Chapter 141.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN.

Part I.

GENERAL PROVISIONS.

12 VAC 30-141-10. Definitions.

"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; provided, however, that determination of eligibility to participate in and termination of participation in the Employer-sponsored health insurance coverage (ESHI) program shall not constitute an adverse action.

"Act" means the Social Security Act.

"Adult caretaker relative" or "caretaker relative" means an individual who is age 18 or older, who is not the parent of, but who is related to, the child by blood or marriage, and who lives with and assumes responsibility for day to day care of the child in a place of residence maintained as his or their own home.

"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 a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or 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.

"Applicant" means a child who has filed an application (or who has an application filed on his behalf) for child health insurance, who has been screened or determined to be ineligible for Medicaid and is awaiting a FAMIS eligibility determination. A child is an applicant until a 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.

"Board" or "BMAS" means that policy board created by the Code of Virginia § 32.1-324 to administer the plans established by the Social Security Act.

"CMSIP" means that original child health insurance program that preceded FAMIS.

"Central Processing Unit or CPU" means the private contractor 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.

"Child Health Insurance application" means the form or forms developed and approved by the Department of Medical Assistance Services that is used by local departments of social services and the FAMIS CPU for determining eligibility for Medicaid for poverty level children and for the Family Access to Medical Insurance Security Plan (FAMIS).

"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 a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"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 Services.

"Employer-sponsored health insurance coverage" or "ESHI" means comprehensive employer-sponsored health insurance offered by the employer when the employer contributes at least 40 percent towards the cost of dependent or family coverage, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS). 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.

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

"External Quality Review Organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS.

"Family" (when determining financial eligibility) means parents, including adoptive and step-parents, and their children under the age of 19, 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.

"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.

"Fee-for-service" means the traditional Medicaid health care delivery and payment system in which physicians and other providers receive a payment for each unit of service they provide.

“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.

“Guardian” means a person appointed by a court of competent jurisdiction, to be responsible for the affairs of an incapacitated individual, including responsibility for making decisions regarding the person’s support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

“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 student.

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

"Incapacitated individual" means person who, pursuant to an order of a court of competent jurisdiction, ahs been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of his or her health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for his or her support or for the support of his or her legal dependents without the assistance or protection of a conservator.

“LDSS” or “local department” means the local department of social services.

“Legally emancipated” 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.

"Managed care health insurance plan” or “MCHIP” as defined in § 32.1-137.1 means an arrangement for the delivery of health care in which a health carrier means under contract with DMAS for Title XXI delivery systems, undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains one or more incentive arrangements, including any credential

requirements intended to influence the cost of the health care services between the health carrier and one or more providers, with respect to the delivery of health care services, and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

“Member of a family,” for purposes of determining whether the child is eligible for coverage under a state employee health insurance plan, means a parent or parents, including 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.

"Primary care case management (PCCM)" means a system under which a physician, acting as a primary care case manager to furnishes case management services to FAMIS enrollees pursuant to a contract with DMAS.

“Primary Care Provider” or “PCP” means a physician enrolled in the PCCM program as a primary case manager.

"Provider" means the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP, a PCCM, or in fee-for-service to render services to FAMIS enrollees eligible for services.

"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, 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 MCHIPs, PCCMs, and through fee-for–service or through any other heath care delivery system deemed appropriate by the Commonwealth.

12 VAC 30-141-30. Outreach and public participation. DMAS will work cooperatively with other state agencies and contractors to ensure that federal law and any applicable federal regulations are met.

A. Pursuant to § 32.1-351.2 of the Code of Virginia, DMAS shall establish an Outreach Oversight Committee (the "Committee") to discuss strategies to improve outreach activities. The Committee members shall be selected by DMAS and shall be composed of representatives from community-based organizations engaged in outreach activities, advocates, social services eligibility workers, the provider community, health plans, other state agencies,

and consumers. The Committee shall meet on a quarterly basis. As may be appropriate, the Committee shall make recommendations regarding state-level outreach activities, the coordination of regional and local outreach activities, and procedures for streamlining and simplifying the application process, brochures, other printed materials, forms, and applicant correspondence.

B. The Board, in consultation with the Committee, shall develop a comprehensive, statewide community-based outreach plan to enroll children in the FAMIS program and, if so eligible, in Medicaid. The outreach plan shall include specific strategies for: (i) improving outreach and enrollment in those localities where enrollment is less than the statewide average, and (ii) enrolling uninsured children in either the FAMIS or Medicaid programs.

C. DMAS shall develop a comprehensive marketing and outreach effort. The marketing and outreach efforts will be aimed at promoting the FAMIS and Medicaid programs and increasing enrollment, and may include contracting with a public relations firm, coordination with other state agencies, coordination with the business community, and coordination with health care associations and providers.

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 MCHIP, local department of social services, CPU or DMAS.

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

C. Review of an adverse action made by the local department of social services, 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 MCHIP must be conducted by a person or agent of the MCHIP who has not been directly involved in the adverse action under review.

E. After final review by the MCHIP, there shall also be opportunity for final independent external review by the external quality review organization.

F. 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. There will be no opportunity for review based on which type of delivery system (i.e., fee-for-service, MCHIP) is assigned. There will be no opportunity for review if the sole basis for the adverse action is a state or federal provision requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

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

H. At no time shall the MCHIP's, local department's of social services, the CPU's, or DMAS' failure to meet the time frames set in this chapter or set in the MCHIP's or DMAS' written review procedures constitute a basis for granting the applicant or enrollee the relief sought.

I. 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 MCHIP, the local

department of social services, 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.

A. The local department of social services, the CPU, or DMAS shall send written notification to enrollees at least 10 calendar days prior to suspension or termination of enrollment.

B. The local department of social services, the CPU, DMAS or the MCHIP shall send written notification to applicants and enrollees of all other adverse actions within 10 calendar days of the adverse action.

C. 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 MCHIP adverse actions shall be submitted in writing to the MCHIP.

B. Requests for review of adverse actions made by the local department of social services, the CPU, or DMAS shall be submitted in writing to DMAS.

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

D. To be timely, requests for review of a MCHIP determination shall be received by the MCHIP no later than 30 calendar days from the date of the MCHIP's notice of adverse action.

E. To be timely, requests for review of a local department of social services, DMAS, or CPU determination shall be received by DMAS no later than 30 calendar days from the date of the CPU's, LDSS' or DMAS' notice of adverse action. Requests for review of a local department of social services, 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. At a minimum, the MCHIP review shall be conducted pursuant to written

procedures as defined in § 32.1-137.6 of the COV and as may be further defined by DMAS. Such procedures shall be subject to review and approval by DMAS.

B. The DMAS review shall be conducted pursuant to written procedures developed by DMAS.

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

D. Copies of the procedures shall be promptly mailed by the MCHIP or DMAS to applicants and enrollees upon receipt of timely requests for review. Such 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 MCHIP, local department of social services, DSS, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;

2. The right to timely review their files and other applicable information relevant to the review of the decision;

3. The right to fully participate in the review process, whether the review is conducted in person or in writing, including the presentation of supplemental information during the review process;

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

5. The right to a written final decision within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.

6. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90 calendar day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written final decision within 3 business days after DMAS receives, from the physician or health plan, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the applicant's or enrollee's life or health or ability to

attain, maintain or regain maximum function, unless the applicant or enrollee or his or her authorized representative causes a delay.

7. For health services matters for FAMIS enrollees receiving services through MCHIPs, if the enrollee's physician or health plan determines that the 90 calendar 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, a request for review shall result in a written decision by the external quality review organization within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

8. For health services matters for FAMIS enrollees receiving services through fee-for-service and PCCM, if the enrollee's physician or health plan determines that the 90 calendar day timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for

review shall result in a written decision within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

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:

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 non-citizens,

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

6. Not be a member of a family eligible for subsidized dependent coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency,

7. Not be a member of a family eligible for health benefits coverage on the basis of a family member's employment with an agency that participates in the Local Choice program where the employer contributes to the cost of dependent health insurance,

8. 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 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. 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 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 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.

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 30-40-10 3b and 3c 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 child health insurance shall include an inquiry about health insurance the child currently has or had within the past six months. If the child had health insurance that ended in the past six months, inquiry as to why the health insurance ended is made. Each re-determination of eligibility shall also document inquiry about current health insurance or health insurance the child had 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 child, 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 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 within the six 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 step-parent, e.g., the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc.

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

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

12 VAC 30-141-110. Duration of eligibility.

A. 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 meets all eligibility requirements. The parent, adult relative caretaker, 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 30-141-120. 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;

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 child's parent or other authorized representative does not meet the requirements of assignment of rights to benefits or requirements of cooperation with the agency in identifying and providing information to assist the Commonwealth in pursuing any liable third party, the child shall be ineligible for FAMIS.

C. If a child, if age 18, or if under age 18, a parent, adult relative caretaker, 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 child, if age 18, or if under age 18, the parent, adult relative caretaker, 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 30-141-130. 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 30-141-140. 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 30-141-150. 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. Co-payment amounts required; and

4. The rights and responsibilities of applicants and enrollees.

B. Opportunity to apply. DMAS or its designee must afford an individual, wishing to do so, the opportunity to apply for child health insurance. Child Health Insurance applications will be accepted at a central site designated by DMAS and at local departments of social services throughout the Commonwealth. Applicants may file an application for child health insurance by mail, by fax, or in person at local departments of social services. Applications filed at the FAMIS CPU can be submitted by mail, by fax or by phone. Face-to-face interviews for the program are not required. Eligibility determinations for FAMIS shall occur at either local departments of social services or 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 Child Health Insurance 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 State approved application forms submitted, even if another person fills out the form, unless the application is filed and signed by the applicant's parent, adult relative caretaker, legal guardian or conservator, attorney-in-fact or authorized representative or adult relative caretaker.

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 Child Health Insurance application on his behalf. If a competent individual wants another person to file a Child Health Insurance 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 Child Health Insurance application or until the

applicant changes his authorized representative. If the Child Health Insurance application is approved, the authorized representative statement is valid for any subsequent review and re-determination until the applicant's eligibility is cancelled. If the applicant reapplies for child health insurance, 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 Child Health Insurance 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 child health insurance 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 Child Health Insurance 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 Child Health Insurance 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 relative caretaker with whom the child lives or 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, adult relative caretaker, guardian or legal custodian may designate an authorized

representative to complete a Child Health Insurance 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 adult relative caretaker, 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 Child Health Insurance 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 Child Health Insurance 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 child’s 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 child health insurance application 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 Child Health Insurance 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, 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 FAMIS payments shall not sign a Child Health Insurance application on behalf of an individual who cannot designate an authorized representative.

I. Written application. DMAS or its designee shall require a written application from the applicant if he is at least 18 years of age or older, or from a parent, adult relative caretaker, 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 form prescribed by DMAS, and must be signed under a penalty of perjury. The application form shall contain information sufficient to determine Medicaid and FAMIS eligibility.

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. The time processing standards for determining eligibility for child health insurance begin with the date a signed application is received either at a local department of social services or the FAMIS CPU. Child Health Insurance applications received at local departments of social services must have a full Medicaid eligibility determination and, when a child is determined to be ineligible for Medicaid due to excess income, a FAMIS eligibility determination performed, within Medicaid case processing time standards.

Except in cases of unusual circumstances as described below, Child Health Insurance applications received at the FAMIS CPU and screened as ineligible for Medicaid, shall have a FAMIS eligibility determination completed within 10 business days of the date the complete application was received at the

CPU. Applications that are screened as Medicaid likely will be processed within Medicaid case processing time standards.

1. Unusual circumstances include: administrative or other emergency beyond the agency's control. In such case, DMAS, or its designee, or the LDSS must document, in the applicant's case record, the reasons for delay. DMAS or its designee or the local department of social services 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', its designee's or the local department of social services' decision concerning eligibility. DMAS, its designee or the local department of social services 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 the adverse actions.

M. Case documentation. DMAS, its designee or the local department of social services 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. Case maintenance. All cases approved for FAMIS shall be maintained at the FAMIS CPU. Children determined by local departments of social services to be eligible for FAMIS shall have their cases transferred to the FAMIS CPU for ongoing case maintenance. The FAMIS CPU will be responsible for providing newly enrolled recipients with program information, benefits available, how to secure services under the program, a FAMIS handbook, and for processing changes in eligibility and annual renewals within established time frames.

O. Re-determination of eligibility. DMAS or the FAMIS CPU must re-determine the eligibility of enrollees with respect to circumstances that may change at least every 12 months. Enrollees must make timely and accurate reports of all changes in circumstances that may affect their eligibility. DMAS or the FAMIS CPU must promptly re-determine eligibility when it receives information about changes in a FAMIS enrollee's circumstances that may affect eligibility. If the FAMIS CPU has information about anticipated changes in a FAMIS enrollee's circumstances, it must re-determine eligibility at the appropriate time based on those changes.

P. Notice of decision concerning eligibility. DMAS or the FAMIS CPU must give enrollees timely notice of proposed action to terminate their eligibility under FAMIS. The notice must meet the requirements of 42 CFR §457.1180.

12 VAC 30-151 through 12 VAC 30-141-158. Reserved.

PART IV.

COST SHARING.

12 VAC 30-141-160. Co-payments for families not participating in employer-sponsored health insurance (ESHI).

A. Co-payments. Co-payments shall apply to all enrollees in an MCHIP (above and below 150 percent of the Federal Poverty Level (FPL) Income Guidelines, as published by the U. S. Department of Health and Human Services in the *Federal Register*).

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

1. Total cost sharing for each 12-month eligibility period shall be limited to: (a) for families with gross incomes equal to or less than 150

percent of FPL, the lesser of (i) $180.00 and (ii) two and one-half percent of the family's income for the year (or 12-month eligibility period); and (b) for families with incomes greater than 150 percent of FPL, the lesser of $350.00 and (ii) five percent of the family's income for the year (or 12-month eligibility period).

2. The Commonwealth shall ensure that the annual aggregate cost sharing for all FAMIS enrollees in a family does not exceed the aforementioned caps.

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. Once the cap is met, DMAS or its designee will issue a new eligibility card excluding such families from paying additional co-pays.

C. Exceptions to the above cost-sharing provisions:

1. Co-payments shall not be required for well-child, well baby services, and for 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;

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

d. Other preventive services as defined by the Department.

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.

12 VAC 30-141-161 through 12 VAC 30-141-169. Reserved.

12VAC 30-141-170. 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.

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 all of 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. AND

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 Commonwealth.

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 ESHI:

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 enrollees.

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-sponsored coverage for family members will be identified through the Child Health Insurance 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, within 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. . To the extent readily determinable by DMAS from the employer's plan documents, the portion of the premium associated with covering the FAMIS child only under the employer's plan will be used in determining the cost-effectiveness. If DMAS is not able to fully isolate the cost of covering only the FAMIS child, premium assistance may result in the coverage of an adult or other relative/dependant; however, this coverage shall be solely incidental to covering the FAMIS child. The cost-effectiveness determination will be conducted for individual families on a case-by-case basis.

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

(a) The sum of the premium assistance amount, plus the cost of supplemental coverage, plus the administrative cost; and,

(b) The cost of covering the FAMIS child or children under FAMIS. The cost will be determined by using the capitated

payment rate paid to MCHIPs, or an average cost amount developed by DMAS.

2. If (a) is less than or equal to (b), 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 receive coverage under FAMIS 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's coverage to the ESHI component will be coordinated between DMAS and the CPU 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 as long as the proper timing and procedures established by DMAS are followed to ensure continued health 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. Payment of premium assistance shall end:

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

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

3. The last day of the month in which the family notifies DMAS that they wish to dis-enroll their child or children from the ESHI component; OR

4. The last day of the month in which adequate notice period expires (consistent with federal requirements) when 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 under the ESHI component refuses to bill DMAS for the co-payment amount, DMAS will reimburse the enrollee directly.

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

2. ESHI families will pay deductibles, coinsurance, and enrollment fee amounts under their employers' plans up to the cost-sharing caps allowed for non-ESHI FAMIS families ($180 annually for those equal to or less than 150 percent FPL and $350 annually 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 cost-sharing 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.

12 VAC 30-141-180. Liability for excess benefits; liability for excess benefits or payments obtained without intent; recovery of FAMIS payments.

A. Any person who, without the 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 enrollee 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 DMAS.

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

12VAC 30-141-181 through 12 VAC 30-141-199. Reserved.

Part V.

BENEFITS AND REIMBURSEMENT.

12 VAC 30-141-200.

A. The Commonwealth's Title XXI State Plan utilizes two benefit packages within FAMIS as set forth in the FAMIS State Plan, as many be amended from time to time. One package is a modified Medicaid look-alike component offered through a fee-for-service program and a Primary Care Case Management (PCCM) program; the other package is modeled after the state employee health plan and delivered by contracted MCHIPs.

B. The Medicaid look-alike Plan is also used as a benchmark for the ESHI of FAMIS.

12 VAC 30-141-241 through 12 VAC 30-141-449. Reserved.

12 VAC 30-141-500. Benefits reimbursement. Reimbursement for the services covered under FAMIS fee-for-service and PCCM and MCHIPs 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, and hospice services shall be based on the Title XIX rates in effect as of July 1 of each year for the subsequent state fiscal year.

B. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

C. 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 other than by free standing psychiatric hospitals 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 outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages 6-18. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for prescription drugs will be based on the Title XIX rates in effect as of July 1 each year for the subsequent state fiscal year. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

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 for the following either as administered by DMAS or as determined by contract with DMAS: access to, well-child health services, immunizations, provider network adequacy, a system to provide enrollees urgent care and emergency services, systems for

complaints, grievances and reviews, a data management system and quality improvement programs and activities.

B. Each MCHIP shall meet requirements determined by the contract for the internal and external quality monitoring and reporting of access to services, timeliness of services, and appropriateness of services, as determined by DMAS.

12 VAC 30-141-570. Utilization control.

A. Each MCHIP shall implement a utilization review system as determined by contract with DMAS, or administered by DMAS.

B. For both the fee-for-service and PCCM programs, DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance.

C. DMAS may collect and review comprehensive 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., of the COV, the recipient audit unit shall investigate allegations of acts of fraud or abuse, committed by persons enrolled in the FAMIS program or the parent, adult caretaker relative, guardian, legal custodian or authorized representative on behalf of a person or persons enrolled in the FAMIS program, which result in misspent funds.

B. Any FAMIS enrollee, parent, adult caretaker relative, guardian, legal custodian or authorized representative of a FAMIS enrollee who, on the behalf of others, attempts to obtain benefits to which the enrollee 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 fraud or abuse has been committed, 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 enrollees who received benefits through managed care.

E. Access to FAMIS enrollees' records by authorized DMAS representatives shall be permitted upon request.

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

12 VAC 30-141-650. Provider review.

A. The 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 shall 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 shall be permitted upon request.

D. Providers shall be required to refund payments made by DMAS if they are found to have billed DMAS contrary to policy, failed to maintain records 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 2.2-4000 et seq. of the Code of Virginia) and the Virginia Administrative Code sections12 VAC 30-10-1000 and 12 VAC 30-50-500 through 12 VAC 30-50-560

F. MCHIPs shall be responsible for keeping provider profile and utilization mechanisms to monitor provider activities. MCHIPs shall be reviewed by DMAS.

12 VAC 30-141-700. Assignment to Managed Care.

A. All eligible enrollees shall be assigned in managed care through the Department or the central processing unit (CPU) under contract to DMAS. FAMIS recipients, during the pre-assignment period to a PCP or MCHIP, shall receive Title XXI benefits via fee-for-service utilizing a FAMIS card issued by DMAS. After assignment to a PCP or MCHIP, benefits and the delivery of benefits shall be administered specific to the type of managed care program in which the recipient is enrolled.

1. MCHIPs shall be offered to enrollees in certain areas.

2. In areas with one contracted MCHIP, all enrollees shall be assigned to that contracted MCHIP.

3. In areas with multiple contracted MCHIPs or in PCCM areas without contracted MCHIPs, enrollees shall be assigned through a random system algorithm; provided however, all children within the same family shall be assigned to the same MCHIP or primary care provider (PCP), as is applicable.

4. In areas without contracted MCHIPs, enrollees shall be assigned to the Primary Care Case Management Program (PCCM) or into the fee-for-service component.

5. Enrolled individuals residing in PCCM areas without contracted MCHIPs or in areas with multiple MCHIPs, will receive a letter indicating that they may select one of the contracted MCHIPs or primary care provider (PCP) in the PCCM program, in each case, which serve such area. Enrollees who do not select an MCHIP/PCP as described above, shall be assigned to an MCHIP/PCP as described in A.3 above.

6. Individuals assigned to an MCHIP or a PCCM who lose and then regain eligibility for FAMIS within 60 days will be re-assigned to their previous MCHIP or PCP.

B. Following their initial assignment to a MCHIP/PCP, those enrollees shall be restricted to that MCHIP/PCP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request re-assignment for any reason from that MCHIP/PCP to another MCHIP/PCP serving that geographic area. Such re-assignment shall be effective no later than the first day of the second month after the month in which the enrollee requests re-assignment.

2. Re-assignment is available only in areas with the PCCM program or where multiple MCHIPs exist. . If multiple MCHIPs exist, enrollees may only request re-assignment to another MCHIP serving that geographic area. In PCCM areas, an enrollee may only request re-assignment to another PCP serving that geographic area.

3. After the first 90 calendar days of the assignment period, the enrollee may only be re-assigned from one MCHIP/PCP to another MCHIP/PCP upon determination by DMAS that good cause exists pursuant to subsection C of this section.

C. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must be made in writing to DMAS and cite the reasons why the enrollee wishes to be re-assigned. The Department shall establish procedures for good cause re-assignment through written policy directives.

2. DMAS shall determine whether good cause exists for re-assignment.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

_____ _____

Date

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