Chapter 2

THE BASICS OF STATE SPONSORED INSURANCE PROGRAMS & WAIVERS

The Basics of State Sponsored Insurance Programs & Waivers

Medicaid is a joint program between federal and state governments. Medicaid was set up by Congress to provide health care primarily to people who have low income and who are elderly, disabled, or pregnant; and to low-income families with children. Children with disabilities enrolled on a Medicaid Waiver can also get Medicaid insurance.

Medicaid covers certain services for all Medicaid eligible people who need those services. The federal Medicaid center publishes a list of mandatory services that all states must provide. There is also a second list published that lists optional services states can choose to provide. States can control the cost of Medicaid by limiting the number of services it chooses to provide or by making eligibility requirements more strict.

Medically Indigent Medicaid (F.A.M.I.S. Plus) & Family Access to Medical Insurance Security (F.A.M.I.S.)

Virginia has two state sponsored health insurance programs for children. FAMIS is Virginia's state children's health insurance program. FAMIS Plus is Virginia's name for children's Medicaid. Both programs are operated by the Virginia Department of Medical Assistance Services (www.dmas.virginia.gov).

Who Qualifies?

Your child may be eligible for FAMIS or FAMIS Plus (Medicaid) if they:

- Live in Virginia
- Are under the age of 19
- Are U.S. citizens or certain aliens who are legal residents (a parent's citizenship is not considered)
- Live in families that meet income guidelines

For FAMIS only, children:

- Must be uninsured at the time of application
- Cannot have had health insurance in the past 4 months (There are some exceptions that apply to this rule)
- Cannot be eligible for the Virginia state employee health plan

How Much Does it Cost?

There are no enrollment costs or monthly premiums to pay for FAMIS or FAMIS Plus. There are no co-payments for any medical services under FAMIS Plus if you are under the age of 21. It is free. With FAMIS, there is a small charge (co-payment) when your child receives certain services. It is usually $2 to $5.

Important:

Enrollment in FAMIS or FAMIS Plus will have no effect on your immigration status. Information on your application for insurance is not shared with immigration authorities.

More About F.A.M.I.S. & F.A.M.I.S. Plus

Famis Income Limits

Effective January 22, 2015. Income limits are adjusted annually.

Family Size	Gross Income Limit
1 Family Member	$23,540 per year or $1,962 per month
2 Family Members	$31,860 per year or $2,655 per month
3 Family Members	$40,180 per year or $3,349 per month
4 Family Members	$48,500 per year or $4,042 per month
5 Family Members	$56,820 per year or $4,735 per month
6 Family Members	$65,140 per year or $5,429 per month
7 Family Members	$73,460 per year or $6,122 per month
8 Family Members	$81,780 per year or $6,815 per month
Each Additional Family Member	$8,320 per year or $694 per month

Qualifying for FAMIS or FAMIS Plus also depends upon household income and family size. Children are eligible for FAMIS Plus with family income up to 143% of the Federal Poverty Level. The family income can be higher (up to 200% of the Federal Poverty Level) for FAMIS.

When calculating family size for FAMIS and FAMIS Plus, parents and children up to age 21 in the home are counted. Grandparents, friends and relatives are not counted. Some income is not counted. For example, student income is not counted. Stepparent's income is not counted for FAMIS Plus, but is counted for FAMIS.

There are deductions to income that can be taken (for working parents, child support, child care, etc.) If your family is close to the income limits, these deductions can make a difference, so apply to find out if your children qualify.

What are the Income Requirements?

The chart to the left gives you an idea of how much you can make and still qualify for FAMIS.. The income numbers used in the chart are current as of January 2011. Maximum income guidelines increase each year. You can contact your local Department of Social Services (DSS) for current income guidelines. You can also find income numbers for FAMIS and other information about FAMIS by calling 1-866-87-FAMIS or at www.famis.org. Information is available on this website in English and Spanish and some information is available in other languages.

How Do I Apply?

It is easy to apply for FAMIS and FAMIS Plus. The same application is used for both programs. Eligibility for these programs is determined by local Departments of Social Services (DSS) or by the FAMIS Central Processing Unit (CPU). You can apply by phone, fax to 1-888-221-9402 (fax), online, or mail your completed application to your local DSS or to FAMIS, P.O. Box 1820, Richmond, Virginia 23218-18209.

To get started, call the CPU toll free at 1-866-87FAMIS Monday through Friday (8 am to 7 pm) or Saturday (9 am to 12 noon). Interpreters are available at this number. Or visit your local DSS to apply.

Who Can Apply?

Parents and legal guardians can apply on behalf of the child. If you are taking care of a relative's child, you can apply for that child. If you have written permission from the child's parents, any adult can apply on behalf of the child.

When you apply, you will need to show proof of income. The application requirements are:

- Child's Social Security Number, or a copy of application for a Social Security card
- If you are not the parent & not related to the child by blood or marriage, proof of legal guardianship (or written permission from a parent is required)
- Proof of the child's immigration status, if applicable
- Paycheck stubs from the previous month's pay stub (or a letter from your employer that verifies wages)
- If parent is self-employed, copy of income tax return
- Copies of monthly benefit checks or Social Security statement, if applicable
- Verification of child support, if applicable

More About F.A.M.I.S. & F.A.M.I.S. Plus

What Happens Once My Child is Enrolled?

When an application is determined to meet eligibility requirements (a 45 day timeline from the time a completed application is received), the child/children are enrolled. Once enrolled, FAMIS cases are maintained by the CPU and FAMIS Plus cases are maintained by the local DSS.

All children start out in a fee-for-service plan and will receive a DMAS identification card. Some children (i.e., those in foster care or already receiving health insurance through a comprehensive group or individual health insurance plan) will remain in fee-for-service regardless of where they live. Most children, however, will be assigned within a month to a managed care plan (if there is one available in their region) or to a Primary Case Manager plan. When there is more than one managed care option available in the region, the family will be given a choice of plans. If the family does not choose, they will be assigned to a plan. Once enrolled in a managed care plan, the child will also receive a plan identification card. Both cards (DMAS and health plan) must be kept and presented to the provider (i.e., doctor, hospital) when services are received.

Every 12 months the child/family must be re-determined for continued eligibility for FAMIS or FAMIS Plus. That is, there is an annual renewal required (based upon the child's enrollment date) in order for the insurance coverage to continue. If your child's application for FAMIS or FAMIS Plus is denied, or benefits are terminated, you should appeal the decision. More information on filing appeals can be found at the end of this chapter.

For FAMIS children, if the application is approved, the insurance coverage is effective the first day of the month the completed application was received. FAMIS has no premiums and there are no co-pays for preventative care. But, there are co-pays for other medical services ($2 - $3); and for hospital admissions ($15 - $25). If a service is billed above the coverage limit, the family may receive a bill.

For FAMIS Plus children, once the child is determined to be eligible, health care bills that are as much as 3 months old can be submitted for payment consideration. FAMIS Plus is free; there are no premiums or co-pays if under the age of 21.

What Services are Covered?

The following summarizes covered services under FAMIS and FAMIS Plus:

FAMIS Plus

- Doctor/clinic visits
- EPSDT – Early & Periodic Screening, Diagnosis & Treatment (See the next page for more information)
- Hospitalization
- Prescription drugs
- Dental care
- Orthodontics (necessary)
- Vision care
- Mental health (via CSB)
- School-based services
- Non-emergency transportation

FAMIS (in a Managed Care Area)

- Doctor/clinic visits
- Well-child checkups
- Hospitalizations
- Prescription drugs
- Dental care (capped)
- Orthodontics (capped)
- Vision care (capped)
- Mental health (limited)
- School-based services

Please note that in some areas of Virginia where there are no managed care organizations, FAMIS benefits differ from above.

For more information, call 1-866-87FAMIS or go to the Virginia Department of Medical Assistance Services website at www.dmas.virginia.gov.

Early & Periodic Screening, Diagnosis & Treatment

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive package of benefits available to children and youth under age 21 enrolled in Medicaid. As mentioned earlier, when we talk about Medicaid for children under 19 in Virginia, we are talking about FAMIS Plus. Under EPSDT, FAMIS Plus children and youth are entitled to regular physical exams, and full physical and mental health care to treat any conditions found as a result of the examinations. Your child does not have to be sick in order to be screened.

These screenings must include examinations in four areas: physical health, dental health, vision, and hearing. The purpose of these screenings is to:

- Find any problems or conditions as early as possible so that they may be treated; and
- Ensure that children receive necessary health care on a routine basis (i.e. immunizations)

There are three types of screenings provided. The first is called an initial screen. This is a physical exam that must be provided when a child enters the FAMIS Plus program. The second type of screen is called a periodic screen (child "well" visits) which should occur at regular intervals (for example, a baby should get six hearing and vision screenings in the first 12 months). The third type of screen is called an interperiodic screen. This is a physical exam that can happen any time outside of a regular scheduled visit if a child shows signs of illness or a change in his/her condition.

Once a child is seen by his/her doctor and a screen reveals a problem, a diagnosis is made and appropriate treatment can be provided. By law, states must cover "necessary health care, diagnostic services, treatment and other measures… to correct or ameliorate defects and physical and mental illnesses and conditions." This means that states cannot refuse to provide services based on whether or not they will cure a condition. For instance, a child with an intellectual disability can receive speech therapy under EPSDT to keep from losing any current function, if the therapy is determined to be medically necessary to maintain the child in their current condition.

For a treatment to be covered under EPSDT, it must:

- Be medically necessary
- Fit within a recognized Medicaid service category; and
- Be prescribed and provided by a Medicaid provider

The Medicaid Act defines the comprehensive package of EPSDT services. Covered services under EPSDT include all mandatory and optional services that the states are allowed to cover under Medicaid, whether or not such services are covered for adults. Some of the EPSDT covered services include:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Laboratory & X-ray Services
- EPSDT Screening Services
- Physician Services
- Home Health Care Services
- Private Duty Nursing Services
- Personal Care Services
- Dental Services
- Physical, Occupational & Speech Therapy
- Prescribed Drugs
- Prosthetic Devices
- Eyeglasses
- Inpatient Psychiatric Hospital Services
- Hospice Care
- Case Management Services
- Respiratory Care Services
- Other Needed Services, Treatment & Measures For Physical & Mental Illnesses & Conditions
- Assistive Technology
- Durable Medical Equipment
- Supported Living Arrangement Services (Personal Assistance, Assistive Technology, etc.)

Important:

Some EPSDT services must be pre-authorized by DMAS in order for the cost to be covered.

The Health Insurance Premium Payment (H.I.P.P.) & H.I.P.P. for Kids Programs

The Health Insurance Premium Payment (HIPP) and HIPP For Kids Programs are Medicaid premium assistance programs, administered by the Department of Medical Assistance Services (DMAS) for Medicaid enrollees. These programs may reimburse part or all of your monthly cost of the employer sponsored group health insurance premium. Members of your family eligible for FAMIS Plus will still be covered by FAMIS Plus, but as a secondary insurance plan. Your group insurance plan will be the primary plan. That is, FAMIS Plus will pay for some services not covered by the employer's group health insurance.

Eligibility for the HIPP program is determined through a cost-effectiveness evaluation of your health insurance plan, services, and premium. This evaluation looks at your current health insurance plan and performs a comparison of the average Medicaid cost for your Medicaid eligible family member to the cost of your health insurance premium. If it is determined to be cost-effective, DMAS will reimburse part or all of your health insurance premium.

Requirements for the HIPP For Kids program is that the Medicaid eligible member is under the age of 19, is eligible for or enrolled in "qualified employer-sponsored coverage," and the family member's employer must contribute at least 40% towards the cost of the health insurance premium.

If you are determined eligible for one of these programs, on a monthly basis, DMAS will reimburse you for a portion of, or the entire amount of, the insurance premiums that are deducted from your paycheck. Your premiums will be reimbursed by DMAS as long as the family member remains FAMIS Plus eligible and continues to qualify for the HIPP or HIPP For Kids program.

Under the HIPP and HIPP For Kids programs, any changes in employment, insurance coverage, or household must be reported to DMAS immediately. Every month you will be required to send DMAS a copy of your most recent paycheck showing the insurance premium deductible. If you have questions, call the DMAS HIPP toll free line at 1-800-432-5924.

F.A.M.I.S. Select Premium Program

Virginia also has a premium assistance program for working families who may not be able to afford the premiums of private or employer-based health insurance. This program, FAMIS Select, helps families pay for private or employer-sponsored health insurance. It offers families with children enrolled in FAMIS more health care coverage options. The FAMIS Select program allows families to choose between covering their children through FAMIS or through a private or employer-sponsored health plan. Families enrolled in FAMIS Select get up to $100 per enrolled child per month to help pay the family health insurance premium. Although the total monthly FAMIS Select payment cannot exceed the total amount of the family premium, this payment may help parents afford private or employer-based coverage for the whole family for the first time.

Income guidelines for FAMIS Select are the same as for FAMIS. That is, FAMIS Select is available to eligible Virginia residents with an income between 133% and 200% of the Federal Poverty Level (see FAMIS Income chart earlier in this chapter). Through FAMIS Select, the family has a choice to enroll their FAMIS eligible child in their employer's insurance plan rather than choose the FAMIS plan. This could benefit the family by allowing all members of a family to have the same health coverage, and may also increase access to providers who accept insurance through private plans.

For more information about the FAMIS Select Premium program, call 1-888-802-KIDS or visit the FAMIS website at www.FAMIS.org.

Home & Community-Based Medicaid Waivers

Home and community-based Waivers were established by Congress to slow the growth of Medicaid spending for nursing home care and other institutional costs. The Waiver program also addresses the concerns of people with disabilities who object to being institutionalized as the only means to get support for their needs.

If your child is disabled and/or has a severe chronic illness and requires long-term care, he may be eligible for a Medicaid Waiver. Eligibility is determined first by whether the child would require placement in a nursing home or hospital, or in an intermediate care facility for people with an intellectual disability. A Medicaid Waiver essentially says that your child is eligible for such placement, but you waive his/her right to live in an institutional setting and choose to have him/her live at home or in your community.

In Virginia there are 7 Medicaid Waivers, each with its own eligibility criteria and specific population served. These are:

- Alzheimer's Assisted Living (AAL) Waiver
- Day Support Waiver
- Elderly or Disabled with Consumer Direction (EDCD) Waiver
- HIV/AIDS Waiver
- Individual & Family Developmental Disabilities Support (DD) Waiver
- Intellectual Disability (ID) Waiver
- Technology Assisted (Tech) Waiver

All Waivers are not created equal. Some Waivers have a higher cost of living allowance than others. Services vary between Waivers. Some services have limits, some do not. And some Waivers have waiting lists.

Once your child is enrolled in a Waiver, you will receive a Medicaid card for your child to receive state plan Medicaid (FAMIS Plus) services. If you already have other insurance, Medicaid (FAMIS Plus) becomes your secondary insurance plan.

Current Waivers require a great deal of choice and control by the individual. You choose the case management/support coordination agency, the service agencies, and the services needed. You control when, where, and how you receive services. The following pages list the eligibility criteria and services currently available under Virginia's Medicaid Waivers for which most children with special health care needs and disabilities are eligible.

For more information, contact the DMAS at www.dmas.virginia.gov or 1-804-786-1465, the Medicaid Waiver Technical Assistance Center at 1-866-323-1088, or a Medicaid Waiver Mentor at VaWaivers@yahoogroups.com.

Current Waivers

Individual & Family Developmental Disabilities Waiver (DD)

Who it Serves:
Individuals who are over 6 years old, who have a developmental disability and do not have a diagnosis of an intellectual disability.

Financial Eligibility:

Local Department of Social Services determines income eligibility (45 day timeline). Monthly income limits of 300% of Federal Poverty Level and up to $2,000 of assets (bonds, savings, etc.). Parent's income not considered for children.

How Screened:
Virginia Department of Health Child Development Clinics and certain local Health Districts conduct the screenings using a Level of Functioning survey.

Services Included:

- Adult Companion (Consumer-Directed & Agency)
- Assistive Technology
- Crisis Stabilization
- Day Support & Prevocational Services
- Environmental Modifications
- Family/Caregiver Training
- In-Home Residential, Personal Assistance (Consumer-Directed & Agency)
- Personal Emergency Response System (PERS)
- Respite Care
- Skilled Nursing
- Supported Employment
- Therapeutic Consultation.

Elderly or Disabled with Consumer Direction Waiver (EDCD)

Who it Serves:
Individuals who are over age 65 or individuals who are disabled and meet level of care requirements for admission to a nursing facility.

Financial Eligibility:
Local Department of Social Services determines income eligibility (45 day timeline). Monthly income limits of 300% of Federal Poverty Level and up to $2,000 of assets (bonds, savings, etc.). Parent's income and assets are not considered for children.

How Screened:
A Local Pre-Admission Screening Team conducts the screening, unless the individual is in a hospital (then hospital discharge planner completes screening). The Uniform Assessment Instrument is used to determine eligibility.

Services Included:

- Adult Day Health Care
- Personal Care (Agency & Consumer-Directed)
- Personal Emergency Response System (PERS)
- Respite (Agency, Consumer-Directed & Skilled)

For Individuals Transitioning from an Institutional Setting:

Money Follows the Person (MFP) transition coordination, transition services, assistive technology, and environmental modifications are available for all of the Waivers except the Day Support Waiver.

Additional Current Waivers

Intellectual Disability Waiver (ID)

Who it Serves:
Individuals up to age 6 who have a developmental delay and persons who are over 6 years old who have a diagnosis of an intellectual disability.

Financial Eligibility:
Local Department of Social Services determines income eligibility (45 day timeline). Monthly income limits of 300% of Federal Poverty Level and up to $2,000 of assets (bonds, savings, etc.). Parent's income not considered for children.

How Screened:
The local Community Services Board conducts the screening using a Level of Functioning survey.

Services Included:

- Adult Companion (Consumer-Directed & Agency)
- Assistive Technology
- Crisis Stabilization
- Day Support
- Prevocational & Environmental Modifications
- Personal Assistance
- Personal Emergency Response System
- Residential Support (Group Home Or Individual's Home)
- Respite Care (Consumer-Directed & Agency)
- Skilled Nursing
- Supported Employment
- Therapeutic Consultation

Technology Assisted Waiver

Who it Serves:
Individuals who are dependent upon technological support and require ongoing, substantial nursing care.

Financial Eligibility:
Local Department of Social Services determines income eligibility (45 day timeline). Monthly income limits of 300% of Federal Poverty Level and up to $2,000 of assets (bonds, savings, etc.). Parents income not considered for children.

How Screened:
A Local Pre-Admission Screening Team conducts the screening, unless the individual is in a hospital (then hospital discharge planner completes screening). The Uniform Assessment Instrument is used to determine eligibility.

Services Included:

- Assistive Technology
- Environmental Modifications
- Personal Care (Only for Over Age 21)
- Private Duty Nursing & Respite Care (Skilled)

Day Support Waiver

Who it Serves:
Individuals up to age 6 who have a developmental delay and persons who are over 6 years old who have a diagnosis of an intellectual disability on the ID Waiver waiting list.

Financial Eligibility:
Local Department of Social Services determines income eligibility (45 day timeline). Monthly income limits of 300% of Federal Poverty Level and up to $2,000 of assets (bonds, savings, etc.). Parent's income not considered for children.

How Screened:
The local Community Services Board conducts the screening using a Level of Functioning survey.

Services Included:

- Day Support
- Prevocational & Supported Employment Services

How to File Appeals

FAMIS Plus & FAMIS

Application Denied

If your application is denied or insurance benefits terminated, contact your local Department of Social Services immediately as there are timelines.

You must request your appeal in writing within 30 days to the Virginia Department of Medical Assistance Services. Your local Department of Social Services worker can help you fill out the forms for the appeal. If you need an advocate or lawyer to help you, you can call Legal Aid at 1-800-578-8111.

Once you file an appeal, you will have a hearing before a Hearing Officer. Before this hearing, your local Department of Social Services may contact you to discuss your situation in an informal conference. Do not drop your appeal. Within 90 days of submitting your appeal, the Hearing Officer must make a decision. If the Hearing Officer denies your application or termination of insurance benefits, further appeal is available to a state court.

It is important to note that if your child's insurance benefits are terminated, and you request an appeal within 10 days of receiving your termination notice, you can continue to receive benefits throughout this appeal process if you clearly state that you want your benefits to continue. But, if you lose your appeal, you may be asked to repay any benefits received during the appeal process.

Services Denied

If you are receiving benefits and a claim is denied, you have 30 days to request an appeal. As mentioned above, you may want to begin by informally contacting the Medicaid office by phone and in writing to try to resolve the problem. But don't take too much time. Remember, you only have 30 days.

If the problem still exists after your informal attempts to resolve the problem, submit a request for an appeal. Requests must be sent in writing to the Virginia Department of Medical Assistance Services. Within 90 days of your request, the hearing officers should issue a decision. If you do not agree with the decision, you may appeal through the courts.

Medicaid Waivers

You have 30 days to request an appeal for these situations:

- Services are denied, reduced, or terminated;
- There is a delay in your request for services; or
- There are no providers for services that you are approved to receive.

Hearing requests should be submitted in writing to the Virginia Department of Medical Assistance Services. Within 90 days of your request, the hearing officers should issue a decision. If you do not agree with the decision, you may appeal through the courts.

Notes: