

MEDICAL ASSISTANCE for AGED, BLIND or DISABLED INDIVIDUALS HANDBOOK

Commonwealth of Virginia
Department of Medical Assistance Services

www.dmas.virginia.gov



Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219-1857

Our mission is to provide a system of high quality comprehensive health services to qualifying Virginians and their families.

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GENERAL INFORMATION

Medical Assistance Programs in Virginia

Medical Assistance programs in Virginia are administered by the Virginia Department of Medical Assistance Services (DMAS). Eligibility for the programs is determined by the local Departments of Social Services (DSS).

Patient Protection and Affordable Care Act

Most individuals who do not receive Medicaid benefits must sign up for health insurance starting in 2014 or pay a penalty. If you currently receive Medicaid or FAMIS benefits, you will probably still receive them. When your case is up for renewal, the local DSS will review it and let you know in writing of any changes. If you lose your Medicaid coverage a referral will automatically be sent to the Federal Health Insurance Marketplace. If you need help applying for medical assistance or insurance go to the Cover Virginia website at www.coverva.org or call Toll Free: 1-855-242-8282 •

TDD: 1-888-221-1590. To apply directly for health insurance, subsidies or the Advance Premium Tax Credit (APTC), go to the Federal Health Insurance Marketplace at www.healthcare.gov or call 800-318-2596 (TTY: 855-889-4325).

Medicaid is Virginia's government program to help pay for medical care. To be eligible for Medicaid you must have limited income and resources and you must be in one of the groups of individuals covered by Medicaid. Among the groups covered by Medicaid are individuals with disabilities and individuals age 65 and older.

Medicaid is funded by the state and federal governments. Not everyone with high medical bills qualifies, but all individuals within a group are treated the same.

Medicaid has three levels of benefits:

- **Full coverage** – Provides the full range of benefits including doctor, hospital, and pharmacy services for those individuals not enrolled in Medicare.
- **Time Limited coverage** - Individuals who meet a spenddown (as described on page 4) have time limited full coverage.
- **Medicare Savings Program coverage** – Provides Medicaid payment related to Medicare coverage; applicants with lower income may also receive payment of Medicare deductibles and coinsurance, up to Medicaid's maximum payments.

Medicaid for Families and Children and FAMIS (Family Access to Medical Insurance Security) - which are similar medical programs for children, parents and pregnant women - each have separate handbooks available from the DMAS website or your local DSS office.

How Do I Apply for Medical Assistance?

An application form for Medicaid can be completed online at the CommonHelp website <https://commonhelp.virginia.gov/access/>. You can print an application form from the DSS website www.dss.virginia.gov/form/. You can also contact the local department of social services (DSS) in the city or county where you live to pick up an application or have one mailed. The phone numbers for local DSS offices (sometimes called “human services” or “family services”) are listed in the blue pages of the phone book and online at <http://www.dss.virginia.gov/localagency/>.

Applications can be filed at some hospitals. Applications for medical assistance are also accepted through the Cover Virginia customer care center by phone 1-855-242-8282 or through the website (www.coverva.org).

An application must be signed by the person who needs assistance unless it is completed and signed by the applicant’s legal guardian, conservator, attorney-in-fact, or authorized representative. Electronic signature is acceptable. A parent, guardian, authorized adult representative, or caretaker relative with whom the child lives must sign the application for a child under the age of 18. Children under the age of 18 cannot apply for themselves, unless they are emancipated. However, if a child under the age of 18 has a child of his or her own, he or she as the parent can file an application for the child. A face-to-face interview is not required. You can provide information and authorize your application counselor or navigator while completing your application in CommonHelp, but that person cannot sign the application for you.

A screening tool is available on the Virginia Department of Social Services website to help determine whether you or someone in your family may be eligible for Medicaid. The screening tool can be found on the website at <https://commonhelp.virginia.gov>. The final decision regarding eligibility will be made by an eligibility worker at your local department of social services.

What Will I Be Asked?

Applicants for Medicaid are asked to provide their Social Security number, declare Virginia residency, and may be asked to provide documentation of United States citizenship and identity. If you are not a U.S. Citizen you must provide information and documents about your immigration status. Some immigrants can be eligible for full Medicaid coverage; others can be eligible for Medicaid payment only for emergency services. If you say you are unable to work due to a disability, you will be asked whether you have applied for disability benefits. If you have not, you may be asked for additional information about your medical condition so you can be referred for a disability determination.

All income that you receive must be listed on the application. Income includes earned income, such as wages and self-employment, as well as other income such as Social Security, retirement pensions, certain Veteran's benefits, alimony, etc. Countable sources of income are added together and compared to the income limit to determine eligibility. You will also be asked questions about how you file your taxes to make sure we are counting the right income.

The income limits vary according to the covered group and the type of coverage. For some groups, the income limits vary depending on the county or city where you live. Total "gross income" is evaluated; deductions are allowed according to Medicaid policy, and the amount of income remaining is compared to the appropriate Medicaid limit. "Gross income" is the amount before taxes or any deductions from the income are withheld. Your bills or debts are not used when we calculate whether your income is within the Medicaid limit.

Some individuals who meet all Medicaid eligibility requirements except for income may be placed on a spenddown. The spenddown amount is like a medical deductible – if medical expenses are higher than the spenddown amount, the individual may be eligible for Medicaid for a limited period of time.

Resources (Assets)

You may be required to give information about all resources that you or others in your household own. Resources are not evaluated and do not require verification for some covered groups. Resources include money on hand, in the bank and in a safe deposit box, stocks, bonds, certificates of deposit, trusts, or pre-paid burial plans. Resources also include cars, boats, life insurance policies, and real property. **All resources must be reported;** however, not all resources are counted when determining eligibility for Medicaid. For example, ownership of all vehicles must be reported, but one vehicle that you own is not a countable resource for Medicaid purposes.

If the value of your resources is more than the Medicaid resource limit when you apply for Medicaid coverage, you may become eligible for Medicaid by reducing your resources to or below the limit. **A resource that is sold or given away for less than what it is worth may cause you to be found ineligible for Medicaid coverage of long-term care services for a period of time determined by the amount of resources transferred compared to the average nursing facility rate.**

Long-Term Care (LTC) Asset Transfer

If you need LTC services, either in a nursing facility or in your home, you will be asked to describe all transfers of assets (resources) that have occurred within the past five (5) years. This can include such actions as transferring the title to a vehicle, removing your name from a property deed, setting up a trust, or giving away money. Medicaid applicants or participants who transfer (sell, give away, or dispose of) assets without receiving adequate compensation may be ineligible for Medicaid payment of long-term care services for a period of time. Some asset transfers may not affect eligibility depending on the circumstances or if the Medicaid program determines that the denial of Medicaid eligibility would cause an undue hardship. Transfers occurring after enrollment in Medicaid may also result in a penalty for payment of your long-term care services.

Special Rules for Married Individuals Who Need Long Term Care

Medicaid uses special rules to determine Medicaid eligibility when one member of a married couple receives long-term care and the other does not. These rules are referred to as “spousal impoverishment protections”. Resources and income are evaluated to determine how much may be reserved for the spouse who does not need LTC without affecting the Medicaid eligibility of the other spouse.

A review of resources (resource assessment) may be requested when a spouse is admitted to a nursing facility or receives nursing facility level care in the community. A resource assessment **must** be completed when a married institutionalized individual with a spouse in the community applies for Medicaid, even when the couple is not living together.

Because the LTC policy is very complex, contact your local DSS if you have further questions. Local DSS staff will not advise anyone on how to become eligible for Medicaid, but they can provide detailed policy information pertaining to your application.

Who Makes the Decision, and How Long Does It Take?

Once a signed application is received, local DSS staff will determine whether you meet a Medicaid covered group (see section on Covered Groups) and if your resources and income are within required limits. The amount of income and resources you can have and still be eligible for Medicaid depends on how many family members are living together and the limits established for your covered group.

An eligibility decision will be made on your Medicaid application

(1) Within 45 calendar days **OR**

(2) Within 90 calendar days if a disability decision is needed

of the date your application is filed with a local DSS.

A written notice that your application has either been approved or denied will be mailed or given to you. If you disagree with the decision, you may file an appeal (see section on ***When and How to File an Appeal***).

When Does Medicaid Start?

Medicaid coverage usually starts on the first day of the month in which you apply and are found to be eligible. Medicaid coverage can start as early as three months before the month in which you applied if you received a medical service during that time and met all eligibility requirements. Coverage under the Qualified Medicare Beneficiary (QMB) group **always** starts the month **after** the approval action. Spenddown coverage begins once the spenddown is met and continues until the end of the spenddown period. Contact your local DSS office if you have questions about when your Medicaid coverage starts and ends.

How Do I Keep My Coverage?

Once approved for Medicaid, coverage will continue for 12 months, as long as the eligibility requirements continue to be met. Medicaid coverage **must** be reviewed at least once every 12 months to determine continued eligibility for coverage. If this annual review is not completed, coverage may be canceled. When your annual review is due, your local DSS will send you a notice. You may be asked to complete a form and supply proof of your current income. Some individuals will also have to provide proof of their current resources.

If you are asked to complete a form or send in proof of income or resources, it is very important that you do so **immediately**. If you do not provide the information by the deadline given, the Medicaid coverage may be canceled. If you need assistance completing the forms, contact your eligibility worker.

Sometimes your eligibility may be reviewed for another 12 months using information available to your local DSS eligibility worker. If the local DSS is able to renew Medicaid or coverage with information they already have, you will receive a notice telling you the coverage has been reviewed and the date of your next annual renewal. You can also renew your coverage on a computer by visiting the CommonHelp website.

REMEMBER - You must report any change in circumstances (such as a change of address or locality, income, or health insurance coverage) **within 10 calendar days of the change on the CommonHelp website or by contacting your local DSS worker.** If the reported change affects your eligibility for Medicaid, your case will be reviewed and you will be notified of the outcome. If you apply or are reviewed for another program provided by social services [such as SNAP (Food Stamps) or TANF] the eligibility worker will renew your Medicaid at the same time if possible and extend your coverage for another 12 months from that date.

If you continue to receive coverage because you failed to report changes timely, your case may be referred to the DMAS Recipient Audit Unit (RAU) for an evaluation of possible Medicaid fraud and/or misspent dollars. That evaluation could result in the RAU requesting repayment for Medicaid services or for premiums paid to Managed Care Organizations (if any) to cover your medical services.

IT IS VERY IMPORTANT to tell your local DSS right away if you move or change your address. If they do not have a correct address, you will not receive a notice when it is time to renew Medicaid coverage and **your coverage may be canceled.** If you change your address at any time, contact your local DSS immediately to protect your coverage.

COVERED GROUPS

Federal and state laws describe the groups of individuals who may be eligible for Medicaid, referred to as “Medicaid covered groups”. Individuals who meet one of the covered groups may be eligible for Medicaid if their income and resources are within the required limits of the covered group. Services may also differ depending on the covered group. Medicaid information for Families and Children groups is contained in the **Families and Children Medical Assistance Handbook** and the **FAMIS Handbook**.

The Aged, Blind and Disabled Medicaid covered groups are:

- **Aged** (65 and older), **blind**, or **persons with disabilities** determined using Social Security Administration standards
 - with income up to 300% of the Supplemental Security Income (SSI) payment rate who have been screened and approved to receive services in a nursing facility or through one of the Medicaid Home and Community-Based Care Waivers
 - who have income that does not exceed 80% of the Federal Poverty Level (FPL) Income Guidelines*
 - who receive Supplemental Security Income (SSI) and who meet Medicaid resource limits
- **Auxiliary Grant** (AG) participants in Assisted Living Facilities or Adult Foster Care
- Individuals with income within 80% of FPL who are blind or disabled, at least 16 years old but not 65 years of age, and who are working or can work (**Medicaid Works** program)
- **Medically Needy** individuals who meet Medicaid covered group requirements but have excess income
- Individuals who are terminally ill and have elected to receive **hospice** care

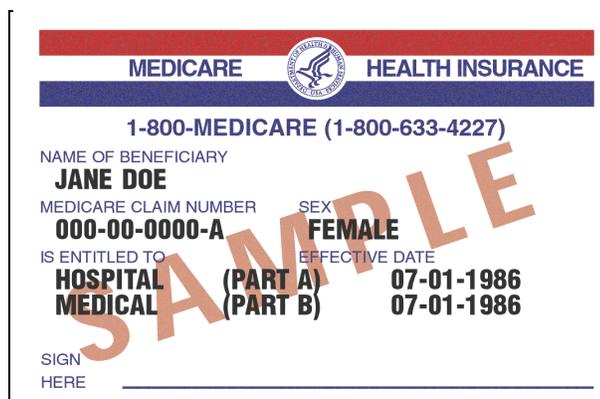
The Federal Poverty Level Income Guidelines are available on the DSS website at:

http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi

Medicare-Related Covered Groups

Individuals who are eligible for Medicare Part A and who meet one of the following covered groups may receive **limited** Medicaid coverage. Medicaid pays the Medicare costs on behalf of these Medicare beneficiaries as indicated below (resource limits for all Medicare-related covered groups except Qualified Disabled and Working Individuals (QDWI) are \$7,160 for a single person and \$10,750 for a couple - amounts as of January 1, 2014):

- **Qualified Medicare Beneficiaries (QMBs)** Income must be at or below 100% of the Federal Poverty Income Guidelines. Medicaid pays the Medicare Part A and Part B premiums and the coinsurance and deductibles that Medicare does not pay.
- **Special Low-Income Medicare Beneficiaries (SLMBs)** Income must be between 100% and 120% of the Federal Poverty Income Guidelines. Medicaid pays the Medicare Part B premiums.
- **Qualified Individuals (QI)** Income must equal or exceed 120% but be less than 135% of the Federal Poverty Income Guidelines. Medicaid pays the Medicare Part B premiums.
- **Qualified Disabled and Working Individuals (QDWIs)**—Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals must have income below 200% of the federal poverty income guidelines and resources must be at or below \$4,000 for a single person and \$6,000 for a couple.



A sample Medicare Health Insurance card for Jane Doe. The card features a red header with 'MEDICARE' and 'HEALTH INSURANCE' in white, separated by the Virginia state seal. Below the header is a blue bar with the phone number '1-800-MEDICARE (1-800-633-4227)'. The card lists the beneficiary's name as 'JANE DOE', Medicare claim number as '000-00-0000-A', and sex as 'FEMALE'. It also indicates entitlement to Hospital (Part A) and Medical (Part B) insurance, both effective as of 07-01-1986. A signature line is provided at the bottom with the text 'SIGN HERE'.

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY			
JANE DOE			
MEDICARE CLAIM NUMBER		SEX	
000-00-0000-A		FEMALE	
IS ENTITLED TO		EFFECTIVE DATE	
HOSPITAL (PART A)		07-01-1986	
MEDICAL (PART B)		07-01-1986	
SIGN HERE _____			

Plan First – Virginia’s Family Planning Services Program

Men and women who meet the income requirements but do not meet a full benefit Medicaid covered group may be eligible for the limited Medicaid benefit Plan First.

Plan First covers:

- Annual family planning exams for men and women
- Pap tests
- Sexually transmitted infections (STI) testing
- Family planning education and counseling
- Sterilization procedures
- Transportation to a family planning service
- Most Food and Drug Administration (FDA) approved contraceptives (prescription and over-the-counter)

Individuals applying for full benefit Medicaid or losing full Medicaid coverage because they no longer meet the requirements for full benefits may have eligibility for Plan First evaluated. **If applicants do not want to be considered for Plan First enrollment, they must tell the eligibility worker.** Individuals 65 or over and parents of individuals under 19 may request an eligibility evaluation for this covered group.

All Plan First participants will be referred to the Federal Health Insurance Marketplace to be evaluated for APTC or cost sharing reductions.

Emergency Services for Non-Citizens

Special rules apply to non-citizens. If a person meets one of the covered groups listed above and all other Medicaid requirements except alien status, then he or she may be eligible for Medicaid benefits to pay for emergency medical treatment.

MEDICAID AND OTHER HEALTH INSURANCE

If you already have health insurance you can still be covered by Medicaid. The other insurance plan is billed first. Having other health insurance does not change the Medicaid co-payment amount (if any) that you pay to providers as a Medicaid enrollee. If you have a Medicare supplemental policy, you can suspend your policy for up to 24 months while you have Medicaid without penalty from your health insurance company. You must notify the insurance company within 90 days of the end of your Medicaid coverage to reinstate your supplemental insurance. If you drop private health insurance coverage or enroll in a private health insurance plan, tell your local eligibility worker. If you don't, medical bill payment could be delayed.

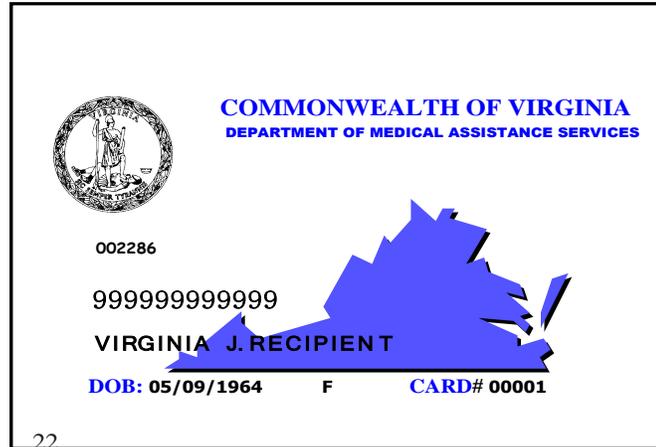
Sometimes Medicaid pays claims for covered services and it is later found that another payment source was available. In this situation Medicaid will try to recover the money from the other source, whether from commercial health insurance, Medicare, Worker's Compensation, or liability insurance (if the claim is for an accident). The agreement to "Assign Rights to Medical Support and Third-Party Payments" is included in the Medical Assistance application. If you are paid by an insurance company after Medicaid has already paid the same bill, you must send that money to DMAS.

Health Insurance Premium Payment Programs (HIPP)

Medicaid may help with the cost of private health insurance premiums when certain criteria are met. The HIPP Programs only reimburse for employer sponsored group health plans; they do not reimburse premiums for individual policies. For more information call the Health Insurance Premium Payment Unit at 1-800-432-5924 or send an email to hippcustomerservice@dmas.virginia.gov.

VIRGINIA MEDICAID CARD

When you are found eligible you will be mailed a blue and white plastic medical assistance card (Virginia Medicaid card) on which your name and identification number are printed. **It is your responsibility to show your Virginia Medicaid Card to providers at the time you go for services and to be sure the provider accepts payment from Virginia Medicaid.** If you have a Virginia Medicaid card because you were eligible at an earlier time, **keep it.** That card will be valid again if and when your coverage is reinstated.



Using Your Medical Card

Each person in your family who is eligible for Medicaid will receive his or her own card (unless only eligible for payment of Medicare premiums). You will **not** be mailed a new card if your benefits change. You can request a replacement card from the local DSS if your card is lost, stolen or destroyed.

Show your card(s) **each time you get a medical service** so that your medical provider can verify your current eligibility status. If you are enrolled in a Managed Care Organization (MCO), you will get a separate card from that organization. **You need to show both the MCO and the Virginia Medicaid cards when you receive medical care.** If you do not show your card(s), you may be treated as a private-pay patient and receive a bill from the medical provider.

It is your responsibility to show your medical identification card(s) to providers at the time you go for service and to be sure the provider accepts payment from Virginia Medicaid or from your assigned MCO, if you have one. Report the loss or theft of your Virginia Medicaid card to the local DSS right away. The loss or theft of your MCO card should be reported to your MCO.

USING YOUR MEDICAID BENEFITS

Medicaid provides medical services both by direct payments to providers and by paying premiums for participants to Managed Care organizations.

“Fee for Service” Medicaid Coverage

Providers who are enrolled with DMAS offer care to some Medicaid participants. If you do not have an assigned doctor or MCO, you can choose any provider for medical services as long as the provider accepts Virginia Medicaid payments. If you receive services from providers who are not enrolled in Virginia Medicaid, **you will have to pay the bill. Medicaid will not pay you back for the medical bills that you have paid.** Try to use one doctor and one pharmacy for most of your care, and continue with that doctor unless you are referred to a specialist. If you need help finding a provider who accepts Medicaid, check the DMAS Provider search

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/SearchForProviders>

If a provider type you are looking for is not listed contact our Helpline at 804-786-6145.

Commonwealth Coordinated Care Program (CCC)

Effective March 1, 2014, the CCC Program coordinates Medicare and Medicaid services (primary, preventive, acute, behavioral and long term care services and supports) under one entity. Members have their choice of available health plans in their locality. Benefits include one ID card, one toll-free number to call for assistance, and a unified appeals process. Those eligible for this program must be over twenty-one and include full benefit Medicare-Medicaid recipients, participants in the Elderly or Disabled with Consumer Direction (EDCD) waiver, and Medicaid members residing in nursing facilities. Participation in the CCC is voluntary. For more information call toll-free 1-855-889-5243 or email CCC.@dmas.virginia.gov.

Managed Care

Most Virginia Medicaid members are required to receive their medical care through managed care organizations (MCOs). Program eligibility is determined by where you live. If you meet the criteria to be assigned to an MCO you will receive a letter from DMAS requiring you to choose a MCO for your health care. You will receive information about the programs such as a MCO Comparison Chart and a brochure.

If you do not make a choice, DMAS will assign you to an MCO.

Managed Care Organizations (MCOs)

An MCO is a health service organization that coordinates health care services through a network of providers including primary care providers (PCPs), specialists, hospitals,

clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers. Once you select an MCO, a packet of information will be mailed directly to you. You also will receive an MCO identification card to use with your Virginia Medicaid card. **Please keep both cards with you and present both cards each time medical care is received.** The MCO will require you to choose a PCP in its network who will manage all of your health care needs. You are not required to enroll all members of your family in the same MCO or with the same PCP.

You will be required to follow managed care program rules. These rules are described in the MCO member handbook, which is included in the information packet that your MCO will send to you. If you do not follow the managed care program rules (for example, if you receive services without obtaining a referral from your PCP or an authorization from your MCO), you may have to pay the full bill yourself. Refer to your MCO member handbook for more details.

Open Enrollment

There is an annual open enrollment period for the MCO programs. This open enrollment period allows you to change your MCO. If you want to know when your open enrollment period takes place or have other questions regarding your managed care enrollment, call the DMAS Managed Care Helpline at 1-800-643-2273. See the DMAS website for more information:

http://dmasva.dmas.virginia.gov/Content_pgs/mc-home.aspx

Client Medical Management (CMM)

Some individuals need special help with their doctor and pharmacy use. If you are identified for enrollment in Client Medical Management (CMM), you will receive a letter from the DMAS Recipient Monitoring Unit (RMU). You will have the chance to choose your PCP and pharmacy within 30 days of receiving the enrollment notice. **If you do not tell Medicaid your choices, DMAS will choose providers for you.** Once you are assigned to one doctor and/or pharmacy, you must get your care only from them unless they refer you to other providers. Your PCP must give you written permission (a referral form) when you need to see a specialist. You may only use another pharmacy in an emergency as explained by CMM rules. Your card contains information like a credit card, which tells the provider the names of your CMM providers. Each CMM member is assigned a RMU case manager to answer questions about the program and assist you in following the program rules.

Each Managed Care Organization has a program similar to the CCM. If you are identified for enrollment in one of these programs you will be notified by your MCO.

MEDICAL CARE UNDER MEDICAID

Most medical care, both inpatient and outpatient, is covered by Medicaid. There are certain limits and rules that apply. For example, some medical procedures must be performed as outpatient surgery unless there is a medical need for hospital admission. Care in an institution for the treatment of mental diseases is not covered for individuals between the ages of 21-64. There are limits to the number of visits approved for home health, psychiatric services, and other professional services. Some services require prior authorization.

Behavioral Health Services

As of December 1, 2013, Magellan Behavioral Health, Inc. (Magellan of Virginia) manages behavioral health services. Magellan manages all Medicaid and FAMIS covered mental health and substance abuse treatment services for fee-for-service enrolled members, and coordinates benefits with the MCOs. Services managed by Magellan include:

- Intensive In-Home Services for Children and Adolescents (IIH)
- Therapeutic Day Treatment for Children and Adolescents (TDT)
- Group Home Services for Children and adolescents
- Residential Treatment
- Day Treatment/Partial Hospitalization
- Psychosocial Rehabilitation
- Intensive Community Treatment (ICT)
- Mental Health Support Services (MHSS)
- Crisis Intervention and Stabilization
- Case Management
- Substance abuse programs
- Outpatient Therapy (if you are not enrolled in a MCO)
- Traditional mental health needs, such as medications for mental health or substance abuse needs, are managed by the Managed Care Organizations for MCO members)

For more information about behavioral health services call Magellan at 1-800-424-4046.

Dental Care

Medicaid provides coverage for limited medically necessary oral surgery services for adults (age 21 and older).

Inpatient Hospital Admissions

Your doctor must call for pre-authorization before you are admitted to the hospital, or within 24 hours after an emergency admission.

Medical Professional Visits

Psychiatric, nursing, physical therapy, occupational therapy and speech therapy visits must be pre-approved.

Pharmacy

Your doctor may have to get pre-authorization in order for a pharmacy to fill some prescriptions. Within a family of drugs, there may be one or a few select drugs that Medicaid or the Managed Care Organization would like your doctor to use to treat your condition because they are safe, effective, or less costly. This is called a Preferred Drug List (PDL) or formulary. You can still receive medication to effectively treat your medical condition. Prior approval is required to fill the prescription if the drug is not on the PDL. A doctor may also prescribe or order some over-the-counter drugs equivalent to certain prescription drugs if it is cost effective to do so. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. This is true whether you get services directly through Medicaid (administered by Magellan Health Services) or through an MCO. If you have questions about the PDL, call Magellan at 1-800-932-6648, your MCO, or talk to your doctor.

Members who have Medicare Part A or Part B coverage must receive prescription drug coverage under Medicare Part D. Virginia Medicaid will not pay for prescription drugs that are covered under Medicare Part D for Medicare-eligible members. For information about coverage under Medicare Part D contact Medicare at 1-800-MEDICARE (800-633-4227).

Transportation

Transportation services are provided when necessary to help individuals access Medicaid covered services. Full-benefit Medicaid covers two types of transportation:

- **Emergency** – Medicaid pays for 911 emergency transportation to receive medical treatment.
- **Non-Emergency** – Non-emergency medical transportation is provided through a transportation broker or through your Managed Care Organization.

Transportation may be provided if you have no other means of transportation and need to go to a physician or a health care facility for a Medicaid-covered service. In case of a life-threatening emergency, call 911. For non-emergency medical appointments, call the reservation line at 1-866-386-8331 at least five business days (5 days) prior to the scheduled appointment. (Verifiable “URGENT” trips, like hospital discharges or a sudden illness, may be accepted with less than five days notice.) Please have your Medicaid ID number, appointment address and telephone number available when you call. Members in an MCO should call the transportation number listed in the MCO member handbook to arrange for non-emergency trips.

Additional Non-Emergency Medicaid Transportation information can be found at <http://transportation.dmas.virginia.gov>.

Remember: Trips must be for a Medicaid covered service and medically necessary. Examples: doctor appointment, counseling, dialysis, adolescent dental appointment. The transportation broker may verify your Medicaid covered service with the Medicaid provider.

Out-of-State Medical Coverage

Virginia Medicaid will cover emergency medical services you receive while temporarily outside of Virginia if the provider of care agrees to participate in Virginia’s Medicaid Program and to bill Medicaid. **No payments are made directly to members for service costs incurred out of state.** Rules for out-of-state care may be different if your coverage is through an MCO. If you are enrolled in an MCO, contact MCO staff for procedures regarding out-of-state treatment.

If you receive emergency medical services out of state from a provider not enrolled in Virginia Medicaid, ask the provider to contact the DMAS Provider Enrollment Unit:

Virginia Medicaid Provider Enrollment Services
P.O. Box 26803
Richmond, Virginia 23261
Phone: 1-888-829-5373 or 804-270-5105

Virginia Medicaid does not cover medical care received outside of the United States.

CO-PAYMENTS

Some Medicaid members must pay a small amount for certain services. This is called a co-payment.

The following members do not pay a co-payment for services covered by Medicaid

- Children younger than age 21
- Individuals receiving institutional or community-based long-term care services (patient pay may be applicable)
- Individuals in hospice programs

Medicaid does not charge a co-payment for the following services

- Emergency services (including dialysis treatments)
- Pregnancy-related services
- Family-planning services
- Emergency room services

Medicaid charges co-payments for members age 21 and older for the following services:

Service	Co-Payment Amount
Inpatient hospital	\$100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit
Physician office visit	1.00 per visit
Other physician visit	3.00 per visit
Eye examination	1.00 per examination
Prescription	1.00 for generic 3.00 for brand name
Home health visit	3.00 per visit
Rehabilitation service	3.00 per visit

You are responsible for paying the co-payment, if any. However, a medical provider **cannot** refuse to treat you or provide medical care if you are not able to pay the co-payment. As an additional benefit of participation in an MCO, Managed Care Organizations do not charge co-payments for services rendered.

BENEFITS UNDER MEDICAID

A description of each benefit follows this list. If your coverage is provided by an MCO, contact the MCO for coverage criteria.

- Behavioral therapy
- Clinic Services
- Community Mental Health and Intellectual Disability Services
- Limited Dental Care Services
- Durable Medical Equipment and Supplies (**DME**)
- Eye Examinations
- Family Planning Services
- Glucose Test Strips
- Home Health Services
- Hospice Services
- Hospital Care – Inpatient/Outpatient
- Hospital Emergency Room
- Inpatient Psychiatric Hospital Services for Individuals 65 or Older
- Long-Term Care
- Money Follows the Person (**MFP**) Program
- Nursing Facility
- Organ Transplants
- Personal Care
- Physician’s Services
- Podiatry Services (foot care)
- Prenatal and Maternal Services
- Prescription Drugs when ordered by a Physician
- Program of All-Inclusive Care for the Elderly (**PACE**)
- Prosthetic Devices
- Psychiatric or Psychological Services
- Renal (Kidney) Dialysis Clinic Visits
- Rehabilitation Services
- Residential Treatment Services (Level C)
- Therapeutic Behavioral Services (Level B)
- Transportation Services for Medical Treatment
- Treatment Foster Care – Case Management (TFC-CM)

Clinic Services - Facility (public and private) for the diagnosis and treatment of persons receiving outpatient care.

Community Mental Health and Intellectual Disability Services – Services provided in the individual’s home or community that provide diagnosis, treatment, or care of persons with mental illnesses, substance abuse or intellectual disabilities. These services are provided primarily by Community Services Boards and private providers.

Dental Care Services – Adult coverage is limited to medically necessary oral surgery and associated diagnostic services.

Durable Medical Equipment and Supplies (DME) – Medically necessary medical equipment and supplies may be covered when they are necessary to carry out a treatment prescribed by a physician. For example:

- Ostomy supplies
- Oxygen and respiratory equipment and supplies
- Home dialysis equipment and supplies

Eye Examinations – Limited to once every two years.

Family Planning Services/Birth Control – Services that delay or prevent pregnancy including diagnosis, treatment, drugs, supplies, devices and certain elective sterilization procedures (for men and women). Coverage of such services does not include services to treat infertility or services to promote fertility.

Glucose Test Strips – Blood glucose self-monitoring test strips are covered when medically necessary.

Home Health Services – Visits by a nurse, physical therapist, occupational therapist, or speech and language therapist require prior approval. The visits of a home health aide are limited to 32 visits annually.

Hospice Services – Medically-directed program providing a range of home, outpatient, and homelike inpatient care for the terminally ill. (Terminally ill is defined as having a medical opinion that life expectancy is six months or less).

Hospital Care -

- **Inpatient:** Admission to a hospital for bed occupancy to receive hospital services. Approved days are covered.
- **Outpatient:** Receiving medical services without admission to a hospital.

Hospital Emergency Room – Visits are covered for emergency treatment of serious life- or health-threatening medical problems

Inpatient Psychiatric Hospital Services for Individuals 65 Years of Age or Older – Services that provide diagnosis, treatment, or care of persons with mental illnesses in a hospital setting. This includes medical attention, nursing care, and related services. These services are provided in institutional settings called “Institutions for Mental Disease,” (IMD) which can be hospitals, nursing facilities, or other institutions with more than 16 beds.

Long-Term Care – This may include care in an institutional setting such as a Nursing Facility or Intermediate Care Facility for the Intellectually Disabled or in the community through a Home-and-Community-Based Services Waiver.

Money Follows the Person (MFP) Program - This eight year project, funded by federal and state sources, provides individuals of all ages and all disabilities who live in institutions in the Commonwealth of Virginia (such as nursing facilities, Intermediate Care Facilities for Individuals with Developmental Disabilities [ICFs/ID] and long-stay hospitals, institute for mental disorders (IMD), psychiatric residential treatment facility [PRTF]) options to transition to a home-and-community setting. For additional information see www.olmsteadva.com/mfp/.

Nursing Facility – A licensed and certified facility which provides services to individuals who do not require the degree of care and treatment provided in a hospital setting.

Organ Transplants – Kidney, liver, heart, lung, cornea, high-dose chemotherapy, and bone marrow/stem cell transplantation are covered. All transplants except corneas require pre-authorization.

PACE (Program of All-Inclusive Care for the Elderly) - A community-based alternative to institutional long-term care. PACE helps participants remain in their homes by providing comprehensive medical and social services based in one facility.

Personal Care – Support services to assist with activities of daily living (bathing, dressing, toileting, transferring, eating, bowel and bladder continence necessary to maintain health and safety), monitoring of self-administered medications, and the monitoring of health status and physical condition. These services are provided for individuals of any age enrolled in a home or community based waiver who meet established medical necessity criteria, and for members under the age of 21 under EPSDT. Services do not take the place of informal support systems.

Physician's Services – Medical services provided by General Practitioners, Specialists, and Osteopaths.

Podiatry Services (foot care) – Routine and preventive foot care is not covered by Medicaid. Payment for the trimming of the nails for a medical condition such as diabetes is limited to once every 2 months.

Prescription Drugs when ordered by a Physician – Medicaid has a preferred drug list (PDL), but drugs not on the list can be covered if pre-authorized. Prescriptions are filled with no more than a 34-day supply at a time. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. Some over-the-counter drugs can be covered if ordered by a doctor instead of a prescription drug. **Medicaid members who have Medicare coverage must receive their prescription drug coverage under Medicare Part D.** For information about coverage under Medicare Part D, call 1-800-MEDICARE (1-800-633-4227).

Prosthetic Devices – Limited to artificial arms, legs, and the items necessary for attaching the prostheses; must be preauthorized.

Psychiatric or Psychological Services – Medicaid covers up to 26 out-patient mental health or substance abuse service hours without preauthorization. Additional treatment must be pre-authorized. Contact your Managed Care Organization for their criteria.

Renal (Kidney) Dialysis Clinic Visits – Outpatient visits for dialysis treatment of end-stage renal disease are a covered service. The visit may have two components, the outpatient facility and the physician evaluation and management fees.

Rehabilitation Services – Outpatient services for physical therapy, occupational therapy, and speech-language pathology.

Transportation Services to Medicaid Covered Services:

Emergency – Full Medicaid covers 911 transportation to receive medical treatment.

Non-Emergency – Non-emergency medical transportation is arranged through a transportation broker or through your MCO. Not all Medicaid members receive transportation services. If you are eligible for transportation benefits and do not have a car or a family member who can transport you to a Medicaid-covered service appointment and you are not enrolled in an MCO, call for assistance toll-free at 1-866-386-8331.

Additional Non-emergency Transportation information can be found at [/transportation.dmas.virginia.gov](http://transportation.dmas.virginia.gov)

WHAT IS NOT COVERED BY MEDICAID

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Alcohol and drug abuse therapy Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Broken appointments
- Certain drugs not proven effective and those offered by non-participating manufacturers (enrolled doctors, drugstores, and health departments have lists of these drugs)
- Certain experimental surgical and diagnostic procedures
- Chiropractic services Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Dentures for members age 21 and over
- Doctor services during non-covered hospital days
- Drugs prescribed to treat hair loss or to bleach skin
- Eyeglasses or their repair for members age 21 or older
- Hospital charges for days of care not authorized for coverage including Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk)
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid
- Personal care services (except in some home and community-based service waivers or under EPSDT)
- Prescription drugs if the member has coverage under Medicare Part A or Part B
- Private duty nursing (except in some home and community-based service waivers or under EPSDT)
- Routine dental care if you are age 21 or older
- Telephone consultation
- Weight loss clinic programs

This list does not include every service that is not paid for by Medicaid. If you receive a service not covered by Medicaid or you receive more services than the Medicaid limit for that service, you will have to pay those bills.

LONG-TERM CARE (LTC) SERVICES

Medicaid pays for LTC services in some institutional settings, such as nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities and for individuals in their communities through Home and Community-Based Care Waivers, PACE (Program of All-Inclusive Care for the Elderly) and hospice. To qualify for LTC services, an individual must meet certain level-of-care requirements. These requirements may include assistance with activities of daily living and a medical nursing need. In order to receive waiver services there is a Federal requirement that the individual be at risk of institutionalization within 30 days if waiver services are not provided. There are eligibility rules and requirements (such as pre-admission screening, asset transfer evaluation and patient pay) which only apply to individuals who need Medicaid coverage for long-term care services. Contact your local DSS for details if Medicaid long-term care services are needed.

Screening for Long-Term Care Services

A pre-admission screening is required to determine whether an individual meets the level-of-care criteria for long-term care services. Screening is not required if the person is entering the facility directly from another state. Screenings for institutional and community-based long term care are completed by the following teams:

- Local teams composed of health and social service agencies
- Staff of acute care hospitals
- Community Services Board Staff (Intellectual Disability waiver only)
- Child Development Clinics Staff (Developmental Disabilities waivers only)

Home and Community-Based Waivers

Virginia provides a variety of services (such as personal care) under home and community-based waivers to specifically targeted individuals. Each waiver provides specialized services to help eligible individuals remain in their communities. These individuals receive acute and primary medical services from a MCO and waiver services (and the related transportation) through the fee-for-service program. The waivers are:

Elderly or Disabled with Consumer Direction (EDCD) Waiver - provides supports in the community for individuals who are elderly or have a disability. Individuals may choose to receive agency-directed services, consumer-directed services or a combination of the two as long as it is medically appropriate and duplicate services are not provided.

Individual and Family Developmental Disability (DD) Support Waiver - provides supports in the community rather than in an Intermediate Care Facility. The DD waiver serves individuals 6 years of age and older who have a related condition and do not have a diagnosis of intellectual disability, and who (1) meet the Intermediate Care Facility for Individuals with/Intellectual Disabilities (ICF/IID) level of care criteria, (2) are determined to be at imminent risk of ICF/IID placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/IID.

Intellectual Disability (ID) Waiver - provides supports in the community rather than in an ICF/IID for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have an intellectual disability.

Technology Assisted (Tech) Waiver - provides care in the community for individuals who are dependent upon technological support and require substantial, ongoing nursing care.

Day Support (DS) Waiver for Individuals with Intellectual Disability (ID) – provides home and community-based services to individuals with intellectual disabilities who have been determined to require the level of care provided in an ICF/IID and are on the waiting list for the ID Waiver.

Alzheimer’s Assisted Living (AAL) Waiver – is available only to individuals who live in a licensed Assisted Living facility, are Auxiliary Grant (AG) recipients, and have a diagnosis of Alzheimer’s disease or a related dementia with no diagnosis of mental illness or intellectual disability.

YOUR RIGHTS AND RESPONSIBILITIES

You have the right to ...

- File an application for assistance.
- Receive written information about specific eligibility policies.
- Have a decision made promptly.
- Receive a written notice of the decision.
- Have your personal and health information kept private.
- Have advance notice of actions that end or reduce your coverage.
- Appeal any action, such as:
 - any decision denying, terminating or reducing Medicaid eligibility;
 - any unreasonable period of time taken to decide if you are eligible;
 - any decision denying, terminating or reducing Medicaid-covered medical services.

You have the responsibility to...

- Complete the application and renewal forms fully and accurately.
- Supply requested information, or to tell your eligibility worker about any problems you are having getting the necessary information.
- Inform your eligibility worker of any other medical insurance that may cover some of your bills.
- **Immediately report** changes in your circumstances to your worker such as:
 - Change in address, birth of a child, death of a family member, marriage, new employment, adding or dropping other health insurance or any change in household arrangements.
 - The early termination or loss of pregnancy.
 - Changes in your financial condition (which includes both earned and unearned income such as Social Security, SSI, going to work, changes in employment, transfers of assets or inheriting). Any medical insurance that may cover some of your bills.
 - Filing a personal injury claim due to an accident.
- Keep scheduled appointments.
- Show your medical provider your Medicaid and other medical insurance card(s) when you go for care.

FRAUD AND OTHER RECOVERIES

Medicaid fraud means deliberately withholding or hiding information or giving false information to get Medicaid benefits. Medicaid fraud also occurs when a provider bills Medicaid for services that were not delivered to a Medicaid member, or if a member allows another person to use his/her Medicaid number to get medical care for someone who has not been determined eligible for Medicaid benefits.

Anyone convicted of Medicaid fraud in a criminal court must repay the Medicaid program for all losses (paid claims and managed care premiums) and cannot receive Medicaid benefits for one year after conviction. In addition, the sentence could include a fine up to \$25,000 and/or up to 20 years in prison. You may also have to repay the Medicaid program for any claims and managed care premiums paid during periods you were not eligible for Medicaid due to acts not considered criminal. Fraud and abuse should be reported to your local Department of Social Services or to the DMAS Recipient Audit Unit at (804) 786-0156. Additional numbers for reporting suspected fraud and abuse are (804) 786-1066 (local) and toll free 1 (866) 486-1971. Fraud and abuse can also be reported by e-mail to recipientfraud@dmas.virginia.gov.

Medicaid can also recover payments made for services received by, or managed care premiums paid on behalf of, ineligible members who did not intend to commit fraud. **This also includes recovery for medical services received during an appeal process when the agency's action is upheld.** There is no time limit for Medicaid recoveries.

If you are enrolled in a Medicaid MCO, premiums are paid by Medicaid to the MCO every month for your coverage, even if you do not use any medical services that month. These premiums are considered losses to the program and can be recovered if you are determined ineligible for any prior period. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your caseworker, you may be liable to repay these monthly premiums.

Third Party Liability and Personal Injury Claims

If you have been injured in any type of accident and have a personal injury claim, you must inform your eligibility worker so that Medicaid may recover payment from the person responsible for the accident. Your worker will need information such as the date of the accident/injury, type of accident and the name of the attorney or insurance company, if any.

Estate Recovery

Report the death of a Medicaid member to your local DSS office. DSS will close the member's file; however Medicaid can recover money from the estate of a Medicaid member over age 55. Recovery may take place only after the death of any surviving spouse and only if there are no minor or disabled children. For more information about Estate Recovery see the fact sheet on the state DSS web page.

WHEN AND HOW TO FILE AN APPEAL

You have the right to request an appeal of any adverse action related to initial or continued eligibility for Medicaid. This includes delayed processing of your application, actions to deny your request for medical services, or actions to reduce or terminate coverage after your eligibility has been determined.

To request an appeal, notify DMAS and/or your MCO in writing of the action you disagree with within 30 days of receipt of the agency's notice about the action. You may write a letter or complete an Appeal Request Form. Forms are available on the Internet at dmas.virginia.gov (under client services).

Please be specific about what action or decision you wish to appeal and include a copy of the notice about the action if you have it. Be sure to sign the letter or form.

Appeal requests can be mailed to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Telephone: (804) 371-8488
Fax: (804) 452-5454

If you are appealing reduction or termination of coverage and your request is made before the effective date of the action, your coverage may continue pending the outcome of the appeal. You may, however, have to repay the Medicaid program for any services you receive during the continued coverage period if the agency's action is upheld. After you file your appeal, you will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.

PRIVACY INFORMATION

When you receive health care services from an agency like DMAS, that agency may get medical (health) information about you. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your health information is protected. Health information includes any information that relates to: (1) your past, present or future physical or mental health or condition, (2) providing health care to you, or (3) the past, present or future payment of your health care.

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never share or sell your information for marketing purposes.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available by mail upon request and on our web site.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

DEFINITIONS

Activities of Daily Living	Personal care tasks, (e.g. bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of dependence in performing these activities is part of determining the appropriate level of care and service needs.
Asset Transfer	Medicaid applicants and recipients must be fully compensated for any transfers of money, property or other assets.
Authorized Representative	Person who is authorized in writing to conduct the personal or financial affairs for an individual.
Caseworker	Eligibility Worker at the local department of social services who processes the application to determine Medicaid eligibility and maintains the ongoing case. This is the person to contact regarding changes, such as address or income, or problems, such as not receiving the Medicaid card.
Certified Application Assistor	Volunteer trained by the government and authorized by you to assist with your application.
Coinsurance	The portion of Medicare, Medicaid, or other insurance, allowed charges for which the patient is responsible.
Co-Payment	The portion of Medicaid-allowed charges which a member is required to pay directly to the provider for certain services or procedures rendered.
DMAS	Department of Medical Assistance Services, the agency that administers the Medicaid program in Virginia.
DSS	Department of Social Services, the agency responsible for determining eligibility for medical assistance and the provision of related social services. This includes the local departments of social services.

Fraud	A deliberate withholding or hiding of information or giving false information to obtain or attempt to obtain Medicaid benefits.
Generic Drugs	Copies of drugs that are the same as a brand-name drug in dosage, safety, strength, quality, performance, and intended use. The Food and Drug Administration requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Manufacturers of generic drugs don't have the same investment costs as a developer of new drugs; therefore generic drugs are less expensive.
Health Insurance Marketplace (HIM)	Online federal marketplace for private health insurance plans. Individuals can shop for health insurance, compare private plans, and determine whether they qualify for a subsidy to help pay for health insurance.
Managed Care	Delivery of health care services emphasizing the relationship between a primary care provider (PCP) and the Medicaid member (referred to as a "medical home"). The goal of managed care is to have a central point through which all medical care is coordinated. Managed care has proven to enhance access to care, promote patient compliance and responsibility when seeking medical care and services, provide for continuity of care, encourage preventive care, and produce better medical outcomes. Most Virginia Medicaid members are required to receive their medical care through managed care programs.
MCO	Managed Care Organizations are health plans contracted to provide medical services and coordinate health care services through networks of providers.
Medicaid	An assistance program that helps pay for medical care for certain individuals and families with low incomes and resources.
Medically Necessary	Reasonable and necessary services for the diagnosis or treatment of an illness or injury or to improve physical functioning.

Patient Pay	Individuals with income may have to contribute to the cost of their long term care services.
Uniform Assessment Instrument (UAI)	Pre-Admission Screening form completed by team that evaluates applicants' ability to complete activities of daily living.
Primary Care Provider (PCP)	The doctor or clinic that provides most personal health care needs, gives referrals to other health care providers when needed, and monitors Medicaid member health. A PCP may be an internist, a pediatrician (children's doctor), OB/GYN (women's doctor), or certain clinics and health departments.
Resources (Assets)	Resources include money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, pre-paid burial plans; cars, boats, life insurance policies, and real property.
SSI	Supplemental Security Income is a federal program administered by the Social Security Administration that pays monthly benefits to disabled, blind or age 65 or older individuals with limited income and resources. Blind or disabled children, as well as adults, can get SSI benefits.

ADDRESSES, PHONE NUMBERS and WEBSITES

Local departments of social services in your city or county

Check the government (blue) pages of the local telephone book for the proper contact number for the following information:

- Questions about applying for Medicaid or your eligibility for the program
- Report a change in residence, income, or other significant event
- Questions about pre-admission screening for long-term care services
- Request Fact Sheets about Medicaid eligibility

Virginia Department of Social Services

For questions or concerns regarding the actions of staff employed by your local department of social services, write the Virginia Department of Social Services, Bureau of Customer Service, 801 E. Main Street, Richmond, Virginia 23219. You can also call the customer service hotline at 1-800-552-3431 or email your concern to citizen.services@dss.virginia.gov.

Department of Medical Assistance Services

- For Medicaid **appeal** information, call (804) 371-8488
- Client Medical Management (**CMM**) 1-888-323-0589
- Dental Services, **Smiles for Children**, 1-888-912-3456
- For information about **FAMIS and Medicaid**, call Cover Virginia 1-855-242-8282. To report Medicaid fraud or abuse, call the DMAS Recipient Audit Unit at (804) 786-0156 or your local department of social services or (804) 786-1066 and toll free 1-866-486-1971.
- Health Insurance Premium Payment Program (**HIPP**) toll free, 1-800-432-5924
- For information about **Managed Care** enrollment, comparison charts, and MCO contact information, call 1-800-643-2273 or visit <http://www.virginiamanagedcare.com>
- For problems with bills or services from providers call the **Recipient Helpline** at (804) 786-6145, or write the Recipient Services Unit at the address on the cover of this handbook
- **Transportation**; if you need transportation for a Medicaid covered service appointment and you are not enrolled in an MCO, call **Logisticare** toll free, 1-866-386-8331.
- Medical service providers submit requests for treatment prior authorization to **KePRO**, Virginia's health utilization management company. Services that do not require preauthorization include pharmacy, dental and transportation.
- For Behavioral Health information call Magellan at 1-800-424-4046 or visit www.magellanofvirginia.com

Website Information Cover Virginia www.coverva.org
Centers for Medicare and Medicaid Services www.cms.hhs.gov
Social Security Administration www.ssa.gov
Virginia Department of Health www.vdh.virginia.gov
Virginia Department of Medical Assistance Services www.dmas.virginia.gov
Virginia Department of Social Services www.dss.virginia.gov
CommonHelp commonhelp.virginia.gov

OTHER RESOURCES

Benefit Programs

Eligibility for Supplemental Nutrition Assistance Program (**SNAP**), Temporary Assistance for Needy Families (TANF), Heating and Cooling Assistance and other benefits programs are determined by your local DSS.

www.dss.virginia.gov/ or commonhelp.virginia.gov

CoverVA.org – Virginians can get information regarding Medicaid and the Federal Health Insurance Marketplace and other community health care options from the new Cover Virginia website. Virginians without access to a computer can apply for Medicaid or FAMIS by dialing the Cover Virginia Call Center at 1-855-242-8282.

Healthcare.Org – Individuals can access the Federal Health Insurance Marketplace online at this website or by calling 1-800-318-2596 to purchase private health insurance. They can determine if they are eligible for federal tax credits or subsidies to help pay for health insurance.

Medicare

Individuals with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for Individuals with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.

Senior Navigator

Visit the **Senior Navigator** website to find programs, services and information helpful to seniors, caregivers, baby boomers and their families. The website is www.seniornavigator.org

Social Security Administration

For information about Social Security benefits and services and to find information about getting a Social Security card or applying for benefits, go online to www.socialsecurity.gov

Virginia Easy Access

The Virginia Easy Access program offers information for individuals in need of long-term supports about community supports, emergency preparedness, financial help, housing, rights, transportation, veterans and other related links. The link is www.easyaccess.virginia.gov.

Virginia Easy Access can also be reached by dialing 211.