12VAC30-141-10. Definitions.

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

"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.

"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~~ FAMIS Select program shall not constitute an adverse action.

"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 and is awaiting a determination of eligibility. A child is an applicant until his eligibility has been determined.

"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 §32.1-324 of the Code of Virginia 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.

"Maternal and Child ~~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.

"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 an employer. 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" means parents, including adoptive and stepparents, and their children under the age of 19, who are living in the same household. Family shall not mean grandparents, other relatives, or legal guardians.

"Family," when used in the context of the ~~ESHI~~ FAMIS Select 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.

"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, 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, 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.

"FAMIS" means the Family Access to Medical Insurance Security Plan.

"FAMIS Select" means an optional program available to children determined eligible for FAMIS, whereby DMAS provides premium assistance to the family to cover the child through a private or employer sponsored health plan instead of directly through the FAMIS program.

"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.

"Fixed premium assistance amount" means a predetermined amount of premium assistance that DMAS will pay per child to a family who chooses to enroll their FAMIS eligible child in a private or employer sponsored health plan. The fixed premium assistance amount will be determined annually by DMAS to ensure that the FAMIS Select program is cost-effective as compared to the cost of covering a child directly through the FAMIS program.

"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.

"Group health plan" or "health insurance coverage" means that health care coverage as defined in §2791 of the Public Health Services Act (42 USC §300gg-91(a) and (b)(1).

"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.

"Incapacitated individual" means a person who, pursuant to an order of a court of competent jurisdiction, has 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 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 support or for the support of his legal dependents without the assistance or protection of a conservator.

"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.

"LDSS" or "local department" means the local department of social services.

"Managed care health insurance plan" or "MCHIP" as defined in §32.1-137.1 of the Code of Virginia 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 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 arent 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~~ a private or employer's health plan that DMAS will pay ~~to the family~~ to cover the FAMIS

eligible children under the private or employer sponsored 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 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.

“Private or employer sponsored health insurance coverage means a health insurance policy that is either purchased by an individual directly or through an employer. This component of FAMIS refers to the ability of DMAS to provide coverage to FAMIS eligible children by providing premium assistance to families who enroll the FAMIS eligible children in a private or employer sponsored health plan.

"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 eligible children covered under the ~~ESHI~~ FAMIS Select component so that they can receive all childhood immunizations included in ~~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.

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

_____ _____

Date

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

12VAC30-141-40. 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 law or regulation 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)~~ through the FAMIS Select program ~~plan~~ shall be resolved between the insurance company or employer's plan and the ~~ESHI~~ FAMIS Select 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 Part II (12VAC30-141-40 et seq.) of this chapter.

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

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

12VAC30-141-100. Eligibility requirements.

A. This section shall be used to determine eligibility of children for FAMIS.

B. FAMIS shall be in effect statewide.

C. Eligible children must:

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

2. Be under 19 years of age;

3. Be residents of the Commonwealth;

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

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

6. Not be a member of a family eligible for subsidized dependent coverage, as defined in 42 CFR 457.310(c)(1)(ii)i 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 subsidized dependent coverage, as defined in 42 CFR 457.310(c)(1)(ii), on the basis of a family member's employment with an agency that participates in the local choice program;

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 countable income to 200% of the federal poverty level for the family size, as defined in the State Plan for Title XXI as approved by the Centers for Medicare & Medicaid. Children who have income at or below 200% of the federal poverty level, but are ineligible for Medicaid due to excess income, will be income eligible to participate in FAMIS.

3. Grandfathered CMSIP children. Children who were enrolled in the Children's Medical Security Insurance Plan at the time of conversion from CMSIP to FAMIS and whose eligibility determination was based on the requirements of CMSIP shall continue to have their income eligibility determined using the CMSIP income methodology. If their income exceeds the FAMIS standard, income eligibility will be based on countable income using the same income methodologies applied under the Virginia State Plan for Medical Assistance for children as set forth in 12VAC30-40-90. Income that would be excluded when determining Medicaid eligibility will be excluded when determining

countable income for the former CMSIP children. Use of the Medicaid income methodologies shall only be applied in determining the financial eligibility of former CMSIP children for FAMIS and for only as long as the children meet the income eligibility requirements for CMSIP. When a former CMSIP child is determined to be ineligible for FAMIS, these former CMSIP income methodologies shall no longer apply and income eligibility will be based on the FAMIS income standards.

4. Spenddown. Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS. If the family income exceeds the income limits described in this section, the individual shall be ineligible for FAMIS regardless of the amount of any incurred medical expenses.

E. Residency. The requirements for residency, as set forth in 42 CFR 435.403, will be used when determining whether a child is a resident of Virginia for purposes of eligibility for FAMIS. A child who is not emancipated and is temporarily living away from home is considered living with his parents, adult relative caretaker, legal guardian, or person having legal custody if the absence is temporary and the child intends to return to the home when the purpose of the absence (such as education, medical care, rehabilitation, vacation, visit) is completed.

F. Qualified noncitizen. The requirements for qualified aliens set out in Public Law 104-193, as amended, and the requirements for noncitizens set out in subdivisions 3 b and c of 12VAC30-40-10 will be used when determining whether a child is a qualified noncitizen for purposes of FAMIS eligibility.

G. Coverage under other health plans.

1. Any child covered under a group health plan or under health insurance coverage, as defined in §2791 of the Public Health Services Act (42 USC §300gg-91(a) and (b)(1)), shall not be eligible for FAMIS.

2. No substitution for private insurance.

a. Only uninsured children shall be eligible for FAMIS. A child is not considered to be insured if the health insurance plan covering the child does not have a network of providers in the area where the child resides. Each application for child health insurance shall include an inquiry about health insurance the child currently has or had within the past four months. If the child had health insurance coverage that was terminated in the past four months, inquiry as to why the health insurance was terminated is made. Each redetermination of eligibility shall also document inquiry about current health insurance or health insurance the child had within the past four months. If the child has been covered under a health insurance plan other than through the ~~ESHI~~ FAMIS Select component of FAMIS within four 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 Medicare, 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 four- month period prior to the month of application if one of the following good cause exceptions is met.

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

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

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

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

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

insurance was discontinued by the child's absent parent, grandparent, aunt, uncle, godmother, etc.

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

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

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

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

12VAC30-141-160. Copayments for families not participating in ~~employer-sponsored health insurance (ESHI)~~ FAMIS Select.

A. Copayments shall apply to all enrollees in an MCHIP.

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 (i) for families with incomes equal to or less than 150% of FPL, the lesser of (a) $180 and (b) 2.5% of the family's income for the year (or 12-month eligibility period); and (ii) for

families with incomes greater than 150% of FPL, the lesser of $350 and 5.0% of the family's income for the year (or 12-month eligibility period).

2. DMAS or its designee 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 copayment 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 copays.

C. Exceptions to the above cost-sharing provisions:

1. Copayments shall not be required for well-child~~,~~ and 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 copayment amount, for emergency services furnished outside of the individual's managed care network. Only one copayment charge will be imposed for a single office visit.

3. No cost sharing will be charged to American Indians and Alaska Natives.

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

_____ _____

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

~~**12VAC30-141-170. Employer-sponsored health insurance (ESHI).**~~

~~A. 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 in this section.~~

~~B. 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 to the cost of dependent or family coverage as defined in the Virginia Plan for Title XXI of the Social Security Act, or as otherwise approved by the Centers for Medicare & Medicaid Services in the U.S. Department of Health and Human Services;~~

~~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 in subsection F of this section;~~

~~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.~~

~~C. 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.~~

~~D. DMAS will continually verify the child's or children's coverage under the employer's plan and will redetermine 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.~~

~~E. 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. DMAS may elect to provide health insurance coverage to FAMIS children by having FAMIS children and their families enroll in ESHI. DMAS will provide interested families with applications for ESHI.~~

~~3. A written application for the ESHI component shall be required from interested families.~~

~~4. 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 for ESHI, and, if approved, his obligations under the program. If eligibility is denied, notice will be given concerning the reasons for the denial.~~

~~F. 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.~~

~~G. 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.~~

~~H. 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 disenroll 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.~~

~~I. 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.~~

~~J. Cost sharing. ESHI families will not be responsible for copayments for FAMIS Title XXI benefits. DMAS will instruct providers to submit billings to DMAS or its designee for payment of applicable copayments. In situations where the provider under the ESHI~~

~~component refuses to bill DMAS for the copayment amount, DMAS will reimburse the enrollee directly.~~

~~1. FAMIS children will have to pay copayments 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 nonESHI FAMIS families ($180 annually for those equal to or less than 150% FPL and $350 annually for those over 150% 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.~~

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

_____ _____

Date

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

12VAC30-141-175. FAMIS Select.

A. Enrollees in FAMIS may, but shall not be required to, enroll in a private or employer sponsored health plan if DMAS or its designee determines that such enrollment is cost effective, as defined in this section.

B. Eligibility determination. FAMIS children may elect to receive coverage under a health plan purchased privately or through an employer and DMAS may elect to provide coverage by paying all or a portion of the premium if all of the following conditions are met:

1. The children are determined to be eligible for FAMIS;

2. The cost of coverage for the child or children under FAMIS Select 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 in subsection E of this section;

3. The policyholder agrees to assign rights to benefits under the private or employer's plan to DMAS to assist the Commonwealth in pursuing these third party payments for childhood immunizations. When a child is provided coverage under a private or employer's plan, that plan becomes the payer for all other services covered under that plan; and

4. The policyholder is not under a court order to provide medical support for the applicant child.

C. DMAS will continually verify the child's or children's coverage under the private or employer's plan and will redetermine the eligibility of the child or children for the FAMIS Select 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 indicated an interest in FAMIS Select:

a. The eligibility requirements for FAMIS Select;

b. A description of how the program operates, the amount of premium assistance available, and how children can move from FAMIS Select into FAMIS if requested;

c. A summary of the covered benefits and cost sharing requirements available through FAMIS;

d. A guide to help families make an informed choice by comparing the FAMIS plan to their private or employer sponsored health plan. Such guide shall include a notice to the effect that children covered by FAMIS Select will not receive FAMIS covered services, but only those health services covered by their private or employer sponsored health plan,

and that the FAMIS Select enrollee shall be responsible for any and all costs associated with their chosen health plan.

e. Information on coverage for childhood immunizations through FAMIS; and

f. The rights and responsibilities of applicants and enrollees.

2. DMAS will provide interested families with applications for FAMIS Select.

3. A written application for the FAMIS Select component shall be required from interested families.

4. DMAS shall determine eligibility for the FAMIS Select 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 FAMIS Select 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 FAMIS Select applications shall be held for a period of 30 calendar days to enable applicants to provide outstanding information needed for a FAMIS Select 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 FAMIS Select eligibility shall have his application denied.

6. DMAS must send each applicant a written notice of the agency's decision on his application for FAMIS Select, and, if approved, his obligations under the program. If eligibility is denied, notice will be given concerning the reasons for the denial.

E. Cost effectiveness. DMAS may elect to provide coverage to FAMIS children by paying all or a portion of the family's private or employer-sponsored health insurance premium if the cost of such premium assistance under FAMIS Select 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. Providing premium assistance for the FAMIS eligible children may result in the coverage of an adult or other relative/dependant; however, this coverage shall be solely incidental to covering the FAMIS child.

1. To ensure that the FAMIS Select program remains cost-effective, DMAS will establish a fixed premium assistance amount per child that will be paid to a family choosing to enroll their FAMIS eligible child in FAMIS Select. The fixed premium assistance amount will be determined annually by:

(a) Determining the cost of covering a child under FAMIS. The cost will be determined by using the capitated payment rate paid to MCHIPs, or an average cost amount developed by DMAS; and

(b) Determining the administrative costs associated with the FAMIIS Select program; and

(c) Establishing a fixed premium assistance amount that includes administrative costs and is less than or equal to the cost of covering the FAMIS child or children under FAMIS.

(d) DMAS will ensure that the total of the fixed premium assistance amounts for all the FAMIS eligible children per family do not exceed the total cost of the family's health insurance premium payment for the private or employer sponsored coverage. If the total fixed premium assistance amounts do exceed the family's premium payment, then the family premium assistance will be reduced by an amount necessary to ensure the premium assistance payment is less than or equal to the family's premium payment.

F. Enrollment and disenrollment.

1. FAMIS children applying for FAMIS Select will receive coverage under FAMIS until their eligibility for coverage under the FAMIS Select component is established and until they are able to enroll in the private or employer-sponsored health plan.

2. The timing and procedures employed to transfer FAMIS children's coverage to the FAMIS Select component will be coordinated between DMAS and the CPU to ensure continuation of health plan coverage.

3. Participation by families in the FAMIS Select component shall be voluntary. Families may disenroll their child or children from the FAMIS Select 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 FAMIS Select 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 private or employer's plan;

3. The last day of the month in which the family notifies DMAS that they wish to disenroll their child or children from the FAMIS Select component.

4. On the next business day following a request by the family to immediately transfer the child from FAMIS Select into the FAMIS program. The request must include notification that the child’s private or employer sponsored coverage has been terminated as of the date of transfer and an agreement by the family to return to DMAS the premium assistance payment prorated for that portion of the month in which the child was not enrolled in the private or employer sponsored plan.

H. Supplemental health benefits coverage will be provided to ensure that FAMIS children enrolled in the FAMIS Select component receive all childhood immunizations available under the FAMIS benefits. FAMIS children can obtain these supplemental benefits through Medicaid providers.

I. Cost sharing. FAMIS Select families will be responsible for all copayments, deductibles, coinsurance, fees, or other cost sharing requirements of the private or employer sponsored health plan in which they enroll their children. There is no Title XXI family cost-sharing cap applied to families with children enrolled in FAMIS Select. There is no co payment required for the supplemental immunization benefits provided through FAMIS.

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

_____ _____

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

12VAC30-141-200. Benefit packages.

~~A.~~ The Commonwealth's Title XXI State Plan utilizes two benefit packages within FAMIS as set forth in the FAMIS State Plan, as may 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.~~

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

_____ _____

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