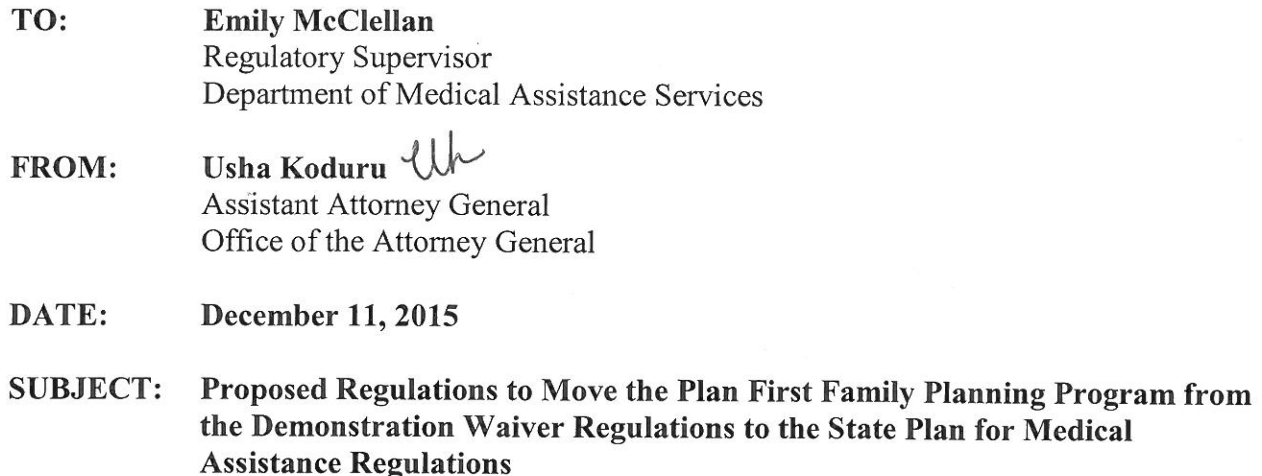
COMMONWEALTH of VIRGINIA

Office of the Attorney General

Mark R. Herring
Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120
7-1-1

<u>MEMORANDUM</u>



TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Usha Koduru**
Assistant Attorney General
Office of the Attorney General

DATE: **December 11, 2015**

SUBJECT: **Proposed Regulations to Move the Plan First Family Planning Program from the Demonstration Waiver Regulations to the State Plan for Medical Assistance Regulations**

I have reviewed the attached proposed regulations moving the Plan First Family Planning program, which had been a Demonstration Waiver to the general Medicaid program as a new eligibility group for people with income of up to 200% of the federal poverty level. The Patient Protection and Affordable Care Act as amended by the Health Care and Education Recovery Act allowed states this option. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-325, has the authority to promulgate these regulations b, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Virginia Code § 32.1-325 grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and §§ 32.1-324 and 325 grant the authority to the Director to administer the Plan according to the Board's requirements. Additionally, Section 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing

authority for payment for Medicaid services. These particular regulations are authorized by Chapter 665 of the 2015 Virginia Appropriations Act, Item 301.UU. These regulations amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services also is required and has already been received.

If you have any additional questions, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

townhall.virginia.gov

Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12VAC30-30-20, 12VAC30-50-130
Regulation title(s)	12VAC30-30-20. Optional groups other than the medically needy. 12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services and family planning. Repeal 12VAC30-135-10 to 12VAC30-135-90. Family Planning Waiver
Action title	Plan First Family Planning Services (Optional Group)
Date this document prepared	August 10, 2015

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

The purpose of this regulation is to move the Family Planning program from demonstration waiver regulations to state plan regulations in compliance with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2011. This change modifies the income eligibility level for the program to the level that is currently approved by CMS (200% of the federal poverty level, or FPL). This regulatory change will protect the health, safety and welfare of the qualifying, low-income citizens of the

Commonwealth by covering medical family planning services. These services help to decrease unintended pregnancies and increase the spacing between births to promote healthier mothers and infants. Preventing unintended pregnancies has significant social and economic advantages, including savings in health care and social support service expenditures.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

CMS = Centers for Medicare and Medicaid Services.
DMAS = Department of Medical Assistance Services.
EPSDT = Early and Periodic Screening, Diagnosis and Treatment.
FAMIS = Family Access to Medical Insurance Security Plan.
FPL = Federal Poverty Level.
PPACA = Patient Protection and Affordable Care Act.
STIs = Sexually Transmitted Infections

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The *Code of Virginia* (1950) as amended, section 32.1-325, grants to the Board of Medical Assistance Services the authority to administer the Plan for Medical Assistance. The Code of Virginia (1950) as amended, section 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance when the Board is not in session, subject to such rules and regulations as may be prescribed by the Board. The Medicaid authority was established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a], which provides the governing authority for DMAS to administer the State's Medicaid system.

The Patient Protection and Affordable Care Act (Public Law 111-148) (PPACA), as amended by the Health Care and Education Recovery Act of 2010 (Public Law 111-152), contained section 2303 State Eligibility Option for Family Planning Services which established a new Medicaid eligibility group and the option for States to begin providing family planning services and supplies to individuals (both men and women) found to be eligible under this new group. Coverage of both of these services was previously only available under a demonstration project waiver for men and women not eligible for full Medicaid benefits.

Chapter 665 of the 2015 Acts of Assembly, Item 301.UU provided:

"The Department of Medical Assistance Services shall seek federal authority to move the family planning eligibility group from a demonstration waiver to the State Plan for Medical Assistance. The department shall seek approval of coverage under this new state plan option for individuals with income up to 200 percent of the federal poverty level. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change."

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The Plan First program was initially covered by CMS as a demonstration waiver program and covered general family planning services for persons who could not qualify for full Medicaid eligibility. The covered services included: (i) examinations for both men and women for sexually transmitted diseases; (ii) birth control; (iii) cancer screenings for men and women, and; (iv) family planning education and counseling. Demonstration projects, regardless of their subject, create significant administrative costs and reporting requirements for Medicaid programs. In order to approve a demonstration grant for a state, CMS requires significant data reporting, formal evaluations, and periodic grant renewals. By converting this family planning service to the State Plan, as now permitted by PPACA, it relieves DMAS of these administrative costs and duties.

The purpose of this action is to move the waiver regulations into the state plan regulations which has no effect on the health, safety, or welfare of citizens. The increase of the income eligibility level will permit more individuals to receive services under this program. The advantage to the individuals who qualify for this service is the coverage of family planning services and examinations for sexually transmitted diseases.

There are no disadvantages to the public or the Commonwealth associated with the proposed regulatory action.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

The sections of the State Plan for Medical Assistance that are affected by this action are: 1) Groups Covered and Agencies Responsible for Eligibility Determination: Optional Groups

Other than the Medically Needy (12VAC30-30-20) and 2) Amount, Duration, and Scope of Medical and Remedial Care Services: Skilled Nursing Facility Services, EPSDT, School Health Services and Family Planning (12VAC30-50-130). Sections 12VAC30-135-10 to 12VAC30-135-90 are being repealed because the program is no longer operated as a demonstration project waiver.

The planned regulatory action makes three types of changes: (1) substantive changes required by CMS as a condition of the state plan amendment approval, (2) substantive changes to the income level approved by CMS; and (3) non-substantive editorial changes. In addition to moving this program out of demonstration waiver regulations and into state plan regulations, this action also increases the income level for eligibility, authorizes use of the DMAS Central Processing Unit or other contractor for determining eligibility (should DMAS determine that this is the most practicable approach), and clarifies that those individuals eligible for full-benefit coverage under Medicaid or FAMIS are not eligible under this program. The proposed regulatory action also authorizes coverage for additional (beyond initial) testing for sexually transmitted infections (STI) and newer methods of cervical cancer screening. These changes are designed to facilitate administration and update the services provided. In addition, this regulatory action includes non-substantive changes to selected language.

CURRENT POLICY

Current regulations treat individuals eligible for coverage under the Medicaid family planning option as a demonstration waiver versus the state plan option as approved by CMS. Under the demonstration waiver, the Commonwealth was allowed to waive certain limits for eligibility, including disallowing eligibility based on age, gender, having had a sterilization procedure or hysterectomy. The demonstration waiver also disallowed retroactive eligibility. These limitations were required by CMS as a condition of waiver approval. The current regulations also limit the income level for eligibility to 133% FPL.

Current regulations limit eligibility determination to local departments of social services and are unclear with regard to enrollment for persons eligible for Medicaid or FAMIS under a full-benefits category. Current regulations limit testing for sexually transmitted diseases (STDs) to the initial visit and restrict cervical cancer screening to the Pap test.

ISSUES

By meeting CMS requirements for continuation of the Family Planning program as a state plan service, the proposed regulatory action brings the regulations into compliance with the state plan amendment currently approved by CMS. This action assures that the eligibility rules for the state plan family planning option are consistent with those for full benefit Medicaid program. Raising the income level for eligibility makes the program consistent with the FAMIS MOMS program for pregnant women, and offers more men and women access to family planning services. Updating the clinical services available (STI testing and cervical cancer screening options) conforms to the present standard of care.

The Family Planning program is a benefit to qualified low income families by providing them with the means for obtaining medical family planning services to avoid unintended pregnancies and increase the spacing between births to help promote healthier mothers and infants.

The primary advantage of the Family Planning program to the Commonwealth is a cost savings to Medicaid for prenatal care, delivery, and infant care by preventing unintended pregnancies. According to the Virginia Department of Health's Pregnancy Risk Assessment Monitoring System (2010), unintended pregnancy continues to occur at a high rate in Virginia, where 42% of all pregnancies are unintended across the Commonwealth. Of these unintended pregnancies, 31% were mistimed (women who reported they wanted to be pregnant later) and 11% were unwanted (women who reported they did not want the pregnancy then or in the future).

Family planning services do not cover abortion services or referrals for abortions. This regulatory action would not affect individuals younger than 19 years of age unless they are in the FAMIS income range but are not eligible for FAMIS because of having other creditable health insurance. The majority of individuals younger than 19 years of age would be eligible for full Medicaid or FAMIS benefits.

RECOMMENDATIONS

The intent of this action is to align Virginia policy with that afforded by federal law, and in doing so expand family planning options for individuals who would not otherwise qualify for Medicaid or FAMIS coverage.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

The primary advantage to the public is that more low-income women and men will have access to family planning services. This will support these individuals' efforts to better plan for pregnancy. It will also allow greater access to testing for STI and screening for cervical cancer.

The primary disadvantage to these individuals is that, by definition, this is a limited benefit program. Some individuals may not understand those limits as they apply for full Medicaid benefits or seek services that are not encompassed by this family planning program, requiring remedial education and redirection to more appropriate resources. A disadvantage of this program for providers is that they also do not understand this program's limits and, after failing to determine that their patient has limited available benefits, provide a full range of services only to have their claims denied.

There are no identified disadvantages to the Commonwealth.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements that exceed applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No locality is particularly affected by this regulation.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the Agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Joanne Boise, Maternal and Child Health Services Unit, Health Care Services Division, Department of Medical Assistance Services, 600 E. Broad St., Richmond, VA; joanne.boise@dmas.virginia.gov. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of this stage of this regulatory action.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	There are no projected costs, as this regulatory action is only changing under which authority the agency is providing the service.
Projected cost of the new regulations or changes to existing regulations on localities.	There is no cost to localities from these regulations.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Individuals not eligible for full-benefit Medicaid or CHIP (FAMIS) who may benefit from family planning services. Physician practices serving the affected population are generally assumed to be small businesses.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	There are currently 105,000 individuals enrolled in the Family Planning Program. It is not known how many physician practices provide services to individuals in the Family Planning program.
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: **a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and** **b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.**	Physicians serving the affected population will continue to receive reimbursement for these services, contributing to income for those small businesses. The administrative costs resulting from this regulation are expected to be minimal. There are no costs related to the development of real estate.
Beneficial impact the regulation is designed to produce.	Decrease in the number of unplanned pregnancies; decrease in the number of poor birth outcomes (premature births, low birth weight infants), and; decrease in the incidence of STIs.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

The language for this regulatory action follows CMS requirements for program participation and no other alternative regulatory methods were identified that would accomplish the objectives of applicable law.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

This regulation will not create an adverse impact on small business.

Family Impact

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

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, and has no impact on disposable family income.

Public comment

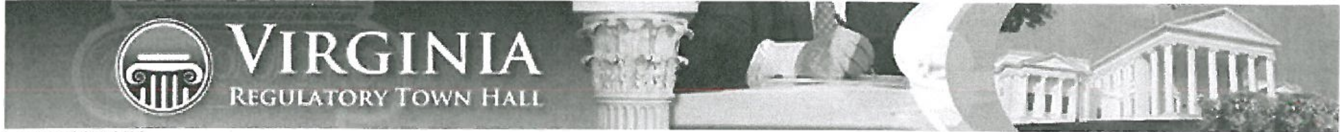
Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

DMAS submitted its Notice of Intended Regulatory Action (NOIRA) on May 29, 2015. It was published in the *Virginia Register* on June 29, 2015, to begin the thirty day comment period. The comment period ended July 29, 2015. No comments were received during the public comment period following publication of the NOIRA.

Detail of changes

Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the ***pre****-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC30-30-20		The family planning option group is not part of this regulatory section.	The addition of the state plan family planning optional group with the income level specified as 200% of FPL (the same income standard for pregnant women). Services are defined in 12VAC30-50-130D.
12VAC30-50-130		Family planning services are not specifically defined in this regulatory section.	The addition of this section defines family planning services as established by section 1905 of the Social Security Act.
12VAC30-135-10 to 12VAC30-135-90		Defines family planning eligibility option under demonstration waiver authority.	Strike the waiver authority language.



Proposed Text

Action: Plan First Family Planning Services (Optional Group)
Stage: Proposed 12/11/15 8:12 AM [latest]

12VAC30-30-20. Optional groups other than the medically needy.

The Title IV A agency determines eligibility for Title XIX services.

1. Caretakers and pregnant women who meet the income and resource requirements of AFDC but who do not receive cash assistance.

2. Individuals who would be eligible for AFDC, SSI or an optional state supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

3. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the state's § 1915(c) waiver under which this group(s) is covered. In the event an existing § 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

4. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in § 1905(o) of the Act.

5. The state does not cover all individuals who are not described in § 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC state plan and who are under the age of 21. The state does cover reasonable classifications of these individuals as follows:

a. Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

(1) In foster homes (and are under the age of 21).

(2) In private institutions (and are under the age of 21).

(3) In addition to the group under subdivisions 5 a (1) and (2) of this section, individuals placed in foster homes or private institutions by private nonprofit agencies (and are under the age of 21).

b. Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

c. Individuals in NFs (who are under the age of 21). NF services are provided under this plan.

d. In addition to the group under subdivision 5 c of this section, individuals in ICFs/MR (who are under the age of 21).

6. A child for whom there is in effect a state adoption assistance agreement (other than under Title IV-E of the Act), who, as determined by the state adoption

agency, cannot be placed for adoption without medical assistance because the child has special care needs for medical or rehabilitative care, and who before execution of the agreement:

a. Was eligible for Medicaid under the state's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the Title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The state covers individuals under the age of 21.

7. Section 1902(f) states and SSI criteria states without agreements under §§ 1616 and 1634 of the Act.

The following groups of individuals who receive a state supplementary payment under an approved optional state supplementary payment program that meets the following conditions. The supplement is:

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a statewide basis.

d. Paid to one or more of the following classifications of individuals:

(1) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(2) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(3) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(4) Individuals receiving a state administered optional state supplement that meets the conditions specified in 42 CFR 435.230.

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

The standards for optional state supplementary payments are listed in 12VAC30-40-250.

8. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in 12VAC30-40-220.

The state covers all individuals as described above.

9. Individuals who are 65 years of age or older or who are disabled as determined under § 1614(a)(3) of the Act, whose income does not exceed the income level specified in 12VAC30-40-220 for a family of the same size, and whose resources do not exceed the maximum amount allowed under SSI.

10. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of one month.

11. Women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in

accordance with § 1504 of the Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix. These women are not otherwise covered under creditable coverage, as defined in § 2701(c) of the Public Health Services Act, are not eligible for Medicaid under any mandatory categorically needy eligibility group, and have not attained age 65.

12. Individuals who may qualify for the Medicaid Buy-In program under § 1902(a)(10)(A)(ii)(XV) of the Social Security Act (Ticket to Work Act) if they meet the requirements for the 80% eligibility group described in 12VAC30-40-220, as well as the requirements described in 12VAC30-40-105 and 12VAC30-110-1500.

13. Individuals under the State Eligibility Option of P.L. 111-148 § 2303 who are not pregnant and whose income does not exceed the State established income standard for pregnant women in the Virginia Medicaid and CHIP State Plan and related waivers, which is 200% of the Federal Poverty Level, shall be eligible for the Family Planning program. Services are limited to family planning services as described in 12 VAC 30-50-130 D.

12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services and family planning.

A. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

5. Community mental health services.

a. Intensive in-home services to children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being

transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks. After an initial period, prior authorization is required for Medicaid reimbursement.

b. Therapeutic day treatment shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication; education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy.

c. Community-Based Services for Children and Adolescents under 21 (Level A).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by a licensed mental health professional.

(3) Individuals must be discharged from this service when other less intensive services may achieve stabilization.

(4) Authorization is required for Medicaid reimbursement.

(5) Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.

(6) Providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Education under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

(7) Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management.

(8) The facility/group home must coordinate services with other providers.

d. Therapeutic Behavioral Services (Level B).

(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to

improve the child's condition or prevent regression so that the services will no longer be needed. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.

(2) Authorization is required for Medicaid reimbursement.

(3) Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.

(4) Providers must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

(5) Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

(6) The child must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

(7) Individuals must be discharged from this service when other less intensive services may achieve stabilization.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership.

b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of this chapter.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's Individualized Education Program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services;

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. the licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written

order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D. Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

D. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

3. Family planning services as established by § 1905(a)(4)(C) of the *Social Security Act* include annual family planning exams; cervical cancer screening for women; sexually transmitted infection (STI) testing; lab services for family planning and STI testing; family planning education, counseling and preconception health; sterilization procedures; non-emergency transportation to a family planning service; and Food and Drug Administration (FDA) approved prescription and over-the-counter contraceptives, subject to limits as noted in 12VAC30-50-210.

Statutory Authority

Part I
Family Planning Waiver

12VAC30-135-10. ~~Definitions.~~ (Repealed.)

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

~~"Creditable health coverage" means "creditable coverage" as defined under § 2701(c) of the Public Health Service Act (42 USC § 300gg(c)) and includes coverage that meets the requirements of § 2103 provided to a targeted low-income child under Title XXI of the Social Security Act or under a waiver approved under § 2105(c)(2)(B) (relating to a direct service waiver).~~

~~"Family planning" means those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.~~

~~"FAMIS" means the Family Access to Medical Insurance Security Plan described in 12VAC30-141.~~

~~"Over-the-counter" means drugs and contraceptives that are available for purchase without requiring a physician's prescription.~~

~~"Third party" means any individual entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Plan for Medical Assistance.~~

12VAC30-135-20. ~~Administration and eligibility determination.~~ (Repealed.)

~~A. The Department of Medical Assistance Services shall administer the family planning demonstration waiver services program under the authority of § 1115(a) of the Social Security Act and 42 USC § 1315.~~

~~B. Local departments of social services or a department contractor shall be responsible for determining eligibility of and for enrolling eligible individuals in the family planning waiver. Local departments of social services or a department contractor shall conduct periodic reviews and redeterminations of eligibility at least every 12 months while recipients are enrolled in the family planning waiver.~~

12VAC30-135-30. ~~Eligibility.~~ (Repealed.)

~~A. To be eligible under the family planning waiver, an individual must meet the eligibility conditions and requirements found in 12VAC30-40-10, have family~~

~~income less than or equal to 133% of the federal poverty level, not have creditable health coverage, and not be eligible for enrollment in a Medicaid full benefit coverage group or FAMIS.~~

~~B. Individuals who have received a sterilization procedure or hysterectomy are ineligible under the waiver.~~

~~C. Individuals enrolled in the family planning waiver will not be retroactively eligible.~~

~~D. A recipient's enrollment in the family planning waiver shall be terminated if the individual receives a sterilization procedure or hysterectomy or is found to be ineligible as the result of a reported change or annual redetermination. The recipient's enrollment in the family planning waiver also shall be terminated if a reported change or annual redetermination results in eligibility for Virginia Medicaid in a full benefit coverage group or eligibility for FAMIS. A 10-day advance notice must be provided prior to cancellation of coverage under the family planning waiver unless the individual becomes eligible for a full benefit Medicaid covered group or FAMIS.~~

12VAC30-135-40. ~~Covered services.~~ (Repealed.)

~~A. Services provided under the family planning waiver are limited to:~~

~~1. Family planning office visits including annual gynecological or physical exams (one per 12 months), sexually transmitted diseases (STD) testing, cervical cancer screening tests (limited to one every six months);~~

~~2. Laboratory services for family planning and STD testing;~~

~~3. Family planning education and counseling;~~

~~4. Contraceptives approved by the Food and Drug Administration, including diaphragms, contraceptive injectables, and contraceptive implants;~~

~~5. Over-the-counter contraceptives; and~~

~~6. Sterilizations, not to include hysterectomies.~~

~~B. Services not covered under the family planning waiver include, but are not limited to:~~

~~1. Performance of, counseling for, or recommendations of abortions;~~

~~2. Infertility treatments;~~

~~3. Procedures performed for medical reasons;~~

~~4. Performance of a hysterectomy; and~~

~~5. Transportation to a family planning service.~~

12VAC30-135-50. ~~Provider qualifications.~~ (Repealed.)

~~Services provided under this waiver must be ordered or prescribed and directed or performed within the scope of the licensed practitioner. Any appropriately licensed Medicaid enrolled physician, nurse practitioner, or medical clinic may provide services under this waiver.~~

12VAC30-135-60. ~~Quality assurance.~~ (Repealed.)

~~The Department of Medical Assistance Services shall provide for continuing review and evaluation of the care and services paid by Medicaid under this waiver. To ensure a thorough review, trained professionals shall review cases either~~

~~through desk audit or through on-site reviews of medical records. Providers shall be required to refund payments made by Medicaid if they are found to have billed Medicaid for services not covered under this waiver, if records or documentation supporting claims are not maintained, or if bills are submitted for medically unnecessary services.~~

12VAC30-135-70. ~~Reimbursement.~~ (Repealed.)

~~A. Providers will be reimbursed on a fee-for-service basis.~~

~~B. All reasonable measures including those measures specified under 42 USC § 1396 (a) (25) will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients.~~

~~C. A completed sterilization consent form, in accordance with the requirements of 42 CFR Part 441, Subpart F, must be submitted with all claims for payment for sterilization procedures.~~

12VAC30-135-80. ~~Recipients' rights and right to appeal.~~ (Repealed.)

~~Individuals found eligible for and enrolled in the family planning waiver shall have freedom of choice of providers. Individuals will be free from coercion or mental pressure and shall be free to choose their preferred methods of family planning. The client appeals process at 12VAC30-110 shall be applicable to applicants for and recipients of family planning services under this waiver.~~

12VAC30-135-90. ~~Sunset provision.~~ (Repealed.)

~~Consistent with federal requirements applicable to this § 1115 demonstration waiver, these regulations shall expire effective with the termination of the federally approved waiver.~~