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MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **ELIZABETH M. GUGGENHEIM**
Assistant Attorney General

DATE: **January 9, 2018**

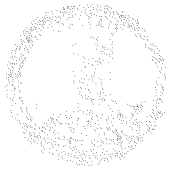
SUBJECT: **Proposed regulations regarding FAMIS and FAMIS MOMS**

I have reviewed the proposed regulations that would incorporate federal changes regarding eligibility based on a new Modified Adjusted Gross Income (MAGI) methodology and update operational processes supporting eligibility and renewal actions. Based on my review, DMAS has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Virginia Code §§ 32.1-324 and 32.1-325 grant to the Board of Medical Assistance Services the authority to administer and amend the plan for Medical Assistance and authorizes the Director of DMAS to administer and amend the plan for Medical Assistance according to the Board's requirements. The authority for these proposed regulations derives from Virginia Code § 32.1-351(J).

If you have any questions or need additional information, please feel free to contact me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General



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Logged in as
Elizabeth Guggenheim

Proposed Text

Action: FAMIS and FAMIS MOMS Periodic Review
Stage: Proposed
1/4/18 11:25 AM [latest]

Part I
General Provisions

12VAC30-141-10. Definitions.

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

~~"Act" means the Social Security Act.~~

~~"Adult caretaker relative" or "caretaker relative" means an individual who is age 18 or older, who is not the parent of, but who is related to, the child by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.~~

~~"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in part; provided, however, that determination of eligibility to participate in and termination of participation in the FAMIS Select program shall not constitute an adverse action.~~

"Adverse action" consistent with 42 C.F.R. § 457.1130, means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment, including disenrollment for failure to pay cost sharing; or delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and failure to approve, furnish, or provide payment for health services in a timely manner; provided, however, that determination of eligibility to participate in and termination of participation in the FAMIS Select program shall not constitute an adverse action.

"Adverse Benefit Determination" Consistent with 42 C.F.R. § 438.400, adverse benefit determination refers to the denial or limited authorization of a requested service; the failure to take action or timely take action on a request for service; the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a service; failure to provide services within the timeframes required by the state; for a resident of a rural exception area with only one MCO, the denial of a enrollees request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside of the network; the denial of a enrollees request to dispute a financial liability as provided in 42 CFR 438(b)(7); or the failure of an MCO to act within the timeframes provided in 42 CFR 438.408(b).

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

~~"Agency error" means a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or the central processing unit.~~

"Agent" means an individual designated in writing to act on behalf of a FAMIS Plan applicant or enrollee during the administrative review process.

"Appeal" means an enrollees request for review of an adverse benefit determination by an MCO or an adverse action by the VDSS, CPU, or DMAS.

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

"Application for health insurance" means the ~~form or forms developed and approved by the Department of Medical Assistance Services that are used for determining eligibility for Family Access to Medical Insurance Security Plan (FAMIS), FAMIS Plus (Children's Medicaid), for Medicaid for pregnant women, and for FAMIS MOMS~~. single streamlined application for determining eligibility in public health insurance programs operated by the Commonwealth.

"Authorized representative" means a person, 18 years of age or older, who is authorized to conduct the personal or financial affairs for an individual ~~who is 18 years of age or older~~.

~~"Board" or "BMAS" means that policy board created by § 32.1-324 of the Code of Virginia to administer the plans established by the Social Security Act.~~

~~"CMSIP" means that original child health insurance program that preceded FAMIS.~~

"Central processing unit" or "CPU" means the ~~private contractor that will determine eligibility for and administer part of the Family Access to Medical Insurance Security Plan or FAMIS.~~ centralized entity supported by DMAS to accept and act on applications for health insurance.

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

~~"Competent individual" means a person who has not been judged by a court to be legally incapacitated.~~

~~"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services; physician's surgical and medical services; and laboratory and radiological services.~~

"Creditable health coverage" means coverage that meets the definition in 42 CFR § 457.10.

"Conservator" means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"Continuation of ~~enrollment~~ coverage" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for FAMIS.

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

"Eligibility worker" means an individual who, under supervision, applies regulations, policies, and procedures to determine eligibility for public assistance programs, including FAMIS and FAMIS MOMS.

"Enrollee" means a child who has been determined eligible to participate in FAMIS and is enrolled in the FAMIS program.

"Ex parte review" means the review of administratively available information pertinent to the application/renewal process, conducted by eligibility staff, in order to expediently process the applicants renewal without seeking that information from the applicant.

"External quality review organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS.

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

"Family," when used in the context of the FAMIS Select component, means a unit or group that has access to ~~an~~ a private or employer's group health plan. Thus, it includes the policyholder or employee and any dependents who can be covered under the ~~employer's~~ plan.

~~"Family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before-tax earnings from a job, including cash, wages, salary, commissions, tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions, retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships for educational expenses or earned income of a child who is a student.~~

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

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

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

"Fee-for-service" means the traditional Medicaid health care delivery and payment system in which physicians and other providers receive a payment for each unit of service they provide.

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

~~"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.~~

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

"Guardian" means a person appointed by a court of competent jurisdiction to be responsible for the affairs of an incapacitated individual, including responsibility for

making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

"Household" means the household composition and follows the federal tax rules through the use of modified adjusted gross income (MAGI) methodology. An individuals household is based upon the tax filing relationships of applicant, person(s) living with the individual, and those claimed as dependent(s) and as outlined in 42 U.S.C. §435.603(3)(f)(1) through (f)(4).

"Household income" means the sum of MAGI-based income as outlined in 42 U.S.C. §435.603(3)(d) through (e), to include every individual in the household.

"Incapacitated ~~individual~~" means a person who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator.

"Internal Appeal" means a request to the MCO by an enrollee, an enrollees authorized representative, or provider, acting on behalf of the enrollee and with the enrollees written consent, for review of an MCOs adverse benefit determination. The internal appeal is the only level of appeal with the MCO and must be exhausted by an enrollee or deemed exhausted according to 42 CFR § 438.408(c)(3) before the enrollee may initiate a state fair hearing.

"Lawfully residing" means the individual is lawfully present in the United States.

~~"Legally emancipated" means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A~~ Pursuant to Va. Code § 16.1-331, ~~married minor is not emancipated unless a court has declared the married minor emancipated from his parents.~~

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

"Managed care health insurance plan" or "MCHIP" as defined in § 32.1-137.1 of the Code of Virginia means an arrangement for the delivery of health care in which a health carrier ~~means~~ under contract with DMAS for Title XXI delivery systems, undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains one or more incentive arrangements, including any credential requirements intended to influence the cost of the health care services between the health carrier and one or more providers and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"Managed care organization" or "MCO" means an organization that offers managed care health insurance plans (MCHIP) as defined in this section.

~~"Maternal and child health insurance application" means the form or forms developed and approved by the Department of Medical Assistance Services that are used by local departments of social services and the FAMIS CPU for determining eligibility for Medicaid for poverty-level children and for the Family Access to Medical Insurance Security Plan (FAMIS).~~

~~"Member of a family," for purposes of determining whether the child is eligible for coverage under a state employee health insurance plan, means a parent or~~

~~parents, including stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.~~

"Notice of reasonable opportunity" means the written notice that is sent to the applicant to inform him that he must provide verification of citizenship or identity within 90 days.

"Premium assistance" means the portion of the family's cost of participating in a private or 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 cost effective to do so.

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

"Provider" means the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP or in fee-for-service to render services to FAMIS enrollees eligible for services.

"Reasonable opportunity period" means a 90-day period given to applicants to supply verification of citizenship or identity.

~~"Supplemental coverage" means coverage provided to FAMIS-eligible children covered under the FAMIS Select component so that they can receive all childhood immunizations included in the FAMIS benefits.~~

"Targeted low-income child (or children)" means an uninsured child or children under age 19 whose household income is within the FAMIS eligibility standards established by the Commonwealth.

"Targeted low-income pregnant woman" means uninsured pregnant woman/women whose household income is within the Medicaid or FAMIS MOMS eligibility standards established by the Commonwealth.

"Title XXI" means the federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"VDSS" or "Virginia Department of Social Services" means the State Department of Social Services and the local departments of social services.

~~"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees.~~

12VAC30-141-20. Administration and general background.

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements for a State Child Health Insurance Plan (also known as Title XXI).

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.~~

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

12VAC30-141-30. Outreach and public participation.

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

B. Pursuant to § 32.1-351.2 of the Code of Virginia, DMAS shall establish ~~an Outreach Oversight Committee (committee) to discuss strategies to improve outreach activities. The committee members shall be selected by DMAS and shall be composed of representatives from community-based organizations engaged in outreach activities, social services eligibility workers, the provider community, health plans, and consumers. The committee shall meet on a quarterly basis. As may be appropriate, the committee shall make recommendations regarding state-level outreach activities, the coordination of regional and local outreach activities, and procedures for streamlining and simplifying the application process, brochures, other printed materials, forms, and applicant correspondence.~~ a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for FAMIS and FAMIS Plus, and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of DMAS and the Secretary of Health and Human Resources.

~~C. The board, in consultation with the committee, shall develop a comprehensive, statewide community-based outreach plan to enroll children in the FAMIS program and, if so eligible, in Medicaid. The outreach plan shall include specific strategies for: (i) improving outreach and enrollment in those localities where enrollment is less than the statewide average and (ii) enrolling uninsured children of former Temporary Assistance to Needy Families (TANF) recipients.~~

~~D.~~ C. DMAS shall develop a comprehensive marketing and 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, non-profit agencies and foundations, coordination with other state agencies, coordination with the business community, and coordination with health care associations and providers.

D. DMAS shall ensure consultation by Native American Tribes on the development and implementation of enrollment processes and procedures to exempt cost-sharing for American Indian and Alaskan Native children in compliance with 42 CFR §§ 457.120 and 457.125.

Part II
~~Review~~ Appeal of Adverse Actions

12VAC30-141-40. ~~Review~~ Appeal of adverse actions or adverse benefit determinations.

A. Upon written request, all FAMIS ~~Plan~~ applicants and enrollees shall have the right to a ~~review~~ state fair hearing of an adverse action made by the ~~MCHIP, local department of social services,~~ DSS, CPU or DMAS, and to an internal appeal of an adverse benefit determination made by an MCO.

B. During ~~review~~ the appeal of a suspension or termination of enrollment or a reduction, suspension, or termination of services, the enrollee shall have the right to continuation of coverage if the enrollee requests ~~review~~ an internal appeal with the MCO or an appeal to DMAS prior to the effective date of the suspension or termination of enrollment or suspension, reduction, or termination of services.

C. ~~Review~~ An appeal of an adverse action made by the ~~local department of social services,~~ DSS, CPU or DMAS shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under ~~review~~ appeal.

D. ~~Review~~ An internal appeal of an adverse ~~action~~ benefit determination made by the ~~MCHIP~~ MCO must be conducted by a person or agent of the ~~MCHIP~~ MCO who has not been directly involved in the adverse ~~action~~ benefit determination under ~~review~~ appeal.

E. ~~After final review by the MCHIP,~~ Pursuant to 42 CFR 438.402(c)(1)(B), after exhausting the MCOs internal appeals process, there shall ~~also~~ be opportunity for the enrollee to request an ~~final independent~~ external medical review by ~~the~~ an independent external quality review organization. The review is optional and shall not be required before proceeding to a state fair hearing. The review shall not extend any of the timeframes for issuing a decision and shall not disrupt any continuation of benefits granted to the enrollee.

F. There will be no opportunity for ~~review~~ appeal of an adverse action to the extent that such adverse action is based on a determination by the director that funding for FAMIS has been terminated or exhausted. ~~There will be no opportunity for review based on which type of delivery system (i.e., fee-for-service, MCHIP) is assigned.~~ There will be no opportunity for ~~review~~ appeal if the sole basis for the ~~adverse action is a state or federal law or regulation requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.~~ decision is a provision in the State Plan or in a state or federal law requiring an automatic change in eligibility or enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

G. The burden of proof shall be upon the applicant or enrollee to show that an adverse action or adverse benefit determination is incorrect.

H. At no time shall the ~~MCHIP's, local department's of social services,~~ MCO, VDSS, ~~the CPU's, or DMAS'~~ CPU, or DMAS failure to meet the time frames set in this chapter or set in the ~~MCHIP's~~ MCOs or DMAS' written ~~review~~ appeal procedures constitute a basis for granting the applicant or enrollee the relief sought.

I. Adverse actions related to health benefits covered through the FAMIS Select program shall be resolved between the insurance company or employer's plan and the FAMIS Select enrollee, and are not subject to further ~~review~~ appeal by DMAS or its contractors. ~~Adverse actions made by an MCHIP, the local department of social services, the CPU, or DMAS shall be subject to the review process set forth in Part II (12VAC30-141-40 et seq.) of this chapter.~~

12VAC30-141-50. Notice of adverse action or adverse benefit determination.

A. The ~~local department of social services,~~ VDSS, ~~the~~ CPU, or DMAS shall send written notification to enrollees at least 10 calendar days prior to suspension or termination of enrollment.

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

C. The ~~local department of social services,~~ VDSS, ~~the~~ CPU, DMAS or the ~~MCHIP~~ MCO shall send written notification to applicants and enrollees of all other adverse actions within 10 calendar days of the adverse action.

D. ~~Notice shall include the reasons for determination, an explanation of applicable rights to a review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment or services may continue pending review.~~ Notice shall include:

1. The determination the VDSS, CPU, DMAS, or MCO has made or intends to make;

2. The reasons for the determination, including the right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the determination;

3. An explanation of applicable rights to request an appeal of that determination. For adverse benefit determinations by an MCO, this shall include information on the MCOs internal appeal process and, after the internal appeal process is exhausted, a state fair hearing, pursuant to 42 CFR 402(b) and (c);

4. The procedure for exercising these appeal rights;

5. The circumstances under which an appeal process can be expedited and how to request it; and

6. The circumstances under which enrollment or services may continue pending appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

12VAC30-141-60. Request for ~~review~~ appeal.

A. Requests for ~~review~~ internal appeal of ~~MCHIP~~ MCO adverse ~~actions~~ benefit determinations shall be submitted orally or in writing to the ~~MCHIP~~ MCO. Unless the enrollee requests an expedited appeal, an oral appeal request must be followed by a written appeal request. The enrollee must exhaust the MCOs internal appeals process before appealing to DMAS.

B. If the MCO fails to adhere to the notice or timing requirements set for the in this Part, the enrollee is deemed to have exhausted the MCOs internal appeals process and may initiate a state fair hearing.

~~B.~~ C. Requests for ~~review~~ appeal of adverse actions made by the ~~local department of social services,~~ VDSS, ~~the~~ CPU, or DMAS, or of internal appeal decisions by the MCO shall be submitted ~~in writing~~ to DMAS.

~~C.~~ D. Any ~~written~~ communication ~~clearly~~ expressing a desire to have an adverse ~~action~~ benefit determination by an MCO reviewed shall be treated as a request for ~~review~~ an internal appeal. Any communication expressing a desire to have an adverse action by the VDSS, CPU, or DMAS reviewed shall be treated as a request for a state fair hearing. Any communication expressing a desire to have an MCOs internal appeal decision reviewed shall be treated as a request for a state fair hearing.

~~D.~~ E. To be timely, requests for ~~review~~ internal appeal of ~~a MCHIP~~ an MCOs adverse benefit determination shall be received by the ~~MCHIP~~ MCO no later than ~~30~~ 60 calendar days from the date of the ~~MCHIP's~~ MCOs notice of adverse ~~action~~ benefit determination.

F. To be timely, a request for an appeal of an adverse benefit determination upheld in whole or in part by the MCOs internal appeal decision shall be received by DMAS within 120 calendar days from the date of the internal appeal decision.

~~E.~~ G. To be timely, requests for ~~review~~ appeal of a ~~local department of social services,~~ VDSS, DMAS, or CPU ~~determination~~ adverse action 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~~ appeal 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.

12VAC30-141-70. ~~Review~~ Appeal procedures.

A. At a minimum, the ~~MCHIP review~~ MCO internal appeal shall be conducted pursuant to written procedures as defined in § 32.1-137.6 of the Code of Virginia and ~~as may be further defined by DMAS~~ 42 CFR 438.400 et seq. Such procedures shall be subject to review and approval by DMAS.

B. Any adverse benefit determination upheld in whole or in part by the internal appeal decision issued by the MCO may be appealed by the enrollee to DMAS in accordance with the DMAS client appeals regulations at 12VAC30-110-10 through 12VAC30-110-370. DMAS shall conduct an evidentiary hearing in accordance with the 12VAC30-110-10 through 12VAC30-110-370 and shall not base any appealed decision on the record established by any internal appeal decision of the MCP. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

~~B.~~ C. ~~The DMAS review~~ Appeals of adverse actions by the VDSS, CPU, or DMAS shall be conducted pursuant to ~~written procedures developed by DMAS~~ 12VAC30-110-10 et seq.

~~C. The procedures in effect on the date a particular request for review is received by the MCHIP or DMAS shall apply throughout the review.~~

D. Copies of the procedures shall be promptly ~~mailed~~ provided by the ~~MCHIP~~ MCO or DMAS to applicants and enrollees upon receipt of timely requests for ~~review~~ internal appeals or state fair hearings. Such written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the ~~MCHIP~~ MCO, ~~local department of social services,~~ DSS, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;

2. The right to timely review of their files and other applicable information relevant to the ~~review of the~~ internal appeal or state fair hearing decision;

3. The right to fully participate in the ~~review~~ internal appeal or state fair hearing process, whether the ~~review~~ internal appeal or state fair hearing is conducted in person or in writing, including the presentation of supplemental information during the ~~review~~ internal appeal or state fair hearing process;

4. The right to have personal and medical information and records maintained as confidential; and

5. The right to a written final decision; ~~within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.~~

a. For internal appeals to the MCO, within 30 calendar days of receipt of the request for an internal appeal; or

b. For state fair hearings, within the time limitations for appeals imposed by federal regulations and as permitted in 12VAC30-110-30.

6. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to request an expedited ~~review~~ appeal. Under these conditions, a request for ~~review~~ expedited appeal shall result in a written final decision within ~~three business days~~ 72 hours after DMAS receives~~,~~ the expedited appeal request from the physician or health plan~~,~~ with the case record and information indicating that taking the time for

a standard resolution of the ~~review~~ appeal request could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain or regain maximum function, unless the applicant or enrollee ~~or his authorized representative causes a delay~~ requests an extension.

7. For health services matters for FAMIS enrollees receiving services through ~~MCHIPs~~ an MCO~~,~~:

a. ~~if~~ If the enrollee's physician or health plan determines that the ~~90-calendar-day~~ 30-calendar-day timeframe for a standard internal appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to request an expedited ~~review~~ internal appeal. Under these conditions, a request for ~~review~~ an internal appeal shall result in a written decision by the ~~external quality review organization~~ MCO within 72 hours from the time ~~an enrollee requests~~ the expedited ~~review~~ internal appeal is requested, unless the applicant, enrollee, or authorized representative requests ~~or causes~~ a delay. If a delay is requested ~~or caused~~ by the applicant, enrollee, or authorized representative, then the expedited ~~review~~ internal appeal may be extended up to 14 calendar days.

b. If the adverse benefit determination is upheld in whole or in part by the expedited internal appeal decision issued by the MCO, and if the enrollees physician or health plan determines that the timeframe for a standard appeal to DMAS could seriously jeopardize the enrollees life or health or ability to attain, maintain, or regain maximum function, and enrollee will have the opportunity to request an expedited appeal to DMAS. Under these conditions, a request for a state fair hearing shall result in a written decision within 72 hours from the time an enrollee requests the expedited appeal, unless the applicant, enrollee, or authorized representative requests a delay. If a delay is requested by the applicant, enrollee, or authorized representative, then the expedited appeal may be extended up to 14 calendar days.

8. For health services matters for FAMIS enrollees receiving services through fee-for-service, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe for a standard appeal could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to request an expedited review. Under these conditions, a request for ~~review~~ an expedited appeal shall result in a written decision within 72 hours from the time ~~an enrollee requests~~ the expedited ~~review~~ appeal is requested, unless the applicant, enrollee, or authorized representative requests ~~or causes~~ a delay. If a delay is requested ~~or caused~~ by the applicant, enrollee, or authorized representative, then expedited ~~review~~ appeal may be extended up to 14 calendar days.

Part III
Eligibility Determination and Application Requirements

12VAC30-141-100. ~~Eligibility requirements.~~ General conditions of eligibility.

A. The DSS or the DMAS CPU determines eligibility for Title XXI services.

B. FAMIS shall be in effect statewide.

C. FAMIS serves targeted low-income children consistent with requirements at 42 CFR §§ 457.310, 457.315, and 457.320.

D. Each individual covered under the plan shall be:

1. Financially eligible (using the methods and standards described in 12VAC30-141-100(F)) to receive services; and

2. Meet the applicable nonfinancial eligibility conditions.

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

~~B. FAMIS shall be in effect statewide.~~

~~C.~~ E. ~~Eligible children must:~~ Nonfinancial eligibility conditions.

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

~~2~~1. Age: Eligible individuals shall ~~Be~~ be under 19 years of age.

~~3~~2. Residency: Eligible individuals shall ~~Be~~ be residents of the Commonwealth.

a. A child is considered to be a resident of the Commonwealth under the following conditions:

(1) A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and intends to reside in the state, including without a fixed address.

(2) A non-institutionalized child not described above and a child who is not in the custody of the state:

(a) Residing in the state, with or without a fixed address, or

(b) The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.

(3) An institutionalized child, who is not a ward of the state, if the state is the state of residence of the childs custodial parent or caretaker at the time of placement, or

(4) A child who is in the custody of the state regardless of where the child lives, or

(5) A child physically located in the state when there is a dispute with one or more states as to the childs actual state of residence.

3. Citizenship status: FAMIS eligibility is open to:

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

a. U.S. citizens;

b. U.S. nationals;

c. Qualified noncitizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

d. Individuals who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903 (x), 1137 (d), and 1902(ee) of the Act, and 42 CFR 435.407, 407, 956 and 457.380.

(1) The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

(2) An extension of the reasonable opportunity period is allowed if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency determining eligibility needs more time to complete the verification process.

(3) The agency will provide benefits to otherwise eligible individuals during the reasonable opportunity period.

e. Lawfully residing in the United States, as provided in Section 2107 (e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3). An individual is considered to be lawfully residing in the United States if he or she is:

(1) A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

(2) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101 (a)(17));

(3) A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) A non-citizen who belongs to one of the following classes;

(a) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

(b) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(c) Granted employment authorization under 8 CFR 274a.12(c);

(d) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649. as amended;

(e) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President:

(f) Granted Deferred Action status;

(g) Granted an administrative stay of removal under 8 CFR 241;

(h) Beneficiary of approved visa petition who has a pending application for adjustment of status;

(5) Is an individual with a pending application for asylum under 8 U.S.C. 1158 or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture, who:

(a) Has been granted employment authorization; or

(b) Is under the age of 14 and has had an application pending for at least 180 days;

(6) Has been granted withholding of removal under the Convention Against Torture;

(7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

(8) Is lawfully present in American Samoa under the immigration laws of American Samoa; or

(9) Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

(10) Exception: An individual with deferred action under the Department of Homeland Securitys deferred action for the childhood arrivals process, as described in the Secretary of Homeland Securitys June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

~~5~~4. No other coverage; Eligible individuals shall be uninsured, that is, not have creditable health insurance coverage.

a. Individuals eligible for FAMIS shall not be found eligible or potentially eligible for Medicaid under policies of the State plan determined through the screening process described at 42 CFR §457.350.

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

(1) FAMIS shall not be a substitution for private insurance.

(2) Only uninsured children shall be eligible for FAMIS. A child is not considered to be insured if the health insurance plan covering the child does not have a network of providers in the area where the child resides. Each application for child health insurance shall include an inquiry about health insurance. Each redetermination of eligibility shall also document inquiry about current health insurance.

(3) 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 known as FAMIS Select.

~~6. Not be a member of a family eligible for subsidized dependent coverage, as defined in 42 CFR 457.310(c)(1)(ii) under any Virginia state employee health insurance plan on the basis of the family member's employment with a state agency; and~~

~~7~~5. Residents of an institution: Eligible individuals may ~~Not~~ not be an inpatient in an institution for mental diseases (IMD), or an inmate in a public institution that is not a medical facility at the time of the initial eligibility determination, or redetermination.

6. Social Security Number:

a. All eligible individuals must furnish their social security numbers (SSN), with the following exceptions: (i) individuals refusing to obtain a SSN because of well-established religious objections, or (ii) Individuals who are not eligible for a SSN, or (iii) individuals who are issued a SSN only for a valid non-work purpose.

b. DMAS or its designee(s):

(1) assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN;

(2) informs individuals required to provide their SSN (1) by what statutory authority the number is solicited; and (2) how the state will use the SSN;

(3) will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration; and,

(4) will not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individuals SSN by the Social Security Administration.

c. The utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

d. The state requests non-applicant household members to voluntarily provide their SSN. When requesting an SSN for non-applicant household members, the

state (i) informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and (ii) uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

~~D. Income.~~

F. Financial eligibility

1. Screening. ~~All child health insurance applications received at the FAMIS central processing unit must be screened to identify applicants who are potentially eligible for Medicaid. Children screened and found potentially eligible for Medicaid cannot be enrolled in FAMIS until there has been a finding of ineligibility for Medicaid. Children who do not appear to be eligible for Medicaid shall have their eligibility for FAMIS determined. Children determined to be eligible for FAMIS will be enrolled in the FAMIS program.~~ All ~~Child health insurance~~ applications ~~received at a local department of social services~~ shall have a ~~full~~ Medicaid income eligibility ~~determination~~ screen completed. Children determined to be ineligible for Medicaid due to excess income will have their eligibility for FAMIS determined. ~~If a child is found to be eligible for FAMIS, the local department of social services will enroll the child in the FAMIS program.~~

2. Standards.

a. The Commonwealth shall apply Modified Adjusted Gross Income (MAGI) methodologies for all separate CHIP covered groups, consistent with 42 CFR 457.315 and 435.603(b) through (i). FAMIS shall be available for targeted low-income children. Income standards are applied statewide. ~~Income standards for FAMIS are based on a comparison of countable income to 200% of the federal poverty level for the family size, as defined in the State Plan for Title XXI as approved by the Centers for Medicare& Medicaid Services.~~ Children from birth to age 19 years who have income above the Medicaid-eligible limit and at or below 200% of the federal poverty level, with a 5% income disregard ~~but are ineligible for Medicaid due to excess income,~~ will be income eligible to participate in FAMIS.

b. In determining family size for the eligibility determination of other individuals in the household that includes a pregnant woman, the pregnant woman 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 monthly income and family size.

(2) When determining eligibility for current beneficiaries, financial eligibility is based on current monthly household income and family size.

(3) In determining current household income, the Agency will use reasonable methods to account for current income and reasonable prediction of change(s) in future income and/or family size.

d. Unless an exception exists, 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 for every person counted in the individuals MAGI household.

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

~~12VAC30-40-90. Income that would be excluded when determining Medicaid eligibility will be excluded when determining countable income for the former CMSIP children. Use of the Medicaid income methodologies shall only be applied in determining the financial eligibility of former CMSIP children for FAMIS and for only as long as the children meet the income eligibility requirements for CMSIP. When a former CMSIP child is determined to be ineligible for FAMIS, these former CMSIP income methodologies shall no longer apply and income eligibility will be based on the FAMIS income standards.~~

~~4.~~ 3. Spenddown. ~~Deduction of incurred medical expenses from countable income (spenddown) shall not apply in FAMIS. If the family income exceeds the income limits described in this section, the individual shall be ineligible for FAMIS regardless of the amount of any incurred medical expenses.~~ The Commonwealth does not apply a spenddown process for FAMIS where household income exceeds the income eligibility limit for FAMIS.

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

~~F. U.S. citizen or nationality. Upon signing the declaration of citizenship or nationality required by § 1137(d) of the Social Security Act, the applicant or recipient is required under § 2105(c)(9) to furnish satisfactory documentary evidence of U.S. citizenship or nationality and documentation of personal identity unless citizenship or nationality has been verified by the Commissioner of Social Security or unless otherwise exempt.~~

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

~~H. Coverage under other health plans.~~

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

~~2. No substitution for private insurance.~~

~~a. Only uninsured children shall be eligible for FAMIS. A child is not considered to be insured if the health insurance plan covering the child does not have a network of providers in the area where the child resides. Each application for child health insurance shall include an inquiry about health insurance. Each redetermination of eligibility shall also document inquiry about current health insurance.~~

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

I. Eligibility of newborns.

1. If a child otherwise eligible for FAMIS is born within the three months prior to the month in which a signed application is received, the eligibility for coverage is effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time. ~~A child born to a mother who is 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 be deemed eligible for FAMIS for one year from birth unless the child is otherwise eligible for Medicaid.~~

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.

a. The child is deemed to have applied for and been found eligible for FAMIS or Medicaid, as appropriate, as of the date of the childs birth, and remains eligible without regard to changes in circumstances until the childs first birthday.

b. The Commonwealth shall cover as a deemed newborn a child born to a mother who is covered under Medicaid or CHIP through the authority of the states section 1115 demonstration, on the date of the newborns birth.

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~~ For all other children, 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 earlier than the date of the child's birth.

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 Title 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.

C. Renewal of coverage.

1. Renewal of coverage for individuals whose financial eligibility is based on the applicable Modified Adjusted Gross Income (MAGI) standard are performed as follows, consistent with 42 CFR §457.343:

a. Renewal of coverage is completed once every 12 months, and

b. Without requiring information from the individual if able to do so based on an ex parte review of reliable information contained in the individuals account or other more current information available to the agency.

2. If the agency cannot determine eligibility solely on the basis of the ex parte review, or otherwise needs additional information to complete the redetermination, the individual is provided with a renewal form that is pre-populated with information contained in the individuals case. The individual shall be allowed 30 days to return the renewal form and the necessary verifications.

a. If the individual's coverage is cancelled because the renewal was not completed (either electronically, by phone, or on paper) or because verifications needed to complete the renewal were not returned, the individual has 90 days after the coverage is cancelled to provide the information necessary to complete the renewal without having to file a new application. This 90-day period is called the reconsideration period. If all necessary information is provided during the

reconsideration period and the individual found eligible, enrollment will be restored without any lapse in coverage.

12VAC30-141-120. ~~Children ineligible for FAMIS.~~ (Repealed.)

~~A. If a child is:~~

~~1. Eligible for Medicaid, or would be eligible if he applied for Medicaid, he shall be ineligible for coverage under FAMIS. A child found through the screening process to be potentially eligible for Medicaid but who fails to complete the Medicaid application process for any reason, cannot be enrolled in FAMIS;~~

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

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

~~4. An inpatient in an institution for mental disease (IMD) as defined in 42 CFR §435.1010, he shall be ineligible for FAMIS.~~

~~B. If a child's parent or other authorized representative does not meet the requirements of assignment of rights to benefits or requirements of cooperation with the agency in identifying and providing information to assist the Commonwealth in pursuing any liable third party, the child shall be ineligible for FAMIS.~~

~~C. If a child, if age 18, or if under age 18, a parent, adult relative caretaker, guardian, or legal custodian obtained benefits for a child or children who would otherwise be ineligible by willfully misrepresenting material facts on the application or failing to report changes, the child or children for whom the application is made shall be ineligible for FAMIS. The child, if age 18, or if under age 18, the parent, adult relative caretaker, guardian, or legal custodian who signed the application shall be liable for repayment of the cost of all benefits issued as the result of the misrepresentation.~~

12VAC30-141-150. Application requirements.

A. Availability of program information. DMAS or its designee shall furnish the following information in written form and orally as appropriate to all applicants and to other individuals who request it:

1. The eligibility requirements;

2. Summary of covered benefits;

3. Copayment amounts required; and

4. The rights and responsibilities of applicants and enrollees.

B. Opportunity to apply. DMAS or its designee must afford an individual, wishing to do so, the opportunity to apply ~~for child health insurance~~. ~~Applications for health insurance will be accepted at a central site designated by DMAS and at local departments of social services throughout the Commonwealth.~~ Applicants may file an application ~~for child health insurance~~ by mail, by fax, by phone, via the internet, or in person at local departments of social services. ~~Applications filed at the FAMIS CPU can be submitted by mail, by fax, via the Internet, or by phone.~~ Face-to-face interviews for the program are not required. Eligibility determinations for FAMIS shall occur at either ~~local departments of social services~~ DSS or at the DMAS designated ~~central site~~ CPU.

C. Application. DMAS or its designee shall require an application from the applicant if he is at least 18 years of age or older, or from a parent, adult relative caretaker, guardian, legal custodian, or authorized representative if the applicant is less than 18 years of age or the applicant is incapacitated.

1. DMAS employs a single, streamlined application developed by the state and approved by the Secretary of the Department of Health and Human Services in accordance with section 1413(b)(I)(B) of the Affordable Care Act.

2. DMAS may employ an alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

~~C.~~ D. Right to apply. An individual who is 18 years of age shall not be refused the right to complete an application for ~~health insurance for~~ himself and shall not be discouraged from asking for assistance for himself under any circumstances.

~~D.~~ E. Applicant's signature. The applicant must sign state-approved application forms submitted, even if another person fills out the form, unless the application is filed and signed by the applicant's parent, adult relative caretaker, legal guardian or conservator, attorney-in-fact or authorized representative.

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

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

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

~~H. Written application. DMAS or its designee shall require an written application from the applicant if he is at least 18 years of age or older, or from a parent, adult relative caretaker, guardian, legal custodian, or authorized representative if the applicant is less than 18 years of age or the applicant is incapacitated. The application must be on a form prescribed by DMAS, and must be signed under a penalty of perjury. The application form shall contain information sufficient to determine Medicaid and FAMIS eligibility.~~

I. Assistance with application. DMAS or its designee shall allow an individual or individuals of the applicant's choice to assist and represent the applicant in the application process, or a ~~redetermination~~ renewal process ~~for eligibility~~, or both.

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, by telephone, by fax, or received in hard copy either at ~~a local department of social services~~ VDSS or the ~~FAMIS~~ CPU. An application for health insurance ~~received at local departments of social services must~~ shall have an eligibility determination ~~a full Medicaid eligibility determination and, when a child is determined to be ineligible for Medicaid due to excess income, a FAMIS eligibility determination~~ performed~~,~~ within the ~~same~~ established ~~Medicaid~~ federal case processing time standards.

~~Except in cases of unusual circumstances as described below, an application for health insurance received at the FAMIS CPU and screened as ineligible for Medicaid, shall have a FAMIS eligibility determination completed within 10 business days of the date the complete application was received at the CPU.~~

~~Applications that are screened as Medicaid likely will be processed within Medicaid case processing time standards.~~

~~1. Unusual circumstances include: administrative or other emergency beyond the agency's control. In such case, DMAS, or its designee, or the LDSS must document, in the applicant's case record, the reasons for delay. DMAS or its designee or the local department of social services must not use the time standards as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the time standards.~~

~~2. Incomplete applications shall be held open for a period of 30 calendar days to enable applicants to provide outstanding information needed for an eligibility determination. Any applicant who fails to provide, within 30 calendar days of the receipt of the initial application, information or verifications necessary to determine eligibility, shall have his application for FAMIS eligibility denied.~~

K. Notice of ~~DMAS', its designee's or~~ the ~~local department of social services'~~ decision concerning eligibility. ~~DMAS, its designee or the local department of social services must~~ The determining agency shall send each applicant a written notice of the agency's/designee's decision on his application, and, if approved, his obligations under the program. If eligibility for both FAMIS and Medicaid is denied, notice must be given concerning the reasons for the action and an explanation of the applicant's right to request a review of the adverse actions, as described in 12VAC30-141-50.

L. Case documentation. ~~DMAS, its designee, or the local department of social services must~~ The determining agency shall include in each applicant's record all necessary facts to support the decision on his application, and must dispose of each application by a finding of eligibility or ineligibility, unless (i) there is an entry in the case record that the applicant voluntarily withdrew the application and that the agency or its designee sent a notice confirming his decision; or (ii) there is a supporting entry in the case record that the applicant cannot be located.

M. Case maintenance. All cases approved for FAMIS shall be maintained at 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 or assistance to the enrollee.

N. ~~Redetermination~~ Renewal of eligibility. DMAS, DSS, or the ~~FAMIS~~ CPU ~~must~~ shall redetermine the eligibility of enrollees with respect to circumstances that may change at least every 12 months. During the 12-month period of coverage, enrollees must make timely and accurate reports if an enrollee no longer resides in the Commonwealth of Virginia or when changes in income exceed 200% of the federal poverty level plus a 5% income disregard. ~~DMAS or the FAMIS CPU~~ The agency responsible for managing the case ~~must~~ shall promptly redetermine eligibility when it receives information about changes in a FAMIS enrollee's circumstances that may affect eligibility. DMAS or its designee may assist with documenting changes reported by the enrollee.

O. Notice of decision concerning eligibility. ~~DMAS or the FAMIS CPU~~ The agency responsible for managing the case ~~must~~ shall give enrollees timely notice of proposed action to terminate their eligibility under FAMIS. The notice must meet the requirements of 42 CFR 457.1180.

Part IV
Cost Sharing

12VAC30-141-160. Copayments for families not participating in FAMIS Select.

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

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

1. Total cost sharing for each 12-month eligibility period shall be limited to (i) for families with incomes equal to or less than 150% of FPL, the lesser of (a) $180 and (b) 2.5% of the family's income for the year (or 12-month eligibility period); and (ii) for families with incomes greater than 150% of FPL, the lesser of $350 and 5.0% of the family's income for the year (or 12-month eligibility period).

2. DMAS or its designee shall ensure that the annual aggregate cost sharing for all FAMIS enrollees in a family does not exceed the aforementioned caps.

3. Families will be required to submit documentation to DMAS or its designee showing that their maximum copayment amounts are met for the year.

4. Once the cap is met, DMAS or its designee will issue a new eligibility card excluding such families from paying additional copays for the 12-month enrollment period.

C. Exceptions to the above cost-sharing provisions:

1. Copayments shall not be required for well-child, well baby, and pregnancy-related services. This shall include:

a. All healthy newborn inpatient physician visits, including routine screening (inpatient or outpatient);

b. Routine physical examinations, laboratory tests, immunizations, and related office visits;

c. Routine preventive and diagnostic dental services (i.e., oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays);

d. Services to pregnant females related to the pregnancy; and

e. Other preventive services as defined by the department.

2. Enrollees are not held liable for any additional costs, beyond the standard copayment amount, for emergency services furnished outside of the individual's managed care network. Only one copayment charge will be imposed for a single office visit.

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

12VAC30-141-175. FAMIS Select.

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

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

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

2. The cost of coverage for the child or children under FAMIS Select is equal to or less than the Commonwealth's cost of obtaining coverage under FAMIS only for the eligible targeted low-income children involved. The cost-effectiveness determination methodology is described in subsection E of this section;

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

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

C. DMAS will continually verify the child's or children's coverage under the private or employer's plan and will redetermine the eligibility of the child or children for the FAMIS Select component when it receives information concerning an applicant's or enrollee's circumstances that may affect eligibility.

D. Application requirements.

1. DMAS shall furnish the following information in written form and orally, as appropriate, to the families of FAMIS children who have indicated an interest in FAMIS Select:

a. The eligibility requirements for FAMIS Select;

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

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

d. A guide to help families make an informed choice by comparing the FAMIS plan to their private or employer-sponsored health plan. Such guide shall include a notice to the effect that children covered by FAMIS Select will not receive FAMIS-covered services, but only those health services covered by their private or employer-sponsored health plan, and that the FAMIS Select enrollee shall be responsible for any and all costs associated with their chosen health plan;

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

f. The rights and responsibilities of applicants and enrollees.

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

3. An electronic or written application for the FAMIS Select component shall be required from interested families.

4. DMAS shall determine eligibility for the FAMIS Select component promptly, within 45 calendar days from the date of receiving an application that contains all information and verifications necessary to determine eligibility, except in unusual circumstances beyond the agency's control. Actual enrollment into the FAMIS Select component may not occur for extended periods of time, depending on the ability of the family to enroll in the employer's plan.

5. Incomplete FAMIS Select applications shall be held for a period of 30 calendar days to enable applicants to provide outstanding information needed for a FAMIS Select eligibility determination. Any applicant who, within 30 calendar days of the receipt of the initial application, fails to provide information or verifications necessary to determine FAMIS Select eligibility shall have his application denied.

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

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

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

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

b. Determining the administrative costs associated with the FAMIS Select program; and

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

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

F. Enrollment and disenrollment.

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

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

3. Participation by families in the FAMIS Select component shall be voluntary. Families may disenroll their child or children from the FAMIS Select component as long as the proper timing and procedures established by DMAS are followed to ensure continued health coverage.

G. Premium assistance. When a child is determined eligible for coverage under the FAMIS Select component, premium assistance payments shall become effective the month in which the FAMIS child or children are enrolled in the employer's plan. Payment of premium assistance shall end:

1. On the last day of the month in which FAMIS eligibility ends;

2. The last day of the month in which the child or children lose eligibility for coverage under the private or employer's plan;

3. The last day of the month in which the family notifies DMAS that it wishes to disenroll its child or children from the FAMIS Select component; or

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

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

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

There is no copayment required for the supplemental immunization benefits provided through FAMIS.

Part V
Benefits and Reimbursement

12VAC30-141-200. Benefit packages.

The Commonwealth's Title XXI State Plan utilizes two benefit packages within FAMIS as set forth in the FAMIS State Plan, as may be amended from time to time. One package is a modified Medicaid look-alike component offered through a fee-for-service program; the other package is modeled after the state employee health plan and delivered by contracted MCHIPs.

12VAC30-141-500. Benefits reimbursement.

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

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, behavioral therapy services including but not limited to applied behavior analysis, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

D. Exceptions.

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

visits. Prior authorization ~~is required after 26 visits for outpatient mental health visits in the first year of service and prior authorization~~ is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. Prior authorization for dental services will be based on the Title XIX prior authorization requirements for dental services.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

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

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

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

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

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

8. Reimbursement for covered prescription drugs for noninstitutionalized FAMIS recipients receiving the fee-for-service benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.

12VAC30-141-660. Assignment to managed care.

A. Except for children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia, all eligible enrollees shall be assigned in managed care through the department or ~~the central processing unit (~~CPU~~) under contract to DMAS~~. FAMIS individuals, during the preassignment period to an MCHIP, shall receive Title XXI benefits via fee-for-service utilizing a FAMIS card issued by DMAS. After assignment to an MCHIP, benefits and the delivery of benefits shall be administered specific to the managed care program in which the individual is enrolled. DMAS shall contract with MCHIPs to deliver health care services for infants born to mothers enrolled in FAMIS for the month of birth plus two additional months regardless of the status of the newborn's application for FAMIS. If federal funds are not available for those months of coverage, DMAS shall use state funding only.

1. MCHIPs shall be offered to enrollees in all areas.

2. All enrollees shall be assigned to the contracted MCHIPs.

3. Applicants for FAMIS may choose an MCHIP at the time of application. If a choice is not made at application, ~~Enrollees~~ enrollees shall be assigned through a random system algorithm; provided however, all children within the same family shall be assigned to the same MCHIP.

4. All children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program shall be assigned to the fee-for-service component.

5. Enrolled individuals will receive a letter indicating that they may select one of the contracted MCHIPs that serve such area. Enrollees who do not select an MCHIP as described above, shall be assigned to an MCHIP as described in subdivision 3 of this subsection.

6. Individuals assigned to an MCHIP who lose and then regain eligibility for FAMIS within 60 days will be reassigned to their previous MCHIP.

B. Following their initial assignment to an MCHIP, those enrollees shall be restricted to that MCHIP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request reassignment for any reason. Such reassignment shall be effective no later than the first day of the second month after the month in which the enrollee requests reassignment.

2. Enrollees may only request reassignment to another MCHIP serving that geographic area.

3. After the first 90 calendar days of the assignment period, the enrollee may only be reassigned from one MCHIP to another MCHIP upon determination by DMAS that good cause exists pursuant to subsection C of this section or for any reason at annual renewal.

C. Disenrollment for good cause (defined in 12VAC30-120-370) may be requested at any time.

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must ~~be made in writing to DMAS and~~ cite the reasons why the enrollee wishes to be reassigned. The department shall establish procedures for good cause reassignment through written policy directives.

2. DMAS shall determine whether good cause exists for reassignment.

Part VII
FAMIS MOMS

12VAC30-141-670. Definitions.

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

~~"Act" means the Social Security Act.~~

~~"Adult caretaker relative" or "caretaker relative" means an individual who is 18 years of age or older, who is not the parent of but who is related to the child applicant by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child applicant in a place of residence maintained as his or their own home.~~

~~"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in part.~~

"Adverse action" consistent with 42 C.F.R. § 457.1130, means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment, including disenrollment for failure to pay cost sharing; or delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and failure to approve, furnish, or provide payment for health services in a timely manner; provided, however, that determination of eligibility to participate in and termination of participation in the FAMIS Select program shall not constitute an adverse action.

"Adverse Benefit Determination" Consistent with 42 C.F.R. § 438.400, adverse benefit determination refers to the denial or limited authorization of a requested service; the failure to take action or timely take action on a request for service; the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a service; failure to provide services within the timeframes required by the state; for a resident of a rural exception area with only one MCO, the denial of a enrollees request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside of the network; the denial of a enrollees request to dispute a financial liability as provided in 42 CFR 438(b)(7); or the failure of an MCO to act within the timeframes provided in 42 CFR 438.408(b).

"Agency" means ~~a local department of social services, the central processing unit, or other entity designated by DMAS to make eligibility determinations for FAMIS MOMS.~~ the same as defined in 12VAC30-141-10.

~~"Agency error" means a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or the central processing unit.~~

"Agent" means an individual designated in writing to act on behalf of a FAMIS MOMS Plan applicant or enrollee during the administrative review process.

"Appeal" means an enrollees request for review of an adverse benefit determination by an MCO or an adverse action by the VDSS, CPU, or DMAS.

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

"Application for health insurance" means the ~~form or forms developed and approved by the Department of Medical Assistance Services that are used for determining eligibility for Medicaid for poverty level children, for the Family Access to Medical Insurance Security Plan (FAMIS) for children, for Medicaid for pregnant women, and for FAMIS MOMS coverage for pregnant women.~~ single streamlined application for determining eligibility in public health insurance programs operated by the Commonwealth.

"Authorized representative" means a person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

~~"Board" or "BMAS" means that policy board created by § 32.1-324 of the Code of Virginia to administer the plans established by the Social Security Act.~~

"Central processing unit" or "CPU" means the ~~private contractor that will determine eligibility for and administer part of the FAMIS MOMS Plan.~~ same as defined in 12 VAC 30-141-10.

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

~~"Competent individual" means a person who has not been judged by a court to be legally incapacitated.~~

~~"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services, physician's surgical and medical services, and laboratory and radiological services.~~

"Conservator" means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"Continuation of ~~enrollment~~ coverage" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"Creditable health coverage" means coverage that meets the definition at 42 CFR §457.10.

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for Title XXI.

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

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

"External quality review organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS MOMS.

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

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

~~"Family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before-tax earnings from a job, including cash, wages, salary, commissions, tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions, retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships for educational expenses or earned income of a child who is a student.~~

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

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

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

"Fee-for-service" means the traditional Medicaid health care delivery and payment system in which physicians and other providers receive a payment for each unit of service they provide.

~~"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.~~

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

"Guardian" means a person appointed by a court of competent jurisdiction to be responsible for the affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and, if not inconsistent with an order of commitment, residence.

"Incapacitated ~~individual~~" means a person who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of her health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for her support or for the support of her legal dependents without the assistance or protection of a conservator.

"Lawfully residing" means the individual is lawfully present in the United States and meets state residency requirements.

~~"Legally emancipated" means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A married minor is not emancipated unless a court has declared the married minor emancipated from her parents.~~

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

"Managed care health insurance plan" or "MCHIP" as defined in § 32.1-137.1 of the Code of Virginia means an arrangement for the delivery of health care in which a health carrier under contract with DMAS for Title XXI delivery systems undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains one or more incentive arrangements, including any credential requirements intended to influence the cost of the health care services between the health carrier and one or more providers and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"Managed care organization" or "MCO" means an organization that offers managed care health insurance plans (MCHIP) as defined in this section.

~~"Member of a family," for purposes of determining whether the applicant is eligible for coverage under a state employee health insurance plan, means a spouse, parent or parents, including stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.~~

"Pregnant woman" means a woman of any age who is medically determined to be pregnant. The pregnant woman definition is met from the first day of the earliest month that the medical practitioner certifies as being a month in which the woman

was pregnant, through the last day of the month in which the 60th day occurs, following the last day of the month in which her pregnancy ended, regardless of the reason the pregnancy ended.

"Provider" means the individual, facility, or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP or in fee-for-service to render services to FAMIS MOMS enrollees eligible for services.

"Title XXI" means the federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"VDSS" means the State Department of Social Services and the local departments of social services.

~~"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees.~~

12VAC30-141-680. Administration and general background.

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

B. The DMAS director will have the authority to contract with entities for the purposes of establishing a centralized processing site, determining eligibility, enrolling eligible pregnant women into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the FAMIS MOMS program~~; and for employing state staff to perform Medicaid eligibility determinations on pregnant women referred by the contractor's staff.~~.

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

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, non-profit agencies and foundations, coordination with other state agencies, coordination with the business community, and coordination with health care associations and providers.

12VAC30-141-700. ~~Review~~ Appeal of adverse actions or adverse benefit determinations.

A. Upon ~~written~~ request, all FAMIS MOMS program applicants and enrollees shall have the right to a ~~review~~ state fair hearing of an adverse action made by the ~~MCHIP, local department of social services,~~ DSS, CPU or DMAS, or an internal appeal of an adverse benefit determination made by the MCO.

B. During ~~review~~ the appeal of a suspension or termination of enrollment or a reduction, suspension, or termination of services, the enrollee shall have the right to continuation of coverage if the enrollee requests ~~review~~ an internal appeal with the MCO or an appeal to DMAS prior to the effective date of the suspension or termination of enrollment or suspension, reduction, or termination of services.

C. ~~Review~~ An appeal of an adverse action made by the ~~local department of social services,~~ DSS, CPU or DMAS shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under ~~review~~ appeal.

D. ~~Review~~ An internal appeal of an adverse ~~action~~ benefit determination made by the ~~MCHIP~~ MCO must be conducted by a person or agent of the ~~MCHIP~~ MCO who has not been directly involved in the adverse ~~action~~ benefit determination under ~~review~~ appeal.

E. Pursuant to 42 CFR 438.402(c)(1)(B), after ~~After final review by~~ exhausting the ~~MCHIP~~ MCOs internal appeals process, there shall ~~also~~ be opportunity for the enrollee to request an ~~final independent~~ external medical review by ~~the~~ an independent external quality review organization. The review is optional and shall not be required before proceeding to a state fair hearing. The review shall not extend any of the timeframes for issuing a decision and shall not disrupt any continuation of benefits granted to the enrollee.

F. There will be no opportunity for ~~review~~ appeal of an adverse action to the extent that such adverse action is based on a determination by the director that funding for FAMIS MOMS has been terminated or exhausted. ~~There will be no opportunity for review based on which type of delivery system (i.e., fee-for-service, MCHIP) is assigned.~~ There will be no opportunity for ~~review~~ appeal if the sole basis for the ~~adverse action~~ decision is a provision in the State Plan or in a state or federal law ~~or regulation~~ requiring an automatic change in eligibility or enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

G. The burden of proof shall be upon the applicant or enrollee to show that an adverse action or adverse benefit determination is incorrect.

H. At no time shall the ~~MCHIP's, local department's of social services,~~ MCOs, VDSS, ~~the CPU's~~ CPUs, or ~~DMAS'~~ DMAS failure to meet the time frames set in this chapter or set in the ~~MCHIP's~~ MCOs or DMAS' written ~~review~~ appeal procedures constitute a basis for granting the applicant or enrollee the relief sought.

12VAC30-141-710. Notice of adverse action or adverse benefit determination.

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

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

C. The ~~local department of social services,~~ VDSS, ~~the~~ CPU, DMAS or ~~the MCHIP~~ MCO shall send written notification to applicants and enrollees of all other adverse actions within 10 calendar days of the adverse action.

D. Notice shall include: ~~the reasons for determination, an explanation of applicable rights to a review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment or services may continue pending review.~~

1. The determination the VDSS, CPU, DMAS, or MCO has made or intends to make;

2. The reasons for the determination, including the right of the enrollee to be provided upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the determination;

3. An explanation of applicable rights to request an appeal of that determination. For adverse benefit determinations by an MCO, this shall include information on the MCOs internal appeals process and, after the internal appeals process is exhausted, a state fair hearing pursuant to 42 CFR 402(b) and (c);

4. The procedures for exercising these appeal rights;

5. The circumstances under which an appeal process can be expedited and how to request it; and

6. The circumstances under which enrollment or services may continue pending appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

12VAC30-141-720. Request for ~~review~~ appeal.

A. Requests for ~~review~~ internal appeal of ~~MCHIP~~ MCO adverse ~~actions~~ benefit determinations shall be submitted orally or in writing to the ~~MCHIP~~ MCO. Unless the enrollee requests an expedited appeal, an oral appeal request must be followed by a written appeal request. The enrollee must exhaust the MCOs internal appeals process before appealing to DMAS.

B. If the MCO fails to adhere to the notice or timing requirements set forth in this Part, the enrollee is deemed to have exhausted the MCOs internal appeals process and may initiate a state fair hearing.

~~B.~~ C. Requests for ~~review~~ appeal of adverse actions made by the ~~local department of social services,~~ VDSS, ~~the~~ CPU, or DMAS, or of internal appeal decisions by the MCO shall be submitted ~~in writing~~ to DMAS.

~~C.~~ D. Any ~~written~~ communication ~~clearly~~ expressing a desire to have an adverse ~~action~~ benefit determination by an MCO reviewed shall be treated as a request for ~~review~~ an internal appeal. Any communication expressing a desire to have an adverse action by the VDSS, CPU, or DMAS reviewed shall be treated as a request for a state fair hearing. Any communication expressing a desire to have an MCOs internal appeal decision reviewed shall be treated as a request for a state fair hearing.

~~D.~~ E. To be timely, requests for ~~review~~ an internal appeal of ~~a MCHIP~~ an MCOs adverse benefit determination shall be received by the ~~MCHIP~~ MCO no later than ~~30~~ 60 calendar days from the date of the ~~MCHIP's~~ MCOs notice of adverse ~~action~~ benefit determination.

F. To be timely, requests for an appeal of an adverse benefit determination upheld in whole or in part by the MCOs internal appeal decision shall be received by DMAS within 120 calendar days from the date of the internal appeal decision.

~~E.~~ G. To be timely, requests for ~~review~~ appeal of a ~~local department of social services,~~ VDSS, DMAS, or CPU ~~determination~~ adverse action 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~~ appeal 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.

12VAC30-141-730. ~~Review~~ Appeal procedures.

A. At a minimum, the ~~MCHIP review~~ MCO internal appeal shall be conducted pursuant to written procedures as defined in § 32.1-137.6 of the Code of Virginia and ~~as may be further defined by DMAS~~ 42 CFR 438.400 et seq. Such procedures shall be subject to review and approval by DMAS.

B. Any adverse benefit determination upheld in whole or in part by the internal appeal decision issued by the MCO may be appealed by the enrollee to DMAS in accordance with the DMAS client appeals regulations at 12VAC30-110-10 through 12VAC30-110-370. DMAS shall conduct an evidentiary hearing in accordance with 12VAC30-110-10 through 12VAC30-110-370 and shall not base any appealed decision on the record established by any internal appeal decision of the MCO. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

~~B.~~ C. ~~The DMAS review~~ Appeals of adverse actions by the VDSS, CPU, or DMAS shall be conducted pursuant to ~~written procedures developed by DMAS~~ 12VAC30-110-10 et seq.

~~C. The procedures in effect on the date a particular request for review is received by the MCHIP or DMAS shall apply throughout the review.~~

D. Copies of the procedures shall be promptly ~~mailed~~ provided by the ~~MCHIP~~ MCO or DMAS to applicants and enrollees upon receipt of timely requests for ~~review~~ internal appeals or state fair hearings. Such written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the ~~MCHIP, local department of social services, DSS,~~ MCO, DSS or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;

2. The right to timely review of their files and other applicable information relevant to the ~~review~~ internal appeal or state fair hearing of the decision;

3. The right to fully participate in the ~~review~~ internal appeal or state fair hearing process, whether the ~~review~~ internal appeal or state fair hearing is conducted in person or in writing, including the presentation of supplemental information during the ~~review~~ internal appeal or state fair hearing process;

4. The right to have personal and medical information and records maintained as confidential; and

5. The right to a written final decision; ~~within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.~~

a. For internal appeals to the MCO, within 30 calendar days of receipt of the request for an internal appeal; or

b. For state fair hearings, within the time limitations for appeals imposed by federal regulations and as permitted in 12VAC30-110-30.

~~E.~~ 6. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to request an expedited ~~review~~ appeal. Under these conditions, a request for ~~review~~ expedited appeal shall result in a written final decision within ~~three business days~~ 72 hours after DMAS receives~~,~~ the expedited appeal request from the physician or health plan~~,~~ with the case record and information indicating that taking the time for a standard resolution of the ~~review~~ appeal request could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain or regain

maximum function, unless the applicant or enrollee ~~or her authorized representative causes a delay~~ requests an extension.

~~F.~~ 7. For health services matters for FAMIS MOMS enrollees receiving services through ~~MCHIPs,~~ an MCO:

a. ~~if~~ If the enrollee's physician or health plan determines that the ~~90-calendar-day~~ 30-calendar-day timeframe for a standard internal appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to request an expedited ~~review~~ internal appeal. Under these conditions, a request for ~~review~~ an internal appeal shall result in a written decision by the ~~external quality review organization~~ MCO within 72 hours from the time ~~an enrollee requests~~ the expedited ~~review~~ expedited internal appeal is requested, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited ~~review~~ internal appeal may be extended up to 14 calendar days.

b. If the adverse benefit determination is upheld in whole or in part by the expedited internal appeal decision issued by the MCO, and if the enrollees physician or health plan determines that the timeframe for a standard appeal to DMAS could seriously jeopardize the enrollees life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to request an expedited appeal to DMAS. Under these conditions, a request for a state fair hearing shall result in a written decision within 72 hours from the time an enrollee requests the expedited appeal, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then the expedited appeal may be extended up to 14 calendar days.

~~G.~~ 8. For health services matters for FAMIS MOMS enrollees receiving services through fee-for-service, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe for a standard appeal could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to request an expedited review. Under these conditions, a request for ~~review~~ an expedited appeal shall result in a written decision within 72 hours from the time ~~an enrollee requests~~ the expedited ~~review~~ appeal is requested, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited ~~review~~ appeal may be extended up to 14 calendar days.

12VAC30-141-740. ~~Eligibility requirements.~~ General conditions of eligibility.

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

B. FAMIS MOMS shall be in effect statewide.

C. Eligible pregnant women must:

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

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

3. Be a resident of the Commonwealth as described in 12VAC30-141-100(C)(2);

4. Be either a U.S. citizen, U.S. national, lawfully residing, or a qualified noncitizen as described in 12VAC141-100(C)(3);

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

~~6. Not be a member of a family eligible for subsidized dependent coverage, as defined in 42 CFR 457.310(c)(1)(ii) under any Virginia state employee health insurance plan on the basis of the family member's employment with a state agency; and~~

~~7.~~ 6. Not be an inpatient in an institution for mental diseases (IMD), or an inmate in a public institution that is not a medical facility.

D. ~~Income~~Financial eligibility.

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

2. Standards. Income standards for FAMIS MOMS are the same as those described at 12VAC30-141-100(F)(2), applied to pregnant women. For purposes of income determination, the family size of the pregnant woman 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 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 income eligibility limit for FAMIS MOMS.

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

~~F. U.S. citizenship or nationality. Upon signing the declaration of citizenship or nationality required by § 1137(d) of the Social Security Act, the applicant or recipient is required under § 2105(c)(9) to furnish satisfactory documentary evidence of U.S. citizenship or nationality and documentation of personal identify unless citizenship or nationality has been verified by the Commissioner of Social Security or unless otherwise exempt.~~

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

~~H~~E. Coverage under other health plans.

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

2. ~~No~~ FAMIS MOMS shall not be a substitution for private insurance.

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

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

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~~ an 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.

B. Eligibility for FAMIS MOMS will continue through the last day of the month in which the 60th day occurs, following the last day the woman was pregnant, regardless of the reason the pregnancy ended. Eligibility will continue until the end of the coverage period, regardless of changes in circumstances such as income or family size.

12VAC30-141-760. Pregnant women ineligible for FAMIS MOMS.

A. If a pregnant woman is:

1. Eligible for Medicaid, ~~or would be eligible if she applied for Medicaid,~~ she shall be ineligible for coverage under FAMIS MOMS. ~~A pregnant woman found through the screening process to be potentially eligible for Medicaid but who fails to complete the Medicaid application process for any reason, cannot be enrolled in FAMIS MOMS~~;

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

~~3.~~ 2. An inmate of a public institution as ~~defined~~ provided in ~~42 CFR §435.1009~~ 42 CFR § 435.1009(a)(1), she shall be ineligible for FAMIS MOMS at the initial determination of eligibility; or

~~4.~~ 3. An inpatient in an institution for mental disease (IMD) as ~~defined~~ provided in ~~42 CFR §435.1010~~ 42 CFR §435.1010(a)(2), she shall be ineligible for FAMIS MOMS at the initial determination of eligibility.

B. If a pregnant woman age 18 or older or, if under age 18, a parent or other authorized representative does not meet the requirements of assignment of rights to benefits or requirements of cooperation with the agency in identifying and

providing information to assist the Commonwealth in pursuing any liable third party, the pregnant woman shall be ineligible for FAMIS MOMS.

C. If a pregnant woman age 18 or older, or if under age 18, a parent, adult relative caretaker, guardian, or legal custodian obtained benefits for a pregnant woman who would otherwise be ineligible by willfully misrepresenting material facts on the application or failing to report changes, the pregnant woman for whom the application is made shall be ineligible for FAMIS MOMS. The pregnant woman age 18 or older, or if under age 18, the parent, adult relative caretaker, guardian, or legal custodian who signed the application shall be liable for repayment of the cost of all benefits issued as the result of the misrepresentation.

12VAC30-141-790. Application requirements.

A. Availability of program information. DMAS or its designee shall furnish the following information in written form and orally as appropriate to all applicants and to other individuals who request it:

1. The eligibility requirements;

2. Summary of covered benefits;

3. Copayment amounts required; and

4. The rights and responsibilities of applicants and enrollees.

B. Opportunity to apply. DMAS or its designee must afford a pregnant woman, wishing to do so, the opportunity to apply for the FAMIS MOMS program. ~~Applications from pregnant women will be accepted at a central site designated by DMAS and at local departments of social services throughout the Commonwealth.~~ Applicants may file an application ~~for health insurance~~ by mail, by fax, by phone, via the internet, or in person at local departments of social services. ~~Applications filed at the FAMIS CPU can be submitted by mail, by fax, by the Internet, or by phone.~~ Face-to-face interviews for the program are not required. Eligibility determinations for FAMIS MOMS shall occur at ~~either local departments of social services~~ VDSS, ~~or at the~~ ~~DMAS-designated~~ DMAS, or ~~central site~~ the CPU.

C. Application. DMAS or its designee shall require an application from the applicant if she is at least 18 years of age or older, or from a parent, adult relative caretaker, guardian, legal custodian, or authorized representative if the applicant is less than 18 years of age or the applicant is incapacitated.

1. The Commonwealth employs a single, streamlined application developed by the state and approved by the Secretary of the Department of Health and Human Services in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

The Commonwealth may employ an alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

~~C.~~ D. Right to apply. An individual who is 18 years of age or older shall not be refused the right to complete an application for health insurance for herself and shall not be discouraged from asking for assistance for herself under any circumstances.

~~D.~~ E. Applicant's signature. The applicant must sign state-approved application forms submitted, even if another person fills out the form, unless the application is filed and signed by the applicant's parent, spouse, adult relative caretaker, legal guardian or conservator, attorney-in-fact or authorized representative.

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

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

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

~~H. Written application. DMAS or its designee shall require a written application from the applicant if she is at least 18 years of age or older, or from a parent, adult relative caretaker, guardian, legal custodian, or authorized representative if the applicant is less than 18 years of age or the applicant is incapacitated. The application must be on a form prescribed by DMAS and must be signed under a penalty of perjury. The application form shall contain information sufficient to determine Medicaid and FAMIS MOMS eligibility.~~

I. Assistance with application. DMAS or its designee shall allow an individual or individuals of the applicant's choice to assist and represent the applicant in the application process, or a redetermination process for eligibility.

J. Timely determination of eligibility. The time processing standards for determining eligibility for FAMIS MOMS coverage begin with the date an ~~signed~~ application is submitted online, by telephone, by fax, or received ~~either~~ in hard copy 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 for pregnant women ~~due to excess income, a~~ and FAMIS MOMS ~~eligibility determination~~ performed~~,~~ within the ~~same~~ Medicaid case processing time standards (10 business days) if all information necessary to make the determination has been received.

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

~~1. Unusual circumstances include administrative or other emergency beyond the agency's control. In such case, DMAS or its designee or the LDSS must document, in the applicant's case record, the reasons for delay. DMAS or its designee or the local department of social services must not use the time standards as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the time standards.~~

~~2. Applications filed at the CPU that are incomplete shall be held open for a period of 30 calendar days to enable applicants to provide outstanding information needed for an eligibility determination. Incomplete applications determined complete by the receipt of additional information required to determine FAMIS MOMS eligibility will be processed in an expedited manner upon receipt of the~~

~~additional information. Any applicant who fails to provide, within 30 calendar days of the receipt of the initial application, information or verifications necessary to determine eligibility, shall have her application for FAMIS MOMS eligibility denied.~~

K. Notice of ~~DMAS', its designee's or~~ the ~~local department of social services'~~ decision concerning eligibility. The DMAS, ~~its designee~~ or the ~~local department of social services must~~ VDSS, or the CPU shall send each applicant a written notice of the agency's/designee's decision on her application, and, if approved, her obligations under the program. If eligibility for FAMIS MOMS is denied, notice ~~must~~ shall be given concerning the reasons for the action and an explanation of the applicant's right to request a review of the adverse actions, as described in 12VAC30-141-50.

L. Case documentation. DMAS, ~~its designee, or~~ the ~~local department of social services~~ DSS, or the CPU ~~must~~ shall include in each applicant's record all necessary facts to support the decision on her application, and ~~must~~ shall dispose of each application by a finding of eligibility or ineligibility, unless (i) there is an entry in the case record that the applicant voluntarily withdrew the application and that the agency or its designee sent a notice confirming her decision; or (ii) there is a supporting entry in the case record that the applicant cannot be located.

M. Case maintenance. All cases approved for FAMIS MOMS shall be maintained at ~~the FAMIS CPU~~ 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 or assistance to the enrollee.

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

12VAC30-141-800. Copayments.

A. Pregnant women enrolled in FAMIS MOMS will be subject to copayments for medical services in the same manner and amount as pregnant women covered by the Medicaid program as defined in 12VAC30-10-570 B and C.

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

1. Total cost sharing for a pregnant woman shall be limited ~~to the lesser of~~ (i) for families with incomes equal to or less than 150% of FPL, the lesser of (a) $180 and (b) 2.5% of the family's income for the year; and (ii) for families with incomes greater than 150% of FPL, the lesser of $350 and 5.0% of the family's income ~~(i) $180 and (ii) 2.5% of the family's income~~ for the year for the duration of her enrollment in FAMIS MOMS.

2. If a family includes a pregnant woman enrolled in FAMIS MOMS and a child or children enrolled in FAMIS, DMAS or its designee shall ensure that the annual aggregate cost sharing for all Title XXI enrollees in a family does not exceed the cost sharing caps as defined in 12VAC30-141-160 B.

3. Families will be required to submit documentation to DMAS or its designee showing that their maximum copayment amounts are met for the year.

4. Once the cap is met, DMAS or its designee will issue a new eligibility card or written documentation excluding such families from paying additional copays.

C. Exceptions to the above cost-sharing provisions. No cost sharing will be charged to American Indians and Alaska Natives.

12VAC30-141-880. Assignment to managed care.

A. All eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS MOMS individuals, during the preassignment period to an MCHIP, shall receive Medicaid-like benefits via fee-for-service utilizing a FAMIS MOMS card issued by DMAS. After assignment to an MCHIP, benefits and the delivery of benefits shall be administered specific to the managed care program in which the individual is enrolled.

1. MCHIPs shall be offered to enrollees in all areas.

2. All enrollees shall be assigned to that contracted MCHIP.

3. Enrollees shall be assigned through a random system algorithm.

4. Enrolled individuals will receive a letter indicating that they may select one of the contracted MCHIPs that serve such area. Enrollees who do not select an MCHIP as described above, shall be assigned to an MCHIP as described in subdivision 3 of this subsection.

5. Individuals assigned to an MCHIP who lose and then regain eligibility for FAMIS MOMS within 60 days will be reassigned to their previous MCHIP.

B. Following their initial assignment to an MCHIP, those enrollees shall be restricted to that MCHIP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request reassignment for any reason from that MCHIP to another MCHIP serving that geographic area. Such reassignment shall be effective no later than the first day of the second month after the month in which the enrollee requests reassignment.

2. After the first 90 calendar days of the assignment period, the enrollee may only be reassigned from one MCHIP to another MCHIP upon determination by DMAS that good cause exists pursuant to subsection C of this section.

C. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must ~~be made in writing to DMAS and~~ cite the reasons why the enrollee wishes to be reassigned. ~~The department shall establish procedures for good cause reassignment through written policy directives~~.

2. DMAS shall determine whether good cause exists for reassignment.

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