16.1 INTRODUCTION

The West Virginia Medicaid Program provides payment for covered medical services to certified medical providers for eligible individuals who are aged, blind or disabled and to eligible members of families with dependent children.

The determination of which medical services are covered under Medicaid and which medical providers are certified to accept Medicaid patients is the responsibility of the Bureau for Medical Services and is not addressed in this Manual. Unless otherwise specified, the coverage group receives all services covered under Medicaid.

For eligibility for nursing care services and MR/DD and HCB Waiver coverage groups, refer to Chapter 17.

This Chapter provides an overview of the Medicaid Program. In addition, each coverage group has specific requirements which must be met and procedures to follow that may not apply to other Income Maintenance programs or other Medicaid coverage groups. These are contained in this Chapter.

NOTE: Children determined eligible for QC or PL Medicaid remain eligible for 12 continuous months, regardless of any changes after approval, except those specified in Section 2.8.

In addition to the coverage groups described in this Chapter which make up the Medicaid Program, the Department has special procedures in place to pay for certain necessary drugs for individuals not eligible for Medicaid. These costs are paid from State money only and cover only the costs shown in items A and B below. Procedures to obtain payment for these expenses are also described below. Workers must submit information about all persons who might qualify for payment of such services. None of the costs paid for through this process may be used to meet spenddown.

A. SPECIAL APPROVAL, IMMUNOSUPPRESSANT DRUGS FOR TRANSPLANT PATIENTS

Individuals who have received a transplanted organ and who are not eligible for Medicaid due solely to failure to meet a spenddown, may have the cost of anti-rejection drugs paid by the Department. To qualify, it must be established that the client does not have sufficient income available to pay for the medication. The individual must have been denied Medicaid for the above reason within six months of the date of the client's request for payment. In addition, the Worker must review the previous application to determine if the client's circumstances have changed. If he continues to be ineligible for Medicaid, due solely to failure to meet a spenddown, at the time he requests payment of the drugs, special approval is considered.

To have the client considered for this special approval, the Worker must submit a memorandum to Director, **DFA**. The memorandum must show "Special Drug Approval" on the top of the page and must contain the following information:

- Client's name, address, date of birth, SSN, sex, county of residence and race
- Number of people in the client's home and their relationship to the client
- Date of application
- Income of all family members
- Whether or not Medicare eligible. If eligible, date coverage began.
- Name of the prescribed drug(s)
- Average Monthly cost of the prescribed drug(s)

NOTE: Medicare pays for 80% of the cost of immunosuppressant drugs for 3 years after a transplant. When Medicare participates in the payment of the drug(s), the Worker must indicate only the amount for which the client is responsible after Medicare pays its portion. Only this amount is used to determine eligibility and is subsequently paid by the Department.

- Name and telephone number of pharmacy
- Physician's name
- Date of transplant
- Date of last Medicaid denial for failure to meet a spenddown.

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.

NOTE: Certain recipients of the Division of Children and Adult Services (CAS) are eligible to receive coverage for immunosuppressant drugs through FACTS. During the application or renewal process, the Worker must inquire if the Special Pharmacy applicant is receiving medical coverage through CAS. If the Worker believes the individual may be dually eligible through both FACTS and RAPIDS, the Worker must electronically notify the DFA Policy Unit with the following information:

- **Applicant/Recipient's Name**

- **Date of Birth**

- **Social Security Number**

- **Client's FACTS ID (if known)**

Upon receipt, the Policy Unit will contact CAS to establish if coverage already exists or if further eligibility determination is necessary.

Once the eligibility decision is made, the county office is notified by **DFA**. The Worker must then provide the client with all necessary information to obtain the drug(s).

B. SPECIAL APPROVAL, CLOZAPINE/CLOZORIL, DRUG MANAGEMENT AND TESTING

Individuals for whom Clozapine/Clozoril has been prescribed and who are not eligible for Medicaid due solely to failure to meet a spenddown may have the cost of this medication paid by the Department. To qualify, it must be established that the cost of the Clozapine/Clozoril, if paid by the client, would reduce the family income below 100% of the AFDC/U standard of need for a family of the same size. The individual must have been denied Medicaid for the above reason within six months of the date of the client's request for payment. In addition, the Worker must review the previous application to determine if the client's circumstances have changed. If he continues to be ineligible for Medicaid, due solely to failure to meet a spenddown, at the time he requests payment of the drugs, special approval is considered. To have the client considered for this special approval, the Worker must submit a memorandum to Director, **DFA**. The memorandum must contain all of the information specified in item A above with the following additions:

- Average monthly cost of Clozapine/Clozoril

- Average monthly 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.

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- **Applicant/Recipient's Name**
- **Date of Birth**
- **Social Security Number**
- **Client's FACTS ID (if known)**

Upon receipt, the Policy Unit will contact CAS to establish if coverage already exists or if further eligibility determination is necessary.

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

C. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS

Provided they are legally able to do so, all adult Medicaid applicants and recipients must assign to the department any rights to medical support and to payments for medical care from any third party. This information is entered in the medical insurance coverage screen in RAPIDS.

When the adult receives Medicaid under any coverage group, under any case number, the assignment of medical support rights is a condition of eligibility and he must cooperate in identifying and providing information to use in pursuing third parties, unless good cause is established for not cooperating. Good cause is determined by **DFA** based on written information obtained by the Worker.

NOTE: All other adults who have the legal ability to do so, but who are not Medicaid recipients, must assign Medicaid support rights as well.

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 may not be penalized for failure to cooperate with this requirement until the expiration of the postpartum period.

An applicant for SSI 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 (**DFA**-HIP-1), when Medicaid benefits stop.

This applies to all individuals whose Medicaid benefits stopped on or after July 1, 1996. See Section 2.1,B.

E. CHILD SUPPORT REQUIREMENTS AND PROCEDURES

Federal law mandates that efforts be made to locate absent parents, establish paternity and obtain medical support for dependent children who receive Medicaid. The responsible adult included in an AFDC Medicaid or AFDC-Related Medicaid AG must cooperate with child support activities and provide the Department with appropriate information.

EXCEPTION: Recipients of TM cannot lose eligibility for failure to cooperate with BCSE. However, BCSE services must be explained and a voluntary referral made when appropriate.

When the responsible adult is not a Medicaid recipient under any coverage group, he must be informed of the availability of BCSE services and encouraged to accept a voluntary referral. Voluntary BCSE referrals do not sign an **DFA**-AP-1. There is no penalty when a voluntary referral subsequently fails to cooperate with BCSE.