

Plan First: Provider Frequently Asked Questions

Eligibility and Enrollment



Application for Medical Assistance

Q: How do individuals apply for Plan First?

A: Virginia has one streamlined application for Medical Assistance. Applicants are initially evaluated for a full Medicaid coverage by the local department of social services (LDSS) eligibility worker. If the worker determines the applicant is not eligible for a full coverage based on the applicant's countable income, the worker will evaluate the individual for Plan First eligibility if the applicant is at least age 19 years but under age 65 years and has not opted out. For applicants under age 19 or 65 years or older, the applicant/parent/legal guardian must request a Plan First evaluation. Whether or not the applicant opts out of Plan First evaluation, the worker will send a referral for the applicant to the Federal Health Insurance Marketplace for full benefit health insurance coverage options.

Q: I think a Plan First member should be enrolled in full benefit Medicaid. What is required to evaluate them for Medicaid?

A: The member should report any changes to the information they provided on the Medical Assistance application within 10 days to their LDSS eligibility worker. Their eligibility will be reevaluated based on the updated information. Members also have their eligibility reevaluated annually for continued eligibility.

Q: If a patient doesn't put dates of service during the last 3 months on the application, can services provided in the retroactive period be covered?

A: Yes. For the eligibility period to be corrected, the member would need to notify the LDSS eligibility worker that she/he had a Plan First covered service in prior 3 months and provide income information for the month they had the service.

Q: How long does it take for my application to be processed?

A: LDSS has 45 calendar days in which to take action on a Medical Assistance application.

Q: What is the effective date of Plan First coverage?

A: Coverage begins on the 1st of the month in which the application was received and logged by the LDSS office. For example, if the LDSS received and logged the application on April 15th, the effective date for coverage will be April 1st, pending all eligibility requirements are met.

Income and Residency

Q: Can a child younger than 18 years of age apply for Plan First without her/his parents' signature?

A: A child under age 18 years is not able to sign his or her own Medical Assistance application unless he or she is legally emancipated from parents.

Q: Does LDSS count college students' residence by where their parents live or their address at college? What about parents' income?

A: A college student living in a dorm is considered temporarily away from home. Medicaid counts the income of a parent for a child of any age who is living in the home and is claimed as

a tax dependent by that parent. If the family does not file taxes, the income of parents will be counted for an individual under age 19 considered living with the family.

Students living off-campus in their own apt/house would be considered residents of that locality, with their forms going to the LDSS. They would not be considered living with their parents (even if on the parents' health insurance).

Q: Does a patient under 21 living with parents but paying rent still need to show proof of the parents' income?

A: Yes.

Q: Can we use year-to-date (YTD) gross income from pay stub for income verification?

A: No.

- Most recent federal tax filing information (if available).
- Job and income information for members of your household for the month prior or the current month. Having recent pay stubs or W-2s to reference may be helpful.
- Information about other taxable income for members of your household such as unemployment benefits, Social Security payments, pensions, retirement income, rental income, alimony received, etc.

Q: If the person has no form of income (i.e., unemployed), what documentation is needed for the application?

A: Proof of income is not required during application process if \$0 income is reported on application. Signing the application signifies that the information provided is true. Any available data from income verification systems will be evaluated during the eligibility determination

Q: If someone was just laid off (and living alone) and now without income or insurance, how should he/she document income on the Medical Assistance application, given that he/she had income the previous month?

A: He/she should report their previous month's income but then state they are currently unemployed.

Q: Is there a required length of residency for a person to be eligible for Plan First?

A: No. The day the applicant comes to Virginia with the intent to stay meets the residency requirement. There is no fixed address requirement for the applicant (e.g. being homeless) as long as the eligibility worker has an address to send mail to the applicant (this is worked out at local level).

Identification Card and Materials

Q: Will individuals enrolled in Plan First receive a Plan First card?

A: Effective March 1, 2016, newly enrolled Plan First members will receive a green and white Plan First identification card in the mail to use for Plan First services. If an individual was previously enrolled in a Medicaid or FAMIS program, other than Plan First, the Commonwealth of Virginia (blue and white plastic) ID card will no longer be valid. Replacement Plan First ID cards can be requested by contacting the LDSS eligibility worker.



Q: Where can I order Plan First brochures and posters?

A: Yes, materials may be ordered at no cost through Cover Virginia at:
https://www.coverva.org/partners_materials.cfm##

Renewal

Q: When does an individual renew his/her Plan First coverage?

A: Coverage under Plan First is effective for 12 months. In many cases, the worker is able to renew the coverage using available income data and will notify the member that Plan First coverage has been renewed. If coverage cannot be renewed using available income data, the member will receive a renewal form from the LDSS. This form will need to be reviewed for any changes, signed and returned along with any requested verification within 30 days. Members may also renew online at <https://commonhelp.virginia.gov/access/>.

Q: What should we do if the person's Plan First coverage has lapsed?

A: Refer the individual to his or her eligibility worker at their LDSS to request coverage. If the individual's coverage was cancelled because he or she did not return a renewal form, the form may be sent in for up to three months after the cancellation. The LDSS worker will notify the member if she/he needs to complete a new application. LDSS sends a "Notice of Action" at least 10 days before a termination of coverage, so you should also remind the member to be on the lookout for mail from the LDSS.

Postpartum Women

Q: How can postpartum women who was not previously on Medicaid, FAMIS or FAMIS MOMS apply for Plan First?

A: If the postpartum patient is not enrolled in Medicaid, FAMIS or FAMIS MOMS, she should complete an application for Medical Assistance in one of four ways:

1. Call Cover Virginia at **1-855-242-8282** to apply on the phone Mon - Fri: 8:00 am to 7:00 pm and Sat: 9:00 am to 12:00 pm or
2. Apply online at www.commonhelp.virginia.gov or
3. Print out and complete a [paper application](#) (Spanish version available [here](#)) and mail it to their local [Department of Social Services](#) (* Additional forms or applications may be required) or
4. Visit her local [Department of Social Services](#) in the city or county in which she lives.

Q: When can a postpartum woman who was already receiving Medicaid/FAMIS/FAMIS MOMS be evaluated for Plan First?

It is important for the woman to notify her worker of the birth of her baby so that the baby gets enrolled for coverage. The birth can also be reported by a hospital worker, family member, etc.

Before the end of the woman's postpartum period (the end of the month following the 60th postpartum day), the LDSS will review her case and notify her if she qualifies for continuing full coverage or for Plan First coverage. She may have to provide updated income information. If she qualifies for Plan First, she will receive a letter from her local DSS that will notify her of her enrollment.

Other Eligibility Questions

Q: Is there an upper age limit on people applying to Plan First?

A: The Centers for Medicare and Medicaid Services (CMS) will not allow states to exclude individuals based on age, sex, fertility status, etc. Plan First cannot exclude an eligible individual from enrolling; however, if he/she no longer needs or wants pregnancy prevention services, then any visits or services will not be covered by Plan First.

Q: If a patient previously had a tubal ligation, is she eligible for Plan First?

A: The Centers for Medicare and Medicaid Services (CMS) will not allow states to exclude individuals based on age, sex, fertility status, etc. Plan First cannot exclude an eligible individual from enrolling; however, if he/she no longer needs or wants pregnancy prevention services, then any visits or services will not be covered by Plan First. Plan First can cover back up contraception for members who have had a sterilization procedure until the sterilization has been determined to be successful. Once the sterilization has been determined successful, the member would no longer require birth control/pregnancy prevention services, thus would not have a service covered through Plan First.

Q: What if a Plan First member's tubal ligation has failed and she gets pregnant – can she sign up for Plan First again after she delivers?

A: If she does get pregnant after a tubal, she should tell her LDSS eligibility worker so that she gets evaluated for full-benefit Medicaid/FAMIS MOMS for prenatal care. Once pregnancy ends, and if not eligible for ongoing full benefit coverage, she will be evaluated for Plan First again unless she notifies her working she does not want to be evaluated for Plan First.

Q: Please explain a scenario where a 56 year old woman status post hysterectomy who is currently enrolled in Plan First, would qualify for a routine /preventative annual GYN exam and/or PAP Smear.

A: This member would not have any services covered by Plan First because she is no longer in need of family planning, thus the provider could not use the required ICD “Encounter for Contraception Management” diagnosis required to reimburse a claim through Plan First.

Q: We have had some patients want to dis-enroll from Plan First because they were told their coverage makes them ineligible for Every Woman's Life (breast and cervical cancer early detection) program. Is that right?

A: No, that is not correct. Women on Plan First **are** eligible for Every Woman's Life, assuming they meet all other criteria. Plan First does not cover treatment of breast or cervical cancer, so it does not impact an individual's potential eligibility for Every Woman's Life.

For complete information about Plan First covered eligibility and enrollment, go to www.PlanFirst.org