



Your 2016 Guide to Medicaid

A program administered by the West Virginia
Department of Health and Human Resources

Introduction

Authorized under Title XIX of the Social Security Act, Medicaid is an entitlement program financed by the state and federal governments and administered by the state. The Bureau for Medical Services (BMS) is the single state agency responsible for administering the West Virginia Medicaid Program. BMS is administered by the West Virginia Department of Health and Human Resources (DHHR).

This booklet provides you with a brief overview of the West Virginia Medicaid Program and the services available to you. The information in this book should **not** be considered Medicaid policy. It is intended as a resource to answer some of the questions you may have. If you have questions that are not answered in this book, please call the phone numbers provided.

Mission Statement

The Bureau for Medical Services is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate, medically necessary, and quality health care services for all members; provide these services in a user friendly manner to providers and members alike; and focus on the future by providing preventive care programs.

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Who is Eligible for Medicaid

Medicaid provides health insurance to:

- Supplemental Security Income (SSI) beneficiaries;
- Pregnant women;
- Children under age 19;
- Very low income families;
- People who are aged/blind/disabled;
- Medically needy (some examples of those who may be medically needy are described on the next page); and
- Adults ages 19 to 64.

Medicaid eligibility is determined based on income and other factors, depending on your eligibility category. Eligibility is determined by West Virginia Department of Health and Human Resources (DHHR) workers in county offices.

SSI Income beneficiaries are automatically eligible for Medicaid coverage and do not have to apply for benefits at the local DHHR office.

For pregnant women, children, and adults ages 19 to 64, eligibility is dependent on their Modified Adjusted Gross Income (MAGI) and household size.

Income not counted when determining MAGI includes:

- Scholarships, grants and awards for educational purposes;
- Child support income;
- Worker's compensation benefits;
- Veterans benefits; and
- Certain American Indian and Alaska Native income.

Household size is based on who is claimed as a dependent on your federal tax return. This may include:

- You;
- Your spouse;
- Your dependent children (biological, adopted, or stepchildren); and
- Other relatives and even non-relatives who qualify as dependents.

The chart below provides general guidance for 2016 on whether you and/or your family may qualify for Medicaid based on MAGI. Check with your county DHHR office to determine if you meet the income guidelines.

Family Size	Adults ages 19 to 64 and/or Children age 6 to 19 Yearly income up to:	Pregnant Women and/or Children Under age 1 Yearly income up to	Children ages 1 to 6 Yearly income up to:
1	\$16,242	\$17,820	\$16,752
2	\$21,983	\$24,036	\$22,596
3	\$27,724	\$30,240	\$28,428
4	\$33,465	\$36,456	\$34,272

Medically Needy and Other Special Eligibility Groups

Women diagnosed with breast or cervical cancer by a Centers for Disease Control (CDC) program under the age of 65 and do not have other health insurance may qualify for Medicaid coverage when certain other non-financial requirements are met.

Some **Medicare recipients** may be eligible to receive assistance from Medicaid in paying the Medicare Part A and/or B premium and/or Medicare co-payments and deductibles.

Medicaid Work Incentive (M-WIN) is for individuals between ages 16 and 65 who have a disability and are working. Individuals must meet financial and asset levels. In addition, the individual must pay a \$50 enrollment fee and a monthly premium based on income.

Medicaid Coverage for Long-Term Care

Medicaid long-term care includes:

- Nursing home care;
- Intermediate care facilities for individuals with intellectual disabilities;
- Aged and Disabled Waiver Services;
- Intellectual/Developmental Disabilities Waiver Services; and

- Traumatic Brain Injury Waiver Services.

In order to qualify for any of these services, a person must meet financial and asset limits as well as certain medical criteria.

Some individuals and families who are ineligible for Medicaid at the time of application because of income higher than the maximum allowed level, may become eligible under “spenddown.” The local DHHR worker will explain this process if it is



Applying for Medicaid

If you receive Supplemental Security Income (SSI), you are automatically eligible for Medicaid and will receive a medical card on or about the first day of the month you become eligible for SSI.

If you do not receive SSI, you must apply for Medicaid benefits:

- Online at the Health Insurance Marketplace at www.HealthCare.gov;
- Contact the Federal Call Center at 1-800-318-2596;
- Online at www.wvinRoads.org; or
- In person or via mail to your county DHHR office, which is open Monday through Friday from 8:30 a.m. to 5:00 p.m., except on state holidays. For your convenience, you may call for an appointment. A list of offices can be

found at www.dhhr.wv.gov/bcf/; you can also call the DHHR Change Center at 1-877-716-1212.

Many local hospitals and primary care clinics have staff available to assist you in filling out an application.

If, because of a physical disability, you are unable to go to the local office, you may request a staff person to visit your home and take the application. To request a home visit, call your local DHHR office or the Office of Client Services toll free at 1-800-642-8589.

Once you have applied for Medicaid you will receive notification informing you if you are eligible or if the local DHHR office needs more information from you.

Required Information & Documentation

When applying for Medicaid, you must attest to being a West Virginia resident, a United States citizen or a legal alien. Non-U.S. citizens will be asked for an immigration document and ID number. Examples of an immigration document include:

- Permanent Resident Card, “Green Card” (I-551);
- Reentry Permit (I-327);
- Refugee Travel Document (I-571);
- Employment Authorization Card (I-766);
- Machine Readable Immigrant Visa (with temporary I-551 language);
- Arrival/Departure Record (I-94/I-94A);
- Arrival/Departure Record in Foreign Passport (I-94);
- Foreign Passport;
- Certificate of Eligibility for Nonimmigrant Student Status (I-20);
- Certificate of Eligibility for Exchange Visitor Status (DS2019);
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR); and
- Alien Number (also called alien registration number or USCIS number) or I-94 Number.

If you need assistance establishing your immigration status, contact your county DHHR office. All applicants must be given a reasonable opportunity

to provide documents to establish U.S. citizenship or immigration status, unless we can verify this information electronically.

All applicants will need to provide the following information:

- Social Security Numbers (or document numbers for any legal immigrants who need insurance);
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms or wage and tax statements);
- The number of people you will claim as a dependent on your tax return, or if you will be claimed as a dependent by someone else on their tax return;
- Policy numbers for any current health insurance; and
- Information about any job-related health insurance available to your family.

The information you provide will be used to determine if you qualify for Medicaid and the coverage type. DHHR will also check your answers using information already in its databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn’t match, you may be asked to provide proof that your answers are correct.

All information you provide to DHHR will be kept confidential and secure, as required by law.

Your Medicaid Card

If you qualify for Medicaid, you will receive a medical card in the mail once a year. If you lose or displace the card, you can get a replacement card by:

- Calling your case worker at the local DHHR office;
- Calling the DHHR Customer Service Center at 1-877-716-1212; or
- Printing a Letter of Creditable Coverage.

The Letter of Creditable Coverage is valid only for the day on which it is printed. To print the letter go to www.wvmmis.com and click on Member at the top of the page. Enter your name (or the name of the person whose card is needed that day), date of birth and the last four digits of the Social Security Number.

It is important to keep your appointments with the local DHHR office so your Medicaid eligibility will

continue uninterrupted.

If you are a member of Mountain Health Trust, the BMS managed care program, you will also receive an insurance card from them.

When you visit a medical provider, you need to present your Medicaid card along with any other private or public medical insurance cards you have, such as your Medicaid managed care card, your red, white and blue Medicare card or your private

insurance card.

Be sure to carry your most recent card with you at all times and present it to the medical provider each time you need medical care.

If you lose your managed care card, please contact your Managed Care Organization (MCO).

Remember: It is against the law to let anyone else use your card.

Example of a Medicaid Card

UNAUTHORIZED USE IS A FRAUDULENT PRACTICE		WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES MEDICAL I.D. CARD				SEE NOTICE ON BACK KEEP THIS CARD	
SMITH, JENNIFER 1012 KANAWHA BLVD CHARLESTON, WV 25312		CASE NO. 3333333333	FS CK	FROM TO	VALID ONLY		
MA ID NO.	PLAN	CLIENT NAME	BIRTH DATE	PAAS/LOCKIN/HMO PROV	PROVIDER PHONE	TPC PROVIDER	POLICY NO.
0022222222		SMITH, JENNIFER	09/12/1997				
0033333333		SMITH, CALVIN	03/17/1999				
Provider: Login to provider portal at www.wvmmis.com or call AVRS 888-483-0793 to verify HMO and Benefits Package.							

Other Medical Insurance

You may have other health insurance and still be eligible for Medicaid. Your private insurance (employer, Medicaid, etc.) will be the primary payer and will pay your health care provider first. Medicaid will be your secondary insurance and will pay what your private insurance does not pay (up to the limit of what Medicaid pays). You cannot be billed for deductibles or co-payments if your provider accepts your other insurance and your Medicaid card.

If you receive money from an insurance company or as a result of a lawsuit which is for medical care, you must use it to pay the provider. If Medicaid has already paid for your care, a refund must be made to Medicaid.

If you have access to health insurance through your employer, you may be eligible for the Health Insurance Premium Payment (HIPP) Program. This program may pay your insurance premium for you as long as you or a family member is eligible for Medicaid.



Medically Frail

If an individual in your household qualifies for the adult coverage group and has a physical, mental or an emotional health condition that limits daily activities or forces the individual to reside in a nursing facility, the affected individual has a choice of benefit packages. You may choose between the

alternative benefit package provided to adults enrolled in Medicaid and the traditional Medicaid plan that includes expanded services.

If you meet the definition of medically frail at anytime, you may report this to your county DHHR office or by calling 1-877-716-1212.

Medical Services Covered by Medicaid

<u>Benefit Provided</u>	<u>Traditional Medicaid Plan</u>		<u>West Virginia Health Bridge Alternative Benefit Plan (ABP) (Expansion Plan)</u>	
	<u>Covered</u>	<u>Service Limits</u>	<u>Covered</u>	<u>Service Limits</u>
Primary Care Office Visits	X		X	
Specialty Care	X		X	
Podiatry	X		X	
Chiropractic	X		X	<i>Limit of 24 treatments per year. An additional 6 treatments per year can be authorized if OT and PT services have not been utilized in combination with this service.</i>
Diagnostic X-Ray	X		X	
Outpatient Hospital Services	X		X	
Hospice	X		X	
Nursing Home	X		Not Covered	
Emergency Room Outpatient Hospital Services	X		X	
Emergency Transportation/ Ambulance	X		X	
Inpatient Hospital Care	X		X	
Hospital Inpatient/ Maternity	X		X	
Outpatient/Maternity	X		X	
Outpatient Psychiatric Treatment	X		X	
Rehabilitative Psychiatric Treatment	X		X	
Inpatient Psychiatric Hospital	X		X	
Prescription Drugs	X		X	

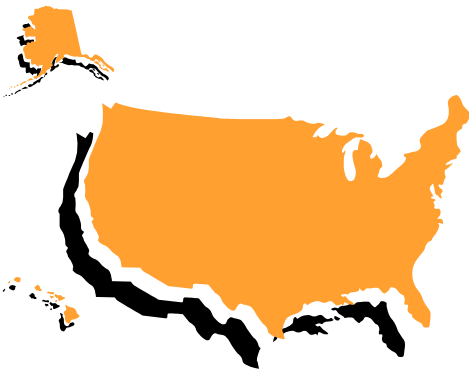
<u>Benefit Provided</u>	<u>Traditional Medicaid Plan</u>		<u>West Virginia Health Bridge Alternative Benefit Plan (ABP) (Expansion Plan)</u>	
	<u>Covered</u>	<u>Service Limits</u>	<u>Covered</u>	<u>Service Limits</u>
Physical Therapy	X	20 visits per year (combined PT and OT, additional authorization required over limit)	X	30 visits per year for Habilitative and Rehabilitative services (combined PT and OT)
Occupational Therapy	X	20 visits per year (combined PT and OT, additional authorization required over limit)	X	30 visits per year for Habilitative and Rehabilitative services (combined PT and OT)
Speech Therapy	X		X	Habilitative and Rehabilitative services
Cardiac Rehabilitation	X		X	
Pulmonary Rehabilitation	X		X	
Durable Medical Equipment	X		X	
Orthotics and Prosthetics	X		X	
Home Health	X	60 visits per year (additional authorization required over limit)	X	100 visits per year
Inpatient Rehabilitation Hospital Services	X		X	
Laboratory Services and Testing	X		X	
Diabetes Education	X		X	
Early Periodic Screening, Diagnosis and Treatment	X		X	
Family Planning Services and Supplies	X		X	
Nutritional Counseling	X		X	
Tobacco Cessation	X		X	
Non-Emergency Medical Transport (NEMT)	X		X	
Personal Care Services	X		Not covered	

Out-of-State Medicaid Coverage

You must receive your Medicaid services from a West Virginia provider except in the following circumstances:

- Some medical providers practicing within 30 miles of the West Virginia border have been granted “border status.” These medical providers are considered in-state providers and do not have to obtain prior approval for services except in those instances where it is required of in-state providers;
- Emergency treatment that is received while traveling or visiting out of state; or
- Treatment received after prior approval from Medicaid.

Out-of-state services are usually not approved if they are available in West Virginia.



Denial of Payment for Services

There are certain reasons why Medicaid may deny payment of your medical bills or prescription drugs:

- Your doctor may not have asked for special permission (prior approval) for certain services paid;
- Certain services are not covered by the West Virginia Medicaid Program;
- You may have gone beyond the limits of coverage;
- You may not have been entitled to a Medicaid card on the date of services; or
- Your doctor may not have filled out the forms properly or may not have been a Medicaid provider when the service was rendered.

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is available to Medicaid members who need assistance in order to keep scheduled medical appointments and treatments.

In order to be eligible for NEMT, a person must be a Medicaid member and have an appointment for medical treatment that is approved under Medicaid guidelines.

For more information, to request gas mileage reimbursement or schedule a trip, please call the Medicaid NEMT broker, MTM, at 1-844-549-8353, Monday-Friday from 7 a.m. to 6 p.m. at least 5 business days before your appointment.

You will need to have the member's name, Medicaid ID number, home address, phone number, where the member is to be picked up, the name, phone number and address of the health care provider, the date and time of your appointment and general reason for the appointment. Also, please let the operator know if you have any special needs such as a wheelchair accessible vehicle, assistance during the trip or someone to ride with you.

Co-Payments

As of January 1, 2014, some individuals who receive Medicaid services will be expected to pay co-payments for certain services.

Exempt from the co-payment requirement are:

- Pregnant women, including pregnancy-related services up to 60 days post-partum;
- Children under age 21; and
- Native American and Alaska natives.

Services exempt from co-payment include:

- Long term care;
- Hospice;

- Medicaid Waiver;
- Breast and Cervical Cancer Treatment Program;
- Family planning; and
- Emergency services.

Co-payments are based on your level of income and may not exceed 5% of your household income. Providers may not deny services to individuals whose household income falls below 100% of the federal poverty level due to their inability to make a co-payment.

Below is an example of the out-of-pocket maximum per quarter for a household of two people at the three different tier levels:

Tier Level	Gross Quarterly Income Range for a Household of 2	Out of Pocket Maximum
1 (Up to 50.00% FPL)	\$0 to \$1,966	\$8
2 (50.01-100.00% FPL)	\$1,967 to \$3,932	\$71
3 (100.01% FPL and above)	\$3,933 and above	\$143

Below are the charts of co-payments:

<u>Service</u>	<u>Up to 50.00% FPL</u>	<u>50.01- 100.00% FPL</u>	<u>100.01% FPL and above</u>
Inpatient Hospital (Acute Care)	\$0	\$35	\$75
Office Visit (Physicians and Nurse Practitioners)	\$0	\$2	\$4
Non-Emergency use of Emergency Department	\$8	\$8	\$8
Any outpatient surgical services rendered in a physician's office, ambulatory surgical center or outpatient hospital excluding emergency rooms	\$0	\$2	\$4

Pharmacy co-payments are the same for all Medical members regardless of income, however out of pocket maximums do apply:

Total Allowed Charge	Co-payment
\$0.00-\$5.00	\$0.00
\$5.01-\$10.00	\$0.50
\$10.01-\$25.00	\$1.00
\$25.01-\$50.00	\$2.00
\$50.01 and above	\$3.00

Your Medicaid Rights and Responsibilities

Discrimination Prohibited

Medicaid benefits will be extended in full compliance with the 1964 Civil Rights Act, which prohibits discriminatory administration of benefits from federally funded programs because of sex, race, color, religion, national origin, ancestry, age, political affiliation or physical/developmental/mental challenges.

Medicaid does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services or activities. If you have questions or complaints or if you want to talk about whether you have a disability according to the Americans with Disabilities Act (ADA), you may contact the State ADA Coordinator at: WV Department of Administration, Building 1, Room E-119, 1900 Kanawha Blvd., East, Charleston, WV 25305, or call (304) 558-4331, extension 57004.

Confidentiality

Any information obtained from you or concerning you, including your Social Security Number (SSN), shall be kept confidential. No information regarding applicants or members shall be disclosed, without consent, for any purpose other than those directly concerned with administrative requirements.

Right to Appeal

You have the right to appeal if you are not satisfied with the decision regarding your application and/or it is not handled within a reasonable period of time; if you were not allowed to file an application; or if you think you were treated unfairly in any way. Requests for appeals should be directed to your local DHHR office.

If you have received notice of a reduction, suspension or termination of a Medicaid covered service, you have a right to appeal that denial or termination through the fair hearing process. The notice that you receive will include an explanation of your appeal rights and a form that you may use to request a fair hearing. You may represent yourself or use legal counsel, a relative, friend or other spokesperson.

If you appeal prior to the date of termination of a covered service, you may continue the service until

a decision is made regarding your appeal. However, if the state's action is upheld, the agency may start recovery actions to recoup the cost of the services furnished.

Services

You have the right to choose and/or make decisions about health care for you and your children. You may receive medical assistance for your child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Upon request, you may receive information regarding:

- Family planning services; and
- Domestic violence services.

If your income is above the Medicaid limits, you may still be eligible to receive a medical card if you have excess medial bills. Ask your DHHR worker if you qualify.

You may be qualified to apply for low-priced telephone services called America and Tel-Assistance/Lifeline that the telephone company in your area offers. With your permission, DHHR may release information to the telephone company concerning your eligibility for this service. If your eligibility for Medicaid is stopped, DHHR will notify the telephone company.

Right to Information

You have the right to see your medical records and ask questions about health care.

You have the right to be treated fairly and with respect.

You have the right to know the laws and rules of the Medicaid Program and to ask questions about your plan.

Cooperating with Other Entities

You may be required to cooperate with the Bureau for Child Support Enforcement (BCSE) in child support activities, including obtaining medical support. If you think cooperating to collect medical support will harm you or your child(ren), tell your DHHR worker.

You must cooperate with the Quality Control Reviewer in any review of your benefits. This may require a home visit by the reviewer and include additional verification of your situation. You do not have to permit the reviewer to enter your home.

Changes Affecting Eligibility

You must notify DHHR of the following within 10 days if:

- Your address, name or telephone number changes;
- Your housing costs change;
- Anyone in your household obtains/loses employment or there are changes in your household income;
- There are changes in your household's amount or source of unearned income;
- Anyone moves into/out of your household;
- Any individual in your home starts, finishes or drops out of school or job training;
- There are changes in your household assets, including receiving, selling, purchasing, or losing a vehicle, including recreational vehicles and equipment;
- Anyone in your household receives a lump sum payment; and/or
- You are involved in an accident which results in

a settlement either in or out of court.

Repayment of Benefits

Certain federal and state laws require Medicaid members to make repayments for benefits received if:

- Unintentional errors were made by you or by DHHR which resulted in your receiving benefits for which you were ineligible; and/or
- You or any person in your household receiving Medicaid receive payment from an insurance company, with or without a court order, for medical and/or hospital bills for which Medicaid has or will make payment. This includes insurance settlements resulting from an accident

You must cooperate with DHHR and any provider of medical services in pursuing any resources available to meet the medical expenses resulting from an injury or an accident.

Fraud

Any person who obtains or attempts to obtain benefits from Medicaid by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device, can be charged with fraud. Punishment upon a conviction may be a fine up to \$5,000 and/or a jail sentence of 5 years in a state correctional facility.

Medicaid members receiving long-term care services have these additional rights and responsibilities:

A period of ineligibility for Medicaid long-term care may result if resources, including certain trusts, were transferred within the 60-month period prior to the date of application.

You must disclose to the state any interest you or your spouse have in an annuity. The state must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided.

After June 9, 1995, any Medicaid funds paid on behalf of individuals age 55 or older for long-term care services and related hospital and prescription drug services must be recovered. For more information regarding Estate Recovery call

(304) 342-1604.

If you are in a nursing home, you must notify your county DHHR office within 10 days if:

- You are discharged from a nursing or intermediate care facility to go to another facility or return home;
- There are changes in your gross unearned or earned income or the income of your spouse and any dependent children who live with your spouse; and/or
- There are changes in your assets or those of your spouse, including receiving, selling, purchasing or giving away assets.

Mountain Health Trust - Managed Care

Mountain Health Trust is the West Virginia Medicaid Managed Care Program. A Managed Care Organization (MCO) is a health care company which contracts with various health care providers to provide members with quality and cost-effective health care.

Individuals who are required to sign up with an MCO will receive a packet in the mail explaining their choices. If you receive such a packet you must choose one of four Managed Care Organizations (MCOs). If you do not choose an MCO, one will be chosen for you. The MCO you choose will ask you to pick a primary care provider (PCP) who will handle most of your medical needs.

The MCOs for West Virginia are:

- Coventry Cares of WV;
- The Health Plan of the Upper Ohio Valley;
- UniCare; and
- WV Family Health Plan.

If you need a specialist or hospital care, your PCP will set that up for you.

Currently, the only services not covered by the MCOs are personal care services and non-

emergency medical transportation. If you require one or more of these services contact your MCO.

When you are enrolled in an MCO, you will receive a medical card from the MCO as well as a medical card from DHHR. **You must take both cards to all of your appointments.**

Mountain Health Trust members in Cabell and Wayne counties may choose to enroll in the Physician Assured Access System (PAAS). This program is designed to enhance access to medical care and to coordinate your health care needs and services. You will be asked to choose a Primary Care Provider (PCP) from among a group of doctors.

Your PCP must give you a referral before you may see a specialist.

Doctors in the PAAS Program have agreed to provide access to 24-hour care. If you have a true emergency, go to the nearest emergency care center. You do not need approval from your PCP for an emergency.

If you have questions, want to change your PCP or MCO, or have a complaint, call 1-800-449-8466 or visit your PCP or MCO website.

****The PAAS Program will end as of June 30, 2016.***



Medicaid Managed Care Consumer Rights

If you have Medicaid and you belong to an MCO or PAAS, you have the right to request the following at least once a year by calling 1-800-449-8466:

- A directory of all current contracted providers including:
 - Names/addresses/telephone numbers;
 - Languages other than English;
 - Closed or open practice; and
 - Primary care/specialist/hospital.
- Instructions on how to use the directory:
 - Your choice of provider;
 - Referral process for specialty care; and
 - Explanation of network.
- Information on grievance and fair hearing procedures and the time frame.
- Services which continue to be accessed under fee-for-service including:
 - Some family-planning services;
 - Non-emergency medical transportation; and
 - Long-term care/nursing homes.
- Information on:
 - How to obtain benefits;
 - Non-covered services;
 - After-hours access;
 - Advanced Directives or a “living will” that allows someone else to make medical decisions for you if you are unable to make your own decision; and
 - How doctors are paid.
- A copy of your rights and responsibilities:
 - You also have the right to go to the nearest emergency room or call 911 in cases of emergency. Prior authorization is not required for emergencies.

Important Telephone Numbers

To find your local DHHR Office.....1-877-716-1212

DHHR Office of Client Services.....1-800-642-8589

Medically Frail Form.....1-888-483-0797

Questions regarding payments to medical provider
Molina Medicaid Solutions.....1-888-483-0797

Questions regarding your Managed Care coverage,
change your primary care provider, etc.....1-800-449-8466

Medical Emergency.....911

Your Local DHHR Office..... _____

Your Doctor..... _____

Your Dentist..... _____

Your Child(ren)'s Doctor _____