

MANUAL MATERIAL TRANSMITTED					
MANUAL: INCOME MAINTENANCE			CHANGE NUMBER: 83		
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			2 b	16	8/97
			2 c	16	9/96
			OFS-HIP-1	FORM	8/97
DATE: June, 1997			TO: All Income Maintenance Manual Holders		

This change implements a Medicaid notification requirement mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This act requires that all individuals in a Medicaid case receive a certificate of coverage each time Medicaid benefits are stopped. It prevents any subsequent group health plan from imposing exclusions for preexisting medical conditions.

A procedure for automating the issuance of these certificates is currently being devised. In the interim, any individual who lost Medicaid on or after July 1, 1996 must be issued a certificate of coverage UPON REQUEST. No coverage period prior to July 1, 1996 is required to be provided.

Form OFS-HIP-1 has been created for this purpose. Upon request, the Worker completes a certificate for the client using information found in the case record and data systems. The client is given the original and a copy is kept in the case record. The information required on the form is brief and self-explanatory.

When all individuals in the same family or coverage group have at least 18 months of coverage, or the same coverage dates, they may be included on the same certificate. When coverage dates vary for individuals, or not all have at least 18 months of coverage, a separate certificate is required for each.

you received _____ months from the State of _____.
This is a total of _____ months received."

d. Closure at Client's Request

The Worker must close the case when the client requests that such action be taken. The Worker should encourage the client to state the reason he is making the request, but acts on the case closure even if he does not. Advance notice is required.

e. Certificate of Coverage (Medicaid Only)

For any individual in any Medicaid coverage group whose Medicaid benefits stopped on or after July 1, 1996, the Worker must, upon request, complete form OFS-HIP-1, Certificate of Medicaid Coverage.

All individuals in the same benefit group with the same period of coverage may be included on the same certificate. A separate certificate must be issued for individuals who have different dates of coverage, or when all individuals do not have 18 months of coverage.

C. PROCEDURES FOR ADDING NEWBORN CHILDREN (AFDC/U AND MEDICAID ONLY)

Each CSM is responsible for assigning one person in each of the counties under his supervision to seek out information about newborn children. This individual is responsible for ensuring that information about newborn children is added to the TANF, WV WORKS or Medicaid case and that the information is entered into the appropriate data system within 5 working days of the date information is obtained. This individual is also expected to work with medical providers and clients in the county to develop mutually agreeable procedures for obtaining the necessary information as quickly as possible. The CSM must also have a back-up designee when the contact person is unavailable.

A statewide list of the contact people is maintained by the IM Policy Unit and shared as appropriate. Each CSM is responsible for notifying the IM Policy Unit as soon as changes occur.

A printout titled Births Due In (mm/yy) is produced monthly which shows all families expecting a birth in the following month. Special coding in Blocks 49 and 55 in the C-219 system and Block 35 in the M-219 system is the basis for

2.2 FOOD STAMPS

Case maintenance and corrective procedures specific to the Food Stamp program are outlined in this Section.

A. SOURCES OF INFORMATION

In addition to the sources listed in Section 2.1, the following are specific to the Food Stamp Program.

- Report Form, ES-FS-2

The ES-FS-2 serves 2 purposes. It provides the client with a means to report changes and serves as the 12-month review form for cases certified for more than 12 months, according to Section 1.4,N. The information in this Section (item A) applies when the form is used to report changes. Its use as a 12-month review form is described in item B below.

The ES-FS-2 is mailed with computer-generated notification letters. Quarterly reporters who choose to use the ES-FS-2 are considered to have reported outside the QR system, and the information is acted on.

When the Worker receives an ES-FS-2, he makes any appropriate changes in the data system. When the information is unclear or follow-up is needed, the Worker contacts the client before taking action. Another ES-FS-2 must be sent to non-QR clients who submit a completed ES-FS-2.

When the information provided on the ES-FS-2 results in a change in benefits, proper notification is sent. See Chapter 6. Along with this notification, the Worker requests additional verification needed, if any, and states that failure to provide verification will result in the increased benefits reverting to the original allotment.

When the household does not provide the required verification, the Worker takes the necessary action to change the benefits. Changes reverting to the original coupon allotment because of the client's failure to verify are subject to 13 days advance notice.

- Data System Printouts

See Chapter 3 for IEVS information.

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information specified in item A above with the following two additions:

- Weekly cost of lab tests
- Name of facility which will perform the lab tests.

No verification of the information submitted is required unless the client does not know the information or the Worker has reason to doubt the client's statement.

Once the eligibility decision is made, the county office is notified by the Director of the IM Policy Unit. The Worker must then notify the client and provide him with all necessary information to obtain the services.

C. ASSIGNMENT OF RIGHTS

As a condition of eligibility, all applicants and recipients must assign to the Department any rights to medical support and to payments for medical care from any third party, provided they are legally able to do so. They must cooperate in identifying and providing information to use in pursuing third parties, unless good cause is established for not cooperating. Cooperation includes establishing paternity and obtaining medical support and payments. Good cause will be determined by OFS based on written information submitted by the Worker to the Policy Unit.

When an otherwise eligible individual cannot legally assign his own rights, and the person legally able to do so does not cooperate, the individual remains eligible.

EXAMPLE: A mother refuses to assign benefits for herself and her children, for whom she can legally make an assignment. The mother is ineligible and the children remain eligible for Medicaid.

NOTE: Poverty-Level Pregnant Women, through the two months postpartum, are exempt from establishing paternity and obtaining medical support.

An SSI applicant is required to assign third party rights to the Department as part of his application for SSI. If he refuses to assign these rights, he is ineligible for Medicaid.

D. CERTIFICATE OF COVERAGE WHEN MEDICAID COVERAGE ENDS

All Medicaid recipients who so request, must be issued a Certificate of Coverage (OFS-HIP-1), when Medicaid benefits stop.

16.2 RELATIONSHIP WITH THE OFFICE OF HANDICAPPED CHILDREN (OHC)

A child may be simultaneously eligible for and receiving services from the Medicaid Program and from the Office of Handicapped Children (OHC). The child may already be receiving Handicapped Children's services when application is made for an OIM Program. In addition, at the time of application, and anytime thereafter, the Worker may determine that a child could benefit from Handicapped Children's services.

A. NON-OHC RECIPIENTS WHO ARE APPLICANTS FOR OIM PROGRAMS

Anytime a child's eligibility is being considered for any Income Maintenance Program and the Worker believes the child could benefit from services provided by the OHC, the Worker must refer the child to the OHC. Refer to the OHC Manual for covered medical conditions.

The referral is accomplished by completion of the following OHC forms:

- HC-10 - Handicapped Children's Application
- HC-11 - Eligibility Review
- HC-11A - Eligibility Review Supplement

If the child is applying for AFDC/U or Medicaid, a memorandum must be attached to the forms listed above indicating the status of the application. If the child is later approved for OHC services and AFDC/U or Medicaid, the OHC must be advised by memorandum of any change in the status of the case and the reason for such change.

B. OHC RECIPIENTS WHO ARE APPLICANTS FOR AFDC/U OR MEDICAID

When a family applies for AFDC/U or Medicaid and is already an active OHC case, the Worker must notify the OHC if the application is approved and must specify the eligibility dates. This is accomplished by memorandum and the Worker must indicate whether or not the child is eligible for Medicaid.

In addition, when the child is already an active OHC case, the Worker must notify the OHC by memorandum if the application is denied or withdrawn or the active Medicaid case is closed. The memorandum must indicate the reason for such action.

STATE OF WEST VIRGINIA
Department of Health And Human Resources
CERTIFICATE OF MEDICAID COVERAGE

DATE: _____

PARTICIPANT'S NAME: _____

CASE NUMBER: _____

PERSONAL IDENTIFICATION NUMBER (PIN): _____

NAMES OF INDIVIDUALS TO WHOM THIS CERTIFICATE ALSO APPLIES:

NAME: _____ PIN: _____ NAME: _____ PIN: _____

NAME: _____ PIN: _____ NAME: _____ PIN: _____

NAME: _____ PIN: _____ NAME: _____ PIN: _____

NAME: _____ PIN: _____ NAME: _____ PIN: _____

(Additional names may be listed on back)

This is to certify that the above individual(s) have received Medicaid coverage on or after July 1, 1997 for:

_____ 18 months or more

_____ Less than 18 months with the following dates of coverage: _____

This coverage is creditable toward the requirements specified in the Health Insurance Portability and Accountability Act of 1996.

This certificate issued under the authority of the:

Bureau For Medical Services
7012 MacCorkle Avenue, S.E.,
Charleston, West Virginia 25304-2943
Phone: 304-926-1703

which is the designated State Medicaid Agency in West Virginia.

Questions about the information on this certificate, including dates of coverage and individuals included should be directed to the local DHHR office:

Phone: _____