12VAC30-150-40. Eligibility criteria.

An individual is eligible to receive Uninsured Medical Catastrophe Funds for the period of time that he:

1. Is a citizen of the United States or a legally resident alien;

2. Is a resident of the Commonwealth (eligibility will end if the recipient is no longer a resident);

3. Has a gross income equal to or less than 300% of the federal nonfarm poverty income guidelines as published in the United States Code of Federal Regulations, 66 CFR 10695 (Feb. 16, 2001), updated each July 1;

4. Has a life-threatening illness or injury;

5. Is uninsured for the needed treatment on the date of application and is not eligible for coverage for the needed treatment through private insurance or federal, state, or local government medical assistance programs. If an individual becomes insured for the needed treatment after the date of application, the UMCF will only pay for services not otherwise covered by the existing insurance.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-150-50. Treatment plan.

A. Except as otherwise provided in this section, any medical services that are not experimental or investigational may be covered under a treatment plan.

B. Services provided for in the treatment plan must be for a course of treatment approved by DMAS to remediate, cure, or ameliorate the life-threatening illness or injury. The course of treatment proposed in the plan may not exceed 12 months.

C. The treatment plan should reflect the standard of practice for treating the life-threatening illness or injury given the applicant's health status at the time the treatment plan is approved. Treatment plans will not be approved for any illness or injury that is expected to be terminal even with the treatment.

D. DMAS may approve the treatment plan as submitted, modify the treatment plan, or deny the treatment plan. DMAS may review and revise treatment plan decisions based on additional information up until the time a contract is signed. A treatment plan may only be altered if, during the course of treatment approved, the medical condition of the person substantially changes and renders the original course of treatment no longer appropriate, as determined by the contracting health provider. If ~~Any~~ any alteration increases the established dollar amount, additional funds can be approved if available. Any alternation cannot exceed ~~either the established total dollar amount or~~ the one-year time frame from initial authorization.

E. The UMCF is not responsible for maintenance medications or additional treatments beyond the course of treatment approved by DMAS and contracted with a provider.

F. The UMCF will not commit funds or pay for services provided prior to the date the application is approved ~~contract is signed between DMAS and the contracting provider~~.

G. Covered services include specialized medical treatment, hospitalization, or both, to include the following to the extent they are part of the approved treatment plan:

1. Inpatient hospital services;

2. Outpatient hospital services and ambulatory surgical centers;

3. Ambulatory care;

4. Laboratory and x-ray services;

5. Physician's services and other ambulatory care;

6. Medical care furnished by licensed practitioners within the scope of their practice as defined by state law;

7. Prescribed drugs; and

8. Rehabilitative services to the extent necessary to recover from medical treatment.

H. Noncovered services include:

1. Transportation services;

2. Mental health services;

3. Nursing facility services;

4. Case management;

5. Hospice care;

6. Private duty nursing services;

7. Prosthetic devices;

8. Eyeglasses, dentures, hearing aids and other similar devices;

9. Alternative medicine therapies such as homeopathic remedies, hypnosis, or herbal remedies; and

10. Emergency services.

I. Only the following organ and tissue transplant procedures will be covered:

1. Kidney;

2. Liver;

3. Heart;

4. Lung; and

5. Bone marrow.

J. Patients receiving transplants must be acceptable for coverage and treatment by meeting the same selection criteria (except for the age limitation) outlined in 12VAC30-50-540, 12VAC30-50-560, and 12VAC30-50-570 of the Virginia Title XIX State Plan for Medical Assistance.

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_____	_____
Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Service

12VAC30-150-70. Contracts with providers.

A. It shall be the responsibility of the applicant to find a qualified provider willing to contract with DMAS under the terms in this section.

B. Reimbursement for covered services shall be a global fee based on existing Medicaid or Medicare rates (whichever is higher) or Medicaid reimbursement methodology to cover all services in the approved treatment plan. The global fee will cover: procurement costs for transplants; any hospital costs from admission to discharge; total physician costs for all physicians providing services during the course of treatment; and any other medical or drug costs associated with the treatment plan approved by DMAS.

C. A provider may agree to less than the full global fee as long as the provider agrees to complete the treatment plan with no additional payment by the applicant or on behalf of the applicant subject to subsection D of this section.

D. A provider may accept private funds raised on behalf of the applicant. The sum of private funds plus UMCF commitment may not exceed the global fee determined in subsection B of this section. Private funding must be fully disclosed in the contract, and the contract cannot be contingent on funds to be raised in the future. Private funds are not considered part of the applicant's income for purposes of determining eligibility. Private funds are not a factor in determining access to the UMCF or its waiting list.

E. A contract shall commit Uninsured Medical Catastrophe Funds to a course of treatment for up to one year from the date the contract is signed.

F. Reimbursement agreed to in the contract pursuant to this section shall constitute payment in full.

G. An application shall be denied if no provider is willing to sign a contract pursuant to this section within 30 days after the date all of the following are in place: a favorable determination of eligibility, approval of the treatment plan, and the availability of funds.

H. Facilities providing transplant procedures must be recognized as being capable of providing high quality care in the performance of the transplant by meeting the selection criteria outlined in 12VAC30-50-540, 12VAC30-50-560, and 12VAC30-50-570 under the Virginia Title XIX State Plan for Medical Assistance.

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_____ _____

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12VAC30-150-80. Payments.

A. Payments shall be made only to providers that have contracted with DMAS in accordance with 12VAC30-150-70. No payments shall be made directly to eligible individuals or applicants.

B. Payments are based on a global fee as provided for in 12VAC30-150-70. Payments may be made to more than one provider if it is determined that one global payment cannot be made due to a provider's limitation to disburse funds to other medical providers. An individual provider's payments shall be based upon that provider's component of the global fee. DMAS may establish a schedule of payments in the contract consistent with phases of the treatment plan. Payments will be made to contracting providers upon the completion of the treatment or phases of the treatment as specified in the contract.

C. Any committed funds not paid out by the fund within one year from the date of the contract will revert back to the UMCF and will be made available for other applicants. If a recipient dies during the contract period, the UMCF is responsible for payment of that

portion of the treatment plan that has been completed. The remainder of the committed funds revert back to the UMCF to be available for other applicants.

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Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Service

12VAC30-150-90. Application procedures and waiting list.

A. An application for assistance under the Uninsured Medical Catastrophe Fund must be on a form prescribed by DMAS and signed by the applicant. Funds will be committed on behalf of eligible individuals on a first-come, first-served basis based on the date and time the original signed application is received by DMAS or its agent.

B. Applicants must: (i) provide a statement signed by a physician licensed in the state in which he practices who has examined the individual certifying that the individual has a life-threatening illness or injury as defined in this regulation and (ii) submit a treatment plan developed by a potential contracting provider and signed by a physician licensed in the state in which he practices.

C. It is the responsibility of the applicant to provide financial and medical information necessary to determine eligibility and approve the treatment plan. Failure to complete the application, submit the items in subsection B of this section, or provide requested

information within ~~45~~ 30 days of the date of the original signed application is grounds for denial.

D. Eligibility for Uninsured Medical Catastrophe Funds and approval of the treatment plan shall be determined by DMAS within ~~60~~ 45 days of the date the original signed application was received. DMAS will not fully evaluate an application if it has determined that there is at least one cause for disqualification. DMAS shall advise in writing all applicants within ~~60~~ 45 days of its determination about their applications.

E. DMAS may establish a waiting list if funds are insufficient to make commitments for all applicants. Applicants will be placed on the waiting list in the order that the original signed application was received by DMAS or its agent. An applicant will be taken off the waiting list if (i) there is an adverse determination regarding eligibility and no expedited appeal has been requested, (ii) the treatment plan is denied, (iii) the applicant requests to be taken off the waiting list, or (iv) the applicant dies. An applicant who prevails on appeal or in circuit court will be restored to the waiting list based on the date of the original signed application, but this action does not affect any contracts signed in the interim.

F. If more than 60 days have elapsed between the date that DMAS initially determines an applicant eligible and approves the treatment plan and the date that funds become available, DMAS may review and revise the eligibility and treatment plan decisions. DMAS may require applicants to update the information provided in the original application.

G. An application may be denied if no provider is willing to contract with DMAS pursuant to 12VAC30-150-70 within 30 days of a favorable determination of eligibility, approval of the treatment plan, and the availability of funds.

H. DMAS may establish additional application procedures as necessary.

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_____	_____
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