Chapter 141.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN.

Part I.

GENERAL PROVISIONS.

12 VAC 30-141-10. Definitions.

"Abuse by providers" means practices which are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia FAMIS Program or in reimbursement for a level of utilization or pattern of services that is not medically necessary.

"Abuse by recipients" means practices by a recipient or recipients, which are inconsistent with sound fiscal or medical practices and result in unnecessary costs to the Virginia FAMIS Program.

"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in part.

"Agency" means a local department of social services, the Central Processing Unit, or other entity designated by DMAS to make eligibility determinations for FAMIS.

"Agency error" means cases in which a person(s) received benefits to which they were not entitled as a result of an error on the part of someone at the Central Processing Unit.

"Agent" means an individual designated in writing to act on behalf of a FAMIS Plan applicant or enrollee during the administrative review process.

"Act" means the Social Security Act.

"Applicant" means a child who has filed an application (or who has an application filed on his behalf) for health coverage through FAMIS. A child is an applicant until the child's eligibility has been determined for FAMIS.

"Authorized representative" means a person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

"Central Processing Unit" means the entity that will determine eligibility for and administer part of the Family Access to Medical Insurance Security Plan or FAMIS.

"Child" means an individual under the age of 19 years.

"Competent individual" means a person who has not been judged by a court to be legally incapacitated.

"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services, physician's surgical and medical services, and laboratory and radiological services.

"Conservator" means a person appointed by the Court who is responsible for managing the estate and financial affairs of an incapacitated person as defined in § 37.1-134.6 of the Code of Virginia.

"Continuation of Enrollment" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"COV" means Code of Virginia.

"Creditable health coverage" means that health coverage as defined in 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 FAMIS.

"DMAS or Department" means the Department of Medical Assistance.

"Employer-sponsored health insurance coverage" means comprehensive health insurance coverage offered by the employer when the employer contributes at least fifty percent towards the cost of dependent or family coverage, or as otherwise approved by the Health Care Financing Administration in the U.S. Department of Health and Human Services.

"Enrollee" means a child who has been determined eligible to participate in FAMIS and is enrolled in the FAMIS program.

"ESHI or ESHI component" means employer-sponsored health insurance and this component of FAMIS refers to the ability of DMAS to provide coverage to FAMIS children by providing premium assistance to families who enroll the FAMIS children in their employer's health plan.

"External Quality Review Organization" means the independent contractor assigned by DMAS to conduct final review of MCE determinations for FAMIS

"Family" (when determining financial eligibility) means parents, including adoptive and step-parents and their children who are living in the same household. Family shall not mean grandparents or legal guardians. A child who is temporarily living outside the home while attending an educational or training program shall be considered to be living in the same household with his parents.

"Family" (when used in the context of the ESHI component) means a unit or group that has access to an employer's group health plan. Thus, it includes the employee and any dependents who can be covered under the employer's plan.

"FAMIS" means Family Access to Medical Insurance Security Plan.

"FAMIS premium" means the monthly premium which families having incomes exceeding 150% of FPL pay to have their children enrolled in the FAMIS program. Families having incomes exceeding 150% of the Federal Poverty Level are also required to pay this premium if they are enrolled in the ESHI component.

"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.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"Gross family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before tax earnings from a job, including cash, wages, salary, commissions and tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal

support, pensions and retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships for educational expenses or earned income of a child who is a full-time student.

"Group health plan" or "health insurance coverage" means that health care coverage as defined in 42 U.S.C. § 1397jj(c)(3).

“Guardian” means a person appointed by the court who is responsible for the personal affairs of an incapacitated person as defined in § 37.1-134.6 of the Code of Virginia.

"Incapacitated individual" means person who has been judged by a court to be incapacitated and for whom a guardian or conservator has been appointed as defined in § 37.1-134.6 of the Code of Virginia.

“Legal emancipation” means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

“MCE” means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, and primary care case managers.

"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.

"Premium assistance" means the portion of the family's cost of participating in the employer's plan that DMAS will pay to the family to cover the FAMIS children under the employer plan if DMAS determines it is cost-effective to do so.

"Provider" means the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCE to render services to FAMIS recipients eligible for services.

"Recipient" means an individual who is enrolled to receive services under FAMIS.

"Supplemental coverage" means additional coverage provided to FAMIS children covered under the ESHI component so that they can receive all of the FAMIS benefits and they are not required to pay any more cost sharing than they would have under FAMIS.

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

"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 employees' enrollment in the State Employee Health Insurance Plan.

12 VAC 30-141-20. 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. The DMAS Director will have the authority to contract with entities for the purpose of establishing a centralized processing site, determining eligibility, enrolling eligible children into health plans, collecting premiums, performing outreach, data collection, reporting, and other services necessary for the administration of the Family Access to Medical Insurance Security Plan and for employing state staff to perform Medicaid eligibility determinations on children referred by FAMIS staff.

C. Health care services under FAMIS shall be provided through the delivery systems established under Virginia Code § 32.1-351(F). 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 30-141-30. Outreach and public participation.

A. Public participation. DMAS will work cooperatively with other state agencies and contractors to ensure that federal law and any applicable federal regulations are met.

PART II.

REVIEW OF ADVERSE ACTIONS

12 VAC 30-141-40. Review of adverse actions.

A. Upon written request, all FAMIS Plan applicants and enrollees shall have the right to a review of an adverse action made by the MCE, CPU or DMAS.

B. During review of a suspension or termination of enrollment the enrollee shall have a right to continuation of enrollment, if the enrollee requests review prior to the effective date of the suspension or termination of enrollment.

C. Review of an adverse action made by the CPU or DMAS shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under review.

D. Review of an adverse action made by the MCE must be conducted by a person or agent of the MCE who has not been directly involved in the adverse action under review. After final review by the MCE, there shall also be opportunity for final independent external review by the External Quality Review Organization.

E. There will be no opportunity for review of an adverse action to the extent that such adverse action is based on a determination by the Director that funding for FAMIS has been terminated or exhausted.

F. The burden of proof shall be upon the applicant or enrollee to show that an adverse action is incorrect.

G. At no time shall the MCE's, the CPU's, or DMAS' failure to meet the time frames set in this chapter or set in the MCE's or DMAS' written review procedures constitute a basis for granting the applicant or enrollee the relief sought.

H. Adverse actions related to health benefits covered under an employer sponsored health insurance (ESHI) plan shall be resolved between the employer's plan and the ESHI enrollee, and are not subject to further review by DMAS or its contractors. Adverse actions made by an MCE, the CPU, or DMAS shall be subject to the review process set forth in this part of the regulations.

12 VAC 30-141-50. Notice of adverse action. The MCE shall send written notification to enrollees of an adverse action within 10 calendar days.The CPU or DMAS shall send written notification to applicants of an adverse action within 10 calendar days of an adverse action. The CPU or DMAS shall send written notification to enrollees 10 days prior to suspension or

termination of enrollment. Notice shall include the reasons for determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

12 VAC 30-141-60. Request for review.

A. Requests for review of adverse actions made by the MCE shall be submitted in writing to the MCE, and requests for review of adverse actions made by the CPU or DMAS shall be submitted in writing to DMAS.

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

C. To be timely, requests for review of a MCE determination shall be received by the MCE no later than 30 calendar days from the date of the MCE's notice of adverse action. Requests for review of a DMAS or CPU determination shall be received by DMAS no later than 30 calendar days from the date of the CPU's or DMAS' notice of adverse action. Requests for review of a DMAS or CPU determination shall be considered received by DMAS when the request is date stamped by the DMAS Appeals Division in Richmond, Virginia.

12 VAC 30-141-70. Review procedures.

A. MCE review shall be conducted pursuant to written procedures developed by the MCE, and DMAS review shall be conducted pursuant to written procedures developed by DMAS.

B. The MCE's written procedures and any modifications thereto shall be reviewed and approved in writing by DMAS.

C. The procedures in effect on the date a particular request for review is received by the MCE or DMAS shall apply throughout the review.

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

E. The written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the MCE, the CPU, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;

2. The right to have personal and medical information and records maintained as confidential; and

3. The right to a written final decision within 90 calendar days of receipt of the request for review.

4. If the enrollee's physician or health plan determines that the 90 day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, review by the MCE and review by the External Quality Review Organization may each take no longer than 72 hours from the time an enrollee requests expedited review. Expedited review may be extended up to 14 calendar days, if the enrollee requests an extension.

12 VAC 30-141-71 through 12 VAC 30-141-99. Reserved.

PART III.

ELIGIBILITY DETERMINATION AND APPLICATION REQUIREMENTS.

12 VAC 30-141-100. Eligibility requirements.

A. This section shall be used to determine eligibility of children for FAMIS.

B. FAMIS shall be in effect statewide.

C. Eligible children must be under 19 years of age, be residents of the Commonwealth, and be either U.S. citizens, U.S. nationals OR qualified non-citizens.

D. Income.

1. Screening. All FAMIS applications must be screened to identify applicants who are potentially eligible for Medicaid. Children found potentially eligible for Medicaid cannot be enrolled in FAMIS until there has been a finding of ineligibility for Medicaid based on a full review of a Medicaid application. Children who do not appear to be eligible for Medicaid shall have their eligibility for FAMIS determined.

2. Standards. Income standards for FAMIS are based on a comparison of gross family income to 200% of the Federal Poverty Level for the family size. Children who have gross family income at or below 200% of the Federal Poverty Level, but are ineligible for Medicaid due to excess income, will be income eligible to participate in FAMIS.

3. Children enrolled in the Children's Medical Security Insurance Plan will be automatically enrolled in FAMIS at the time of conversion from CMSIP to FAMIS. To protect those currently enrolled children whose eligibility determination was based on the requirements of CMSIP and whose gross family income exceeds the FAMIS standard, income eligibility will be based on countable income using the same income methodologies applied under the Virginia State Plan for Medical Assistance for children as set forth in 12 VAC 30-40-90. Income that would be excluded when determining Medicaid eligibility will be excluded when determining countable income for the former CMSIP children. Use of the Medicaid income methodologies shall only be applied in determining the financial eligibility of former CMSIP children for FAMIS and for only as long as the children meet the income eligibility requirements for CMSIP. When a former CMSIP child is determined to be ineligible for FAMIS, these income methodologies shall no longer apply and income eligibility will be based on the FAMIS income standards.

4. Spenddown. Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS. If the family income exceeds the income limits described in this section, the individual shall be ineligible for FAMIS regardless of the amount of any incurred medical expenses.

E. Residency. The requirements for residency, 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 FAMIS.

F. Qualified non-citizen. The requirements for qualified aliens set out in Public Law 104-193, as amended, and the requirements for non-citizens set out in 12 VAC 30-110-1300 B will be used when determining whether a child is a qualified non-citizen for purposes of FAMIS eligibility.

G. Coverage under other health plans.

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

2. No substitution for private insurance.

a. Only uninsured children shall be eligible for FAMIS. Each application for FAMIS 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 re-determination of eligibility shall document inquiry about health

insurance within the past six months. If the child has been covered under a health insurance plan other than through the ESHI component of FAMIS within six months of application for or receipt of FAMIS services, the child will be ineligible, unless the parent, guardian, or legal custodian demonstrates good cause for discontinuing the coverage.

b. Health insurance does not include Medicaid nor insurance for which DMAS paid premiums under Title XIX through the Health Insurance Premium Payment (HIPP) Program.

c. Good cause. A child shall not be ineligible for FAMIS if health insurance was discontinued for good cause within the six-month period prior to the month of application. 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 FAMIS. DMAS shall not enroll children who are in FAMIS in the HIPP Program.

12 VAC 30-141-90. Duration of eligibility.

A. The effective date of FAMIS eligibility shall be no earlier than the first day of the month following the month the child was determined to meet all eligibility factors for the program. In no case shall a child's eligibility be effective earlier than the date of the start of the program.

B. Eligibility for FAMIS will continue for 12-months so long as the child meets all eligibility requirements. The parent, legal guardian, or authorized representative of the child must report all changes affecting eligibility when such changes occur. A change in eligibility will be effective the first of the month following expiration of a ten-day advance notice. Eligibility will be re-determined no less often than annually.

C. 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 30-141-110. Children ineligible for FAMIS.

A. If a child is:

1. Eligible for Medicaid, or would be eligible if he applied for Medicaid, he shall be ineligible for coverage under FAMIS. A child found through the screening process to be potentially eligible for Medicaid

but who fails to complete the Medicaid application process for any reason, cannot be enrolled in FAMIS.

2. 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 where the employer contributes towards the cost of dependent coverage, shall be ineligible for FAMIS. Children of an absent parent shall be ineligible for FAMIS if the absent parent is eligible for coverage under the State Employee Health Insurance Plan or through the Local Choice Program where the employer contributes towards the cost of dependent coverage;

3. An inmate of a public institution as defined in 42 CFR § 435.1009, shall be ineligible for FAMIS ; or

4. An inpatient in an institution for mental disease (IMD) as defined in 42 CFR § 435.1009, shall be ineligible for FAMIS.

B. If a 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 FAMIS. 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.

12 VAC 30-141-120. Nondiscriminatory provisions. FAMIS shall be conducted in compliance with all civil rights requirements. FAMIS shall not:

A. Discriminate during the eligibility determination process on the basis of diagnosis;

B. 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

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

12 VAC 30-141-130. No entitlement.

In accordance with § 2102(b)(4) of the Social Security Act and § 32.1-353 of the COV, FAMIS 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 30-141-141. 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;

3. Premium and co-payment amounts required; and

4. 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 FAMIS. FAMIS applications will be accepted at a central site designated by DMAS. Applicants may apply for the FAMIS program by mail, by phone, by fax, OR by Internet. Face-to-

face interviews for the program will not be conducted at the central site. Local departments of social services may provide applications and assist families in completing FAMIS applications; however, eligibility determinations for FAMIS shall occur at the DMAS designated central site.

C. Right to apply. An individual who is 18 years of age shall not be refused the right to complete a Family Access to Medical Insurance Security application for himself and shall not be discouraged from asking for assistance for himself under any circumstances.

D. Applicant's signature. The applicant must sign a State approved official application form, even if another person fills out the form, unless the application is filed and signed by the applicant's parent, legal guardian or conservator, attorney-in-fact or authorized representative.

E. Authorized representative for individuals 18 years of age or older.

1. The authorized representative of an incapacitated individual shall be the individual's legally appointed conservator or guardian.

2. A competent individual may sign an application on his own behalf where appropriate, or he may designate anyone to be his authorized representative to file a Family Access to Medical Insurance Security

application on his behalf. If a competent individual wants another person to file a Family Access to Medical Insurance Security application for him, he must designate the authorized representative in a written statement that is signed by the individual applicant. The authorized representative statement is valid for the life of the Family Access to Medical Insurance Security application or until the applicant changes his authorized representative. If the application is approved, the authorized representative statement is valid for any subsequent review and re-determination until the applicant's Family Access to Medical Insurance Security eligibility is cancelled. If the applicant reapplies for the Family Access to Medical Insurance Security, he must sign the application or a new authorized representative statement.

3. When an individual has given power-of-attorney to another person that includes the power to conduct the applicant's business affairs, the attorney-in-fact is considered the applicant's authorized representative.

4. For an individual who has not been determined by a court to be legally incapacitated, but who is reported to be mentally unable to sign his name or to make a mark, an application may be signed under the following circumstances. When it is reported that an individual

cannot sign the application and the individual does not have an attorney-in-fact, or authorized representative, the individual's inability to sign the application must be verified by a written statement from the individual's doctor that the individual is mentally unable to sign and file a Family Access to Medical Insurance Security application because of the individual's diagnosis or condition.

F. Authorized representative for children under 18 years of age.

1. A minor child under 18 years of age who is a parent may apply for the Family Access to Medical Insurance Security for his or her own child.

2. An authorized employee of the public or private child placing agency that has custody of the child must sign the Family Access to Medical Insurance Security application for a child under 18 years of age that is in foster care.

3. A child applicant who is under 18 years of age is not legally able to sign a Family Access to Medical Insurance Security application for himself unless he is legally emancipated from his parents. If the child applicant is not legally emancipated, his parents shall sign the application on the child applicant’s behalf. If the child applicant is married and the child applicant’s spouse is 18 years of age or older,

the spouse may sign the application on the child applicant's behalf. If the child applicant does not live with a parent or spouse who is 18 years of age or older, the adult who has legal custody or who is the legal guardian of the child applicant must sign the application. A child applicant's parent, guardian or legal custodian may designate an authorized representative to complete a Family Access to Medical Insurance Security application on behalf of the child applicant. The authorization must be in writing in accordance with this section.

G. If no adult is the child applicant's guardian or no adult has legal custody of the child applicant, whoever is caring for the child applicant shall be responsible for seeking custody or guardianship of the child applicant:

1. If a motion has been filed in court to appoint a guardian or seek legal custody of the child, the Family Access to Medical Insurance Security application shall be held in a pending status. If verification is received within 10 working days that court action has been initiated, the application will be continued until the guardian is appointed or custody is awarded. When the guardian has been appointed or custody awarded, the eligibility worker must provide the Family Access to Medical Insurance Security application to the guardian or custodian. The guardian or custodian must return the signed application and documentation of his appointment within 10 working

days. If the application or documentation is not returned by either 10 day deadline, the Family Access to Medical Insurance Security eligibility shall be denied.

2. If guardianship or custody procedures have not been filed with the court, the eligibility worker must refer the child to the appropriate child welfare service worker. The application for the Family Access to Medical Insurance Security shall be held in a pending status until the service investigation is completed and any court proceedings are completed. If the court emancipated the child, the child must sign the application and return it to the eligibility worker within 10 working days. If a guardian has been appointed or custody awarded, the eligibility worker must provide the Family Access to Medical Insurance Security application to the guardian or custodian. The guardian or custodian must return the signed application and documentation of his appointment within 10 working days. If the application or documentation is not returned by the deadline, the Family Access to Medical Insurance Security eligibility shall be denied.

H. Persons prohibited from signing an application. An employee of, or an entity hired by, a medical service provider who stands to obtain Family Access to Medical Insurance Security payments shall not sign a Family Access to

Medical Insurance Security application on behalf of an individual who cannot designate an authorized representative.

I. Written application. DMAS or its designee shall require a written application for the FAMIS program from the applicant if at least 18 years of age or older, or from a parent, guardian, legal custodian, or authorized representative if the applicant is less than 18 years of age or the applicant is incapacitated. The application must be on a separate form prescribed by DMAS, one not used to determine eligibility under Title XIX (Medicaid), and must be signed under a penalty of perjury. The application form shall contain information sufficient to screen applicants for Medicaid eligibility, but shall not serve as a Medicaid application.

J. Assistance with application. DMAS or its designee shall allow an individual or individuals of the applicant's choice to assist and represent the applicant in the application process, or a re-determination process for eligibility.

K. Timely determination of eligibility. Except for cases of unusual circumstances as described below, DMAS or its designee shall determine eligibility and inform the applicant of a decision within 10 business days from the date of receiving an application that contains all information and verifications necessary to determine eligibility.

1. Unusual circumstances include: administrative or other emergency beyond the agency's control. In such case, 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.

2. Incomplete applications shall be held open for a period of 30 calendar days to enable applicants to provide outstanding information needed for an eligibility determination. Any applicant who fails to provide, within 30 calendar days of the receipt of the initial application, information or verifications necessary to determine eligibility, shall have his application for FAMIS eligibility denied.

L. 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/designee's decision on his application, and, if approved, his obligations under the program. If eligibility for FAMIS is denied, notice must be given concerning the reasons for the action and an explanation of the applicant's right to request a review of adverse case actions.

M. Case documentation. DMAS or its designee must include in each applicant's record all necessary facts to support the decision on his application, and 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 or its designee sent a notice confirming his decision; (ii) there is a 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.

N. Re-determination of eligibility. DMAS or its designee must re-determine the eligibility of recipients with respect to circumstances that may change at least every 12 months. Recipients must make timely and accurate reports of all changes in circumstances that may affect their eligibility. DMAS or its designee must promptly re-determine 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 re-determine eligibility at the appropriate time based on those changes.

O. Notice of decision concerning eligibility. DMAS or its designee must give recipients timely notice of proposed action to terminate their eligibility under FAMIS. The notice must meet the requirements of 42 CFR §457.1180.

12 VAC 30-142 through 12 VAC 30-141-149. Reserved.

PART IV.

COST SHARING.

12 VAC 30-141-150. Co-payments and premiums for families not participating in employer sponsored health insurance (ESHI).

A. Premiums. FAMIS-eligible children, in families with incomes above 150 percent of the Federal Poverty Level (FPL) Income Guidelines (as published annually by the U.S. Department of Health and Human Services in the *Federal Register*), shall be required to contribute to the cost of health care coverage by paying premium payments. Income levels are provided as a percentage of FPL based on gross income.

B. Co-payments. Co-payments shall apply to all recipients (above and below 150 percent of the FPL).

C. These cost-sharing provisions shall be implemented with the following restrictions:

1. Total cost sharing shall be limited to two and one-half percent of a family's income for the year (or 12-month eligibility period) for

income equal to or under 150 percent of FPL, and five percent for family incomes above 150 percent of FPL.

2. The State shall ensure that the annual aggregate cost sharing for all FAMIS enrollees in a family does not exceed the aforementioned five percent and two and one-half percent caps as required by §2103(e)(3)(b) of Title XXI.

3. Families will be required to submit documentation to DMAS or its designee, showing that their maximum co-payment amounts are met for the year.

4. Cost sharing will be monitored to ensure that maximum allowable cost sharing per family is not exceeded. Once the cap is met, DMAS or its designee will issue a new eligibility card excluding such families from paying additional co-pays.

D. Exceptions to the above cost-sharing provisions:

1. Co-payments shall not be required for well-child, other preventive services, and families participating in ESHI. This shall include:

a. All healthy newborn inpatient physician visits, including

routine screening (inpatient or outpatient);

b. Routine physical examinations, laboratory tests, immunizations, and related office visits; and,

c. Routine preventive and diagnostic dental services (i.e., oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays).

2. Enrollees are not held liable for any additional costs, beyond the standard co-payment amount, for emergency services furnished outside of the individual's managed care network. Only one co-payment charge will be imposed for a single office visit.

3. No cost sharing will be charged to American Indians and Alaska Natives.

E. Dis-enrollment for non-payment of premium. FAMIS will dis-enroll families who fail to make their family contribution. DMAS or its designee shall provide a 30-day prior notice to the family in writing that premium payment has not been received. The child will be dis-enrolled 60 days after the period covered by the last payment. During the dis-enrollment process the enrollee will have the opportunity to show that the enrollee's income has declined prior

to disenrollment for non-payment of cost sharing charges. Children disenrolled pursuant to this section will be eligible for re-enrollment after six months and payment of the premiums in arrears. FAMIS may waive the six-month re-enrollment exclusion period if it finds that a family had "good cause for nonpayment." The Director shall make a determination of good cause based on DMAS written policy.

12 VAC 30-141-151 through 12 VAC 30-141-159. Reserved.

12VAC 30-141-160. Employer sponsored health insurance (ESHI). Enrollees in FAMIS who have access to employer sponsored health insurance coverage may, but shall not be required to, enroll in an employer's health plan if DMAS or its designee determines that such enrollment is cost-effective, as defined below. DMAS reserves the right to implement in phases the ESHI component for children enrolled in CMSIP. The method and the timing for phasing in the ESHI component will be determined by DMAS after it has assessed the potential volume of CMSIP enrollees with access to an employer plan and interest in the ESHI component

A. Eligibility determination. FAMIS children who have access to health insurance coverage under an employer-sponsored plan may elect to receive coverage under the employer plan and DMAS may elect to provide coverage by paying a portion of the premium if the following conditions are met:

1. The children are enrolled in FAMIS.

2. The employer's plan provides comprehensive health insurance coverage.

3. The employer contributes at least forty percent of the cost of family or dependent coverage.

4. The cost of coverage for the child or children under ESHI is equal to or less than the Commonwealth's cost of obtaining coverage under FAMIS only for the eligible targeted low-income children involved. The cost-effectiveness determination methodology is described below.

5. The family receives the full premium contribution from the employer.

6. The applicant agrees to assign rights to benefits under the employer's plan to DMAS to assist the Commonwealth in pursuing these third party payments. (When a child is provided coverage under an employer's plan, that plan becomes the primary payer for the services covered under that plan.)

B. When more than one employer plan is available to the family, the family shall enroll in the plan that DMAS has determined to be the most cost-effective for the State.

C. DMAS will continually verify the child's or children's coverage under the employer's plan and will re-determine the eligibility of the child or children for the ESHI component when it receives information concerning an applicant's or enrollee's circumstances that may affect eligibility.

D. Application requirements.

1. DMAS shall furnish the following information in written form and orally as appropriate to the families of FAMIS children who have access to employer sponsored health insurance:

a. The eligibility requirements;

b. Summary of covered benefits and supplementation of employer benefits;

c. Cost sharing requirements; AND

d. The rights and responsibilities of applicants and recipients.

2. Opportunity to apply. DMAS may elect to provide health insurance coverage to FAMIS children by having FAMIS children and their families enroll in ESHI. Families with access to employer coverage for family members will be identified through the FAMIS application. DMAS will provide these families with applications for ESHI.

3. Written application. A written application for the ESHI component shall be required from interested families.

4. Timely determination of eligibility. DMAS shall determine eligibility for the ESHI component promptly not to exceed 45 calendar days from the date of receiving an application which contains all information and verifications necessary to determine eligibility except in unusual circumstances beyond the agency's control. Actual enrollment into the ESHI component may not occur for extended periods of time depending on the ability of the family to enroll in the employer's plan.

5. Incomplete ESHI applications shall be held for a period of 30 calendar days to enable applicants to provide outstanding information needed for an ESHI eligibility determination. Any applicant who, within 30 calendar days of the receipt of the initial application, fails to provide

information or verifications necessary to determine ESHI eligibility shall have his application denied.

6. DMAS must send each applicant a written notice of the agency's decision on his application, and, if approved, his obligations under the program. If eligibility is denied, notice will be given concerning the reasons for the action.

E. Cost-effectiveness. DMAS may elect to provide coverage to FAMIS children by paying a portion of the family's employer-sponsored health insurance premium if the cost of family coverage under ESHI is equal to or less than the Commonwealth's cost of obtaining coverage under FAMIS only for the eligible targeted low-income child or children involved. The cost-effectiveness determination will be conducted for individual families on a case-by-case basis. DMAS must determine that the premium subsidy plus the cost of the supplemental coverage, plus the administrative cost for a family enrolled in the ESHI component is less than the amount the Commonwealth would have paid to cover the child or children in that family under FAMIS.

1. The cost-effectiveness determination is a three-step process:

a. The cost of covering only the FAMIS child or children under the employer plan must be isolated as much as possible from the cost of covering the adults.

b. The premium subsidy DMAS would pay is obtained by taking the cost of covering the children obtained in step one, and subtracting any FAMIS premium the family is responsible for paying.

c. To determine whether it is cost-effective to cover the family, DMAS will compare the following two amounts:

(1) The sum of the premium assistance amount from step two plus the cost of supplemental coverage, plus the administrative cost; and,

(2) The cost of covering the FAMIS child or children under FAMIS. The cost will be determined by using the capitated payment rate paid to managed care entities, or an average cost amount developed by DMAS.

d. If (1) is less than (2), covering the child or children under the ESHI component is cost-effective.

F. Enrollment and Disenrollment.

1. FAMIS children with access to employer-sponsored health insurance will be enrolled in a FAMIS MCE if in a non-managed care entity area until their eligibility for coverage under the ESHI component is established and until they are able to enroll in the employer sponsored health plan.

2. The timing and procedures employed to transfer FAMIS children to the ESHI component will be coordinated between DMAS and the Central Processing Unit to ensure continuation of health plan coverage.

3. Participation by families in the ESHI component shall be voluntary. Families may disenroll their child or children from the ESHI component and enroll them in a FAMIS MCE if in a non-managed care entity area as long as the proper timing and procedures established by DMAS are followed to ensure continuation of health plan coverage.

4. If a child becomes ineligible to participate in the ESHI component, but is still eligible for FAMIS, DMAS will transfer this child back to a FAMIS

MCE. DMAS will coordinate with the Central Processing Unit to ensure continuous health plan coverage

G. Premium assistance. When a child is determined eligible for coverage under the ESHI component, premium assistance payments shall become effective the month in which the FAMIS child or children are enrolled in the employer's plan.

1. Payment of premium assistance shall end:

a. On the last day of the month in which FAMIS eligibility ends;

b. The last day of the month in which the child or children lose eligibility for coverage under the employer's plan;

c. The last day of the month in which the family notifies DMAS that they wish to disenroll their child or children from the ESHI component and enroll them in a FAMIS MCE, OR

d. The last day of the month in which adequate notice period expires (consistent with federal requirements) given by DMAS whereby DMAS has determined that the employer's plan is no longer cost-effective.

H. Supplemental health benefits coverage will be provided to ensure that FAMIS children enrolled in the ESHI component receive all of the FAMIS benefits. FAMIS children can obtain these supplemental benefits through DMAS providers.

I. Cost Sharing. ESHI families will not be responsible for co-payments for FAMIS Title XXI benefits. DMAS will instruct providers to submit billings to DMAS or its designee for payment of applicable co-payments. In situations where the provider refuses to bill DMAS for the co-payment amount, DMAS will reimburse the enrollee directly.

1. FAMIS children will have to pay co-pays for any services covered under the employer's plan that are not FAMIS benefits and for benefits provided beyond the FAMIS Title XXI benefits. The cost sharing paid by families for these benefits do not count towards the cost-sharing cap.

2. Families with incomes equal to or less than 150 percent of FPL will not pay premiums. All families above 150 percent FPL shall be required to contribute to the cost of health care coverage by means of monthly premium payments.

3. ESHI families will pay deductibles, coinsurance, and enrollment fee amounts under their employers' plans up to the cost sharing limits allowed for non-ESHI FAMIS families ($180 for those equal to or less than 150 percent FPL and $350 for those over 150 percent FPL). After the family has reached its cost-sharing cap, DMAS will reimburse the family for any additional deductibles or coinsurance they incur for the FAMIS-enrolled children in the family for FAMIS Title XXI benefits received. Families will need to track their deductibles and coinsurance. Once the cap is reached for a family, that family will submit Explanation of Benefits forms or other forms approved by DMAS for reimbursement each time the family incurs a deductible or coinsurance amount for a FAMIS child for a FAMIS Title XXI benefit. DMAS will track these caps by family and reimburse these families.

12 VAC 30-141-175. Third party liability for excess benefits; lability for excess benefits or payments obtained without intent; recovery of FAMIS payments.

A. Any person who, without intent to violate this section obtains benefits or payments under FAMIS to which he is not entitled shall be liable for any excess benefits or payments received. If the recipient knew or reasonably should have known that he was not entitled to the excess benefits, he may also be liable for interest on the amount of the excess benefits or payments at the judgment rate as defined in the §6.1-330.49 COV from the date upon which excess benefits or payments to the date on which repayment is made to the Commonwealth. No person shall be liable for payment of interest, however, when excess benefits or payments were obtained as a result of errors made solely by the DMAS.

B. Any payment erroneously made on behalf of a FAMIS recipient or former recipient may be recovered by DMAS from the recipient or the recipient's income, assets, or estate unless state or federal law or regulation otherwise exempts such property.

Part V.

BENEFITS AND REIMBURSEMENT.

12 VAC 30-141-200. The following benefits shall be covered for persons eligible for FAMIS consistent with the XXI State Plan as set out, and amended, in the member handbook, the PPO option for state employees that is offered statewide, with several enhanced or additional benefits. This benchmark will be used for both the regular FAMIS plan and for the employer sponsored health insurance component (ESHI). The covered services shall be: inpatient hospital, outpatient, physician, surgical, clinic, prescription drugs, laboratory and radiological, prenatal care and prepregnancy family services and supplies, inpatient mental health, outpatient mental health, durable medical equipment and other medically-related or remedial devices, disposable medical supplies, home and community-based health care services, nursing care, abortion if necessary to save the life of the mother, dental services, inpatient substance abuse treatment services and residential substance abuse treatment, outpatient substance abuse treatment, physical/occupational/speech-hearing-language therapies, chiropractic services, premiums for private health care insurance coverage, ambulance services under certain conditions as defined in the Virginia Title XXI State Plan.

12 VAC 30-141-225. Enhanced services in excess of the benchmark package:

A. Well-child care from ages 6 through 18 years of age including visits, laboratory services, and any immunizations recommended by the Advisory Committee on Immunization Practice (ACIP).

B. Physical therapy, occupational therapy, speech language pathology, and skilled nursing services for special education students.

12 VAC 30-141-226. Services covered in excess of the benchmark package covered with all state funds. These specified services shall not be subject to the limits on cost sharing applicable to other covered services and cost sharing for these services shall not be credited towards the cumulative cap.

A. Complex restorative dental services: inlays, onlays, crowns, dentures, bridges, relining dentures for a better fit, and implants, covered at 50 percent of the approved charge.

B. Orthodontic services for specified conditions are covered up to a maximum of $1,200 per lifetime per enrolled member.

C. Lead testing.

D. Vision Services

E. Hearing Aids

12 VAC 30-141-227 through 12 VAC 30-141-449. Reserved.

12 VAC 30-141-500. Benefits reimbursement. Reimbursement for the services covered under FAMIS shall be as specified below.

A. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, vision services,

medical transportation shall be based on the Title XIX rates in effect as of July 1 of each year for the subsequent state fiscal year.

B. Exceptions.

1. Reimbursement for inpatient hospital 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 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 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.

4. 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.

5. Reimbursement for inpatient and outpatient substance abuse treatment 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 30-141-501 through 12 VAC 30-141-559. Reserved.

PART VI

QUALITY ASSURANCE AND UTILIZATION CONTROL.

12 VAC 30-141-560. Quality assurance.

A. Each provider entity shall meet requirements determined by contract with DMAS for the following: access to well-baby, well-child, and well-adolescent care, immunizations; referral systems, prior authorization requirements, clinical practice guidelines, provider network adequacy, a system to provide enrollees urgent care and emergency services,

implementation of systems for complaints, grievances and reviews, implementation of a data management system to meet data collection requirements of quality assurance projects, a quality improvement program and annual quality improvement plan, and annual performance measures.

B. Each provider entity shall meet requirements determined by contract for the monitoring and reporting of access to services, timeliness of services, appropriateness of services, and prior authorization decisions for all enrollees, including those with complex or serious medical conditions. Requirements may include the calculation and reporting of performance measures and the implementation of performance improvement projects, as determined by DMAS.

12 VAC 30-141-570. Utilization control.

A. Each provider entity shall implement a utilization review system as determined by contract with DMAS.

B. DMAS may collect and review comprehensive encounter and fee-for-service claims data to monitor utilization after receipt of services.

12 VAC 30-141-571 through 12 VAV 30-141-599. Reserved.

12 VAC 30-141-600. Recipient audit unit.

A. Pursuant to §32.1-310 et seq., COV, the recipient audit unit shall investigate allegations of acts of fraud or abuse, committed by persons enrolled in the FAMIS program, which result in misspent funds.

B. Any FAMIS recipient, either on his own behalf or on the behalf of others, who attempts to obtain benefits to which he is not entitled by means of a willful false statement or by willful misrepresentation, or by willful concealment of any material facts, shall be liable for repayment of any excess benefits received and the appropriate interest charges.

C. Upon the determination that the recipient has committed fraud or abuse, criminal or civil action may be initiated.

D. When determining the amount of misspent funds to be recovered, capitation fees shall be included for FAMIS recipients who are in managed care.

E. Access to FAMIS recipients' eligibility records by authorized DMAS representatives will be permitted upon request.

12 VAC 30-141-601 through 12 VAC 30-141-649. Reserved.

12 VAC 30-141-650. Provider review.

A. Provider review unit shall be responsible for reviewing enrolled FAMIS providers to identify potential inappropriate utilization of services and potential billing errors.

B. Providers agree to keep such records as DMAS determines necessary. The providers will furnish DMAS upon request information regarding payments claimed for providing services under the State Plan for Title XXI.

C. Access to records and facilities by authorized DMAS representatives will be permitted upon reasonable request.

D. Providers will be required to refund payments made by DMAS if they are found to have billed DMAS contrary to policy, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services.

E. A review of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia.

F. Managed Care providers will be reviewed by the managed care unit of DMAS.