CHAPTER 400–MEMBER ELIGIBILITY

CHANGE LOG

Replace	Title	Change Date	Effective Date
400, 420, 430, 440, 450,460, 470, 480	Various	12/02/04	01/01/05
430	Medicaid Managed Care	12/02/04	01/01/05
430.2	Mountain Health Trust (MHT), Health Maintenance Organization (HMO) Program	12/02/04	01/01/05
430.3	Enrollment Broker	12/02/04	01/01/05
440	Explanation of the Medicaid Member ID Card	12/02/04	01/01/05
450	Home and Community Based Waivers	12/02/04	01/01/05
470.2	Member Responsibilities	12/02/04	01/01/05
470.3	Member Liability	12/02/04	01/01/05

January 1, 2005

Sections 400, 420, 430, 440, 450, 460, 470, 480

Introduction: The terms beneficiary and recipient have been replaced by member throughout the entire manual.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.

Section 430

DISCLAMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Added "Mountain Health Trust Program" to heading, removed "Temporary Assistance for Needy Families" as an eligibility category for Managed Care since there are no longer TANF cash assistance recipients who automatically receive Medicaid.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 430.2

Introduction: Deleted "Mountain Health Trust (MHT)" from heading, added "Mountain Health Trust Program" at beginning of first paragraph, added "dental" to third bullet, added a bullet "Transplant services", and changed last paragraph in section.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 430.3

Introduction: Deleted "and PAAS" in the first paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 450

Introduction: Specified that the first waiver program described is the Aged and Disabled Waiver Program. For further clarification in the MR/DD section, the statement "for members who require ICF/MR level of care" was added, replaced "require" with "qualify for" in the second paragraph.

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 470.2

Introduction: Added a bullet, "Payment or required co-pays, if applicable".

Directions: Replace the page containing this section.

Change: Replace current section with the update.

Section 470.3

Introduction: Fees for missed appointments added to list for which members can not be billed.

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Directions: Replace the page containing this section.

Change: Replace current section with the update.

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CHAPTER 400—MEMBER ELIGIBILITY

TABLE OF CONTENTS

TOPIC **PAGE NO.**

400 Introduction 2
410 Coverage Groups and Categories 2
420 Dual-Eligible Members 2
430 Medicaid Managed Care—Mountain Health Trust Program 2
430.1 Physician Assure Access System (PAAS) Program 3
430.2 Health Maintenance Organization (HMO) Program 3
430.3 Enrollment Broker 4
430.4 Freedom of Choice 4
440 Explanation of the Medicaid Member ID Card 4
440.1 Individuals Without Medicaid Identification Cards 4
450 Home and Community Based Waivers 5
460 Special Programs 5
460.1 Children with Special Health Care Needs (CSHCN) 5
460.2 Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) 5
460.3 Birth to Three Services 6
460.4 Vaccines for Children 6
470 Member Rights and Responsibilities 6
470.1 Member Rights 6
470.2 Member Responsibilities 6
470.3 Member Liability 7
470.4 Member's Responsibility for Certain Charges 7
470.5 Subrogation 8
480 Member Fair Hearings and Appeals 8

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CHAPTER 400–MEMBER ELIGIBILITY

400 INTRODUCTION

Medicaid pays for medical care for individuals who may not be able to afford other health care. Services are provided based on federal guidelines relating to individual or family income, assets, and health care needs. Individuals receiving Supplemental Security Income (SSI) automatically qualify for Medicaid. The Department of Health and Human Resources (DHHR) determines Medicaid eligibility through its local administrative offices. Individuals who wish to apply for medical assistance are referred to the office located in their county of residence. “Covered periods” for eligibility are indicated on the Medicaid identification card for each specific Medicaid member.

FOR VERIFICATION OF MEMBER ELIGIBILITY AND MANAGED CARE COVERAGE, PROVIDERS MAY UTILIZE THE MEDICAID VOICE RESPONSE SYSTEM AT 1-888-483-0793.

410 COVERAGE GROUPS AND CATEGORIES

The following are the primary categories of Medicaid coverage:

- Coverage Groups for Children and Their Caretakers
- Coverage Groups for Aged, Blind or Disabled Individuals or Married Couples
- Coverage Groups for Pregnant Women
- Coverage for Children Only
- Special Medicaid Coverage.

420 DUAL-ELIGIBLE MEMBERS

Members eligible for both Medicare and Medicaid are called dual-eligible members. Medicare is the primary payer for Medicare/Medicaid members. Medicare, a federal health insurance program for the aged and disabled, covers certain hospital, Part A, and medical benefits, Part B, for eligible members. Claims for Medicare/Medicaid members are filed with the Medicare Fiscal Intermediary or carrier on the appropriate Social Security Administration (SSA) claim form prior to billing Medicaid.

Some Medicare carriers cross claims over directly to Medicaid without a paper submission. If this is being done, do NOT bill on paper unless Medicare has denied the claim. There are instances in which Medicare claims are electronically forwarded to Medicaid for payment, but are not successful, because the provider’s Medicare number is not on file with Medicaid. If this is the case, please contact Unisys Provider Services so the Medicaid provider files can be properly updated with the additional Medicare provider number(s).

430 MEDICAID MANAGED CARE – MOUNTAIN HEALTH TRUST PROGRAM

Managed care is a health system in which a network of health care providers agree to coordinate and provide health care to a population. This program is offered as an alternative to the traditional fee-for-service (FFS) Medicaid Program. Medicaid’s Health Maintenance Organization (HMO) Program focuses on preventive health care, member education and outreach, and a guaranteed cost (premium) for the contracted services regardless of use.

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WV Medicaid uses two different managed care models: the HMO model and the primary care management FFS model.

Managed care enrollment is mandatory for Medicaid members in certain eligibility categories; certain pregnant women, and children are required to enroll in managed care. The choices of managed care programs vary by geographical area. The two West Virginia (WV) Medicaid managed care programs are described below.

430.1 PHYSICIAN ASSURED ACCESS SYSTEM (PAAS) PROGRAM

PAAS is WV Medicaid's Primary Care Case Management (PCCM) Managed Care Program. The program is designed to enhance access to medical care and coordinate health care needs and services. Managing costs and ensuring quality care are both important factors of the program. The program encourages newly-eligible members to select a Primary Care Provider (PCP) that will be responsible for providing and coordinating their health care needs. Members who do not select a PCP are assigned one by the enrollment broker. By assigning PCP responsibility, the Bureau achieves desired levels of access, quality, cost savings, continuity of care, and member satisfaction. Participating providers accept the responsibility of directing all aspects of primary and preventive care. The PAAS Program allows the PCP to refer the member to another qualified provider if medically necessary.

Each provider participating in the PAAS Program is an active WV Medicaid provider with special enrollment in the PAAS Program. An enrollment broker is responsible for member enrollment. Members who do not respond to the enrollment efforts of the broker are assigned a primary care provider.

430.2 HEALTH MAINTENANCE ORGANIZATION (HMO) PROGRAM

Mountain Health Trust Program (MHT) began in 1996 as a managed care program that contracts with HMOs. The HMOs receive a monthly capitation payment from BMS for each member enrolled, based on an average projection of medical expenses for a typical member category and/or by age/sex.

HMO enrollment may be mandatory for eligible individuals, depending upon the county of residence. The Medicaid HMO Program focuses on preventive health care, member education and outreach.

MHT HMOs are responsible for providing directly, or under arrangements, the following covered services:

- Primary preventive services
- Acute care services
- Inpatient and outpatient medical/dental care services
- Emergency dental services
- Vision services
- Hearing services
- Durable medical equipment services
- Transplant services

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Some services normally covered by Medicaid are excluded from MHT. Those enrolled in managed care may obtain excluded services through the traditional FFS Medicaid Program. The following are excluded services:

- Behavioral health services
- Pharmacy services
- Nursing facility services
- Non-emergency medical transportation services
- Children's preventive and restorative dental services.

MHT is available on a county-by-county basis within WV. In counties considered urban, where two or more MCOs will be available, and enrollment will be mandatory for managed care eligibles. In rural counties where only one HMO is available, the member will be provided a choice of providers within the MCO network. To identify the program (s) available in each county in WV, please utilize the website at http://www.wvdhhr.org/bms/county_map/county_map.html.

430.3 ENROLLMENT BROKER

The Bureau contracts with an enrollment broker to manage member enrollment. The enrollment broker performs county-specific outreach education and enrollment services to assist potential managed care members in their program choices and in the selection of a Managed Care Organization (MCO) or PCP. The enrollment broker provides coordination and information related to available PCPs in the MHT Programs. Field staff in targeted counties performs managed care education and enrollment functions.

The enrollment broker may be contacted at 1-800-449-8466.

430.4 FREEDOM OF CHOICE

Members have full freedom of choice of a participating medical service provider. Members covered by an HMO must use the HMO's provider network for full coverage. Choice also may be restricted with other waiver services.

440 EXPLANATION OF THE MEDICAID MEMBER ID CARD

Eligible members receive identification cards monthly. **Payment is made only for** medically necessary covered services rendered to eligible members; therefore, it is important that the provider carefully check the Medicaid identification card each time a service is rendered. It is also recommended that the voice response system be used each time to verify eligibility and managed care coverage (1-888-483-0793). Medicaid members who are members of an HMO also have eligibility cards issued by the HMO.

Those individuals participating within the Children with Special Health Care Needs Program are assigned an 11-digit identification number by that Program. The Children with Special Health Care Needs number begins with "99", and the last two digits are "01". These individuals may or may not also have a Medicaid identification card.

440.1 INDIVIDUALS WITHOUT MEDICAID IDENTIFICATION CARDS

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Any person requesting services without a Medicaid identification card should be advised that he/she is financially liable for all services received until eligibility is verified. The member is responsible for furnishing his/her identification card to the provider. If the card is lost, eligibility may be verified through the Medicaid Voice Response System at 1-888-483-0793. Managed Care identification cards are only replaced on regularly scheduled issuance dates.

450 HOME AND COMMUNITY BASED WAIVERS

Aged and Disabled Waiver – Medicaid members who require a nursing home level of care, but who are able to access the care at home, may receive services such as case management, homemaker services, and adult day care. These services are considered an extension of Medicaid services for the aged and disabled. Current enrolled Medicaid members may seek enrollment in this waiver by completing an assessment form.

Mentally Retarded/Developmentally Disabled (MR/DD) Waiver – The MR/DD coverage group pays for health care and social needs of Medicaid members with mental retardation and developmental disabilities in the community setting rather than an ICF/MR facility or institution for members who qualify for ICF/MR level of care. Services in this program include: case management, adult companion care, comprehensive day and residential habilitation, in-home extended nursing care, respite care, and environmental adaptations or modifications to meet medical needs, such as ramp access to home.

460 SPECIAL PROGRAMS

The following programs exist within the framework of the Medicaid Program.

460.1 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

This program arranges for statewide direct care providers to deliver clinic and non-clinic services to children with special health care needs using physicians, staff nurses, social workers, and administrative support staff.

Potential members become eligible after completion and approval of a Specialty Care Intake Form (SCIF). Completion may be initiated by referral from a hospital, any health care professional, DHHR office, or any other private or public health-related entity.

Children who are eligible for this service also may be eligible for managed care coverage. If the member is a managed care member, the provider network must be used for services. Services not approved by the HMO may not be billed over the eligibility card; only those carved-out services defined previously may be billed over the eligibility card. Please follow the specific rules and regulations of the HMO when coordinating services.

460.2 EARLY & PERIODIC SCREENING, DIAGNOSIS, & TREATMENT (EPSDT)

HealthCheck is the EPSDT program for WV Medicaid. The purpose of the program is to ensure all covered children receive needed medical and dental services before health problems develop and become chronic, or irreversible damage occurs. The importance of preventive health services and early detection and treatment of diseases in children is emphasized in this program.

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HealthCheck is applicable to all Medicaid members under 21 years of age. Medicaid-eligible children receive regularly scheduled health checkups or screens by enrolled providers under contract with the DHHR or a WV Medicaid-participating HMO. Providers must make application and receive approval from DHHR to conduct and receive Medicaid reimbursement for EPSDT screens. Screening providers must follow periodicity requirements that dictate age components of the screens and minimum frequency with which the screens should take place.

460.3 BIRTH TO THREE SERVICES

This program arranges for access to early intervention therapies for infants and toddlers that have developmental delays, or present significant risks for developmental delays. The program operates from the Office of Maternal Child and Family Health (OMCFH) within the Bureau for Public Health, DHHR. OMCFH provides services for education and training of family members, caregivers, and educators to develop a team to manage and correct the developmental delays of the children. This program is for children from birth to age three. The focus of the program is on the early identification and therapeutic management of speech, physical, or occupational delays of children.

460.4 VACCINES FOR CHILDREN

This program operates in conjunction with the Department of Health, Vaccines for Children Program (VFC) to provide specific vaccines to Medicaid-eligible children. This program provides vaccines to adults on a limited basis.

The vaccines for this program are purchased by the federal government and are made available to the states by the Centers for Disease Control and Prevention (CDC) within DHHS. The West Virginia DHHR, Bureau for Public Health, operates the program. Providers are required to register as participants in the VFC program and are furnished the covered vaccines at no cost.

470 MEMBER RIGHTS AND RESPONSIBILITIES

There are certain rights and responsibilities applicable to Medicaid members. They are described below.

470.1 MEMBER RIGHTS

Members are free to choose a participating medical service provider. This applies to all members as long as they do not have a restricted Medicaid card or are not enrolled in a managed care program.

Members enrolled in Medicaid managed care are free to choose a PCP from among those participating in the plan. Referral procedures must be followed in managed care programs. The contracted enrollment broker for BMS assures neutrality and member freedom of choice.

470.2 MEMBER RESPONSIBILITIES

The responsibilities of Medicaid members include, but are not limited to, the following:

- Notify providers promptly of changes in Medicaid coverage
- Notify providers of any other insurance coverage, such as Medicare or private health insurance

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- Present a valid Medicaid identification card at each visit
- Notify providers of any change in Medicaid or other insurance coverage
- Forward money or denials received from other insurance payers to their Medicaid providers
- Inform their local DHHR office of any changes in address, income, etc.
- Payment or required co-pays, if applicable

470.3 MEMBER LIABILITY

Provider claims filed with the WV Medicaid Program are filed on an assignment basis. Therefore, a provider must accept Medicaid payment as payment in full for covered services. A claim is considered paid in full even when the actual Medicaid payment is zero dollars if the Medicaid payment has been reduced to zero due to payments from Medicare or private insurance.

Refer to Chapter 800 for information on Medicaid Cost Avoidance Requirements, including TPL/COB.

Providers are prohibited from imposing any additional charges on the member above the Medicaid allowable reimbursement amount. This does not include Medicaid co-payments if applicable.

Medicaid members must not be billed, or otherwise held responsible for:

Payments denied for provider error. For example:

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

Also:

- Billings denied because provider did not:
  - Follow procedures
  - Get approval from Medicaid or the managed care provider
  - Notify member before the service is provided that it is not covered by Medicaid
- Charges left after payments by insurance or Medicaid are made.
- Fees for missed appointments

Providers must follow the guidelines and procedures set forth by the WV Medicaid Program in relation to billing practices and the member's responsibility for charges.

470.4 MEMBER'S RESPONSIBILITY FOR CERTAIN CHARGES

Medicaid members, if given prior notice may be billed for:

1. Services received after Medicaid benefits are exhausted
2. Services not medically necessary elected by the member
3. Services not approved by the managed care provider (except for medical emergencies)

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4. Convenience items not required for medical care
5. Services rendered when the member is not eligible
6. Prior to services being rendered by a provider, the provider informs or gives notice to the member that he/she will not bill Medicaid
7. Services provided when the member refuses to use other available insurance.

It is the responsibility of the member to follow all guidelines set forth by the Medicaid Program in connection with eligibility and payment of services rendered by providers.

470.5 SUBROGATION

If medical assistance is paid, or will be paid, to a provider of medical care on behalf of a member because of any sickness, injury, disease, or disability, and another person is legally liable for such expenses, either pursuant to contract, negligence, or otherwise, the DHHR shall have a right to recover full reimbursement from any award or settlement for medical assistance from any other person, or from the member of such assistance, if he/she has been reimbursed by the other person. The DHHR shall be legally assigned the rights of the member against the person so liable, but only to the extent of the reasonable value of the medical assistance paid and attributable to the sickness, injury, disease, or disability for which the member has received damages.

480 MEMBER FAIR HEARINGS AND APPEALS

WV Medicaid members can take advantage of the WV DHHR Fair Hearings process. Requests for a Fair Hearing must be submitted in writing to:

West Virginia DHHR	or	Bureau for Medical Services
c/o MMIS Contractor		Appeals Section
P.O. Box 2002		Room 251
Charleston, WV 25327-2002		350 Capitol Street
Consumer Review Unit		Charleston, WV 25301-3706

HMO enrollees have additional avenues of appeal concerning adverse decisions made within their HMOs and should call their respective customer service centers. The enrollment broker, who can be reached at 1-800-449-8466, also documents telephone calls involving complaints and appeals that concern managed care issues. The enrollment broker will forward them to the appropriate entity for evaluation.

Refer to Chapter 800 for details regarding Member Appeals.

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