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Proposed Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	12 VAC30-141-10, 12 VAC30-141-20, 12 VAC30-141-30, 12 VAC30-141-40, 12 VAC30-141-50, 12 VAC30-141-60, 12 VAC30-141-70, 12 VAC30-141-100, 12 VAC30-141-110, 12 VAC30-141-120, 12 VAC30-141-150, 12 VAC30-141-660, 12 VAC30-141-670, 12 VAC30-141-680, 12 VAC30-141-700, 12 VAC30-141-710, 12 VAC30-141-720, 12 VAC30-141-730, 12 VAC30-141-740, 12 VAC30-141-750, 12 VAC30-141-760, 12 VAC30-141-790
Regulation title(s)	Family Access to Medical Insurance Security (FAMIS) Plan
Action title	FAMIS and FAMIS MOMS Periodic Review
Date this document prepared	July 19, 2017

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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

Regulations currently in place describe the implementation and oversight of the state's Children's Health Insurance Program (CHIP) (known in Virginia as the Family Access to Medical Insurance Security (FAMIS) Plan) and the CHIP waiver program for pregnant women known as FAMIS MOMS. Effective January 1, 2014, the Affordable Care Act (ACA) required eligibility for health coverage under all health insurance affordability programs, including CHIP, to be based on a new Modified Adjusted Gross Income (MAGI) methodology. Calculating

applicants' MAGI eligibility entails defining household composition and executing income-counting procedures based on Internal Revenue Service rules. Federal law required these changes to be made in the State Child Health Plan under Title XXI of the Social Security Act.

The proposed regulation incorporates the required changes in eligibility determination standards as well as updates to operational processes supporting eligibility and renewal actions. Because the FAMIS MOMS program operates as a CHIP waiver, corresponding regulations related to FAMIS MOMS are also proposed

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.

ACA = Affordable Care Act
CHIP = Children's Health Insurance Program
CHIPAC = Children's Health Insurance Program Advisory Committee
CPU = Claims Processing Unit
DMAS = Department of Medical Assistance Services
FAMIS = Family Access to Medical Insurance Security
MAGI = Modified Adjusted Gross Income
VDSS = Virginia Department of Social Services

Legal basis

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

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and directs that such Plan include a provision for the Family Access to Medical Insurance Security (FAMIS) program. The *Code of Virginia* (1950) as amended, § 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 *Code of Virginia* (1950) as amended, § 32.1-351, authorizes the Department of Medical Assistance Services, or the Director, as the case may be, to develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan, and revise such plan and promulgate regulations as may be necessary. Title XXI of the Social Security Act § 2105 [42 U.S.C. 1397ee] provides governing authority for payments for services.

Section 1115 of the Social Security Act [42 U.S.C. 1315] provides states with the opportunity to implement demonstration projects that extend benefits to additional population groups with the

intent of promoting program objectives, including those of Title XXI . Virginia implements the FAMIS MOMS program through a section 1115 Health Insurance Flexibility and Accountability (HIFA) Demonstration called "FAMIS MOMS and FAMIS Select" (No. 21 – W -00058/3).

The Center for Medicare and Medicaid Services (CMS) has approved the CHIP state plan amendment to implement MAGI rules. CMS has also approved an amendment to the demonstration waiver that reinstated enrollment in FAMIS MOMS using MAGI rules and setting the income eligibility to that of the CHIP program.

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 purpose of this action is to bring state regulations into line with federal rules and current Virginia practice. This action does not directly affect the health, safety, and welfare of citizens of the Commonwealth.

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 Family Access to Medical Insurance Security Plan that are affected by this action are:

Chapter Citation	Chapter Title	Nature of Recommended Changes
12 VAC 30-141-10	Definitions	Adds new definitions and modifies existing definitions pertinent to MAGI and operational processes
12 VAC 30-141-20	Administration and general background	Updates operational processes to reflect current practice
12 VAC 30-141-30	Outreach and public participation	Updates the reference to the Children's Health Insurance Program Advisory Committee (CHIPAC)
12 VAC 30-141-40	Review of adverse actions	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-50	Nature of adverse actions	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-60	Request for review	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-70	Review procedures	Updates terminology and operational processes at VDSS and CPU

12 VAC 30-141-100	Eligibility requirements	Specifies financial and non-financial eligibility standards consistent with MAGI requirements, and updated operational processes at VDSS and CPU
12 VAC 30-141-110	Duration of eligibility	Updates terminology from 'redetermination' to 'annual renewal'
12 VAC 30-141-120	Children ineligible for FAMIS	Updates terminology consistent with MAGI standards and operational processes; clarifies that inpatient status in an institution for mental disease is a factor for ineligibility at initial enrollment or renewal
12 VAC 30-141-150	Application requirements	Updates terminology and operational processes at VDSS and CPU consistent with implementation of MAGI standards; use of a single streamlined application; case documentation and maintenance
12 VAC 30-141-660	Assignment to managed care	Specifies that a choice of managed care organization may be made at the time of application
12 VAC 30-141-670	Definitions	Adds new definitions and modifies existing definitions pertinent to MAGI and operational processes
12 VAC 30-141-680	Administration and general background	Updates operational processes to reflect current practice
12 VAC 30-141-700	Review of adverse actions	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-710	Nature of adverse actions	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-720	Request for review	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-730	Review procedures	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-740	Eligibility requirements	Specifies financial and non-financial eligibility standards consistent with MAGI requirements, and updated operational processes at VDSS and CPU
12 VAC 30-141-750	Duration of eligibility	Updates terminology and operational processes at VDSS and CPU
12 VAC 30-141-760	Pregnant women ineligible for FAMIS MOMS	Updates terminology consistent with MAGI standards and operational processes
12 VAC 30-141-	Application requirements	Updates terminology and operational

790		processes at VDSS and CPU consistent with implementation of MAGI standards; use of a single streamlined application; case documentation and maintenance

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 advantages to the public, the Agency, and the Commonwealth from this regulatory package are greater clarity in the program rules for FAMIS and FAMIS MOMS, and greater consistency between Virginia regulations and current practice. There are no disadvantages to the public or the Commonwealth as a result of these regulatory changes.

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 in this regulation that are more restrictive than 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 localities will be particularly affected, as this regulation will apply statewide.

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/board 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 Emily McClellan, DMAS, 600 E. Broad Street, Richmond VA 23219, 804-371-4300, Emily.McClellan@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**	No costs are associated with this regulatory package.
Projected cost of the new regulations or changes to existing regulations on localities.	No costs are associated with this regulatory package.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Individuals seeking coverage under FAMIS or FAMIS MOMS will be affected by these regulations, along with local Departments of Social Services, which conduct eligibility screenings for FAMIS and FAMIS MOMS.
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.	No small businesses will be affected by this regulatory package. There are 121 local departments of social services.
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**	There are no costs associated with this regulatory package.

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.	
Beneficial impact the regulation is designed to produce.	The changes in this regulatory package will bring the VAC into accordance with federal rules and current Virginia practice.

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 majority of these changes are required by federal regulations, and there are no other alternatives. Other changes are edits to update terminology and align with current operational practices.

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.

The majority of these changes are required by federal regulations, and there are no other alternatives. Other changes are edits to update terminology and align with current operational practices.

Periodic review and small business impact review report of findings

If you are using this form to report the result of a periodic review/small business impact review that was announced during the NOIRA stage, please indicate whether the regulation meets the criteria set out in Executive Order 17 (2014), e.g., is necessary for the protection of public health, safety, and welfare, and is clearly written and easily understandable. In addition, as required by 2.2-4007.1 E and F, please include a discussion of the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation from the public; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to

which technology, economic conditions, or other factors have changed in the area affected by the regulation.

Although parts of Chapter 12 VAC 30-141 have been amended in recent years, this is the first periodic review of the Chapter as a whole.

This regulation is necessary to the protection of public health, safety, and welfare because it establishes rules for the FAMIS and FAMIS MOMS programs, which provide health insurance coverage to low-income children and pregnant women so that they can obtain needed medical care.

This regulation continues to be needed because it provides clarity to individuals seeking FAMIS or FAMIS MOMS coverage, and to local Department of Social Services workers about how individuals may access these programs. This regulation does not overlap with, duplicate, or conflict with federal or state law or regulation.

The Agency considered the public comments received from the public and has incorporated changes as a result of these comments. Some of these comments aimed at making the regulation less complex, and easier to understand.

Public comment

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

Commenter	Comment	Agency response
Virginia Poverty Law Center (VPLC)	**12 VAC 30-141-10 Definitions** 1. “Agency Error” - should also include “persons who did not receive benefits to which they were entitled” as a result of error… 2. “Authorized representative” – change to “means a person, 18 years of age or older, who is authorized to conduct the personal or financial affairs for an individual.” 3. “CMSIP” this definition can be deleted since there’s no reference to it in	1. Wording changed to "Agency error" means a person or persons, as a result of an error on the part of an eligibility worker, either received benefits to which they were not entitled; or were entitled to receive benefits but did not. 2. Wording changed 3. Deleted

	the following regulations. 4. "Continuation of enrollment" - this definition refers to the "review process", which is contained in 12 VAC 30-141-40. However, in that section the phrase is "continuation of coverage". The language in the two provisions should be consistent. 5. "Family" for FAMIS select should be consistent with definition of "FAMIS Select" and the definition of "Fixed premium assistance amount" which both refer to premium assistance to cover the child "through <u>a private or employer-sponsored health plan</u>…" The definitions of "premium assistance" , "private or employer-sponsored health insurance coverage" also need to be consistent. I believe FAMIS select can be available for either private OR employer based coverage. All the definitions and related regulations need to reflect this. 6. The definition of "Family income" is deleted. Since MAGI methodology now applies, there should be new definitions of "household" and "income"	4. Wording changed 5. Wording changed throughout to include private or employer-sponsored insurance 6. Definitions have been added for "Household" and "Household Income" consistent with MAGI methodology.

	7. "Lawfully residing" – "…lawfully present in the United States … 8. "Managed care health insurance plan" - delete "means" after the word "carrier"	7. Wording changed 8. Wording changed
VPLC	**12 VAC 30-141-30 Outreach and Public Participation** C. Should also refer to potential contracts with "non-profit agencies and foundations"	Wording changed
VPLC	**12 VAC 30-141-40 Review of adverse actions** E. FAMIS enrollees should be able to seek review of an adverse decision by an MCHIP by appealing to DMAS, not to an external review organization. This is the available process for Medicaid enrollees, and it should be the same in FAMIS. DMAS review of adverse MCHIP decisions also provides important oversight of MCO operations. I. The last sentence of this subsection is redundant, since it refers to the same section it's in.	E. Federal regulation allows CHIP to use staff or external review organization. The review timeframes under CHIP are more stringent, not referring to "business days" but "72 hours". DMAS is unable to assure staff availability to meet the stipulated timeframes, whereas the contracted external review organization has this capacity due to the other functions they perform. This also assures that the criteria used for assessing medical necessity and appropriateness of care under a review of adverse action are consistent with those being applied to prior authorization and other utilization management processes. I. Wording changed
VPLC	**12 VAC 30-141-50 Notice of Adverse Action** D. Notice should also include reference to policy that supports	This section states that the Notice "shall include the reasons for determination". This is consistent with the approved CHIP

	the action and specific information that was used to make the decision.	State Plan.
VPLC	**12 VAC 30-141-60- Request for review** – change references to "VDSS" to "DSS"	The term "VDSS" is used to refer to the central office of the Virginia Department of Social Services, and local departments, inclusively. VDSS is the acronym used by the agency. A definition of VDSS is added, and wording is changed throughout the regulation to be consistent.
VPLC	**12 VAC 30-141-70 – Review Procedures –** D.3 – add the following language "…including the presentation of supplemental information during the review process <u>which shall be fully considered by the decision maker to determine eligibility for coverage or services</u>." D 6-8 - Expedited review from various entities should be consolidated. An MCIP initial decision should also have an option for expedited review. As noted above (30-141-40.E), after an MCIP decision, review should be available through DMAS, not an external quality review organization.	D.3 The agency does not support the suggested wording because "fully considered by the decision maker" is subject to interpretation, and not enforceable. D 6-8 These sections are organized to align with the CHIP State Plan, which follows federal guidance and differentiates enrollment and eligibility matters from health services matters. The option for an expedited review is available at all decision points. Addressed under 12 VAC 30-141-40 Review of adverse actions, above
VPLC	**12 VAC 30-141-100 –** this regulation is very long. Can you subdivide into shorter sections for ease of reference? **E.2** – Residency – in a.3 and a.5	This section aligns with changes to the CHIP State Plan related to eligibility, and incorporates language directly from the State Plan; these changes have made the "General Conditions of Eligibility" more comprehensive. **E.2** – Wording changed

	change "childs" to "child's"	
	E.3.d.iii – It is unclear what this subsection means. Should it state "…period, beginning with the date of application…"	**E.3.d.iii** – Changed to "The agency begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status."
	E.3.e.x – the reference should be to "…paragraphs (i) through (ix)…"	**E.3.e.x –** Changed
	E.4.b.i – should be amended into a full sentence	**E.4.b.i** – Changed to "FAMIS shall not be a substitution for private insurance."
	E.6.b – amend to read "DMAS or its designee(s) shall:" [and appropriately change the verbs in subsections 1-4]	**E.6.b** – Changed
	F.2.a – d - Regulation should include definition of "household" and not use both "household" and "family size" when describing income eligibility. The regulation should also allow for an estimate – based on annual MAGI income – when an applicant documents fluctuating income and/or expected changes in income.	**F.2.a – d** – The wording in these sections is consistent with the approved CHIP State Plan that went into effect with the use of Modified Annual Gross Income (MAGI) methodologies. Definitions have been added for Household and Household income.
	F.3 - At end of section insert, "However, the child shall be evaluated for spend-down coverage through the Medicaid program."	The Commonwealth does not apply a spend-down process for FAMIS. However, an applicant may be evaluated for a spend-down for Medicaid if the household income exceeds the eligibility limit for FAMIS and all other criteria are met, including resource limits.
		I.2.A – The approved CHIP State Plan

	I.2.A – "targeted low-income pregnant women" is not a phrase defined in these regulations. It would be clearer to state "A child born to a pregnant women eligible for or receiving Medicaid or FAMIS Moms coverage is deemed to have applied for …."	uses the term "targeted low-income pregnant women"; a definition for this term has been added.
VPLC	**12 VAC 30-141-110 – Duration of Eligibility and Renewal** A – This section is not consistent with 30-141-100.I.1 which provides for 3 months retroactive coverage to certain newborns who apply within 3 months of their birth. C.1.b – the phrase "ex parte review" should be incorporated into the provision C.3 – should specify that individuals found eligible during the reconsideration period will have eligibility restored without a gap in coverage.	A – It is not clear how these sections are inconsistent. Eligibility cannot precede the date of birth, but can be retroactive to the date of birth as noted in 12 VAC 30-141-100.I.1 C.1.b – Wording changed and definition of "ex parte review" added. C.3 – Wording changed to specify that individuals found eligible during the reconsideration period will have eligibility restored without a gap in coverage.
VPLC	**12 VAC 30-141-120 – Children ineligible for FAMIS** A.1-3 – repeats provisions in section 100.D.4 and may not be necessary	This section has been deleted.
VPLC	**12 VAC 30-141-150 Application requirements** – I - "…application or renewal process." L.ii – "…cannot be located after numerous efforts to contact the applicant using alternative methods of contact that are	I – Wording changed L.ii – The Agency does not support the suggested wording as it is not enforceable. This level of direction would be more appropriately included in applicable

	documented by the case worker." M – "…information or assistance…"	operating manuals. M – Wording changed
VPLC	**12 VAC 30-141-175 – FAMIS Select** B.3 and C delete the word "private", but other sections (e.g. A, B, D.1.d and definitions) refer to both private and employer based plans. As noted earlier, consistency is needed. I believe the FAMIS Select program is designed for employer based or any type of private insurance purchased by the family.	Wording changed throughout
VPLC	**FAMIS MOMS** **12 VAC 30-141-690 – Outreach and public participation** B - Should also refer to potential contracts with "non-profit agencies and foundations"	Wording changed
VPLC	**12 VAC 30-141-700 – Review of Adverse actions** E. Review of an adverse MCHIP should be made by DMAS, not an external quality review organization	See comment on 12 VAC 30-141-40 E.
VPLC	**12 VAC 30-141-710 – Notice of Adverse actions** D. Notice should also include reference to policy that supports the action and specific information that was used to make the decision.	See response to similar comment at 12 VAC 30-141-50 Notice of Adverse Action
VPLC	**12 VAC 30-141-730 – Review procedures** D.3 – add the following language "…including the presentation of supplemental information during the review process which shall be	See comments on 12 VAC 30-141-70 – D.3 and D. 6-8

	fully considered by the decision maker to determine eligibility for coverage or services." E - G - Expedited review from various entities should be consolidated. And MCIP initial decision should also have an option for expedited review. As noted above (30-141-700.E), after an MCIP decision, review should be available through DMAS, not an external quality review organization.	
VPLC	**12 VAC 30-141-740 - General conditions of eligibility** D.3 – At end of section insert, "However, the pregnant woman shall be evaluated for spend-down coverage through the Medicaid program." E.2 – needs a complete sentence	D. 3 - See response to comment for 12 VAC 30-141-100 F.3 E.2 – Wording changed
VPLC	**12 VAC 30-141-790 – Application Requirements** J – It is not clear whether this section refers to the 10-day timeliness standard that applies to Medicaid pregnant women applications or the regular 45 day standard for most Medicaid applications. I strongly support the 10-business day processing limit for pregnant women. There is no justification for any substantive change during a periodic review of regulations. The 10-day expedited time frame is necessary to ensure that prenatal care is provided as early as possible during pregnancy. This regulation should clearly state the 10-day requirement.	J – Wording changed to clarify that the standard is the 10-day processing limit for pregnant women. M – Wording changed

	M – "…information or assistance…"	
Virginia Health Care Foundation (VHCF)	**12 VAC 30-141-10 Definitions** 1. "Agency Error" - should also include "persons who did not receive benefits to which they were entitled" as a result of error 2. Is the term "family income" and "member of a family" removed now that Virginia uses MAGI to determine income eligbility? 3. "Family," when used in the context of the FAMIS Select component, means a unit or group that has access to an employer's group health plan [insert: or private health insurance plan?]. Thus, it includes the employee and any dependents who can be covered under the employer's plan. 4. "Lawfully residing" means the individual is lawfully present [insert: in the US] and meets state residency requirements. 5. Need to define residency requirements? 6. "Premium assistance" means the portion of the family's cost of participating in an ~~private~~ employer's health plan that DMAS will pay to cover the FAMIS-eligible children under the private or employer-sponsored plan if DMAS determines it is	1. See response to similar VPLC comment above 2. See response to similar VPLC comment above 3. Wording changed 4. Wording changed 5. Residency requirements are detailed in 12VAC 30-141-100 (E) (2) 6. Wording changed throughout 7. Wording changed

	cost effective to do so. - Is premium assistance no longer available to families who purchase private insurance that is not through an employer? 7. "Targeted low-income child/ren" means uninsured child/ren under age 19 whose household income is within the [insert: eligibility] standards established by the Commonwealth.	
VHCF	**12VAC30-141-20. Administration and general background.** B. The DMAS director will have the authority to contract with entities for the purpose of establishing a centralized processing site, determining eligibility, enrolling eligible children into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the Family Access to Medical Insurance Security Plan ~~and for employing state staff to perform Medicaid eligibility determinations on children referred by FAMIS staff.~~ - why remove the blacklined section?	The statement is removed because it is historically related to a previous budget amendment. The Agency position is that it is no longer necessary to have this statement in regulation.
VHCF	**12VAC30-141-30. Outreach and public participation.** ~~D.~~ C. DMAS shall develop a comprehensive marketing and	The comment does not include information on the "VHCF description". The intent of the wording is to include both statewide outreach and public participation, as well as one-on-one assistance with applications, as needed.

	outreach effort. The marketing and outreach efforts will be aimed at promoting the FAMIS and Medicaid programs and increasing enrollment, and may include contracting with a public relations firm, coordination with other state agencies, coordination with the business community, and coordination with health care associations and providers. - VHCF description or one-on-one application assistance?	
VHCF	**12VAC30-141-60. Request for review.** B. Requests for review of adverse actions made by the ~~local department of social services,~~ VDSS, the CPU, or DMAS shall be submitted in writing to DMAS. - to be consistent with the definitions, should be DSS instead of VDSS. E. To be timely, requests for review of a ~~local department of social services,~~ VDSS, DMAS, or CPU determination shall be filed with 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~~ an agency determination shall be considered filed with DMAS on the date the request is postmarked, if mailed, or on the date the request is received, if delivered other than by mail, by DMAS. - to be consistent with the	The term "VDSS" is used to refer to the central office of the Virginia Department of Social Services, and local departments, inclusively. VDSS is the acronym used by the agency. Wording is changed throughout the regulation to be consistent.

	definitions, should be DSS instead of VDSS.	
VHCF	**12VAC30-141-80 to 12VAC30-141-90. (Reserved.)** Historical Notes Part III Eligibility Determination and Application Requirements (4)(b) iii. 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. - Should this specify FAMIS Select? - 4(b)(3): It might be clearer to refer to "Title XXI through the SCHIP premium assistance program" as FAMIS Select, as it is referred to as FAMIS Select throughout. 6(a): This section suggests that a Social Security Number (SSN) must be provided for all individuals listed on the application, when an SSN is only required for those individuals for whom coverage is requested. F. Financial eligibility 2. Standards. b. In determining family size for the eligibility determination of other individuals in the household that includes a pregnant woman,	Wording changed to “through the SCHIP Premium Assistance program known as FAMIS Select.” This section addresses general eligibility requirements, and refers to “all eligible individuals”. All applicants seeking eligibility, listed on the application, therefore must provide a SSN. The term “pregnant woman” is inclusive of teens; this is consistent with general health care terminology. The Agency does not distinguish pregnancy status by age. Wording changed to strike “current”.

	the pregnant woman [insert: or teen] is counted just as herself._c. Financial eligibility is determined consistent with the following provisions: (1) For new applicants, financial eligibility is based on the current monthly income and family size. -how is "current" defined? Month in which the family submits an application? - F(2)(c)(1): It might be clearer to indicate that "current monthly household income" means the month in which the family submits its application for FAMIS or FAMIS MOMS. <u>(3) In determining current monthly household income, the Agency will use reasonable methods to account for a reasonably predictable decrease in future income and/or family size.</u> - is "change" an acceptable substitute for "decrease"? <u>d. Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual in the individual's household.</u> - confusing as written. Could it be "MAGI-based income of the individual's household"? ~~4.~~ <u>3.</u> Spenddown. ~~Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS. If the family income exceeds the~~	Wording changed to reflect "a change" rather than "decrease" Wording changed to "Unless an exception exists… household income is the sum of the MAGI-based income for every person counted in the individual's MAGI household." See response to similar comment above regarding spend-down. Wording changed to "where household income exceeds the income eligibility limit." A definition of "targeted low-income pregnant woman" has been added consistent with the cited federal law.

	~~income limits described in this section, the individual shall be ineligible for FAMIS regardless of the amount of any incurred medical expenses.~~ The Commonwealth does not apply a spenddown process for FAMIS where household income exceeds the qualifying income limit. - Should there be a spenddown process for FAMIS? Clarify that whether "qualifying income" applies to FAMIS or spenddown? I. Eligibility of newborns. 2. A child born to a targeted low-income pregnant woman is deemed to have applied for and be eligible for FAMIS or Medicaid until the child turns age one in accordance with section 2112 of the Social Security Act. -what is the definition of "targeted"?	
VHCF	**12VAC30-141-110. Duration of eligibility and renewal.** A. The effective date of FAMIS eligibility shall be the date of birth for a newborn deemed eligible under 12VAC30-141-100 I. Otherwise the effective date of FAMIS eligibility shall be the first day of the month in which a signed completed application was received by either the ~~FAMIS~~ VDSS or CPU central processing unit or a local department of social services if the applicant met all eligibility requirements in that month. In no case shall a child's eligibility be effective	See above response regarding VDSS references. Wording changed

	earlier than the date of the child's birth. - for consistency, should be "DSS" in lieu of VDSS. B. Eligibility for FAMIS will continue for 12 months so long as the child remains a resident of Virginia and the child's countable income does not exceed 200% of the federal poverty level. A child born to a mother who was enrolled in FAMIS, under either the XXI Plan or a related waiver (such as FAMIS MOMS), on the date of the child's birth shall remain eligible for one year regardless of income unless otherwise found to be eligible for Medicaid. A change in eligibility will be effective the first of the month following expiration of a 10-day advance notice. Eligibility based on all eligibility criteria listed in 12VAC30-141-100 C will be redetermined no less often than annually.	
VHCF	**12VAC30-141-120. Children ineligible for FAMIS.** ~~3.~~ 2. An inmate of a public institution as defined in 42 CFR §435.1009, he shall be ineligible for FAMIS; or ~~4.~~ 3. An inpatient in an institution for mental disease (IMD) at initial eligibility or renewal as defined in 42 CFR §435.1010, he shall be ineligible for FAMIS. - when does enrollment	This regulation addresses initial and eligibility and renewal, not cancellation of enrollment. Wording changed to " 2. An inmate of a public institution at initial eligibility or renewal as defined in 42 CFR §435.1009~~,~~ ~~he~~ shall be ineligible for FAMIS

	get cancelled. The date the person enters the facility or the end of the month the person enters the facility? Would "initial eligibility or renewal" apply to inmate of a public institution, too?	
VHCF	**12VAC30-141-150. Application requirements.** (C)1. DMAS employs a single, streamlined application developed by the state and approved by the Secretary of the Department of Health and Human Services [replace "Service" with "Resources" if this refers to Virginia] in accordance with section 1413(b)(I)(B) of the Affordable Care Act. 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, [insert: and/" or a ~~redetermination~~ renewal process ~~for eligibility~~. J: The term "signed" in this section suggests a physical signature on a paper application. Today, applicants may "sign" an online application as well as a telephonic application. • It is not clear if this section also includes applications that are received via snail mail or by hand-delivering an application to the local department of social services. • L(2): "... cannot be	Secretary of Health and Human Services is the correct citation. See responses to similar comment above from VPLC The proposed text is as follows: "J. Timely determination of eligibility. The time processing standards for determining eligibility ~~for child health insurance~~ begin with the date an ~~signed~~ application is submitted online or by telephone or received either at ~~a local department of social services~~ DSS or the ~~FAMIS~~ CPU." Wording is also changed to include "hard copy received…" See response to similar comment by VPLC, above.

	located after numerous efforts to contact the applicant using alternative methods of contact that are documented by the case worker." M. Case maintenance. All cases approved for FAMIS shall be maintained at local departments of social services or other entity designated by DMAS. ~~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~~ The determining agency 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. DMAS outreach resources may also provide information of assistance to the enrollee.	 Wording changed
VHCF	**12VAC30-141-175. FAMIS Select.** B. DMAS will continually verify the child's or children's coverage under the ~~private or~~ employer's plan and will redetermine the eligibility of the child or children for the FAMIS Select component when it receives information concerning an applicant's or enrollee's circumstances that may affect eligibility. - The language in this section	Wording changed throughout to reflect “private or employer-sponsored” coverage Wording changed to clearly identify FAMIS Select.

	sounds like it is referring to the Health Insurance Premium Program (HIPP), rather than FAMIS Select. G. Premium assistance. When a child is determined eligible for coverage under the FAMIS Select component, premium assistance payments shall become effective the month in which the FAMIS child or children are enrolled in the employer's plan. Payment of premium assistance shall end:	Wording changed throughout
VHCF	**12VAC30-141-660. Assignment to managed care.** 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 reassigned. The department shall establish procedures for good cause reassignment through written policy directives. - Can families call DMAS to make an MCO change or must it be in writing?	Reference to the request being in writing is deleted.
	Part VII FAMIS MOMS **12VAC30-141-670. Definitions.** ~~"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~~	The terms are edited due to the implementation of MAGI rules.

	~~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.~~ ~~"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~~	Wording changed

	~~claims the child as a dependent on the employee's federal tax return.~~ - Why are the terms above being removed? Due to use of MAGI versus family under the ACA?	
VHCF	**12VAC30-141-690. 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. - VHCF description or one-on-one application assistance?	The comment does not include information on the "VHCF description". The intent of the wording is to include both statewide outreach and public participation, as well as one-on-one assistance with applications, as needed.
	12VAC30-141-730. Review procedures. F and G: It might be easier to follow if sections F and G were combined into one section. If not, could the phrase "by the external quality review organization" that is in Section F be included in Section G, so the paragraphs are parallel?	See response to similar comment by VPLC, above. The eligibility determination is made for the applicant, and notice is made to the applicant, not the physician. The physician would not be requesting a review of an eligibility determination.

	Also, it would be helpful to clarify if a fee-for-service enrollee's physician requests an expedited review of a FAMIS MOMS eligibility determination, whether the written decision is reviewed by an external quality review organization, like it would be for a FAMIS MOMS MCHIP enrollee.	
VHCF	**12VAC30-141-740.** ~~**Eligibility requirements.**~~ **General conditions of eligibility.** 2. Standards. Income standards for FAMIS MOMS are the same as those described at 12VAC30-141-100(F)(2), applied to pregnant women. For purposes of income determination, the family size will count the unborn child/children. ~~based on a comparison of countable income to 200% 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 12VAC30-40-100 e. Pregnant women 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 MOMS.~~ 3. Spenddown. ~~Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS MOMS. If the family income exceeds the~~	Wording changed Wording changed See response to similar comment above regarding spend-down.

	~~income limits described in this section, the individual shall be ineligible for FAMIS MOMS regardless of the amount of any incurred medical expenses.~~ DMAS does not apply a spenddown process for FAMIS MOMS where household income exceeds the qualifying income limit - It is not clear if there is a spenddown process for FAMIS MOMS and, if there is, whether the "qualifying income" refers to FAMIS MOMS or a spenddown process.	
VHCF	**12VAC30-141-750. 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 DSS, DMAS, or the CPU ~~either the FAMIS central processing unit or a local department of social services~~ if the applicant met all eligibility requirements in that month. - To be consistent, add “DMAS” to Duration of Eligibility and Renewal in the FAMIS section, as well as Timely Processing Standards and	Wording changed
VHCF	**12VAC30-141-760. Pregnant women ineligible for FAMIS MOMS.** ~~3~~ 2. An inmate of a public institution as defined in 42	This regulation addresses initial and eligibility and renewal, not cancellation of enrollment. Wording changed to “ 2. An inmate of a

	CFR §435.1009, she shall be ineligible for FAMIS MOMS; or ~~4.~~ 3. An inpatient in an institution for mental disease (IMD) as defined in 42 CFR §435.1010, she shall be ineligible for FAMIS MOMS at the initial determination of eligibility. - When does enrollment get cancelled. The date the person enters the facility or the end of the month the person enters the facility? Would "initial eligibility or renewal" apply to inmate of a public institution, too? M. Case maintenance. All cases approved for FAMIS MOMS shall be maintained at ~~the FAMIS CPU~~departments of social services or the 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~~ The DSS or the agency determining eligibility 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. DMAS outreach resources may also provide information of assistance to the enrollee.	public institution at initial eligibility or renewal as defined in 42 CFR §435.1009~~,~~ ~~he~~ shall be ineligible for FAMIS MOMS" Wording changed
VHCF	**12VAC30-141-790. Application**	

	requirements. J. Timely determination of eligibility. The time processing standards for determining eligibility for FAMIS MOMS coverage begin with the date an ~~signed~~ application is submitted online or by telephone or received ~~either~~ at a local department of social services or the ~~FAMIS~~ CPU. All ~~Applications received at local departments of social services must~~ applications shall have ~~a full Medicaid~~ an eligibility determination ~~and, when a pregnant woman is determined to be ineligible~~ for Medicaid ~~due to excess income, a~~ and FAMIS MOMS ~~eligibility determination~~ performed~~,~~ within the ~~same~~ Medicaid case processing time standards if all information necessary to make the determination has been received. - The "Timely Determination of Eligibility Requirements" section is confusing. It might be clearer if it mirrored the language in 12VAC-30-141-150, "Timely Determination of Eligibility Requirements" for FAMIS. Also, it might be helpful to include language regarding the 10 business day processing time, since that language is removed from the section that follows.	Wording changed as noted under response to VPLC comments Wording changed
VHCF	**12VAC30-141-800. Copayments.** B. These cost-sharing provisions shall be implemented with the	Wording changed

	following restrictions: 1. Total cost sharing for a pregnant woman shall be limited to the lesser of (i) $180 and (ii) 2.5% of the family's income for the year for the duration of her enrollment in FAMIS MOMS. - Why wouldn't the cost-sharing limits be the lesser of $350 and 5.0% of the family's income for the enrollment period for families with incomes over 150% FPL?	
VCHF	**12VAC30-141-880. Assignment to managed care.** 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 reassigned. The department shall establish procedures for good cause reassignment through written policy directives. - Can families call DMAS to make an MCO change or must it be in writing?	Reference to the request being in writing has been deleted.

Family impact

Please assess the impact of this 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 does not increase or decrease disposable family income.

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 follow the instructions in the text following the three chart templates below.

As noted above, none of the changes in the following chart have an economic impact. These are language changes that update the existing language to match current practice.

Chapter Citation	Chapter Title	Nature of Recommended Changes
12 VAC 30-141-10	Definitions	Adds new definitions and modifies existing definitions pertinent to MAGI and operational processes. The following definitions were removed: Act, adult caretaker relative, agency error, Board, CMSIP, competent individual, comprehensive health insurance coverage, family, family income, fraud, group health plan, legally emancipated, LDSS, maternal and child health insurance application, member of a family, supplemental coverage, Virginia State Employee Health Insurance Plan. The following definitions were added: adverse benefit determination, appeal, creditable health insurance coverage, eligibility worker, ex parte review, household, household income, internal appeal, lawfully residing, managed care organization, notice of reasonable

		opportunity, reasonable opportunity period, targeted low-income child, targeted low-income pregnant woman, VDSS. The following definitions were updated: application for health insurance, authorized representative, central processing unit, continuation of enrollment, family.
12 VAC 30-141-20	Administration and general background	Updates operational processes in paragraph B to reflect current practice.
12 VAC 30-141-30	Outreach and public participation	Updates operational processes in paragraph B to reflect current practice. Updates the reference to the Children's Health Insurance Program Advisory Committee (CHIPAC). Removes paragraph C, which is no longer accurate. Designates old paragraph D as paragraph C. A new paragraph D includes information on tribal consultation.
12 VAC 30-141-40	Review of adverse actions	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-50	Nature of adverse actions	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-60	Request for review	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-70	Review procedures	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-100	Eligibility requirements	Includes significant changes to reflect the current financial and non-financial eligibility standards that are contained within federal regulations for Modified Adjusted Gross Income requirements (and that have been in

		effect at DMAS since 2014). (MAGI updates to other regulatory sections were accomplished in Town Hall Action 4374.)
12 VAC 30-141-110	Duration of eligibility	Includes significant changes to reflect the current financial and non-financial eligibility standards that are contained within federal regulations for Modified Adjusted Gross Income requirements that have been in effect at DMAS since 2014. Updates terminology from 'redetermination' to 'annual renewal'
12 VAC 30-141-120	Children ineligible for FAMIS	This section is repealed consistent with MAGI requirements.
12 VAC 30-141-130		There are no changes to this section and it is not included in this regulatory package.
12 VAC 30-141-140		There are no changes to this section and it is not included in this regulatory package.
12 VAC 30-141-150	Application requirements	Includes significant changes to reflect the current financial and non-financial eligibility standards that are contained within federal regulations for Modified Adjusted Gross Income requirements that have been in effect at DMAS since 2014. Updates terminology and operational processes at VDSS and CPU consistent with implementation of MAGI standards; use of a single streamlined application; case documentation and maintenance updates.
12 VAC 30-141-160	Copayments for families not participating in FAMIS Select	Added clarification that the cap on copays applies for the 12-month enrollment period.
12 VAC 30-141-175	FAMIS Select	Added clarification that an application may be submitted electronically. Updated a reference to the CPU to

		the "agency managing the case."
12 VAC 30-141-200	Benefit packages	There are no changes to this section and it is not included in this regulatory package.
12 VAC 30-141-500	Benefits reimbursement	The 26-visit limit in paragraph D(1) has been removed as federal regulations do not permit limits on services for individuals under the age of 21.
12 VAC 30-141-660	Assignment to managed care	Removes outdated language related to CPU. Specifies that a choice of managed care organization may be made at the time of application. Permits reassignment at annual renewal.
12 VAC 30-141-670	Definitions	Adds new definitions and modifies existing definitions pertinent to MAGI and operational processes. The following definitions were removed: Act, adult caretaker relative, agency error, Board, CMSIP, competent individual, comprehensive health insurance coverage, family, family income, fraud, group health plan, legally emancipated, LDSS, member of a family, Virginia State Employee Health Insurance Plan. The following definitions were added: adverse benefit determination, appeal, creditable health insurance coverage, lawfully residing, managed care organization, VDSS. The following definitions were updated: agency, application for health insurance, central processing unit, continuation of enrollment.
12 VAC 30-141-680	Administration and general background	Updates operational processes to reflect current practice – DMAS staff no longer perform eligibility determinations.
12 VAC 30-41-690	Outreach and public	Adds non-profit agencies and

	participation.	foundations.
12 VAC 30-141-700	Review of adverse actions	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-710	Nature of adverse actions	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-720	Request for review	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-730	Review procedures	Updates language about appeals processes to reflect federal regulatory requirements.
12 VAC 30-141-740	Eligibility requirements	Includes significant changes to reflect the current financial and non-financial eligibility standards that are contained within federal regulations for Modified Adjusted Gross Income requirements that have been in effect at DMAS since 2014.
12 VAC 30-141-750	Duration of eligibility	Updates terminology (central processing unit updated to CPU, etc.)
12 VAC 30-141-760	Pregnant women ineligible for FAMIS MOMS	Includes significant changes to reflect the current financial and non-financial eligibility standards that are contained within federal regulations for Modified Adjusted Gross Income requirements that have been in effect at DMAS since 2014.
12 VAC 30-141-790	Application requirements	Includes significant changes to reflect the current financial and non-financial eligibility standards that are contained within federal regulations for Modified Adjusted Gross Income requirements that have been in effect at DMAS since 2014. Updates terminology and operational processes at VDSS and CPU consistent with implementation of MAGI standards; use of a single streamlined application; case documentation and maintenance.