may receive Marketplace benefits. If approved for other non-MAGI Medicaid coverage, the Marketplace is electronically notified. See Section 1.24,G.

6. Redeterminations Submitted by Mail

Recipients of some Medicaid coverage groups, WV CHIP and other Programs receive an instruction letter and redetermination form which is submitted by mail, along with appropriate verifications. The client must complete, sign and mail or bring the form and other required information to his local DHHR office or the Customer Service Reporting Center as directed by the letter. See below for redeterminations submitted by inROADS. The client may always request a face-to-face interview. See Program Sections for specific information about the redetermination process.

7. Redeterminations Submitted by inROADS

Recipients of some Medicaid coverage groups, WV CHIP and other Programs receive an instruction letter and redetermination form. The client may choose to return the completed form and information by mail or complete the redetermination online by use of inROADS. The recipient receives certain information in the letter which must be entered online to use the inROADS redetermination process. See program sections for specific information about the redetermination process.

No signature page is required and the redetermination is considered electronically signed when the recipient uses this process and enters information from the letter and other identifying information requested.

The online process is available for use through the end of the month the redetermination is due. Redeterminations submitted in inROADS are processed by use of eRAPIDS Inbox screen or the Worker's dashboard.

The client may also submit an application for another benefit(s) at the time of the inROADS redetermination.

8. Presumptive Eligibility

Individuals receiving services at a qualified hospital, or other entity identified in the West Virginia Medicaid State Plan - Comprehensive Behavioral Health Centers, Free Clinics and Federally Qualified Health Centers, may apply for Medicaid with the assistance of an Authorized Employee (AE). Qualified entities may elect to provide Presumptive Eligibility (PE) determinations to individuals who are without any other form of health coverage. Presumptive financial eligibility is not permitted for any other program and is unrelated to Presumptive Medical decisions for the Medical Review Team (MRT). Eligibility is established on date of determination. Back-dating does not apply to this provision.

Categories Eligible for PE:

- Children under age 19
- Pregnant Women
- Parents/Caretaker Relatives
- Adult Group
- Former WV Foster Children
- Breast and Cervical Cancer Women Receiving Current Treatment

a. Duties of the AE

The AE makes a PE decision based on preliminary information provided by either the individual seeking treatment or someone with the patient who would reasonably be expected to know about the individual. They can attest to the individual's US Citizenship or satisfactory immigration status. The AE is prohibited from requiring any other verification prior to approval. Additional information gathered includes name, household size, income limit, sex, address, and prior approval for PE in the last 12 months. Using the same inROADS portal as Community Partners, the AE sends the information electronically to the data system and issues a medical card with a PE Medical ID. The PE determination is not subject to fair hearing rights and advance notice is not required.

The presumptive eligibility period begins on the date of the PE determination and concludes on the last day of the following month. Eligibility may not be backdated.

PE eligibility ends:

- The date the eligibility determination is completed based on the submission of a full application.

- The last day of the month following the month of the PE approval without submission of a full application.

EXAMPLES: Eligibility for PE is determined on June 15th. A full Medicaid eligibility is determined August 3 based on an application dated July 30. PE coverage ends August 3.

PE is determined June 15th. Eligibility would expire July 31 if an application was not filed.

If a patient is determined PE on June 15, applies for Medicaid and is denied on July 10, PE ends July 10.

NOTE: PE is limited to once every twelve months, starting with the effective date of the initial presumptive eligibility period, with the exception of pregnant women, who are eligible once per pregnancy.

The AE must assist the applicant or his representative in completing full Healthcare application and forward the application to the Department. The full Healthcare application can be submitted online, by mail, fax, telephone, or in person.

If the patient or the authorized representative (AR) is unable or unwilling to complete the full application at the time of service, the AE will tell the patient or AR of the different options they have to complete the full application. If the patient indicates that they would like to complete their application via the telephone, the worker must have them contact the call center at 1-877-716-1212. The worker should explain that they must call this number because they will be required to give a recorded telephonic signature.

b. DHHR Worker Responsibilities

Upon receipt of a completed application, the DHHR worker begins processing the application which includes the PE Medicaid Identification Number. This process combines the two applications together, and closes the PE period upon approval or denial of the Medicaid application. The Worker must establish whether the client was eligible at the time of the PE determination, as well as ongoing. Medicaid eligibility begins on the first day of the month of the PE determination. Retroactive back-dating is allowed with the full Medicaid application, if the client is eligible.

The DHHR Worker or qualified entity must take the BMS approved PE training and receive certification prior to becoming an Authorized Employee that will be permitted to take application for Presumptive Eligibility. The qualified entities at which the DHHR Worker is placed will have made agreement to accept responsibility for all decisions and outcomes of the DHHR AE. The DHHR Worker that is at the hospital will follow the same procedures for taking Presumptive Eligibility applications as any other PE Worker.

c. Other PE Specifications

(1) Qualified Entity

To be qualified to make presumptive eligibility determinations, a hospital or other entity must:

- Be a qualified entity identified in the WV Medicaid State Plan as eligible to conduct PE;
- Be enrolled in WV Medicaid as a provider;
- Elect to participate in the PE program by:
  - Submitting a PE application attesting to their qualifications to participate in the PE program, and
  - Agree to all the terms and conditions related to the use of the presumptive eligibility determination portion of the WVinROADS on-line system.
- Assign an employee to serve as the Presumptive Eligibility Administrative Point of Contact;

- Assist applicants with the completion of the full Medicaid application;
- Follow state and federal privacy and security requirements;
- Follow state requirements for data submission.

(2) Authorized Employee (AE)

For all authorized employees, DHHR workers and other third party contractors, the following conditions must be met:

- Before a hospital employee, DHHR worker or other third party contractor can be authorized to perform presumptive eligibility determinations he or she must satisfactorily complete the training course provided by BMS.
- A certificate of course completion must be kept in the AE worker file at the qualified entity and must be made available to BMS within five (5) days of request. A file must be kept on third party vendors and DHHR workers who are assigned to do presumptive eligibility determinations.
- Access to WVinROADS may not be granted by the Presumptive Eligibility Administrator or the Administrative Point of Contact until all training is completed and a certificate is presented by the employee.
- All authorized presumptive eligibility employees must complete and submit a User Agreement with WVinROADS prior to conducting presumptive eligibility determinations.
- When an AE leaves the employment of the hospital, their contract ends or is no longer assigned to determine presumptive eligibility on behalf of the hospital the Presumptive Eligibility Administrative Point of Contact must immediately remove his/her access to the WVinROADS system.

9. Applications Submitted Through inROADS From the West Virginia Division of Corrections (DOC) or Regional Jail Authority (RJA)

The West Virginia Division of Corrections (DOC) or Regional Jail Authority (RJA) will provide the Bureau for Medical Services (BMS) a list of incarcerated individuals that have been admitted as an inpatient in a medical institution for at least 24 hours. Hospitals will also provide a list to BMS of incarcerated individuals who have been admitted for services for reconciliation against the DOC and RJA list.

If the individual is a current Medicaid recipient, BMS will code MMIS with the appropriate incarceration status. This will place a restriction on payment of Medicaid services while the recipient is an inmate, or incarcerated. BMS will also notify the Customer Service Reporting Center (CSRC) if the recipient is not coded as incarcerated, so the living arrangement code in the case can be updated

If the individual is not a current Medicaid recipient, BMS will notify DOC or RJA to assist the individual with submitting a Healthcare Application via inROADS.

The inROADS applications will be forwarded to the Customer Service Reporting Center (CSRC) for processing. If Medicaid eligible, the incarcerated individual living arrangement code will inform BMS/MMIS of the recipients' incarcerated status. The CSRC notifies BMS by email that the application has been processed.