Medicaid

Medicaid is a federal/state program that gives certain groups of people a card that can be used to get free medical care, nursing home care, and prescription drugs at reduced prices. In general, eligibility for Medicaid is for people who have low income and low resources (property).

Who can get Medicaid?

Federal and state laws describe the groups of people who may be eligible for Medicaid. These groups of people are called Medicaid covered groups. The eligibility rules and medical services available are different for certain covered groups. People who meet one of the covered groups may be eligible for Medicaid coverage if their income and resources are within the required limits of the covered group. The Medicaid covered groups are:

- Aged, blind or disabled people with income up to 300% of the SSI payment rate who have been screened and approved to receive services in a nursing home or through one of the Medicaid Home and Community-Based Waivers.
- Auxiliary Grant (AG) enrollees who live in Assisted Living Facilities.
- Certain people who lost SSI because their income or living situation changed.
- Certain refugees for a limited time period.
- Children from birth to age 19 whose family is at or below 133% of poverty.
- Children under age 21 who are in foster care or subsidized adoptions.
- Infants born to Medicaid eligible women.
- Low Income Families with Dependent Children. This includes all people who receive Temporary Assistance to Needy Families (TANF) benefits. If you received TANF in three of the last six months, but no longer receive TANF because of increased earnings or work hours, you keep getting Medicaid for four months after TANF stops.

- Individuals who are blind or disabled, at least 16 years old but not 65 years of age, who are working or can work and earn income and whose income does not exceed 80% of the Federal Poverty Income Guidelines*. Earned income and resources retained from earnings are disregarded up to a certain level once enrolled in the Medicaid Works program.
- Medically Needy Individuals who meet Medicaid covered group rules, but have excess income.
- Persons who are age 65 or older, blind or disabled whose income does not exceed 80% of poverty.
- Persons who are terminally ill and have chosen to receive hospice care.
- Pregnant women whose family income is at or below 133% of poverty.
- Supplemental Security Income (SSI) enrollees who are age 65 or older, blind or disabled, who also meet Medicaid resource limits.
- Women screened by the Center for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program who have been diagnosed with and need treatment for breast or cervical cancer.

What are the resource rules to get Medicaid?

When you apply for Medicaid, you must tell about all the resources you own. This includes cash, bank accounts, real property (house and land), motor vehicles, boats, other personal property, and life insurance properties. You must report all resources. The resource rules vary according to the covered group. Not all resources are counted. For example, the house you own and live in, one motor vehicle, household furnishings, personal effects, some life insurance policies, some burial funds and cemetery plots, and some irrevocable trusts are not counted.

What if I have too many resources to get Medicaid?

If this happens, you may become eligible for Medicaid by reducing your resources below the limit. However, *if you give away or sell resources for less than what they are worth, you will be found ineligible for Medicaid coverage for long-term care services (such as nursing home care) for a long period of time.* You will be asked about any resources you transferred in the last 60 months. Transfers that you make after you are eligible for Medicaid also can result in you being ineligible for Medicaid coverage for long-term care services for a long period of time.

What are the income rules to get Medicaid?

Some people may be eligible for Medicaid because they are already receiving other public benefits for low-income persons, such as Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF). Others may be eligible even if they are not receiving other benefits if they can show that their income is below certain limits. Income includes “earned” income, such as wages or earnings from self-employment, and “unearned” income, such as Social Security, unemployment compensation, interest, pensions, and alimony and support payments.

If your total income exceeds the income limits, you still may get a Medicaid card under the "spend-down” rule. The spend-down rule is like having an insurance deductible. To get a Medicaid card under the spend-down rule, you must "incur" or be billed for a certain amount of medical care in a six month period. You don’t actually have to pay those expenses, but need to prove you owe them. Once this

happens, you get a Medicaid card for the rest of the six months. When the six months are up, you must reapply for Medicaid.

What is Medicaid Expansion?

Medicaid Expansion took effect in Virginia on January 1, 2019. It is a new category of Medicaid eligibility for thousands of residents. To be eligible, applicants must be between ages 19 and 64, not entitled to or enrolled in Medicare, not otherwise eligible for full Medicaid coverage, and have a household income under 138% of the federal poverty level. There is no resource test for this Medicaid category. This new group of eligible applicants include those already enrolled in Medicaid programs such as Plan First or GAP with income below 138%. It also includes, but is not limited to, childless adults, Blind/Disabled with income over 80%, or Blind/Disabled with excess resources, with income below 138%.

What does Medicaid cover?

Full Medicaid benefits include these services:

- Inpatient and outpatient hospital care,
- Physician, nurse midwife, and pediatric and family nurse practitioner services,
- Federally qualified health centers and rural health clinic services,
- Laboratories and x-ray services,
- Transportation services,
- Prenatal care,
- Family planning services,
- Skilled nursing facility and home health care services for persons over age 21, and
- Early and Periodic Screening, Diagnosis, and Treatment program for children ("EPSDT").
- Routine dental care for people under age 21,
- Prescription drugs,
- Rehabilitation services such as occupational, physical, and speech therapy,
- Intermediate care facilities for persons with developmental and intellectual disabilities and related conditions,
- Mental health services, and
- Substance Abuse Services.

Medicaid beneficiaries also receive coverage through home and community-based "waiver" programs. These waivers provide community services as an alternative to institutionalization. The following waiver programs are available to Medicaid beneficiaries who meet level of care criteria:

- AIDS Waiver,
- Alzheimer's Waiver,
- Day Support for Persons with Intellectual Disabilities Waiver,
- Elderly or Disabled with Consumer-Direction Waiver,
- Intellectual Disabilities Waiver,
- Technology Assisted Waiver, and
- Individual and Family Developmental Disabilities Support Waiver.

What additional services are available for children?

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a special Medicaid program for children up to the age of 21. It detects and treats health care problems early through:

- Regular medical, dental, vision, and hearing check-ups.
- Diagnosis of problems.
- Treatment of dental, eye, hearing, and other medical problems found during checkups.

If your child's doctor finds a health problem during an EPSDT check-up, he may be able to treat the problem or may send you to another provider (specialist) who can treat it.

Getting regular EPSDT Check-Ups even when your child is not sick is the best way to make sure your child stays healthy!

Use the chart below to find out when your child should receive regular check-ups:

Babies need check-ups at:	**Toddlers & Children need check-ups at:**	**Older Children need check-ups at:**	**Teenagers need check-ups at:**
1 month * 2 months * 4 months * 6 months * 9 months * 12 months *	15 months * 18 months * 2 years * 3 years 4 years *	5 years * 6 years * 8 years 10 years	12 years * 14 years 16 years 18 years 20 years

* Most immunizations (shots) are given during these visits

When does Medicaid start?

Medicaid coverage usually starts on the first day of the month you apply and are found to be eligible. Medicaid can start as early as three months before the month in which you applied if you meet all eligibility rules and received a covered medical service during that time.

What are the costs to get Medicaid?

Some Medicaid enrollees must pay a small amount for certain services. This is called a copayment. The following enrollees do not pay a co-payment for services covered by Medicaid:

- People younger than age 21;
- People receiving institutional or community-based long-term care services (patient pay may be applicable); and
- People in hospice programs.

Medicaid does not charge a co-payment for the following services:

- Emergency services (including dialysis treatments);
- Pregnancy-related services;

- Family-planning services; and
- Preventive services for children.

Medicaid charges co-payments for enrollees age 21 and older for services such as physician visits, eye examinations, prescriptions, home health and rehabilitation services, but the cost is under $5 per visit. However, an in-patient hospitalization will cost $100 per admission.

What is not covered under Medicaid?

Medicaid will not cover all medical services. Among them are these:

- Abortions, unless the pregnancy is life-threatening or health-threatening;
- Acupuncture;
- Administrative expenses, such as completion of forms and copying records;
- Alcohol and drug abuse therapy (except as provided through EPSDT or for pregnant women through the Community Services Boards and under the BabyCare program);
- Artificial insemination, in-vitro fertilization, or other services to promote fertility;
- Broken appointments;
- Certain drugs not proven effective and those offered by non-participating manufacturers (enrolled doctors, drugstores, and health departments have lists of these drugs);
- Certain experimental surgical and diagnostic procedures;
- Chiropractic services (except as provided through EPSDT);
- Cosmetic treatment or surgery;
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers);
- Dentures for enrollees age 21 and over;
- Doctor services during non-covered hospital days;
- Drugs prescribed to treat hair loss or to bleach skin;
- Eyeglasses or their repair for enrollees age 21 or older;
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is pre-authorized;
- Hospital charges for days of care not authorized for coverage;
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk);
- Inpatient hospital care in an institution for the treatment of mental disease for enrollees under age 65 (unless they are under age 22 and receiving inpatient psychiatric services);
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid;
- Personal care services (except in some home and community-based service waivers or under EPSDT);
- Prescription drugs if the enrollee has coverage under Medicare Part A or Part B
- Private duty nursing (except in some home and community-based service waivers or under
- EPSDT);
- Psychological testing done for school purposes, educational diagnosis, school, or
- institution admission and/or placement or upon court order;
- Remedial education;

- Routine dental care if you are age 21 or older;
- Routine school physicals or sports physicals;
- Sterilization of enrollees younger than age 21;
- Telephone consultation; and
- Weight loss clinic programs.

How do I apply for Medicaid?

You apply for Medicaid at your city or county Department of Social Services (DSS). You can also apply online at www.easyaccess.virginia.gov. The agency has 45 days to make a decision on your application. When an application is based on your disability, DSS has 90 days to decide your claim. The Medicaid disability rules are the same as those for Social Security and SSI disability. If the Social Security Administration (SSA) has approved disability, DSS will follow that. If SSA has denied disability within the past year, DSS will also follow that.

How do I appeal a Medicaid decision I disagree with?

If Medicaid is denied or ended, or if you disagree with any action on your Medicaid care, you may file an appeal by asking for a fair hearing, in writing, at the local DSS office. You must file an appeal within 30 days of learning that Medicaid has been denied or ended.

To request an appeal, notify DMAS in writing of the action you disagree with within 30 days of receipt of the agency's notice about the action. You may write a letter or complete an Appeal Request Form. Forms are available on the Internet at www.dmas.virginia.gov.
Please be specific about what action or decision you wish to appeal and include a copy of the notice about the action if you have it. Be sure to sign the letter or form.

Please mail appeal requests to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Telephone: (804) 371-8488
Fax: (804) 371-8491

In a Medicaid termination case, if you file an appeal before the effective date of the action, Medicaid benefits continue pending the hearing and the decision. You may, however, have to repay the Medicaid program for any services you receive during the continued coverage period if the agency's action is upheld.

After you file your appeal, you will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. However, if you disagree with the Hearing Officer's decision, you may appeal it to your local circuit court.

What if the appeal is from the Managed Care Organization (MCO)?

If you are in the Medicaid program and receive services from a Managed Care Organization (MCO), different rules apply to the appeal timeframes and procedure. If you would like your benefits to continue during the appeal, you may have as little as 10 days to appeal. Be sure to read your notices carefully for how to proceed with an appeal.

THIS INFORMATION IS NOT LEGAL ADVICE. *Legal advice is dependent upon the specific circumstances of each situation. Therefore, the information contained in this pamphlet cannot replace the advice of competent legal counsel.*

Free Legal information by Web and Phone: www.vlas.org and
1-866-LeglAid (534-5243