

MEDICAID AND FAMIS-PLUS HANDBOOK



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Mission Statement: *To provide a system of high quality comprehensive health services to qualifying Virginians and their families.*

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GENERAL INFORMATION ABOUT MEDICAID AND FAMIS PLUS

Medicaid and FAMIS Plus (Medicaid coverage 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 (things that you or someone in your household own) and you must be in one of the groups of people covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children, parents who have children under age 18 in the home, people with disabilities, and people age 65 and older. Each group has its own eligibility rules but all people within the same group are treated the same. Medicaid is not designed to help everyone with every medical expense.

Medicaid and FAMIS Plus are programs paid for by the state and federal governments. In Virginia, the Department of Medical Assistance Services (DMAS) manages the Medicaid and FAMIS Plus programs. The local Department of Social Services (DSS) agencies take applications and determine eligibility for Medicaid and FAMIS Plus.

Medicaid has three types of benefits:

- **Full coverage** – Provides all of the Medicaid benefits including doctor, hospital, and pharmacy services. Individuals enrolled in Medicare Part A and or Part B receive pharmacy coverage through Medicare Part D.
- **Limited coverage** – Provides coverage for either a limited time period or coverage of limited services. Time limited coverage may include people who have to meet a Medicaid "spenddown" to be eligible for Medicaid. Coverage of limited services includes the Plan First program which covers family planning services only for individuals who are not eligible for full Medicaid coverage.
- **Medicare Savings Programs** – 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?

To apply for Medicaid and FAMIS Plus, contact the local DSS agency in the city or county where you live to request an application. The phone number for your local DSS can be found in the blue pages of your phone book, by contacting the Virginia Information and Referral hotline by dialing 211 or on-line at www.dss.virginia.gov/localagency. In addition, some hospitals have a Medicaid office where applications can be turned in.

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. A parent, guardian, authorized adult representative, or adult relative with whom the child lives must sign applications for children under the age of 18. Children under the age of 18 cannot apply for themselves unless they are emancipated. However, parents who are under age 18 may apply for their own children. A face-to-face interview is not required.

Medicaid, FAMIS Plus and Plan First applications are available online and can be downloaded at www.dss.virginia.gov/benefit/me_famis/forms.cgi. FAMIS Plus applications may also be downloaded from www.famis.org and Plan First applications downloaded from

www.planfirst.org. An online Application for Adult Medical Assistance is available on the web at <https://jupiter.dss.state.va.us/VDAMedicaid/info/info.faces>.

You may use the screening tool on the DSS website to help find out whether you may be eligible for Medicaid or FAMIS Plus, at www.dssiad.dss.state.va.us/EligibilityScreening, but the final decision must be made by an eligibility worker at your local DSS.

What Will I Be Asked?

If you are applying for Medicaid and FAMIS Plus you will be asked to give your Social Security number, declare that you live in Virginia, show proof of your identity and that you are a citizen of the U.S.. If you are not a U.S. citizen you must provide information and documents about your immigration status. Some immigrants can get full Medicaid coverage. Others can get only emergency services (see page 7). If you claim to be 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 further information about your medical condition. If you claim to be pregnant, you will be asked to provide proof of pregnancy from a medical provider, such as the written medical results of your pregnancy test.

Income

You must tell DSS about all income that you receive. Income includes earned income, such as wages, net profit from self-employment, as well as unearned income such as Social Security benefits, retirement pensions, veteran's benefits, and child support. All of your income is added together and compared to the appropriate income limit set by the federal government to determine if you are income eligible for Medicaid or FAMIS Plus.

The income limits vary according to the covered group, the type of coverage and for some groups depending on the county or city where you live. Total "gross income" is used to determine income eligibility for Medicaid or FAMIS Plus. "Gross income" is the amount before taxes or any deductions are taken from your income. The amount of your debts or bills that you owe cannot be used in determining whether your income is within the Medicaid or FAMIS Plus income limits.

Pregnant women, children, aged, blind, and disabled individuals whose family income is above the established income limit may be eligible for a limited period of time in the Medically Needy group. The Medically Needy group allows you to use incurred/unpaid medical bills to "spend down" the difference between your income and the income limit, to become income eligible for Medicaid or FAMIS Plus.

Children and pregnant women who have income over the Medicaid or FAMIS Plus income limits may qualify for the Family Access to Medical Insurance Security (FAMIS) or FAMIS MOMS program. For more information, call FAMIS toll free at 1-866-87FAMIS, (1-866-873-2647), or visit www.famis.org.

Resources (Assets)

You may be required to tell the local DSS about all your resources (things that you or someone in your household own). There is no resource review for FAMIS Plus, certain pregnant women or Plan First. Resources include money on hand and in the bank, stocks, bonds, certificates of deposit, trusts, or pre-paid burial plans. Resources also include cars, boats, life insurance policies, and real property. If you are required to report resources, all resources must be reported; however, not all resources are counted in deciding eligibility for Medicaid. For

example, you must report all vehicles you own; however, one vehicle that you own is not counted as a resource for Medicaid purposes.

If your resources are worth more than the Medicaid resource limit when you apply for Medicaid coverage, you may become eligible for Medicaid by lowering the amount of 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 certain period of time.

Long-Term Care (LTC) Asset Transfer

If you need long-term care (LTC) services, either in a nursing facility or in your home, you will be asked to describe all transfers (things that you own or things owned by a spouse that were given away) of assets or resources, or trust funds that have been set up within the past five (5) years. This can include transferring the title to a vehicle, removing your name from a property deed, or giving away money. If you transfer (sell, give away, or get rid of) assets without receiving payment or enough payment, you may be ineligible for Medicaid payment of long-term care services for a period of time. Some transfers of assets (resources) may not change eligibility depending on the situation or if the Medicaid program determines that the denial of Medicaid eligibility would cause an undue hardship. Transfers that you make after enrollment in Medicaid may also affect the 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 looked at to determine how much may be kept for the spouse who remains at home without changing 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 hospital. A resource assessment must be completed when a married individual in an institution, who has a spouse in the community, applies for Medicaid.

Because the LTC policy is very complex, you or someone on your behalf should contact your local DSS if you have questions. Local DSS staff will not tell any individual to take a specific course of action to get Medicaid, but they can give detailed policy information.

Who Makes A Decision, And How Long Does It Take?

Once the local DSS staff receives a signed application, they will determine whether you meet a Medicaid covered group (see Full and Limited Coverage Groups, page 5 and 6) and if your income and resources are within required limits. The amount of income and resources you can have and still be eligible for Medicaid depends on how many people you have in your family living with you and the resource and income limits set up for your covered group.

The local DSS will make a decision about your application:

- within 45 calendar days, or
- within 90 calendar days if a disability decision is needed, or
- within 10 working days of the local DSS receiving a signed application if all necessary paperwork has been provided to determine eligibility for pregnant women or women participating in the Virginia Department of Health's Every Woman's Life Program.

The local DSS will send you a written notice that your application has either been approved or denied. If you disagree with the decision made by the local DSS, you may file an appeal (see When and How to File an Appeal, page 24).

When Does Medicaid Start?

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

How Do I Keep My Coverage?

Once approved for Medicaid or FAMIS Plus, you will be covered for 12 months, as long as you continue to meet Medicaid requirements. Your eligibility must be reviewed at least once every 12 months to determine if you are still eligible for the program. If this annual review is not completed, you will lose coverage and you may have to pay for any medical care you or your child receives. 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 fill out a form and supply proof of your current income. Some people may also have to provide proof of their current resources. Or, your eligibility may be renewed for another 12 months using information already available to your local DSS eligibility worker.

If you are notified to fill out 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 date it is due, you will lose Medicaid or FAMIS Plus coverage. If you need help filling out the forms, call the local DSS eligibility worker.

If the local DSS is able to continue your Medicaid or FAMIS Plus coverage with information they already have, you will receive a notice telling you the coverage has been continued and the date of your next annual renewal.

REMEMBER - You must report any change in circumstances (change of address; marital status; persons in the household; person in home no longer disabled; amount of income; change in resources if resources were considered for your eligibility determination; motor vehicles owned; dependent care expenses; source of income, etc.) within 10 calendar days of the change. If you are not sure whether to report a particular change, contact your local DSS eligibility worker.

If a reported change(s) affects your eligibility for Medicaid or FAMIS Plus, your case will be reviewed at that time and you will be notified of the results. If you apply or are reviewed for another program offered by social services, such as Supplemental Nutrition Assistance Program (SNAP) formerly known as Food Stamps or Temporary Assistance for Needy Families (TANF), it is possible the eligibility worker will renew your Medicaid/FAMIS Plus at the same time and continue your coverage for another 12 months from that date.

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 you will lose your coverage. If you move or change your address at any time, contact your local DSS right away to protect your coverage. **Letters, medical assistance ID cards, and notices about your Medicaid benefits sent to you from DMAS will not be forwarded by the local post office if you only change your address with the Post Office.**

FULL COVERAGE GROUPS

Federal and state laws describe the groups of people who may be eligible for Medicaid. These groups of people are called Medicaid covered groups. The eligibility rules and medical services available are different for certain covered groups. If you meet one of the covered groups, you may be eligible for Medicaid coverage if your income and resources are within the required limits of the covered group. The Medicaid covered groups are:

- Aged (65 and older), blind, or persons with disabilities:
 - Who receive Supplemental Security Income (SSI) and meet Medicaid resource limits;
 - Who lost SSI because their income or living situation changed and meet federal requirements for protection of their Medicaid eligibility;
 - Who have income that does not exceed 80% of the Federal Poverty Income Guidelines*;
 - Individuals who are blind or disabled, at least 16 years old but not 65 years of age, who are working or can work and earn income and whose income does not exceed 80% of the Federal Poverty Income Guidelines. Earned income and resources retained from earnings are disregarded up to a certain level once enrolled in the MEDICAID WORKS program (a program that allows individuals with a disability to work and keep Medicaid coverage);
 - 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.
- Auxiliary Grants (AG) enrollees living in Assisted Living Facilities.
- 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 from birth to age 19 whose family income is above 133% of the Federal Poverty Income Guidelines may qualify for FAMIS);
 - Under age 21 who are in foster care or subsidized adoptions;
 - Under age 1 born to Medicaid-eligible women.
- Low Income Families with Dependent Children (LIFC). The group includes parents who have a dependent child under the age of 18 living in the household.
- Pregnant women (single or married) whose family income is at or below 133% of the Federal Poverty Income Guidelines; (Pregnant women whose family income exceeds 133% of the Federal Poverty Level may qualify for FAMIS MOMS or be placed on a spenddown.)

- Women screened by the Virginia Department of Health's Every Woman's Life Program who have been diagnosed and need treatment for breast or cervical cancer.
- Individuals who are terminally ill and have elected to receive hospice care.
- Medically Needy individuals who meet Medicaid covered group requirements but have excess income.

*The Federal Poverty Income Guidelines are available on the DMAS website at:
www.dmas.virginia.gov/downloads/pdfs/rcp-povlimit.pdf.

LIMITED COVERAGE GROUPS

Medicare Savings Programs (MSP)

If you are eligible for Medicare and meet one of the following MSPs covered groups you may receive limited Medicaid coverage. Medicaid pays the Medicare costs for these Medicare beneficiaries as indicated:

- **Qualified Medicare Beneficiaries (QMBs)** must be entitled to Medicare Part A. 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)** must be entitled to Medicare Part A. Income must be between 100% and 120% of the Federal Poverty Income Guidelines. Medicaid pays the Medicare Part B premiums.
- **Qualified Individuals (QIs)** must be entitled to Medicare Part A. Income must equal or exceed 120% but be less than 135% of the Federal Poverty Income Guidelines. Medicaid pays the Medicare Part B premiums.

Beginning January 1, 2010 the resource limit for QMBs, SLMBs and QIs is the limit that is used by the Medicare Part D Low Income Subsidy program, referred to as the Extra Help program. The resource limit can be found at www.ssa.gov/prescriptionhelp.

- **Qualified Disabled and Working Individuals (QDWIs)**—Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. Income must be 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.

Plan First (Family Planning Services Program)

Plan First pays for family planning services for eligible men and women who have income less than or equal to 133% of the federal poverty level (resources are not considered). Individuals who have had a sterilization procedure including a vasectomy for men, have medical insurance coverage or are eligible for full-coverage Medicaid are not eligible to participate in Plan First.

Plan First services are limited to:

- Annual pelvic exam & PAP test for women;
- Annual family planning physical exam for men;

- Sexually transmitted infection (STI) testing;
- Family planning education & counseling;
- Birth control methods such as:
 - Depo Provera (the Depo shot)
 - Contraceptive implants
 - Diaphragms, IUDs, contraceptive rings and patches
 - Birth control pills, foam and condoms
- Sterilizations (including having your tubes tied or vasectomy) if that is your choice

Emergency Services for Non-Citizens

Special rules apply to non-citizens. If you meet one of the covered groups listed above but are not a U.S. citizen, then the immigration status and date of entry into the U.S. will determine eligibility for full Medicaid coverage. If the immigration status prohibits full Medicaid coverage then Medicaid coverage of emergency medical treatment could be provided if all other Medicaid eligibility requirements are met.

MEDICAID AND OTHER INSURANCE

You can have private health insurance and still be covered by Medicaid or FAMIS Plus (excluding Plan First). If you have other insurance, the other insurance plan pays for medical services first. Having other health insurance does not change the Medicaid co-payment amount, if one is required, that you will 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 you enroll in a private health insurance plan, tell your eligibility worker at the local DSS, otherwise, payment of your bills could be delayed.

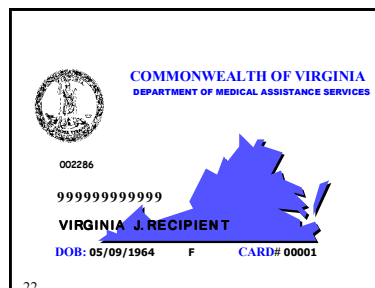
When Medicaid has paid the bills for covered services and it is later found that another payment source was available, Medicaid will try to get back the money from the other source, whether it is other insurance, Medicare, Worker's Compensation, or liability insurance (if the claim is for an accident). If you are paid by your insurance company after Medicaid has paid the same bill, you must send that money to DMAS.

Health Insurance Premium Payments (HIPP)

Medicaid may help with the cost of private health insurance premiums when it is determined to be cost-effective. The HIPP Program makes payments for employer sponsored group health plans or for individual policies if you are self-employed. You may get further information by calling the HIPP Program at 1-800-432-5924.

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), which contains your name, DOB and identification number. **It is your responsibility to show your Medical Card to providers at the time you go for services and to be sure the provider takes Virginia Medicaid.**



Medical Assistance Card

You will get a plastic medical assistance card in the mail when you are approved for Medicaid or FAMIS Plus (unless you are only eligible for payment of your Medicare premiums or emergency services). Every person in your family who is eligible for Medicaid or FAMIS Plus gets his or her own card. You will not receive 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 each time you get a medical service so that your medical provider can make sure you are eligible to receive services. If you receive your medical care through a Managed Care Organization (MCO), you will get a separate card from that organization. **You need to show both the MCO and the medical assistance cards when you get care.** If you do not take your card(s), you may be treated as a private-paying patient and you will be responsible for paying the bill.

Report the loss or theft of your medical identification card to the local DSS or your MCO card to your MCO right away. Do not allow anyone else to use your medical assistance card. If you knowingly allow anyone else to use your medical assistance card, you may be held responsible under the law.

USING YOUR MEDICAID BENEFITS

Regular Medicaid Coverage

Providers who are enrolled with DMAS and offer care directly to some Medicaid or FAMIS Plus enrollees are called Fee-For-Service (FFS) providers. If you do not have an assigned doctor or MCO (Managed Care Organization), you can choose any provider of care for medical services as long as the provider takes Virginia Medicaid payments. If you receive services from providers who are not signed up 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 are not sure if your provider is enrolled with the Virginia Medicaid program, ask them. You can also use the Provider Search function on the DMAS website at: www.dmas.virginia.gov or you may contact the DMAS Recipient Helpline at 804-786-6145 for help in finding a provider.

Managed Care

Most Virginia Medicaid and FAMIS Plus enrollees are required to receive their medical care through managed care programs. Virginia has two managed care programs that give quality health care services to enrollees – the MEDALLION Program and the Managed Care Organizations (MCOs). If you are eligible for a managed care program, within 15-45 days after your Medicaid approval you will receive a letter from DMAS telling you to pick either a MEDALLION Primary Care Provider (PCP) or an MCO for your health care. You will receive helpful information about the programs such as a list of MEDALLION PCPs and a Help Sheet, or an MCO Comparison Chart and a brochure. You will have about one month to choose a MEDALLION PCP or an MCO. **If you do not make a choice, DMAS will assign you to a PCP or MCO.**

MEDALLION

In MEDALLION, you will choose a PCP who will provide your primary health care services, give you referrals to other health care providers when needed, and arrange your healthcare needs. You can choose a different PCP for each person in your family who is covered by MEDALLION. Ask your family doctor if he or she accepts MEDALLION. The name of your PCP will be on a letter introducing your MEDALLION enrollment. Call the DMAS Managed Care Helpline at 1-800-643-2273 for more information.

Managed Care Organizations (MCOs)

An MCO is a health service organization that arranges health care services through a group of providers that includes PCPs, specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers. DMAS has 5 MCO plans, AMERIGROUP, Anthem, CareNet, Optima Family Care, and Virginia Premier. Once you pick the MCO of your choice, the MCO will mail a packet of information directly to you. You also will receive an MCO identification card to use with your plastic medical assistance card. **Please keep both cards with you and present both cards each time medical care is received.** You must pick one of the MCO's doctors to manage all of your health care needs. You do not have to enroll all members of your family in the same MCO or with the same PCP.

You must follow managed care program rules. These rules will be in the MCO member handbook that will be in the information packet that your MCO will send to you. If you do not follow the managed care program rules you may have to pay the bill for medical care. Look at your MCO member handbook for more details. Call the DMAS Managed Care Helpline at 1- 800-643-2273 for information.

Open Enrollment

There is an annual open enrollment time for the MEDALLION and MCO programs. At this open enrollment time you can change your MEDALLION PCP or 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.

Client Medical Management (CMM)

Some people need special help with their doctor and pharmacy use. If you are selected 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 letter. **If you do not tell Medicaid of your choices, DMAS will pick the providers for you.** Once you are assigned to one doctor and/or

pharmacy, you must get your care only from them unless they tell you to go to another provider. 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 described by CMM rules. Your plastic card contains information like a credit card, which tells the provider the names of your CMM providers. Each CMM enrollee is assigned a case manager to answer questions about the program and assist you in following the program rules.

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 done as outpatient surgery unless there is a medical need to be admitted to the hospital. Some services require that you get permission from the doctor before receiving them. This is known as authorization. Care in an institution for the treatment of mental diseases is not covered for people 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. For more information about services covered under Medicaid and FAMIS Plus, contact the DMAS Recipient Helpline at 804-786-6145.

BabyCare - Maternal and Child Health

BabyCare is a program for pregnant women and infants who get services through FAMIS Plus, or Medicaid and who are not currently enrolled in a Managed Care Organization (MCO). Women and infants enrolled in an MCO should contact their MCO for information on pregnancy and infant programs. BabyCare Case Management Services are for pregnant women or infants up to age two who are at higher risk for health problems during pregnancy or early childhood. BabyCare Expanded Services for pregnant women include childbirth and parenting classes, nutrition services, homemaker services for women on bed rest, and substance abuse treatment services. For more information about BabyCare, please contact the Maternal and Child Health Division at 804-786-6134.

Dental Care (Smiles For Children)

The *Smiles For Children* program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia (braces) services for Medicaid and FAMIS Plus children. The program also covers limited medically necessary oral surgery services for adults (age 21 and older) such as emergency extractions. If you need help finding a dentist or making a dental appointment, call *Smiles For Children* at 1-888-912-3456. Information is also available on the DMAS website at www.dmas.virginia.gov/dental-home.htm.

Pharmacy

Most prescription drugs are covered. Medicaid has a preferred drug list (PDL), but drugs not on the list may be covered if authorized. Prescriptions are filled with no more than a 34-day supply at a time. When available, generic drugs are given unless the doctor specifies that a particular brand name is medically necessary. In addition, some over-the-counter drugs may be covered if ordered by a doctor.

A doctor may also prescribe or order some over-the-counter drugs that are equal to certain prescription drugs if it costs less to do so. When available, generic drugs are given unless the doctor states that a particular brand name is medically necessary. This is true whether you get

services from Medicaid or through an MCO. If you have questions about the PDL, call 1-800-932-3923, your MCO, or talk to your doctor.

Enrollees who have Medicare Part A or Part B coverage must get 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 enrollees. Virginia Medicaid, however, continues to cover over-the-counter drugs, cough and cold drugs, barbiturates, benzodiazepines, and certain vitamins. For information about coverage under Medicare Part D contact Medicare at 1-800-MEDICARE (1-800-633-4227).

Transportation

DMAS provides pre-approved transportation using public transit, gas reimbursement, volunteer drivers, commercial transportation or ambulance. Transportation is provided if you need to go to a physician or a health care facility and you do not have any other means of transportation. Medicaid covers two types of transportation:

- **Emergency** - Medicaid pays for emergency transportation to receive emergency medical treatment. In case of a life-threatening emergency, call 911.
- **Out-of-State** - Transportation is provided when the DMAS Medical Support Unit preapproves a physician's request to send a patient out-of-state to receive specialized medical treatment that is not available in Virginia.
- **Non-Emergency** – All non-emergency medical transportation is provided through a transportation broker or through your Managed Care Organization (MCO).

Your medical condition should not be life threatening. To arrange a non-emergency trip, call 1-866-386-8331 **at least 5 days** before the scheduled medical appointment. Urgent trips, such as sudden non-emergency illnesses, are provided without 5 days notice if the doctor has agreed to see you. Patients discharged from hospitals are transported within 3 hours of the hospital's request. Please have the street address where you are going and your medical assistance ID number (the number on your Medicaid card) available when you call. Enrollees in an MCO should call the transportation number listed in your handbook to arrange for non-emergency trips.

Remember: Trips must be for a Medicaid covered service and must be medically necessary. Examples: doctor appointments, counseling, dialysis, dental appointments, etc. Medicaid transportation cannot make stops for shopping except if you need to go to a pharmacy to pick up a prescription that is being filled for you.

Out of State Medical Coverage

Coverage for out-of-state services is limited. Virginia Medicaid will cover emergency medical services you receive while temporarily outside of Virginia if the provider of care agrees to join Virginia's Medicaid Program and bill Medicaid. **No payments are made directly to you for the costs of services that you received while out of state.** Medical services received out of state may also be covered if it is determined on the basis of medical advice that the service was more readily available or accessible in the other state such as enrollees who live on the Virginia border. Rules for out-of-state care may be different if you get care through an MCO. If you are enrolled in an MCO, contact that MCO for its rules regarding out of state treatment.

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

Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261
Phone: 1-888-829-5373

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

CO-PAYMENTS

As a Medicaid enrollee you may be asked to pay a small part of the cost of some of your medical services. This is called a co-payment. You will pay this co-payment to the doctor, clinic or other provider. Co-payments for Medicaid covered services are shown below:

Medicaid charges co-payments for enrollees 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 drugs 3.00 for brand name drugs
Home health visit	3.00 per visit
Rehabilitation service	3.00 per visit

If you cannot pay your co-payment at the time of your doctor visit, you will still receive services. Your provider will bill you for the co-payment amount.

You Do Not pay a co-payment if you are:

- younger than age 21
- receiving institutional or community-based care, long-term care services (patient pay may be applicable)
- in a hospice program

You Do Not pay a co-payment for the following services:

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

BENEFITS UNDER MEDICAID AND FAMIS PLUS

Medicaid covers the following: (Description provided in next section)

- Clinic Services
- Community-Based Residential Services for Children and Adolescents under 21- Level A
- Community Mental Health and Mental Retardation Services
- Dental Care Services
- Durable Medical Equipment and Supplies (DME)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – See section SERVICES FOR CHILDREN/EPSDT, page 18, for additional information. In addition to routine covered services, the most frequently provided specialized services are:
 - Hearing Aids
 - Medical Formula and Medical Nutritional Supplements
 - Personal Care
 - Private Duty/Specialized Nursing
 - Specialized Inpatient and Residential Treatment Services to Address Complex Medical Needs
 - Substance Abuse Treatment (including residential)
 - Behavioral Treatment in the Home
- Eye Examinations
- Eyeglasses
- Family Planning Services (including family planning services through Plan First)
- Glucose Test Strips (Diabetes)
- Home Health Services
- Home and Community Based Waiver Services
- Hospice Services
- Hospital Care – Inpatient/Outpatient
- Hospital Emergency Room
- Inpatient Psychiatric Hospital Services for Individuals 65 or Older
- Intermediate Care Facilities for the Mentally Retarded/Intellectually Disabled
- Lead Testing
- Maternal and Infant Care Coordination (BabyCare)
- Nursing Facility
- Organ Transplants
- Personal Care
- Physician's Services
- Podiatry Services (foot care)
- Prenatal Care Expanded Services (BabyCare)
- Prescription Drugs when ordered by a Physician
- Prosthetic Devices
- Psychiatric or Psychological Services
- Renal (Kidney) Dialysis Clinic Visits
- Rehabilitation Services
- Residential Treatment Services (Level C)
- Substance Abuse
- Therapeutic Behavioral Services (Level B)
- Transportation Services for Medical Treatment
- Treatment Foster Care – Case Management

Covered Services Description (If enrolled in an MCO, please refer to the MCO handbook.)

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- Services are a combination of therapeutic services provided in a residential setting. The residential service will provide structure of daily activities to reach the therapeutic mental health goals in the individual service plan (plan of care). The child or adolescent must also receive psychotherapy services in addition to the therapeutic residential services.

Community Mental Health and Intellectual Disability (Mental Retardation) Services – Services provided in the individual’s home or community that provide diagnosis, treatment, or care of persons with mental illnesses or mental retardation. The following services are provided primarily by Community Services Boards and private providers:

- Community-Based Residential Services for Children and Adolescents (requires authorization)
- Crisis Intervention
- Crisis Stabilization
- Day Treatment/Partial Hospitalization for Adults (requires authorization)
- Intensive Community Treatment (requires authorization)
- Intensive In-Home services for Children and Adolescents (requires authorization)
- Mental Health Support (requires authorization)
- Mental Health Case Management (requires authorization)
- Psychosocial Rehabilitation (requires authorization)
- Substance Abuse Services
 - Day Treatment for Pregnant Women
 - Residential Treatment for Pregnant Women
 - Crisis Intervention
 - Day Treatment
 - Case Management
 - Opioid Treatment
- Therapeutic Day Treatment for Children and Adolescents (requires authorization)
- Therapeutic Behavioral Services for Children and Adolescents (requires authorization)

Dental Care Services – Routine services are available only for enrollees under 21 years of age. Braces require authorization. Dental treatment for adults is covered under certain circumstances through Virginia’s dental program *Smiles For Children*. Adult dental services are limited to medically necessary oral surgery and the services used to determine the medical problem such as X-rays and surgical extractions.

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

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

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) – The Well Child Checkup (screening) Program is for all Medicaid eligible children up to 21 years of age.

This screening program provides for well child checkups so any disease or physical problem can be detected early and the child can receive needed treatment. During the Well Child visit, you will receive health education to help you watch your child's development. If the doctor finds a medical problem during a screening, the child can be referred for extra doctor visits and may qualify for other medically necessary services (see SERVICES FOR CHILDREN/EPSTD page 18).

Eye Examinations – Limited to once every two years.

Eyeglasses – Covered only for enrollees 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 women and men. Coverage does not include services to treat infertility or services to promote fertility.

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

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

Home and Community Based Waiver Services – Services offered through one of the waiver programs such as personal care or respite care or adult day health care. There are several waiver programs to choose from. Additional information is available on the DMAS website at www.dmas.virginia.gov/ltc-home.htm.

Hospice Services – Comfort care for terminally ill recipients with a life expectancy of six months or less. Hospice manages all care related to the illness. These services may be provided in a home or an inpatient setting by hospice.

Hospital Care:

- **Inpatient** - Admissions must be medically necessary and authorized by DMAS. Inpatient psychiatric admissions are covered only for persons over age 65 and children under age 21 if identified as necessary by EPSTD screening or exam and pre-authorized by DMAS.
- **Outpatient** – A patient receiving medical services but not admitted to a hospital.

Hospital Emergency Room – Visits are covered for emergencies, when you have a serious health problem that you reasonably believe could cause serious damage to your health or body if you do not get medical care right away.

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 of more than 16 beds.

Intermediate Care Facility for the Mentally Retarded/Intellectually Disabled – A licensed and certified facility which provides services to individuals with intellectual disabilities.

Lead Testing – This test is required for every Medicaid-eligible child as part of the 12- and 24-month EPSDT screenings. It is also given to any child between the ages of 3 and 6 who has not been previously screened.

Maternal and Infant Care Coordination (MICC) – Case management services provided through BabyCare for high risk pregnant women and infants up to age 2 enrolled in a fee-for-services program. Managed care enrollees should contact their individual MCO for program information.

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

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

Personal Care – Support services provided in the home and community setting for enrollees under the age of 21 under the EPSDT program who meet established medical necessity criteria to assist with activities of daily living (basic daily tasks of 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. Services will not take the place of informal support systems.

Physician's Services – Services provided by doctors licensed to practice medicine, osteopathy and psychiatry.

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

Prenatal Care Expanded Services – Expanded prenatal services provided through BabyCare are available to any pregnant woman enrolled in a fee-for-services program regardless of enrollment in MICC, to assist in a positive pregnancy outcome. Managed Care enrollees should contact their individual MCO for program information. Expanded prenatal services include:

- Prenatal education in smoking cessation, preparation for childbirth, and parenting;
- Nutritional assessment and counseling; and
- Homemaker services to clients for whom the doctor has ordered complete bed rest.

For more information about the services available through BabyCare, please contact the DMAS Maternal and Child Health Division at 804-786-6134 or visit the Maternal and Child Health section of the DMAS website at www.dmas.virginia.gov.

Prescription Drugs when ordered by a Physician – Most prescription drugs are covered. Medicaid has a preferred drug list (PDL), but drugs not on the list may be covered if authorized. Prescriptions are filled with no more than a 34-day supply at a time. When

available, generic drugs are given unless the doctor specifies that a particular brand name is medically necessary. In addition, some over-the-counter drugs may be covered if ordered by a doctor. Medicaid enrollees 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 authorized by DMAS.

Psychiatric or Psychological Services – Medicaid requires authorization of all visits after the first 26 sessions in the first year of treatment. No more than 26 sessions per year will be authorized.

Renal (Kidney) Dialysis Clinic Visits – Outpatient visits for dialysis treatment of end-stage renal disease. The visit may have two parts, 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 services is identified through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Services must be medically necessary and authorization is required.

Substance Abuse Treatment – Outpatient services, crisis intervention, assessment and evaluation, and case management services.

Therapeutic Behavioral Services (Level B) – Community-Based Residential Services for Children and Adolescents under 21 are provided in a residential setting. These services will provide structure for daily activities to reach the therapeutic mental health goals as identified in the individual service plan (plan of care). The child or adolescent must also receive psychotherapy services in addition to the therapeutic residential services.

Transportation Services for Medical Treatment:

- **Emergency** – Medicaid pays for 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 enrollees get transportation services.

See MEDICAL CARE UNDER MEDICAID AND FAMIS PLUS for more information regarding Transportation services on page 11.

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

SERVICES FOR CHILDREN/EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a comprehensive and preventive child health program for enrollees in Medicaid or FAMIS Plus up to the age of 21 that detects and treats health care problems early 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.
- Medicaid will provide transportation to your child's appointment. Contact your Managed Care Organization (MCO) or if you do not have a Managed Care Organization call toll-free: 1-866- 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 one

If a treatment or service is needed to correct, 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.

Your child should visit the doctor for check-ups early and on a regular basis.

If your child's doctor finds a health problem during an EPSDT check-up, he may be able to treat the problem or may send you to another provider (specialist) who can treat it. Additional information is located on the DMAS website at www.dmas.virginia.gov/ch-home.htm#EPSDT.

Getting regular EPSDT Check-Ups even 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 need check-ups at:	Toddlers & Children need check-ups at:	Older Children need check-ups at:	Teenagers need check-ups at:
1 month *	15 months *	5 years *	12 years *
2 months *	18 months *	6 years *	14 years
4 months *	2 years *	8 years	16 years
6 months *	3 years	10 years	18 years
9 months *	4 years *		20 years
12 months *			

* Most immunizations (shots) are given during these visits

Dental check-ups with a dentist should be done every 6 months. For assistance finding a participating dentist, contact *Smiles For Children* at 1-888-912-3456.

<<<<<<Ask your doctor for more information about immunizations>>>>>>

WHAT IS NOT COVERED BY MEDICAID AND FAMIS PLUS

Medicaid will NOT PAY for:

- Abortions, unless the pregnancy is life-threatening or health-threatening
- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- 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 services waiver)
- Dentures if you are 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 enrollees age 21 or older
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is pre-authorized

- Hospital charges for days of care not authorized for coverage
- 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 enrollees 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 you are covered under Medicare Part A or Part B (some exceptions apply)
- Private duty nursing (except in some home and community-based service waivers or under EPSDT)
- Psychological testing done for an educational diagnosis, 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 if you are younger than age 21
- Telephone consultation
- Weight loss clinic programs

Some services above may be covered if you are younger than age 21 under EPSDT. EPSDT can provide special health care when medically necessary. Under EPSDT, Medicaid may provide certain services to children that are not covered for adults.

Once you are found eligible, 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 the Intellectually Disabled and for individuals in their communities through Home and Community Based Care Waivers. Medicaid also pays for LTC services for those individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE). To qualify for LTC services, you must meet certain level-of-care requirements. These requirements may include assistance with activities of daily living and you must have a medical or nursing need.

There are different eligibility rules and requirements such as: pre-admission screening, asset transfer and patient pay, which only apply to people who need Medicaid coverage for long-term care services. Individuals may be required to pay a portion of his or her income toward the cost of LTC services. This payment is called "patient pay." 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 if the level-of-care criteria for long-term care services is met. Screening is not required if a person is already in a nursing facility or is entering the facility directly from another state. Screenings for institutional and community-based long term care can be completed by the following teams:

- Local teams composed of health and social services agencies;
- Staff of acute care hospitals; or
- Child Development Clinics for the Individual and Family Developmental Disabilities (DD) Waiver

The team that must screen for LTC services varies depending on the services needed, as explained below.

Home and Community-Based Care Waivers

Virginia provides a variety of services under home and community-based care waivers to certain individuals, such as personal care. Each waiver provides specific services to help certain individuals to remain in their communities. The seven waivers available are:

AIDS Waiver - provides care in the community rather than in a hospital or nursing facility for individuals who are experiencing medical and functional symptoms related to HIV/AIDS.

Elderly or Disabled with Consumer Direction (ED/CD) Waiver - provides care in the community rather than in a nursing facility 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 assistance, 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 (ICF) for individuals with Intellectual Disabilities (ID) and for individuals 6 years of age and older with a condition related to mental retardation, but who do not have a diagnosis of mental retardation. The individual must, (1) meet the ICF/ID level of care criteria (2) be determined to be at imminent risk of ICF/ID placement, and (3) have a determination 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/ID.

Intellectual Disabilities Waiver (formerly known as the Mental Retardation/MR Waiver) - provides care in the community rather than in an ICF for individuals with ID up to 6 years of age who are at developmental risk and individuals age 6 and older who have intellectual disabilities/ 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.

Day Support (DS) Waiver for Individuals with Intellectual Disabilities - provides home and community-based services to individuals with ID who have been determined to require the level of care provided in an ICF and who are on the waiting list for the ID Waiver. Services provided under this waiver include day support and prevocational services.

Technology Assisted (Tech) Waiver - provides care in the community rather than in a nursing facility for individuals who are dependent upon technological support such as a ventilator 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.

Alzheimer's Assisted Living (AAL) Waiver – is available only to individuals who receive Auxiliary Grants (AG) to live in an assisted living facility and who have a diagnosis of Alzheimer's disease or a related dementia and no diagnosis of mental illness or mental retardation/intellectual disabilities. The services provided under this waiver include, assistance with activities of daily living, medication administration by licensed professionals, nursing services for assessments and evaluations. Therapeutic social and recreational programming provides daily activities for individuals with dementia.

Waiver Services and Managed Care Enrollment

If you are in managed care and become enrolled in a waiver (except the Tech Waiver), you may stay in managed care AND get waiver services. This will help us to make sure that you are getting the best possible health care. You will get to stay with your MCO for your medical care services. Use your ID card you received from your MCO to receive medical services. Your home and community based care waiver services will be provided by your current service providers or the Medicaid provider you choose. Use the DMAS medical assistance ID card to receive services under the waiver. If you need transportation to a medical appointment you should contact your MCO. For transportation to an approved waiver service, call Logisticare at 1-800-386-8331. See section MEDICAL CARE UNDER MEDICAID AND FAMIS PLUS for additional information about transportation, page 11.

Program of All-Inclusive Care for the Elderly (PACE) – provides a community-based alternative to nursing facility care that integrates primary and long-term care services. The program allows frail seniors to remain in familiar surroundings, maintain self-sufficiency and preserve the highest level of physical, social and cognitive function and independence. All services are provided through an adult day care center. PACE also combines Medicaid and Medicare funding to provide all the care to seniors. Services provided under this program include: medical services, including Primary Care Physician and nursing, social work, restorative therapies, including physical therapy, occupational therapy, speech therapy, transportation, nutritional counseling, recreational therapy, meals, prescription drugs, home health, laboratory, respite, personal care, hospital, nursing facility care and medical specialty services. For more information on PACE, please visit the PACE website at: www.dmas.virginia.gov/ltc-home.htm.

Money Follows the Person (MFP) Demonstration - is a national initiative through the Centers for Medicare & Medicaid Services. The MFP Demonstration's vision is to create a system of long-term services and supports for individuals of all ages and all disabilities who choose to transition from long-term care institutions into the community. Virginia's MFP Demonstration launched on July 1, 2008, and will operate through September 20, 2011. Virginia's MFP Demonstration creates more opportunities for individuals to transition successfully into the community using one of five Medicaid home and community based waivers or one of Virginia's Programs for All-Inclusive Care for the Elderly (PACE). For more information on MFP, visit the MFP Demonstration website at www.olmsteadva.com/mfp.

Please contact your local DSS, the local Community Services Boards (CSB), or DMAS 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; or,
 - 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 caseworker of any problems you are having in getting the necessary information.
- inform your local DSS eligibility worker of any other medical insurance that may cover some of your bills.
- **immediately report** changes in your circumstances to the local DSS such as:
 - moving, birth or death of a child, marriage, divorce, new employment, adding or dropping other insurance;
 - 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 inheritance);
 - 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 proof of your coverage by showing your medical assistance ID card(s) when you go for care.

FRAUD AND OTHER RECOVERIES

Medicaid fraud is a deliberate withholding or hiding of information or giving false information to get Medicaid or FAMIS Plus benefits. Medicaid fraud also happens when a provider bills Medicaid for services that were not delivered to a Medicaid recipient, or if a recipient shares his or her Medicaid number with another person to get medical care.

A Medicaid recipient who is found guilty in a criminal court of fraud or deliberately misusing the Medicaid program can lose their Medicaid for at least one year after being convicted and until

any money owed to the program is repaid in full. In addition, the punishment could include a fine of up to \$25,000 and/or up to 20 years in prison.

Fraud and abuse should be reported to your local DSS or to the DMAS Recipient Audit Unit at 1-866-486-1971; 804-786-1066 or by e-mail at RecipientFraud@dmas.virginia.gov.

Medicaid can also get back payments made for services received by, or managed care premiums paid on behalf of, ineligible enrollees who did not intend to defraud. This also includes recovery for medical services received during an appeal process where the action taken by the local DSS eligibility worker is upheld. There is no time limit for referrals of Medicaid recoveries.

If you are enrolled in a Medicaid MCO, payments are paid by Medicaid to the MCO every month to ensure your coverage, even if you do not use medical services. If Medicaid finds out that you are not eligible for prior months of health care coverage because you failed to report truthful information or changes in your circumstances to your caseworker, you may have to pay back all money paid to the MCO on your behalf.

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 local DSS eligibility worker so that Medicaid may recover payment from the person(s) responsible for the accident. The local DSS will need information such as the date of the accident or injury, type of accident and the name of the attorney or insurance company, if any.

Estate Recovery

The death of a Medicaid enrollee should be reported to the person's local DSS office as soon as possible. Medicaid can recover money from the estate of a Medicaid enrollee 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 on estate recovery see Fact Sheets under IMPORTANT PHONE NUMBERS AND WEBSITE INFORMATION, page 25.

WHEN AND HOW TO FILE AN APPEAL

The Code of Federal Regulations at 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 380, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's Medicaid or FAMIS Plus coverage. Most adverse actions may be appealed by the Medicaid/FAMIS Plus client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in coverage or services, suspensions, and terminations. Also, failure to act on a request for coverage or services within required timeframes may be appealed. Clients who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual will be provided.

If an appeal is filed before the effective date of the action, coverage or services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued coverage or services. The agency

or provider will be notified by DMAS to reinstate coverage or services if continuation of coverage is applicable. If coverage is continued or reinstated due to an appeal, the agency or provider may not terminate or reduce coverage or services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. The form is available on the internet at www.dmas.virginia.gov/downloads/forms/DMAS-200.pdf, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action that the client is appealing should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 11th floor
Richmond, Virginia 23219
Appeal requests may also be faxed to: (804) 371-8491

The Appeals Division will notify clients of the date, time and location of the appeal hearing. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer's decision is the final administrative decision by DMAS. If the client does not agree with the Hearing Officer's decision, he/she may appeal it directly to the circuit court in the city or county in which they reside.

IMPORTANT PHONE NUMBERS AND WEBSITE ADDRESSES

Local Department of Social Services in your City or County

Check the government (blue) pages of your local telephone book for the proper contact number for your local DSS office or visit the Virginia Department of Social Services (VDSS) web site at www.dss.virginia.gov/localagency for a list of local DSS agencies. You should contact the local DSS to:

- Ask questions about applying for Medicaid, FAMIS Plus, or your eligibility for the program.
- Report a change in residence, income, or other significant event.
- Ask questions about pre-admission screening for long-term care services and to request a pre-admission screening.
- Request Fact Sheets about Medicaid eligibility, available on the Internet at www.dss.virginia.gov/benefit/me_famis/guidelines.cgi.

Virginia Department of Social Services (VDSS)

For questions or complaints regarding the actions of staff employed by a local DSS, please write the Virginia Department of Social Services (VDSS), Bureau of Customer Service, 7 North Eighth Street, Richmond, Virginia 23219. You can also call the customer services hotline at 1-800-552-3431 or email your concern to <http://www.dmas.virginia.gov>.

Department of Medical Assistance Services (DMAS)

DMAS is the state agency that manages the Medicaid program in all areas other than your eligibility for Medicaid and FAMIS Plus. The eligibility worker should not be contacted for issues about the payment of a bill, transportation, covered services, or providers. Information is available on the internet at www.dmas.virginia.gov or you can call one of the telephone numbers below for help with questions other than your Medicaid eligibility:

- **Appeals** - For Medicaid appeal information call 804-371-8488
- **Dental Services** - *Smiles For Children*, 1-888- 912-3456 or www.dmas.virginia.gov/dental-home.htm
- **EPSDT** - Early and Periodic Screening, Diagnosis, and Treatment Services – For information call 804-786-6134 www.dmas.virginia.gov/ch-home.htm#EPSDT
- **FAMIS** - Family Access to Medical Insurance Security - For information about FAMIS call 1-866-87FAMIS, 1-866- 873-2647 or www.famis.org
- **Fraud** - To report Medicaid fraud or abuse call the DMAS Recipient Audit Unit at 1-866-486-1971, 804-786-1066 or your local DSS, or email at RecipientFraud@dmas.virginia.gov.
- **HIPP** - Health Insurance Premium Payment Program call 1-800-432-5924
- **Long Term Care** – For information or problems call 804-225-4222 or www.dmas.virginia.gov/ltc-home.htm
- **Managed Care** - For information about managed care enrollment call 1-800-643-2273 or www.virginiamanagedcare.com
- **Pharmacy PDL**- For information or questions about the Preferred Drug List (PDL) call 1-800-932-3923
- **Recipient Helpline** – For problems with bills or services from providers call 804-786-6145, or write the Recipient Services Unit at the address on the cover of this handbook
- **Transportation** – If you do not have transportation for a Medicaid covered service or appointment and you are not enrolled in an MCO, call 1-866-386-8331
- **Waivers** - For Medicaid Waiver programs call 804-786-1465 or www.dmas.virginia.gov/ltc-home.htm

Other Internet Website and Contact Information

- Centers for Medicare & Medicaid Services - www.cms.hhs.gov
- ExtraHelp Medicare Part D Prescription Drug information - www.ssa.gov/prescriptionhelp
- Medicare - 1-800-MEDICARE - www.medicare.gov
- Money Follows the Person - www.olmsteadva.com/mfp
- Plan First – www.planfirst.org
- Social Security Administration – www.ssa.gov
- Virginia Department of Health - www.vdh.virginia.gov
- Virginia Department of Social Services - www.dss.virginia.gov

OTHER RELATED PROGRAMS

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

WIC is a supplemental food and nutrition education program that provides vouchers to purchase specific 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.

The Virginia Department of Health's Nutrition Services Team is committed to practicing and promoting good health. Contact the Nutrition Services Team at 1-888-942-3663.

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.

Healthy Start

Some areas in Virginia have high amounts of babies born with low birth weights, late-term miscarriages, infant deaths, and births to teenage mothers. Pregnant women in these areas are often unable to see doctors because they do not have insurance or enough insurance. The Virginia Healthy Start Initiative (VHSI) is designed to reduce infant deaths in these urban and rural areas and small towns: Norfolk, Petersburg, Portsmouth, and Westmoreland County.

Information about Healthy Start can be obtained by contacting the Healthy Start Program Coordinator at the VDH Division of Women's and Infant's Health at 804-864-7764.

Early Intervention Program

Early intervention services, also known as "Part C" of the Individuals with Disabilities Act (IDEA), are available throughout Virginia to help infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. For more information, visit the Early Intervention Program website at www.infantva.org or call the toll-free number 1-800-234-1448.

Resource Mothers Program

Teenagers are a group 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, continue in school, and encourage 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.

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, FAMIS Plus and the EPSDT Program. Most local school divisions are also contracted with DMAS to provide and receive reimbursement for specific health related services for children in special education.

PRIVACY INFORMATION

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

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 Notice tells you about 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 Notice does not apply to health information that does not 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 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 Notice from us, either by phone, by mail or on our website at www.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 DMAS 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 DMAS 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 DMAS has about you, regardless of when DMAS received or created the information.
- As a part of their job, 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 about this Notice 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 by 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 Medical Information That Identifies You

1. *Payment*

DMAS may use or disclose health information about you to pay or collect payment for your health care. For example, when your doctor sends a bill to Medicaid, it includes information about your illness and treatment.

2. *Health care operations*

DMAS may use or disclose health information about you for health care operations, such as performing quality assessments, medical reviews, legal services or auditing functions. Examples of use and disclosures of 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 you to tell you about treatment alternatives or additional benefits you may be interested in.

3. *Family member, other relative, or close personal friend*

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

- The health information is related to that person's involvement with your care or payment for your care;
- You have had an opportunity to stop or limit the disclosure before it happens.

4. *Government programs providing public benefits*

DMAS may disclose health information about you to another government agency offering public benefits if the information relates to whether you qualify for or are signed-up for Virginia Medicaid or the (Family Access to Medical Insurance Security) FAMIS Plus program, and the law requires or specifically allows the disclosure.

5. *Health oversight activities*

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

6. *Public health*

DMAS may disclose health information about you 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; and
- A government agency allowed to receive reports of child abuse or neglect.

7. *Victims of abuse, neglect, or domestic violence*

If DMAS believes you are the victim or abuse, neglect, or domestic violence, health information may sometimes be disclosed about you to a government agency that receives reports of abuse, neglect or domestic violence.

8. *Serious threat to health or safety*

DMAS may use or disclose health information about you 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.

9. *For other law enforcement purposes*

DMAS may disclose health information about you to a law enforcement agency official, for 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 Plus 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; or
- To report evidence of a crime on DMAS' property.

10. *For judicial or administrative proceedings*

DMAS may disclose health information about you 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.

11. *As required by law*

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

12. *Contractors*

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

- Needs the information to perform services for DMAS; and
- Agrees to protect the privacy and security of the information.

13. *Secretary of Health and Human Services*

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

14. Research

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

15. Other uses and disclosures

DMAS may use or disclose health information about you:

- To create health information that does not identify any specific individual;
- To the U.S. military or foreign military for military purposes, if you are 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 you are an inmate of that prison or jail, or to law enforcement personnel if you are in custody;
- To comply with worker's compensation laws or similar laws; and
- To tell or help in telling a family member or another person involved with your case about your location, general condition and death.

This notice was published and became effective on March 1, 2007.

GLOSSARY

Activities of Daily Living	Personal care tasks include bathing, dressing, toileting, getting into or out of a bed or chair, and eating or 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	Eligibility worker at the local DSS who reviews your application or case to determine if you are eligible or remain eligible for Medicaid or FAMIS Plus. This is the person you would contact regarding changes, such as address or income, or problems, such as not receiving your Medicaid card.
Coinsurance	The portion of Medicare, Medicaid, or other insurance allowed charges for which the patient is responsible.
Co-Payment	The specific amount an enrollee is required to pay directly to the provider for certain services or procedures rendered. If you cannot pay your co-payment at the time of the visit, you will still receive services. Your provider will bill you the co-payment amount.
DMAS	Department of Medical Assistance Services, the agency that administers Medicaid and FAMIS Plus programs in Virginia.
DSS	Department of Social Services, the agency responsible for determining eligibility for medical assistance programs and the provision of related social services. This includes the local and the state DSS.
EPSDT	The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a program of preventive health care and well child examinations with appropriate tests and immunizations for children and adolescents from birth up to age 21. 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 Medicaid benefit plan.
FAMIS	Family Access to Medical Insurance Security is Virginia's Children's Health Insurance Program, a program that helps pay for medical care for children under age 19 and pregnant women, FAMIS MOMS. FAMIS has a higher income level than Medicaid.
FAMIS Plus	The name of the Medicaid 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.
Fraud	A deliberate withholding or hiding of information or giving false information to obtain or attempt to obtain Medicaid and FAMIS Plus benefits.
HIPAA	The Health Insurance Portability and Accountability Act was signed in law on August 21, 1996, and applies to most healthcare insurance companies and health care providers. The HIPAA law is geared to improving the health insurance efficiency, protecting a patient's privacy and rights, and safeguarding patient confidential information.

Local Department of Social Services (Local DSS)	The office of the local social services department serving the locality in which a person resides, responsible for determination of eligibility for medical assistance and the provision of related social services, under the supervision of the Virginia Department of Social Services.
Long Term Care	Medical treatment and services provided to individuals who require care in a medical facility or whose care can be provided in the home and whose income and resources are insufficient to cover the cost of their care.
MCO	The delivery of health care services that sets up a relationship between a primary care provider (PCP) and the enrollee (referred to as a “medical home”). The goal of managed care is to have a central point through which all medical care is coordinated. Most Virginia Medicaid enrollees are required to receive their medical care through managed care programs.
MCO	Managed Care Organization is a health plan that provides medical services and coordinates health care services through a group of providers.
Medicaid	An assistance program that helps pay for medical care for certain individuals and families with low incomes and resources. The Department of Medical Assistance Services (DMAS) is the agency that administers the Medicaid and FAMIS Plus programs in Virginia.
Medically Necessary	Services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the function of a malformed extremity.
Patient Pay	The amount of income which must be paid as the patient’s share of Long Term Care (LTC) services costs.
Primary Care Provider (PCP)	The doctor or clinic that provides most of your health care needs, gives you referrals to other health care providers when needed, and monitors your health.
Resources (Assets)	Resources include money on hand, in the bank, and/or in a safe deposit box, stocks, bonds, certificates of deposit, trusts, pre-paid burial plans, cars, boats, life insurance policies, and real property.
Spenddown	A spenddown for people who meet all the Medicaid eligibility requirements except for income. People who have countable income higher than the medically needy income limit for their city or county are placed on a spenddown. Spenddown works like an insurance policy deductible. The amount of the “deductible” is called the “spenddown liability”.
SSI	Supplemental Security Income is a federal program administered by the Social Security Administration (SSA) that pays monthly benefits to people with limited income and resources who are disabled, blind or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits. In Virginia, SSI recipients must apply for Medicaid separately; Medicaid is not automatic.
VDSS	Virginia Department of Social Services is the State agency that has responsibility for oversight of Medicaid eligibility determinations and administration, supervision and delivery of social services programs.