

MEDICAID AND FAMIS PLUS HANDBOOK

Commonwealth of Virginia

Department of Medical Assistance Services

dmasva.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

Medicaid and **FAMIS Plus**, Medicaid's program for children, are programs that help pay for medical care. To be eligible for Medicaid or FAMIS Plus you must have limited income and resources and you must be in one of the groups of individuals covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children, individuals with disabilities, and individuals age 65 and older.

Medicaid and FAMIS Plus are funded by the state and federal governments. Not everyone with high medical bills qualifies. The eligibility rules may be different for children, adults, and individuals in nursing facilities, 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.
- **Limited coverage**
 - Individuals who meet a spenddown have time limited coverage.
 - Men and women who have income within 200% of the Federal Poverty Level (FPL) may be eligible for limited benefits (family planning services) through Plan First.
- **Medicare-related coverage** – Provides Medicaid payment of Medicare premiums; may also include payment of Medicare's deductible and coinsurance, up to Medicaid's maximum payments.

How Do I Apply?

An application form for Medicaid and FAMIS Plus can be printed or completed online at the DSS website www.dss.virginia.gov/form/. You can also contact the local department of social services (LDSS) 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. Applications can be filed at some larger hospitals. Applications for children and pregnant women are also accepted through the FAMIS Central Processing Unit (CPU) **1-866-87FAMIS (1-866-873-2647)** www.famis.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 her own, she as the parent can file an application for the child. A face-to-face interview is not required.

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 or children's health insurance. The final decision regarding eligibility will be made by an eligibility worker at your local DSS or the CPU. The screening tool can be found on the website at jupiter.dss.state.va.us/EligibilityScreening.

What Will I Be Asked?

Applicants for Medicaid and Plan First are asked to provide their Social Security number, declare Virginia residency, and 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. If you are pregnant, you will be asked to provide proof of pregnancy from a medical provider, such as the written medical results (documentation) of your pregnancy test and an estimated date of delivery.

Income

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, Veteran's benefits, child support, etc. All sources of income are added together and compared to the income limit to determine eligibility.

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 people who meet all Medicaid eligibility requirements except for income may be placed on a Medically Needy "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 determined by the amount of resources transferred compared to the average nursing home rate.

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 defined period of time.**

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 enrollees 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 remains at home 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 medical institution. 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.

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

Once a signed application is received, LDSS or CPU 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 **OR**

(3) Within 10 working days for pregnant women and participants in the Virginia Department of Health's Every Woman's Life Program (BCCPTA) **AFTER** the signed application and all necessary documentation have been received.

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.

How Do I Keep My Coverage?

Once approved for Medicaid or FAMIS Plus, coverage will continue for 12 months, as long as the eligibility requirements continue to be met. Medicaid or FAMIS Plus 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 and you may have to pay for any medical care the enrollee has received. In some cases your Medicaid or FAMIS Plus coverage may be reviewed before the end of the 12 months. 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 or FAMIS Plus 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 LDSS eligibility worker. If the LDSS is able to renew Medicaid or FAMIS Plus 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.

REMEMBER - You must report any change in circumstances (such as new or changed address, income, or health insurance coverage) **within 10 calendar days of the change.** If the reported change affects your eligibility for Medicaid or FAMIS Plus, 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/FAMIS Plus 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 Recipient Audit Unit (RAU) for an evaluation of possible Medicaid fraud. That evaluation could result in the RAU requesting repayment for Medicaid 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 or FAMIS Plus coverage and **your coverage may be canceled.** If you move or change your address at any time, contact your local DSS right away to protect your coverage.

FULL COVERAGE 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.

The **Medicaid covered groups** are:

- **Aged** (65 and older), blind, or persons with disabilities
 - 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 Income Guidelines*
 - who receive Supplemental Security Income (SSI) and who meet Medicaid resource limits

- Auxiliary Grant (**AG**) enrollees in Assisted Living Facilities
- 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
- Low Income Families with Dependent Children (**LIFC**) – parents with low income
- Certain **refugees** for a limited time period
- **Children:**
 - from birth to age 19 whose family income is at or below 133% of the Federal Poverty Income Guidelines*
 - Children under age 21 who are in foster care or subsidized adoptions
 - Infants born to Medicaid-eligible women
- **Pregnant women** (single or married) whose family income is at or below 133% of the Federal Poverty Income Guidelines*
- Women screened by the Virginia Department of Health's Every Woman's Life Program (**BCCPTA**) who have been diagnosed and need treatment for breast or cervical cancer

Note: Pregnant women and children from birth to age 19 whose family income is above 133% of the Federal Poverty Income Guidelines* may qualify for FAMIS

*The Federal Poverty Income Guidelines are available on the DSS website at:
http://www.dss.virginia.gov/benefit/medical_assistance/index.cgi

LIMITED COVERAGE GROUPS

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 QDWI are \$6,940 for a single person and \$10,410 for a couple - amounts as of January 1, 2012):

- **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.

| | | | | |
|---------------------------------|--|---|-------------------------|--|
| 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 routine and periodic family planning office visits including

- Annual family planning exams for men and women
- Pap tests
- Sexually transmitted disease (STD) 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)

Any Plan First member needing health services not covered by the Plan First program may seek services through their primary care provider, the Virginia Primary Care Association, the local Health Department, and/or the Virginia Association of Free Clinics.

Individuals applying for full benefit coverage or losing full benefit coverage because they no longer meet a covered group 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.

Emergency Services for Non-Citizens

Special rules apply to non-citizens. If a person meets one of the covered groups listed above but is not a U.S. citizen, then his immigration status and date of entry into the United States affect his eligibility for full Medicaid coverage. If the immigration status prohibits full Medicaid coverage, he may be eligible for Medicaid payment for emergency medical treatment if he meets all other Medicaid eligibility requirements.

MEDICAID AND OTHER INSURANCE

If you already have health insurance you can still be covered by Medicaid or FAMIS Plus. 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 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 eligibility worker at DSS. If you don't, medical bill payment could be delayed.

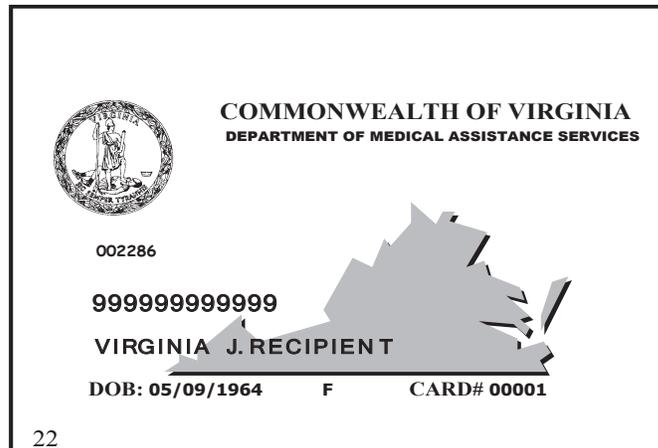
Sometimes Medicaid pays claims for covered services and it is later found that another payment source was available. In this situation Medicaid will try to recover the money from the other source, whether from commercial insurance, Medicare, Worker's Compensation, or liability insurance (if the claim is for an accident). Applicants for Medicaid sign a statement called "Assignment of Rights to Medical Support and Third-Party Payments." 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. DSS can provide information regarding this program. For more information call the Health Insurance Premium Payment Unit at 1-800-432-5924 or send an email to hippcustomerservice@dmas.virginia.gov.

MEDICAID OR FAMIS PLUS MEDICAL CARD

When you are found eligible you will be mailed a blue and white plastic medical assistance card (Medicaid or FAMIS Plus card) on which your name and identification number are printed. **It is your responsibility to show your Medical 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 Medicaid or FAMIS Plus card because you were eligible at an earlier time, **keep it.** That card will be valid again if your coverage is reinstated.



Using Your Medical Card

Each person in your family who is eligible for Medicaid or FAMIS Plus 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 medical card 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 identification 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

Regular Medicaid Coverage

Providers who are directly enrolled with the Department of Medical Assistance Services offer care directly to some Medicaid/FAMIS Plus enrollees. 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 Department of Medical Assistance Provider search http://www.dmas.virginia.gov/provider_search.ASP or call the Recipient Helpline at (804) 786-6145.

Managed Care

Most Virginia Medicaid and FAMIS Plus 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, then within 15-45 days after your Medicaid approval you will receive a letter from DMAS requiring you to choose either an MCO for your health care. You will receive information about the programs such as an MCO Comparison Chart and a brochure. You will have approximately one month to choose an MCO. **If you do not make a choice, you will be assigned 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 plastic medical ID 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 their 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 pick 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 plastic 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 its own similar program. If you are identified for enrollment in one of these programs you will be notified by your MCO.

MEDICAL CARE UNDER MEDICAID AND FAMIS PLUS

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. Routine dental care for adults is not covered. There are limits to the number of visits approved for home health, psychiatric services, and other professional services. Some services require prior authorization.

Dental Care - Smiles for Children

The Smiles for Children program provides coverage for diagnostic, preventive, restorative/surgical procedures and orthodontia services for Medicaid and FAMIS Plus children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). DentaQuest is the single dental

benefits administrator that coordinates the delivery of all Smiles for Children dental services. If you need help finding a dentist or making a dental appointment, please call 1-888-912-3456 to speak with a Smiles for Children representative.

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

After a certain number of appointments, additional 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).

School Health Services

If your child is eligible for Medicaid or FAMIS and he or she receives health-related services specified in an Individualized Education Program (IEP), federal funds available to DMAS can help the public school division pay for these health-related services. Health-related services can include, but are not limited to:

- physical, occupational or speech therapy
- audiology
- nursing
- psychological or personal care services
- health screening associated with Early Periodic Screening Diagnosis and Treatment (EPSDT).
- Specialized transportation on days your child is receiving a health-related service may also be covered

Your child's health coverage for services outside the school system will not be impacted by the school billing Medicaid or FAMIS.

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** – All non-emergency medical transportation is provided through a transportation broker or through your Managed Care Organization.

Transportation is provided if you have no other means of transportation and need to go to a physician or a health care facility. 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 if the doctor will see you sooner.) 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 them for their 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:

FHSC Unit
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 |

A medical provider cannot refuse to treat you or provide medical care if you are not able to pay the co-payment. However, you are still responsible for paying the co-payment, if any. Managed Care Organizations (MCOs) do not charge a co-payment.

BENEFITS UNDER MEDICAID AND FAMIS PLUS

A description of each benefit follows this list.

- Babycare (including prenatal and maternal care)
- Clinic Services
- Community-Based Residential Services for Children and Adolescents under 21
- Community Mental Health and Mental Retardation Services
- Dental Care Services
- Durable Medical Equipment and Supplies (**DME**)
- Early and Periodic Screening, Diagnosis, and Treatment (**EPSDT**) – most frequently provided specialized services are:
 - Hearing Aids
 - Medical Formula and Medical Nutritional Supplements
 - Personal Care
 - Private Duty/Specialized Nursing
 - Specialized Services to Address Complex Medical Needs
 - Substance Abuse Treatment
- Early Intervention
- Eye Examinations
- Eyeglasses
- 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
- Lead Testing
- Long-Term Care
- Money Follows the Person (**MFP**) Program
- Nursing Facility
- Organ Transplants
- Personal Care
- Physician's Services
- Podiatry Services (foot care)
- 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

BabyCare – Case Management for high-risk pregnant women and infants up to age two enrolled in Medicaid, FAMIS, FAMIS Plus and FAMIS MOMS. Expanded prenatal services provided through BabyCare are available to help women have a positive pregnancy outcome. These services are

- Prenatal education for a variety of topics including tobacco cessation, preparation for childbirth, and parenting
- Nutritional assessment and counseling
- Homemaker services to members for whom the physician has ordered complete bed rest
- Substance Abuse Treatment Services

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

Community-Based Residential Services for Children and Adolescents under 21 - Level A – Community Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. The residential service will provide structure of daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service.

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

Dental Care Services – Individuals under age 21 are eligible for comprehensive services including diagnostic, preventative, restorative/surgical procedures and orthodontics. Dentures, braces, and permanent crowns are covered for those under 21 when prescribed by a dentist and pre-authorized by DMAS. 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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A program of preventive health care and well child examinations with appropriate tests and immunizations for children and teens from birth up to age 21 to keep children healthy. Medically necessary services, which are required to correct or improve

defects and physical or mental illnesses that are discovered during a screening examination, may be covered as a part of the EPSDT program even if they are not covered under the State's Medical benefit plan.

Early Intervention – Case management and other services designed to meet the developmental needs of infants or toddlers with a developmental delay up to age three. This program also helps meet the needs of the family related to enhancing the child's development.

Eye Examinations – Limited to once every two years.

Eyeglasses – Covered only for members younger than 21 years of age.

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 for more than five visits. 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:** A patient who has been admitted to a hospital for bed occupancy to receive hospital services. Approved days are covered.
- **Outpatient:** A patient receiving medical services but not admitted 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. This includes medical attention, nursing care, and related services. These services are provided in institutional settings called "Institutions for Mental Disease," which can be hospitals, nursing facilities, or other institutions with more than 16 beds.

Lead Testing – Lead testing is required for every Medicaid-eligible child as part of the 12- and 24-month EPSDT screenings. It is also administered to any child between the ages of 36 and 72 months old who has not been previously screened.

Long-Term Care – This may include care in an institutional setting such as a Nursing Facility or Intermediate Care Facility for the Mentally Retarded 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 (such as nursing facilities, Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/MR) and long-stay hospitals, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF)) in the Commonwealth of Virginia 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 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 by DMAS.

Psychiatric or Psychological Services – Medicaid covers up to 26 mental health or substance abuse visits without preauthorization. Additional sessions (up to 26 per year) must be pre-authorized.

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.

Residential Treatment Services (Level C)- Freestanding Hospital and Residential Treatment Facility Services for Children and Adolescents under Age 21 whose need for psychiatric services to treat severe mental, emotional and behavioral disorders is identified through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Services must be medically necessary and preauthorization is required.

Therapeutic Behavioral Services (Level B) – Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. These services will provide structure for daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs or facilities with 16 or fewer beds are eligible to provide this service.

Transportation Services for Medical Treatment:

Emergency – Full Medicaid covers 911 emergency 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)

Treatment Foster Care – Case Management – Case Management Services for children who are in therapeutic foster care.

WHAT IS NOT COVERED BY MEDICAID AND FAMIS PLUS

Some services below may be covered for members under age 21 under EPSDT.

- Abortions, unless the pregnancy is life-threatening
- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Alcohol and drug abuse therapy (except as provided through EPSDT or for pregnant women through the Community Services Boards and under the BabyCare program)
- 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 (except as provided through EPSDT)
- 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)
- Inpatient hospital care in an institution for the treatment of mental disease for members under age 65 (unless they are under age 22 and receiving inpatient psychiatric services)
- 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)

- Psychological testing done for school purposes, educational diagnosis, school, or institution admission and/or placement or upon court order
- Remedial education
- Routine dental care if you are age 21 or older
- Routine school physicals or sports physicals
- Sterilization of members younger than age 21
- 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.

SERVICES FOR CHILDREN/EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a comprehensive and preventive child health program for members in Medicaid or FAMIS Plus up to age 21 that detects and treats health care problems through:

- ✓ Regular medical, dental, vision, and hearing check-ups
- ✓ Diagnosis of problems
- ✓ Treatment of dental, eye, hearing, and other medical problems discovered during check-ups

EPSDT IS FREE:

- ✓ Medicaid will pay for the EPSDT check-ups.
- ✓ Medicaid will pay for the treatment of dental, vision, hearing, and other medical problems, found during a check-up.
- ✓ If eligible for transportation benefit, Medicaid will provide transportation to your child's appointment. Contact your Managed Care Organization, or if you do not have a Managed Care Organization call toll-free: (866) 386-8331.

EPSDT exams (check-ups) are done by your child's doctor and must include:

- ✓ A complete history of your child's health, nutrition, and development
- ✓ A head-to-toe physical exam
- ✓ Health education
- ✓ A growth and development check
- ✓ Lab tests

- ✓ All children must be tested for lead exposure at 12 and 24 months of age or before the age of 6 if not previously tested
- ✓ Shots/immunizations, as needed
- ✓ Eye check-up
- ✓ Hearing check-up
- ✓ Referral to a dentist by the age of three

Dental check-ups with a dentist should be done every 6 months. For a referral to a dentist contact Smiles for Children at 1-888-912-3456.

You should take your child to the doctor for check-ups early and on a regular basis.

Getting regular EPSDT check-ups when your child is not sick is the best way to make sure your child stays healthy!

Use the chart below to find out when your child should receive regular check-ups:

| Babies Toddlers | Children | Older Children | Teenagers |
|--------------------|----------|-------------------|-----------|
| Birth | 15 mo* | 5 yrs * | 12 yrs * |
| 1 mo * | 18 mo* | 6 yrs * | 13 yrs |
| 2 mo * | 24 mo* | 8 yrs | 14 yrs |
| 4 mo * | 36 mo | 10 yrs | 15 yrs |
| 6 mo * | 4 yrs* | | 16 yrs |
| 9 mo * | | | 17 yrs |
| 12 mo * | | | 18 yrs |
| | | | 19 yrs |
| | | | 20 yrs |

* Most immunizations (shots) are given during these visits

Ask your doctor for more information about immunizations

If a treatment or service is needed to correct or improve a problem that is found during an EPSDT check-up, or prevent a problem from getting worse, talk with your child's doctor. There are services covered through EPSDT that are not normally covered by Medicaid. Your child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment.

LONG-TERM CARE (LTC) SERVICES

Medicaid pays for LTC services in some institutional settings, such as nursing facilities and Intermediate Care Facilities for the Mentally Retarded/Intellectually Disabled, and for individuals in their communities through Home-and-Community-Based-Care Waivers. 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/or 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
- Child Development Clinics Staff

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. The seven waivers are:

- **AIDS Waiver** - provides care in the community for individuals who are experiencing medical and functional symptoms associated with HIV/AIDS.
- **Elderly or Disabled with Consumer Direction (ED/CD) Waiver** - provides care 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 appropriate and duplicate services are not provided. Services offered in this waiver include personal care, respite (including skilled respite), adult day health care, and personal emergency response system services.

- **Individual and Family Developmental Disabilities (DD) Support Waiver** - provides care 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 mental retardation/intellectual disability, and who (1) meet the ICF/MR level of care criteria, (2) are determined to be at imminent risk of ICF/MR/ID 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/MR/ID.
- **Mental Retardation (MR)/Intellectual Disabilities (ID) Waiver** - provides care in the community rather than in an Intermediate Care Facility (for persons with)/Mental Retardation/Intellectual Disability (ICF/MR/ID) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation. Services available under this waiver include residential support, day support, supported employment, prevocational services, personal assistance, respite, companion, assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems.
- **Technology Assisted (Tech) Waiver** - provides care in the community for individuals who are dependent upon technological support and require substantial, ongoing nursing care. Services available under this waiver include personal care (adults only), private duty nursing, respite care, environmental modifications and assistive technology.
- **Day Support (DS) Waiver for Individuals with Mental Retardation/Intellectual Disability (MR/ID)** – provides home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR/ID and are on the waiting list for the MR/ID Waiver. The services provided under this waiver include day support and prevocational services.
- **Alzheimer’s Assisted Living (AAL) Waiver** – is available only to individuals who live in an Assisted Living facility, receive care through DSS, are Auxiliary Grant (AG) recipients, and have a diagnosis of Alzheimer’s disease or a related dementia with no diagnosis of mental illness or mental retardation. The services provided under this waiver include assistance with activities of daily living, medication administration by licensed professionals, nursing services for assessments and evaluations, and therapeutic social and recreational programming which provides daily activities for individuals with dementia.

Please contact the local department of social services, Community Services Boards, or DMAS at 804-225-4222 for further information.

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:
 - Moving, birth of a child, death of a family member, marriage, new employment, adding or dropping other insurance or any change in living 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 plastic medical 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 or FAMIS Plus 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 or FAMIS Plus 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 get Medicaid 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 Department of Medical Assistance Services 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 to ensure 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. DSS 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.

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 or FAMIS Plus. 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 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 dmasva.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.

Please mail appeal requests to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Telephone: (804) 371-8488
Fax: (804) 371-8491

For reduction or termination of coverage, if 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.

IMPORTANT ADDRESSES AND PHONE NUMBERS

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, FAMIS Plus, 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**, call 1-866-87FAMIS (1-866-873-2647)
- 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**) call toll free, 1-800-432-5924
- For information about **Managed Care** enrollment, call 1-800-643-2273
- **Long Term Care** information or problems, call 804-225-4222
- 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.

Website Information

FAMIS – Family Access to Medical Insurance Security www.famis.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 dmasva.dmas.virginia.gov

Virginia Department of Social Services www.dss.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 department of social services.
www.dss.virginia.gov/

Early Intervention Program

Early Intervention services are available throughout Virginia to help infants and toddlers (under age 3 who have developmental delays or disabilities) and their families. Contact: Infant & Toddler Connection of Virginia 804-786-3710 or
infantva.org/

Head Start

Head Start is a federally funded pre-school program that serves low-income children and their families. Contact your local school division for more information.
www.headstartva.org/

Healthy Start

The Virginia Healthy Start Initiative (VHSI) is designed to reduce infant mortality in these urban and rural areas and small towns: Norfolk, Petersburg, Portsmouth, and Westmoreland County. For information contact the Healthy Start Program Coordinator at VDH at 804-864-7764, or online at
www.vdh.virginia.gov/LHD/threeriv/HealthyStart.htm

Linkages with Schools

Schools are key links in improving child health because they are in regular contact with students and parents. Schools play an important role in identifying children's health problems and improving access to a wide range of health care services. Schools help to inform eligible children and families about Medicaid and the EPSDT Program. See the Virginia Department of Education website for more information
www.doe.virginia.gov/students_parents/

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.

Resource Mothers Program

Teenagers are at high risk for poor birth outcomes, both medically and socially. The Resource Mothers Program trains and supervises laywomen to serve as a social support for pregnant teenagers and teenage parents of infants. The program helps low-income pregnant teenagers get prenatal care and other community services, follow good health care practices and continue in school. It also encourages the involvement of the infant's father and teens' parents to create a stable, nurturing home. For further information, contact the Division of Women's and Infants' Health, Virginia Department of Health at (804) 864-7768 or go to www.vdh.state.va.us

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

Supplemental Nutrition Program for Women, Infants, and Children (WIC)

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods. It provides nutrition counseling to pregnant, postpartum, or breastfeeding women, infants, and children under age five with nutritional and financial needs. Your child's doctor or EPSDT screening providers must refer eligible infants and children to the local health department for additional information and a WIC eligibility determination. Contact them by calling 1-888-942-3663 or online at www.wicva.com/

Virginia Easy Access

The Virginia Easy Access program offers information for people 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.

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.

This section explains your privacy rights, our duty to protect health information that identifies you, and how we may use or disclose health information that identifies you without your written permission. This information does not apply to health information that doesn't identify you or anyone else.

Your Privacy Rights

You have the following rights regarding health care information we maintain about you:

- You can look at or get a copy of health information we have about you, in most situations;
- You can ask us to correct certain information, including certain health information, about you if you believe the information is wrong or incomplete. Most of the time we cannot change or delete information, even if it is incorrect. However, if we decide to make a change, we will add the correct information to the record and note that the new information takes the place of the old information. The old information will remain in the record. If we deny your request to change the information, you can have your written disagreement placed in your record;
- You can ask for a list of the occasions we have disclosed health information about you;
- You can ask us to limit the use or disclosure of health information about you more than the law requires. However, the law does not make us agree to do that;
- You can tell us where and how to send messages that include health information about you, if you think sending the information to your usual address could put you in danger. You must put this request in writing, and you must specify where and how to contact you;
- You can ask for and get a paper copy of this information from us, either by phone, by mail or on our website at dmasva.dmas.virginia.gov;
- You can withdraw permission you gave us to use or disclose health information that identifies you, unless we have already taken action based on your permission. You must withdraw your permission in writing.

Our Duty To Protect Health Information That Identifies You

The law requires DMAS to protect the privacy of health information that identifies you. It also requires us to give you a Notice of its legal duties and privacy practices.

- In most situations, DMAS may not use or disclose health information that identifies you without your written permission. This Notice explains when we may use or disclose health information that identifies you without your permission.
- If DMAS changes its privacy practices, it must notify you of the changes. The new practices will apply to all health information we have about you, regardless of when DMAS received or created the information.
- As a part of their jobs with the agency, DMAS employees must protect the privacy of health information that identifies you. DMAS does not give employees access to health information unless they need it for business reasons, such as benefit decisions, paying bills and planning for the care you need. DMAS will punish employees who do not protect the privacy of health information that identifies you.

If you have any questions or need more information on your privacy rights, you may contact the following:

The Office of Compliance and Security at (804) 225-2860.

If you believe DMAS has violated your privacy rights, you may file a complaint by contacting the HIPAA Privacy hotline at (804) 225-2860. You may also file a written complaint at:

Office of Compliance and Security
Department of Medical Assistance Services (DMAS)
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services by mail at:

Office for Civil Rights, Region III
U.S. Department of Health & Human Services
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499

You can also call the Office of Civil Rights at phone at (215) 861-4441, by TDD at (215) 861-4440, or fax them at (215) 861-4431.

There will be no retaliation for filing a complaint.

How We Use Identifying Medical Information

Payment

DMAS may use or disclose health information to pay or collect payment for health care. For example, when a doctor sends a bill to Medicaid, it includes information about the medical assistance member's illness and treatment.

Health care operations

DMAS may use or disclose health information for health care operations, such as performing quality assessments, medical reviews, legal services or auditing functions. Examples of use and disclosures of for health care operations include using or disclosing health information for case management; surveying nursing homes; or making sure providers bill only for care you receive. DMAS may contact members to tell about treatment alternatives or additional possible benefits.

Family member, other relative, or close personal friend

DMAS may disclose health information to a family member, other relative or close personal friend when:

- The health information is related to that person's involvement with care or payment for the member's care
- There is an opportunity to stop or limit the disclosure before it happens

Government programs providing public benefits

DMAS may disclose health information to another government agency offering public benefits if the information relates to whether a

person qualifies for or is signed up for Virginia Medicaid or the FAMIS program, and the law requires or specifically allows the disclosure.

Health oversight activities

DMAS may sometimes use or disclose health information for health oversight activities, and only to another health oversight agency or someone acting on behalf of a government agency.

Public health

DMAS may disclose health information to:

- A public health authority for purposes of preventing or controlling disease, injury or disability
- An official of a foreign government agency who is acting with the public health authority
- A government agency required to receive reports of child abuse or neglect

Victims of abuse, neglect, or domestic violence

If DMAS believes the Medicaid member is a victim or abuse, neglect, or domestic violence, the agency may sometimes disclose health information to a government agency that receives reports of abuse, neglect or domestic violence.

Serious threat to health or safety

DMAS may use or disclose health information if it believes the use or disclosure is needed, such as to prevent or lessen a serious and immediate threat to the health and safety of a person or the public.

For other law enforcement reasons

DMAS may disclose health information to a law enforcement agency official, such as the following law enforcement purposes:

- To comply with a grand jury subpoena
- To comply with an administrative request, such as a civil investigative demand, if the information is relevant to an administrative investigation of the Medicaid or FAMIS programs
- To identify and locate a suspect, fugitive, witness or missing person
- In response to a request for information about an actual or suspected crime victim
- To alert a law enforcement official of a death that DMAS suspects is the result of criminal conduct
- To report evidence of a crime on DMAS' property

For judicial or administrative proceedings

DMAS may disclose health information in response to an order from a regular or administrative court, or a subpoena or other discovery request by a party to a lawsuit, when DMAS is a party to the lawsuit.

As required by law

DMAS must use or disclose health information when a law requires the use or disclosure.

Contractors

DMAS may disclose health information to one of its contractors if the contractor:

- Needs the information to perform services for DMAS

- Agrees to protect the privacy and security of the information

Secretary of Health and Human Services

DMAS must disclose health information to the Secretary of Health and Human Services when the Secretary wants it to enforce privacy protections.

Research

DMAS may use or disclose health information for research if a research board approves the use. The board will ensure that member privacy is protected when information is used in research.

Other uses and disclosures

DMAS may use or disclose health information:

- To create health information that does not identify any specific individual
- To the U.S. military or foreign military for military purposes, if the enrollee is a member of the group asking for the information
- For purposes of lawful national security activities
- To Federal officials to protect the President and others
- To a prison or jail, if the enrollee is an inmate of that prison or jail, or to law enforcement personnel if in custody
- To comply with worker's compensation laws or similar laws
- To tell or help in telling a family member or another person involved with a case about enrollee location, general condition and death

DEFINITIONS

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| Activities of Daily Living | Personal care tasks, (e.g. bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of independence in performing these activities is part of determining the appropriate level of care and service needs. |
| 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. |
| 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. |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a program of preventive health care and well child examinations with tests and immunizations for children and teens from birth up to age 21. Medically necessary services needed to correct or improve defects and physical or mental illnesses (discovered during a screening examination) may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan. |
| FAMIS | Family Access to Medical Insurance Security is Virginia's Children's Health Insurance Program that helps pay for medical care for children under age 19 and pregnant women, FAMIS MOMS. FAMIS has higher income limits than Medicaid. |
| FAMIS Plus | An assistance program that helps pay for medical care for children under age 19 whose family income is within 133% of the Federal Poverty Limit for the family size. |

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| 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. |
| 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 Organization is a health plan contracted to provide medical services and coordinate health care services through a network 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 the function of a malformed arm or leg. |
| 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. |

