *PDPM* code amount at the time of the spenddown calculation multiplied by 31 days. **For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.**

D. Compare

Compare the individual's spenddown liability to the individual's Medicaid rate.

E. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the individual's Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the individual's Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.750 below for enrollment procedures.

F. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is greater than the Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, which equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

3. Example - Spenddown Liability Greater than Cost of Care, (using July 2014 figures)

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 and was determined disabled by Disability Determination Services (DDS). He is in a nursing facility and was admitted on April 1. His income is $2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CN because his $2,800 gross income exceeds the 300% SSI income limit. The individual's Medicaid rate is $100 per day. His MN income eligibility is calculated:

$2,800.00	disability benefit
- 20.00	general income exclusion
$2,780.00	MN countable income
- 457.63	MNIL for 1 month for 1 person in Group III
$2,322.37	spenddown liability

The individual's Medicaid rate for the admission month is calculated as follows:

$100.00	daily *PDPM* code amount
x 30	days
$3,000.00	individual's projected Medicaid rate

The $2,322.37 spenddown liability is less than the individual's Medicaid rate of $3,000.00. Because his spenddown liability is less than the Medicaid rate, his application is approved for ongoing coverage.

Her income starting May 1, 2015 increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of $600 per month; total income is $2,220 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$2,220.00	total monthly income
- 20.00	general income exclusion
2,200.00	countable income
- 305.09	MNIL for 1 month for 1 person in Group I
$1,894.91	spenddown liability

Ms. Was' daily *PDPM* code amount is $45. The projected Medicaid rate for the month is calculated as follows:

$ 45	daily *PDPM* code amount
x 31	days
$1,395	individual's projected Medicaid rate

The $1,894.91 spenddown liability is greater than her Medicaid rate of $1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2015 through April 30, 2016.

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

$ 53	private per diem cost
x 31	days in May
$1,643	private cost of care

The private cost of care, $1,643, is less than her spenddown liability of $1,894.91. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, 2015. Since all of her old bills were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of $400. Her spenddown eligibility for May is determined:

$1,894.91	spenddown liability
- 1,590.00	30 days @ $53 per day (5-1 through 5-30)
- 400.00	noncovered doctor's expense 5-30-2015
0	spenddown balance on 5-30-2015

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, 2015 and ending May 31, 2015.

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Pages 26, 32, 54
TN #DMAS-35	7/1/25	Pages 1 and 48
TN #DMAS-34	1/1/25	Pages 1, 2, 10, 11, 19, 20, 24
TN #DMAS-33	10/1/24	Pages 1, 2, 2a
TN #DMAS-32	7/1/24	Pages 1, 2, 5, 12, 15, 18-20, 28-30, 44, 54, and 55
TN #DMAS-31	4/1/24	Page 10, 12a, 14 and 14a
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20

2) dental services *not provided by a Medicaid provider or covered by by Medicaid*. Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D). Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the Service;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP were responsible for the payment of co-pays for prescriptions filled prior to January 1, 2012.
Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays for prescriptions covered under their Medicare Part D PDP. CBC recipients are not subject to payment of deductibles or a coverage gap in their Part D benefits.

Do not change the personal needs allowance to the facility amount unless notification is received from PACE. After notification from PACE of the individual's placement in a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. Do not refer to the Recipient Audit Unit. When the change is made, the individual is entitled to a personal needs allowance of $40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient under 22 years of age receiving inpatient psychiatric services in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the patient's daily *Patient-Driven Payment Model (PDPM)* code amount multiplied by the number of days in the month. A patient's *PDPM* code amount is based on his room and board and ancillary services. The *PDPM* code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's *PDPM* code amount must be obtained by contacting the facility. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the daily *PDPM* code amount by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

* for a facility patient, the monthly rate is the patient's daily *PDPM* rate multiplied by 31 days.

- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example-- Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. Monthly income is $500 from Social Security (SS) and $100 VA Compensation. Patient pay of $560 is less than the Medicaid rate. The individual pays the amount of his excess resources ($200) to the nursing facility as part of March's patient pay, remains eligible.

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- 40 personal needs allowance
$ 560 current patient pay (prior to adding excess resources)

$ 560 current patient pay
+ 200 excess resources
$760 patient pay for March only

Changed With	Effective Date	Pages Changed
TN #DMAS-36	10/1/25	Pages 8a and 9
TN #DMAS-35	7/1/25	Pages 7 and 18
TN #DMAS-33	1/1/25	Page 9
TN #DMAS-33	10/1/24	Change List; Pages 1, 2a, 4a – 6, 10 – 11, 12a

New or revised information provided by the enrollee must be entered into the system. The enrollee is responsible for reporting any changes. If the enrollee does not check either "yes" or "no" in response to a particular question, there is considered to be no change with regard to that question.

Verifications must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. Notes by the eligibility worker that the verifications were viewed are not sufficient.

Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later.

When an individual does not return the renewal form and action is taken to cancel coverage, a three-month reconsideration period applies (see M1520.200 C.4). *The reconsideration period begins the month after the case is cancelled.*

Note: Follow Auxiliary Grants (AG) policy regarding the appropriate renewal form to use for AG/Medicaid enrollees.

3. Online and Telephonic Renewals

Enrollees may opt to complete a renewal online using CommonHelp or by telephone through the Cover Virginia Call Center.

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must documented in the VaCMS case record. If the enrollee reports having no income ($0 income), follow the procedures in M1520.200 B.1.b).

If a paper or electronic renewal application is submitted by the enrollee, the renewal should be processed even if the scheduled renewal date is in the future. If the case is in a current certification period, the renewal should be evaluated for possible changes.

Telephonic renewals may be taken only by the Cover Virginia Call Center. Telephonic renewals cannot be taken directly by the local agency because a telephonic signature is required.

C. Disposition of Renewal

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility (see M1520.300).

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

3. Referral to Virginia's Insurance Marketplace (VIM)

Unless the individual has Medicare, a referral to the VIM—also known as the State Based Exchange (SBE)--must be made when an individual's coverage is cancelled so that the individual's eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual's renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the VIM referral to be made.

4. Renewal Filed During the Three-month Reconsideration Period

If the individual's coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. *The reconsideration period begins the month after the case is cancelled.* The individual must be given the entire reconsideration period to submit the renewal form and any required documentation. When the renewal or verifications are provided within the 90 day reconsideration period, process the renewal as soon as possible but at least within 30 calendar days from receipt.

The reconsideration period applies to renewals for all covered groups.

If the individual files a renewal or returns verifications at any time during the reconsideration period and is determined to be eligible, reinstate the individual's coverage back to the date of cancellation.

For individuals who were enrolled as Qualified Medicare Beneficiaries (QMB) at the time of cancellation, reinstate coverage back to the date of cancellation.

If an individual began receiving Medicare during the reconsideration period and is eligible as QMB, the QMB coverage is effective the month **in which Medicare began**. Evaluate eligibility for the other months of the reconsideration period in other possible covered groups, including Medically Needy.

Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.