# CHAPTER 200
# REGULATIONS GOVERNING ELIGIBILITY STANDARDS AND CHARGES FOR ~~HEALTH~~ MEDICAL CARE SERVICES TO INDIVIDUALS

## Part I

## Definitions

12 VAC 5-200-10. Definitions.

The following words and terms, when used in this chapter have the following meanings unless the context clearly indicates otherwise:

"Applicant" means the person requesting ~~health~~ medical care services for himself or on whose behalf a request is made.

"Board" means the State Board of Health. ~~The Board of Health is the policy board of the state Department of Health.~~

"Child" means a person under 18 years of age and includes any biological or adopted child, and any child placed for adoption or foster care unless otherwise treated as a separate unit ~~by~~ for the purposes of determining eligibility and charges under these regulations.

"Commissioner" means the Commissioner of Health. ~~The commissioner is the chief executive officer of the state Department of Health. The commissioner has the authority to act for the Board of Health when it is not in session.~~

"Department" means the state Department of Health and includes the central office, regional offices, health districts, and local health departments.

"Eligibility determination" means the process of obtaining required information regarding family size, income, and other related data in order to establish charges to the applicant.

"Extraordinary financial hardship" includes hardship due to such events as natural disasters, damage to or the loss of uninsured real or personal property, unpaid legal liabilities, and obligatory and unavoidable expenditures for close relatives outside the family unit.

"Family" or "family unit" means the applicant and other household members who together constitute one economic unit. An economic unit is one or more individuals who generally reside together and share income. ~~The economic unit shall include the constellation of persons among whom legal responsibilities of support exist; or an individual, even if otherwise within such a constellation, if he independently receives subsistence funds in his own right.~~ The economic unit shall count in its income any contributions to the unit from persons not necessarily living with the ~~constellation~~ unit.

A parent ~~Parent~~ may be ~~includes~~ a biological, adoptive, or ~~step parent~~ stepparent.

A woman who is pregnant may be counted as a multiple beneficiary when the pregnancy has been verified by a physician or a nurse practitioner working under the supervision of a physician.

A husband and wife who ~~have been~~ are separated and are not living together~~, and who are not dependent on each other for support~~ shall be considered to be separate family units.

"Flat rate charges" means charges for specified goods or services ~~which~~ that are to be charged to all clients regardless of income and with no eligibility determination.

"Gross income" means total cash receipts before taxes from all sources. These include money wages and salaries before any deductions, but do not include food or rent in lieu of wages. These receipts include net receipts from nonfarm or farm self-employment (e.g., receipts from an applicant's own business or farm expenses) income, plus any depreciation shown on income tax forms. They include regular payments from social security or railroad retirement, unemployment and workers' compensation, strike benefits from union funds, veterans' benefits, training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; and income from dividends, interest, net rental income, net royalties, or periodic receipts from estates or trusts, lump sum settlements, and net gambling or lottery winnings.

"Gross income" does not include the value of food stamps; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) checks; fuel assistance payments; housing assistance; money borrowed; tax refunds; gifts; withdrawal of bank deposits from earned income; earnings of minor children; money received from the sale of property; general relief from the Department of Social Services; or college or university scholarships, grants, fellowships, and assistantships when provided to pay for, or in the form of, tuition, fees, other direct educational expenses, housing, or meals.

"Income scales" means scales based on individual or family gross income. They shall be based on the official federal poverty guidelines updated annually by the U.S. Department of Health and Human Services in accordance with §§652 and 6763(2) of the Omnibus Reconciliation Act of 1981 (Public Law 97-35). There shall be two income scales: one for Northern Virginia and one for the remainder of the Commonwealth as follows:

Income Level A - those clients with incomes up to and including 100% of the federal poverty income guidelines will qualify as Income Level A clients, except for Northern Virginia where the Income Level A will be up to and including 110% of the federal poverty income guidelines ~~will qualify as Income Level A clients~~.

Income Level B - those clients with incomes above 100% and no more than 110% of the federal poverty guidelines will qualify as Income Level B

clients, except for Northern Virginia where the Income Level B will be above 110% and no more than 133.3% of the federal poverty income guidelines.

Income Level C - those clients with incomes above 110% and no more than 133.3% of the federal poverty income guidelines will qualify as Income Level C clients, except for Northern Virginia where the Income Level C will be above 133.3% and no more than 166.6% of the federal poverty income guidelines.

Income Level D - those clients with incomes above 133.3% and no more than 166.6% of the federal poverty income guidelines will qualify as Income Level D clients, except for Northern Virginia where the Income Level D will be above 166.6% and no more than 200% of the federal poverty income guidelines.

Income Level E - those clients with incomes above 166.6% and less than 200% of the federal poverty income guidelines will qualify as Income Level E clients, except for Northern Virginia where the Income Level E will be above 200% and less than 233.3% of the federal poverty income guidelines.

Income Level F- those clients with incomes equal to or above 200% and less than 250% of the federal poverty income guidelines will qualify as Income Level F clients, except for Northern Virginia where Income Level F

will be equal to or above 233.3% and less than ~~266.6%~~ 283.3% of the federal poverty income guidelines.

Income Level G - those clients with incomes equal to or above 250% of the federal poverty level guidelines will qualify as Income Level G clients, except for Northern Virginia where income level G will be equal to or above ~~266.6~~ 283.3% of the federal poverty income guidelines.

~~"Legally responsible" means the biological or adoptive parent(s), or those parents whose parentage has been admitted by affidavit or by order of the court.~~

"Medical care services" means clinical medical, dental, and nursing services provided to patients by physicians, dentists, nurses, and other health care providers employed by health districts or contracted by health districts to provide these services. It does not include laboratory tests, pharmaceutical and biological products, radiological or other imaging studies, other goods or products, or other medical services that a health district does not directly provide.

"Medically indigent" means applicants whose individual or family gross income is defined ~~at~~ as Income Level A.

"Minor" means a person less than 18 years of age whose parents are responsible for his care. A minor will be considered a separate family unit when married or not living with any relative or deemed an adult.

A minor shall be deemed an adult for the purposes of consenting to:

1. Medical or health services needed to determine the presence of, or to treat venereal disease or any infectious or contagious disease which the State Board of Health requires to be reported.

2. Medical and health services required for birth control, pregnancy, or family planning except for the purposes of sexual sterilization.

"Nonchargeable services" means the ~~health~~ medical care and related goods and services ~~which~~ that the department has determined will be provided without charge and without an eligibility determination to all citizens regardless of income. ~~There is no charge for WIC services, but WIC services do require an eligibility determination.~~

"Northern Virginia" means the area which includes the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, and the counties of Arlington, Fairfax, Loudoun, and Prince William.

"Venereal disease" is synonymous with "sexually transmitted infection."

Part II

General Information

12 VAC 5-200-20. Authority for regulations.

Section 32.1-~~12~~ 11 of the Code of Virginia establishes the responsibility of the board as follows: "~~A.~~ The board may formulate a program of environmental health services, laboratory services and preventive, curative and restorative medical care services, including home and clinic health services described in Titles V, XVIII and XIX of the

United States Social Security Act and amendments thereto, to be provided by the department on a regional, district or local basis.

~~B.~~ The board shall define the income limitations within which a person shall be deemed to be medically indigent. Persons so deemed to be medically indigent shall receive the medical care services of the department without charge. The board may also prescribe the charges to be paid for the medical care services of the department by persons who are not deemed to be medically indigent and may, in its discretion and within the limitations of available funds, prescribe a scale of such charges based upon ability to pay. Funds received in payment of such charges are hereby appropriated to the board for the purpose of carrying out the provisions of this title. The board shall review periodically the program and charges adopted pursuant to this section."

12 VAC 5-200-30. Purpose of chapter.

The board has promulgated this chapter to: (i) establish financial eligibility criteria to determine if a person is medically indigent and therefore qualified to receive ~~health~~ medical care services from the department without charge; (ii) establish income scales and a mechanism for determining charges for ~~health~~ medical care provided by the department to individuals who are not medically indigent, based upon their ability to pay; (iii) establish a mechanism for handling appeals and waivers; and (iv) establish continuity of eligibility among state agencies. The regulations are constructed to assure that eligibility criteria remain appropriate for changing economic conditions.

12 VAC 5-200-40. Administration of chapter.

This chapter is administered by the commissioner.

The commissioner shall assure uniformity and consistency by interpreting and implementing the rules of the department for ~~health~~ the provision of medical care and related goods and services. The commissioner may issue a guidance document that interprets these regulations, and provides guidance for their implementation. Such a document shall be reviewed and revised whenever the regulations of this chapter are reviewed, and may also be amended or revised as needed to meet changing circumstances.

Whenever possible, charges for services shall use the most appropriate current Medicaid charges (and matching Medicaid codes). If there is no Medicaid code for a particular service, the most appropriate current Medicare charge (and matching code) shall be used. If both Medicaid and Medicare charges (and codes) exist for the same service, the Medicaid charge (and code) will be used. If neither a Medicaid nor a Medicare code exists for a particular service, the commissioner, or a designee, shall determine an appropriate charge and develop a matching code. A guidance document shall include procedures for determining the costs and establishing the charges for medical care and related goods and services when any of these are not otherwise addressed in these regulations or the Code of Virginia.

The commissioner shall publish specific income levels expressed in dollar amounts for determining eligibility for ~~health~~ medical care services of the department in accordance with the income scales defined in 12VAC5-200-10 above.

12VAC5-200-50. Recipients of services.

This chapter shall apply to all persons seeking ~~health~~ medical care services provided by the department, except where other eligibility criteria are required for programs administered under federal statute.

~~12VAC5-200-70. Powers and procedures of chapter not exclusive.~~

~~The board reserves the right to authorize any procedure necessary for the enforcement of the provisions set forth herein under the provisions of §32.1-12 of the Code of Virginia.~~

Part III

Application and Charges

12 VAC 5-200-80. Application process.

Upon an applicant's request for ~~health~~ medical care services (excepting those services described in 12 VAC 5-200-150, 12 VAC 5-200-160, and 12 VAC 5-200-170) the department will require information as to the family size, financial status and other related data as described on the application for ~~health~~ medical care. The applicant must be informed during the interviewing process of the provisions as described in this section of the regulations.

An application date is established when the applicant completes and signs the application for ~~health~~ medical care services.

When an applicant is in need of emergency medical services, the district director, or his designee, shall waive this application process for that individual until such time as the individual is able to ~~respond normally to~~ participate in the interviewing process.

It is the applicant's responsibility to furnish the department with ~~the~~ proof of the applicant's financial data in order to be appropriately classified according to income level and family size so that eligibility for discounts for ~~health~~ medical care services can be determined.

Any individual who is acting on behalf of an applicant will be responsible for the accuracy of all financial data provided to the department.

Individuals who have failed to make any payment within the past 90 days for medical care services, or other goods or services, they have received may have their medical care services terminated. The district director may terminate services only following notice to the individual that such services will be terminated and only after determining that terminating services would not be detrimental to the individual's health. Medical care services cannot be terminated for individuals receiving ongoing care without making a good faith effort to secure alternative care.

12 VAC 5-200-90. Charges for services.

Charges for services means the reasonable charges established by the board for ~~health~~ medical care services. No charge shall be established outside the provisions of these regulations. The department may prescribe a scale of discounts for certain ~~health~~ medical care services. Charges will be based on current published Medicaid

reimbursement levels. In those instances where Medicaid does not reimburse for a service provided by the department, charges shall be based on ~~the costs of providing the services~~ the appropriate current Medicare reimbursement levels. Where neither Medicaid nor Medicare reimburse for a service, the commissioner shall establish charges based on the costs of providing the medical care services. Charges for goods and services not directly provided by the Agency may be based on the agency's cost. Directors of health districts may request permission from the commissioner, or commissioner's designee, to round charges to a convenient value.

On selected occasions it may be desirable to provide certain medical services, e.g. influenza immunization, to large numbers of people quickly and conveniently and thereby promote their use by the public. In order to accomplish this, districts may charge a flat rate charge for these services under these circumstances. This provision includes services that are otherwise available at a discounted charge. No eligibility determination will be done and all service recipients will be charged the same flat rate charge. However, the district must also provide convenient alternative times and venues where applicants can request an eligibility determination and obtain these services at a discounted rate if eligible. The commissioner, or commissioner's designee, must approve such flat rate charge arrangements in advance, including approval of the specific flat rate charge.

12VAC5-200-100. Flat rate ~~fees~~ charges.

Except as otherwise set out in this chapter or Chapter 210, ~~Charges~~ charges for certain ~~health~~ goods and medical care services ~~that are not essential for public health protection~~ may be set at a flat rate charge not subject to discounting ~~except that there shall be no charge for individuals determined to be medically indigent~~. All flat rate ~~fees~~ charges must be expressly approved by the commissioner, or commissioner's designee, prior to their implementation.

12 VAC 5-200-105. Charges for services and goods provided by contract.

The department, health districts, and local health departments may enter into contracts with entities external to the department whereby the department, health district, or local health department provides medical services and goods. Charges for such services and goods will be determined by the contract. If a patient co-payment is required in the contract, the patient shall pay the full co-payment to the department, district, or local health department regardless of the patient's income status. The patient shall not be required to pay if state or federal law precludes a co-payment.

12 VAC 5-200-110. Income levels for charges.

The department shall annually publish specific income levels expressed in dollar amounts for determining eligibility for discounts to the charges for ~~health~~ medical care services.

The charges made to the applicant shall be subject to 100% discounting for those who are found to be medically indigent as defined in Part I.

Applicants for ~~health~~ medical care services, including those in Northern Virginia as defined in Part I, whose family income exceeds Income Level A shall be assessed a charge as follows:

1. Income Level A - 100% discount *of the established charge* for the service.
2. Income Level B - 90% discount of the established charge for the service.
3. Income Level C - 75% discount of the established charge for the service.
4. Income Level D - 50% discount of the established charge for the service.
5. Income Level E - 25% discount of the established charge for the service.
6. Income Level F - ~~No discount will be given.~~ 5% discount of the established charge for the service.
7. Income Level G - No discount will be given.

12VAC5-200-120. Automatic eligibility.

Applicants receiving the following public assistance programs will receive services as Income Level A patients without additional income verification.

General Relief

Title XIX - Medicaid

National School Lunch Program for children receiving school meals at no cost. Only used for child dental services.

Applicants who are eligible for services under this section, and are not participating in Medicaid or any other children's medical insurance program sponsored by the state, should apply for these programs. Applicants who do not apply for Medicaid or a

children's medical insurance program within 60 days of receiving services may be assessed the undiscounted charge for the medical care and related goods and services provided.

12 VAC 5-200-130. Explanation of charges.

Prior to services being rendered, an explanation of the estimated charges, applicable discounts, and expected payment shall be provided to the applicant.

12 VAC 5-200-140. Redetermination of eligibility.

Eligibility to receive discounts from established charges must be redetermined at least every 12 months, or when income or family status changes, unless otherwise ~~dictated~~ required by law or regulation.

## Part IV

## Nonchargeable Services

12 VAC 5-200-150. Services provided at no charge to the patient.

The following services are provided at no charge:

1. Those immunizations for children as required by §32.1-46 of the Code of Virginia, and of persons up to the age of 21 when the person lacks evidence of complete and appropriate immunizations for the diseases covered by that section of the Code of Virginia.
2. Examination and testing of persons suspected of having or known to have tuberculosis as required by §32.1-50 of the Code of Virginia.

3. Examination, testing and treatment of persons for venereal disease as required by §32.1-57 of the Code of Virginia.
4. Anonymous or confidential testing for human immunodeficiency virus as required by §32.1-55.1 of the Code of Virginia.

12VAC5-200-160. Immunization services.

The department may provide immunization services free of charge to ~~all~~ appropriate individuals in the event of an epidemic or when declared necessary by the commissioner or district health director to protect the public health of ~~all~~ citizens of the Commonwealth.

12VAC5-200-170. Other health care services.

The department may elect to provide other ~~health care~~ medical services at no charge to ~~all~~ appropriate citizens of the Commonwealth when directed by the board ~~or~~, the commissioner or a district health director.

Part V

Exceptions

12VAC5-200-180. Exceptions.

A continuing exception to the above ~~standard principles~~ regulations for assessing charges for ~~health~~ medical care services will exist for patients determined to be eligible for services provided under those programs of the department specified in the Code of Virginia or published in separate state plans.

12VAC5-200-190. Limitations

A. The district director ~~or program director~~ can limit the provision of ~~certain health~~ medical care services based on an assessment of public need and available department resources.

B. The district director ~~or program director~~ may establish policies to limit the provision of ~~certain health~~ medical care services provided by the department based on legal residence and visa status except where federal funds are appropriated for the service.

12VAC5-200-200. [Reserved]

~~12VAC5-200-210. Changes.~~

~~The district director, with department approval, may establish appropriate charges for services that are provided in the district and for which no statewide charges are identified.~~

Part VI

Waiver of Charges

12VAC5-200-220. General.

In instances when patients have ~~unusually serious health problems or extraordinary~~ financial hardships ~~are demonstrated to exist~~, and there are no other avenues of care, the patient, guardian or other authorized person may request a waiver of charges for up to ~~90~~ 180 calendar days. A waiver shall be requested in writing to the ~~program or~~ district director. If a waiver is granted, it shall be for the duration of the financial hardship or 180 days, whichever is shorter.

If the waiver request is approved, the patient will receive a full discount for all ~~services charged to him~~ charges while covered by the waiver. If the waiver request is denied, the charges will continue as before.

12 VAC 5-200-230. Waivers

A. The ~~Commissioner of Health~~ commissioner is ~~designated to act for the Board of Health~~ authorized to grant or deny requested waivers and may delegate ~~the~~ this authority to the ~~program or~~ district directors ~~who may then designate the authority to individuals under their supervision to grant or deny the waiver~~. A waiver to all or a portion of a charge may be granted for reasons of unusually serious health problems or extraordinary financial hardship. A resulting waived or partially-waived charge shall be determined by the commissioner or designee, and reviewed and revised as needed. The commissioner or designee shall also identify those expenses which are considered to be medical bills, and shall review and revise this determination as needed.

B. In the event of an adverse decision, the patient, guardian or other authorized person will be advised of their rights to appeal under Part VII.

C. Waivers will not be continued past ~~90~~ *180* days. Additional waivers ~~can~~ may be granted, but the applicant ~~will have to~~ must reapply at least every ~~90~~ 180 days.

D. No person believed to be eligible for Medicaid or any state-sponsored children's medical insurance program, and ~~having failed to complete a Medicaid~~

~~application~~ who has failed to complete an application for these programs will be eligible for a waiver.

Part VII

Appeal Process

12 VAC 5-200-270. Rights.

If an applicant for or recipient of ~~health~~ medical care services as defined in these regulations is denied such services, has services terminated, wishes to contest the determined income level, or is denied a waiver as defined in Part VI of these regulations, the applicant/recipient is entitled to appeal that action as set forth under this part. There are no further rights of appeal except as set forth in this part.

A. The applicant/recipient has the right to be informed in writing of the appeal process, including time limits, and the right to receive a written statement of the reasons for denial. If a person already receiving services is denied those services, a written notice of termination shall be given 30 days in advance of discontinuing services. The person has the right to confront any witnesses who may have testified against him.

B. An individual or his representative may make a written or oral appeal to the district ~~or program~~ director within 30 days of the denial of service.

C. Upon receipt of the appeal, the district director shall review and make written recommendations to the ~~operations director and~~ commissioner, or commissioner's designee, within 15 days. ~~The operations director shall submit~~

~~his recommendations to the commissioner within 15 days of the receipt of the district director's recommendations.~~ Within 45 days following the date on which an appeal is filed, the commissioner, or commissioner's designee, shall make a final decision.

~~D. Upon receipt of the appeal, the program director shall review and make written recommendations to the deputy commissioner and the commissioner within 15 days. The deputy commissioner shall submit his recommendations to the commissioner within 15 days of the receipt of the program director's recommendation. Within 45 days following the date on which an appeal is filed, the commissioner shall make a final decision.~~

E. Services to applicants/recipients shall continue during the appeal process.

Part VIII

Fraud

12VAC5-200-280. Fraud.

If the district director ~~or program director~~ identifies a patient willfully misrepresenting himself, or withholding or falsifying information in an attempt to obtain ~~health~~ medical services free or at a reduced rate, the director may discontinue services to the affected person 30 days after notifying the person that services will be discontinued. Such recipient is entitled to the appeal process set forth in Part VII of this chapter.

Part IX

Charges by Income Levels

12VAC5-200-290. Charges and payment requirements. This chapter shall be administered by the commissioner. The commissioner shall establish a procedure for the ongoing development, maintenance, revision and updating and promulgation of the charges and payments schedules. There shall be two sets of schedules, one for Northern Virginia (as defined in 12 VAC5-200-10) and one for the remainder of the Commonwealth.

Pursuant to this chapter, promulgated by the Board of Health in accordance with §§32.1-11 and 32.1-12 of the Code of Virginia, the charges for medical care services, stating the minimum required payments to be made by patients or other responsible persons toward their charges according to income levels, are available to the public for inspection and copying at the headquarters, district, and local health department offices of the department.

~~CHAPTER 210~~

~~CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS~~

~~12VAC5-210-10. Except for Northern Virginia~~.

~~CHART I.~~

~~By the provisions of the "Regulations Governing Eligibility Standards and Charges for Health Care Services to Individuals" (12VAC5-200-10 et seq.) promulgated by the authority of the Board of Health in accordance with §§32.1-11 of the code of Virginia,~~

~~listed below are the charges for medical care services, stating the minimum required payments to be made by patients toward their charges, according to income levels.~~

~~12VAC5-210-20. Charges and payment requirements for Northern Virginia.~~

~~CHART 2.~~

~~By the provisions of the "Regulations Governing Eligibility Standards and Charges for Health Care Services to Individuals" (12VAC5-200-10 et seq.) promulgated by the authority of the Board of Health in accordance with §32.1-12 of the Code of Virginia, listed below are the charges for medical care services, stating the minimum required payments to be made by patients toward their charges, according to income levels.~~