Virginia's Medicaid Covered Groups for Individuals who are Aged, Blind, or Disabled (ABD)

Virginia's Medicaid program offers coverage to individuals who meet financial **and** non-financial criteria, and who meet a **covered group.** Virginia Medicaid has several covered groups for Virginians who are Aged, Blind, or Disabled (ABD). These groups cover individuals (or couples) who are Aged (65 years of age or older), **or** meet either the U.S. Social Security Administration (SSA) or the Virginia Department of Aging & Rehabilitative Services (DARS) Disability Determination Services (DDS) definition of Blind or Disabled .

Some of the ABD Medicaid covered groups provide **full-benefit coverage** through Medicaid. This means they offer comprehensive benefits, on par with those received through private insurance. Others, known as the **Medicare Savings Programs (MSPs)**, only provide Medicaid payment for some Medicare costs (e.g. premiums, deductibles, copayments). For certain individuals, Medicaid may also provide time-limited full coverage if a "spenddown" is met.

FULL-BENEFIT ABD MEDICAID COVERED GROUPS

Some of the Medicaid covered groups for Virginians who are Aged, Blind, or Disabled (ABD) offer **full benefits**, meaning they cover a comprehensive set of benefits, including:

- Doctor, hospital and emergency services, including primary and specialty care
- Prescription medicines
- Laboratory and X-ray services
- Home health services
- Behavioral health services, including addiction and recovery treatment services
- Rehabilitative services, including physical, occupational and speech therapies
- Dental care, including restorations, prosthodontics (dentures), and periodontics (with some limitations)
- Medical equipment and supplies
- And more!

Aged, Blind, or Disabled (ABD) with Income ≤80% FPL

This covered group is for Virginians who are Aged, Blind, or Disabled, and who have income at or below 80% of the Federal Poverty Level (FPL). This group, like other ABD groups, must meet resource requirements, too. The "ABD ≤80% FPL" group receives **full** Medicaid benefits. Those covered can receive Long-Term Services and Supports (LTSS), but even an individual/couple who does not require LTSS can be covered in ABD ≤80% FPL.

Individual receiving Supplemental Security Income (SSI)

Individuals who receive Supplemental Security Income (SSI) from the SSA are already income-qualified to receive Medicaid in Virginia. SSI is a federal program that provides monthly payments to meet basic needs, including food, clothing, and shelter, for those who are Aged, Blind, or Disabled. In 2024, SSI provides monthly payments of up to $943 for a single person, or up to $1,415 for a couple.

Because of a slight difference in the way the SSA looks at resources versus the way Virginia Medicaid looks at them, Virginia still requires SSI recipients to apply for Medicaid (they do not automatically qualify). But, most people who receive SSI also qualify for Medicaid. Many people who **used to** receive SSI, but do not receive it anymore, may also qualify for Medicaid as one of the "Protected Cases."

"Protected Cases" Covered Groups

Some individuals may be eligible for ABD Medicaid as part of a group of Protected Cases. If they previously received SSI, but no longer do, there is a good chance they may still be eligible for Medicaid! There are some specific rules around each of these groups, but the following are considered Protected Cases for Medicaid ABD eligibility:

- Pickle Amendment: Those who would be eligible for SSI if certain cost-of-living increases were disregarded (since 1977)
- Disabled widow/er
- Former disabled child or adult
- Qualified Severely Impaired Individuals who are ineligible for SSI due to earnings

Additional details about the Protected Cases covered groups can be found on pages 3.5-3.6.

Individual receiving an Auxiliary Grant (AG)

Virginians who receive an Auxiliary Grant (AG) are automatically qualified for Medicaid. The AG program is run through the Virginia Department of Social Services (VDSS), and is co-administered by the Virginia Department of Aging & Rehabilitative Services (DARS).

An Auxiliary Grant is a supplement to income for recipients of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals **residing in a state-approved licensed Adult Care Residence** (ACR), such as an Assisted Living Facility (ALF), adult foster care home, or Supportive Housing (SH) arrangement. A Virginian can apply for an AG through his/her local Department of Social Services (LDSS). A complete listing of Virginia's LDSS offices and their contact information is in Section 5. AGs exist to help individuals maintain a standard of living that meets a basic level of need.

Individual with income up to 300% of SSI in a Nursing Home, Community-Based Care, or Hospice

Individuals who receive or need to receive Long-Term Services and Supports (LTSS, sometimes called "Long-Term Care" or LTC) through a nursing home, hospice, or in the community, can be eligible for Medicaid if they meet income and resource requirements. These groups are sometimes called the "300% of SSI" groups. These individuals have to meet resource-related criteria (countable resources of $2,000 or less for an individual, or $3,000 or less for a couple), and must meet the definition of being "institutionalized."

Institutionalization means receipt of 30 consecutive days of:

- care in a medical institution (such as a nursing facility), or
- Medicaid Home and Community-Based Services (HCBS), or
- a combination of the two.

Someone would meet the definition of being "institutionalized" if s/he is receiving Medicaid-covered LTSS for 30 days or more, or has signed a hospice election that has been in effect for 30 days or more, or has been screened and approved to receive Medicaid-covered LTSS in a home or community-based setting, and it is anticipated (based on an individual's Pre-Admission Screening) that s/he will receive those services for 30 or more days.

The 30-consecutive-days requirement is expected to be met if the Pre-Admission Screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care services. The 30 days begins with the day of admission to the medical institution or receipt of Medicaid HCBS.

MEDICAID WORKS

The MEDICAID WORKS program is Virginia's program **for individuals who have a disability and who are employed or want to be employed.** It allows workers with disabilities to earn higher incomes and retain more in savings than is usually allowed by Medicaid. To participate, workers must apply directly through their local Department of Social Services (DSS), and establish a special bank account called a Work Incentive (WIN) account, where their earnings are deposited.

MEDICARE SAVINGS PROGRAMS

What are the Medicare Savings Programs (MSPs)?

Some of the ABD covered groups provide **only payment** for someone's costs under **Medicare**, rather than full benefits. These are known as the **Medicare Savings Programs (MSPs)**, because they work in tandem with Medicare to provide health insurance to dually-enrolled individuals or couples.

Medicare is a Federal health insurance program covering Americans who:

- Are 65+ years old and eligible for either Social Security Retirement or Railroad Retirement benefits
- Have been entitled to Social Security Disability benefits for 24 months or more
- Have End-Stage Renal Disease or Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's disease

When someone is enrolled in an MSP, Medicaid pays for all or part of his/her Medicare costs:

- **Qualified Medicare Beneficiary (QMB)** pays premiums, deductibles, coinsurance, and copayments for Medicare Part A (inpatient medical care such as hospital expenses, skilled nursing facilities, hospital and home health services) and Part B (outpatient medical care such as doctor visits, x-rays, some home health, durable medical equipment, mental health and substance abuse treatment and a variety of preventive care services). Medicare is always charged first. Medicaid functions as the "Payer of Last Resort" to cover premiums, and/or deductibles, copays, and coinsurance costs (sometimes called "cost-sharing") for a Medicare enrollee.
- **Special Low-Income Medicare Beneficiary (SLMB)** pays premiums for Medicare Part B (outpatient medical care such as doctor visits, x-rays, some home health, durable medical equipment, mental health and substance abuse treatment and a variety of preventive care services).
- **Qualified Individual (QI)** also pays premiums for Medicare Part B. It has a higher income limit than SLMB.
- **Qualified Disabled and Working Individual (QDWI)** is unique: it is for individuals who have a qualifying disability who have lost free Medicare Part A coverage (after having returned to work for 48 months), and must now re-enroll in Part A and pay a premium to do so. QDWI pays for the Medicare Part A premium.

MEDICAID "SPENDDOWN" – MEDICALLY NEEDY

When an individual/family meets all non-financial requirements, and resource eligibility requirements, **but has more countable income than the allowed limit for their Medicaid covered group**, they may be **eligible for Medicaid as "Medically Needy," through a spenddown.** A spenddown is similar to an insurance policy deductible: incurring medical expenses above the spenddown amount makes a person eligible (temporarily) for full-benefit Medicaid.

The individual's spenddown amount depends on his/her income, and locality of residence. When an individual is determined eligible to potentially receive

Medicaid through a spenddown, s/he would have a particular "**spenddown liability**," which is the amount of bills s/he must incur to be eligible under a spenddown. A person's spenddown liability should be included on the *Notice of Action* s/he receives from the local DSS after applying, if s/he is ineligible for full-benefit Medicaid (including if only eligible for a Medicare Savings Program).

The **spenddown period is limited in duration**: one month for an institutionalized person (including someone in hospice or receiving Community-Based Care), and six months for someone who is not institutionalized. After that period, the person's eligibility will be re-assessed.