Chapter 140.

VIRGINIA CHILDREN'S MEDICAL SECURITY INSURANCE PLAN

Part I.

GENERAL PROVISIONS.

12 VAC 30-140-10. Definitions.

"Adverse action" means the denial of enrollment and coverage under the Children's Medical Security Insurance Plan, termination, suspension or reduction of coverage; denial of payment for a particular medical service, in whole or in part; denial of a required pre-authorization; or failure of the Department of Medical Assistance Services, as defined in this section, to act with reasonable promptness on an application for enrollment and coverage, a request for a particular medical service or a request for a required pre-authorization. There shall be no adverse action under this definition in any of the circumstances described in this section if funding for the Children's Medical Security Insurance Plan has been terminated or exhausted.

"Agency" means a local department of social services or other entity designated by DMAS to make eligibility determinations for VCMSIP.

"Agent" means an individual designated in writing to act on behalf of a Children's Medical Security Insurance Plan applicant or enrollee during the administrative review process.

"Act" means the Social Security Act.

"Applicant" means an individual seeking to enroll in the Children's Medical Security Insurance Plan.

"Attorney" means an attorney licensed in Virginia or a paralegal, working under the supervision of an attorney so licensed, who is authorized to represent an applicant or enrollee. A written statement on the attorney's letterhead that the attorney is authorized to represent the applicant or enrollee shall be accepted as a designation of representation.

"Creditable health coverage" means that health coverage as defined in [~~the Employee Retirement Income Security Act (ERISA) of 1974, title I, Subtitle B, section 701(c~~). 42 USC 1397jj(c)(2).]

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for VCMSIP.

"DMAS" means the Department of Medical Assistance Services or a designee.

"Enrollee" means an individual qualifying for coverage under the Virginia Children's Medical Security Insurance Plan.

"EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program.

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

["Group health plan" or "Health insurance coverage" means that health care coverage as defined in the Public Health Service Act § 2791.]

"Member of a family," for purposes of determining whether the child is eligible for coverage under a state employee health insurance plan means (i) parent or parents, including absent parents, or (ii) stepparent or stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.

"Title XXI" means the Federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"Title XIX" means that program of medical assistance as established by Title XIX of the Social Security Act ([42] USC § 1396a et seq.).

"VCMSIP" means Virginia Children's Medical Security Insurance Plan.

"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees and includes the Local Choice Program whereby local governmental entities elect to provide local employee's enrollment in the State Employee Health Insurance Plan.

12 VAC 30-140-20. Administration and general background.

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements for a State Child Health Insurance Plan (also known as Title XXI).

B. Health care services under VCMSIP shall be provided through managed care and fee-for-service delivery systems. The director, solely in his discretion, may rely on but is not limited to the delivery system procured and established under § 32.1-325 of the COV and federal law by the authority of § 1915(b) of the *Social Security Act*. These delivery systems may consist of prepaid health plans that manage and deliver health care for enrollees for a monthly capitated amount and through the Primary Care Case Management Program (PCCM) that may be reimbursed on a fee-for-service basis. Services may be offered through preferred provider organizations or other providers not currently under contract with DMAS.

12 VAC 30-140-30. Outreach and public participation.

A. Public participation. DMAS will work cooperatively with other state agencies and contractors to ensure that the intent and purpose of the federal law and any applicable federal regulations are met. The DMAS Director will have the authority to form and convene a committee of interested citizens for purposes of advising the agency about VCMSIP.

B. Outstationing of eligibility workers. The DMAS Director will have the authority to contract with either local departments of social services or other entities for the purpose of locating workers, who can determine eligibility for VCMSIP, in agencies or offices not directly affiliated with social services.

PART II.

ADMINISTRATIVE REVIEW.

12 VAC 30-140-40. Administrative review of adverse action.

A. Upon written request, all Virginia Children's Medical Security Insurance Plan applicants and enrollees shall have the right to an administrative review of any adverse action proposed or taken by the Department of Medical Assistance Services [or its designee] with respect to enrollment in or coverage under the Virginia Children's Medical Security Insurance Plan.

B. At all times during the administrative review process, Children's Medical Security Insurance Plan applicants and enrollees shall have the right to representation by an attorney of their choosing.

C. At all times during the administrative review process, Children's Medical Security Insurance Plan applicants and enrollees, who are under the age of 18 years or who

are age 18 but legally incompetent, shall have a designated agent act on their behalf.

D. At no time shall the Department of Medical Assistance Services [or its designee] be required to obtain or compensate attorneys representing or agents acting on behalf of applicants and enrollees.

E. The burden of proof shall be upon the applicant or enrollee to show that an adverse action proposed or taken by the agency is incorrect.

12 VAC 30-140-50. Notice of adverse action.

A. DMAS [or its designee] shall send written notification to applicants and enrollees whenever adverse action is proposed or taken.

B. When an application for enrollment and coverage is denied, DMAS [or its designee] shall mail a notice of adverse action within 10 calendar days of the decision.

C. When DMAS [or its designee] proposes to take an adverse action relating to termination, suspension or reduction of coverage; denial of payment for a particular medical service, in whole or in part; or denial of a required preauthorization, the notice of adverse action shall be mailed at least 10 calendar

days before the action is taken.

12 VAC 30-140-60. Request for administrative review.

A. Requests for administrative review of adverse actions proposed or taken by DMAS [or its designee] shall be sent or delivered in writing to DMAS' Appeals Division at the following address:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Suite 1300

Richmond, Virginia 23219

B. Any written communication clearly expressing a desire to have an adverse action reconsidered shall be treated as a request for administrative review.

C. To be effective, requests for administrative review shall be received by DMAS or postmarked no later than 30 calendar days from the date of DMAS' notice of adverse action. Requests may be delivered by way of facsimile transmission during normal business hours. Facsimile requests received after 5:00 p.m. shall be treated as having been received the following business day.

D. Requests for administrative review alleging that DMAS [or its designee] has not acted promptly are not subject to the 30-day receipt/postmark requirement.

12 VAC 30-140-70. Administrative review procedures.

A. Administrative reviews shall be conducted pursuant to written procedures developed by DMAS.

B. At no time shall DMAS' [or its designee's] failure to meet the time frames set in this chapter or the VCMSIP administrative review procedures constitute a basis for granting the applicant or enrollee the relief sought.

C. During the course of administrative reviews, applicants and enrollees shall have the following:

1. The right to be represented by an attorney as described in 12 VAC 30-140-40;

2. The right, when applicable, to have an agent act on behalf of the applicant or enrollee for purposes of requesting and obtaining administrative review of an adverse action;

3. The right to have duly designated family members, friends and others

serve as the agent. A parent may both execute the required written designation and act as the agent. In the absence of a parent, the agent may be designated by other individuals including legal guardians, individuals duly authorized by way of power of attorney, custodial family members, other parties with whom the applicant or enrollee resides on a permanent basis, or such other individuals deemed appropriate by DMAS. In the absence of a parent, the agent may be one of the individuals described in this subdivision;

4. The right to have personal and medical information and records maintained as confidential. Personal and medical information and records obtained during the course of an administrative review shall be released only to the applicant or enrollee, the applicant's or enrollee's agent or such other individual who is duly authorized in writing to receive the information or records; and

5. The right to a written final decision [which shall include but not be limited to a summary of facts, the reasons for the decision, and identification of supporting evidence, regulations and policies. There shall be no further right of appeal under VCMSIP.]

D. The administrative review procedures and any modifications thereto shall be reviewed and approved in writing by the director.

E. Copies of the procedures shall be promptly mailed by DMAS to applicants and enrollees upon receipt of timely requests for administrative review.

F. The procedures in effect on the date a particular request for administrative review is received by DMAS shall apply throughout the proceeding.

12 VAC 30-140-71 through 12 VAC 30-140-99. Reserved.

Part III.

ELIGIBILITY DETERMINATION, APPLICATION RERQUIREMENTS,AND CHILDREN'S COST SHARING.

12 VAC 30-140-100. Eligibility requirements.

A. This section shall be used to determine eligibility of targeted low-income children for the VCMSIP.

B. The VCMSIP shall be in effect statewide.

C. Eligible children must be under age 19.

D. Income.

1. Standards. Income standards for the VCMSIP are divided into two components. Children in families with incomes up to and equal to 150% of the federal poverty income level (FPL) will be in Component One. Children in families with incomes between 150% and up to and equal to 185% FPL will be in Component Two.

2. Methodology. The VCMSIP shall use the same income methodologies applied under the Virginia State Plan for Medical Assistance for children as set forth in the Attachment 2.6-A.C.1.e (12 VAC 30-40-90). Income that would be excluded when determining Medicaid eligibility will be excluded when using such methodologies when determining countable income for the VCMSIP.

3. Spenddown. Deduction of incurred medical expenses from countable income (spenddown) does not apply in the VCMSIP. If the family income exceeds the income limits described in this section, the individual shall be ineligible for the VCMSIP regardless of the amount of any incurred medical expenses. DMAS shall offer the applicant the opportunity to be evaluated under the State Plan for Medical Assistance as medically needy.

E. Residency. The requirements for residency rules as set forth in 42 CFR 435.403 will be used when determining whether a child is a resident of Virginia for purposes of eligibility for the VCMSIP.

F. Coverage under other health [insurance] coverage.

1. Any child covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 USC § 300gg-91(a) and (b)(1)), shall not be eligible for VCMSIP.

2. No substitution for private insurance.

a. Only uninsured children shall be eligible for VCMSIP. Each application for VCMSIP shall include a declaratory statement that the child for whom the application is being filed is not covered under any group health plan. Each application and redetermination of eligibility shall document inquiry about health insurance within the past 12 months. If the child has been covered under a health insurance plan within 12 months of application for or receipt of VCMSIP services, the child will be ineligible, unless the parent, guardian or legal custodian demonstrates good cause for discontinuing the coverage.

b. Benefits paid as medical assistance are not health insurance. Health insurance does not include insurance for which DMAS paid premiums under the Health Insurance Premium Payment (HIPP) Program.

c. Good cause. A child shall not be ineligible for VCMSIP if health insurance was discontinued within the 12-month period prior to the month of application for good cause. The director shall make a determination of good cause based upon DMAS written policy.

3. Health Insurance Premium Payment (HIPP) Program does not apply to VCMSIP. DMAS will not enroll children who are in VCMSIP in the HIPP Program.

12 VAC 30-140-90. Duration of eligibility.

A. The effective date of VCMSIP coverage shall be no earlier than the first day of the month in which application was received by the local department of social services if the applicant met all eligibility factors in that month. In no case shall the child's eligibility be effective earlier than the date of the child's birth and no earlier than July 1, 1998, or the start of the program, whichever is later.

B. Eligibility for the VCMSIP will continue for 12-months so long as the child meets all eligibility requirements. The parent or legal guardian of the recipient must report all changes affecting eligibility when they occur. A change in eligibility will be effective the first of the month following the month the child is determined to be ineligible. Eligibility will be redetermined no less often than annually.

Exception. If the child becomes an inpatient in an institution for mental disease or an inmate of a public institution, ineligibility will be effective the date that the child is

admitted to the institution.

12 VAC 30-140-110. Children ineligible for VCMSIP.

A. If a child is:

1. A member of a family eligible for coverage under any Virginia State Employee Health Insurance Plan, including members of any family eligible for coverage under the Virginia State Employee Health Insurance Plan through the Local Choice Program, he is ineligible for VCMSIP. Children of an absent parent shall be ineligible for VCMSIP if the absent parent is eligible for coverage under the State Employee Health Insurance Plan or the Local Choice Program;

2. An inmate of public institutions as defined in 42 CFR 435.1009, he is ineligible for VCMSIP; or

3. An inpatient in an institution for mental disease as defined in 42 CFR 435.1009, he is ineligible for VCMSIP.

B. Unless a child's parent or guardian meets the requirements on assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation with DMAS in identifying and providing information to assist the state in pursuing any liable third party as described in 42 CFR 433.145 and 433.147, he is ineligible for VCMSIP. If the parent, guardian or legal custodian fails to make assignment as required in this subsection, the child for whom he is applying shall be ineligible for the VCMSIP. A parent, guardian or legal custodian shall apply to the Division of Child Support Enforcement in each case involving an absent parent. If the parent, guardian or legal custodian fails to make assignment or fails to apply for Division of Child Support Enforcement services as

required in this subsection, the child for whom he is applying shall be ineligible for the VCMSIP.

C. If sufficient evidence exists to prove that the parent, guardian, or legal custodian obtained benefits for a child or children who would otherwise be ineligible by willfully misrepresenting material facts on the application or failing to report changes, the child or children for whom the application is made shall be ineligible for VCMSIP. An administrative hearing shall be held to present the facts and, upon a finding of intentional misrepresentation, the child or children shall be excluded from participation for 12 months from the date of the finding. The parent, guardian, or legal custodian who signed the application shall be liable for repayment of the cost of all benefits issued as the result of the misrepresentation.

Disposition of cases shall occur through an administrative disqualification hearing or a court of appropriate jurisdiction.

12 VAC 30-140-120. Nondiscriminatory provisions.

VCMSIP shall be conducted in compliance with all civil rights requirements. VCMSIP shall not:

1. Discriminate on the basis of diagnosis;

2. Cover children of higher income without first covering children with a lower

family income within a defined group of covered targeted low-income children; and

3. Deny eligibility based on a child having a preexisting medical condition.

12 VAC 30-140-130. No entitlement.

In accordance with § 2102(b)(4) of the *Social Security Act* and § 32.1-353 of the COV, the VCMSIP shall not create any individual entitlement for, right to, or interest in payment of medical services on the part of any medically indigent child or any right or entitlement to participation.

12 VAC 30-140-140. Application requirements.

A. Availability of program information. DMAS or its designee shall furnish the following information in written form and orally as appropriate to all applicants and to other individuals who request it:

1. The eligibility requirements;

2. Summary of covered benefits; and

3. The rights and responsibilities of applicants and recipients.

B. Opportunity to apply. DMAS or its designee must afford an individual wishing to do so the opportunity to apply for VCMSIP.

C. Written application. DMAS or its designee requires a written application from the applicant, if 18 years of age, or from a parent, guardian or legal custodian if less than 18 years of age, incompetent or incapacitated. The application must be on the form prescribed by DMAS and must be signed under a penalty of perjury.

D. Assistance with application. DMAS or its designee shall allow an individual, or individuals, of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

E. Timely determination of eligibility. DMAS or its designee must establish reasonable time standards for determining eligibility and inform the applicant of what the time standards are. These standards shall not exceed 45 days except in unusual circumstances. For example:

1. When DMAS or its designee cannot reach a decision because the applicant or his representative fails to take a required action, or

2. When there is an administrative or other emergency beyond the agency's control, DMAS or its designee must document, in the applicant's case

record, the reasons for delay. DMAS or its designee must not use the time standards as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the time standards.

F. Notice of DMAS' or its designee's decision concerning eligibility. DMAS or its designee must send each applicant a written notice of the agency's decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing.

G. Case documentation. DMAS or its designee must include in each applicant's record facts to support the decision on his application, must dispose of each application by a finding of eligibility or ineligibility, unless (i) there is an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision; (ii) there is supporting entry in the case record that the applicant has died; or (iii) there is a supporting entry in the case record that the applicant cannot be located.

H. Redetermination of eligibility. DMAS or its designee must redetermine the eligibility of recipients with respect to circumstances that may change at least every 12 months. There must be procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect

their eligibility. DMAS or its designee must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect eligibility. If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

I. Timely and adequate notice. DMAS or its designee must give recipients timely and adequate notice of proposed action to terminate their eligibility under the VCMSIP. The notice must meet the requirements of subpart E of 42 CFR Part 431.

12 VAC 30-140-141 through 12 VAC 30-140-149. Reserved.

PART IV.

12 VAC 30-140-150. Cost sharing and payment.

Cost sharing, subsequent to approval by the Health Care Financing Administration, will be instituted by DMAS. There shall be no cost-sharing requirements for children with family incomes at or below 150% of the Federal Poverty Income Guidelines (as published annually by the U.S. Department of Health and Human Services in the *Federal Register*). Eligible children in families with incomes above 150% of the Federal Poverty Income Guidelines shall be required to contribute to the cost of health care coverage through CMSIP by means of premiums and copayments. DMAS may also apply co-insurance and enrollment fees. These cost-sharing provisions shall be implemented with the following restrictions:

1. The annual aggregate cost sharing for all eligible children in a family shall not exceed 5.0% of the family gross income. Family contributions shall be reported and monitored by DMAS or stop/loss controls will be implemented in the participating health plans' systems to ensure contributions do not exceed the above stated maximums or that the family is reimbursed for any amounts in excess of this limit.

2. Cost-sharing shall not be required for well-baby and well-child care including age-appropriate well-child immunizations, specifically:

   a. All healthy newborn inpatient physician visits, including routine screening (inpatient or outpatient) shall be excluded from cost sharing;

b. Routine physical examinations, laboratory tests, immunizations, and related office visits shall be excluded from cost sharing;

c. Routine preventive and diagnostic dental services (i.e., oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) shall be excluded from cost sharing.

3. DMAS will implement the cost-sharing provisions upon obtaining federal approval.

4. VCMSIP recipients shall be given at least 60 days' prior written notice of the imposition of these provisions, which will include a detailed explanation of the cost-sharing features of the plan. Public notice, via guidance documents (Medicaid Memoranda), Virginia Register and newspaper notices, also shall be issued at least 60 days before these provisions become effective.

12 VAC 30-140-151 through 12 VAC 30-140-199. Reserved.

Part V.

BENEFITS AND REIMBURSEMENT.

12 VAC 30-140-200. The following benefits shall be covered, to the extent indicated in each following section, for persons eligible for VCMSIP.

12 VAC 30-140-210. Inpatient services **(Section 2110(a)(1)).**

A. Inpatient services shall be provided pursuant to § 1905(a) of the *Social Security Act* (the *Act*) (42 USC § 1396d) and in accordance with 42 CFR§ § 440.2 and 440.10 when medically necessary consistent with 12 VAC 30-50-100 and 12 VAC 30-50-105.

B. DMAS shall not reimburse for services rendered [to inpatients] in an institution for mental diseases (IMD) as defined in 42 CFR 435.1009 that includes freestanding psychiatric hospitals.

C. DMAS shall reimburse for induced abortion services only in instances in which the attending physician certifies to DMAS prior to rendering the service, except in emergencies which must be documented in the medical record, that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

12 VAC 30-140-220. Outpatient services **(Section 2110(a)(2)).**

A. Outpatient services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d).

B. Outpatient hospital services, rural health clinic services and federally qualified health center (FQHC) services shall be provided according to the requirements in 12 VAC 30-50-

110 with the following exception. DMAS shall cover induced abortion services only in instances in which the attending physician certifies to DMAS prior to rendering the service, except in emergencies which must be documented in the medical record, that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

12 VAC 30-140-230. Physician services **(Section 2110(a)(3)).**

A. Physician services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d) and 42 CFR § 440.50. Physicians services shall be provided according to the requirements in 12 VAC 30-50-140 with the exceptions provided in this section.

B. DMAS shall cover induced abortion services only in instances in which the attending physician certifies to DMAS prior to rendering the service, except in emergencies which must be documented in the medical record, that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

C. Psychiatric physician visits to inpatient hospital patients shall be covered only when the recipient is an inpatient of a psychiatric unit in a general acute care hospital. Physician visits to inpatients in any institution for mental diseases, as defined in 42 CFR 435.1009,

shall not be covered.

12 VAC 30-140-240. Surgical services **(Section 2110(a)(4)).**

A. Surgical services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d). Surgical services shall be covered according to the requirements in 12 VAC 30-50-140 with the following exception. DMAS shall reimburse induced abortion services only in instances in which the attending physician certifies to DMAS prior to rendering the service, except in emergencies which must be documented in the medical record, that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

12 VAC 30-140-250. Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5)).**

Clinic services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d) and 42 CFR § 440.90. Clinic services shall be covered in accordance with 12 VAC 30-50-180 with the following exception. DMAS shall reimburse for induced abortions only in instances in which the attending physician certified prior to rendering the service, except in emergencies which must be documented in the medical record, that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

12 VAC 30-140-260. Prescription drugs **(Section 2110(a)(6)).**

Prescription drug services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d), 42 CFR 440.120, and 12 VAC 30-50-210.

12 VAC 30-140-270. Over-the-counter medications **(Section 2110(a)(7).**

Over-the-counter medications services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d), 42 CFR 440.120, and 12 VAC 30-50-210.

12 VAC 30-140-280. Laboratory and radiological services **(Section 2110(a)(8)).**

Laboratory and radiological services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d), 42 CFR § 440.30, and 12 VAC 30-50-120.

12 VAC 30-140-290. Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9)).**

A. Prenatal care and prepregnancy family services and supplies services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d).

B. Family planning services and supplies for individuals of child-bearing age must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts. Family planning services shall be covered in accordance with the requirements in 42 CFR 440.40 and 12 VAC 30-50-130. Family planning services shall be defined as those services or supplies, which delay or prevent pregnancy. Such services or supplies shall not include services to treat infertility or services to promote fertility.

C. Pregnancy-related and postpartum services, referred to as enhanced prenatal care services, shall be covered for any medical condition that may complicate pregnancy if otherwise covered under the Title XXI state plan. Enhanced prenatal care services, including nutrition, patient education, homemaker services, blood glucose meters (including test strips), shall be covered in accordance with the requirements in 12 VAC 30-50-510. For pregnant and postpartum women see 12 VAC 30-140-370 and 12 VAC 30-140-380 for substance abuse treatment services.

12 VAC 30-140-300. Inpatient mental health services, other than services described in 12 VAC 30-140-370 **(Section 2110(a)(10)).**

Inpatient mental health services, other than services described in 12 VAC 30-140-170 shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d). Inpatient mental health services shall be offered only in general acute care hospitals. Services offered in IMDs shall be prohibited under this Title because inpatients in institutions for mental diseases (IMDs) as defined in 42 CFR 1009, shall not be eligible for the Virginia Children's Medical Security Insurance Plan. Inpatient mental health services shall be covered in general acute care hospitals in accordance with 12 VAC 30-50-100 and 12 VAC 30-50-105.

12 VAC 30-140-310. Outpatient mental health services, other than services described in 12 VAC 30-140-380 but including services furnished to outpatients of a state-operated mental hospital and including community-based services **(Section 2110(a)(11).**

A. Outpatient mental health services, as defined, shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d).

B. Psychiatric services shall be covered in accordance with the requirements in 12 VAC 30-50-150 limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability shall be further restricted to no more than 26 sessions each succeeding year when approved by DMAS. Psychiatric services shall further be restricted to no more than three sessions in any given seven day period. Medically necessary psychiatric services shall be covered when prior authorized by DMAS for children when the need for such services has been identified through an EPSDT screen.

C. Other outpatient mental health services shall be covered in accordance with the requirements in 12 VAC 30-50-130, [~~12 VAC 30-50-225~~ 12VAC 30-50-110], and 12 VAC30-50-226.

12 VAC 30-140-320. Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12)).**

A. Durable medical equipment and other medically related or remedial device, as defined, services shall be provided pursuant to § 1905(a) the *Act* (42 USC § 1396d) and 42 CFR 440.120.

B. Prosthetic devices shall be covered in accordance with 12 VAC 30-50-140, 12 VAC 30-50-210, and 12 VAC 30-50-220. Prosthetic devices shall be provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license. This service, when provided by an authorized vendor, must be medically necessary and preauthorized for the minimum applicable component necessary for the activities of daily living.

C. Eyeglasses shall be covered in accordance with the requirements of 12 VAC 30-50-210.

D. Hearing aids shall be covered in accordance with the requirements of VAC 30-50-130.

E. Adaptive devices shall be covered in accordance with 12 VAC 30-50-140 and 12 VAC 30-50-220.

12 VAC 30-140-330. Disposable medical supplies **(Section 2110(a)(13).**

Disposable medical supplies services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d).

12 VAC 30-140-340. Home and community-based health care services **(Section 2110(a)(14)).**

Home and community-based health care services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d) and 42 CFR 440.70 (home health services).

12 VAC 30-140-350. Abortion **(Section 2110(a)(16)).**

Abortion services shall be provided pursuant to § 1905(a) of the *Act* (42 USC §1396d). DMAS shall reimburse for induced abortions only in instances in which the attending physician certifies prior to rendering the service, except in emergencies which must be documented in the medical record, that the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

12 VAC 30-140-360. Dental services **(Section 2110(a)(17)).**

Dental services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d) and 42 CFR 440.100.

12 VAC30-140-370. Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18)).**

A. Inpatient substance abuse treatment services and residential substance abuse treatment services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d).

B. Only one course of treatment in a lifetime of residential treatment for pregnant women shall be covered. The treatment facility shall not be an institution for mental disease.

C. Inpatient substance abuse treatment for pregnant women shall be covered in accordance with the requirements in 12 VAC 30-50-510, 12 VAC 30-130-590.

12 VAC30-140-380. Outpatient substance abuse treatment services **(Section 2110(a)(19)).**

A. Outpatient substance abuse treatment services shall be provided pursuant to § 1905(a) of the *Act* (42 USC § 1396d).

B. Group and individual counseling shall be covered with a limitation of up to 26 sessions annually and must be preauthorized before delivery of services. If medically necessary, additional sessions may be preauthorized. Substance abuse services providers shall have expertise with children and adolescents and be required to meet the standards and criteria listed below.

1. [~~A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of the Department of Health Professions (DHP) or as a Certified Addictions Counselor by the Substance Abuse Certification Alliance of Virginia, or~~ A qualified provider who is licensed and approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to provide outpatient substance abuse services. Substance abuse services providers shall be required to meet the standards and criteria established by DMHMRSAS. Professionals employed by these qualified providers must meet the same professional credentialing requirements established for professionals contained in item 2 a-c. OR,

2. [~~A professional who must be certified by the Virginia Association of Drug and Alcohol Abuse Counselors as demonstrating competencies described in *Addiction Counselor Competencies* and who is also licensed by the appropriate board of DHP as either a professional counselor, clinical social worker, registered nurse, clinical~~

~~psychologist, or physician, or~~ An individual who is licensed by the appropriate board of the Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician, who is also either certified:

a) as a substance abuse counselor by the Board of Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals of the Department of Health Professions (DHP);

b) as a Certified Addictions Counselor by the Substance Abuse Certification Alliance of Virginia, or physicians credentialed by the American Society of Addictions Medicine, OR

c) clinical psychologists certified in the treatment of alcohol and other psychoactive substance use disorders by the American Psychological Association.]

~~[3. A substance abuse professional or a certified clinical supervisor, as certified by the Substance Abuse Certification Alliance of Virginia, or~~

~~4. A qualified provider who is licensed and approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to provide outpatient substance abuse services. Substance abuse services providers shall be required to meet the standards and criteria established by DMHMRSAS. Professionals as set forth~~

~~in item 1, 2, or 3 of this subsection shall provide treatment.]~~

C. Day treatment for pregnant women shall be covered in accordance with the requirements of 12 VAC 30-50-510.

12 VAC 30-140-390. Case management services **(Section 2110(a)(20)).**

A. Targeted case management as defined in § 1915(g) of the *Act* will be covered in accordance with DMAS policy.

B. For high-risk pregnant women and infants up to age two, case management shall be covered in accordance with the requirements of 12 VAC 30-50-280, 12 VAC 30-50-410 and § 1915(g)(1) of the *Act*;

C. For individuals with mental retardation, case management shall be covered in accordance with the requirements of 12 VAC 30-50-440;

D. For children with serious emotional disturbance, case management shall be covered in accordance with the requirements of 12 VAC30-50-420; and

E. For youth at risk for serious emotional disturbance, case management shall be covered in accordance with the requirements of 12 VAC 30-50-430.

12 VAC 30-140-400. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22)).**

A. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders services shall be provided pursuant to § 1905(a) of the *Act* (42 USC §1396d).

B. For individuals meeting home bound criteria under home health services, physical therapy, occupational therapy, or speech pathology and audiology services shall be covered in accordance with the requirements of 12 VAC 30-50-140.

C. Physical therapy, occupational therapy, and speech-language pathology services which are not part of home health services shall be covered in accordance with the requirements in 12 VAC 30-50-200 and 12 VAC 30-50-220;

12 VAC 30-140-410. Hospice care **(Section 2110(a)(23)).**

Hospice services shall be provided pursuant to § 1905(a) the *Act* (42 USC § 1396d).

12 VAC30-140-420. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. **(Section 2110(a)(24)).**

A. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services shall be provided pursuant to § 1905(a) of the *Act* (42 USC §1396d).

B. Intensive physical rehabilitation shall be provided in accordance with 12 VAC-30-50-225.

C. Community mental health services shall be provided according to the requirements of 12 VAC 30-50-130, [~~12 VAC 30-50-225~~ 12 VAC 30-50-110] and 12 VAC 30-50-226.

D. Diagnostic examination and optometric treatment procedures and services by optometrists and opticians, as allowed by the *COV* and by regulations of the Boards of Medicine and of Optometry, shall be provided in accordance with the requirements in 12 VAC 30-50-150. Routine refractions shall be limited to once in 24 months except as may be authorized by DMAS.

E. Covered podiatry services shall be provided in accordance with the requirements in 12 VAC 30-50-150.

F. Nursing facility services in a Medicaid certified facility (other than in an institution for mental disease) shall be provided in accordance with the requirements in 12 VAC 30-50-130.

G. Nurse-midwife services, defined as those services allowed under the licensure requirements of the state statute and as specified in the *Act*, shall be provided consistent with 12 VAC 30-50-260.

H. Psychiatric services are covered when provided by a psychologist licensed by the Board of Medicine, by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric licensed by the appropriate state board in accordance with the requirements of 12 VAC 30-50-140 and 12 VAC 30-50-150.

12 VAC30-140-430. Medical transportation **(Section 2110(a)(26)).**

Medical transportation services shall be provided pursuant to § 1905(a) the *Act* (42 USC § 1396d). Transportation services are provided to ensure that recipients have necessary access to and from providers of all covered medical services. Transportation to both emergency and nonemergency services shall be covered. Transportation shall be covered in accordance with 12 VAC 30-50-300 and 12 VAC 30-50-530.

12 VAC30-140-440. Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28)).**

A. Any other health care services or items specified by the Secretary and not included under this section shall be provided pursuant to §1905(a) of the *Act* (42 USC §1396d).

B. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the services and requirements in accordance with 12 VAC 30-50-130 shall be provided, subject to the requirements and limits of Title XXI.

12 VAC 30-140-441 through 12 VAC 30-140-449. Reserved.

12 VAC 30-140-500. Benefits reimbursement.

A. Reimbursement for the services covered under VCMSIP shall be as specified below.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, over-the-counter medication services, laboratory and radiological services, prenatal care and prepregnancy family services and supplies, outpatient mental health services, durable medical equipment, disposable medical supplies, home and community-based health care services, abortion services, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, community mental health services, optometric services, podiatric services, certified nurse midwifery services, medical transportation, Early and Periodic Screening, Diagnosis, and Treatment services shall be based on the Title XIX rates in effect as of July 1 of each year for the subsequent state fiscal year.

C. Exceptions.

1. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each [~~hospitals~~ hospital] as of July 1 each year for the subsequent state fiscal year. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

2. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital as of July 1 each year for the subsequent state fiscal year. Payments made will be final and there will be no retrospective cost settlements.

3. Reimbursement for Clinic services including Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) will be based on the Title XIX rates in effect as of July 1 each year for the subsequent state fiscal year. Payments made will be final and there will be no retrospective cost settlements for FQHC's and RHC's.

4. Reimbursement for inpatient mental health services will be based on the Title XIX rates in effect for each hospital as of July 1 each year for the subsequent state fiscal year. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each Rehabilitation Agency as of July 1 each year for the subsequent state fiscal year. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse services will be based on rates determined for children ages 6-18. Payments made will be final and there will be no retrospective cost settlements.

12 VAC 30-140-510 through 12 VAC 30-140-559. Reserved.

PART VI
QUALITY ASSURANCE AND UTILIZATION CONTROL.

12 VAC 30-140-560. Quality assurance.

Quality of and access to care in managed care and fee-for-service delivery systems shall be assessed using measures developed by the director. The director shall coordinate, in his discretion, with state agencies, providers, and other interested parties on quality care and access issues.

12 VAC 30-140-570. Utilization control.

A. Utilization control systems are administrative mechanisms that are designed to ensure that children use only that health care that is appropriate, medically necessary, and approved by DMAS. DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance. Administrative mechanisms to be employed may include those provided in [the] following subsections of this section:

B. Prepayment reviews.

1. Use of covered service limitations in the State Plan for Medical Assistance such as

medical necessity, noncoverage of cosmetic or experimental procedures/drugs/services.

2. Prior authorization for some services, according to DMAS policy.

3. Managed Care Organizations (MCOs) shall be required to have referral systems, prior authorization requirements, clinical practice guidelines, and an internal quality assurance program. Each MCO shall be required to obtain State licensure, as well as obtain a nationally recognized accreditation as part of the contracting process. MCOs shall be required to meet network access requirements including PCP ratios, time and distance standards, appointment times guidelines, toll-free telephone numbers and after hours access as determined by contract with DMAS.

4. Fee-for-service utilization controls shall include:

a. Preauthorization functions performed by a state contractor using criteria specified by DMAS.

b. Internal utilization review committees in hospitals that review admission and length-of-stay issues.

c. Service limits shall be the same, as those in the State Plan for Medical Assistance with prior permission required to extend particular services if determined to be medically necessary.

d. Special service preauthorization shall be the same as in the State Plan for Medical Assistance for items such as organ transplants, out-of-state rehabilitation, and ventilator contracts.

C. Post-payment review. DMAS shall collect and review comprehensive encounter data and fee-for-service claims data to monitor utilization after service receipt. Findings will determine the appropriate disposition of the review, including but not limited to, enrollment in a utilization control program or referral to other investigative agencies.

CERTIFIED:

8/24/99
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services