Your Guide to Medicaid 2021

A program administered by the West Virginia Department of Health and Human Resources, Bureau for Medical Services

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Mountain HEALTH TRUST

WV HEALTH BRIDGE
MY HEALTHCARE CONNECTION

Effective March 1, 2021

Introduction

Authorized under Title XIX of the Social Security Act, Medicaid is an entitlement program financed by 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, and/or disabled;
- Individuals determined "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 2020 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	**Children Ages 0 to 1**	**Children Ages 1 to 6**	**Children Ages 6 to 19**	**Pregnant Women and their Newborns**	**Adults Ages 19 to 65**
	Yearly Income up to 163% FPL	Yearly Income up to 146% FPL	Yearly Income up to 138% FPL	Yearly Income up to 190% FPL	Yearly Income up to 138% FPL
1	$20,995	$18,805	$17,775	*Minimum family size of 2, including unborn baby(ies)	$17,775
2	$28,395	$25,434	$24,040	$33,098	$24,040
3	$35,795	$32,062	$30,305	$41,724	$30,305
4	$43,195	$38,690	$36,570	$50,350	$36,570

Medically Needy and Other Special Eligibility Groups

Women diagnosed with breast or cervical cancer by a Centers for Disease Control and Prevention (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 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.

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.

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 applicable to the individual.

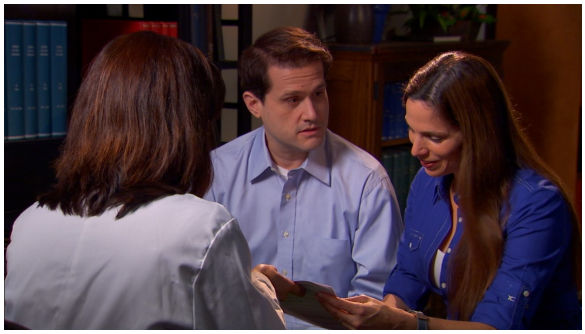
Applying for Medicaid

If you receive Supplemental Security Income (SSI), you are automatically eligible for Medicaid and will receive a medical ID 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.wvpath.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/; or 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 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 and Documentation

When applying for Medicaid, you must attest to being a West Virginia resident and 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 1-94 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 does not match, you may be asked to provide proof that your answers are correct.

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

Your Medical ID Card

If you qualify for Medicaid, your medical ID card will be included with your approval notice. If you lose or misplace the card, you can get a replacement card by:

- Logging in to your WVPATH account at www.wvpath.org and reprinting the approval notice.
- Calling the DHHR Customer Service Center at 1-877-716-1212; or
- Calling your case worker at the local DHHR office;
- 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 WV Medicaid managed care program, you will also

receive an insurance card from them.

When you visit a medical provider, you need to present your medical ID 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 medical ID 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 Medical ID Card

UNAUTHORIZED USE IS A FRAUDULENT PRACTICE AND WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW

West Virginia Medical ID Card

MA ID	Member Name	Birth Date
00609193385	DWYXZDSE RBESRDAW	01/05/2012
00609193384	JHSUYWSI OVDNAFZS	12/05/2010
00609193382	UICEFRPH LKYKPJUI	06/27/1992
00609193383	ICODCULS BHPZFECU	10/04/1978

This card does not guarantee coverage. Verify coverage at www.wvmmis.com or 888-483-0793. Prior Authorization may be required for certain services.

For more information about Medicaid services, co-payments for certain services, Non-Emergency Medical Transportation (NEMT) for scheduled medical appointments and treatments, and more see *'Your Guide to Medicaid'* at www.dhhr.wv.gov/bms.

If you have questions about your Medicaid eligibility, call Client Services at 800-642-8589 or 304-558-2400; hearing impaired 304-558-3515.

If you have questions about Managed Care Organizations (MCO), call 800-449-8466. If you are enrolled in Managed Care, you will also receive an MCO card that must be taken to your healthcare provider. Questions about services or billing should be directed to the MCO you are enrolled in.

If you are not in Managed Care and have questions about services or billing, call Member Services at 888-483-0797.

For more information about NEMT, please contact the broker at 844-549-8353.

Other Medical Insurance

You may have other health insurance and still be eligible for Medicaid. Your private insurance (employer, Medicare, 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 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 expansion 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 to 1-877-716-1212.

Medical Services Covered by Medicaid

Benefit Provided	Traditional Medicaid Plan		West Virginia Health Bridge Alternative Benefit Plan (ABP) (Expansion Plan)	
	Covered	Service Limits	Covered	Service Limits
Primary Care Office Visits	X		X	
Specialty Care	X		X	
Podiatry	X		X	
Chiropractic	X		X	*Limit of 24 treatments per year. An additional 6 treatments per calendar year can be prior authorized if OT and PT services have not been utilized in combination with this service.*
Diagnostic X-Ray	X		X	
Outpatient Hospital Services	X		X	
Hospice	X		X	
Nursing Home			*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	

Benefit Provided	Traditional Medicaid Plan		West Virginia Health Bridge Alternative Benefit Plan (ABP) (Expansion Plan)	
	Covered	Service Limits	Covered	Service Limits
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.*	

Dental Services

Medicaid members under 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontics, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Dental periodic screenings are based on the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Covered dental services for enrolled adults 21 years of age and older are divided into two levels of service: 1) emergent procedures to treat fractures, reduce pain, or eliminate infection and 2) diagnostic, preventative, and restorative services. Prior authorization may be required for specific emergent services and when service limits are exceeded

Beginning January 1, 2021, services classified as diagnostic, preventative, and restorative in nature will require authorization prior to services being rendered and have a coverage limit of $1,000 per member per calendar year. Members are responsible for payment of service cost exceeding the $1,000 yearly limit. Remaining balances at the end of the year CANNOT be carried over to the following year. Services classified as cosmetic in nature are not covered for adults over the age of 21.

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.

Effective September 1, 2018, for more information, to request gas mileage reimbursement, or schedule a trip, please call the Medicaid NEMT broker at 1-844-549-8353, Monday-Friday from 7 a.m. to 6 p.m. at least five 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:

Service	Up to 50.00% FPL	50.01-100.00% FPL	100.01% FPL and above
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

Member Liability

- If you get a bill for medical care received in the past 12 months for which you presented your medical ID card, call the provider to see why, then send that bill to:

  Member Services
  P.O. Box 2002
  Charleston, WV 25327-2002

  By Telephone: call 1-888-483-0797 or 304-348-3365
- If you have questions about Medicaid coverage, call Client Services at:
  1-800-642-8589
  304-558-2400
  Hearing impaired: 304-558-3515
- If you have questions about Managed Care call: 1-800-449-8466
- Services provided out-of-state must be preapproved by Medicaid or Managed Care for a medical emergency

Medicaid patients MUST PAY for:

- Services NOT covered by Medicaid
  - After Medicaid benefit is exhausted
  - Not medically necessary
  - Not approved by the Managed Care provider (except for medical emergency)
  - Convenience items not related to the medical care
  - Services provided when a patient is not eligible

- Services from a provider who tells a patient that he/she will not bill Medicaid before the services is provided
- Services provided when the patient refuses to use other private insurance
- Services provided when the patient does not follow the plan provisions of their primary insurance, which includes but is not limited to utilizing in-network providers and following all pre-certification guidelines
- Any Medicaid co-payments that apply to the services the patient receives

Medicaid members must not be billed, or otherwise held responsible for claims denied for provider error.
For example:

- Claims filed more than one year after date of services
- Wrongful billing or missing information

A directory of West Virginia Medicaid (fee-for-service) Enrolled Providers can be found at DXC Technology at https://www.wvmmis.com

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. A copy of the Medicaid Notice of Privacy Practices is provided at the end of this booklet.

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.

You may be qualified to apply for low-priced telephone services called 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.

Changes Affecting Eligibility

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

- Your address, name, or telephone number changes;
- 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;
- 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 five 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.

Notice of Privacy Practices

Effective date of this notice: April 14, 2003

If you have questions about this notice, please contact Client Services at 1-800-642-8589 or the Privacy Officer at the address or phone listed on page 16.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PRIVACY AND YOU

Your health information is personal and private. The West Virginia Medicaid Program must keep your health information private. Your doctors, dentists, clinics, labs, and hospitals send information to us when they ask us to approve and pay for your health care. We must give you this Notice of the law of how we keep your health information private.

CHANGES TO NOTICE OF PRIVACY PRACTICES

All Medicaid employees, staff, students, volunteers, and other personnel whose work is under direct control of Medicaid must obey the rules in this notice. We have the right to change our privacy practices. If we do make changes, we will send a new Notice right away to all people covered by Medicaid. We are required to provide this Notice of our privacy practices and legal duties regarding health information to anyone who asks for it.

HOW WE MAY USE AND SHARE YOUR INFORMATION

The Medicaid program must obey laws on how we use and share your information, such as your name, address, personal facts, the medical care you had and your medical records. Any information shared must be for a reason related to the administration of the Medicaid program. Such reasons include:

- To approve eligibility for medical and dental benefits
- To establish ways to pay for health care
- To approve, provide, and pay for Medicaid health care
- To investigate or prosecute Medicaid cases (like fraud)

WHY WE MAY USE OR SHARE YOUR HEALTH INFORMATION:

1. **For treatment:** Medicaid may need to approve care before you see a doctor, dentist, clinic, or other health care provider. We will share information with necessary providers to make sure you get the care you need. For instance, we may use your health records to identify if you need special information about a health problem like diabetes.
2. **For payment:** When Medicaid pays your health care bills, we share information with your health care provider and others who bill us for your health care. We may send some bills to other health plans or groups who pay bills. For instance, if you are taken to an emergency room, they may call to see if you are covered.
3. **For health care operations:** We may use your health records to check the quality of the health care you receive. We may also use them in audits, fraud and abuse programs, planning, and managing the Medicaid Program. For instance, your prescriptions are reviewed to ensure the medicines can be used together without harm to you.
4. **For health notices:** We may use your health records to provide you with additional information. This may include sending appointment reminders to your address, giving you information about treatment options, alternative settings for care, or other health-related services.

5. **For legal reasons:** We may give your information to a court, investigator, or lawyer in cases about Medicaid. This may be about fraud or abuse, to get back money from others who should pay your Medicaid bills, or other issues related to the Medicaid Program. If a court orders us to give out your information, we will do so.
6. **To report abuse:** We may disclose your health information when the information relates to a victim of abuse, neglect, or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.
7. **Public health activities:** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.
8. **Research:** We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your permission.
9. **For appeals:** You or your health care provider may appeal Medicaid decisions made about your health care services. Your health information may be used to decide these appeals.
10. **For eligibility:** We may share your information with federal, state, and local agencies when you apply for Medicaid to verify eligibility, and for other purposes related to the administration of the Medicaid Program.

An electronic signature has the same legal effect and can be enforced in the same way as a written signature.

WRITTEN PERMISSION

Medicaid may use or share your information in limited ways. If we want to use your health information in a way not listed above, we must get your permission in writing. If you give permission, you may withdraw it in writing at any time.

WHAT ARE MY PRIVACY RIGHTS?

You have the right to:

- Ask us to restrict how we use or disclose your health information. The request must be in writing. We may not be able to comply with your request if we have already used your authorization, if the information is needed to pay for your care, or if we are required by law to disclose it.
- Ask us to communicate with you at a special address or by a special means.
- Look at or get a copy of your Medicaid information. A personal representative who has the legal right to act for you may look at and get it for you. We have information about your Medicaid eligibility, your health care bills, and some medical records. To get a copy of your records, ask us to send you a form to fill out. We may charge a fee to copy and mail the records. We may keep you from seeing parts of your records when allowed by law.
- Ask to change information in your records if it is not correct or complete. We may refuse to change the information if Medicaid did not create or keep it, or if it is already correct and complete. You may request a review of the denial or send a letter to disagree with the denial. This letter will be kept with your Medicaid records.
- Ask us for a report of information shared about you for reasons other than treatment, payment, or Medicaid operations. You may ask for a list of those with whom we shared your information, when, why, and what information was shared. The list will start on April 14, 2003.
- Ask us to send your information somewhere. You will be asked to sign an authorization form to tell us what information to send and where it is to go. The authorization can be used for up to one year, but you may tell us a specific time. You may write to stop the authorization at any time.
- Ask for a paper copy of this Notice of Privacy Practices. You can also find this Notice on our website at: http://www.dhhr.wv.gov/bms/Members/Pages/Notice-of-Privacy-Practices.aspx.

IMPORTANT

Medicaid does not have full copies of your medical records. If you want to look at, get a copy of, or change your medical record, please contact your doctor, dentist, clinic, or health plan. If you are in a Managed Care plan, that plan may have information about bills paid for you after you joined the plan. Please contact the managed care plan to look at or get a copy of these bills.

HOW DO I ASK ABOUT MY PRIVACY RIGHTS?

If you want to use any of the privacy rights explained in this Notice, please call or write us at:

Client Services
West Virginia Department of Health and Human Resources
350 Capitol Street
Charleston, West Virginia 25301-3711
Phone: (304) 558-2400 or (800) 642-8589 or Fax: (304) 558-4501

HOW DO I COMPLAIN?

If you think your privacy rights have been violated and wish to complain, you may contact:

Privacy Officer
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3709
Phone: (304) 558-1700 or Fax: (304) 558-4397

Privacy Officer
West Virginia Department of Health and Human Resources
1 Davis Square, Suite 100 East
Charleston, West Virginia 25301
Phone: (304) 558-0684 or Fax: (304) 558-1130

Secretary of the U. S. Department of Health and Human Services
Office for Civil Rights
Attention Regional Manager
150 So. Independence Mall West, Suite 372
Philadelphia, PA 19106-3499

NO RETALIATION

Medicaid cannot take away your health care benefits or retaliate in any way if you file a complaint or use any of the privacy rights in this Notice.

QUESTIONS

If you have questions about this notice and want more information, please contact the Privacy Officer at the West Virginia Department of Health and Human Resources, Bureau for Medical Services by phone at (304) 558-1700 or by fax at (304) 558-4397.

Copies of this notice are available at local county offices of the West Virginia Department of Health and Human Resources. This notice is available by e-mail. Contact the Bureau for Medical Services at the above location. This notice is also available on the web at: http://www.dhhr.wv.gov/bms/Members/Pages/Notice-of-Privacy-Practices.aspx.

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 that 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 three 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.

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 abortion services, school-based services, transplant services, long-term care, waiver, personal care, pharmacy, and non-emergency medical transportation. If you require one or more of these services, contact your MCO for more information. As of July 1, 2017, pharmacy services are paid by the traditional Medicaid fee-for-service program.

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.**

The MCOs for West Virginia are:

- Aetna Better Health of WV (formerly Coventry Cares of WV)
  - 1-888-348-2922
  - TTY: 711
  - www.aetnabetterhealth.com/westvirginia
- The Health Plan
  - 1-888-613-8385
  - TTY: 1-800-622-3925
  - www.HealthPlan.org
- UniCare
  - 1-800-782-0095
  - TTY: 1-800-982-8771
  - http://mss.unicare.com/

aetna®

AETNA BETTER HEALTH® OF WEST VIRGINIA

The HealthPlan

UniCare®

Medicaid Managed Care Consumer Rights

If you have Medicaid and you belong to an MCO, 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 Client Services 1-800-642-8589

Medically Frail Form 1-888-483-0797

Questions regarding payments to medical provider
DXC Technology 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 ..... _____