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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory and Manual Section Manager
Department of Medical Assistance Services

FROM: **ELIZABETH A. MCDONALD**
Special Counsel to DMAS

DATE: **January 12, 2010**

SUBJECT: **Final Exempt Regulation – CHIPRA Deemed Newborns of FAMIS Enrollees (12 VAC 30-141-100; -141-100; and 30-30-10)**

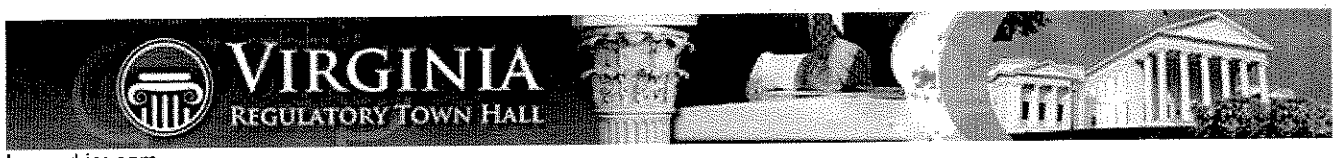
I have reviewed the attached final exempt regulations that will implement Section 111 of the Child Health Insurance Plan Reauthorization Act (CHIPRA) of 2009, which provides for automatic enrollment for children born to women receiving pregnancy-related assistance under Title XXI of the Social Security Act. You have asked the Office of the Attorney General to review and determine if DMAS has the legal authority to promulgate the final exempt regulations and if they comport with state and federal law.

Based on that review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

These regulations are required by the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, Section 111. It is my view that the promulgation of these regulations is exempt from the procedures of Article 2 of the Administrative Process Act pursuant to Virginia Code § 2.2-4006(A)(4)(c).

If you have any questions, please feel free to contact me at 786-7363.

cc: Kim F. Piner
Senior Assistant Attorney General



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Final Text

Action: CHIPRA Deemed Newborns of FAMIS Enrollees

Stage: Final 12/18/09 3:58 PM [latest]

12VAC30-30-10. Mandatory coverage: Categorically needy and other required special groups.

The Title IV-A agency or the Department of Medical Assistance Services Central Processing Unit determines eligibility for Title XIX services.

1. Recipients of AFDC.

a. The approved state AFDC plan includes:

(1) Families with an unemployed parent for the mandatory six-month period and an optional extension of 0 months.

(2) AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

b. The standards for AFDC payments are listed in 12VAC30-40-220.

2. Deemed recipients of AFDC.

a. Individuals denied a Title IV-A cash payment solely because the amount would be less than $10.

b. Effective October 1, 1990, participants in a work supplementation program under Title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with § 482(e)(6) of the Act.

c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of § 406(h) of the Act.

e. Individuals deemed to be receiving AFDC who meet the requirements of § 473 (b)(1) or (2) for whom an adoption of assistance agreement is in effect or foster care maintenance payments are being made under Title IV-E of the Act.

3. Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under § 407 of the Act because the principal wage earner is unemployed.

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to 12 months of extended benefits in accordance with § 1925 of the Act.

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

a. Families denied AFDC solely because of income and resources deemed to be available from:

(1) Stepparents who are not legally liable for support of stepchildren under a state law of general applicability;

(2) Grandparents;

(3) Legal guardians; and

(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

6. Individuals who would be eligible for AFDC except for the increases in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972 and who were receiving cash assistance in August 1972.

a. Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in the state's August 1972 plan).

b. Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

7. Qualified pregnant women and children.

a. A pregnant woman whose pregnancy has been medically verified who:

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

(2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the state had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the state's approved AFDC plan.

b. Children born after September 30, 1973 (specify optional earlier date), who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the state's approved AFDC plan.

12VAC30-40-280 and 12VAC30-40-290 describe the more liberal methods of treating income and resources under § 1902(r)(2) of the Act.

8. Pregnant women and infants under one year of age with family incomes up to 133% of the federal poverty level who are described in §§ 1902(a) (10)(A)(i)(IV) and 1902(l)(A) and (B) of the Act. The income level for this group is specified in 12VAC30-40-220.

9. Children:

a. Who have attained one year of age but have not attained six years of age, with family incomes at or below 133% of the federal poverty levels.

b. Born after September 30, 1983, who have attained six years of age but have not attained 19 years of age, with family incomes at or below 100% of the federal poverty levels.

Income levels for these groups are specified in 12VAC30-40-220.

10. Individuals other than qualified pregnant women and children under subdivision 7 of this section who are members of a family that would be receiving

AFDC under § 407 of the Act if the state had not exercised the option under § 407 (b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved state plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

b. A pregnant women who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

12. a. A child born to a woman who is eligible for and receiving Medicaid ~~as categorically needy~~ on the date of the child's birth. The child is deemed eligible for one year from birth.

b. A child born to a woman under the age of 19 who is eligible for and receiving Title XXI coverage through the Family Access to Medical Insurance Security Plan (FAMIS) as of the date of the child's birth and who is screened to be income eligible for coverage under Medicaid. The child is deemed Medicaid eligible for one year from his date of birth.

13. Aged, blind and disabled individuals receiving cash assistance.

a. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under § 1619(a) of the Act or who meet the eligibility requirements for SSI status under § 1619(b)(1) of the Act and who met the state's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under § 1619(a) or met the requirements under § 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the § 1619(a) eligibility standard or the requirements of § 1619(b) of the Act.)

b. These persons include the aged, the blind, and the disabled.

c. Protected SSI children (pursuant to § 1902(a)(10)(A)(i)(II) of the Act) (P.L. 105-33 § 4913). Children who meet the pre-welfare reform definition of childhood disability who lost their SSI coverage solely as a result of the change in the definition of childhood disability, and who also meet the more restrictive requirements for Medicaid than the SSI requirements.

d. The more restrictive categorical eligibility criteria are described below:

(1) See 12VAC30-30-40.

(2) Financial criteria are described in 12VAC30-40-10.

14. Qualified severely impaired blind and disabled individuals under age 65 who:

a. For the month preceding the first month of eligibility under the requirements of § 1905(q)(2) of the Act, received SSI, a state supplemental payment under § 1616 of the Act or under § 212 of P.L. 93-66 or benefits under § 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under § 1619 (b) of the Act and were eligible for Medicaid. These individuals must:

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under § 1611(b) of the Act;

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under § 1619 (a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under § 1619(b)(1) of the Act and who met the state's more restrictive requirements in the month before the month they qualified for SSI under § 1619(a) or met the requirements of § 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under § 1619(a) of the Act or meet the SSI requirements under § 1619(b) (1) of the Act.

15. Except in states that apply more restrictive requirements for Medicaid than under SSI, blind or disabled individuals who:

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under § 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absence their OASDI eligibility.

c. The state does not apply more restrictive income eligibility requirements than those under SSI.

16. Except in states that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional state supplements (if the agency provides Medicaid under § 435.230 of the Act), because of requirements that do not apply under Title XIX of the Act.

17. Individuals receiving mandatory state supplements.

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the state's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for have his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to: the aged; the blind; and the disabled.

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, they:

a. Continue to meet the December 1973 Medicaid State Plan eligibility requirements;

b. Remain institutionalized; and

c. Continue to need institutional care.

20. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this state's August 1972 plan), and persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

22. Individuals who:

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under § 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

The state applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by § 134 of P.L. 98-21 and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under § 1634(b) of the Act.

The state does not apply more restrictive income eligibility standards than those under SSI.

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least 10 years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The state applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

25. Qualified Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under § 1818 of the Act);

b. Whose income does not exceed 100% of the federal level; and

c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare cost sharing as defined in item 3.2 of this plan.)

26. Qualified disabled and working individuals:

a. Who are entitled to hospital insurance benefits under Medicare Part A under § 1818A of the Act;

b. Whose income does not exceed 200% of the federal poverty level; and

c. Whose resources do not exceed twice the maximum standard under SSI.

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under §§ 1818 and 1818A of the Act.)

27. Specified low-income Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under § 1818A of the Act);

b. Whose income for calendar years 1993 and 1994 exceeds the income level in subdivision 25 b of this section, but is less than 110% of the federal poverty level, and whose income for calendar years beginning 1995 is less than 120% of the federal poverty level; and

c. Whose resources do not exceed twice the maximum standard under SSI.

(Medical assistance for this group is limited to Medicare Part B premiums under § 1839 of the Act.)

28. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of § 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

b. The state applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of § 1611(e)(3)(A) and who continue to meet the more restrictive requirements for Medicaid eligibility under the state plan, are eligible for Medicaid as categorically needy.

Part III
Eligibility Determination and Application Requirements

12VAC30-141-100. 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:

1. Be determined ineligible for Medicaid by a local department of social services or be screened by the FAMIS central processing unit and determined not Medicaid likely;

2. Be under 19 years of age;

3. Be residents of the Commonwealth;

4. Be either U.S. citizens, U.S. nationals or qualified noncitizens;

5. Be uninsured, that is, not have comprehensive health insurance coverage;

6. Not be a member of a family eligible for subsidized dependent coverage, as defined in 42 CFR 457.310(c)(1)(ii) under any Virginia state employee health insurance plan on the basis of the family member's employment with a state agency;

7. Not be an inpatient in an institution for mental diseases (IMD), or an inmate in a public institution that is not a medical facility.

D. Income.

1. Screening. All child health insurance applications received at the FAMIS central processing unit must be screened to identify applicants who are potentially eligible for Medicaid. Children screened and found potentially eligible for Medicaid cannot be enrolled in FAMIS until there has been a finding of ineligibility for Medicaid. Children who do not appear to be eligible for Medicaid shall have their eligibility for FAMIS determined. Children determined to be eligible for FAMIS will be enrolled in the FAMIS program. Child health insurance applications received at a local department of social services shall have a full Medicaid eligibility determination completed. Children determined to be ineligible for Medicaid due to excess income will have their eligibility for FAMIS determined. If a child is found to be eligible for FAMIS, the local department of social services will enroll the child in the FAMIS program.

2. Standards. Income standards for FAMIS are based on a comparison of countable income to 200% of the federal poverty level for the family size, as defined in the State Plan for Title XXI as approved by the Centers for Medicare & Medicaid. Children who have 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. Grandfathered CMSIP children. Children who were enrolled in the Children's Medical Security Insurance Plan at the time of conversion from CMSIP to FAMIS and whose eligibility determination was based on the requirements of CMSIP shall continue to have their income eligibility determined using the CMSIP income methodology. If their 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 12VAC30-40-90. 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 former CMSIP 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. A child who is not emancipated and is temporarily living away from home is considered living with his parents, adult relative caretaker, legal guardian, or person having legal custody if the absence is temporary and the child intends to return to the home when the purpose of the absence (such as education, medical care, rehabilitation, vacation, visit) is completed.

F. Qualified noncitizen. The requirements for qualified aliens set out in Public Law 104-193, as amended, and the requirements for noncitizens set out in subdivisions

3 b and c of 12VAC30-40-10 will be used when determining whether a child is a qualified noncitizen 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. A child is not considered to be insured if the health insurance plan covering the child does not have a network of providers in the area where the child resides. Each application for child health insurance shall include an inquiry about health insurance the child currently has or had within the past four months. If the child had health insurance coverage that was terminated in the past four months, inquiry as to why the health insurance was terminated is made. Each redetermination of eligibility shall also document inquiry about current health insurance or health insurance the child had within the past four months. If the child has been covered under a health insurance plan within four months of application for or receipt of FAMIS services, the child will be ineligible, unless the child is pregnant at the time of application, or, if age 18 or if under the age of 18, the child's parent, caretaker relative, guardian, legal custodian or authorized representative demonstrates good cause for discontinuing the coverage.

b. Health insurance does not include Medicare, Medicaid, FAMIS or insurance for which DMAS paid premiums under Title XIX through the Health Insurance Premium Payment (HIPP) Program or under Title XXI through the SCHIP premium assistance program.

c. Good cause. A child shall not be ineligible for FAMIS if health insurance was discontinued within the four-month period prior to the month of application if one of the following good cause exceptions is met.

(1) The family member who carried insurance, changed jobs, or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage.

(2) The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage.

(3) The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g., the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums.

(4) Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy and no other family member's employer contributes to the cost of family health insurance coverage.

(5) Insurance on the child was discontinued by someone other than the child (if 18 years of age) or if under age 18, the child's parent or stepparent living in the home, e.g., the insurance was discontinued by the child's absent parent, grandparent, aunt, uncle, godmother, etc.

(6) Insurance on the child was discontinued because the cost of the premium exceeded 10% of the family's monthly income or exceeded 10% of the family's monthly income at the time the insurance was discontinued.

(7) Other good cause reasons may be established by the DMAS director.

H. Eligibility of newborns. (1) If a child otherwise eligible for FAMIS is born within

the three months prior to the month in which a signed application is received, the eligibility for coverage is effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time. (2) A child born to a mother who is enrolled in FAMIS on the date of the child's birth shall be deemed eligible for FAMIS for one year from birth unless the child is otherwise eligible for Medicaid.

12VAC30-141-110. Duration of eligibility.

A. The effective date of FAMIS eligibility shall be the date of birth for a newborn deemed eligible under 12VAC30-30-10 (h)(2). Otherwise the effective date of FAMIS eligibility shall be the first day of the month in which a signed application was received by either the FAMIS central processing unit or a local department of social services if the applicant met all eligibility requirements in that month. In no case shall a child's eligibility be effective earlier than the date of the child's birth.

B. Eligibility for FAMIS will continue for 12 months so long as the child remains a resident of Virginia and the child's countable income does not exceed 200% of the federal poverty level. A child born to a mother who was enrolled in FAMIS on the date of the child's birth shall remain eligible for one year regardless of income unless otherwise found to be eligible for Medicaid. A change in eligibility will be effective the first of the month following expiration of a 10-day advance notice. Eligibility based on all eligibility criteria listed in 12VAC30-141-100 C will be redetermined no less often than annually.