Virginia Regulatory Town Hall

Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services
VAC Chapter Number:	12 VAC 30 Chapter 141
Regulation Title:	Family Access to Medical Insurance Security Plan
Action Title:	FAMIS
Date:	5/22/2003; **GOV APPROVAL NEEDED BY JUNE 10TH**

Please refer to the Administrative Process Act (§ 9-6.14:9.1 et seq. of the Code of Virginia), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the Virginia Register Form, Style and Procedure Manual for more information and other materials required to be submitted in the final regulatory action package.

Summary

Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.

The purpose of this proposed regulation is to promulgate new permanent regulations to implement changes in the FAMIS program. These regulations incorporate the many programmatic changes set forth in the emergency regulations promulgated by the agency which became effective on September 1, 2002, while also revising certain of the regulatory provisions set forth therein for purposes of clarity, completeness, and to conform these regulations with other applicable laws and regulations, including: clarifying changes; conforming the definitions and regulations, concerning who is authorized to sign an applications to the agency's Medicaid regulations as there is now a single application; revising the appeals to conform with federal regulatory requirements and programmatic changes; and setting forth the managed care enrollment process.

In addition, clarifications and revisions are made in these suggested final regulations in response to public comment and to incorporate programmatic changes mandated by the 2003 Virginia General Assembly. Changes resulting from legislative action include: a reduction in the waiting period when the child had previous insurance before being eligible for FAMIS; the establishment of a 12-month period of coverage unless the enrolled child is no longer a resident of Virginia or

has family income over 200% of the federal poverty level; the addition of specific community-based mental heath services as covered benefits, and; modifications to the level of required employer contribution in the employer-sponsored health insurance (ESHI) program.

Changes Made Since the Proposed Stage

Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.

VAC Section	Proposed	Final
Definitions **"Applicant"**	Defines an applicant as a child that has been screened for Medicaid and is awaiting a determination of FAMIS eligibility.	Clarifies that an applicant, as used in these regulations, refers to a child awaiting a determination of eligibility.
"Employer-sponsored health insurance coverage"	Defines employer-sponsored health insurance as comprehensive coverage offered by an employer where the employer contributes at least forty percent of the cost.	Removes the required forty percent employer contribution from the definition.
"Family"	Defines family for purposes of determining financial eligibility and clarifies that a child temporarily living outside the home is considered to be living with his parents.	Defines family in the same manner but removes the reference to determining financial eligibility and removes language about a child living outside the home.
"Gross family income"	Defines what types of income constitute gross family income.	Changes the definition to "family income".
"Group health plan" or "Health insurance coverage"	Definition cites 42 USC § 1397jj(c)(3).	Definition cites § 2791 of the Public Health Services Act (42 USC §300gg-91(a) and (b)(1).

12 VAC 30-141-30(B)	Specifies certain strategies to be included in the statewide comprehensive outreach plan.	Adds a required strategy for enrolling the children of former TANF recipients to the statewide comprehensive plan.
12 VAC 30-141-40 (B)	Provides that enrollees have the right to continuation of coverage during the review of an adverse action.	Clarifies that denial of a request for prior authorization of services does not constitute an adverse action of 'reduction, suspension, or termination of services'.
12 VAC 30-141-50 (B)	12 VAC 30-141-50 (A) requires a 10-day advance written notice for suspension or termination from the program.	New section (B) is added to also require 10-day advance written notice of the reduction, suspension, or termination of a previously authorized health service.
12 VAC 30-141-50(C)	Requires that advance written notice for suspension or termination include certain information.	Section (C) becomes (D) and clarifies that advance notice for reduction, suspension or termination of health services also require certain information.
12 VAC 30-141-100(D)(2)	Provides that eligibility determinations are based on a comparison of gross family income to 200 percent of the federal poverty level (FPL).	Provides that eligibility determinations are based on a comparison of countable income as defined in the State Plan for Title XXI to 200 percent of FPL.
12 VAC 30-141-100 (E)	Defines residency for the purposes of eligibility.	Regulation is amended to clarify that a child temporarily living away from home is considered to be living with his parent, custodian, legal guardian, or caretaker relative.
12 VAC 30-141-100(G)(2)(a)	Requires that a child is ineligible for FAMIS if he has been covered by a health insurance plan in the previous six months unless good cause is established.	Reduces the required waiting period from six months to four months.

12 VAC 30-141-100(G)(2)(c)(5)	Provides that a good cause exception to the six-month waiting period is established if someone other than a parent drops the prior insurance.	Clarifies that a good cause exception to the four-month waiting period is also established if an absent parent drops the prior insurance.
	Establishes the period of eligibility as 12 months so long as the child meets all eligibility criteria; requires enrollees to report all changes affecting eligibility; requires the change in eligibility be effective the first of the month following the 10-day advance notice; and requires that FAMIS eligibility be re-determined annually.	Establishes the period of eligibility as 12 months unless the child moves out of state or income exceeds 200 percent FPL; removes reporting requirements from this regulation and clarifies that an annual re-determination of eligibility will be based on all criteria specified in 12 VAC 30-141-100 (C).
	Provides that if the parent willfully misrepresents facts regarding a child who is otherwise ineligible for FAMIS, the child will be found ineligible and will be excluded from the program for a period of 12 months.	Removes the 12-month period of exclusion in such cases.
	Sets out procedures for who may serve as an authorized representative for an individual age 18 or older.	Clarifies that these procedures are the same as in Medicaid regulations.
	Sets out procedures for who may serve as an authorized representative for children under 18 years of age.	Adds clarification to the regulation that a child temporarily living away from home is considered to be living with his parent, custodian, legal guardian, or caretaker relative.
	Sets out requirements if no adult is the child applicant' s guardian, caretaker relative, or has legal custody.	Clarifies that these procedures are the same as in Medicaid regulations.

12 VAC 30-141-150(M)(ii)	Requires that the facts supporting eligibility or in-eligibility decisions be documented in the case file unless there is an entry that the applicant voluntarily withdrew, died, or cannot be located.	Removes the reference to a child who has died to clarify that a child who dies during the application process will have eligibility determined.
12 VAC 30-141-150(O)	Provides that DMAS must re-determine eligibility every 12 months; requires enrollees to report all changes in circumstances; requires DMAS to re-determine eligibility when such information is reported; and requires DMAS to re-determine eligibility at the appropriate time if there is information about anticipated changes.	Limits reporting requirements for enrollees to reports of a child who has moved out-of-state or income that exceeds 200% FPL; and removes language requiring a re-determination of eligibility based on anticipated changes.
12VAC 30-141-170(A)(3)	Provides that an eligibility criterion for participation in the employer-sponsored health insurance program (ESHI) is at least a forty percent contribution by the employer to the cost of the family plan.	Removes the required forty percent employer contribution and replaces it with a required employer contribution as defined in the State Plan for Title XXI.
12 VAC 30-141-170(D)(2)	Provides that families with access to employer-sponsored health insurance will be identified on the FAMIS application for the purpose of providing them with information about the ESHI program.	Removes language stating families will be identified by questions on the FAMIS application.
12 VAC 30-141-500(A)	Lists the health care services provided in FAMIS that are to be reimbursed based on the Title XIX rates. No regulation.	Adds school-based health services and certain community-based mental health services. Establishes a new provision re-

		quiring prior authorization for reimbursement of certain medical services

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended regulations for the Family Access to Medical Insurance Security Plan (12 VAC 30 Chapter 141) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

_____ _____

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Basis

Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

The *Code of Virginia* (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code also provides, in the Administrative Process Act (APA) §§ 2.2-4007 and 2.2-4013, for this agency's promulgation of proposed regulations subject to the Governor's review.

DMAS promulgated emergency regulations, effective September 1, 2002, that substantially revised the FAMIS program and published a Notice of Intended Regulatory Action on August 26, 2002. The comment period for the Notice of Intended Regulatory Action ended on September 25, 2002. The agency's proposed regulations were published in the February 10,

2003, *Virginia Register* (VR 19:11, 1584, 2/10/03) for their public comment period from February 10 through April 11, 2003.

Purpose

Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.

These regulations are essential to protect the health of the children who participate in the FAMIS program. These regulations establish the FAMIS program's eligibility criteria, the covered services and the limitations on the covered services, the cost sharing requirements that apply to eligible families, and establish provider participation requirements.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.

The regulations that are affected by this regulatory action are the Family Access to Medical Insurance Security (FAMIS) regulations (12 VAC 30-141).

The entire Chapter 141 was substantially revised to incorporate programmatic changes. Many of these changes were incorporated in the emergency regulations issued by the agency and effective September1, 2002. Changes to the proposed regulations have also resulted from public comment and legislation enacted by the 2003 Virginia General Assembly, which will be implemented August 1, 2003. A discussion of the changes follows.

DEFINITIONS.

The definitions have been revised, as is appropriate, for clarification purposes and to reflect other changes in the regulations. The definitions of "family" and "gross family income" are modified in response to public comment. This language and other changes to regulations allows DMAS to evaluate the impact of various income methodologies and their impact on families and to implement an equitable and appropriate methodology as delineated in the State Plan for Title XXI of the *Social Security Act*.

ADMINISTRATION and OUTREACH/PUBLIC PARTICIPATION. (12 VAC 30-141-20 and 30)

Reference to premiums (other than with respect to ESHI) has been removed from this section because the FAMIS program will no longer be charging premiums to enrollees or their families.

An additional strategy to enroll uninsured children of former TANF recipients is added to the statewide comprehensive outreach plan in 12 VAC 30-141-30(B) in response to public comment and to mirror language in the *Code*.

REVIEW OF ADVERSE ACTIONS (12 VAC 30-141-40, 50, 60, and 70).

These sections provide for the handling of reviews of adverse actions. In the current FAMIS program, these sections list the Managed Care Health Insurance Plans (MCHIPs), the Central Processing Unit, and DMAS as the entities that may take adverse actions and to which requests for review of such actions may be submitted. These sections also specify the timeframe for sending written notices of adverse action. The revised language adds local departments of social services to the list of entities that can take adverse actions and to which requests for review can be submitted. The revised language also provides for enrollees to have a timely review of their files and other applicable information, to fully participate in the review process, and to receive written final decisions within 90 calendar days unless the applicants/enrollees request or cause delays. Review procedures stipulate that an MCHIP's review policies and procedures must comply with the Commonwealth's MCHIP regulations and DMAS reviews and approves the procedures for adverse actions by MCHIPs for compliance therewith. This change is necessary to support standardized procedures for program enrollees in MCHIPs.

The requirement that DMAS and MCHIPs must also send advance written notice of a reduction or termination of a previously authorized health service is added and the same requirements as to the contents of notices of adverse actions are extended to these notices. This change is in response to public comment and is similar to requirements in Medicaid.

ELIGIBILITY DETERMINATION AND APPLICATION REQUIREMENTS. (12 VAC 30-141-100 through 150).

The following changes and clarifications have been made to facilitate the application and enrollment process for children's health insurance.

12 VAC 30-141-100. Eligibility requirements. This section has been revised to address the use of a single "Child Health Insurance Application" form that will be accepted by either the FAMIS Central Processing Unit or local departments of social services. Previously, separate application forms were required for FAMIS and for Medicaid, and only the FAMIS CPU was permitted to determine FAMIS eligibility. Under these new regulations, local departments of social services will also determine eligibility for the FAMIS program. When a child health insurance application is received by a local department of social services, the local agency will first determine the child's eligibility for Medicaid and if the child is determined Medicaid **in**eligible,

the local department of social services will proceed with a FAMIS eligibility determination and will enroll eligible children in FAMIS.

The good cause reasons for allowing a child to be enrolled in FAMIS when child health insurance has been discontinued in the six-month period prior to the application month have been added. One of the good cause reasons addresses the discontinuance of insurance due to "affordability." Good cause reasons for discontinuing health insurance previously were not included in the regulations.

By action of the 2003 General Assembly, the required six month waiting period since the child had prior insurance before being eligible for FAMIS is further reduced to a four-month waiting period. A corresponding amendment to the State Plan will be submitted to CMS for approval.

12 VAC 30-141-100(D)(2) is also revised to allow DMAS to establish a new methodology of "countable income" in the State Plan for Title XXI as determined appropriate by DMAS and as approved by the Centers for Medicare & Medicaid Services.

Duration of eligibility. Technical changes have been made to this section to include an adult relative caretaker among the persons who may be responsible for reporting changes that affect a child's eligibility.

Substantive changes are also made to 12 VAC 30-141-110(B) to require that children remain eligible for FAMIS during the 12-month period of eligibility unless the child moves out of the Commonwealth or if the family's income exceeds 200 percent FPL. This change is mandated by the 2003 Virginia General Assembly. A corresponding amendment will be submitted to CMS for approval.

12 VAC 30-141-120. Children ineligible for FAMIS. A previous provision, which prohibited children from participation in FAMIS when their absent parent was eligible for coverage under the State Employee Health Insurance Plan, has been eliminated. As modified, this regulation does not include absent parents in the child's family unit and information on the absent parent's employment status is not collected on the new application form. Technical changes have also been made to this section to permit the adult relative caretaker to file an application on behalf of a child under age 18.

In response to public comment, 12 VAC 30-141-120(C) is changed to eliminate the 12-month period of ineligibility imposed on a child whose parent or authorized representative willfully misrepresents information on the application.

12 VAC 30-141-150. Application requirements. This section has been revised to (i) allow Child Health Insurance applications to be accepted at the FAMIS CPU and at local departments of social services, (ii) allow eligibility determinations for FAMIS to occur at either local departments of social services or at the FAMIS CPU, (iii) allow an adult relative caretaker to sign an application on behalf of a child, (iv) specify the time standards for processing applications received at local departments of social services and the FAMIS CPU, and (v) require that all FAMIS cases be maintained at the FAMIS CPU.

Medicaid Expansion of Eligibility to 133% of the Federal Poverty Level (FPL). The 2002 *Acts of Assembly* (Chapter 899, Item 324 D), increased the income limits for children ages six through 18 from 100% to 133% of the Federal Poverty Level (FPL). DMAS addressed this provision in its modification to 12 VAC 30-40-280 which was submitted to the Registrar of Regulations for publication at VR 18:23, page 3099 (July 29, 2002).

12 VAC 30-141-150 (O) is further amended to limit enrollee reporting requirements during the 12-month period of eligibility to reports of a child no longer residing in Virginia or who has income that exceeds 200 percent FPL. This change is necessary to comply with the establishment of 12-months of continuous coverage in FAMIS by the 2003 Virginia General Assembly.

COST SHARING and EMPLOYER-SPONSORED HEALTH INSURANCE. (12 VAC 30-141-160 and 170)

One of the DMAS goals is to enroll all eligible children in Virginia in the FAMIS and Medicaid programs so that all eligible children in Virginia will have health care coverage. It was determined that premiums constituted a hardship for FAMIS families and was serving as a barrier to children enrolling in the program. When the premiums were removed for FAMIS families, they were also removed for ESHI participants to ensure consistency across the program.

This section has been revised to eliminate the provision that required families with incomes above 150% of the Federal Poverty Level (FPL) to pay monthly premiums. In addition, because monthly premium payments will no longer be required, the provisions regarding disenrollment for failing to pay premiums has also been removed.

12 VAC 30-141-170. Employer-Sponsored Health Insurance (ESHI). This section has been revised to eliminate the provision that required ESHI families with incomes above 150% of the FPL to pay monthly FAMIS premiums. Previously, DMAS took into account any monthly premium the family would have paid had they not opted to participate in the ESHI component, and this amount was subtracted from the premium assistance which DMAS paid to the family to enable the family to enroll in their employer's plan. Because the elimination of these FAMIS premiums requires a change in the formula used to calculate the cost-effectiveness of ESHI, this part of the regulations has been revised as well.

Further, changes are made to remove the required forty percent employer contribution for eligible ESHI applicants to conform to the applicable *Code* section amended by the 2003 Virginia General Assembly. Language is also eliminated requiring identification of potential ESHI participants through questions on the FAMIS application as this mechanism has proven to not be cost effective or productive. Currently, DMAS is developing improved strategies for promotion of the ESHI program.

BENEFITS AND REIMBURSEMENT. (12 VAC 30-141-200 through 500)

12VAC 30-141-200. This section establishes two benefit packages for FAMIS children. The first, based on the state employee plan under Title XXI, is available in areas where there are

contracted Managed Care Health Insurance Plans (MCHIPs). The second benefit package, based on modified Title XIX benefits, is available to primary care case management (PCCM) and fee-for-service enrollees. This section also states that FAMIS children not in an MCHIP area will be enrolled in the FAMIS PCCM or fee-for-service program and will receive modified Title XIX look-alike benefits. This change is needed to clarify which benefits and delivery system will be provided in areas without MCHIPs.

12 VAC 30-141-500(A) is changed to include school-based health services and certain community-based mental health services in the list of services to be reimbursed based on Title XIX rates. This change recognizes that FAMIS fee-for-service covers school based health services and, as a result of 2003 General Assembly action, now covers certain community based mental health services.

A new provision, 12VAC 30-141-500(C), is established to require prior authorization for reimbursement of certain medical services as mandated by the General Assembly.

QUALITY ASSURANCE AND UTILIZATION CONTROL. (12 VAC 30-141-560 through 650)

This section establishes the legal liability for any adult who attempts to obtain benefits to which the enrollee is not entitled. Providers found to have billed DMAS inappropriately, have failed to maintain records and documentation of delivered services, or have billed DMAS for medically unnecessary services will be required to refund payments received. This section also establishes providers' right to appeal pursuant to the Administrative Process Act and the DMAS' provider appeals regulations.

Issues

Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions; 2) the advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please include a sentence to that effect.

These changes generally benefit the public by improving access to health insurance coverage to eligible children through discontinuing premiums; providing for a single Medicaid and FAMIS application; authorizing persons, other than a parent or guardian, to file an application for a child; and by expanding the staff determining the eligibility.

The expedited appeals processes outlined in 12 VAC 30-141-70 is expected to create a negative fiscal impact to both the Commonwealth and to localities, in the form of increased costs.

Public Comment

Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.

DMAS' proposed regulations were published in the February 10, 2003, *Virginia Register* (VR 19:11) for their comment period from February 10th through April 11th. Comments were received from The Virginia Poverty Law Center, the Child Health Insurance Program (CHIP/Roanoke), Community Health Advocacy of Bon Secours Health System, Radford University Outreach Project, and the Virginia Primary Care Association.

A summary of the comments received and the agency's response thereto follows:

12 VAC 30-141-10 Definitions:

The **Virginia Poverty Law Center (VPLC)** makes the following comments with regard to several different regulation definitions in this section:

"Adult caretaker relative" – Definition should include clause stating that children temporarily living outside home for educational/training purposes are considered to be living with caretaker relative.

Agency Response:
DMAS agrees clarification is needed that a child temporarily living away from the caretaker relative's home is considered to be living in the home. However, the clarifying language is added to 12 VAC 30-141-150(E) as this section defines residency for the purposes of eligibility.

"Adverse action" – Definition should not exclude actions concerning ESHI decisions.

Agency Response:
DMAS disagrees that the definition of adverse action should be changed, as there is no right to appeal an eligibility decision for a premium assistance program specified in Federal SCHIP regulations. Further, the Department has previously determined that an enrollee in Medicaid does not have the right to appeal the type of health care delivery system provided and DMAS believes the employer's health plan represents a type of health care delivery system and is therefore not subject to appeal. However, DMAS agrees that ESHI applicants should be afforded the opportunity for a review of the calculations used to determine eligibility for ESHI and will incorporate an internal review, at the applicant's request, into program policy.

"Applicant" – Definition should not exclude children ultimately found eligible for Medicaid.

Agency Response:
DMAS agrees that the definition of applicant, as used elsewhere in the regulations, refers to a child awaiting an eligibility determination for either Medicaid or FAMIS and the definition is revised.

"Comprehensive health insurance" – Definition should incorporate issue of adequate network of providers.

Agency Response:
DMAS agrees that if a child has current or prior health insurance with no network of providers where they reside they are not ineligible for FAMIS on that basis. However, the clarification is incorporated in 12 VAC 30-141-100 (G)(2)(a) regarding eligibility requirements and existing health insurance coverage.

"Creditable health coverage" – Definitions should not include this phrase because it is not found in the regulations.

Agency Response:
The term "Creditable health insurance is no longer used in the regulations and is therefore struck.

"Employer-sponsored health insurance coverage" – Definitions should be amended to reflect 2003 legislation.

Agency Response:
The definition of Employer-sponsored health insurance coverage is changed to reflect the actions of the 2003 Virginia General Assembly by eliminating reference to a required 40% employer contribution.

"Family" (when determining financial eligibility) –

(i) **VPLC** felt that since this policy was inconsistent with Title XIX policy, it would create confusion and complications for families and the staff who determine eligibility;

(ii) **VPLC** believes this policy results in children being found ineligible for FAMIS when their countable income is only slightly higher than Medicaid levels. Their point regarding this issue is that such a policy contradicts the basic purpose of FAMIS;

(iii) **VPLC** believes this policy is contrary to welfare reform efforts; and

(iv) **VPLC** believes this policy deters marriage or re-marriage.

VPLC suggests that stepparent income should be "disregarded when counting it results in a FAMIS denial." VPLC also offered the alternative policy of permitting small changes in income, much like the transitional benefits currently available to § 1931 Medicaid children or the

grandfather provisions in place for former CMSIP enrollees. The former Medicaid child's eligibility would continue until the biological/custodial parent's income exceeds 200 percent of the Federal Poverty Income Guidelines.

Further comments on this issue were provided by **CHIP/Roanoke**, which also suggests that stepparent should be excluded. This position is shared by the **Bon Secours Community Health Advocacy**, which believes that exclusion of stepparent income encourages marriage and family stability. This same issue was referenced in comments received from the **Radford University Outreach Project** and the **Virginia Primary Care Association.**

Agency Response:
DMAS has been working to simplify and coordinate the Commonwealth's health insurance programs for children (Medicaid & FAMIS) and intends to evaluate the impact of the different income methodologies on all types of families. However, before implementing a change in eligibility requirements, DMAS must determine the appropriate methodology, evaluate the fiscal impact, and determine the potential impact on local departments of social services and operations of the FAMIS Central Processing Unit, including modification to existing automated eligibility systems. Changes are made to the definition of "family", "gross family income", and the eligibility regulations to allow DMAS to implement an equitable and appropriate income methodology as defined in the State Plan for Title XXI of the Social Security Act.

"Group health plan" or "Health insurance coverage" – This definition differs from the definition of these same terms set forth in 30-141-100(G)(1).

Agency Response:
The definition of group health plans is revised to use the same citation, § 2791 of the Public Health Services Act [42 USC §300gg-91(a) and (b)(1]), as is used elsewhere in the regulations.

"Incapacitated individual" – Definition should specify that it "means a person."

Agency Response:
DMAS agrees with the clarification.

"Managed health insurance plan" – Definition is confusing.

Agency Response:
DMAS agrees with the clarification.

12 VAC 30-141-20(C): **VPLC** suggests substituting "DMAS' for "the Commonwealth."

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-30(B): **VPLC** suggests including "the business community" in list for oversight committee.

Agency Response:
DMAS disagrees with this change. Representatives of the business community are not specifically referenced among the required membership in §32.1-351.2 COV, which establishes the Outreach Oversight Committee. While representatives of the business community are valuable members of the current committee, so too are representatives from other fields and professions not delineated in the Code or regulations.

12 VAC 30-141-30(C): **VPLC** suggests including the provisions regarding outreach to former welfare recipients found in Va. Code sec. 32.1-351.2(ii).

Agency Response:
DMAS agrees, as §32.1-351.2. COV specifically states the comprehensive, statewide, community-based outreach plan shall include specific strategies for "(ii) enrolling uninsured children of former Temporary Assistance to Needy Families (TANF) recipients." However, the change is more appropriately made to 12 VAC 30-141-30(B) of the regulations.

12 VAC 30-141-40(F): **VPLC** suggests changing "state for federal provision" to "state or federal law."

Agency Response:
The regulation is changed to read "state or federal law or regulation."

12 VAC 30-141-50(A): **VPLC** suggests sending advance notice of proposed action when services to a child are to be suspended/terminated.

Agency Response:
DMAS agrees, this change is consistent with 12 VAC 30-141-40 and with Medicaid regulations. A new section 12 VAC 30-141-40(B) is added.

12 VAC 30-141-50(C): **VPLC** believes Notice should include statement regarding circumstances that may permit continuation of services pending review.

Agency Response:
DMAS agrees.

12 VAC 30-141-100(C)(6): **VPLC** believes this section should refer to a definition of "subsidized dependent coverage" as set forth in 42 CFR sec. 457.310(c)(1)(ii).

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-100(C)(7): **VPLC** believes this section should use the same phrasing as subsection (C)(6).

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-100(C)(8): **VPLC** believes this section is more restrictive than 42 CFR § 457.310(c)(2)(ii), which excludes patients in mental institutions.

Agency Response:
DMAS believes the change is unnecessary as Virginia's FAMIS program, now guarantees 12 months of continuous eligibility unless the child is over age 19, moves out-of-state or has income over 200% FPL. Therefore, this eligibility criterion and others listed in this section of regulations will not impact eligibility except at initial application and at annual renewal of enrollment.

12 VAC 30-141-100(D)(2): **VPLC** believes this section should permit adjustment of "family size" for a pregnant girl applying for FAMIS to include unborn children.

Bon Secours Community Health Advocacy and the **Virginia Primary Care Association** agree with the position that family size for pregnant girls should include unborn children. Further comments on this issue were provided by **CHIP/Roanoke**, which suggests that income of parents should not be included.

Agency Response:
DMAS disagrees. Unlike FAMIS, Medicaid provides for a special category of eligibility for pregnant women. Medicaid policy M0520.603 as well as M0520.100 relate only to determining eligibility in the Medically Indigent (MI) or Medically Needy (MN) Pregnant Woman Covered Groups. M0520.100 #4, pg 5 of the Medicaid manual states: ". . . When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person." This rule also applies if eligibility for the pregnant child is being determined in the MI Poverty Level group of Children under Age 19.

Therefore, since FAMIS does not currently provide a special covered group for a pregnant child, her application is evaluated in accordance with eligibility rules for all children. In this way, FAMIS policy is consistent with current Medicaid policy.

12 VAC 30-141-100(G)(1): **VPLC** believes the definition of "group health plan or health insurance coverage" in this section differs from that found in 30-141-10.

Agency Response:
DMAS agrees. The definition of group health plan has been changed in the definition section of the regulations.

12 VAC 30-141-100(G)(2)(a): **VPLC** suggests that because 2003 General Assembly reduced the waiting period to four months, this section should reflect that change.

Agency Response:
The appropriate changes are made to 12 VAC 30-141-100(G)(2)(a).

12 VAC 30-141-100(G)(2)(c)(5): **VPLC** suggests that the waiting period should not apply if insurance terminated by an absent parent.

Agency Response:
DMAS agrees that discontinuation of insurance by a child's absent parent does not require a waiting period before the child is eligible to participate in FAMIS. This policy was implemented by DMAS on September 1, 2002.

12 VAC 30-141-110: **VPLC** suggests this section should incorporate the 12-month coverage period passed by 2003 General Assembly.

Agency Response:
The appropriate changes are made to 12 VAC 30-141-110.

12 VAC 30-141-120: **VPLC** suggests may be possible to merge this section with 30-141-100.

Bon Secours Community Health Advocacy believes this section should be deleted.

Agency Response:
DMAS disagrees. While some provisions are repeated, DMAS believes an explanation of which children are eligible for FAMIS (12 VAC 30-141-100) and an explanation of which children are ineligible for FAMIS (12 VAC 30-141-120) helps clarify eligibility.

12 VAC 30-141-120(C): **VPLC** opposes the twelve-month sanction because it believes this punishes the child instead of the parents. VPLC suggests pursuing civil/criminal sanctions against the parents while leaving the child's coverage intact.

Bon Secours Community Health Advocacy and the **Virginia Primary Care Association** expressed the same opposition to the sanction.

Agency Response:
DMAS agrees that the child should not be denied health care because of the actions of the parent or authorized representative. This change also reflects the policies governing Medicaid in such situations.

12 VAC 30-141-150(D): **VPLC** notes that this section refers to "adult relative caretaker" twice.

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-150(E)(4): **VPLC** suggests changing "application may be signed" to "application considered signed."

Agency Response:
The regulation has been changed to reference the similar regulation in Title XIX. Because there is now a joint application form for both programs, it is necessary to have the same provisions regarding who can sign an application on behalf of a child for both FAMIS and Medicaid.

12 VAC 30-141-150(F)(2): **VPLC** requests clarification as to whether term "foster care" includes all children in custody of public/private child placement agencies.

Agency Response:
The term "foster care" does not include all children in the custody of a public or private child-placing agency so the term is struck from the regulation.

12 VAC 30-141-150(K): **VPLC** notes there is no definition for the term "complete application" and requests clarification as to what eligibility information requires documentation.

Agency Response:
DMAS disagrees. The definition of a complete application will continue to be set out in DMAS policy. DMAS is continuing to simplify and streamline the application process to encourage enrollment and requires the flexibility to continue the streamlining process to administratively determine what documents or information are necessary to constitute a complete application. For example, as of September 1, 2002, DMAS determined that a copy of the child's birth certificate was no longer required as part of the Child Health Insurance application.

12 VAC 30-141-150(K)(2): **VPLC** suggests that notice to provide further eligibility information should be in writing.

Agency Response:
DMAS agrees that the applicant should receive written notice of further information needed to determine eligibility and this is provided for in the current regulation. DMAS does not agree that this written notice must allow 30 days for the applicant to respond. Although the FAMIS Central Processing Unit currently does afford applicants this amount of time, DMAS should maintain flexibility to alter such timeframes to improve overall program performance. The current regulation does require that the application may not be denied in less than 30 days to enable applicants to provide needed information.

12 VAC 30-141-150(L): **VPLC** suggests including a reference to 30-141-50.

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-150(M)(ii): **VPLC** suggests that this section be deleted.

Bon Secours Community Health Advocacy and the **Virginia Primary Care Association** believe this section should be deleted. Further comments were provided by **CHIP/Roanoke** regarding eligibility of children that die during the application process. **CHIP/Roanoke**

suggests that process should continue and cover pre-death expenses if child found otherwise eligible. **Bon Secours Community Health Advocacy** shares this opinion.

Agency Response:
Current DMAS policy requires that an eligibility determination be completed if a child dies during the application process. If the child is found eligible, coverage is provided from the first day of the month of application until the date of death, thus covering payment of medical bills. This regulation only addresses case record documentation and does not affect eligibility determinations. However, to clarify current policy, the language is struck from the regulation.

12 VAC 30-141-150(O): **VPLC** suggests this section should incorporate the 12-month coverage period passed by 2003 General Assembly.

Agency Response:
The regulation has been amended to incorporate appropriate changes.

12 VAC 30-141-160(A): **VPLC** suggests eliminating all language following "MCHIP" as unnecessary.

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-160(B)(2): **VPLC** suggests changing "Commonwealth" to "DMAS or its designee."

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-160(B)(3): **VPLC** suggests changing this section to reflect action of the 2003 General Assembly.

Agency Response:
DMAS has made the appropriate changes to 12 VAC 30-141-160(B)(6).

12 VAC 30-141-170(B)(6): **VPLC** suggests inserting "ESHI" to reference application action.

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-180(A): **VPLC** suggests adding "or its designee" to DMAS language.

Agency Response:
DMAS agrees with the change.

12 VAC 30-141-660(C): **VPLC** suggests adding notice of appeal rights for denial of dis-enrollment request.

Agency Response:
DMAS disagrees. There are no rights to appeal when DMAS determines that good cause does not exist to dis-enroll a FAMIS enrollee from one MCHIP and enroll them in another MCHIP after the 90-day assignment period has lapsed.

Detail of Changes

Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.

DEFINITIONS

Deleted/Added/Revised language and definitions for purposes of clarity and to conform the definitions to certain changes made in the regulations.

REVIEW OF ADVERSE ACTIONS (12 VAC 30-141-40 through 70)

12 VAC 30-141-40 B. - Reference to suspension of services was deleted and reference to a reduction of services was added to conform these regulations with the requirements under 42 CFR 457.1120 and the FAMIS State Plan provisions at 12.2.

12 VAC 30-141-40 F. Inserted the following language, " There will be no opportunity for review based on which type of delivery system…is assigned," to accurately reflect the agency's policy, and inserted the following language, "There will be no opportunity for review if the sole basis…," to conform the regulations to the requirements of 42 CFR 457.1120 and the FAMIS State Plan provisions at 12.1 and 12.2.

30-141-70 D. 6-8. Language was added language regarding expedited appeals to conform the regulations with the requirements of 42 CFR 457.1120 and the FAMIS State Plan provisions Plan at 12.1 and 12.2.

ELIGIBILITY DETERMINATION AND APPLICATION REQUIREMENTS (12 VAC 30-141 - 100 through 150

The definitions, relating to the regulations detailing who is authorized to sign an application for FAMIS, were revised to conform to the agency's Medicaid regulations, as there is now a single application for Medicaid and FAMIS.

12 VAC 30-141-120 B. This provision was added to clarify that a child will be ineligible for FAMIS if the child's parent's or guardian does not meet the requirements of assignment of rights to benefits or cooperation with the agency with regard to third-party liability.

EMPLOYER-SPONSORED HEALTH INSURANCE (ESHI) (12 VAC 30-141-170)

12 VAC 30-141-170 E. (Cost Effectiveness) was revised to clarify how cost-effectiveness is determined. The revision does not reflect a change in how the cost-effectiveness is and has been determined.

BENEFITS AND REIMBURSEMENT. (12 VAC 30-141-200 through 500)

MANAGED CARE ENROLLMENT (12 VAC 30-141-700)

This section was added to clarify the process by which those enrollees in managed care areas are assigned to an MCHIP or PCP, as is applicable, and how enrollees will access benefits during the pre-assignment period.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This regulatory action will have positive effects on the institution of the family and family stability since it provides health insurance for children. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.