PART I.

Family Planning Waiver Services.

12VAC30-135-10. Definitions.

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise.

"Eligible recipients" means those women who give birth after the effective date of the waiver project, whose deliveries were reimbursed by Medicaid, and who continue to meet the Medicaid eligibility income requirements for a pregnant woman.

"FDA" means the Food and Drug Administration.

"Family planning" means those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling, recommendations or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removals of intrauterine devices due to infections.

"Third Party" means any individual entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Plan.

"Over-the-counter" means drugs and contraceptives that are available for purchase without requiring a

physician's prescription.

12 VAC 30-135-20. Administration and eligibility determination.

A. The Department of Medical Assistance Services shall administer the family planning demonstration waiver services program under the authority of § 1115(a) of the Social Security Act and 42 United States Code §1315.

B. The local departments of social services shall be responsible for family planning waiver eligibility determinations and for enrollment of eligible women in the waiver. Local departments of social services shall also conduct periodic reviews and annual redeterminations of eligibility every twelve months while recipients are enrolled in the waiver program.

C. The local departments of social services shall be responsible for ensuring that during the time of eligibility redeterminations or at any point of self-reported changes that result in categorical eligibility enrollment for full Medicaid benefits, that the recipients' enrollment in the family planning waiver program is immediately terminated.

D. Recipients will be notified via a cancellation letter prior to 60 days postpartum that their Medicaid benefits will be terminated at the 60th day after the delivery of their baby. This cancellation notice will include: (i) information about possible eligibility for extended family planning (only) services for an additional 22 months postpartum, and (ii) instructions on how to apply. The letter will inform recipients that if they are determined eligible for another Medicaid

covered group, they shall not be eligible to receive services u nder this waiver.

12VAC-135-30. Eligibility.

A. Women whose deliveries were covered by Medicaid, who delivered after the implementation of this waiver, and who continue to meet the Medicaid eligibility requirements for a pregnant woman, shall be eligible for family planning services under this waiver.

B. Women who qualify for Medicaid under a mandatory or optional covered group will not be eligible for family planning services under this waiver.

12VAC30-135-40. Covered services.

A. Services provided women under this waiver shall include only the following:

1. Family planning office visits including annual exams (one per 12 months), sexually transmitted diseases "STD" testing (limited to the **initial** family planning encounter), Pap tests (limited to one every six months);

2. Laboratory services for family planning and STD testing;

3. Family planning education and counseling;

4. FDA approved contraceptives, including diaphragms, contraceptive injectables, and

contraceptive implants;

5. Over-the-counter contraceptives; and,

6. Sterilizations, not to include hysterectomies. A completed sterilization consent form, in accordance with the requirements of 42CFR441, Subpart F, must be submitted with all claims for payment for this service.

B. Examples of services not covered under the family planning waiver include but are not limited to:

1. Performance of, counseling for, or recommendations of abortions;

2. Infertility treatments;

3. Procedures performed for medical reasons;

4. Performance of a hysterectomy; and

5. Transportation to a family planning service.

12VAC30-135-50. Provider qualifications.

Services must be ordered or prescribed and directed or performed within the scope of the licensed practitioner. Any appropriately licensed Medicaid enrolled physician, nurse practitioner, or medical clinic may be accessed by the waiver recipient for family planning services.

12VAC30-135-60. Quality assurance.

The Department shall provide for continuing review and evaluation of the care and services paid through Medicaid including review of utilization of the services by providers and recipients. To ensure a thorough review, trained professionals review cases either through desk audit or through on-site reviews of medical records. Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid for services that do not meet the policy qualifications, if providers failed to maintain records or documentation to support their claims, or if providers billed for medically unnecessary services.

12VAC30-135-70. Reimbursement.

Providers will be reimbursed on a fee-for-service basis.

All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provide to eligible recipients including those measures specified under 42 USC § 1396 (a) (25).

12VAC30-135-80. Recipients rights and right to appeal.

Women eligible for family planning services under this waiver will have freedom of choice of providers. Women will be free from coercion or mental pressure and shall be free to choose their preferred methods of family planning. The Client Appeals process at 12 VAC 30-110-10 et. seq. shall be applicable to applicants for and recipients of family planning services under this waiver.