



CHAPTER 400 MEMBER ELIGIBILITY

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BACKGROUND

West Virginia Medicaid is public health insurance for all West Virginians that qualify. It is funded jointly by a federal-state partnership and is administered by the West Virginia Department of Human Services (DoHS) Bureau for Medical Services (BMS). Medicaid pays for medical care for individuals who meet federal guidelines relating to individual or family income, assets, and health care needs.

The Affordable Care Act provides a new simplified method for calculating income eligibility for most Medicaid members. This new method calculates eligibility for most programs based on what is called Modified Adjusted Gross Income (MAGI). The use of MAGI standardizes income eligibility rules across all medical assistance and insurance affordability programs. Different standards are used for the elderly and disabled. Individuals receiving Supplemental Security Income (SSI) automatically qualify for Medicaid.

POLICY

The West Virginia DoHS determines Medicaid eligibility through its local administrative offices. Individuals who wish to apply for medical assistance should be referred to the office located in their county of residence, or they may apply online at www.wvpath.wv.gov. Please refer to the [*West Virginia Income Maintenance Manual for Eligibility Policy*](#).

400.1 GENERAL INFORMATION

All Medicaid members have the same general rights regardless of how their eligibility is determined.

400.1.1 Coverage Groups and Categories

The following are the primary categories of Medicaid coverage:

- Coverage Groups for Children and, if applicable, their Caretakers
- Coverage Groups for Aged, Blind, or Disabled Individuals
- Coverage Groups for Pregnant Women
- Special Medicaid Coverage (e.g. breast and cervical cancer)
- Coverage for Adults (expansion population)

400.1.2 Non-Citizen Emergency Services

Illegal or ineligible non-citizens who meet the residence and other Medicaid policy eligibility criteria are eligible for Medicaid only for treatment of emergency medical conditions. For further information refer to [*Chapter 15, West Virginia Income Maintenance Manual for Eligibility Policy*](#).

400.1.3 Dual-Eligible Members

Dual-eligible members are those members who are eligible for Medicare Part A and/or Part B and Medicaid. Medicare is a federal health insurance program for the aged and disabled. It covers certain hospital services (Part A), and medical benefits (Part B), for eligible members. Medicare is the primary payer for covered hospital and medical benefits. When submitting a claim for a dual-eligible member, it

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must be filed and adjudicated by the Medicare fiscal intermediary or approved carrier prior to submitting it for processing to the Medicaid fiscal agent.

400.1.4 Freedom of Choice

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. Medicaid members are strongly encouraged to seek services from a West Virginia enrolled provider, however, if a member wants to see a provider who is not enrolled with Medicaid and they are willing to pay for services out-of-pocket, they can choose to do so. Providers are encouraged to have the member sign an advanced notice of responsibility on the day that the service is delivered.

Members enrolled in Medicaid managed care must choose a primary care provider (PCP) from among those in-network providers participating in their Medicaid managed care organization (MCO) provider panel. If no PCP is selected or the selected PCP's panel is closed, the MCO will work with the member to select another PCP of choice. Members covered by an MCO will use only in-network providers unless prior approval to see an out-of-network provider is granted by the member's MCO. Referral procedures must be followed for each managed care program providing services in West Virginia. The contracted enrollment broker for the BMS assures neutrality and member freedom of choice.

400.1.5 Member Responsibilities

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

- Notifying providers in a timely manner if unable to keep an appointment;
- Notifying providers promptly of changes in Medicaid coverage;
- Notifying providers of any changes in other insurance coverage, such as Medicare or private health insurance;
- Presenting a valid Medicaid identification card at each visit;
- Forwarding money or denials received from other insurance payers to their Medicaid providers;
- Informing their local DoHS office of any changes in address, income, etc.; and
- Paying providers required co-pays, if applicable.

400.1.6 Member Liability

Provider claims filed with the West Virginia 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, it will be considered paid in full.

Refer to [Chapter 100, General Information](#) for information on Medicaid Cost Avoidance requirements, including Third Party Liability/Coordination of Benefits (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:

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- Payments denied for provider error. For example:
 - Claims filed more than one year after the date of service.
 - Wrongful billing or missing information.
- Billings denied because the provider did not:
 - Follow procedures.
 - Obtain prior approval from Medicaid or the managed care provider, if applicable.
 - Notify the member before the service is provided that it is not covered by Medicaid
- Charges remaining after payments by insurance or Medicaid are made.
- Fees for missed appointments.

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

400.1.7 Member Responsibilities for Certain Charges

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

- Services received after Medicaid benefits are exhausted
- Services not medically necessary that the member elected to receive
- Services not covered by Medicaid that the member elected to receive
- Non-emergent services not prior-approved, if applicable
- Convenience items not required for medical care
- Services rendered when the member is not eligible
- Services provided when the member refuses to use other available insurance. The exception to this is the non-methadone medication assisted treatment.

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. For information on out-of-network, please refer to [Chapter 100, General Information](#) of the BMS Provider Manual.

The provider must inform or provide notice to the member prior to rendering services and obtain the member's signature when the West Virginia Medicaid program does not cover the service, and the member may be financially liable for the amount the provider charges for the service. The notice must be signed and dated by the provider and the member, and a copy given to the member. This procedure may help avoid problems that could arise concerning payment for medical bills.

400.1.8 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 DoHS 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 they have been reimbursed by the other person. The DoHS 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.

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400.1.9 Member Fair Hearings and Appeals

Eligibility Hearings

West Virginia Medicaid members can take advantage of the West Virginia DoHS Fair Hearings process for eligibility determinations if the member is not satisfied with the decision regarding the eligibility application and/or it is not handled within a reasonable period of time; not allowed to file an application; or was treated unfairly in any way. Requests for appeals should be directed to the members' local county DoHS office.

Service-Related Hearings

If a member receives a notice of a reduction, suspension, or termination of a Medicaid covered service, the right to appeal the denial or termination may be exercised through the fair hearing process. The notice will include an explanation of the member's appeal rights and a form that must be used to request a fair hearing. Members may represent themselves, use legal counsel, a relative, friend, or other spokesperson during the hearing process.

All requests for a Fair Hearing regarding Medicaid services must be submitted in writing to:

Bureau for Medical Services
Appeals Section
350 Capitol Street, Room 251
Charleston, WV 25301-3706

Managed Care Hearings

The MCO enrollees have additional avenues of appeal concerning adverse decisions made within their MCO 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 the complaints and concerns to the appropriate entity for evaluation.

Non-covered services are not eligible for a West Virginia DoHS Fair Hearing. See [42 CFR § 431.220](#) *When a hearing is required* for more information.

Refer to [Chapter 100, General Information](#) for details regarding member appeals.

400.2 MEDICAID MEMBER IDENTIFICATION CARD

Medicaid eligible members receive identification (ID) cards in all Medicaid approval notices. The MCO enrolled members also receive their member ID cards from the MCO in which they are enrolled. Managed Care identification cards are only replaced on regularly scheduled issuance dates. The member is responsible for furnishing their identification card to the provider at the time of service. Any person requesting services without an identification card should be advised that they are financially liable for all services received until eligibility is verified. Payment will only be made for covered services provided to an actively enrolled member.

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400.2.1 Verification of Member Eligibility

It is the provider's responsibility to carefully check the member's Medicaid eligibility and, if applicable, managed care coverage, each time a service is rendered.

Eligibility for an actively enrolled member may be verified online through the BMS [fiscal agent provider portal online](#) or through the Medicaid Voice Response System (VRS) at 1-888-483-0793. The online portal and VRS are quick and easy ways to verify member eligibility and are available 24 hours a day, seven days a week. The enrolled provider's National Provider Identifier (NPI) number is required to access these systems.

The Medicaid member number from the ID card (MAID #) can be used to verify eligibility. When the member's ID number is not available, the member's social security number or a combination of the member's last name and date of birth can be used. Members enrolled in the Mountain Health Trust (MHT) program have the name and telephone number of the MCO on their ID cards.

Verification of a member's eligibility does not guarantee payment for the services provided. The services provided, in addition to verification of the members' eligibility, must be:

- Determined to be medically necessary
- A covered Medicaid service
- Prior authorized or approved when applicable
- Referred or approved by the MCO, when applicable
- Billed to the appropriate payer
- Properly documented in the provider's office or facility medical records including, but not limited to, the items above, as applicable.

400.3 CO-PAYMENTS FOR MEDICAID SERVICES

Federal law permits certain Medicaid members to be charged a co-payment for certain medical services. Co-payments should be paid directly to the healthcare provider at the time medical services are provided. Reimbursement for medical services requiring a co-payment will be reduced by that amount.

Federal law requires providers to make a reasonable attempt to collect co-payments from Medicaid members. If a member is unable to pay the co-payment, they cannot be refused medical services unless their income is above 100% of the federal poverty level (FPL). However, this does not excuse the amount that the member will still owe the provider. Providers cannot collect member co-payments in amounts that exceed the Medicaid co-payment amount.

Providers are prohibited by law from collecting co-payments from the following:

- Children under 21 years old
- Pregnant women, including pregnancy-related services up to 12-months postpartum
- Native Americans and Alaskan Natives
- Members in long-term care facilities
- Members receiving Hospice services
- Members receiving Medicaid waiver services

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- Members covered through the Breast and Cervical Cancer Treatment program
- Members receiving Family Planning services
- Members receiving Emergency services

Additional Member co-payment information is available on the [BMS website](#). For Pharmacy related co-payment information, refer to [Chapter 518, Pharmacy Services](#).

400.4 MEDICAID MANAGED CARE – MOUNTAIN HEALTH TRUST PROGRAM

West Virginia Medicaid's managed care program began in 1996 and is referred to as Mountain Health Trust (MHT). The BMS contracts with various MCOs for the provision of medically necessary services provided under the Medicaid program.

An MCO is a health care company, often referred to as a health plan. Each MCO has the responsibility to coordinate the provision, quality, and cost of care for its enrolled members. Because of this, each MCO has certain doctors, clinics, and hospitals that the enrolled members must use. The providers that service the MCOs are often referred to as a "network." Under this program, a member will select the MCO and PCP from whom they want to receive services.

Managed care enrollment is mandatory for Medicaid members in certain eligibility categories (e.g., children and certain pregnant women). Members have freedom of choice to select any MCO serving the county in which they reside. To identify the MCO's available in each county, please refer to the [MHT website](#).

See [Chapter 527, Mountain Health Trust \(Managed Care\)](#) for more information.

400.4.1 Enrollment Broker

The BMS contracts with an enrollment broker to manage MCO member enrollment. The enrollment broker performs county-specific outreach education and enrollment services to assist potential MHT members in their program choices. The enrollment broker provides coordination and information related to available MCOs and PCPs in the MHT Programs. Broker staff perform managed care education and enrollment functions.

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

400.5 HOME AND COMMUNITY-BASED WAIVERS

Home and Community-Based Services (HCBS) focus on providing quality Medicaid funded services to eligible individuals in their homes and communities. HCBS work to create a sustainable, person-driven, long-term support system for people with disabilities, the elderly, and people with chronic conditions so they have outcomes, such as independence, health, and quality of life.

400.5.1 Aged and Disabled Waiver

The Aged and Disabled Waiver (ADW) program is a long-term care alternative which provides services that enable an individual to remain at or return home rather than receiving care in a nursing facility. The

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program provides home and community-based services to West Virginia residents who are eligible to participate in the program. A person must be at least 18 years of age and choose home and community-based services rather than nursing home placement. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, respect, and dignity and community integration. Refer to [Chapter 501, Aged and Disabled Waiver](#) for additional information.

400.5.2 Intellectual and Developmental Disabilities Waiver

The Intellectual and Developmental Disabilities Waiver (IDDW) program is West Virginia's HCBS program for individuals with intellectual and/or developmental disabilities that are at least three years of age. The IDDW program reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The IDDW program provides services based on a person's annual functional assessment and assigned individualized budget in natural settings, homes, and communities where the person resides, works, and shops. Refer to [Chapter 513, Intellectual and Developmental Disabilities Waiver](#) for additional information.

400.5.3 Traumatic Brain Injury Waiver

The Traumatic Brain Injury Waiver (TBIW) program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving care in a nursing facility. The program provides home and community-based services to West Virginia residents who are financially and medically eligible to participate in the program. Applicants must be at least three years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. Refer to [Chapter 512, Traumatic Brain Injury Waiver](#) for additional information.

400.5.4 Children with Serious Emotional Disorder Waiver

The Children with Serious Emotional Disorder Waiver (CSEDW) is an HCBS waiver program that provides services in addition to Medicaid State Plan coverage for members ages three through 20 who are enrolled in the program to enable children who would otherwise require institutionalization to remain in their homes and communities. West Virginia defines the term "children with a serious emotional disorder" (CSED) as children with an SED who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease (ICD) equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities. It is anticipated that this waiver will reduce the number of children housed both in-state and out-of-state in Psychiatric Residential Treatment Facilities (PRTFs) and shorten the lengths of stay for children who require acute care in PRTFs. Refer to [Chapter 502, Children with Serious Emotional Disorder Waiver](#) for more information.

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400.6 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

West Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program offers screenings and other preventive health services at regularly scheduled intervals to enrolled Medicaid members under the age of 21. These services target early detection of disease and illness and provide referral of members for necessary diagnostic and treatment services.

The EPSDT program in West Virginia is referred to as HealthCheck. This program is a preventative health component of Medicaid that requires the coverage of medically necessary health care services to all eligible children. Children under the age of 21, who are enrolled in Medicaid, automatically receive EPSDT services. The importance of preventive health services and early detection and treatment of diseases in children is emphasized in this program.

The inter-periodic screen is used to determine if there is a problem that was not evident at the time of the regularly scheduled screen but needs addressed before the next scheduled screen. Inter-periodic screens are any encounters with a health professional practicing within the scope of his or her practice and who provides medically necessary health care, diagnosis, or treatment to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition.

For additional information, refer to the [West Virginia HealthCheck website](#).

400.7 ALTERNATIVE BENEFIT PLAN

In accordance with the Affordable Care Act (ACA), adults aged 19 through 64 who are not disabled, and who have a MAGI of less than 133% of the federal poverty level (FPL), are eligible for enrollment in West Virginia Medicaid. This expansion population receives services under the Alternative Benefits Plan (ABP). The ABP offers benefits very similar to, but not exactly the same as, benefits offered to other Medicaid members.

For additional information on the benefits for the ABP population please refer to the [West Virginia BMS' Your Guide to Medicaid](#), which includes a comparison of services offered by West Virginia Medicaid under the Alternative Benefit Plan and the Traditional Medicaid Plan. The [West Virginia Income Maintenance Manual for Eligibility Policy](#) provides further details on determination of financial eligibility. Members of the expansion population may be exempted from participation in the ABP by meeting the criteria for medical frailty.

400.7.1 Alternative Benefit Plan (ABP) Covered Services

Each state selects a benefit plan based on federal rules to serve as the standard for the ABP. The ABP must provide coverage for the 10 categories of services known as the "essential health benefits":

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral treatment
6. Prescription drugs

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7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

In most cases the essential health benefits provided will mirror services available to the traditional Medicaid population.

400.7.2 Alternative Benefit Plan Service Limitations

Unless otherwise noted in this chapter or in other Provider Manual chapters pertaining to a specific service, all covered benefits, and authorization requirements for obtaining services are the same as those for the traditional Medicaid members. Services described in this section may be provided for the purposes of habilitation or rehabilitation, as applicable.

- **Chiropractic Services:** There is a limit of 24 treatments per calendar year. An additional six treatments per year may be authorized if Occupational Therapy (OT), and Physical Therapy (PT) services have not been utilized in combination with chiropractic services.
- **Physical and Occupational Therapy:** Prior authorization is required after the first 20 visits for a total of 30 annual visits. All visit limits include combined PT and OT services and habilitative and rehabilitative services.
- **Speech Therapy:** Services for this population include habilitation as well as rehabilitation but are otherwise the same.
- **Cardiac Rehabilitation:** Services for this population include habilitation as well as rehabilitation but are otherwise the same.
- **Pulmonary Rehabilitation:** Services for this population include habilitation as well as rehabilitation but are otherwise the same.

400.8 PRESUMPTIVE ELIGIBILITY

Presumptive eligibility (PE) was designed to identify and provide coverage for individuals who are likely eligible for Medicaid but are not enrolled. This is not an additional eligibility category; it is a method of determining temporary eligibility. A Qualified Provider (QP) may elect to make presumptive eligibility determinations for certain populations identified in the state plan.

The following entities are considered qualified providers:

- Qualified Hospitals
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Comprehensive Community Mental Health Centers
- Free Clinics
- Local Health Departments
- Licensed pharmacists and pharmacy technicians employed by Medicaid enrolled pharmacies
- ACA Navigators and HELP4WV helpline staff employed by First Choice Services

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400.8.1 Presumptive Eligibility Qualified Providers

In order to make presumptive eligibility determinations, a provider must:

- Be enrolled in West Virginia Medicaid as a provider; or other entity as defined in the State Plan as eligible to determine PE;
- Elect to participate in the PE program by:
 - Submitting a PE application attesting to its qualifications to participate in the PE program;
 - Submitting an Administrative User Agreement;
 - Submitting a Data Release Agreement;
 - Submitting a Health Insurance Portability and Accountability Act (HIPAA) Business Associates Agreement; and
 - Agreeing to all the terms and conditions related to the use of the PE determination portion of the on-line system.
- Appoint/assign a facility employee to serve as the PE administrator/point of contact;
- Assist applicants with the completion of the full Medicaid application;
- Follow state and federal privacy and security requirements; and
- Follow state requirements for data submission.

Facilities electing to use third party vendors and/or the DoHS workers to make PE determinations must sign an addendum to their PE application.

400.8.2 Presumptive Eligibility Authorized Employee Requirements

Facilities may elect to provide PE determinations with the support of an authorized employee, which includes individuals making determinations on behalf of the facility, the DoHS hospital employee, or third-party contractors, and will have agreed to accept responsibility for all decisions and outcomes of the authorized employee.

Before an employee, DoHS worker, or other third-party contractor can be authorized to perform presumptive eligibility determinations, they must satisfactorily complete the training course provided by the BMS and/or the Bureau for Family Assistance (BFA)

For all employees, DoHS workers, and other third-party contractors, the following conditions must be met:

- A certificate of course completion must be kept in the worker's file at the facility and must be made available to BMS or BFA within five business days of request. A file must be kept on third party vendors and DoHS workers who are assigned to do PE determinations.
- Access to the on-line system may not be granted by the PE Administrator/Point of Contact until all training is completed and a certificate is presented to the employee, DoHS worker, or third-party contractor.
- All authorized PE employees must complete and submit a User Agreement prior to conducting presumptive eligibility determinations.
- When an authorized employee leaves the employment of the facility, their contract ends or is no longer assigned to determine presumptive eligibility on behalf of the facility; the presumptive eligibility administrator/point of contact must immediately remove their access to the on-line system.

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400.8.3 Presumptive Eligibility Determination Groups and Eligibility

To be determined presumptively eligible for Medicaid, individuals must:

- Be a West Virginia resident,
- Be a US citizen or have satisfactory immigration status,
- Receive only one PE period per 12-months or, if pregnant, per pregnancy,
- Fall into one of these categories:
 - Children under age 19;
 - Pregnant women;
 - Parents and caretaker relatives;
 - Adults between the ages of 19 and 64;
 - Former foster children under age 26; or
 - Women who may gain eligibility through the breast and cervical cancer screening program according to state and federal requirements.
- Have estimated household income below the applicable income level outlined in the State's [Income Maintenance Manual](#).

400.8.4 Presumptive Eligibility Determination Process

Authorized employees will gather data from the individual using the presumptive eligibility determination portion of the on-line system. The employee may obtain information relating to the individual such as name, address, phone number, and social security number from other facility personnel such as registrars; however, this information must be confirmed by the individual or another person with reasonable knowledge of the individual's needs status. An individual or another person with reasonable knowledge of the individual's status seeking PE must attest to the information provided on the application, including attestation of state residency, citizenship, and household income. Authorized employees may not request any documentation or require verification of information provided.

The authorized employee must make the final determination of whether or not the individual may be eligible for Medicaid. This decision is made based on the criteria in [400.8.3, Presumptive Eligibility Determination Groups and Eligibility](#) and the results of the online system. Once a final decision is made by the authorized worker, they will provide the patient with either a temporary Medicaid card or a document stating why they were not determined presumptively eligible.

Applicants are allowed only one PE period per 12-month period or, if pregnant, per pregnancy. In the absence of an automated system that can verify the applicant's past use of presumptive eligibility, the facility will rely on self-attestation.

The PE determination is not subject to the West Virginia's DoHS Fair Hearing process.

400.8.5 Presumptive Eligibility Period

The PE period begins on the date the PE determination is made. The end date of the presumptive period is the earlier of:

- The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the calendar month following the calendar month in which the

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determination of PE is made (for example, if PE is determined June 15th, and regular Medicaid eligibility is determined August 3 based on a Medicaid application that was filed by July 30, then PE would end August 3); or

- The last day of the calendar month following the calendar month in which the determination of PE is made if no application for Medicaid is filed by that date (for example, if PE is determined June 15th eligibility would expire July 31 if no application was filed).
- If a patient is determined presumptively eligible on June 15, applies for Medicaid, and is denied on July 10, PE ends July 10.

400.8.6 Presumptive Eligibility Completion of Full Medicaid Application

It is the responsibility of the facility that completes the PE determination to complete the full Medicaid application prior to the end of the PE period. The full Medicaid application may be completed by:

- The PE authorized employee
- A facility vendor/contractor
- A facility-based DoHS worker
- The patient/authorized representative through the on-line system or by visiting a local DoHS office

If the presumptive eligibility authorized employee, a facility vendor/contractor, or the facility-based DoHS worker is completing the full application, they will use the on-line system. For the facility to receive credit for completing the full application, the temporary Medicaid ID number assigned to the patient must be used in the appropriate field of the full application.

The full Medicaid application must have the signature of the applicant or the applicant's authorized representative. If completing the application over the phone, the authorized employee must obtain the signature of the applicant in one of two ways:

- Sending the application to the applicant for signature. The applicant should then return the application to the facility; OR
- Collecting the signature by telephone by either (1) recording the entire telephone application process with the signature included; or (2) recording only the signature portion of each telephone call.

In either case, the signature must be kept in the facility file for a period of three years.

The PE employees or other facility workers are not required but may assist patients in completing applications for other DoHS programs such as Supplemental Assistance Nutrition Program (SNAP).

400.8.7 Presumptive Eligibility Performance Expectations

Facilities participating in the PE program as qualified providers are expected to assist individuals determined presumptively eligible with submitting a full Medicaid application before the end of their presumptive eligibility period. PE program applications and full Medicaid applications will be tracked to evaluate for accuracy and program integrity.

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The BMS will track the number of individuals who:

- Are determined presumptively eligible;
- Have submitted a full Medicaid application; and
- Are determined eligible for regular Medicaid.

To continue participation in the HBPE program, hospitals must meet the following performance standards on a calendar quarterly basis:

- 75% of individuals determined presumptively eligible must submit a regular application before the end of the presumptive eligibility quarter; and
- 50% of the individuals who are determined presumptively eligible and have submitted a regular application prior to the end of the PE period must be determined eligible for Medicaid.

Once the hospital is notified that the requisite standards have not been met, the hospital will have one quarter to take corrective action before the BMS may revoke the hospital's permission to participate in the HBPE program. In the event a hospital's permission to participate is revoked, the hospital must wait at least six months before reapplying to participate in the program.

The BMS has the authority to disqualify a provider from participation in the PE program if program integrity and accuracy standards are not being met.

400.9 MEDICAID ELIGIBILITY FOR NEWBORNS

A newborn child whose mother is Medicaid eligible at the time of the child's birth is eligible for Medicaid services for up to one year from the date of birth. The service must be billed with the newborn's Medicaid identification number and not with the mother's identification number.

For managed care members, the managed care entity the mother was enrolled in at the time of birth is responsible for claims incurred by a newborn up to two months after birth.

400.10 SPECIAL SERVICES

West Virginia Medicaid members may receive additional healthcare services in conjunction with other DoHS programs.

400.10.1 Children with Special Health Care Needs

The Children with Special Health Care Needs (CSHCN) program, in the [Office of Maternal, Child and Family Health \(OMCFH\)](#) advances the health and well-being of children and youth with certain chronic, debilitating conditions by providing specialized medical care and care coordination services to children under 21 years of age who meet financial and medical eligibility criteria.

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

CHAPTER 400 MEMBER ELIGIBILITY

Potential members become eligible after completion and approval of an application. Application may be initiated by referral from a hospital, any health care professional, DoHS office, or any other private or public health-related entity.

Children who are eligible for this service may also 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 MCO may not be billed. Please follow the specific rules and regulations of the MCO when coordinating services.

Refer to the [CSHCN website](#) for additional program information.

400.10.2 Birth to Three (BTT)

West Virginia Birth to Three is a statewide system of services and supports for children under age three who have a delay in their development or may be at risk of having a delay such as cognitive, physical, social/emotional, adaptive, and communication, and their family. The DoHS, through the Bureau for Public Health (BPH) and the Office of Maternal, Child, and Family Health (OMCFH), West Virginia Birth to Three, as the lead agency for Part C of the Individuals with Disabilities Education Act (IDEA), assures that family centered, community-based services are available to all eligible children and families.

Refer to the West Virginia [BTT program website](#) for additional program information.

400.10.3 Vaccines for Children

The Vaccines for Children (VFC) program operates in conjunction with the BPH to provide specific vaccines to Medicaid-eligible children.

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 the DoHS. The [BPH](#) operates the program. Providers are required to register as participants in the VFC program and are furnished the covered vaccines at no cost.

Refer to the [VFC program website](#) for additional program information.

400.10.4 WV WORKS Program

The WV WORKS program covers dental and optometry services for certain eligible adults through the Pre-Employment Services Project Referral. Please note: While participants in this project may also be Medicaid members, this is not a Medicaid covered service. Contact the local DoHS office for questions regarding specific benefits and possible coverage for patients.

Refer to the [WV WORKS website](#) for additional program information.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter.

CHAPTER 400 MEMBER ELIGIBILITY

REFERENCES

West Virginia State Plan information on eligibility can be found within the following sections - [Medicaid Expansion State Plan Amendments](#) and [Section 2 Coverage and Eligibility](#).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Member Eligibility	December 1, 2015
Entire Chapter	Changes were made to references, links, and language. Section 400.5.4 Children with Serious Emotional Disorder Waiver was added.	April 1, 2020
Section 400.3 Section 400.8	Updated to reflect changing the postpartum period from 60 days to 12 months. Added Local Health Departments as qualified Presumptive Eligibility Entities.	April 1, 2022
Policy Section 400.8	Added link to online application. Added Medicaid-enrolled pharmacies and First Choice Services as qualified Presumptive Eligibility Entities. Clarified current presumptive eligibility policies.	December 1, 2024