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) 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.

“Application for health insurance” means the form or forms developed and approved by the Department of Medical Assistance Services that is used for determining eligibility for Medicaid for poverty level children, for the Family Access to Medical Insurance Security Plan (FAMIS) for children, for Medicaid for pregnant women, and for FAMIS MOMS coverage for pregnant women.

"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.

~~"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 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.

"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.

"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 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 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~~.

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 component of FAMIS within four months of application for or receipt of FAMIS services, the child will be ineligible, unless the child is pregnant at the time of application, or, 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

12VAC30-141-120. 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. 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.

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

_____ _____

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

12VAC30-141-150. 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. Copayment 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~~ Applications for 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, via the Internet, 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~~ an application for 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.

E. The authorized representative for an individual 18 years of age or older shall be those individuals as set forth in 12VAC30-110-1380.

F. The authorized representative for children younger than 18 years of age shall be those individuals as set forth in 12VAC30-110-1390.

G. 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~~

an application for health insurance ~~application~~ on behalf of an individual who cannot designate an authorized representative.

H. 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.

I. 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 redetermination process for eligibility.

J. 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~~ An application for 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 the same Medicaid case processing time standards.

Except in cases of unusual circumstances as described below, ~~Child~~ an application for 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.

K. 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, as described in 12VAC30-141-50.

L. 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; or (ii) there is a supporting entry in the case record that the applicant cannot be located.

M. 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.

N. Redetermination of eligibility. DMAS or the FAMIS CPU must redetermine the eligibility of enrollees with respect to circumstances that may change at least every 12 months. During the 12-month period of coverage, enrollees must make timely and accurate reports if an enrollee no longer resides in the Commonwealth of Virginia or when changes in income exceed 200% of the federal poverty level. DMAS or the FAMIS

CPU must promptly redetermine eligibility when it receives information about changes in a FAMIS enrollee's circumstances that may affect eligibility.

O. 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.

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

_____ _____

Date

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

12VAC30-141-180. 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 ~~§6.1-330.49~~ § 6.1-330.54 of the Code of Virginia 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 or its designee.

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.

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

_____ _____

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

12VAC30-141-650. 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 (§2.2-4000 et seq. of the Code of Virginia) and the Virginia Administrative Code, 12VAC30-10-1000 and ~~12VAC30-50-500 through 12VAC30-50-560.~~ 12VAC30-20-500 through 12VAC30-20-560.

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

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

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

Chapter 141.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN.

Part VII.

FAMIS MOMS

12VAC30-141-810. 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 applicant by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child applicant 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.

"Agency" means a local department of social services, the central processing unit, or other entity designated by DMAS to make eligibility determinations for FAMIS MOMS.

"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 MOMS Plan applicant or enrollee during the administrative review process.

"Applicant" means a pregnant woman who has filed an application (or who has an application filed on her behalf) for health insurance and is awaiting a determination of eligibility. A pregnant woman is an applicant until her eligibility has been determined.

“Application for health insurance” means the form or forms developed and approved by the Department of Medical Assistance Services that is used for determining eligibility for Medicaid for poverty level children, for the Family Access to Medical Insurance Security Plan (FAMIS) for children, for Medicaid for pregnant women, and for FAMIS MOMS coverage for pregnant women.

"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.

"Central processing unit" or "CPU" means the private contractor that will determine eligibility for and administer part of the FAMIS MOMS Plan.

"Child" means an individual under the age of 19 years.

"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 Title XXI.

"DMAS" or "department" means the Department of Medical Assistance Services.

"Enrollee" means a pregnant woman who has been determined eligible to participate in FAMIS MOMS and is enrolled in the FAMIS MOMS 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 MOMS.

"Family" for a pregnant woman under the age of 21, means parents, including adoptive parents, if they are all residing together and the spouse of the pregnant woman if the woman is married and living with her spouse, as well as any children under the age of 21 the woman may have.

For a pregnant woman over the age of 21, family means her spouse, if married and living together, as well as any children under the age of 21 the pregnant woman may have.

"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 MOMS” means the Title XXI program available to eligible pregnant women.

"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 herself 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 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 her support or for the support of her 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 her 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 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 applicant is eligible for coverage under a state employee health insurance plan, means a spouse, 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.

“Pregnant woman” means a woman of any age who is medically determined to be pregnant. The pregnant woman definition is met from the first day of the earliest month that the medical practitioner certifies as being a month in which the woman was pregnant, through the last day of the month in which the 60th day occurs, following the last day of the month in which her pregnancy ended, regardless of the reason the pregnancy ended.

"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 MOMS 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 MOMS enrollees eligible for services.

"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.

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

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Date

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

12VAC30-141-820. Administration and general background.

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements of Title XXI of the Social Security Act and any Waiver of federal regulations approved by the Centers for Medicare and Medicaid Services.

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 pregnant women into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the FAMIS MOMS program; and for

employing state staff to perform Medicaid eligibility determinations on pregnant women referred by the contractor's staff.

C. Health care services under FAMIS MOMS shall be provided through MCHIPs, PCCMs, and through fee-for-service or through any other heath care delivery system deemed appropriate by the Department of Medical Assistance Services.

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_____ _____

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

12VAC30-141-830. Outreach and public participation.

A. DMAS will work cooperatively with other state agencies and contractors to ensure that state and federal law and any applicable state and federal regulations are met.

B. DMAS shall develop a comprehensive marketing and outreach effort. The marketing and outreach efforts will be aimed at promoting FAMIS MOMS and Medicaid for pregnant women 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.

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

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

12VAC30-141-840. Review of adverse actions.

A. Upon written request, all FAMIS MOMS program 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 MOMS 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.

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

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

12VAC30-141-850. Notice of adverse action.

A. The CPU or DMAS shall send written notification to enrollees at least 10 calendar days prior to suspension or termination of enrollment.

B. DMAS or the MCHIP shall send written notification to enrollees at least 10 calendar days prior to reduction, suspension or termination of a previously authorized health service.

C. 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.

D. Notice shall include the reasons for determination, an explanation of applicable rights to a 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 or services may continue pending review.

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

12VAC30-141-860. 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.

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_____ _____

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

12VAC30-141-870. 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 Code of Virginia 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 of 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 three 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 her authorized representative causes a delay.

7. For health services matters for FAMIS MOMS 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 MOMS enrollees receiving services through fee-for-service or 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.

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

12VAC30-141-900. Eligibility requirements.

A. This section shall be used to determine eligibility of pregnant women for FAMIS MOMS.

B. FAMIS MOMS shall be in effect statewide.

C. Eligible pregnant women must:

1. Be determined ineligible for Medicaid due to excess income by a local department of social services or by DMAS eligibility staff co-located at the FAMIS CPU;

2. Be a pregnant woman at the time of application;

3. Be a resident of the Commonwealth;

4. Be either a U.S. citizen, U.S. national or a qualified noncitizen;

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) under any Virginia state employee health insurance plan on the basis of the family member's employment with a state agency;

7. 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 applications for FAMIS MOMS coverage received at the FAMIS central processing unit must be screened to identify applicants who are potentially eligible for Medicaid. Pregnant women screened and found potentially eligible for Medicaid cannot be enrolled in FAMIS MOMS until there has been a finding of ineligibility for Medicaid. Pregnant women who do not appear to be eligible for Medicaid due to excess income shall have their eligibility for FAMIS MOMS determined, and if eligible, will be enrolled in the FAMIS MOMS program. Applications for FAMIS MOMS received at a local department of social services shall have a full Medicaid eligibility determination completed. Pregnant women determined to be ineligible for Medicaid due to excess income will have their eligibility for FAMIS MOMS determined,

and if eligible, the local department of social services will enroll the pregnant woman in the FAMIS MOMS program.

2. Standards. Income standards for FAMIS MOMS are based on a comparison of countable income to 150% of the federal poverty level for the family size. Countable income and family size are based on the methodology utilized by the Medicaid program as defined in 12VAC 30-40-100(e). Pregnant women who have income at or below 150% of the federal poverty level, but are ineligible for Medicaid due to excess income, will be income eligible to participate in FAMIS MOMS.

3. Spenddown. Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS MOMS. If the family income exceeds the income limits described in this section, the individual shall be ineligible for FAMIS MOMS 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 pregnant woman is a resident of Virginia for purposes of eligibility for FAMIS MOMS. A child who is not emancipated and is temporarily living away from home is considered living with her 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 pregnant woman is a qualified noncitizen for purposes of FAMIS MOMS eligibility.

G. Coverage under other health plans.

1. Any pregnant woman 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 MOMS.

2. No substitution for private insurance.

a. Only uninsured pregnant women shall be eligible for FAMIS MOMS. A pregnant woman is not considered to be insured if the health insurance plan covering the pregnant woman does not have a network of providers in the area where the pregnant woman resides. Each application for FAMIS MOMS coverage shall include an inquiry about health insurance the pregnant woman has at the time of application.

b. Health insurance does not include Medicare, Medicaid, FAMIS or insurance for which DMAS paid premiums under Title XIX through the Health Insurance Premium Payment (HIPP) Program or under Title XXI through the SCHIP premium assistance program.

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

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

12VAC30-141-910. Duration of eligibility.

A. The effective date of FAMIS MOMS 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.

B. Eligibility for FAMIS MOMS will continue through the last day of the month in which the sixtieth day occurs, following the last day the woman was pregnant, regardless of the reason the pregnancy ended. Eligibility will continue until the end of the coverage period, regardless of changes in circumstances such as income or family size.

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

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

12VAC30-141-920. Pregnant women ineligible for FAMIS MOMS.

A. If a pregnant woman is:

1. Eligible for Medicaid, or would be eligible if she applied for Medicaid, she shall be ineligible for coverage under FAMIS MOMS. A pregnant woman 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 MOMS;

2. A member of a family eligible for coverage under any Virginia state employee health insurance plan shall be ineligible for FAMIS MOMS; or

3. An inmate of a public institution as defined in 42 CFR 435.1009 shall be ineligible for FAMIS MOMS; or

4. An inpatient in an institution for mental disease (IMD) as defined in 42 CFR 435.1009 shall be ineligible for FAMIS MOMS.

B. If a pregnant woman age 18 or older or, if under age 18, a 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 pregnant woman shall be ineligible for FAMIS MOMS.

C. If a pregnant woman age 18 or older, or if under age 18, a parent, adult relative caretaker, guardian, or legal custodian obtained benefits for a pregnant woman who would otherwise be ineligible by willfully misrepresenting material facts on the

application or failing to report changes, the pregnant woman for whom the application is made shall be ineligible for FAMIS MOMS. The pregnant woman age 18 or older, 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.

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Date Patrick W. Finnerty, Director
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12VAC30-141-930. Nondiscriminatory provisions.

FAMIS MOMS shall be conducted in compliance with all civil rights requirements. FAMIS MOMS shall not:

1. Discriminate during the eligibility determination process on the basis of diagnosis;

2. Cover pregnant women of higher income without first covering pregnant women with a lower family income; and

3. Deny eligibility based on a pregnant woman having a preexisting medical condition.

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

_____ _____

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

12VAC30-141-940. No entitlement.

In accordance with §2102(b)(4) of the Social Security Act and §32.1-353 of the Code of Virginia, FAMIS MOMS shall not create any entitlement for, right to, or interest in payment of medical services on the part of any pregnant woman or any right or entitlement to participation.

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Date Patrick W. Finnerty, Director
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12VAC30-141-950. 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. Copayment amounts required; and

4. The rights and responsibilities of applicants and enrollees.

B. Opportunity to apply. DMAS or its designee must afford a pregnant woman, wishing to do so, the opportunity to apply for the FAMIS MOMS program. Applications from pregnant women 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 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, by the internet, or by phone. Face-to-face interviews for the program are not required. Eligibility determinations for FAMIS MOMS 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 or older shall not be refused the right to complete an application for health insurance for herself and shall not be discouraged from asking for assistance for herself 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, spouse, adult relative caretaker, legal guardian or conservator, attorney-in-fact or authorized representative.

E. The authorized representative for an individual 18 years of age or older shall be those individuals as set forth in 12VAC30-110-1380.

F. The authorized representative for children younger than 18 years of age shall be those individuals as set forth in 12VAC30-110-1390.

G. Persons prohibited from signing an application. An employee of, or an entity hired by, a medical service provider who stands to obtain FAMIS MOMS payments shall not sign an application for health insurance on behalf of an individual who cannot designate an authorized representative.

H. Written application. DMAS or its designee shall require a written application from the applicant if she 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 MOMS eligibility.

I. 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 redetermination process for eligibility.

J. Timely determination of eligibility. The time processing standards for determining eligibility for FAMIS MOMS coverage begin with the date a signed application is received either at a local department of social services or the FAMIS CPU. Applications received at local departments of social services must have a full Medicaid eligibility determination and, when a pregnant woman is determined to be ineligible for Medicaid due to excess income, a FAMIS MOMS eligibility determination performed, within the same Medicaid case processing time standards.

Except in cases of unusual circumstances as described below, health insurance applications for pregnant women received at the local department of social services shall have a Medicaid eligibility determination completed and, if denied Medicaid for excess income, a FAMIS MOMS eligibility determination completed within 10 business days of the date the signed application was received at the local department. An application from a pregnant woman received at the FAMIS CPU and screened as ineligible for Medicaid, shall have a FAMIS MOMS eligibility determination completed within 10 business days of the date the complete application was received at the CPU. Complete applications that are screened as Medicaid likely will be processed within the 10 business day time standard. If the application cannot be processed within this standard, a notice will be sent to the applicant explaining why a decision has not yet been made.

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. Applications filed at the CPU that are incomplete shall be held open for a period of 30 calendar days to enable applicants to provide outstanding information needed for an eligibility determination. Incomplete applications, determined complete by the receipt of additional information required to determine FAMIS MOMS eligibility will be processed in an expedited manner upon receipt of the additional information. 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 her application for FAMIS MOMS eligibility denied.

K. 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 her application, and, if approved, her obligations under the program. If eligibility for FAMIS MOMS 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, as described in 12VAC30-141-50.

L. 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 her 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 her decision; or (ii) there is a supporting entry in the case record that the applicant cannot be located.

M. Case maintenance. All cases approved for FAMIS MOMS shall be maintained at the FAMIS CPU. Pregnant women determined by local departments of social services to be eligible for FAMIS MOMS 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 MOMS handbook, and for processing changes in eligibility within established time frames.

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

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

_____ _____

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

12VAC30-141-960. Co-payments.

A. Pregnant women enrolled in FAMIS MOMS will be subject to copayments for medical services in the same manner and amount as pregnant women covered by the Medicaid program as defined in 12 VAC 30-10-570 (B) and (C).

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

1. Total cost sharing for a pregnant woman shall be limited to the lesser of (a) $180 and (b) 2.5% of the family's income for the year for the duration of her enrollment in FAMIS MOMS.

2. If a family includes a pregnant woman enrolled in FAMIS MOMS and a child or children enrolled in FAMIS, DMAS or its designee shall ensure that the annual aggregate cost sharing for all Title XXI enrollees in a family does not exceed the cost sharing caps as defined in 12 VAC 30-141-160 (B).

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 or written documentation excluding such families from paying additional copays.

C. Exceptions to the above cost-sharing provisions:

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
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12 VAC 30-141-980. Liability for excess benefits.

A. Any person who, without the intent to violate this section, obtains benefits or payments under FAMIS MOMS to which she is not entitled shall be liable for any excess benefits or payments received. If the enrollee knew or reasonably should have known that she was not entitled to the excess benefits, she may also be liable for interest on the amount of the excess benefits or payments at the judgment rate as defined in § 6.1-330.54 of the Code of Virginia 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 or its designee.

B. Any payment erroneously made on behalf of a FAMIS MOMS 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.

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

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

12VAC30-141-1000. Benefit packages. Pregnant women covered through FAMIS MOMS may receive the same medical services and are subject to the same limitations on services as pregnant women covered by the Medicaid program as defined in 12 VAC 30-10-140 and 12 VAC 30-50-10.

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

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

12VAC30-141-1500. Benefits reimbursement.

A. Reimbursement for the services covered under FAMIS MOMS fee-for-service and PCCM and MCHIPs shall be as specified in this section.

B. 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, hospice services, school-based health services, and certain community-based mental health services shall be based on the Title XIX rates.

C. 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.

D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior

authorization is required after five visits for outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, Computer Axial Tomography scans, or Positron Emission Tomography scans.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. 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.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. 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. 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.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages 6 through 18. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for non-institutionalized FAMIS MOMS recipients receiving the fee-for-service or PCCM benefits will be subject to review and prior authorization when their current number of prescriptions exceeds 9 unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12 VAC 30-50-210(A)(7).

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

_____ _____

Date

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

12VAC30-141-1560. 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.

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

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Date

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

12VAC30-141-1570. 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.

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

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

12VAC30-141-1600. Recipient audit unit.

A. Pursuant to Chapter 9 (§32.1-310 et seq.) of Title 32.1 of the Code of Virginia, the recipient audit unit shall investigate allegations of acts of fraud or abuse, committed by persons enrolled in the FAMIS MOMS program or the parent, adult caretaker relative, guardian, legal custodian or authorized representative on behalf of a person or persons enrolled in the FAMIS MOMS program, which result in misspent funds.

B. Any FAMIS MOMS enrollee, parent, adult caretaker relative, guardian, legal custodian or authorized representative of a FAMIS MOMS 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 MOMS enrollees who received benefits through managed care.

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

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

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

12VAC30-141-1650. Provider review.

A. The provider review unit shall be responsible for reviewing enrolled FAMIS MOMS 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 (§2.2-4000 et seq. of the Code of Virginia) and the Virginia Administrative Code, 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

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

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

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

12VAC30-141-1660. 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 MOMS recipients, during the pre-assignment period to a PCP or MCHIP, shall receive Medicaid-like benefits via fee-for-service utilizing a FAMIS MOMS 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.

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 subdivision 3 of this section.

6. Individuals assigned to an MCHIP or a PCCM who lose and then regain eligibility for FAMIS MOMS 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.

D. Exclusion for assignment to a MCHIP. The following individuals shall be excluded from assignment to a MCHIP. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified time frame of the effective date of their MCHIP enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with the enrollee's assigned MCHIP. Exclusion requests made during the third trimester may be made by the enrollee, MCHIP, or provider. DMAS shall determine if the request meets the criteria for exclusion.

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

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Date

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