Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov

MEDICAID BULLETIN

Last Updated: 04/07/2023

Resource Disregard for Institutional and Community Based Waiver Services - REVISED

This bulletin (which supersedes the bulletin entitled "Resource Disregard for Institutional and Community Based Waiver Services" dated February 6, 2023) is a REVISION and REPLACEMENT of that bulletin. The purpose of this bulletin is to notify providers that DMAS is seeking federal authority to disregard certain resources for individuals receiving institutional or home and community based waiver services for eligibility re-determinations beginning in March 2023 after the continuous coverage requirements end.

DMAS has submitted a state plan amendment (SPA) the Centers for Medicare and Medicaid Services (CMS) that would allow DMAS to disregard, during eligibility re- determinations, accumulated income that would have otherwise been part of an individual's liability for his or her institutional or home and community-based waiver services based on application of the post-eligibility treatment-of income (PETI) rules, but which became countable resources on or after March 18, 2020. Income after the month of receipt becomes a resource and the individual's resource may have accumulated and exceeded the resource threshold for eligibility. The disregard will be evaluated if the member has excess resources at redetermination, and only the portion of the excess resource due to inability to increase patient pay will be disregarded. DMAS has requested authority to disregard income that has been accumulated into resources until the individual's second Medicaid renewal that follows the end of the continuous coverage requirement.

The DMAS request involves any income increases that would have normally been applied to the individual's liability for institutional or home and community-based waiver services and resulted in accumulations to resources that exceed the allowable resource limit. If the request is granted, individuals will have until their second Medicaid renewal following the end of the continuous coverage requirement to spend these funds down so that they are not counted as part of the individual's "patient pay" obligations. If the individual has excess resources at the time of the second renewal, the disregard no longer applies and the individual may lose coverage.

If the SPA is approved, local eligibility workers will follow these processes:

Asset Transfers

- If reported, asset transfers that occurred during the PHE and prior to 4/1/2023 will be evaluated and a penalty period calculated (transfers that are not reported are not known to the local agency and can't be evaluated). The option to claim undue hardship (UH) must be given to the member. If UH is denied or not requested, any remaining penalty period (after the 10 day advance notice period) will be applied to the case; a

notice will be sent to the client and a 225 to the provider.
- Asset transfers that occur 4/1/2023 and forward will be evaluated following existing policy in M1450. Negative action cannot be taken if the renewal is overdue; the worker has the ability to trigger a renewal, but CMS has approved that changes can wait to be processed until the scheduled renewal during the unwinding period.

Patient Pay Changes

- Changes reported prior to 4/1/2023 that would decrease patient pay should already have been processed. If not, the worker will process as soon as possible and make the change going forward.
- Changes reported 4/1/2023 and forward that would decrease patient pay should be processed within 30 days of the report.
- A Medicaid eligible individual cannot pay more in patient pay than the Medicaid rate for the month.
- If a change was reported timely and the patient pay for prior months is incorrect, the patient pay is reduced for the prior months only in one of the following situations (patient pay cannot be increased in the past):
    - a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay.
    - a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, patient pay cannot be adjusted.
    - If an individual has moved from a nursing facility to community-based care, the patient pay is adjusted effective the month after the change.
- In these situations, patient pay can be adjusted retroactively. A refund should be issued to the patient and the claim should be re-submitted to DMAS. In all other situations when a change is reported, the worker cannot adjust the patient pay retroactively. The patient pay cannot be increased without giving advance notice.
- Changes reported 4/1/2023 and forward that would increase patient pay can be processed if the case is in an active certification period and the renewal is not overdue (for instance if the individual was approved or renewed within the last year). Patient pay can't be increased without giving the member 10 days advance notice. The effective date of the change must allow for the advance notice period.
- If the renewal is overdue, negative changes cannot be processed unless a renewal is triggered. The worker has the ability to trigger a renewal, but CMS has approved that changes can wait to be processed until the scheduled renewal during the unwinding period.

More on the patient pay process can be found in Chapter M14 of the Eligibility and Enrollment Manual.

DMAS has developed a Fact Sheet document that has been posted to the CoverVirginia

website on the “Return to Normal Enrollment” page (link here).

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or Call: 1-800-424-4046

Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	www.aetnabetterhealth.com/Virginia 1-855-270-2365 1-866-386-7882 (CCC+)
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-833-207-3120 1-833-235-2027 (CCC+)
Molina Complete Care	1-800-424-4524 (CCC+) 1-800-424-4518 (M4)
Optima Family Care	1-800-643-2273 1-844-374-9159 (CCC+) www.optimahealth.com/medicaid
United Healthcare	www.Uhccommunityplan.com/VA www.myuhc.com/communityplan 1-844-284-0149 1-855-873-3493 (CCC+)
Virginia Premier	1-800-727-7536 (TTY: 711), www.virginiapremier.com
Dental Provider DentaQuest	1-888-912-3456