



**CHAPTER 400 MEMBER ELIGIBILITY**

**TABLE OF CONTENTS**

<b>SECTION</b>	<b>PAGE NUMBER</b>
Background .....	3
Policy.....	3
400.1 General Information.....	3
400.1.1 Coverage Groups and Categories.....	3
400.1.2 Non-Citizen Emergency Services.....	3
400.1.3 Dual-Eligible Members.....	3
400.1.4 Freedom of Choice.....	4
400.1.5 Member Responsibilities.....	4
400.1.6 Member Liability.....	4
400.1.7 Member Responsibilities for Certain Charges.....	5
400.1.8 Subrogation.....	5
400.1.9 Member Fair Hearings and Appeals.....	6
400.2 Medicaid Member Identification (ID) Card.....	6
400.2.1 Verification of Member Eligibility.....	7
400.3 Co-Payments for Medicaid Services .....	7
400.4 Medicaid Managed Care – Mountain Health Trust (MHT) Program.....	8
400.4.1 Managed Care Organization (MCO) Program.....	8
400.4.2 Physician Assured Access System (PAAS) Program.....	8
400.4.3 Enrollment Broker.....	9
400.5 Home and Community Based Waivers.....	9
400.5.1 Aged and Disabled Waiver (ADW) .....	9
400.5.2 Intellectual and Developmental Disabilities Waiver (IDDW).....	9
400.5.3 Traumatic Brain Injury Waiver (TBIW).....	9
400.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) .....	10

**DISCLAIMER:** This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.



CHAPTER 400 MEMBER ELIGIBILITY

400.7 Alternative Benefit Plan (ABP)..... 10

400.7.1 ABP Covered Services ..... 11

400.7.2 ABP Service Limitations ..... 11

400.8 Presumptive Eligibility (PE) ..... 11

400.8.1 Qualified Providers..... 12

400.8.2 PE Authorized Employee Requirements..... 12

400.8.3 PE Determination Groups and Eligibility ..... 13

400.8.4 PE Determination Process ..... 13

400.8.5 PE Period..... 14

400.8.6 PE Completion of Full Medicaid Application..... 14

400.8.7 PE Performance Expectations..... 15

400.9 Medicaid Eligibility for Newborns..... 15

400.10 Special Services ..... 15

400.10.1 Children with Special Health Care Needs (CSHCN)..... 15

400.10.2 Birth to Three (BTT)..... 16

400.10.3 Vaccines for Children (VFC)..... 16

400.10.4 WV Works Program ..... 16

Glossary..... 16

Change Log..... 17



## CHAPTER 400 MEMBER ELIGIBILITY

### 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 Health and Human Resources (WV DHHR) 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 WV DHHR 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.wvinroads.org](http://www.wvinroads.org). Please refer to the [West Virginia Income Maintenance Manual \(IMM\) for eligibility policy](#).

## 400.1 GENERAL INFORMATION

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

### 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 18 of the IMM](#).

### 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

## CHAPTER 400 MEMBER ELIGIBILITY

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 WV enrolled provider, however if a member wants to see a non-Medicaid provider, 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 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 WV DHHR office of any changes in address, income, etc.
- Paying providers required co-pays, if applicable

### 400.1.6 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, it will be considered paid in full.

Refer to [Chapter 100, General Administration and Information](#) for information on Medicaid Cost Avoidance Requirements, including third party liability (TPL)/Coordination of Benefits (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:



## CHAPTER 400 MEMBER ELIGIBILITY

- Payments denied for provider error. For example:
  - Claims filed more than one year after 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 WV 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 services please refer to [Chapter 100, General Administration and Information](#) of the BMS Provider Manual.

Prior to services being rendered by a provider, the provider must inform or give notice to the member that the provider will not bill Medicaid for the services and the member will be responsible for the charges.

### 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 WV 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 WV 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.

## CHAPTER 400 MEMBER ELIGIBILITY

### 400.1.9 Member Fair Hearings and Appeals

#### Eligibility Hearings

WV Medicaid members can take advantage of the WV DHHR 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 member's local county WV DHHR 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  
Room 251  
350 Capitol Street  
Charleston, WV 25301-3706

#### Managed Care Hearings

MCO enrollees have additional avenues of appeal concerning adverse decisions made within their MCOs 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 WV DHHR Fair Hearing or a Desk/Document review.

Refer to [Chapter 100, General Administration and Information](#) for details regarding Member Appeals.

### 400.2 MEDICAID MEMBER IDENTIFICATION (ID) CARD

Medicaid eligible members receive identification cards annually. MCO enrolled members 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 his/her identification card to the provider at the time of service. Any person requesting services without an identification card should be advised that he/she is financially liable for all services received until eligibility is verified. Payment will only be made for covered services provided to an actively enrolled member.

## CHAPTER 400 MEMBER ELIGIBILITY

### 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 at: <https://www.wvmmis.com/ProviderHomePage.aspx> or through the Medicaid Voice Response System (VRS) at 1-888-483-0793. The online portal and VRS are a quick and easy way to verify member eligibility and are available 24 hours a day, 7 days a week. Your 10-digit Medicaid Provider number is required to access these systems.

Obtain the Medicaid Member Number from the ID card (MAID #) to verify eligibility. Members enrolled in the Mountain Health Trust (MHT) program have the name and telephone number of the MCO on their ID cards. Members enrolled in the Medicaid Primary Care Case Management (PCCM) Physician Assured Access System (PAAS) program have their Primary Care Physician's name on their ID cards. When the member's ID number is not available, you can use the member's social security number or a combination of the member's last name and date of birth.

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

1. Determined to be medically necessary
2. A covered Medicaid service
3. Prior authorized or approved when applicable
4. Referred or approved by the PAAS primary care provider (PCP) or MCO when applicable
5. Billed to the appropriate payer
6. Properly documented in your office or facility medical records including, but not limited to, items one through four 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 60-days postpartum
- Native American and Alaskan Native
- Members in long term care facilities
- Members receiving Hospice services



## CHAPTER 400 MEMBER ELIGIBILITY

- Members receiving Medicaid Waiver Services
- Members covered through the Breast & Cervical Cancer Treatment Program
- Members receiving Family Planning Services
- Members receiving Emergency services

Additional Member co-payment information is available on the BMS website at:  
<http://www.dhhr.wv.gov/bms/Members/copays/Pages/default.aspx>

For Pharmacy related co-payment information, refer to [Chapter 518, Pharmacy Services](#).

### 400.4 MEDICAID MANAGED CARE – MOUNTAIN HEALTH TRUST (MHT) PROGRAM

West Virginia Medicaid's managed care program began in 1996 and is referred to as Mountain Health Trust (MHT). BMS contracts with various MCOs for the provision of medically necessary services provided under the Medicaid program. Under this program, a member will select the MCO and PCP from whom they want to receive services.

#### 400.4.1 Managed Care Organization (MCO) Program

A 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."

Managed care plans pay allowable claims for eligible members directly to health care providers. Members cannot be required to make any additional payments for covered services.

Physician and non-physician practitioners' services are the responsibility of the MCO. If a Medicaid member is enrolled in an MCO, the MCO's requirements must be met for reimbursement. Medicaid will not reimburse for services provided when requirements of the MCO are not followed.

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, see [www.mountainhealthtrust.com/compare-plans](http://www.mountainhealthtrust.com/compare-plans).

Once a member has selected the MCO of their choice, they must select a PCP within the MCO's Provider Network. If no PCP selection is made, or the selected PCP's panel is closed, the MCO will have the responsibility for assisting the member in making a final selection. MCOs will have 10 days to make a PCP assignment once the member is enrolled.

#### 400.4.2 Physician Assured Access System (PAAS) Program

The Physician Assured Access System (PAAS) is WV Medicaid's Primary Care Case Management (PCCM) Program. This program is designed to enhance access to medical care and coordinate health care needs and services. The program encourages newly-eligible members to select a PCP who will be responsible for providing and coordinating their health care. By assigning PCP responsibility, BMS

## CHAPTER 400 MEMBER ELIGIBILITY

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.

If the Medicaid-covered individual is a member of the PAAS, authorization is required from the PCP for reimbursement of services. Medicaid will not reimburse for services provided when requirements of the PAAS are not followed.

### 400.4.3 Enrollment Broker

The BMS contracts with an enrollment broker to manage 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. Field staff performs managed care education and enrollment functions.

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

## 400.5 HOME AND COMMUNITY BASED WAIVERS

### 400.5.1 Aged and Disabled Waiver (ADW)

The 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 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 (IDDW)

The IDDW Program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities that are at least three years of age. The IDDW Program is a program that 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 (TBIW)

The 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,

## CHAPTER 400 MEMBER ELIGIBILITY

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.

### 400.6 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

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 at <http://www.dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx>

### 400.7 ALTERNATIVE BENEFIT PLAN (ABP)

In accordance with the Affordable Care Act (ACA), adults aged 19 through 64 who are not disabled, and who have modified adjusted gross incomes 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. This section describes the provisions of the Alternative Benefits Plan.

For additional information on the benefits for the ABP population please refer to the West Virginia BMS website at: <http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx>, which includes a [comparison of services](#) offered by WV Medicaid under the Alternative Benefit Plan and the Traditional Medicaid Plan. The [West Virginia Income Maintenance Manual \(IMM\)](#) 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.



## CHAPTER 400 MEMBER ELIGIBILITY

### 400.7.1 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
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 ABP 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 OT and PT services have not been utilized in combination with chiropractic services.
- Physical and Occupational Therapy - Prior authorization is required for the first six visits. Additional, more intensive prior authorization review is required for up to 24 additional 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 (PE)

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 populations whose eligibility is determined using the Modified Adjusted Gross Income (MAGI) methodology described in [Chapter 10, Section 8 of the West Virginia Income Maintenance Manual](#).

## CHAPTER 400 MEMBER ELIGIBILITY

The following entities are considered Qualified Providers:

- Qualified Hospitals - Please refer to [Chapter 510, Hospital Services](#) for additional information on Hospital Based Presumptive Eligibility (HBPE)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Comprehensive Community Mental Health Centers
- Free Clinics

### 400.8.1 Qualified Providers

In order to make presumptive eligibility determinations a provider must:

- Be enrolled in WV Medicaid as a provider;
- Be a provider 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 HIPAA (Health Insurance Portability and Accountability Act) Business Associates Agreement;
  - Agreeing to all the terms and conditions related to the use of the presumptive eligibility determination portion of the on-line system WV [inROADS](#);
- Appoint/assign a facility employee to serve as the presumptive eligibility 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 WV Department of Health and Human Resources (WV DHHR) workers to make presumptive eligibility determinations must sign an addendum to their PE application.

### 400.8.2 PE Authorized Employee Requirements

Facilities may implement presumptive eligibility with the support of third party contractors and DHHR workers as well as their own employees as long as the facility assumes full responsibility for the presumptive eligibility determinations that result.

In this Chapter, the term Authorized Employee (AE) includes all individuals making determinations on behalf of a facility that have completed training and are authorized to make presumptive eligibility determinations.

Before an employee, DHHR worker or other third party contractor can be authorized to perform presumptive eligibility determinations he or she must satisfactorily complete the training course provided by BMS and the Bureau for Children and Families (BCF).



## CHAPTER 400 MEMBER ELIGIBILITY

For all employees, DHHR 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 BCF within five business days of request. A file must be kept on third party vendors and DHHR workers who are assigned to do presumptive eligibility determinations.
- Access to WV inROADS may not be granted by the Presumptive Eligibility Administrator/Point of Contact until all training is completed and a certificate is presented to the employee, DHHR worker, or third party contractor.
- All authorized presumptive eligibility employees must complete and submit a User Agreement with WV inROADS prior to conducting presumptive eligibility determinations.
- When an AE 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 his/her access to the WV inROADS system.

### 400.8.3 PE Determination Groups and Eligibility

In order to be determined presumptively eligible for Medicaid, individuals must fall into one of the new Modified Adjusted Gross Income (MAGI) groups:

- Children
- Pregnant women
- Adults between the ages of 19 and 64
- Former WV foster children under age 26
- Women who may gain eligibility through the breast and cervical cancer screening program according to state and federal requirements

### 400.8.4 PE Determination Process

Presumptive eligibility will be assessed using the rules outlined in the state's Income Maintenance Manual. Authorized employees will gather data from the individual using the presumptive eligibility determination portion of the on-line system WV inROADS. 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. The individual or another person with reasonable knowledge of the individual's status seeking PE must attest to the information provided on the application. Authorized employees may not request any documentation or require verification of information provided.

Applicants are allowed only one PE determination 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 authorized employee must make the final determination of whether or not the individual may be eligible for Medicaid. This decision may be made using a combination of the results of the on-line system WV inROADS, past experience with the individual or any facility policies in place in determining presumptive eligibility. Once a final decision is made by the authorized worker he/she will provide the patient with either a temporary Medicaid card or a document stating why he/she was not determined presumptively eligible.



## CHAPTER 400 MEMBER ELIGIBILITY

The PE determination is not subject to the WV DHHR's fair hearing process.

### 400.8.5 PE Period

The presumptive eligibility 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 determination of presumptive eligibility 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 presumptive eligibility 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 PE Completion of Full Medicaid Application

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

- The PE authorized employee
- A facility vendor/contractor
- A facility based DHHR worker
- The patient/authorized representative through <https://www.wvinroads.org> or by visiting a local DHHR office

If the PE authorized employee (AE), a facility vendor/contractor or the facility based DHHR worker is completing the full application, he/she will use <https://www.wvinroads.org>. In order 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 AE 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.



## CHAPTER 400 MEMBER ELIGIBILITY

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

### 400.8.7 PE 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. Presumptive Eligibility program applications and full Medicaid applications will be tracked to evaluate for accuracy and program integrity.

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.

For Hospital-Based PE performance measurements please refer to [Chapter 510, Hospital Services](#).

BMS has the authority to disqualify a provider from participation in the Presumptive Eligibility Program if necessary 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

#### 400.10.1 Children with Special Health Care Needs (CSHCN)

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.

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



## CHAPTER 400 MEMBER ELIGIBILITY

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 <http://www.wvdhhr.org/cshcn/> for additional program information.

### 400.10.2 Birth to Three (BTT)

The Birth to Three (BTT) 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 WV DHHR Bureau for Public Health. The 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.

Refer to the WV Birth to Three program website <http://www.wvdhhr.org/birth23/> for additional program information.

### 400.10.3 Vaccines for Children (VFC)

The Vaccines for Children (VFC) Program operates in conjunction with the Department of Public Health 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 DHHS. The [WV 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.

Refer to the Vaccines for Children (VFC) Program website <http://www.dhhr.wv.gov/oeps/immunization/vfc/Pages/default.aspx> 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. Please note: While participants in this project may also be Medicaid members, this is not a Medicaid covered service. Contact the local WV DHHR office for questions regarding specific benefits and possible coverage for patients.

Refer to the WV WORKS Program website [http://www.wvdhhr.org/bcf/family\\_assistance/wvworks.asp](http://www.wvdhhr.org/bcf/family_assistance/wvworks.asp) 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	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Member Eligibility		December 1, 2015