MEDICAL ASSISTANCE HANDBOOK

Commonwealth of Virginia
Department of Medical Assistance Services

www.dmas.virginia.gov

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

Our mission is to improve the health and well-being of Virginians through access to quality health care coverage.

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General Information

Medical Assistance programs in Virginia

Medical Assistance programs in Virginia are administered by the Department of Medical Assistance Services (DMAS). Eligibility for the programs are determined by the local Department of Social Services (DSS) offices, by Cover Virginia, or by the Federal Health Insurance Marketplace.

Special Note effective January 1, 2019

General Rules for Individuals Who May Qualify in the Modified Adjusted Gross Income (MAGI) Adults covered group

Adults between the ages of 19 – 64 years of age who meet the eligibility qualifications using MAGI methodology (based on tax rules) may now be eligible for full Medicaid coverage. A MAGI adult must meet citizenship qualifications, be within income guidelines, cannot be eligible for or receiving Medicare Part A or B, cannot be pregnant, and is not currently eligible for or enrolled in a mandatory Medicaid covered group.

The **Federal Health Insurance Marketplace**

When your case is evaluated or renewed, you will be advised, in writing, of any actions taken. If your application is denied or you lose your Medicaid or FAMIS coverage, a referral is automatically sent to the Federal Health Insurance Marketplace to evaluate your eligibility for coverage through the Marketplace and to provide assistance in signing up for health insurance. If you need help applying for medical assistance or insurance go to the Cover Virginia website www.coverva.org or call Toll Free: 1-855-242-8282 • TDD: 1-888-221-1590. To apply directly for health insurance, subsidies or the Advance Premium Tax Credit (APTC), go to the Federal Health Insurance Marketplace at www.healthcare.gov or call 1-800-318-2596 (TTY: 855-889-4325).

Medicaid

Medicaid is funded by the state and federal governments. Medicaid and FAMIS Plus (also known as Children's Medicaid) are Virginia's medical assistance programs to help pay for medical care for qualifying individuals. To be eligible for medical assistance, you must have limited income (and resources for certain groups) and you must be in one of the groups of individuals covered by Medicaid. See the section on Covered Groups on page 6.

Not everyone with high medical bills qualify, but all individuals within a covered group are treated the same.

Medicaid provides either full coverage or limited coverage.

- **Full coverage** provides the full range of medical benefits including doctor, hospital and pharmacy services for those individuals not enrolled in Medicare.

- **Limited coverage**
  - Individuals and families who meet a spenddown have time-limited **full** coverage.
  - Coverage **limited to family planning** is also provided to income-eligible men and women through Plan First.

- **Medicare Savings Program coverage** provides Medicaid payment for Medicare Part A and/or Part B premiums; applicants with lower income may also receive payment of Medicare deductibles and coinsurance, up to Medicaid's maximum payments.

- **Hospital-Based Presumptive Eligibility (HPE)**: The Affordable Care Act requires states to allow approved hospitals to enroll patients who meet certain covered groups in Medicaid for a limited time based on their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible for coordinating the HPE Agreement with approved hospitals, providing training and technical assistance, and monitoring the appropriate use of the HPE enrollments. HPE is not available to individuals who are already actively enrolled in Medicaid or FAMIS. Local eligibility staff do not determine eligibility for HPE.

Note: Handbooks for FAMIS (Family Access to Medical Insurance Security), a similar medical program for children with higher income limits); FAMIS MOMS, a program for pregnant women; and Plan First (Virginia's family planning program) are available from Cover Virginia www.coverva.org or your local Department of Social Services office. FAMIS covers many of the same services as Medicaid – exceptions include transportation (see page 15), EPSDT (see pages 24, 25) and LTSS (see pages 25, 26).

How do I apply for Medical Assistance?

A face-to-face interview is not required. An application for Virginia medical assistance can be completed online at the CommonHelp website https://commonhelp.virginia.gov/access/ or by phone through Cover Virginia toll-free at 1-855-242-8282. An application form for Medicaid Assistance can be printed from www.coverva.org (choose "Apply" tab). You may also contact the local DSS office in the city or county where you live to obtain an application. The phone numbers for local DSS offices (sometimes called "human services" or "family services") are listed in the blue pages of the phone book and online at: www.dss.virginia.gov/localagency/. Applications can also be filed at some hospitals.

An application must be signed by the person aged 18 or older 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 caretaker relative with whom the child lives must sign the application for a child under the age of 18. Children under the age of 18 cannot apply for themselves, unless they are emancipated. However, if a child under the age of 18 has a child of his or her own, he or she, as the parent, can file an application for the child. You can designate an application counselor or navigator through CommonHelp to help you complete an application, but that person cannot sign the application for you. Electronic signatures are acceptable, but telephonic signatures can only be accepted at Cover Virginia.

An eligibility-screening tool is available at the Cover Virginia website at: www.coverva.org/screening . This can help to determine whether you or someone in your family may be eligible for medical assistance. More information can be found on the VDSS website at commonhelp.virginia.gov or at the Cover Virginia website at www.coverva.org.

The final decision regarding eligibility will be made by an eligibility worker at your local DSS office or at Cover Virginia.

What will I be asked?

Applicants for medical assistance are asked a number of items but will need to provide their Social Security number, declare if they are a Virginia resident, and may be asked to provide documentation of United States citizenship and identity. If you are not a U.S. Citizen, you must provide information and documents about your immigration status. Some immigrants can be eligible for full Medicaid coverage; others may be eligible for Medicaid payment only for emergency services.

If you are pregnant, you will be asked how many babies you are expecting and the estimated date of delivery. Medical proof of pregnancy is not required.

You will be asked if you have any medical conditions or if any assistance is needed in the home. This information is used to ensure you are placed into the correct managed care health plan.

If you say you are unable to work due to a disability, you will be asked whether you have applied for disability benefits, or if you have appealed a disability denial.

Income

Income that you receive must be listed on the application. Income includes earned income, such as wages and self-employment, as well as other income such as Social Security, retirement pensions, certain Veterans disability benefits, alimony, etc. Child support received is generally not counted. Countable sources of income are added together and compared to the income limit to determine eligibility. You will also be asked questions about how you file your taxes to make sure we are counting the right income for your application. Most of the income limits are based upon the Federal Poverty Level (FPL) guidelines and are available on the DMAS website at www.dmas.virginia.gov/#/eligibilitypolicy.

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

Some individuals who meet all Medicaid eligibility requirements except for income may be placed on a "spenddown". The spenddown amount is like a medical deductible – if medical expenses are higher than the spenddown amount, the individual may be eligible for Medicaid for a limited period of time. If a spenddown is needed, you will be asked to report your resources and provide verification of their value. Spenddown policy only applies to Medically Needy covered groups.

Resources (Assets)

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

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

Long-Term Services and Supports (LTSS)

Asset Transfer

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

Special Rules for Married Individuals

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 are evaluated to determine how much may be reserved for the spouse who does not need LTSS without affecting the Medicaid eligibility of the other spouse. These "special rules for married individuals" do not apply to MAGI Adults who need or request LTSS.

A review of resources (resource assessment) may be requested without filing a Medicaid application when a spouse is a patient in a nursing facility. Unless the applicant is eligible as a MAGI Adult, a resource assessment **must** be completed when a married institutionalized individual with a spouse in the community applies for Medicaid, even when the couple is not living together.

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

Rules for MAGI Adults receiving Long Term Services and Support (LTSS)
A person in certain MAGI Adult categories may receive LTSS (also known as long-term care); however, any asset transfers, trusts, annuities, and home equity must be reported and evaluated.

Who Makes the Decision and How Long Does It Take?
Once a signed application is received, an eligibility worker will determine whether you meet a Medicaid covered group (see section on Covered Groups pages 6, 7) and if your resources (if required) and income are within required limits. The amount of income and resources you can have and still be eligible for Medicaid depends on how many family members are living together and the limits established for your covered group.

AFTER the signed application is received at the agency and any required information has been provided, an eligibility decision will be made on your Medicaid application:

(1) Within 45 calendar days **OR**
(2) Within 90 calendar days if a disability determination is needed **OR**
(3) Within 10 working days for pregnant women or participants in the BCCPTA program -Breast and Cervical Cancer Prevention and Treatment Act program – provided through the Virginia Department of Health's Every Woman's Life Program (see page 7).

A written notice that your application has either been approved or denied will be mailed or given to you. If you disagree with the decision, you may file an appeal (see the section on **When and How to File an Appeal** page 28).

When Does Medical Assistance Start?
Medicaid coverage usually starts on the first day of the month in which you apply and are found to be eligible. Coverage can start as early as three months before the month in which you applied if you received a medical service during that time and met all eligibility requirements. This is known as retroactive coverage. Coverage under the Qualified Medicare Beneficiary (QMB) group **always** starts the month **after** the approval action. Spenddown coverage begins once the spenddown is met and continues until the end of the spenddown period. Emergency Services Medicaid covers a set number of days determined medically necessary. Your notice will say when your eligibility starts. Contact your local DSS office or Cover Virginia if you have questions about your Medicaid coverage.

How Do I Keep My Coverage?
Once approved for Medicaid, coverage will continue for as long as the eligibility requirements continue to be met. Medical Assistance coverage **must** be reviewed at least once every 12 months to determine continued eligibility for coverage. If this annual review is not completed, coverage may be canceled. In some cases, your Medical Assistance coverage may be reviewed before the end of the 12 months. When your annual review is due, your local DSS will send you

a notice. You may be asked to complete a form and supply proof of your current income. Some individuals will also have to provide current proof of their resources' value.
EXCEPTION: Individuals who meet a spenddown are enrolled in a closed period of coverage for no more than six (6) months and must meet another spenddown for coverage to resume.

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

Sometimes your eligibility may be reviewed for another 12 months without the worker contacting you. If the local DSS is able to renew Medical Assistance coverage with information known to the agency or available from electronic sources, you will receive a notice telling you the coverage has been reviewed and the date of your next annual renewal. You can also renew your coverage on a computer by visiting the CommonHelp website or over the phone by calling Cover Virginia at **1-855-242-8282**.

REMEMBER: You must report any change in circumstances (such as a moving to a different county or city, income, or health insurance coverage) **within 10 calendar days of the change.** You can report such changes on the CommonHelp website, calling Cover Virginia, or contacting your local DSS office. You cannot receive Medical Assistance in more than one state at a time.

***IT IS VERY IMPORTANT* to tell us right away if you move or change your address.** If there is not a correct address on file, you may not receive a notice when it is time to renew Medical Assistance coverage and **your coverage may be canceled**. Report your change right away to protect your coverage.

If the reported change affects your eligibility for Medical Assistance, your case will be reviewed and you will be notified of the outcome. If you apply or are reviewed for another program provided by social services [such as SNAP (Food Stamps) or TANF (Temporary Aid to Needy Families)], the eligibility worker may be able to renew your Medical Assistance at the same time and extend your coverage for another 12 months from that date.

If you continue to receive coverage because you failed to report changes on time, your case may be referred to the DMAS Recipient Audit Unit (RAU) for an evaluation of possible Medical Assistance fraud. That evaluation could result in a request for repayment of charges on your behalf for medical services or for premiums paid to a Managed Care Organization to cover your medical services.

Covered Groups

Federal and state laws describe the groups of individuals who may be eligible for Medical Assistance, referred to as "Medical Assistance covered groups." Individuals who meet a covered group may be eligible for Medical Assistance if income and resources (if required to be evaluated)

are within the required limits of a covered group. Services may differ depending on the covered group. Resources are not evaluated for MAGI groups unless Long-Term Services and Supports (LTSS) are being requested. Income limits vary depending on how many people are in the household.

The **Medical Assistance covered groups for Families and Children** are:

- **Pregnant women** whose family income is at or below 143% of FPL (Federal Poverty Level) limit for Medicaid Pregnant Woman or family income between 143% - 200% FPL (+ 5% income disregard) for eligibility in the FAMIS MOMS program.

- **Children**
  - from birth to age 19 whose family income is at or below 143% of the FPL limit.
  - from birth to age 19 whose family income is between 143% - 200% (+ 5% income disregard) of the FPL limit may qualify for FAMIS.
  - Children under age 21 who are in foster care or subsidized adoptions.
  - Infants born to a Medicaid-eligible woman or a woman eligible for FAMIS MOMS.

- **Adults**
  - Under age 26 who were in foster care and receiving Medicaid when they turned 18 (Former Foster Care).
  - Age 19 – 64 years old who are parents or caretaker adult relatives living with a child under age 19 whose family income is at or below 133% (+ 5% income disregard) of the FPL limit (MAGI Adults).
  - **NEW – Expansion coverage effective 1-1-2019**
    Age 19 – 64 years old who are childless and whose family income is at or below 133% (+ 5% income disregard) of the FPL guidelines (MAGI Adults).

- **Medically Needy** individuals who meet covered group requirements, have income over the Medically Needy limit, and meet a spenddown

- **Breast and Cervical Cancer Prevention and Treatment Act** (BCCPTA) includes individuals screened by the Virginia Department of Health *Every Woman's Life Program (*or those in Northern Virginia and the *Project Wish program)* who have been diagnosed and need treatment for breast or cervical cancer. Through an agreement between Virginia and the District of Columbia (DC), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program.

The **Aged, Blind and Disabled Medical Assistance covered groups** are:

- **Aged** (65 and older), **blind**, or **person with a disability** (determined using Social Security Administration standards)
  - who receive Supplemental Security Income (SSI) and who meet Medicaid resource limits **OR**
  - who have income that does not exceed 80% of the FPL limit **OR**
  - who have income up to 300% of the Supplemental Security Income (SSI) payment amount and 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 Grant** (AG) participants in Assisted Living Facilities or Adult Foster Care.

- **Individuals with income up to 80%** of FPL who are blind or disabled, at least 16 years old but less than 65 years of age, and who are working or can work (**MEDICAID WORKS** program).

- **Medically Needy** individuals who meet Medicaid covered group requirements but have excess income.

- **Individuals who are terminally ill** and have elected to receive **Hospice** care.

The **Medicare-Related Covered Groups (Medicare Savings Plans or MSPs)**; Individuals who are eligible for Medicare Part A and who meet one of the following covered groups may receive limited Medicaid coverage. Medicaid pays the Medicare costs on behalf of these Medicare beneficiaries as indicated below (resource limits apply to all Medicare-related covered groups).

- **Qualified Medicare Beneficiaries (QMBs)** Income must be at or below 100% of the Federal Poverty Level limit. Medicaid pays the Medicare Part A and Part B premiums and the coinsurance and deductibles that Medicare does not pay.

- **Special Low-Income Medicare Beneficiaries (SLMBs)** Income must be between 100% and 120% of the FPL limit. Medicaid pays the Medicare Part B premiums.

- **Qualified Individuals (QI)** Income must equal or exceed 120% but be less than 135% of the FPL limit. Medicaid pays the Medicare Part B premiums.

- **Qualified Disabled and Working Individuals (QDWIs)** Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals must have income below 200% of the FPL and resources must be at or below $4,000 for a single person or $6,000 for a couple.

Emergency Services for Non-Citizens

Special rules apply to non-citizens. If a person meets one of the full benefit covered groups but is not a U.S. citizen, then his/her immigration status and date of entry into the United States affect eligibility for Medical Assistance coverage. If the immigration status affects Medical

Assistance coverage, he/she may be eligible for Medicaid payment limited to emergency medical treatment if all other Medicaid eligibility requirements are met.

Plan First – Virginia's Family Planning Services Program

Men and women who meet the income requirements but do not meet a full-benefit Medical Assistance covered group may be eligible for the limited Medical Assistance benefit known as Plan First, if the household countable income is 138% to 200% of the FPL limit. Plan First covers:

- Annual exams for men and women for family planning purposes including pap tests for women to screen for cervical cancer; sexually transmitted infections (STI) testing (including lab services), and family planning education and counseling
- Sterilization procedures
- Transportation to a family planning service
- Most Food and Drug Administration (FDA) approved contraceptives (methods provided by a clinician or obtained with a prescription)

Individuals applying for full benefit coverage or losing full benefit coverage because they no longer meet a covered group for full benefits may have eligibility for Plan First evaluated. **If applicants do not want to be considered for Plan First enrollment, they must check "no" on the application to opt out.** Individuals aged 65 or over and parents of individuals under 19 may request an eligibility determination in this covered group if they choose. Plan First participants will be referred to the Federal Health Insurance Marketplace to be evaluated for Advance Premium Tax Credit or cost sharing reductions. A separate Plan First ID card will be issued to those enrolled. If another medical assistance card was issued while enrolled in another Medical Assistance program at an earlier time, it will no longer be valid.

MEDICAID AND OTHER INSURANCE

If you already have health insurance (including Medicare) it is possible you could still be covered by Medicaid. The other insurance plan is always billed first. Having other health insurance does not change the Medicaid co-payment amount (if any) that you pay to providers as a Medicaid enrollee. If you drop private health insurance coverage or enroll in a private health insurance plan, tell your eligibility worker. If you do not, medical bill payments could be delayed.

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

Health Insurance Premium Payment Programs (HIPP)

Medical Assistance may help with the cost of private health insurance premiums when certain criteria are met. The HIPP Programs only reimburse for employer sponsored group health plans; they do not reimburse premiums for individual policies. DSS can provide information regarding

this program or you may call the DMAS Health Insurance Premium Payment Unit at 1-800-432-5924, or send an email to: HIPPcustomerservice@dmas.virginia.gov.
November 1, 2018, Virginia Medicaid introduced a new online portal, called HIPP Online, to be used to upload annual and quarterly HIPP documents. HIPP Online will offer features designed to save HIPP members time and increase their control over HIPP information. These features include:

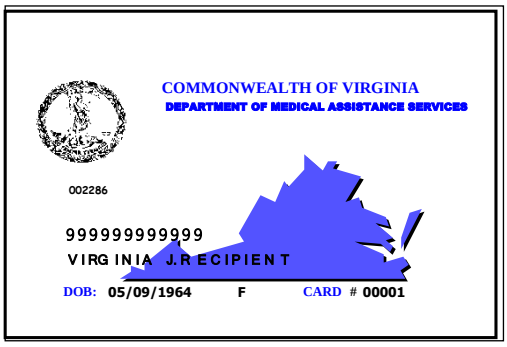
- Secure online portal for annual and quarterly updates
- Automatic reminders to submit documents
- System confirmations that information has been uploaded successfully

Visit the HIPP website at www.dmas.virginia.gov/#/hipp to access this new portal and register for HIPP Online.

MEDICAL ASSISTANCE CARDS

VIRGINIA MEDICAL ASSISTANCE CARD

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



COV Medical Assistance card

Plan First card

Using Your Medical Cards

Each person in your family who is eligible for Medical Assistance will receive his or her own card (unless the person is only eligible for Medicaid payment of Medicare premiums). You ***will not*** be mailed a new card if your benefits change. You ***will*** be mailed a new card if your coverage level changes, such as switching from Plan First to full Medicaid or FAMIS coverage. You can request a replacement card if your card is lost, stolen or destroyed through the CommonHelp website, by calling the Cover Virginia at 1-855-242-8282, or contacting your local DSS office.

Show your card(s) **each time you get a medical service** so that your medical provider can verify your current eligibility status electronically.

Most Virginia Medical Assistance recipients will be enrolled into a Managed Care Organization (MCO) and you will receive a separate card from that organization. **You need to show both the MCO and the Virginia Medicaid cards when you receive medical care.** If you do not show your card(s), you may be treated as a private-pay patient and receive a bill from the medical provider. Make sure the provider accepts payment from Virginia Medicaid or from your assigned MCO.

Report the loss or theft of your Virginia Medical Assistance card and request a new card by calling your local DSS or by calling Cover Virginia (toll-free) 1-855-242-8282. The loss or theft of your MCO card should be reported to your MCO.

USING YOUR MEDICAID BENEFITS

Medicaid provides medical services through either direct payments to providers or by paying premiums for participants to Managed Care Organizations (MCO).

If you qualify for full benefit Medicaid coverage, most people will enroll in an MCO. If you have other insurance or are in a nursing home, you may not have to enroll.

When you first qualify for Medicaid, you may be placed into fee for service medical coverage, and then assigned to an MCO. An MCO may be chosen for you, unless you had an MCO previously, in which case you will be enrolled back to that MCO. Once you are enrolled in an MCO, an ID card and information telling you when you can start using services will be sent. If you want to choose a different MCO, you may be able to change right away, or may have to wait until the open enrollment period.

"Fee for Service" Medical Coverage

Providers who are enrolled with DMAS offer care directly to some Medical Assistance participants. If you do not have an assigned MCO, you can choose any provider for medical services as long as they are enrolled with DMAS to accept payment. If you receive services from providers who are not enrolled as a DMAS provider, **you will have to pay the bill. DMAS will not pay you back for the medical bills that you have paid.** Try to use one doctor and one pharmacy for most of your care, and continue with that doctor unless you are referred to a specialist. If you need help finding a provider who accepts Medical Assistance, check the DMAS Provider Search Engine www.virginiamedicaid.dmas.virginia.gov/wps/portal/searchforproviders. If a provider type you are looking for is not listed, contact our Recipient Helpline at (804) 786-6145.

Managed Care

Most Medical Assistance recipients are required to receive their medical care through a Managed Care Organization (MCO), either through the Medallion 4.0 or CCC Plus programs. An MCO is a health service organization that coordinates health care services through a network of providers including primary care providers (PCPs), specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers. If you meet the criteria to be assigned to an MCO you will receive a letter from DMAS requiring you to choose an MCO for your health care. You will receive information about the programs such as an MCO Comparison Chart and a brochure. **If you do not make a choice, you will be assigned to an MCO.**

Once you are enrolled in an MCO, a packet of information will be mailed directly to you. You will also 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.

The MCO will require you to choose a PCP in their network who will manage all of your health care needs. You are not required to enroll all members of your family in the same MCO or with the same PCP. You will be required to follow managed care program rules. These rules are described in the MCO member handbook, which is included in the information packet that your MCO will send to you. If you do not follow the managed care program rules (for example, if you receive services without obtaining a referral from your PCP or an authorization from your MCO), you may have to pay the full bill yourself. Refer to your MCO member handbook for more details.

Open Enrollment

There is an annual open enrollment period for the MCO plans. This open enrollment period allows you to change your MCO. If you want to know when your open enrollment period takes place or have other questions regarding your managed care enrollment, check your appropriate program information (Medallion 4.0 or CCC Plus) information below. You can also see the DMAS website for more information: www.dmas.virginia.gov.

Medallion 4.0 Program

Medallion 4.0 is the managed care program across the state to help people who have Medicaid get the health services they need. When you are in an MCO, you may choose your own doctor, clinic or other health provider to manage your health care. For questions on enrollment, call the DMAS Managed Care Helpline at 1-800-643-2273 (TDD: 1-800-817-6608) or visit the Managed Care Helpline website at www.virginiamanagedcare.com.

Medallion 4.0 Managed Care Organizations (MCO) Contact Information

Managed Care Organization	Phone Number	Website
Aetna Better Health	(800) 279-1878	www.aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus	(800) 901-0020	www.anthem.com/vamedicaid
Magellan Complete Care	(800) 424-4518	www.MCCofVA.com
Optima Family Care	(800) 881-2166	www.optimahealth.com/familycare
UnitedHealthCare Community Plan	(844) 752-9434	www.uhccommunityplan.com/va
Virginia Premier Health Plan	(800) 8727-7536	www.virginiapremier.com

CCC Plus program

The Commonwealth Coordinated Care Plus, or CCC Plus, is a program designed to help individuals with medical conditions who may need additional or focused coordination of care. If you are enrolled in CCC Plus, a care coordinator from your health plan will be assigned to you and you will be notified. The care coordinator will collaborate with providers and assist you with navigating the health care system. For questions on enrollment, call the CCC Plus Helpline at

1-844-374-9159 or visit the CCC Plus enrollment website cccplusva.com . CCC Plus questions can also be emailed to: cccplus@dmas.virginia.gov.

CCC Plus Managed Care Organizations (MCO) Contact Information

Managed Care Organization	Phone Number	Website
Aetna Better Health	(855) 652-8249	www.aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus	(855) 323-4687	www.anthem.com/vamedicaid
Magellan Complete Care	(800) 424-4524	www.MCCofVA.com
Optima Health Community Care	(888) 512-3171	www.optimahealth.com/communitycare
UnitedHealthCare	(866) 622-7982	www.uhccommunityplan.com
Virginia Premier Health Plan	(877) 719-7358	www.vapremier.com

MEDICAL CARE THROUGH MEDICAID

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

Behavioral Health Services

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

- Intensive In-Home Services for Children and Adolescents (IIH)
- Therapeutic Day Treatment for Children and Adolescents (TDT)
- Group Home Services for Children and Adolescents
- Residential Treatment
- Day Treatment/Partial Hospitalization
- Psychosocial Rehabilitation
- Intensive Community Treatment (ICT)
- Mental Health Support Services (MHSS)
- Crisis Intervention and Stabilization
- Case Management
- Substance Abuse Treatment
- Outpatient Therapy (if you are not enrolled in an MCO)
- Medications for mental health or substance abuse needs (This service is managed by the MCO for MCO members)

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

Addiction and Recovery Treatment Services (ARTS) **program**

In 2017, Virginia's Medicaid program launched an enhanced substance use disorder treatment benefit - Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

Dental Care – Smiles for Children

The Smiles for Children program provides coverage for diagnostic, preventive, restorative/surgical procedures and orthodontia services for Medicaid children, and the same services (except orthodontia) for adult pregnant women. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older and if qualified). DentaQuest is the single dental benefits administrator that coordinates the delivery of all Smiles for Children dental services. If you need help finding a dentist or making a dental appointment, please call 1-888-912-3456 to speak with a Smiles for Children representative.

Inpatient Hospital Admissions

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

Medical Professional Visits

Appointments for psychiatric, nursing, physical therapy, occupational therapy and speech therapy visits must be pre-approved.

Pharmacy

Your doctor may have to get pre-authorization in order for a pharmacy to fill some prescriptions. Within a family of drugs, there may be one or a few select drugs that Medicaid or the MCO would like your doctor to use to treat your condition because they are safe, effective, and less costly. This is called a Preferred Drug List (PDL) or formulary. You can still receive medication to effectively treat your medical condition. Prior approval is required to fill the prescription if the drug is not on the PDL or formulary. A doctor may also prescribe or order some over-the-counter drugs equivalent to certain prescription drugs if it is cost effective to do so. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. This is true whether you get services directly through fee for service Medicaid or through an MCO. Magellan Medicaid Administration is responsible for authorizing prescriptions for members who are enrolled in Fee for Service Medical Assistance. If you have questions about the PDL or formulary, call Magellan at 1-800-932-3923, your MCO if you are enrolled in managed care, or talk to your doctor.

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

School Health Services

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

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

Your child's health coverage for services provided outside the school system will not be affected by the school billing DMAS.

Transportation Services for Medicaid Covered Services

Transportation to access Medical Assistance services may be covered by either a Managed Care Organization (MCO), Commonwealth Coordinated Care (CCC) Plus, Medallion 4.0, or a fee for service (FFS) plan. Depending on your Medical Assistance benefit plan, transportation benefits may cover emergency ambulance services and non-emergency medical transportation (NEMT). Transportation reservations can be made for routine and urgent appointments. An explanation of these services is listed below:

- Routine appointment examples of covered services include but are not limited to: medical treatment; waivered services; counseling; dialysis; physical therapy; and adolescent orthodontics. Routine transportation arrangements are to be called in at least five (5) business days before appointment date.
- Urgent appointments are "URGENT" in nature but not an emergency. For example, you or your child wake up sick and need to see a doctor right away. If your doctor will see you as soon as you can get to their office or less than the five (5) day notice mentioned above, then call the "Reservation" telephone number for your plan and request an "Urgent Trip". Urgent trip reservations will be verified with your doctor or Medical service provider.

To access your NEMT transportation benefit or find out if you are eligible, call the "Reservation" line for your MCO or go to www.dmas.virginia.gov/#/nemtservices and click on "Transportation Contacts". Have your Medical Assistance ID number, telephone number and street addresses of the pickup and drop off locations. You will be given a pickup time and the trip number so please make a note. Transportation providers and types of transport are assigned by your benefit plan.

When eligible, there are different ways to receive transportation services. Additional ways you may be transported are listed below:

- Ride Assist through the MCO

- Non-Emergency Ambulance Services
- Bus Ticket- if you live near a local bus route – if you need help with understanding how to use bus services, you can request and receive "Travel Training". Please discuss this when making your reservation. Travel training is a process where you can learn how to ride public transportation safely and independently.
- Gas Reimbursement for a friend or relative to drive you – reimbursement is only for direct transport from the place of residence to the appointment and back
- Volunteer Driver who is assigned by your MCO
- Transportation Provider – ambulatory and/or wheelchair van services
- Taxi
- Stretcher Van

Each MCO has a "Ride Assist" telephone number for you to call when you have a question or need assistance with transportation. The telephone number to call is based on your benefit plan. See table on the next two pages for the correct phone number.

Examples of reasons to call your plan's "Ride Assist" telephone number.

- Have a question about transportation
- Want to know your pick up time
- Cancel or change your transportation arrangements
- Have a concern about transportation
- Transportation service is running late
- Transportation has not shown up at your scheduled pick up time
- Have a compliment or complaint
- You are ready to return using your "Will Call" ride home

Emergency Ambulance Services – When there is a serious injury or a life-threatening emergency, call 911. The emergency ambulance transport may be a covered service through your benefit plan. See your plans member handbook for emergency ambulance benefit explanation.

Fee for service and MCO Transportation benefits may cover "Out of State Transportation" services that are over 50 miles from the State of Virginia border. All Out of State transportation services must be approved **PRIOR** to travel. If you have not been assigned to an MCO, please contact DMAS Medical Support at (804) 786-8056 for approval prior to travel. If you are covered by an MCO please contact your MCO for prior approval **BEFORE** you travel. Your MCO will give you instructions concerning your travel arrangements and reimbursement.

Remember: Transportation benefits are to be used when going to a Medicaid covered service that your benefit plan covers. FFS and MCO transportation benefits vary depending on your benefit plan. See your health plan Member Handbook for covered services.

Medicaid Members who have a Community Living (CL), Building Independence (BI), or Family and Individual Supports (FIS) waiver will receive transportation benefits to waivered services through the FFS Reservation and Ride Assist numbers for transportation. Please call your CCC Plus plan

Reservation and Ride Assist numbers for transportation services to your Medicaid medical appointment. You may need to know what region you are located in.

Geographic Areas for Region Assignments:

Region 1	Tidewater	Region 4	Roanoke / Alleghany / Lynchburg
Region 2	Central	Region 5/6	Southwest /Norton /Abingdon /Bristol
Region 3	Western / Charlottesville	Region 7	Northern Virginia / Winchester

Additional Information about the FFS Transportation program can be found online at transportation.dmas.virginia.gov .

Non-Emergency Medical Transportation (NEMT) Toll-Free Contact Telephone Numbers for all DMAS Medicaid Programs are listed below:

NEMT Reservation Telephone Numbers

Find the Medicaid Plan you are enrolled in below and call that number to make your transportation arrangements or check to see if you are eligible for transportation. Ask about bus tickets or gas reimbursement for you, a friend, or neighbor to your Medicaid appointment.

Fee For Service (FFS)	Reservation Number	Details
Fee for service (FFS); includes all CL, BI, & FIS Waiver Services	(866) 386-8331	All ages and all levels of service

Medallion 4.0	Reservation Number	Details
Aetna Better Health of Virginia[1]	(800) 734-0430	All ages and all levels of service
Anthem HealthKeepers	(877) 892-3988	All ages and all levels of service
Magellan Complete Care of Va	(833) 273-7416	All ages and all levels of service
Optima Family Care	(877) 892-3986	All ages ambulatory and wheelchair
United HealthCare Community Health Plan[2]	(833) 215-3884	All ages and all levels of service
Virginia Premier Elite Individual	(855) 880-3480	All ages and all levels of service

1 – Aetna Better Health formerly known as CoventryCare 2- United HealthCare formerly known as InTotal Health

CCC Plus	Reservation Number	Details
Aetna Better Health of Virginia[1] -	(800) 734-0430 Option 1	All ages and all levels of service
Anthem HealthKeepers	(855) 325-7581	All ages and all levels of service
Magellan Complete Care of Va.	(877) 790-9472	All ages and all levels of service
Optima Health CCC Plus	(855) 325-7558	All ages and all levels of service
United HealthCare CCC Plus[2]	(844) 604-2078	All ages and all levels of service
Virginia Premier CCC Plus	(855) 880-3480	All ages and all levels of service

1 – Aetna Better Health formerly known as CoventryCare 2- United HealthCare formerly known as InTotal Health

Transportation Ride Assist / Customer Service Telephone Numbers

If you need to cancel your ride, ask questions about your ride or transportation, or have a compliment or complaint, please call your Medical Assistance plan (listed below). For the more information use the following link http://dmas.virginia.gov/#/nemtservices and click on Transportation Contacts for Reservations and Ride Assist/Customer Service.

Fee for Service Transportation (non-MCO)	Telephone Number
Fee-For-Service; All Regions	(866) 246-9979

Fee for Service Rider Handbook, Frequently Asked Questions (FAQs), and on line reservations: http://transportation.dmas.virginia.gov

Medallion 4.0 Transportation	Telephone Number
Aetna Better Health[1]	(800) 734-0430 Option 2
Anthem HealthKeepers	(877) 892-3988 Option 2
Magellan	(800) 424-4518
Optima Family Care	(877) 892-3986 Option 1
United Healthcare[2]	(833) 215-3885
Virginia Premier	(800) 727-7536 Option 2 then Option 3

1 – Aetna Better Health formerly known as CoventryCare 2- United HealthCare formerly known as InTotal Health

CCC Plus Transportation	Telephone Number
Aetna Better Health[1]	(800) 734-0430 Option 2
Anthem HealthKeepers	(855) 325-7581 Option 1
Magellan Complete Care of Virginia	(877) 790-9472 {TTY- (866) 288-3133}
Optima Health	(855) 325-7558 Option 1
United Healthcare[2]	(844) 525-1491 {TTY – (844) 525-1491}
Virginia Premier	(877) 719-7358 Option 1 then Option 2 then option 3

– Aetna Better Health formerly known as CoventryCare 2- United HealthCare formerly known as InTotal Health

CO-PAYMENTS

Some Medicaid members must pay a small amount for certain services. This is called a co-payment, or co-pay. As an additional benefit of participation in an MCO, Managed Care Organizations (MCOs) do not currently charge co-payments for services provided.

Children younger than age 21, pregnant women, individuals receiving institutional or community-based long-term care services and individuals in hospice care do not pay a co-payment for services covered by Medicaid. For children covered in the FAMIS program, a small co-payment may be required for some services.

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

- Emergency services (including dialysis treatments)
- Pregnancy-related services

- Family-planning services
- Emergency room services

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

Service	Co-Payment Amount
Inpatient hospital	$75.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit
Physician office visit	1.00 per visit
Other physician visit	3.00 per visit
Eye examination	1.00 per examination
Prescription	1.00 for generic; 3.00 for brand name
Home health visit	3.00 per visit
Rehabilitation service	3.00 per visit

A Medicaid-enrolled medical provider **cannot** refuse to treat you or provide medical care if you are not able to pay the co-payment, but you are still responsible for paying the co-payment, if any.

BENEFITS THROUGH MEDICAID

A general list of services covered by Medicaid follows. As of January 1, 2018, the majority of Medicaid recipients have chosen or were assigned a Managed Care Organization (MCO). This is only a general list and your benefits may differ. If your coverage is provided by an MCO, contact the MCO for coverage criteria as they may provide additional services or benefits other than listed below.

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

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

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

Dental Care Services – participating dentists through **Smiles for Children** provide dental services for children at no charge. Individuals under age 21 and pregnant women are eligible for comprehensive services including diagnostic, preventative and restorative/surgical procedures. Dentures, braces and permanent crowns are covered for those under 21 when prescribed by a dentist and pre-authorized by DMAS. Pregnant women are not eligible for braces unless they are under 21. Other dental coverage for adults is limited to medically necessary oral surgery and

associated diagnostic services. Call **Smiles for Children** at 1-888-912-3456 for help with finding a dentist.

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

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A preventive health care benefit that provides well child examinations with appropriate tests and immunizations for children and teens from birth up to age 21 to keep children healthy. Medically necessary services, which are required to correct or improve health conditions or keep them from worsening, and physical or mental illnesses that are discovered during a screening examination, may be covered as a part of the EPSDT program even if they are not covered under the State's Medical benefit plan.

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

Eye Examinations – Limited to once every two years.

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

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

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

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

Hospital Care –

- **Inpatient:** A patient who has been admitted to a hospital for bed occupancy to receive hospital services. Approved days are covered.
- **Outpatient:** A patient receiving medical services but not admitted to a hospital.

Inpatient Psychiatric Hospital Services for Individuals under Age 21 and individuals aged 65 or Older – Services that provide diagnosis, treatment, or care of persons with mental illnesses in a hospital setting. Inpatient psychiatric services may be covered in a hospital or in a psychiatric unit of an acute care hospital. An individual aged 22-64 years old may receive inpatient psychiatric services in a psychiatric unit of an acute care hospital.

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

Institution – An establishment that furnishes food, shelter, and varying levels of care. Examples of institutions would include nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), long-stay hospitals, IMDs, or psychiatric residential treatment facility (PRTF). For additional information see: www.dmas.virginia.gov/#/ltss.

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

Long-Term Services and Support – These services may include care in an institutional setting such as a Nursing Facility or Intermediate Care Facility for Individuals with Developmental Disabilities or be provided in the community through a Home and Community-Based Care Waiver. See www.dmas.virginia.gov/#/ltss.

Money Follows the Person (MFP) Program – This program provides individuals of all ages and all disabilities who have chosen to transition from long-term institutions in the Commonwealth of Virginia to a home and community setting with extra support and services. MFP moves Virginia closer to a rebalanced long-term support system that promotes choice, quality, and flexibility.

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

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

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

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

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

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

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

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

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

Psychiatric Residential Treatment Services for Children and Adolescents under age of 21 (EPSDT Services) Residential Treatment Services include Therapeutic Group Home and Psychiatric Residential Treatment Facility services.

Therapeutic group home services for children and adolescents under the age of 21 are combined treatment services. The combination of therapeutic services rendered in a residential setting provides a therapeutic structure of daily psycho-education activities, therapeutic supervision, behavioral modification, and mental health care to ensure the attainment of therapeutic goals.

Residential treatment facilities, are 24-hour, supervised, clinically and medically necessary out-of-home programs designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of individuals under the age of 21 in order to prevent or minimize the need for more intensive inpatient treatment. Each individual seeking admission to a residential services will receive the support of the local Independent Assessment, Certification and Coordination Team (IACCT) in each locality to assess the child's needs. The IACCT will include the child, the child's family/legal guardian and clinical professionals form the child's community. Whenever possible, a primary care physician or psychiatrist who knows the child's history will be involved in the assessment. After the IACCT completes the assessment, the team will develop an appropriate plan of care to meet the individualized needs of the child and family. Plans of care may include residential or community-based services. To request services, members may contact Magellan of Virginia at (800) 424-4046.

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

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

Transportation Services for Medical Treatment
See section starting on page 15.

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

WHAT IS NOT COVERED BY MEDICAID?

- Abortions, unless the pregnancy is life-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
- Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Dentures for members age 21 and over (except for pregnant women)
- Doctor services during non-covered hospital days
- Drugs prescribed to treat hair loss, bleach skin or treat erectile dysfunction
- Eyeglasses or their repair for members age 21 or older
- Hospital charges for days of care not authorized for coverage including Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery
- Immunizations for members age 21 or older (except for flu and pneumonia for those at risk)
- Inpatient hospital care in an institution for the treatment of mental disease for members under age 65 (unless they are under age 21 and receiving inpatient psychiatric services)
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid
- Personal care services (except in some home and community-based service waivers or under EPSDT)
- Prescription drugs if the member has coverage under Medicare Part A or Part B
- Private duty nursing (except in some home and community-based service waivers or under EPSDT)
- Psychological testing performed for school purposes, educational diagnosis, school, or institution admission and/or placement or upon court order (Psychological tests performed by local education agencies that are in a child's Individual Education Plan [IEP] are covered under school-based health services)
- Remedial education
- Routine dental care for those age 21 or older (unless pregnant).
- Routine school physicals or sports physicals

- Sterilization of members younger than age 21
- Telephone consultation
- Weight loss clinic programs

This list does not include every service that is not paid for by Medicaid. If you receive a service not covered by Medicaid or you receive more services than the Medicaid limit for that service, you will have to pay those bills. Some services may be covered for members under age 21 under EPSDT.

SERVICES FOR CHILDREN/EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid's comprehensive and preventive child health benefit for members in Medicaid and FAMIS Plus up to age 21. EPSDT detects and treats health care problems through:

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

EPSDT IS FREE:

- Medicaid will pay for EPSDT check-ups.
- Medicaid will pay for the treatment of dental, vision, hearing, and other medical problems found during a check-up if the services are medically necessary to correct a problem or prevent it from getting worse.
- If eligible for transportation benefits, Medicaid will provide transportation to your child's appointment. Contact your Managed Care Organization, or if you do not have a MCO, call toll-free 866-386-8331.

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

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

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

You should take your child to the doctor for check-ups early and on a regular basis. **Getting regular EPSDT Check-Ups, 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:
3-5 days 1 month 2 months 4 months 6 months 9 months 12 months	15 months 18 months 2 years 30 months 3 years 4 years	5 years 6 years 7 years 8 years 9 years 10 years 11 years	12 years 13 years 14 years 15 years 16 years 17 years 18 years 19 years 20 years

Ask your doctor for more information about immunizations

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

LONG-TERM SERVICES and SUPPORTS (LTSS)

Long-Term Services and Supports (LTSS) Medicaid pays for LTSS (also known as long-term care) services in homes and communities through waivers, and in some institutional settings, such as nursing facilities, Intermediate Care Facilities, and for individuals in their communities through Home and Community-Based Care Waivers.

To qualify for LTSS services, an individual must meet certain level-of-care requirements. These requirements may include assistance with activities of daily living and a medical nursing need. In order to receive LTSS services there is a federal requirement that the individual be at risk of institutionalization within 30 days if LTSS services are not provided.

There are eligibility rules and requirements (such as admission screening, asset transfer evaluation and patient pay) which only apply to individuals who need Medicaid coverage for long-term care services. When a child is medically screened, has been institutionalized for 30 days and requires LTSS services, income and resources of his or her parent (s) are not included in the financial determination.

Contact your local DSS for details if Medicaid long-term care services are needed.

There are waivers that are specifically targeted to individuals with developmental disabilities. Collectively, these are known as the Developmental Disability Waivers (DDW). These waivers provide support in the community rather than in an institutional alternative.

To service individuals, they must have a developmental disability which meets institutional level of care criteria, are determined to be at imminent risk of institutional placement, and can be provided community-based critical services under the waiver enabling the individual to remain at home to avoid institutional placement.

These waivers may have a statewide waiting list for participation. The waivers are as follows:

- **Family and Individual Support Waiver (formerly known as the DD Support waiver)** – For individuals living with their families, friends, or in their own home, including supports for those with some medical or behavioral needs. Available to both children and adults.

- **Community Living Waiver (formerly known as the ID waiver)** – this waiver includes residential supports and a full array of medical, behavioral, and non-medical support. Available to adults and children.

- **Building Independence Waiver (formerly known as the DS waiver)** – For adults (18+) able to live independently in the community. Individuals own, lease, or control their own living arrangements and supports are complemented by non-waiver-funded rent subsidies.

Please contact your local DSS, Community Services Board, the Department of Behavioral Health and Developmental Services, Department of Aging and Rehabilitation Services (DARS), or DMAS Division of Aging and Disability Services (DADS) at (804) 692-0481 for more 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 (within the limits of state and federal rules)
- Receive a written notice of the decision
- Have your personal and health information kept private
- Have advance notice of actions that end or reduce your coverage
- Appeal any action, such as:
  - any decision denying, terminating or reducing Medicaid eligibility;
  - any unreasonable period of time taken to decide if you are eligible
  - any decision denying, terminating or reducing Medicaid-covered medical services

You have the responsibility to…

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

FRAUD AND OTHER RECOVERIES

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

Anyone convicted of Medicaid fraud in a criminal court may be required to repay the Medicaid program for all losses (paid claims and managed care premiums) and cannot get Medicaid for one year after the conviction. In addition, the sentence could include a fine up to $25,000 and/or up to 20 years in prison. You may also have to repay the Medicaid program for any claims and

managed care premiums paid during periods you were not eligible for Medicaid due to acts not considered criminal. Fraud and abuse should be reported to your local Department of Social Services or to the DMAS Recipient Audit Unit at (804) 786-1066 (local) and toll free 866-486-1971. Fraud and abuse can also be reported by e-mail to recipientfraud@dmas.virginia.gov.

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

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

Third Party Liability and Personal Injury Claims

If you have been injured in any type of accident and have filed a personal injury claim, you must inform your eligibility worker at your local DSS. Medicaid will be notified so they may recover payments for medical services related to your accident from the responsible parties. DSS will need information such as the date of the accident/injury, type of accident, and the name of the attorney or insurance company involved in the personal injury claim.

Estate Recovery

The death of a Medicaid member should be reported to the person's local DSS office as soon as possible. DMAS has the responsibility to recover money from the estate of a Medicaid member age 55 and over. Recovery may take place only after the death of the surviving spouse and only if there are no children who are blind, disabled, or under the age of 21. For more information about an estate recovery see the Estate Recovery fact sheet on the DMAS Website.

WHEN AND HOW TO FILE AN APPEAL

You have the right to request an appeal of any adverse action related to initial or continued eligibility for Medicaid. This includes delayed processing of your application, actions to deny your request for medical services, or actions to reduce or terminate coverage after your eligibility has been determined. You must ask for an appeal within 30 days of receipt of the agency's notice about the action.

You or someone you want to represent you may ask for an appeal. If you want someone to represent you in an appeal, they must have your written permission.

You may request a fast (expedited) appeal if you or your doctor think waiting for a decision placing your health or life at risk. Not all appeals qualify to be expedited. DMAS will decide and inform you whether your appeal will be expedited or not.

You may ask to have your coverage continue during your appeal. To receive continued coverage, you must file your appeal before the date coverage ends or within ten (10) days of the agency's notice about the action. Not everyone qualifies to have coverage continued. You may have to pay back Medicaid for the additional coverage you received if you lose your appeal.

How Do I Request an Appeal?

You may request an appeal in one of the following ways:

1. Complete the Appeal Request Form. This is available by:
   - Visiting the DMAS website at www.dmas.virginia.gov
   - Asking for a form at your local Department of Social Services
   - Calling DMAS at (804) 371-8488

2. Write a letter with the information about your appeal. It should include:
   - The reason for your appeal
   - Your full name and the date you were born
   - Your Social Security Number
   - Your case number or a Medicaid Member Number (if known)
   - The name of the agency or office that sent the letter or Notice of Action
   - The date of the letter or Notice
   - A copy of the Notice or letter, including all pages front and back.

3. Call the Department of Medical Assistance Services (DMAS) at (804) 371-8488 and give the same information as above.

4. Visit DMAS at 600 E. Broad Street, Richmond, Va. 23219 and give the same information as above.

Send the Appeal Request Form or letter, and any requested documents, including a complete copy of the notice about the action. You can send this information

Email: appeals@dmas.virginia.gov -or-
Fax: (804) 452-5454 -or-
Mail: DMAS Appeals Division, 600 East Broad Street, Richmond, Virginia 23219

After you file your appeal, you will be notified of the date, time, and location of a scheduled hearing. Most hearings can be conducted by telephone.

The Hearing Officer's decision is the final administrative decision rendered by DMAS. If you disagree with the Hearing Officer's decision, you may appeal it to your local circuit court.

PRIVACY INFORMATION

When you receive health care services from an agency like DMAS, that agency may get medical (health) information about you. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and any later requirements such as the Omnibus of 2014, your health

information is protected. Health information includes any information that relates to: (1) your past, present or future physical or mental health or condition, (2) providing health care to you, or (3) the past, present or future payment of your health care.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights and Our Responsibilities

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- We will not retaliate against you for filing a complaint.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- You can complain if you feel we have violated your rights by contacting the privacy officer at DMAS, 600 East Broad Street, Richmond Virginia 23219 or send an email to: HIPAAprivacy@dmas.virginia.gov.

Your Choices

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

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

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

We *never* share or sell your information for marketing purposes.

Our Uses and Disclosures

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

Help manage the health care treatment you receive

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

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

Run our organization

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

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

DEFINITIONS

Activities of Daily Living (ADL)	Personal care tasks (e.g., bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of dependence in performing these activities is part of determining the appropriate level of care and service needs.
Asset Transfer	Medicaid applicants and recipients must be fully compensated for any transfers of money, property or other assets.
Authorized Representative	Person who is authorized in writing to conduct the personal or financial affairs for an individual.
Caseworker	Eligibility Worker at the local department of social services who processes the application to determine Medicaid eligibility and maintains the ongoing case. This is the person to contact regarding changes, such as address or income, or problems, such as not receiving the Medicaid card.
Coinsurance	The portion of Medicare, Medicaid, or other insurance, allowed charges for which the patient is responsible.
Co-Payment	The portion of Medicaid-allowed charges which a member is required to pay directly to the provider for certain services or procedures rendered.

Cover Virginia	A DMAS operations unit which performs a number of services, which includes a call center to answer questions or submit applications and renewal, a central processing unit to process Medical Assistance and FFM applications, and performs functions for specialty groups such as incarcerated individuals or those eligible for hospital presumptive eligibility. They also maintain the Cover Virginia website: www.coverva.org.
DMAS	Department of Medical Assistance Services, the agency that administers the Medicaid program in Virginia.
DSS	Department of Social Services, the agency which determines eligibility for medical assistance and other services, such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). DSS may also refer to the local departments of social services.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a preventive health care benefit that provides well child examinations with tests and immunizations for children and teens from birth up to age 21. Medically necessary services needed to correct, improve or prevent health issues from worsening and physical or mental illnesses (discovered during a screening examination) may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan.
FAMIS	Family Access to Medical Insurance Security is Virginia's Children's Health Insurance Program that helps pay for medical care for children under age 19 and pregnant women (FAMIS MOMS). FAMIS has higher income limits than Medicaid.
Fraud	A deliberate withholding or hiding of information or giving false information to obtain or attempt to obtain Medicaid benefits.
Generic Drugs	Copies of drugs that are the same as a brand-name drug in dosage, safety, strength, quality, performance, and intended use. The Food and Drug Administration requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Manufacturers of generic drugs do not have the same investment costs as a developer of new drugs; therefore, generic drugs are less expensive.
Health Insurance Marketplace (HIM)	Online marketplace of private insurance plans operated by the Federal government. Individuals can shop for health insurance, compare private plans and premiums, and determine whether they qualify financial assistance to help pay for insurance. Also called FFM (Federally Facilitated Marketplace).

Managed Care	Delivery of health care services emphasizing the relationship between a primary care provider (PCP) and the Medicaid member (referred to as a "medical home"). The goal of managed care is to have a central point through which all medical care is coordinated. Managed care has proven to enhance access to care, promote patient compliance and responsibility when seeking medical care and services, provide for continuity of care, encourage preventative care, and produce better medical outcomes. Most Virginia Medicaid members are required to receive their medical care through managed care organizations.
Managed Care Organization (MCO)	Managed Care Organization is a health plan contracted to provide medical services and coordinate health care services through a network of providers.
Medicaid	An assistance program that helps pay for medical care for certain individuals and families with low incomes and resources.
Medicare	The federal health insurance program for people 65 years or older, those under 65 and receiving Social Security Disability Insurance, or people under 65 and with End Stage Renal Disease (ESRD).
Medically Frail	A term that may describe an individual who may have chronic health conditions, and may include people with mental health and substance use disorders. In addition, to define a person who medical care for daily skilled (nursing) intervention is medically necessary.
Medically Necessary	Reasonable and necessary services for the diagnosis or treatment of an illness, an injury, or to improve physical functioning.
Patient Pay	Individuals with income may have to contribute to the cost of their long term care services
Primary Care Provider (PCP)	The doctor or clinic that provides most personal health care needs, gives referrals to other health care providers when needed, and monitors Medicaid member health. A PCP may be an internist, a pediatrician (children's doctor), OB/GYN (women's doctor), or certain clinics and health departments.
Resources (Assets)	Resources include money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, pre-paid burial plans, cars, boats, life insurance policies, and real property such as a home or land.
SSA	The Social Security Administration (SSA) is the federal agency that administers the Social Security retirement, survivors, and disability insurance programs. They also administer the Supplemental Security Income program for the aged, blind, and disabled.

SSI	Supplemental Security Income (SSI) is a federal program administered by the Social Security Administration that pays monthly benefits to disabled, blind or age 65 or older individuals with limited income and resources. Blind or disabled children, as well as adults, can get SSI benefits.
Uniform Assessment Instrument (UAI)	A screening form completed by a team that evaluates the applicant's ability to complete activities of daily living

ADDRESSES, PHONE NUMBERS and WEBSITES

Local departments of social services in your city or county www.dss.virginia.gov/localagency
Check the government (blue) pages of the local telephone book for the proper contact number for the following information:

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

Virginia Department of Social Services (VDSS) www.dss.virginia.gov
For questions or concerns regarding the actions of staff employed by your local department of social services, write the Virginia Department of Social Services, Bureau of Customer Service, 801 E. Main Street, Richmond, Virginia 23219. You can also call the VDSS at (804) 726-7000 or email concerns to: www.citizen.services@dss.virginia.gov. The DSS website is: www.dss.virginia.gov.

Department of Medical Assistance Services www.dmas.virginia.gov

- For Medicaid **appeal** information, call (804) 371-8488
- Dental Services, **Smiles for Children**, 1-888-912-3456
- For information about **FAMIS and Medicaid**, call Cover Virginia 1-855-242-8282
- To report Medicaid **fraud or abuse, call** the DMAS Recipient Audit Unit at (804) 786-0156 or your local department of social services or (804) 786-1066 and toll free 1-866-486-1971
- Health Insurance Premium Payment Program (**HIPP**) call toll free, 1-800-432-5924
- For information about **Managed Care** enrollment, call 1-800-643-2273
- **Long Term Care** information or problems, call (804) 225-4222
- For problems with bills or services from providers call the **Recipient Helpline** at 804-786-6145, or write the Recipient Services Unit at the address on the cover of this handbook
- **Transportation**; if you need transportation for a Medicaid covered service appointment and you are not enrolled in an MCO, call **Logisticare** toll free, 1-866-386-8331
- Medical service providers submit requests for treatment prior authorization to **KePRO,** Virginia's health utilization management company**.** Services that do not require preauthorization include pharmacy, dental and transportation.
- For Behavioral Health information call Magellan at 1-800-424-4046 or visit www.magellanofvirginia.com

Helpful Resources

The Department of Medical Assistance Services (DMAS) is the state agency which administers and oversees the Medicaid program in Virginia, providing access to health care for the most vulnerable individuals in the Commonwealth.

Cover Virginia
Virginians can receive information regarding Medicaid, FAMIS (the Children's Health Insurance Program), and other community health care options from Cover Virginia. Cover Virginia also processes certain Medicaid applications at their Central Processing Unit. For more information go to www.coverva.org**.** Individuals without access to a computer can apply by dialing the Cover Virginia at 1-855-242-8282.

The Virginia Department of Social Services (VDSS) is the state agency that develops and administers programs that provides a host of programs to assist citizens. This includes eligibility determination of Medical Assistance (MA) applications for Medicaid and Children's Health Insurance Programs (known as FAMIS), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Heating and Cooling Assistance (LIHEAP) and Child Care Assistance. You may locate your local department of social services www.dss.virginia.gov/localagency. They also oversee the CommonHelp web service located at commonhelp.virginia.gov.

CommonHelp is a web-based service that will let you:

- Screen for eligibility for social services benefits and services
- Apply for benefits and services (including renewals)
- Check the status of benefits
- Report changes

Additional Resources

Early Intervention services are available throughout Virginia to help infants and toddlers (under age three who have or are at risk for developmental delays or disabilities) and their families. Contact Infant & Toddler Connections of Virginia (804) 786-3710 or www.infantva.org.

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 or www.headstartva.org.

Health Insurance Marketplace (HIM) is the online source where individuals can access the Federal Health Insurance Marketplace. The federal government operates the Marketplace where an individual can be determined if eligible for federal tax credits or eligible for Medicaid or the Children's Health Insurance Program (CHIP). It also helps people to shop for and enroll into affordable health insurance. More information is available by calling 1-800-318-2596 or visiting online at www.healthcare.gov.

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

The **Resource Mothers Program** trains and supervises laywomen to serve as a social support for pregnant teenagers and teenage parents of infants. Teenagers are at high risk for poor birth outcomes, both medically and socially. The program helps low-income pregnant teenagers get prenatal care and other community services, follow good health care practices, and continue in school. It also encourages the involvement of the infant's father and teen's parents to create a stable, nurturing home. For further information, contact the Division of Child and Family Health, Virginia Department of Health at (804) 864-7673 or go to www.vdh.virginia.gov/family-home-visiting/resource-mothers-program/.

Schools are key links to improve child health. Schools help identify children's health problems and inform families about Medicaid Assistance and the EPSDT program. See the Virginia Department of Education website for more information: www.doe.virginia.gov/students_parents/.

VirginiaNavigator
Visit the **VirginiaNavigator** website to find programs, services and information helpful to seniors, caregivers, baby boomers and their families. They also provide links to their other websites including SeniorNavigator, disAbilityNavigator, VeteransNavigator, and the Lindsay Institute for Innovations in Caregiving. Go to www.seniornavigator.org or phone (804) 525-7728.

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

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

Virginia Easy Access
The Virginia Easy Access program offers information for individuals in need of long-term supports about community supports, emergency preparedness, financial help, housing, rights, transportation, veterans and other related links. The link is www.easyaccess.virginia.gov. Virginia Easy Access can be reached by dialing 211 or also at 1-800-552-3402.

The **Virginia Healthy Start Loving Steps Initiative** (VHSI) is designed to reduce infant mortality in these areas: Norfolk/Portsmouth, Petersburg, and Westmoreland County. Contact the

Healthy Start Program Coordinator at the Virginia Department of Health at 1-804-864-7788 or go to: www.vdh.virginia.gov/family-home-visiting/healthy-start-loving-steps/.

Virginia No Wrong Door (NWD) is a statewide public/private partnership with a virtual system and network of statewide-shared resources, designed to streamline access to long-term services and support; connecting individuals, providers and communities across the Commonwealth. You can contact them at (804) 662-7000 or go to: www.nowrongdoorvirginia.org/.

2-1-1 Virginia is a free service connecting people with free information on available community services. A trained professional listens to your situation and suggests sources of help using one of the largest databases of health and human services in Virginia. The service provides access to resources in your community and statewide. You can contact them at 211virginia.org or use their easy to remember phone number 2-1-1.

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program, works in partnership with Virginia to administer Medicaid and the Children's Health Insurance Programs (CHIP), has oversight of the Health Insurance Marketplace (HIM), and administers health insurance portability standards. The CMS website is located at https://www.cms.gov/.

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