

**STATEMENT OF AGREEMENT  
TO ENSURE MAXIMUM COLLABORATION AND UTILIZATION OF THE NEEDS  
PROGRAM UNDER THE VIRGIN ISLANDS STATE PLAN FOR MEDICAL  
ASSISTANCE, TITLE XIX OF THE SOCIAL SECURITY ACT.**

**I. INTRODUCTION:**

As of this date, June 12, 1995, the Agreement between the MEDICAL ASSISTANCE PROGRAM (MAP) and the MATERNAL AND CHILD HEALTH AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM (MCH & CSHCN) is updated to reflect both new Federal requirements and new programs and services in the Virgin Islands.

The purpose of this document is to record an agreement between the MAP Single State agency and the Maternal and Child Health and Children With Special Health Care Needs Program, and to implement provisions of Section 1902 (a) (11) (a) of the Social Security Act. Federal Regulations require written agreements between Title XIX, State Health Agencies and Title V, Public Health Services and clearly establish the working relationships and respective duties of the agencies involved.

**II. MUTUAL RESPONSIBILITIES**

- A. Coordination, strengthening, development and implementation of medical care services rendered to Children With Special Health Care Needs and other needy children up to 21 years of age, and mothers.
- B. Development of a Joint MAP/MCH Utilization Review Committee to consider amount, duration, scope, and quality of care service provided. Committee membership will include representatives from Division of Maternal and Child Health and Children With Special Health Care Need, and MAP. The committee will also make recommendations as to the improvement of the delivery of health services.
- C. Establishment of effective working arrangements whereby the best utilization is made of manpower and other resources available in rendering services for the benefit of the child's mother.

C. Referrals and Billing Procedures:

The MCH & CSHCN will submit referral requests and claims for payment of services rendered on appropriate MAP forms:

1. The printouts will identify all claims on a monthly basis, and will reflect the agreed fee.
2. Requests for consultation and special services will be used at the point needed services are not available at the clinics or within the Health Department as a whole.
3. MA-5 will be used for arranging special dental services not available at MCH & CSHCN or at the government facilities.

Clinic Procedures for Billing MAP/MCH & CSHCN

1. The clinic will complete all appropriate billing forms previously mentioned.
2. The clinic will maintain a roster of all bills for services as follows:

<u>Control No.</u>	<u>Patient's Name</u>	<u>MAP#</u>	<u>Date</u>	<u>Amount Billed</u>
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Control numbers will be entered in consecutive order.

3. Upon completion of the Form, and after review by the Director of the clinic or his designee, all but the yellow copy is sent to the Bureau of Health Insurance and Medical Assistance.

The yellow copy is retained by the clinic.

Fees - Payment Plan:

Initial Visit-----	\$75.00
(Complete medical history and physical)	
Follow-up Visits-----	\$50.00

New Dr. as per 12/15

11/11

EPSDT package-----\$100.00

Pre-natal Profile-----\$125.00  
(includes Type & Group, CBC, VDRL or ART,  
Urinalysis, Sickle Cell Testing, Rubella Screening)

- D. Development of an orderly referral system and follow-up services. Conduct studies to ascertain and determine the effectiveness of the working agreement, patterns for continued collaborative efforts, the quality of the specific services rendered, and to identify unmet needs and make recommendations regarding ways of meeting those needs.
- E. Inform respective applicants and recipients of the specific services available to them, and the procedures under which needed services can be obtained under the Maternal and Child Health and Children With Special Health Care Needs Program and the Medical Assistance Program.
- F. Confidentiality of information shall be maintained and safeguarded according to state Plan and Departmental requirements and regulations.
- G. Through periodic evaluation by a committee representative of staff of Medical Assistance, Maternal and Child Health and Children With Special Health Care Needs, the quality of duration and scope of services rendered will be reviewed.

### III THE MEDICAL ASSISTANCE PROGRAM (MAP)

- A. Eligibility of medical assistance is determined at the Certification Unit, Bureau of Health Insurance and Medical Assistance. An MAP card is issued to each eligible recipient and is to be presented at the time services are rendered at the Maternal and Child Health and Children With Special Health Care Needs Program. For the purpose of those individuals who are referred by the clinics who do not present a MAP card and might be eligible, the Statement of Facts (See Attachment #1) will be provided by the Medical Social Worker and an appointment will be made for certifications.
- B. The Medical Assistance Program will make available to eligible recipients medical treatment and other health services normally or usually provided by the Maternal and Child Health and Children With Special Health Care Needs Programs. Medical services and care such as inpatient care, outpatient care, appliances, prostheses and other adaptive equipment will be among those services agreed upon for funding by Title XIX under the conditions specified in the agreement.

- C. If needed medical and health services are not available for eligible recipients in the Virgin Islands, the Medical Assistance Program will arrange for off-island travel to Puerto Rico or the Continental U.S. (See Attachment #2) Such specialized services are based on the completion of a referral form signed by the physician, and countersigned by the Director of the referring program, such as Pediatrics, Community Health, Maternal and Child Health and Children With Special Health Care Needs Program and approved by the Medical Assistance Program's Medical Consultant.
  
- D. Medical Assistance agrees to the funding of medical care and services for recipients also eligible under the Maternal and Child Health and Children With Special Health Care Needs Program for conditions not related to primary diagnosis (non-crippling illness), when such conditions are covered under the approved Title XIX plan. Necessary information will be submitted officially to the Medical Assistance Program by the Maternal and Child Health and Children With Special Health Care Needs Program.

**IV. MATERNAL AND CHILD HEALTH AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM.**

- A. The Maternal and Child Health and Children With Special Health Care Needs Program shall be responsible for early case findings, identification, registration and treatment of children with crippling and potentially crippling conditions.
  
- B. The Maternal and Child Health and Children With Special Health Care Needs Program shall be responsible for the provision of preventive and diagnostic health services for mothers, infants, and for children up to 21 years of age.
  
- C. The Maternal and Child Health and Children With Special Health Care Needs Program shall be responsible for the provision of treatment services related to crippling and potentially crippling conditions of children up to 21 years.
  
- D. The Maternal and Child Health and Children With Special Health Care Needs Program shall notify Medical Assistance of aggregate screening findings and shall maintain comprehensive clinic records.

available for Medical Assistance review and audit as needed.

## V. SERVICES

- A. For care in the Virgin Islands, the MAP card will be used for billing purposes at the treatment site. The provider of services will be responsible to see that the recipient has a valid MAP card.
- B. For off-island care the services must be pre-authorized by Medical Assistance after review and approval of the referral by the Medical Assistance Program Medical Consultant. The Medical Assistance program will make all the necessary arrangements for medical, hospital appointments and travel, involving the patient and needed escort.

## VI. PRENATAL SERVICES TO ELIGIBLE WOMEN

MAP will provide coverage for all pregnant women that meet the eligibility guidelines from the date of verification of pregnancy. Any woman eligible for and receiving medical assistance while pregnancy-related and post-partum services through the end of the month in which the 60 days post-partum period ends.

Staff will be utilized in Outreach Programs designed to encourage pregnant women to seek health care early in pregnancy. Emphasis will be placed adolescent outreach, and pregnant teenagers, low-income women, and high risk pregnant women.

These Outreach Programs will be coordinated with existing resources such as the Rural Health Outreach Program, Deliver Your Best, Answer, and Civic and Community Groups.

## VII. THE EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM (EPSDT).

The Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) is intended to assure that all Medicaid eligible children 0-21 receive a broad range of primary and preventive health services. Treatment will be provided for problems and conditions identified during the screening process and will be covered by MAP.

Dental Care, Immunization, Vision and Hearing Treatment, including eye-glass and hearing aids will be provided. Health Education and anticipatory guidance will be required components of the screening services. For reporting purposes, the periodicity schedule for medical examination will follow the general pattern of the Maternal and Child Health and Children With Special Health Care Needs Well Child Clinic Protocols, 4 visits during the first year of life, two visits during the second year of life, annual from age 3 years and annual to age 6 years. Thereafter, every two years until 21 years of age, this periodicity schedule will be revised and updated, adhering to recommendations of AAP, AFP, and other pertinent professional organizations. For Dental, Speech & Hearing, and Vision the periodicity schedule presently in effect is as follows:

**Dental Services:**

0-6 years : Every six (6) months, or twice a year.  
6-21 years: Every six (6) months, or twice a year.

**Speech and Hearing:**

0-6 years : Once a year.  
6-21 years: Once a year.

**Vision:**

0-6 years : Once a year.  
6-21 years: Once a year.

Additionally, once a year a complete physical will be done on these eligible children, 0-6 years and 6-21 years.

**A. MEDICAL ASSISTANCE PROGRAM**

1. Determines eligibility of clients for the EPSDT Program.
2. At the time of application or re-application, informs individuals (parents/guardians) of the EPSDT Program and encourages their participation.
3. Distributes EPSDT material to parents/guardians.
4. Notifies the family to have immunization records and the results of their stool and urine specimens available when they have a schedule appointment at the Maternal Child Health and Children With Special Health Care Needs Program.

**OUTREACH:**

Through the collaborative efforts of the Department of Health, the Department of Human Services and the Voluntary agencies, a plan of continued EPSDT outreach and community education will be carried out. After the initial screening, the above will also collaborate on follow-up activities.

**B. MATERNAL AND CHILD HEALTH AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAMS (MCH & CSHCN)**

1. Develops contents, recommends frequency and standards of screening and follow-up services.
2. Insures availability of services for all eligible children at a projected minimum of 80% per year utilization rate.
3. Performs the required screening services as outlined below on all Medical Assistance Program children identified and interprets the screening results to families.

Health and Developmental History

Comprehensive physical and Developmental Examination

Urinalysis

Immunization as appropriate for the age

Sickle Cell testing

Nutritional Assessment

Tuberculin testing

Vision testing

Anemia testing

Laboratory procedures as appropriate

Speech and Hearing testing

Dental Services for all children over 3 years

4. Assist families in understanding and following prescribed recommendations and treatment, particularly when screening results are positive.
5. Assist families in locating and selecting appropriate medical and other community resources: arrange referral appointments as indicated for needed diagnosis, treatment and follow-up care.
6. Special attention will be given to the immunization schedule of the population group to insure that all EPSDT children are appropriately immunized according to age.
7. Notify MAP of aggregate screening findings and other information needed for federal reports and future health planning.
8. Notify MAP of missed appointments.
9. Assist in the completion on health history forms, and follow-up with families if patient has missed the screening, and other appointments.
10. Prepare MA-2 Billing Form and forward to MAP agency with all identifying and other necessary information.

**C. REFERRAL, BILLING PROCEDURES, AND FEE SCHEDULES:**

(See Attachment #3)

**D. VERIFICATION OF MAP ELIGIBILITY**

The clinic shall be responsible for verification of eligibility for MAP recipients who report for services by checking the expiration date noted.

Services must be rendered prior to that expiration date. Payment made by the Medical Assistance Program constitutes full payment for services rendered to the recipients of the Medical Assistance Program.

**E. THIRD PARTY LIABILITY**

The Maternal and Child Health and Children with Special Health Care Needs Program agrees to take reasonable measures to identify Third Party Resources (Private, Government Health Insurance, etc.) and seek reimbursement from responsible party before submitting claims to the MAP for reimbursement.

The Maternal and Child Health and Children With Special Health Care Needs Program agrees to attach a copy of the document from the insurance company or third party payers to an MA-2 Billing Form and bill Medicaid for only the deductible/co-insurance and for services not covered by the insurance. In addition, the Maternal and Child Health and Children With Special Health Care Needs Program agrees not to charge MAP for services that are free to everyone in the community.

**CLOSING STATEMENT**

Representatives of the Bureau of Health Insurance and Medical Assistance and Maternal and Child health and Children With Special Health Care Needs Programs enter into this Agreement with the mutual objectives of achieving both the best quality of care for Medical Assistance recipients and the maximum use of existing services.

Mavis L. Matthew, MD  
Mavis L. Matthew, MD, MPH, Director  
Maternal and Child Health and  
Children With Special Health Care  
Needs Program

6/9/95  
Date

Priscilla Berry  
Priscilla Berry, Director  
Bureau of Health Insurance and  
Medical Assistance

6/12/95  
Date

Nathalie George-McDowell, M.D.  
Nathalie George-McDowell, M.D.  
Commissioner of Health Designee

6/9/95  
Date

Attachment #1

**Medical Referral System of Patients Wishing  
To Apply For Medical Assistance**

**Procedures To Follow:**

1. Patients wishing to apply for medical assistance can do so by completing the form: Statement of Facts for Medical Assistance as they wait for their clinic appointments.
2. The Statement of facts for Medical Assistance Form is submitted to the Medical Assistance Certification Office daily (Attention: Mrs. Prudencia Guishard, Supervisor, Medical Assistance Certification Unit, St. Thomas and Mrs. Paula Isaac, Supervisor, Medical Assistance Certification Unit, St. Croix).
3. Certification Unit workers will review the form and determine the documentation needed to complete the application.
4. Applicants must call for an appointment before coming to the Certification Unit. This step is very important to avoid applicants having to come back a second time because they do not have the necessary document.

BUREAU OF HEALTH INSURANCE AND MEDICAL ASSISTANCE

Consultation Request for Special Services for Medical Assistance Recipients

PATIENT'S NAME \_\_\_\_\_ MAP NO.: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SEX \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_ HIB NO: \_\_\_\_\_

SPOUSE, PARENT OR GUARDIAN: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PERSON AND ADDRESS TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

\_\_\_\_\_ TEL. NO.: \_\_\_\_\_

REFERRING AGENCY: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

BRIEF MEDICAL SUMMARY (including current treatment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICE REQUESTED: \_\_\_\_\_

IF REQUEST INCLUDES PROVISION OF APPLIANCES, LIST PROVIDER, NAME, ADDRESS:

\_\_\_\_\_  
\_\_\_\_\_

RECOMMENDATION AND JUSTIFICATION FOR SPECIAL TREATMENT: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PATIENT'S CONDITION: ( ) AMBULATORY ( ) OXYGEN ( ) AMBULANCE ( ) WHEELCHAIR  
( ) ESCORT: \_\_\_\_\_ TEL. NO.: \_\_\_\_\_

DATE: \_\_\_\_\_

PHYSICIAN'S SIGNATURE

(COUNTERSIGNED) DIRECTOR OF SERVICES

DISPOSITION  
( ) APPROVED ( ) REJECTED REASON: \_\_\_\_\_

DIRECTOR, BHIMA

PHYSICIAN CONSULTANT, BHIMA

(Please write on reverse side of referral if additional space is needed)