

After Enrollment

This section is divided into six parts. The first five address how recipients in the Medicaid and the FAMIS programs access their benefits. The last section addresses certain situations where the state might pay for an individual's coverage in a private insurance plan (FAMIS *Select* and HIPP).

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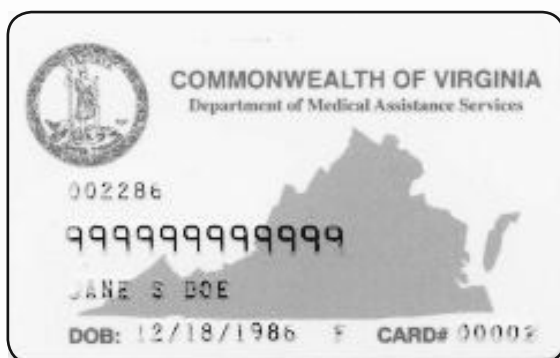
PART I: New Health Coverage for Adults

Once Approved

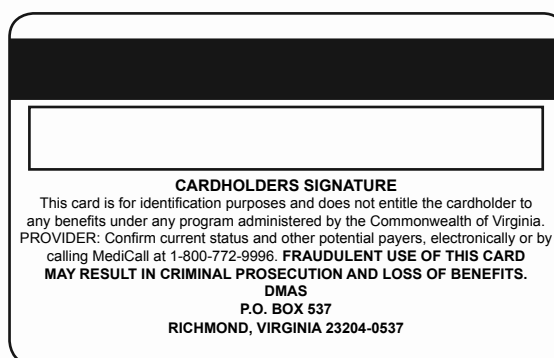
An individual approved for the **New Health Coverage for Adults** will receive a *Notice of Action on Benefits* stating that he/she has been approved. (A Sample Notice of Action is on page 2.39.)

In a separate mailing, the recipient will receive a permanent plastic ID card from DMAS. This card enables the individual to receive services from any Medicaid provider while his/her permanent benefits delivery method is determined. Enrollment into managed care takes less than 30 days. This is the period referred to as "Fee-for-Service". Enrollees do not have to wait for the receipt of this card to get services, their Medicaid (Enrollee ID) number is on the *Notice of Action* and the provider can verify enrollment with it.

FRONT



BACK



Selecting a Provider

In Virginia, Medicaid and FAMIS health care services are ultimately delivered through managed care organizations (MCOs). Recipients will access all care through a primary care provider (PCP) that they will select from the network of primary care providers within the health plan. This PCP will coordinate all of their care within the MCO's network of providers, specialists and hospitals.

The managed care program is called Medallion 4.0 and six MCOs deliver the services:

- | | |
|-----------------------------------|----------------|
| ■ Aetna Better Health of Virginia | (800) 279-1878 |
| ■ Anthem Healthkeepers Plus | (800) 901-0020 |
| ■ Magellan Complete Care | (800) 424-4518 |
| ■ Optima Family Care | (800) 881-2166 |
| ■ UnitedHealthcare Community Plan | (844) 752-9434 |
| ■ Virginia Premier | (800) 727-7536 |

The enrollee will receive a letter from DMAS about the managed care enrollment process. A comparison chart listing the six MCOs and any "added benefits" they provide will be sent along with this letter. The letter directs the

person to call the **Managed Care HelpLine** at **(800) 643-2273** Monday through Friday between 8:30AM and 6PM to choose an MCO by the date indicated or he/she will be assigned to the MCO listed in the letter. The enrollee can also go online to www.virginiamanagedcare.com to make the selection. **Note:** *The HelpLine has access to **interpreter services**, if English is not the recipient's primary or preferred language. (See sample enrollment letter and MCO comparison chart on pages 3.7-3.8)*

If the enrollee does not respond to the letter by the due date, the MCO listed in the letter will be assigned to them. Once a health plan has been chosen, either actively by calling/going online, or assigned by DMAS because the enrollee failed to choose one, a welcome packet and ID card will be sent by the MCO.

After receiving this information, an enrollee **still has about 60 days to change to another MCO**. After this period, the enrollee can only change MCOs during the annual Medicaid MCO "Open Enrollment Period" in his/her locality or if he/she requests a change and demonstrate good cause as to why he/she should be allowed to switch MCOs. *Note: At any time, a enrollee may switch to a different PCP within their MCO. (For clarification of the enrollment process see the chart on page 3.6)*

Medically Complex Individuals

If the recipient indicated that help was needed "with everyday things" or that he/she has a long term disease/disability, addiction or mental/emotional illness on the *Application for Coverage* in Question 9 on the paper application (Question 10 for Person 2/Additional people), he/she will be enrolled in the **Commonwealth Coordinated Care Plus (CCC Plus)** program. CCC Plus coverage includes the extra support of a Care Coordinator so that these individuals get help with coordinating all of their health care needs and is provided by the same six MCOs listed on page 3.1.

The enrollee will receive a letter from DMAS about the CCC Plus enrollment process. A comparison chart listing the six CCC Plus MCOs and any "added benefits" they provide will be sent along with this letter. The letter directs the person to call the CCC Plus **Enrollment HelpLine** at **(844) 374-9159** Monday through Friday between 8:30AM and 6PM to choose an MCO by the due date indicated or he/she will be assigned to the MCO listed in the letter. The enrollee can also go online to www.cccplusva.com to make the selection. **Note:** *The HelpLine has access to **interpreter services**, if English is not the recipient's primary or preferred language. (See sample CCC Plus MCO comparison chart on page 3.9)*

If the enrollee does not respond to the letter by the due date, the MCO listed will be assigned to them. Once a health plan has been chosen, either actively by calling/going online, or assigned by DMAS because the enrollee failed to choose one, a welcome packet and card will be sent by the MCO.

After receiving this information, an enrollee **still has about 60 days to change to another MCO**. After this period, the enrollee can only change MCOs during the annual CCC Plus MCO "Open Enrollment Period" in his/her locality or if he/she requests a change and demonstrate good cause as to why he/she should be allowed to switch MCOs.

After enrollment, the MCO will perform a verification screening to make sure the person was enrolled in CCC Plus correctly. If it is determined the person should not be in CCC Plus, he/she will be switched back to the Medallion 4.0 program, but will remain in the same MCO. No service disruption should occur.

Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, he/she must inform her local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in [Section 5](#) of this *Tool Kit*. If the problem is with the MCO card, the enrollee will need to call the MCO.

The enrollee should **report the loss or theft of his/her DMAS ID card to the local DSS or Call Center** immediately. If the MCO card is lost or stolen, he/she should report this to the MCO. The card should never be lent to anyone.

It is the enrollee's responsibility to show the MCO ID card and the DMAS ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid program. The provider uses the information on the card(s) to verify enrollment prior to delivering services. Failure to present the card(s), or the Medicaid ID number, at the time of service may result in the enrollee being charged for services.

Covered Services Overview

The New Health Coverage for Adults provides a comprehensive package of benefits. Including:

- Doctor, hospital, and emergency services
- Prescription drugs
- Laboratory and X-ray services
- Maternity and newborn care (*If the pregnant woman reports the pregnancy to the state she will be transferred to Medicaid for Pregnant Women*)
- Long-term care and support services
- Home health services
- Behavioral health services including addition/recovery treatment services
- Rehabilitative services including physical, occupational, and speech therapies
- Transportation to Medicaid-covered services when no alternatives are available
- Family planning services
- Medical equipment and supplies
- Preventive and wellness services chronic disease management services
- And more!

It is the same package of benefits received by other adults on Medicaid with enhanced preventive services - annual adult wellness exams; individual and

group smoking cessation counseling; nutritional counseling for individuals with obesity or chronic medical diseases; and recommended adult immunizations. (A detailed listing of Covered Services is on pages 3.19-3.24)

Cost Sharing

There are **small copayments** for services rendered **during the initial fee-for-service period**, for example \$1 for a clinic visit or \$1 for a generic prescription. **Once enrolled in a Managed Care Organization, there are no copayments for any services.**

Copayments and premiums may be possible for some of the enrollees with higher incomes in this coverage in the future. DMAS has submitted a 1115 Waiver to the Centers for Medicare and Medicaid Services (CMS) outlining future program changes that is currently pending approval. **Anyone enrolled in coverage before the changes are approved by CMS will not have to meet the additional requirements until their next renewal date.**

Period of Coverage and Reporting Requirements

When a person is determined to be eligible, the New Adult Coverage may **retroactively pay outstanding medical bills for the three months prior to their application date.** The applicant would need to request retroactive coverage at time of application by answering "Yes" to the question "Does this PERSON want help paying for medical bills from the last 3 months?" If no retroactive coverage was requested, coverage begins the first day of the month in which the Application was received.

Example: if a signed application is received in May and ultimately results in an enrollment, the outstanding medical bills may be covered for February, March, and April, if it is determined that the recipient would have been eligible for coverage during that time and retroactive coverage was requested.

An individual must report any "changes in circumstances" that might affect ongoing eligibility for this coverage to his/her local DSS or the CVCC **within 10 days.** For example, changes in income or household size must be reported. When a change is reported, the caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage.

Additional reporting requirements related to working/volunteering may be coming to this coverage in the future and are part of the 1115 Waiver DMAS has submitted to CMS. Anyone enrolled in coverage before the changes are approved by CMS will not have to meet the additional requirements until their next renewal date.

Note: Reporting a **change of address** is especially important because DSS/DMAS/CPU mail is not forwarded, even if the individual has a forwarding order on record with the post office. If any mail is returned to the agency, the case will be closed and coverage will be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner and it needs a "good" address to do so.

Annual Renewal *(An example of this form is located on pages 3.47-3.64)*

Eligibility for this coverage must be renewed every 12 months. If, in Step 5 on the initial application for coverage, the person indicated willingness to have income information checked electronically in subsequent years to renew coverage (5 years maximum), LDSS will initiate an "Ex Parte" renewal. If current income information can be electronically verified as "reasonably compatible" with the prior year's income and the income is still within program guidelines, the individual will be sent a *Notice of Action* indicating that coverage has been renewed for an additional year. *(A sample Ex Parte renewal approval is on pages 3.11-3.12)*

If the electronic income data is not "reasonably compatible" with the information in the recipient's file, a paper renewal application will be issued. Approximately **45 days prior to the enrollee's renewal month**, the person will be sent an 18+ page renewal form pre-populated with the his/her household and income information. If a person has indicated Spanish as his/her primary language, a pre-populated form in Spanish will be sent instead.

Enrollees have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and return it for processing. It can be returned via mail (in the envelope provided) or hand-delivered to the local DSS. Once the preprinted form is received, enrollees can also complete it by calling the CVCC to report any changes in information or, if they have linked their case in CommonHelp, he/she can complete it online. Instructions on how to link a case in CommonHelp are in Section 5.

Once the information is supplied via any of the above methods, the local DSS will use it to redetermine eligibility. If additional information is needed, the eligibility worker will contact the person in writing to ask for it. If found to be still eligible, the recipient will get a *Notice of Action* stating that coverage has been renewed and giving new dates of coverage.

If the individual fails to return the form by the due date, a cancellation notice will be sent, and coverage will be cancelled effective the end of the renewal month. It is important to note, however that the person **still has an additional 90 days to return the form with any needed verification documents and coverage can be reinstated**. If he/she returns the form after that additional 90-day period, coverage cannot be reinstated, and he/she will have to file a new application. *(A sample cancellation letter is on page 3.10)*

If it is found that the person is no longer eligible for Health Coverage for Adults, coverage will be cancelled. The LDSS will send the information to the Federal Health Insurance Marketplace so the person may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a "Special Enrollment Period" allowing the individual to shop on the Marketplace. The person will also be evaluated for Plan First coverage, if his/her income is under 205% FPL. A person can age out of coverage. This coverage category is for people **ages 19 to 64 only**. Coverage will end on the last day of the month in which the enrollee turns 65.

Managed Care Enrollment - New Health Coverage for Adults¹, FAMIS Plus, Medicaid for Pregnant Women, LIFC, and FFC

A letter is sent from DMAS giving approximately **30 days** for the individual/family to choose an MCO. A comparison chart with the six MCO choices is provided. They are told that if they do not call the Managed Care HelpLine or go to its website to choose, the MCO listed in the letter will be assigned to them.

Did the enrollee contact the Managed Care HelpLine?¹

YES

Gets MCO of choice and is asked to pick their PCP.²

MCO welcome packet sent (ID Card, provider directory, and handbook).

NO

Gets assigned an MCO and the MCO assigns a PCP.²

MCO welcome packet sent (ID Card, provider directory, and handbook).

Does the person want to change to a different MCO?

Enrollees still have about **60 days left** to call the HelpLine and change to a different MCO. After that they can only change during MCO "Open Enrollment" or by writing DMAS and providing "good cause" to change.³

1. For Medically Complex individuals the process is almost the same but the place to contact changes - the CCC Plus Enrollment HelpLine or website.
2. The recipient can call the MCO and change their PCP at any time.
3. Children on Medicaid/FAMIS Plus who are in Foster Care, or receiving adoption assistance, can change their MCO at any time.
4. Open enrollment for the New Adult Coverage group is from November 1 to December 31. For the CCC Plus recipients it is either October 1 or November 1 to December 18. For LIFC, FFC, MPW, and FAMIS Plus, MCO open enrollment varies by region and the dates are available at <https://www.virginiamanagedcare.com/learn/open-enrollment>

August 19, 2018

<CASE NAME>

Case ID: xxx-xxxxxxx-xxx

<ADDRESS>

<CITY><STATE><ZIP>

You are receiving this letter because you were recently enrolled in the Medicaid program. This letter provides information about how you will receive your medical care under the Medicaid program.

Beginning **09/01/2018 (first of next month)**, you will receive your health care coverage through a Managed Care Organization (MCO). A MCO is an organization that offers health care coverage through a group of doctors, hospitals, and specialists that work together to give you the care you need.

An MCO has been selected for you. You have the right to choose a different plan. You know your health needs best, so it's better if you choose. Look at the enclosed comparison chart. It will help you choose the MCO that is best for you and/or your family members. All family members do not need to be enrolled in the same MCO. To change your MCO, search for doctors, check your enrollment and more online go to www.VirginiaManagedCare.com. If you want to speak to a live person to change plans, call the Managed Care Helpline at 1-800-643-2273 (TDD 1-800-817-6608). The helpline is available Monday through Friday from 8:30 am to 6:00 pm (Translation Services Available) to assist you with:

- Answering any questions you have about MCOs or this letter
- Finding out if your doctor is in the MCO you want
- Choose the MCO you want for your medical coverage

To choose a different MCO than what is listed below, you must go online to www.virginiamanagedcare.com or call the Managed Care Helpline. See chart below for when to call.

Change for next month	Call by end of this month
Last day to call and change MCO	Call by end of 11/30/2018

If you do not call by the date listed above, you will not be able to change until the open enrollment period. If you are satisfied with your MCO assignment, you do not need to call. You will receive an identification card from your new MCO. This does not replace your plastic Medicaid ID card. You should show both cards when receiving care and never throw away your plastic card.

NAME

<Recipient Name>

RECIPIENT ID#

<12-Digit Recipient ID #>

MCO PLAN

<MCO Plan>

Medallion 4.0 MCO Comparison Chart

aetna® Aetna Better Health® of Virginia 1-800-279-1878 TTY 711 www.aetnabetterhealth.com/Virginia	Anthem. HealthKeepers Plus Offered by HealthKeepers, Inc. 1-800-901-0020 TTY 711 www.anthem.com/vamedicaid	Magellan COMPLETE CARE. 1-800-424-4518 TTY 711 www.MCofVA.com	OptimaHealth & 1-800-881-2166 TTY 711 www.optimahealth.com/familycare	UnitedHealthcare® Community Plan 1-844-752-9434 TTY 711 www.uhccommunityplan.com/va	VirginiaPremier. Powered by VCU Health 1-800-727-7536 TTY 711 Northern Virginia members* with Kaiser Permanente: 1-855-249-5025 www.virginiapremier.com
Added benefits: Adult dental and vision <ul style="list-style-type: none"> 2 dental exams and cleanings and 1 set of x-rays each year, plus fillings and extractions 1 eye exam and \$100 for frames, glasses or contacts each year Healthy moms and kids <ul style="list-style-type: none"> Maternity incentive program Diapers for one month (300 diapers) Ted E. Bear, M.D.™ Club Free swim lessons Free sports physicals Phone and online tools <ul style="list-style-type: none"> Free smartphone with 350 minutes, data and unlimited texts each month 24/7 Member Services Wellness programs <ul style="list-style-type: none"> Better Breathing asthma program and second inhaler or nebulizer Diabetes Care for Life program Other benefits <ul style="list-style-type: none"> Free rides to grocery store, food bank, church and certain social activities (30 round trips each year) GED certificate incentive Meals delivered to your home after hospital stay, 2 meals each day for 7 days 	Added benefits: Adult dental and vision <ul style="list-style-type: none"> Dental exam, cleaning and set of x-rays each year Tooth removal Healthy moms and kids <ul style="list-style-type: none"> Boys & Girls Club membership Free diapers, umbrella stroller and Books for Babies Sports physicals for kids Phone and online tools <ul style="list-style-type: none"> Free smartphone with 350 minutes, 1 GB of data and unlimited texting Wellness programs <ul style="list-style-type: none"> \$120 of Weight Watchers® vouchers Healthy Rewards gift card up to \$50 per goal Online fitness classes Other benefits <ul style="list-style-type: none"> Free rides to grocery store, farmer's market or food bank (up to 3 rides every 3 months) \$120 in GED testing vouchers \$25 gift card for high school and college students (with A's and B's) Coupons with over \$1,000 in savings at local stores Up to \$20 Walmart gift card for completing health screener Air purifier (with approval) Meals delivered to your home after hospital stay, 2 meals each day for 7 days 	Added benefits: Adult dental and vision <ul style="list-style-type: none"> 2 dental exams and cleanings and 1 set of x-rays each year (\$550 year limit) \$150 for glasses or contact lenses every 2 years Healthy moms and kids <ul style="list-style-type: none"> Pregnancy supplies and mobile information tools Member baby showers hosted quarterly per region Yearly sports physicals for children Bicycle helmets for children Phone and online tools <ul style="list-style-type: none"> Free smartphone with 1,000 minutes, 1 GB of data and unlimited texts each month Wellness programs <ul style="list-style-type: none"> Healthy Rewards gift card up to \$50 Yearly routine physicals for adults Online tool for anxiety, insomnia and depression Other benefits <ul style="list-style-type: none"> Fresh meals delivered to your home after hospital stay Mobile app to help quit smoking 	Added benefits: Adult dental and vision <ul style="list-style-type: none"> 1 dental cleaning and 1 set of x-rays each year Discount for frames, lenses and contacts Healthy moms and kids <ul style="list-style-type: none"> OB care support programs, Baby Showers and incentives up to \$75 Ready, Set, Read! program Free breast feeding classes and breast pumps Phone and online tools <ul style="list-style-type: none"> Free smartphone with 350 minutes, unlimited texts and free calls to health plan each month Web and mobile app tools Wellness programs <ul style="list-style-type: none"> Help to quit smoking Weight management Wellness rewards for healthy behavior Online search tool to find community resources and programs Other benefits <ul style="list-style-type: none"> Up to \$275 for GED prep and testing vouchers Member education home visit Free sports physicals MDLive: 24-hour physician access for non-life threatening health questions or medical needs 	Added benefits: Adult dental and vision <ul style="list-style-type: none"> 1 dental exam, cleaning and set of x-rays each year 1 eye exam each year Frames and lenses every 2 years Healthy moms and kids <ul style="list-style-type: none"> Baby Blocks incentives program Prenatal and maternity incentives Free mattress cover and pillowcase for members with asthma Free sports physical Free Boys & Girls Club registration Phone and online tools <ul style="list-style-type: none"> Help with applying for free cell phone, voice minutes and unlimited texts On My Way™ website for teens Wellness programs <ul style="list-style-type: none"> Weight Watchers® Member rewards Behavior management incentives Adult pain management and treatment (non-opioid) Other benefits <ul style="list-style-type: none"> Fresh EBT mobile app Fresh meals delivered to your home after hospital stay for members who qualify Rides to certain non-medical sites, including WIC appointments and food banks 	Added benefits: Adult dental and vision <ul style="list-style-type: none"> 1 dental exam, cleaning and set of bite wing x-rays each year Full dental coverage for members in foster care ages 21-26 Lenses and up to \$100 for frames or contacts every 48 months Healthy moms and kids <ul style="list-style-type: none"> Baby Showers Breast pump, prenatal and parenting classes, lactation consultant, and family planning Healthy Heartbeats prenatal and postpartum wellness program with incentives Phone and online tools <ul style="list-style-type: none"> Free smartphone with 350 minutes, 1 GB of data and unlimited texts each month Wellness programs <ul style="list-style-type: none"> Personal fitness program for your specific needs Help to quit smoking Nutrition education program Registered nurse and text-based programs to help manage chronic conditions <hr/> <ul style="list-style-type: none"> *Kaiser: Arlington, Alexandria, Fairfax, Fairfax City, Falls Church, Loudoun, Manassas, Manassas Park and Prince William. Starting September 1, 2019: Fauquier, King George and Stafford.

► For a list of **doctors and hospitals** that work with each plan, go to the plan's website or call their toll-free number listed above.

► For a list of **basic benefits** that all plans offer, see the brochure in this packet.

 <p>Aetna Aetna Better Health® of Virginia</p> <p>1-855-652-8249 TTY 711</p> <p>www.aetnabetterhealth.com/Virginia</p>	 <p>Anthem. HealthKeepers Plus Offered by HealthKeepers, Inc.</p> <p>1-855-323-4687 TTY 711</p> <p>www.anthem.com/vamedicaid</p>	<p>Magellan COMPLETE CARE.</p> <p>1-800-424-4524 TTY 711</p> <p>www.MCCofVA.com</p>	<p>OptimaHealth</p> <p>1-888-512-3171 or 1-757-552-8360 TTY 711</p> <p>www.optimahealth.com/communitycare</p>	<p>UnitedHealthcare Community Plan</p> <p>1-866-622-7982 TTY 711</p> <p>www.uhccommunityplan.com/va</p>	 <p>Virginia Premier Community Network</p> <p>1-877-719-7358 TTY 711</p> <p>www.virginiapremier.com</p>
<p>Added benefits:</p> <p>Adult dental</p> <ul style="list-style-type: none"> 2 exams and cleanings and 1 set of x-rays each year, plus fillings, root canal and dentures (up to \$525 each year) <p>Adult hearing</p> <ul style="list-style-type: none"> Exam and 1 hearing aid each year (up to \$500 each year) <p>Adult vision</p> <ul style="list-style-type: none"> Eye exam and \$100 for frames, glasses or contacts each year <p>Phone services</p> <ul style="list-style-type: none"> Free smartphone with 350 free minutes each month, data and free unlimited texts <p>Wellness programs</p> <ul style="list-style-type: none"> Wellness rewards card Regional wellness center <p>Other benefits</p> <ul style="list-style-type: none"> Memory alarms and devices Community health worker Diabetic shoes or inserts Free rides to grocery store, farmers market, food pantry, church or exercise classes (30 round trips each year) Meals delivered to your home after discharge, 2 meals each day for 7 days 	<p>Added benefits:</p> <p>Adult dental</p> <ul style="list-style-type: none"> 2 exams and cleanings and 1 set of x-rays per year <p>Adult hearing</p> <ul style="list-style-type: none"> 1 exam, \$1,000 for hearing aids and 60 batteries per year <p>Adult vision</p> <ul style="list-style-type: none"> 1 eye exam and \$100 for glasses (lenses and frames) per year <p>Phone services</p> <ul style="list-style-type: none"> Free smartphone with 350 free minutes, 1 GB data each month and unlimited texts <p>Wellness programs</p> <ul style="list-style-type: none"> Online search tool to find food, jobs and more Healthy Rewards gift card (up to \$50 per goal) <p>Other benefits</p> <ul style="list-style-type: none"> Up to 3 rides every 3 months to community events, grocery stores and more Coupons with over \$1,000 in savings to local stores \$50 for assistive devices and \$50 for walker and wheelchair accessories Air purifier (with approval) Online peer support services Meal delivery after hospital or nursing facility discharge 	<p>Added benefits:</p> <p>Adult dental</p> <ul style="list-style-type: none"> 2 exams and cleanings and 1 set of x-rays each year (up to \$550 each year) <p>Adult vision</p> <ul style="list-style-type: none"> \$150 for glasses or contact lenses every two years <p>Phone services</p> <ul style="list-style-type: none"> Free smartphone with 1,000 free minutes, 1 GB of data and unlimited texts <p>Wellness programs</p> <ul style="list-style-type: none"> Healthy Rewards gift cards (up to \$50 each year) Annual adult physicals for children <p>Other benefits</p> <ul style="list-style-type: none"> Fresh meals delivered to your home after discharge Environmental, home and vehicle modifications as needed (restrictions apply) Additional personal care attendant support Online tool for anxiety, insomnia and depression Online directory of community services and organizations Enhanced OTC medications (up to \$50 per quarter) Bicycle helmets for children 	<p>Added benefits:</p> <p>Adult dental</p> <ul style="list-style-type: none"> 1 exam, cleaning and set of x-rays each year <p>Adult vision</p> <ul style="list-style-type: none"> Discounts on eye glasses <p>Phone services</p> <ul style="list-style-type: none"> Free smartphone with 350 free minutes, 1 GB of data and unlimited texts <p>Wellness programs</p> <ul style="list-style-type: none"> Help to quit smoking Weight management Online search tool to find community resources, health plan services and programs <p>Other benefits</p> <ul style="list-style-type: none"> Assistive devices Access these services through Care Coordinator: Extended respite for caregivers Diabetic foot care Memory alarms and devices Meals delivered to your home after discharge, 2 meals each day for 7 days Up to 3 round trip rides every 3 months to community events, grocery stores and more MDLive: 24-hour doctor access for non-life threatening health questions or medical needs 	<p>Added benefits:</p> <p>Adult dental</p> <ul style="list-style-type: none"> 2 exams and cleanings and 1 set of x-rays each year <p>Adult vision</p> <ul style="list-style-type: none"> Eye exam each year and frames and lenses every 2 years if needed <p>Phone services</p> <ul style="list-style-type: none"> Free smartphone with 350 free minutes each month and unlimited texts <p>Wellness programs</p> <ul style="list-style-type: none"> Annual adult wellness exam Resources to quit smoking Weight Watchers: 10 meeting vouchers each year, resources for healthy eating and weight loss <p>Other benefits</p> <ul style="list-style-type: none"> Health4Me® free mobile app for health tips, reminders and care team secure messaging Meals delivered to your home after discharge from inpatient hospital or nursing facility, 2 meals each day for 7 days Environmental and home modifications for all members, when needed Prenatal and postpartum program with incentives 	<p>Added benefits:</p> <p>Adult dental</p> <ul style="list-style-type: none"> 1 exam, cleaning and set of bitewing x-rays each year <p>Adult hearing</p> <ul style="list-style-type: none"> 1 hearing aid, exam and fitting (up to \$1,250 every 36 months) <p>Adult vision</p> <ul style="list-style-type: none"> 1 eye exam and up to \$100 for frames or contact lenses every 24 months <p>Phone services</p> <ul style="list-style-type: none"> Free smartphone with 350 free minutes, data and unlimited texts <p>Wellness programs</p> <ul style="list-style-type: none"> Personal fitness program for your specific needs Wellness reward gift cards Nutrition education program Registered nurse and text-based programs to help manage chronic conditions <p>Other benefits</p> <ul style="list-style-type: none"> Access to CVS Minute Clinic Online access to health plan services and resources Meal delivery after hospital or nursing facility discharge for up to 14 days

► These benefits start **January 1, 2020**. Call the plan or visit their website to learn about doctors, hospitals and limits that apply.

► For the **basic benefits** that **all plans** offer, see the brochure in this packet.

CCC Plus MCO Comparison Chart

County/City: Central Office (999)
801 East Main Street
Richmond VA 23219
Phone: (999) 999-9999

Commonwealth of Virginia
Department of Social Services

Date: **03/20/2018**
Case Number: 13090477
Client ID: **2103596868**
Correspondence #: **710082712**

Jerry New Worlds
1100 King ST
Charlottesville VA 22903

*This is the name and
address of the head
of household.*

Notice of Action on Benefits

This letter tells you about your benefits. If you have a question, please contact your agency listed above.

Which benefit?	Status of the benefit?
Medical Assistance (MA)	Advanced Notice of Proposed Action Based on a reported change on your Medical Assistance case, coverage is ending as of 4/30/2018. For more information about your benefits, please read this entire notice.

Comments:

(Note: Second and Third Pages of this notice have been omitted for space. Items included on Page 2 are below and Page 3 has the same wording regarding Appeals and Fair Hearings as in the Sample Approval Notice in Section 2)

Cancelled:

Coverage will be ending as of 4/30/2018 for the following people. The reason why your coverage is ending is below:

Whose benefits are ending?	Benefit Period	Why Benefits are ending?	Manual Reference
Jill New Worlds	As of 05/01/2018	Unable to locate	(M0130.400C)

County/City: **Charlottesville City (540)**
120 Seventh St., N.E. Charlottesville
VA 22902
Phone: **(434) 970-3400**

Commonwealth of Virginia

Department of Social Services

Date: **03/17/2018**
Case Number: 113094733
Client ID: **2103606987**
Correspondence #: **710302260**

Polly Anderson
1100 King ST
Charlottesville VA 22901

*This is the name and
address of the head
of household.*

Notice of Action on Benefits

This letter tells you about your benefits. If you have a question, please contact your agency listed above.

Which benefit?	Status of the benefit?
Medical Assistance (MA)	<p>A Renewal has been automatically completed for Medical Assistance enrollees on your case based on data available to us without requiring you to take any action to renew.</p> <p>Please read this entire notice for information about this renewal.</p>

Comments:

If you indicated when applying for benefits (Medicaid, SNAP, TANF, Energy Assistance, or Child Care) that you wanted to receive an email or text message telling you that you have electronic mail about your benefits, you must first go to CommonHelp, www.CommonHelp.virginia.gov before you can access that mail. In CommonHelp, you will need to set up a secure mailbox. Have your client ID and case number available.

Instructions are provided in CommonHelp.

If you are acting on behalf of an individual as an authorized representative, you will continue to receive all correspondence for that individual through the mail.

***Note:** Your Preferred Method of Correspondence may be changed only once a year (January - December). You may update your email or cell phone number whenever changes are needed.

Your Medical Assistance Benefits

Approved:

Based on a review of your case, coverage continues for the following people. Your next renewal is due 05/31/2019

Who is included?	Benefit Period	Coverage	Enrollee ID	Copay Status
Andy Thompson	04/01/2018- *	MA-FAMIS Plus	350022415019	0
Who is included?	Benefit Period	Coverage	Enrollee ID	Copay Status
Bobby Thompson	04/01/2018-*	MA-FAMIS Plus	350022415027	0

(Note: Third page has been omitted for space, this page contains the same wording regarding Appeals and Fair Hearings as in the Approval notice in Section 2)

Part II: FAMIS Plus, LIFC, and Former Foster Care Youth (FFC)

Once Approved

Once a child is approved for FAMIS Plus, a parent/caretaker relative is approved for LIFC, or a young adult for coverage for Former Foster Care Youth (FFC), the enrollee will receive a *Notice of Action on Benefits* stating that they have been approved for coverage. *(An example of this form is located on page 2.39)*

In a separate mailing, the recipient will receive a permanent plastic ID card from DMAS. This card enables the individual to receive services from any Medicaid provider while his/her permanent benefits delivery method is determined. Enrollment into managed care takes less than 30 days. This initial period is referred to as "Fee-for-Service". Enrollees do not have to wait for the receipt of the card to get services, however, their Medicaid number is on the *Notice of Action* and the provider can verify enrollment with it. *(An sample off this card is on page 3.1)*

Once enrolled in the MCO, the enrollee will still use the DMAS ID card for any services not available through the MCO (e.g. school-based services for children.)

Selecting a Provider

The Medicaid Managed Care Program is called Medallion 4.0. Enrollees must select a Managed Care Organization (MCO) for delivery of their benefits. The six MCOs delivering services to FAMIS Plus children, LIFC parent/caretakers, and FFC recipients are the same as those for the New Health Coverage for Adults and are listed on page 3.1.

Soon after receiving the DMAS ID card, the family will receive a letter from DMAS about the managed care enrollment process. A comparison chart listing the six MCOs and their "added benefits" will be sent along with this letter. *(See sample enrollment letter and MCO comparison chart on pages 3.7-3.8)*

The letter directs the family/enrollee to call the **Managed Care HelpLine** at **(800) 643-2273** Monday - Friday between 8:30AM and 6PM or to go online to www.virginiamanagedcare.com to choose an MCO. The letter lists the name of an MCO they have been pre-assigned to and give a due date to reply. **Note:** The HelpLine has access to **interpreter services**, if English is not the family's primary or preferred language.

If the family/enrollee does not respond to the letter by the date indicated, the health plan listed in the letter will be assigned to them. Once an MCO has been chosen, either actively by calling/going online or assigned by DMAS because the family/enrollee failed to choose one, an MCO welcome packet including an ID card will be sent. An MCO ID card will be issued for each enrolled person.

At this point, there is **still 60 days to switch to another MCO**. After this period, enrollees can only change their plan during the annual Medicaid MCO “Open Enrollment Period” in their locality or if they request a change and demonstrate good cause as to why they should be allowed to switch. *Note: At any time, a family/enrollee may switch to a different PCP within their MCO. (For clarification of the enrollment process see the chart on page 3.6)*

Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, he/she must inform the local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in Section 5. If the problem is with the MCO card, the enrollee will need to call the MCO.

It is the family/enrollee’s responsibility to show both the DMAS ID Card and the MCO card to providers each time medical services are received and to make sure the provider participates in the Medicaid/FAMIS Plus program or with the MCO they have chosen. Failure to present the cards at the time of service may result in the person being held responsible for any expenses incurred.

The family/enrollee should stop using the DMAS and MCO cards immediately when notified by the local Department of Social Services that the child or adult is no longer eligible for the program. *Note: the DMAS ID card should be retained in case the person ever becomes eligible for state-sponsored health insurance again. It can be reactivated at that time.*

The family/enrollee should **report the loss or theft of a DMAS ID card** to the local DSS or the Cover Virginia Call Center immediately. If the **MCO card is lost or stolen**, this should be reported to the MCO. These cards should never be lent to anyone.

Covered Services Overview

FAMIS Plus provides a comprehensive package of benefits uniquely designed to meet the needs of lower income children. In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, FAMIS Plus also covers services such as non-emergency transportation to medical appointments, case management and health education for babies with potential health risks, behavioral health and substance abuse treatment services, eye exams and glasses, dental care, and other services not often covered by private health insurance plans. MCOs may provide additional enhanced services such as health education, 24 hour nurse advice line access, disease management programs, and free sports physicals.

Of special note, children covered by FAMIS Plus are entitled to the **EPSDT** (Early Periodic Screening, Diagnosis and Treatment) program. This valuable component of Virginia’s FAMIS Plus program provides comprehensive health screenings for children **up to age 21**. Any medical condition diagnosed

through an EPSDT screening must be treated at no cost to the family, even if it is a service not normally covered by FAMIS Plus.

LIFC/FFC benefits for adults are similar to those for children and pregnant women, but do not include routine dental care, eyeglasses, or smoking cessation services. If the parent/caretaker or FFC recipient is under age 21, he/she can benefit from the EPSDT program services and dental benefits.

A detailed listing of *Covered Services* is on pages 3.19-3.24.

Cost Sharing

There are **no copayments** or costs for services to children in **FAMIS Plus**.

While in the initial **fee-for-service** period, the LIFC or FFC recipient has to pay **small copayments** for services (\$1 for a clinic visit or generic medication). There are **no copayments for LIFC** parent/caretaker relatives or **FFC recipients** once they are enrolled in an MCO.

Period of Coverage and Reporting Requirements

When a person is determined to be eligible, FAMIS Plus/LIFC/FFC may **retroactively pay outstanding medical bills for the three months prior to their application date**. For example, if a signed application is received in March and ultimately results in an enrollment, the outstanding medical bills may be covered for December, January, and February, if it is determined that the recipient would have been eligible for the program during that time and retroactive coverage was requested. The person would need to request retroactive coverage at time of application by answering “yes” to the question “Does this PERSON want help paying for medical bills from the last 3 months?”

If no retroactive coverage was requested, **coverage begins the first day of the month in which the Application was received**.

Enrollees must report any “changes in circumstances” that might affect ongoing eligibility their local DSS or the CVCC **within 10 days**. For example, changes in income or household size must be reported. When a change is reported, the caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage.

Note: Reporting a **change of address** is especially important because DSS/DMAS/CPU mail is not forwarded, even if the person has a forwarding order on record with the post office. If correspondence is returned to the agency, the case will be closed and coverage will be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner and it needs a “good” address to do so.

Annual Renewal *(An example of the renewal form is located on pages 3.47-3.64)*

Eligibility for FAMIS Plus/LIFC/FFC must be **renewed every 12 months**. If, in Step 5 on the initial application for coverage, the family/individual indicated their willingness to have their income information checked electronically in subsequent years to renew coverage (5 years maximum), LDSS will initiate an "Ex Parte" renewal. If income information can be verified as "reasonably compatible" with the prior year's income and the amount is still within program guidelines, the enrollee will be sent a *Notice of Action* indicating that coverage has been renewed for another year. *(A sample Ex Parte renewal approval is on pages 3.11-3.12)*

If the electronic income data is not "reasonably compatible" with the information in the recipient's file, a paper renewal application will be issued. Approximately **45 days prior to the renewal month**, the enrollee will be sent an 18+ page renewal form pre-populated with the case's household and income information. If the enrollee has indicated Spanish as his/her primary language, a pre-populated form in Spanish will be sent.

Enrollees will have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and return it to LDSS for processing. They can return it via mail (in the envelope provided), hand-deliver it to the local DSS, contact the CVCC to report any changes in information via the telephone, or go online to CommonHelp and complete the renewal there, if after approval for the program they linked their case. Instructions on how to link a case in CommonHelp are in Section 5.

Once the information is provided (via paper, phone or online), the local DSS will use it to redetermine eligibility. If the LDDS worker still needs additional information, a written request will be sent asking for it. If the person is still eligible, a *Notice of Action* will be sent stating that coverage has been renewed and giving new dates of coverage.

If the information is not provided by the due date, a cancellation notice will be sent. Coverage will be cancelled effective the end of the renewal month. It is important to note, however, that the enrollee **still has an additional 90 days to return the form with any needed verification documents and coverage can be reinstated**. If the form is returned after the additional 90 days, coverage cannot be reinstated, and a new application for coverage will be required. *(A sample cancellation letter is on page 3.10)*

FAMIS Plus

Many children are terminated from FAMIS Plus at renewal time because of the family's failure to complete the process. A child cancelled from FAMIS Plus for failure to complete annual renewal may reapply for FAMIS Plus at any time.

During the renewal process, if the family's income has risen, the eligibility worker may determine that the child is eligible for FAMIS instead. If he/she is now eligible for FAMIS, the child will be enrolled in that program and the family will receive a *Notice of Action* with the new dates of coverage.

If the child is not eligible for either FAMIS or FAMIS Plus (i.e. the family's income has risen above 205% of FPL), FAMIS Plus coverage will be cancelled. The LDSS will send the information to the Federal Health Insurance Marketplace so the family may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a Special Enrollment Period that allows the family to shop for private coverage, if eligible.

Coverage will end the last day of the month in which a FAMIS Plus enrolled child turns 19. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

LIFC

At annual renewal, if a LIFC parent/caretaker's income has risen above program guidelines, he/she may still be eligible for LIFC coverage for an additional period of time. If the income increase is as a result of an increase in **spousal support**, the LIFC recipient may be eligible for four additional months of coverage. If the income increase is as a result of an increase in **earned income**, the LIFC recipient may be eligible for twelve months of coverage. The second six months of coverage is contingent upon cooperation with reporting requirements during the first six months.


After this additional coverage period, the parent/caretaker can be evaluated for the New Health Coverage for Adults and, if found eligible, be enrolled in that coverage.

If the person's income is over 138% FPL at that time, the LDSS will send the case information to the Federal Health Insurance Marketplace so the person may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a Special Enrollment Period that allows the person to shop for private coverage, if eligible. The individual would also be evaluated for the Plan First program.

A parent/caretaker relative cancelled from LIFC for failure to complete annual renewal may reapply for LIFC at any time. LIFC coverage will also end when there is no longer a dependent child under the age of 18 living in the home. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

FFC

Former Foster Care coverage recipients still need to renew their coverage yearly even though income is not counted for that program. Coverage, is however, age limited. An enrollee can only be in this category of coverage until the age of 26. Enrollment will end on the last day of the month in which the person reaches that age. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category and if not eligible, referred to the Federal Health Insurance Marketplace so to be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at



annual renewal opens a Special Enrollment Period that allows the individual to shop for private coverage, if eligible.

Medicaid Covered Services

(Covered Services for New Health Coverage for Adults, FAMIS Plus, LIFC, FFC, Medicaid for Pregnant Women, and FAMIS MOMS)

General Note: New Health Coverage for Adults, LIFC, and FFC recipients in MCOs have no copayments. There are no copayments or costs for services for children enrolled in FAMIS Plus. There are no copayments for Medicaid for Pregnant Women or FAMIS MOMS recipients.

Addiction and Recovery Treatment Services (ARTS)

Evidence-based and community based-addiction treatment services including: inpatient detox, residential treatment, partial hospitalization, intensive outpatient programs, opioid treatment programs, case management and peer recovery supports.

BabyCare (High Risk Pregnancy & Infant Program)

The BabyCare program, for pregnant women and infants up to age 2 who are enrolled in Medicaid/FAMIS Plus or FAMIS MOMS/FAMIS, helps pregnant women to determine if they have modifiable health risks or special needs. A nurse or social worker will evaluate the member to screen for potential health risks for either the pregnant woman or her baby. BabyCare services continue up to 60 days post-partum. Services may also be initiated or continued for newborns and babies up to age 2. BabyCare services may include:

- Prenatal education for a variety of topics including tobacco cessation, preparation for childbirth, and parenting
- Nutritional assessment and counseling
- Homemaker services to members for whom the physician has ordered complete bed rest
- Substance Abuse Treatment Services

**Participating Medallion 4.0 MCOs also have their own programs that cover similar services.*

Breast Pumps and Supplies and Lactation Consultation Services

Face-to-face breastfeeding consultation services, breast pumps and supplies are covered for Medicaid for Pregnant Women, FAMIS MOMS, FAMIS, and FAMIS Plus recipients. Covered breast pumps include: manual single user (purchase); electric single user (purchase); hospital grade multi-user (rental only); and milk collection kits for use with pumps (purchase). If enrolled with an MCO, contact Member Services to access these services. If enrolled in fee-for-service, ask the participating provider regarding ordering these services.

Certified Nurse Midwife Services

Covered as allowed by State licensure requirements and Federal Law.

Clinic Services

All clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinics are covered.

Court Ordered Services

All medically necessary court ordered services are covered.

Dental Care Services – (Smiles For Children Program managed by DentaQuest 1-888-912-3456)

Dental services are available to children and pregnant women recipients via the Smiles For Children (SFC) program managed by DentaQuest, DMAS's dental benefits Administrator. Also included is medically necessary oral surgery and associated diagnostic services. LIFC recipients are not eligible for routine dental care.

Once a child/pregnant woman is enrolled in FAMIS Plus/Medicaid/FAMIS MOMS program, they are automatically enrolled in SFC as well. SFC covers all the services listed below when provided by a dentist that participates in Smiles For Children. Members will receive a separate Smiles For Children handbook detailing the program, covered services, how to find a dentist, what to do in an emergency, etc. Recipients access services by seeing a SFC dentist and showing either their DMAS ID Card or MCO card. Transportation to dental appointments is available if necessary, contact the MCO 24-48 hours prior to the dental appointment to arrange transportation. To find a dentist, call 1-888-912-3456 between 8AM and 6PM, Monday through Friday, or look at the listings posted on www.dmas.virginia.gov or <http://www.dentaquestgov.com/state-plans/regions/virginia/>. **There are no costs for services accessed through the SFC Program.**

Covered services are: fluoride (every 6 months), sealants, cleanings (every 6 months), space maintainers, X-rays, fillings, crowns (some caps), extractions, anesthesia, root canal treatments, oral disease services, and braces (if qualified). Routine diagnostic, preventative, primary and prosthetic and complex restorative procedures necessary for oral health (i.e. dentures, inlays, onlays, crowns and relining of dentures for a better fit) are covered. Tooth guidance appliances, complete and partial dentures, surgical preparation for prosthetics, single permanent crowns, and bridges are also covered, but can be subject to prior authorization. Routine bases under restorations are not covered. For recipients under age 21, full banded orthodontics and related services are covered when medically necessary. Post treatment stabilization retainers and follow-up visits are included. Some services require pre-authorization.

There is no routine or preventative dental care available to LIFC recipients. Medically necessary oral surgery is covered. Medically necessary anesthesia and hospitalization services are covered by the MCO when it is determined such services are required to provide dental care. The six MCOs delivering care may cover additional dental services as “added benefits.” This coverage varies by MCO.

Durable Medical Supplies and Equipment

Supplies and equipment are covered when suitable for use in the home and ordered by a physician as medically necessary. Examples of covered supplies are: ostomy supplies, oxygen, respiratory equipment, and home dialysis equipment and supplies. Nutritional supplements for children and adults are covered. Specially manufactured DME equipment is covered when preauthorized.

Early Intervention Services

Are covered for FAMIS Plus/Medicaid children via the MCO. Case management and other services designed to meet the developmental needs of infants or toddlers with a developmental delay up to age three.

EPSDT (Early Periodic Screening, Diagnosis and Treatment)

A special program eligible to FAMIS Plus/Medicaid enrollees under age 21 that helps to detect and treat health care problems early via regular medical, dental, vision and hearing check-ups. Examination and treatment services are provided at no cost to the recipient. The recipient’s primary care provider should provide the medical check-up. Anything diagnosed during an EPSDT screening will be treated, even if the treatment is not normally covered by FAMIS Plus/Medicaid. Inter-periodic screening is available upon request of the caretaker. The schedule for routine checkups follows the recommendations of the American Academy of Pediatrics.

EPSDT checkups include:

- Comprehensive unclothed physical exam
- Patient and family medical history including identifying risk factors for health and mental health status
- Developmental, vision and hearing Screening
- Preventive laboratory services, including mandatory lead testing at 12 and 24 months of age.
- Age appropriate immunizations
- Referral to a dentist at age 1
- Age appropriate anticipatory guidance/health counseling
- Referrals for medical necessary health and mental health treatment

Medicaid for Pregnant Women, FAMIS MOMS, LIFC, and FFC recipients under age 21 are also eligible for EPSDT benefits.

Family-Planning Services/Birth Control

Covered services include drugs, supplies, and devices which delay or prevent pregnancy provided under the supervision of a doctor for members of child-bearing age. These services may be provided by network or out-of-network providers. Also includes certain elective sterilization procedures (for men and women). Coverage of such services does not include services to treat infertility or services to promote fertility.

HIV Treatment and Counseling for Pregnant Women

In compliance with State requirements governing HIV testing and treatment counseling, these services are covered.

Home Health Services

These services (nursing, rehabilitative therapies, and home health aide services) are covered when provided by an authorized home health agency under a plan of treatment prescribed by a doctor up to a specified

3.20 Medicaid Covered Services

number of visits. At least 32 home health aide visits are allowed. Any additional required visits must be pre-authorized. Skilled home health visits are limited based upon medical necessity.

Hospice Services (*Via Fee-For-Service, not MCO*)

Hospice services (palliative as well as curative) offered in certified, FAMIS Plus/Medicaid-enrolled hospices to care for terminally ill patients expected to live no more than six-months, as certified by a physician, are covered.

Hospital Care:

Inpatient

Inpatient stays in a general acute care or rehabilitative hospital are covered. Hospital admissions must be preauthorized, except for emergency admissions which must be authorized within 24 hours of admission. All medically necessary days are covered for children under age 21.

Outpatient

Treatment in the doctor's office or for outpatient hospital clinic services that allow the recipient to return home the same day after the test or operation is over are covered. Some operations and tests must be performed in the doctor's office or outpatient clinic, as outpatient surgery. The doctor or hospital may not bill the recipient if FAMIS/Medicaid denies payment because the recipient did not need to stay in the hospital overnight, unless it was the recipient's choice to stay overnight and the recipient agreed to pay for the hospital stay.

Emergency Room

Emergency room treatment and transportation for real emergencies are covered. Recipients are expected to go to a clinic or make a doctor's appointment for routine, non-emergency medical care. Non-emergency use of the emergency room is monitored and could lead to placement in the Client Medical Management Program.

Immunizations

Immunizations are available to the New Health Coverage for Adult recipients. All necessary immunizations are covered for children, consistent with the US Centers for Disease Control and Prevention (CDC) guidelines. No immunizations are available for pregnant women or LIFC/FFC recipients over age 21 except for flu or pneumonia for those at-risk.

Laboratory and X-ray Services

FAMIS Plus/Medicaid covers all lab and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician's office, hospital, independent and clinical reference labs.

Medicaid Home and Community Based Waivered Services:

Services are available for children with specific health related needs that are not available to all Medicaid/FAMIS Plus recipients in the State. The Home and Community Based Waivers that primarily impact children include the Elderly or Disabled with Consumer Direction (EDCD) waiver; Developmental Disabilities (DD) Waiver; Intellectual Disability (ID) Waiver; and the Technology Assisted (Tech) Waiver.

These Waivers cover a variety of services, including but not limited to:

- Personal care;
- Skilled and private duty nursing;
- Assistive Technology;
- Case management;
- Crisis stabilization, and
- Respite care.

Mental Health Services

Outpatient mental health services

FAMIS Plus/Medicaid/FAMIS MOMS will cover medically necessary outpatient individual, family and group mental health treatment services. Additional community mental health and rehabilitative services include: intensive in home treatment, therapeutic day treatment, crisis intervention, crisis stabilization, mental health support services and case management services. If mental health services are deemed necessary due to an EPSDT screening, all medically necessary care will be delivered. Includes Electroconvulsive Therapy, pharmacological management, psychological/neuropsychological testing, psychotherapy (individual, group and family).

Inpatient mental health services

Medically necessary inpatient mental health services rendered in a freestanding psychiatric hospital are covered for recipients under age 21 or over age 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age.

Community Mental Health Rehabilitation Services (CMHRS)

The following services were formerly carved out of MCO coverage, but will be added to MCO coverage with the onset of Medallion 4.0 no later than December 1, 2018: behavioral health therapy services, crisis intervention services (available 24/7), crisis stabilization services, day treatment/partial hospitalization, intensive community treatment assessment and treatment services, intensive in-home assessment and treatment services, mental health case management services, mental health skill building assessment and treatment services, psychosocial rehabilitation assessment and treatment services (limit 936 units annually), and peer support services (for children and adults when medically necessary). Therapeutic day treatment for children and adolescents and treatment foster care case management for children under 21 years will be carved in to MCO coverage by April 2019.

Nursing Facility Care

The local Health Department Pre-Authorization Screening Committee or the hospital Pre-Admission Screening Committee screens applicants for admission to nursing facilities and community-based care programs offered under a Medicaid waiver.

FAMIS Plus/Medicaid/FAMIS MOMS/LIFC enrollees in a nursing facility must pay the facility the amount identified by DSS on the Notice of Obligation for Medical Expenses (called patient pay), after a personal allowance and other allowable deductions are subtracted. FAMIS Plus pays for the remaining cost of nursing facility care, if the patient is in a nursing facility bed that is certified for FAMIS Plus/Medicaid. Included in the covered cost of the nursing facility care are:

- Room and board;
- Wheelchairs, geriatric chairs, walkers, and other medical equipment; and
- Medical supplies, such as antiseptic lotion, bandages, gauze, incontinence pads (adult diapers) and supplies, urine and blood testing agents, and syringes.

Nurse Midwife Services

Covered as allowed under State licensure requirements and Federal law.

Organ Transplants

Transplant services for children and adults, for kidneys, corneas, hearts, lungs and livers (from living or cadaver donors), and bone marrow/stem cell shall be covered when medically necessary and based on evidence based clinical standards of care. Necessary procurement/donor related services are covered. Transplant services for children (under 21 years of age) shall be covered per EPSDT guidelines. All transplants, except corneas, require pre-authorization.

Out-of-State Medical Coverage

Virginia Medicaid/FAMIS Plus/FAMIS MOMS/LIFC/FFC covers emergency medical services while an enrolled person is temporarily outside of the state, if the provider agrees to bill Virginia Medicaid. It will not cover services rendered outside of the United States. Contact the MCO regarding procedures for out-of-state treatment.

Personal Care

Support services to assist with activities of daily living (bathing, dressing, toileting, transferring, eating, bowel and bladder continence necessary to maintain health and safety), monitoring of self-administered medications, and the monitoring of health status and physical condition. These services are provided for individuals of any age enrolled in a Home or Community Based Waiver who meet established medical necessity criteria, and for members under the age of 21 under EPSDT. Services do not take the place of informal support systems.

Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services

Inpatient, outpatient and home health physical and occupational therapy, speech pathology, and audiology services are covered. This includes coverage for acute and non-acute conditions and must be medically necessary.

3.22 Medicaid Covered Services

Physician's Services

Doctor's services both in the hospital and in the doctor's office are covered including routine physicals up to age 21 under EPSDT. Most visits to the doctor's office for treatment are covered.

If the recipient is younger than age 19, FAMIS Plus will pay the doctor's bills while the recipient is in the hospital as long as the recipient's stay is medically necessary.

Podiatry Services (foot care)

FAMIS Plus/Medicaid/LIFC coverage is limited to medically necessary diagnostic, medical, or surgical treatment of disease, injury or defects of the foot. Routine and preventive foot care is not covered.

Pregnancy-Related Services

MCOs cover services for pregnant women without copays, including smoking cessation services (counseling and needed medications.) The MCO provides additional services including: parenting education, nutritional assessment, counseling and follow-up, homemaker services, and blood glucose meters. Coverage continues through the 60 days post-partum period. (See BabyCare for case management services information.)

Prescription Drugs

FAMIS Plus/Medicaid/FAMIS MOMS/LIFC/FFC covers most prescription drug products, including certain over-the-counter drugs covered for nursing home patients and for most FAMIS/Medicaid patients. This includes medicine prescribed by a provider during a physician visit, or other visit covered by third party payer including mental health visits. There is a preferred drug list (PDL). Drugs not on the PDL may be covered if pre-authorized. According to federal law, certain kinds of drugs are not covered (for example drugs used for cosmetic purposes, drugs determined to be less than effective – DESI drugs). Preauthorization will be required for the ninth distinct prescription within a 180 day period.

Prosthetic/Orthotic Devices

Such devices (arms and legs and their supportive attachments, breasts, and eye prosthesis) are covered when prescribed by a physician as medically necessary. Medically necessary orthotics for children under age 21 and for adults and kids when recommended as part of an intensive rehabilitation program are also covered.

Renal (Kidney) Dialysis Clinic Visits

Dialysis is covered for recipients with end-stage renal disease.

Screenings

Colorectal cancer screenings are covered in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Low dose screening mammograms for determining presence of occult breast cancer for enrollees 40 and over are covered. Pap smears are covered consistent with guidelines published by the American Cancer Society. Screening Prostate Specific Antigen (PSA) and related digital rectal exams (DRE) to screen males for prostate cancer are covered.

School Health Services

Services are those therapy, skilled nursing, and psychiatric/psychological services as outlined in the Individual Education Program (IEP) and rendered to children who qualify under the federal Individual with Disabilities Education Act. Billed directly to DMAS, not through the MCO. EPSDT screenings for the general Medicaid student population are covered.

Substance Abuse Treatment Services for Pregnant and Postpartum Women

Coverage includes residential treatment (up to 300 days per pregnancy, not to exceed 60 days postpartum) and day treatment (2 or more hours/day, multiple times per week, not to exceed ~ 200 hours per pregnancy or 60 days postpartum) for pregnant and postpartum women with serious substance abuse problems for the purpose of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. Includes education and referral for testing, counseling and management of HIV, tuberculosis, and hepatitis.

Telemedicine Services

Telemedicine services that are medically necessary are covered.

Tobacco Dependence Treatment for Pregnant Women, Children and Adolescents

Includes counseling and pharmacotherapy at no cost for pregnant women for smoking cessation treatment. These services are available to children and adolescents up to age 21 via EPSDT. Smoking cessation service are not available to LIFC and FFC recipients over age 21.

Transportation

Emergency

Pays for emergency transportation to receive medical treatment.

Non-Emergency

Pays for non-emergency transportation if the client has no other transportation available and the transportation is to the nearest enrolled FAMIS Plus/Medicaid provider for a covered medical service. Recipients enrolled in MCOs should arrange transportation through their MCO. The MCO may also cover additional transportation services as an added benefit (i.e. rides to Food banks, etc.)

FAMIS Plus/ Medicaid/FAMIS MOMS/LIFC/FFC recipients with Fee-for-Service Medicaid access non-emergency transportation services through LogistiCare, a transportation “broker” under contract with DMAS. The client can contact LogistiCare at (866) 386-8331 who will then make the trip arrangements and pay the transportation provider. The recipient will receive specific information on this service when they are enrolled in state-sponsored coverage.

Vision Services

Vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians are covered. Routine eye examinations for recipients of any age (limited to once every 2 years) are covered. Eyeglasses are covered for recipients younger than 21 years of age only.

The New Health Coverage for Adults, FAMIS Plus, Medicaid for Pregnant Women, FAMIS MOMS, LIFC and FFC do NOT cover the following services:

- Abortions, unless the pregnancy is life-threatening or health-threatening (then via FFS, not MCO)
- Acupuncture
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Broken appointments
- Certain drugs not proven effective and those offered by non-participating manufacturers (*enrolled doctors, drugstores, and health departments have lists of these drugs*)
- Certain experimental surgical and diagnostic procedures
- Chiropractic services (except as provided through EPSDT)
- Christian Science Nurses and Christian Science Sanatoria
- Cosmetic treatment or surgery
- Day care, including sitter services for the elderly (except some home- and community-based service waivers)
- Dentures for members age 21 and over
- Doctor services during non-covered hospital days
- Drugs prescribed to treat hair loss or to bleach skin
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is preauthorized
- Hospital charges for days of care not authorized for coverage
- Immunizations for people age 21 or older (except for flu and pneumonia for those at risk)
- Inpatient hospital care in an institution for the treatment of mental disease for members under age 65 (unless they are under age 22 and receiving inpatient psychiatric services)
- Medical care received from providers not enrolled in Virginia Medicaid or who will not accept payment from Virginia Medicaid as payment in full
- Private duty nursing (except under EPSDT or Home and Community Based Waiver programs)
- Psychological testing done for school purposes, educational diagnosis, school or institution admission and/or placement, or upon court order
- Remedial education
- Routine dental care if age 21 or older (unless an added benefit provided by the MCO)
- Routine school or sports physicals (unless an added benefit provided by the MCO)
- Sterilization of recipients younger than age 21
- Telephone consultation
- Weight loss clinic programs

3.24 Medicaid Covered Services

Part III: FAMIS

Once Approved

The family will receive a *Notice of Action on Benefits* from their child's LDSS or the Cover Virginia CPU. It will include information on choosing their MCO and instructions for tracking copayments. *(A sample Notice of Action is on Page 2.39)*

In a separate mailing, the family will receive a permanent blue and white plastic ID card from DMAS for each enrolled child. This card enables FAMIS children to receive services from any FAMIS/FAMIS Plus/Medicaid provider until they are enrolled in the Managed Care Organization that will manage their ongoing care. This period is called "fee-for-service." Enrollment into a MCO usually takes less than 30 days. Once enrolled in the MCO, the family will still use the DMAS ID card for certain services not available through the MCO (e.g. school-based services and dental care). *(A sample of the DMAS ID card is on page 3.1)*

In an additional mailing from DentaQuest, the family will receive information on *Smiles For Children* directing them to visit its website for the dental handbook and a directory of general and pediatric dentists participating in the program.

Selecting a Provider

In their *Notice of Action*, the family will be given instructions on **how to choose their child's MCO by contacting the Cover Virginia Call Center (CVCC)** at (855) 242-8282. A family may choose the same MCO for all the children in the family, or different MCO's for each, depending on their circumstance, such as a doctor's or provider's participation in an MCO. Included with the *Notice* is a comparison chart listing all six health plans available and any extra "added benefits" they provide. These are the same six MCOs listed on page 3.1.

If the family does not call to choose their child's MCO, one will be assigned to them. *(For added clarification on the MCO enrollment process see the chart on page 3.6. For the FAMIS MCO Comparison Chart see pages 3.30-3.32)*

The family will receive several items from their MCO:

- An MCO ID Card (includes information on copayment amounts)
- A member handbook, and
- A provider directory.

Once this information is received, the family is told to contact their MCO to choose their Primary Care Provider (PCP). The MCO then reissues the child's MCO insurance card. This card is good for the remainder of the child's 12 month enrollment period. The card will include the name of the child's PCP, the PCP's telephone number, and the MCO's identification number. It will also include information on copayment amounts for services.

For 90 days from their initial enrollment in the MCO, **the family can still change their child's MCO by calling the Cover Virginia Call Center.** Once the 90 days has passed, the family can only change their child's MCO at annual renewal of the FAMIS coverage or, if needed sooner, by formally requesting a change and demonstrate "good cause" as to why they should be allowed to switch their child's MCOs.

When the child's FAMIS eligibility is renewed each year, the family will have the chance to switch the child to another MCO or remain with the current health plan. If the family does not proactively make a change at that time, the child will remain with the same MCO.

Using the DMAS ID Card and the MCO Health Insurance Card

When the family receives the child's blue and white plastic DMAS ID card, they should check the information on it to be sure it is correct. If it is not correct, they must inform the Cover Virginia Call Center at (855) 242-8282 of any needed changes or corrections. If there are errors on the MCO card, they should contact their child's MCO.

It is the family's responsibility to show their child's DMAS ID card **and** the MCO ID card to providers each time medical services are received. The provider uses the information on both cards to verify program enrollment prior to delivering services. Failure to present the cards at the time of service may result in the parent or legal guardian being held responsible for any incurred expenses.

The family should stop using both the DMAS ID card and the MCO card immediately when notified by the State that the child is no longer eligible for the program. However, the family should keep the DMAS ID card in case the child becomes eligible for the program again at some future date. It can be reactivated.

The family should **report the loss or theft of their child's DMAS ID to the Cover Virginia Call Center or LDSS immediately.** A listing of the 120 LDSSs is included in *Section 5* of this *Tool Kit*. If the **MCO card is lost or stolen**, this should be reported to the MCO. These cards should never be lent to anyone.

Period of Coverage and Reporting Requirements

When a FAMIS application is approved, health coverage is **retroactive to the 1st day of the month of application.** For example, if the signed and completed application is received on June 14th and the child is approved and enrolled, the coverage is effective June 1st. In the case of a family applying for a **newborn**, coverage would begin **on the date of birth if the application is filed in the birth month (or within 3 months of the date of birth provided the question about help paying for medical bills on the application is completed).**

A child is guaranteed **12 months of continuous coverage** unless the family's income exceeds 205% FPL, the child moves out of state, or turns 19. This means the family does not have to report an increase in income unless it is over that threshold. The FAMIS handbook (available on www.coverva.org) contains a 205% FPL monthly income chart so a family can know when they exceed this amount and detailed instructions on how to report it.

When a child turns 19 his/her FAMIS coverage will be automatically cancelled at the end of the birth month. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

If a child is moving out of state, this must be reported to the family's local DSS in writing, to the Cover Virginia Call Center by calling (855) 242-8282, or online via the CommonHelp Customer Portal.

A family may also want to report if their income goes down. The local DSS will then evaluate ongoing eligibility and notify the family of any adjustment in coverage. If the children are now eligible for FAMIS Plus, the family will have no copayments for services.

If no changes occur, eligibility for FAMIS is reevaluated after a child has been enrolled in FAMIS for 12 months.

Note: Reporting a **change of address** is especially important because DSS/CPU/DMAS mail is not forwarded, even if the family has a forwarding order on record with the post office. If correspondence is returned, the case will be closed and coverage will be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner and it needs a "good" address to do so.

Covered Services Overview

FAMIS children receive a package of benefits that looks a lot like the type of coverage generally available in a comprehensive private health insurance plan. In fact, the FAMIS benefit package is modeled after the state employee health insurance plan. While many medical services are covered, some have annual "caps" or limits on the amount of service. Unlike FAMIS Plus, non-emergency transportation is not covered as an ongoing benefit. Although "well-child" examinations are covered up to age 19, the services provided are less extensive than the FAMIS Plus/Medicaid EPSDT program. Non-emergency transportation and EPSDT are only available to FAMIS children during the initial 30-day fee-for-service period. A complete listing of *FAMIS Covered Services* begins on page 3.34.

Children may receive additional benefits provided by the MCO in which they are enrolled. These may include things like: case management, health education and disease management services, 24-hour nurse advice line, and free sports physicals.

Cost Sharing

FAMIS enrollees must pay copayments for some covered services. There are, however, no copayments required for preventive services such as well-child visits. The amount of the copayment depends on the family income and the service provided. **Note:** *Children of Alaska Native and American Indian descent are not required to pay any copayments.*

The table below shows examples of the copayment amounts for some basic FAMIS services. A full listing of *FAMIS Covered Services* and the corresponding copayments is located on pages 3.34-3.39.

Service	Family Income At/ Below 150% FPL	Family Income Above 150% FPL
Outpatient Hospital or Doctor	\$2 per visit	\$5 per visit
Prescription Drugs	\$2-\$4 per prescription	\$5-\$10 per prescription
Inpatient Hospital	\$ 15 per admission	\$25 per admission
Non-emergency Use of Emergency Room	\$10 per visit	\$25 per visit

FAMIS families should keep receipts of all of the copayments paid when receiving medical services. The amount of copayments paid in a year by a family **cannot exceed \$180 for families at or below 150% FPL** and **\$350 for families above 150% FPL**. Once a family reaches this copayment cap, they should contact the Cover Virginia Call Center and provide proof that the cap has been reached.

A sample *FAMIS Copayment Tracking Form* is included on page 3.33. Once verified by DMAS, the family will not be required to pay any additional copayments for the rest of the 12 month enrollment period. DMAS will notify all interested parties (providers, MCOs, etc.) that additional copayments cannot be charged to this family.

Note: *Families should be made aware that some services may not be fully paid by FAMIS (i.e. FAMIS pays \$25 for eyeglass frames, any cost over this amount is the family's responsibility). Costs like these do not apply toward the annual copayment cap.*

Annual Renewal *(An example of the renewal form is located on pages 3.47-3.64)*

Eligibility for FAMIS must be renewed every 12 months. If, in Step 5 on the initial application for coverage, the family indicated their willingness to have their income information checked electronically in subsequent years to renew coverage (5 years maximum), LDSS will initiate an "Ex Parte" renewal. If current income information can be electronically verified as "reasonably

compatible” with the prior year’s income and the income is still within program guidelines, the family will be sent a *Notice of Action* indicating that coverage has been renewed for an additional year. *(A sample Ex Parte renewal approval notice is on pages 3.11-3.12)*

If the electronic income data is not “reasonably compatible” with the information in the recipient’s file, a paper renewal application will be issued. Approximately **45 days prior to the child’s renewal month**, the family will be sent an 18+ page renewal form pre-populated with the family’s household and income information. If a family has indicated Spanish as their primary language, a pre-populated form in Spanish will be sent instead.

The family will have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and return it to the state for processing. They can return it via mail (in the envelope provided), hand-deliver it to the local DSS, or call the CVCC and report the renewal information via phone. The family can also go online to CommonHelp and report the information there if after approval for the program they linked their child’s case. Instructions on how to link a case in CommonHelp are in Section 5.

Once the family returns the information via paper, phone, or online, the local DSS will use it to redetermine eligibility. If the LDSS still needs additional information, the LDSS worker will contact the family in writing asking for the needed verifications. If the child is still eligible, the family will get a *Notice of Action* stating that coverage has been renewed and giving new dates of coverage.

If the family **fails to return the form** by the due date, a **cancellation notice will be mailed**. Coverage will be cancelled effective the end of the renewal month. It is important to note, however, that the family **still has an additional 90 days to return the form and coverage can be reinstated**. If the renewal is returned after that additional 90-day period, coverage cannot be reinstated, and the family will have to file a new application. *(A sample cancellation notice is on page 3.10)*

Many children are terminated from FAMIS at renewal time because of the family’s failure to complete the process. A child cancelled from FAMIS for failure to complete annual renewal may reapply for FAMIS at any time.

During the renewal process, the eligibility worker may determine that the child is eligible for FAMIS Plus instead, or is not eligible for FAMIS anymore. If he/she is now eligible for FAMIS Plus, the child will be enrolled in that program. If the child is not eligible for either FAMIS or FAMIS Plus (i.e. the family’s income has risen above 205% of FPL), FAMIS coverage will be cancelled. The LDSS will send the family’s application information to the Federal Health Insurance Marketplace so the family may be evaluated for financial assistance toward purchasing private coverage available via the Federal Marketplace. Losing coverage at annual renewal opens a Special Enrollment Period with the Marketplace allowing the family to shop for private coverage, if eligible.

Coverage ends the last day of the month in which the child **turns 19**. At that time, he/she will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

Managed Care Enrollment - FAMIS/FAMIS MOMS

Information on choosing an MCO is included in the *Notice of Action on Benefits* from LDSS or the CVCC giving up to **30 days** for the child's family or the pregnant woman to choose an MCO (list of MCO choices provided). The family is told that if they do not call the Cover Virginia Call Center during that time, they will be assigned an MCO.

Did the enrollee call the Cover Virginia Call Center?

YES

DMAS assigns MCO of choice.

MCO welcome packet sent (ID Card, provider directory, and handbook).

MCO assigns a PCP.¹

NO

DMAS assigns an MCO.

MCO welcome packet sent (ID Card, provider directory, and handbook).

MCO assigns a PCP.¹

Do They Want to change to another MCO?

Enrollees still have about **60 days** left to call and change to a different MCO. After that, change can only happen at the time of program renewal² or by writing DMAS and providing "good cause" to change.

1. The family can call the MCO and change their child's PCP at any time.

2. There is no program renewal for FAMIS MOMS.



It's time to choose a health plan!

FAMIS is a statewide program with six participating health plans. Read the following information to see what basic benefits and services are covered by each health plan. Use the chart on the back to compare benefits covered by each plan.

1

Read the letter you receive in the mail

Choose a health plan for each person in the FAMIS program.

2

How to choose your health plan

- Make a list of your health care providers and places you get care. Include hospitals, doctors, specialists, pharmacies, and therapists.
- Review the comparison chart on the back to compare health plans and choose the best one for you.
- For more information about health plans, call Cover Virginia at **1-855-242-8282** (TTY: 1-888-221-1590). Or go to **www.coverva.org**.

3

How to enroll in a health plan

There are 2 ways to enroll in a health plan:

1. Online at **www.commonhelp.virginia.gov** when you apply.
2. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).

You can call Monday to Friday, 8:00 a.m. and 7:00 p.m. or Saturday 9:00 a.m. to 12:00 p.m. (Interpreters are available)

You can get this information in Spanish or other formats, such as large print or audio. (verify this)

Español (Spanish)
ATENCIÓN: Para servicios gratuitos de interprete, llame al 1-855-242-8282 (Número TTY: 1-888-221-1590).

All health plans offer these benefits and services:

Basic health benefits

- Behavioral therapy
- Community Mental Health Rehabilitative Services (CMHRS)
- Dental care services by Smiles for Children
- Durable medical equipment and supplies (DME)
- Early Intervention (EI) services
- Emergency room care
- Family planning and prenatal care services
- Hearing (audiology) services
- Hospital and home health services
- Hospice services
- Physical, occupational and speech therapies
- Prescription drugs ordered by a physician
- Rides to medical appointments (see plan for restrictions)
- Services for special education students
- Vision care (routine eye exams every 24 months, eyeglasses and medically necessary contact lenses)
- Visits to the doctor when you are sick
- Well visits, including routine checkups and annual exams
- X-ray, lab and imaging services

Special health care needs

Once enrolled, contact your health plan if you or your child needs care for:

- Asthma
- Cancer
- Diabetes
- Heart condition
- High blood pressure
- HIV/AIDS
- Kidney disease or dialysis
- Pregnancy
- Other special health needs

See your member handbook for a full list of services.

Out of pocket costs

Service	Co-pay Status 1	Co-pay Status 2
Outpatient hospital or doctor	\$2 per visit	\$5 per visit
Prescription drugs	\$2 per prescription	\$5 per prescription
Inpatient hospital	\$15 per admission	\$25 per admission
Non-emergency use of emergency room	\$10 per visit	\$25 per visit
Yearly-co payment limit per family	\$180	\$350

Other co-payments may apply to other services

FAMIS Managed Care Organization (MCO) Plan Choices

aetna Aetna Better Health [®] of Virginia 1-800-279-1878 TTY 711 www.aetnabetterhealth.com/virginia	Anthem. HealthKeepers Plus Offered by HealthKeepers, Inc. 1-800-901-0020 TTY 711 www.anthem.com/vamedicaid	Magellan COMPLETE CARE. 1-800-424-4518 TTY 711 www.MCCofVA.com	OptimaHealth 1-800-881-2166 TTY 711 www.optimahealth.com/familycare	UnitedHealthcare Community Plan 1-844-752-9434 TTY 711 www.uhccommunityplan.com/va	VirginiaPremier. POWERED BY VCU HEALTH 1-800-727-7536 TTY 711 www.virginiapremier.com Northern Virginia members* with Kaiser Permanente: 1-855-249-5025
Added benefits: Healthy moms and kids <ul style="list-style-type: none"> ▪ Baby Matters maternity incentive program (\$50 gift card for pre- and postnatal check-ups) ▪ Infant baby box for safer sleep ▪ Diapers for one month (300 diapers) ▪ Free breast pump and lactation classes ▪ Ted E. Bear, M.D.[™] Club ▪ Free swim lessons ▪ Free sports physicals Phone and online tools <ul style="list-style-type: none"> ▪ Free smartphone with 350 minutes, data and unlimited texts each month ▪ 24/7 Member Services Wellness programs <ul style="list-style-type: none"> ▪ Better Breathing asthma program and second inhaler or nebulizer ▪ Diabetes Care for Life program Other benefits <ul style="list-style-type: none"> ▪ Free rides to grocery store, food bank, place of worship, WIC office, and certain social activities (30 round trips each year) ▪ GED certificate incentive ▪ Meals delivered to your home after hospital stay, 2 meals each day for 7 days 	Added benefits: Healthy moms and kids <ul style="list-style-type: none"> ▪ Boys & Girls Club membership ▪ Free diapers and umbrella stroller ▪ Sports physicals for kids ▪ Books for Babies Phone and online tools <ul style="list-style-type: none"> ▪ Free smartphone with 350 minutes, 1 GB of data and unlimited texting Wellness programs <ul style="list-style-type: none"> ▪ \$120 of Weight Watchers[®] vouchers (13 weeks of local meetings and 14 weeks eTools) ▪ Healthy Rewards gift card up to \$50 per goal ▪ Online fitness classes Other benefits <ul style="list-style-type: none"> ▪ Free rides to grocery store, farmer's market or food bank (up to 3 rides every 3 months) ▪ \$120 in GED testing vouchers ▪ \$25 gift card for high school and college students (with A's and B's) ▪ Coupons with over \$1,000 in savings at local stores ▪ Up to \$20 Walmart gift card for completing health screener ▪ Air purifier (with approval) ▪ Meals delivered to your home after hospital stay, 2 meals each day for 7 days 	Added benefits: Vision <ul style="list-style-type: none"> ▪ \$150 for glasses or contact lenses every 2 years Healthy moms and kids <ul style="list-style-type: none"> ▪ Pregnancy supplies and mobile information tools ▪ Member baby showers hosted quarterly per region ▪ Yearly sports physicals for children ▪ Bicycle helmets for children Phone and online tools <ul style="list-style-type: none"> ▪ Free smartphone with 1,000 minutes, 1 GB of data and unlimited texts each month Wellness programs <ul style="list-style-type: none"> ▪ Healthy Rewards gift card up to \$50 ▪ Yearly routine physicals for adults ▪ Online tool for anxiety, insomnia and depression Other benefits <ul style="list-style-type: none"> ▪ Fresh meals delivered to your home after hospital stay ▪ Mobile app to quit smoking 	Added benefits: Healthy moms and kids <ul style="list-style-type: none"> ▪ OB care support program, baby showers and incentives up to \$75 ▪ Ready, Set, Read! child literacy program Phone and online tools <ul style="list-style-type: none"> ▪ Free smartphone with 350 minutes, unlimited texts and free calls to health plan each month ▪ Web and mobile app tools Wellness programs <ul style="list-style-type: none"> ▪ Weight management ▪ Wellness rewards for healthy behavior ▪ Online search tool to find community resources, health plan services and programs Other benefits <ul style="list-style-type: none"> ▪ Member education home visit ▪ Free sports physicals ▪ MDLive: 24-hour physician access for non-life threatening health questions or medical needs ▪ Up to \$275 for GED prep and testing vouchers 	Added benefits: Healthy moms and kids <ul style="list-style-type: none"> ▪ Baby Blocks incentives program ▪ Prenatal and maternity incentives ▪ Free mattress cover and pillowcase for members with asthma ▪ Free sports physical ▪ Free registration for Boys & Girls Club ▪ KidHealth[®] online resources Phone and online tools <ul style="list-style-type: none"> ▪ Help with applying for Lifeline cell phone, voice minutes and unlimited texts ▪ Online member tools ▪ On My Way[™] interactive website for teens Wellness programs <ul style="list-style-type: none"> ▪ Weight Watchers[®] Other benefits <ul style="list-style-type: none"> ▪ Fresh EBT mobile app ▪ Fotonovelas health education pamphlet in Spanish ▪ Fresh meals delivered to your home after hospital stay for members who qualify ▪ Rides to certain non-medical sites, including WIC appointments and food banks 	Added benefits: Vision <ul style="list-style-type: none"> ▪ Up to \$100 for frames or contacts every 48 months Healthy moms and kids <ul style="list-style-type: none"> ▪ Breast pump, lactation consultant, prenatal and parenting classes, and family planning ▪ Healthy Heartbeats prenatal and postpartum wellness program with incentives ▪ Safe Sleep education program ▪ Watch Me Grow: Childhood wellness program with incentives Phone and online tools <ul style="list-style-type: none"> ▪ Free smartphone with 350 minutes, 1 GB of data and unlimited texts each month ▪ Free calls to Member Services Wellness programs <ul style="list-style-type: none"> ▪ Personal fitness program for your specific needs ▪ Help to quit smoking ▪ Nutrition education program ▪ Registered nurse and mobile programs to help manage chronic conditions

*Kaiser: Arlington, Alexandria, Fairfax, Fairfax City, Falls Church, Loudoun, Manassas, Manassas Park and Prince William. Starting September 1, 2019: Fauquier, King George and Stafford



FAMIS Co-payment Tracking Form

Some doctor visits and services require a fee called a co-payment. Use this form to track those fees. Your family's co-payments will end when you reach your yearly limit. If you have questions, call Cover Virginia at 1-855-242-8282.

HERE IS WHAT YOU NEED TO DO:

- ☐ Save your receipts showing what you paid for each FAMIS doctor visit and medicine.
- ☐ List each receipt on this form. Use additional paper to list more receipts and attach to this form.
- ☐ Mail this form and your receipts to us when they total your family's co-pay limit.
- ☐ We will review your receipts and tell you if the fees you paid meet the yearly limit.
- ☐ If your family has met the yearly limit for co-payments they have paid, we will send you a letter and a new ID card showing \$0 co-payment amounts.

Name: _____ FAMIS Family ID #: _____

Address: _____ Phone Number: () _____

Date of Service	Patient's Name	Who did you pay?	How much?

Total Paid: \$ _____

Mail this completed form and receipts to:

Cover Virginia
PO Box 1820
Richmond, VA 23218-1820

FAMIS Covered Services

General Notes:

Except where noted, these services are delivered by the 6 Medallion 4.0 MCOs.

Annual copayment limits:

$\leq 150\% \text{ FPL}$ - \$180 per year per family $> 150\% \text{ FPL}$ - \$350 per year per family

Additional services available through the MCOs may include: free smartphones, free sports physicals, case management, health education and disease management services, skilled nursing services, and a 24-hour nurse advice phone line.

The amounts listed for charges & caps follow the pattern:

[the charge for people in FAMIS $\leq 150\% \text{ FPL}$] / [the charge for people $> 150\% \text{ FPL}$ up to $200\% \text{ FPL}$].

Note: There are no copayments for preventive services (well-child checks, dental checkups, etc.) or for American Indians or Alaska Natives

Ambulance

Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary. The ambulance service must be prearranged by the Primary Care Physician and authorized by the MCO if, because of the member's medical condition, the member cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the member's condition suddenly becomes worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the MCO as having services adequate to treat the member's condition. The services received in that facility or provider's office must be covered services; and if the MCO or the Department requests it, the attending provider must explain why the member could not have been transported in a private car or by any other less expensive means. **Transportation services are not provided for routine access to and from providers of covered medical services, unless covered by the MCO as an added benefit.**

Charges & Caps:

\$2 per trip/\$5 per trip

Chiropractic Services

Medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of illness or injury are covered.

Charges & Caps:

\$2 per visit/\$5 per visit

Services capped at \$500 per enrollee per calendar year

Clinic Services

Preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to outpatients and that are provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients (health center or ambulatory care center), are covered. With the exception of nurse midwife services, clinical services are furnished under the direction of a physician or dentist. Renal dialysis clinic visits are also covered. There are no copayments for maternity services.

Charges & Caps:

\$2 per visit/\$5 per visit

Dental Care Services – (Smiles For Children Program managed by DentaQuest 1-888-912-3456)

Dental care in FAMIS is accessed through the *Smiles For Children* (SFC) program managed by DentaQuest. Once children are enrolled in FAMIS, they are automatically enrolled in SFC as well. SFC covers all the services listed below when provided by a dentist that participates in *Smiles For Children*. Members will receive a separate *Smiles For Children* handbook detailing the program, covered services, how to find a dentist, what to do in an emergency, etc. Children access services by seeing a SFC dentist and showing either their DMAS ID Card or MCO card. To find a dentist, call 1-888-912-3456 between 8AM and 6PM, Monday through Friday, or look at the listings posted on

3.34 FAMIS Covered Services

www.dmas.virginia.gov or www.dentaquestgov.com. **There are no costs for services accessed through the SFC Program.**

Covered services are: fluoride (every 6 months), sealants, cleanings (every 6 months), space maintainers, X-rays, fillings, crowns (some caps), extractions (tooth pulling), anesthesia, root canal treatments, oral disease services, and braces (if qualified). Routine diagnostic, preventative, primary and prosthetic and complex restorative procedures necessary for oral health (i.e. dentures, inlays, onlays, crowns and relining of dentures for a better fit) are covered. Tooth guidance appliances, complete and partial dentures, surgical preparation for prosthetics, single permanent crowns, and bridges are also covered, but can be subject to prior authorization. Routine bases under restorations are not covered. Full banded orthodontics and related services are covered when medically necessary. Post treatment stabilization retainers and follow-up visits are included. Some services require pre-authorization.

The MCO is required to cover CPT codes billed by a physician as a result of an accident and medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care.

Early Intervention Services

FAMIS covers services provided through the Infant & Toddler Connection of Virginia for children from birth up to age three with developmental concerns. Medically necessary speech, physical and occupational therapies and assistive technology are available, if certified by the Department of Behavioral Health and Developmental Services or applicable Early Intervention Interagency Council under Part C of the Individuals with Disabilities Education Act (IDEA).

Emergency Services (Using Prudent Layperson Standards for Access)

FAMIS covers emergency room treatment and services for life-threatening conditions. Coverage includes reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary's presentation to the emergency room indicate that an emergency may exist. Emergency services are available 24 hours a day/7 days a week. FAMIS does cover emergency services provided by out-of-network providers. No prior authorization is needed.

Charges & Caps:

Emergency Room \$2 per visit/\$5 per visit

Physician Care \$2 per visit (waived if part of ER visit for true emergency)/\$5 per visit (waived if part of ER visit for a true emergency)

Diagnostic X-rays, Laboratory Services, Etc. \$2 per visit/\$5 per visit

*Non-emergency Use of the ER \$10 per visit/\$25 per visit**

*(*The hospital may bill for the difference between the Emergency and Non-emergency copayments.)*

Post stabilization care that is medically necessary following Emergency Services are also covered. No pre-authorization is required.

Family Planning Services

FAMIS includes services, drugs, and devices for individuals of childbearing age which delay or prevent pregnancy provided under the supervision of a physician. FAMIS does not include services to treat infertility or to promote fertility. Minors are deemed adults for the purpose of consenting to medical services required for birth control, pregnancy or family planning, except for purposes of sterilization.

Charges & Caps:

\$2 per visit/\$5 per visit

Home Health Services

FAMIS covers nursing, personal care, and home health aide services, as well as physical therapy, occupational therapy, speech, hearing, and inhalation therapy. Personal care means assistance with walking, taking a bath, dressing, giving medicine, teaching self-help skills, and performing a few essential housekeeping tasks. FAMIS does not cover medical social services and services that would not be paid for by FAMIS if provided to an inpatient of a hospital; community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services and services related to cosmetic surgery are not covered.

Charges & Caps:

\$2 per visit/\$5 per visit

Capped at 90 visits per enrollee per calendar

Hospice Services

Includes a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a provider licensed to do so, furnished and billed by a licensed hospice, and medically necessary. Care is available if the member is diagnosed with a terminal illness with a life expectancy of six months or fewer and is available concurrently with care related to the treatment of the child's condition with respect to which diagnosis of terminal illness has been made.

Charges & Caps:

There are no copayments for hospice services.

Hospital Services – Inpatient

Inpatient hospital stays in general acute care and rehabilitation hospitals for all enrollees up to 365 days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy are covered. (Medically necessary ancillary charges are included.) The MCO shall cover an alternative treatment plan for a patient who would otherwise require more expensive services, including but not limited to long-term inpatient care. The alternative treatment plan must be pre-authorized.

Charges & Caps:

\$15 per confinement/\$25 per confinement

Hospital Services – Outpatient

Services that are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital are covered. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Coverage includes: emergency services, surgical services, diagnostic and professional provider services. Facility charges are also covered.

Charges & Caps:

\$2 per visit (waived if admitted)/\$5 per visit (waived if admitted)

Immunizations

Immunizations are covered in accordance with most current Advisory Committee on Immunization Practices (ACIP). Note: FAMIS enrollees do not qualify for the Free Vaccines for Children Program.

Charges & Caps:

There are no charges for immunizations.

Laboratory and X-ray Services

FAMIS covers all lab and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician's office, hospital, independent and clinical reference labs. Includes lead testing at no cost as part of well-baby/well-child care; low-dose screening mammograms at no cost for determining the presence of occult breast cancer; and pap smears.

Charges & Caps:

*\$2 per visit/\$5 per visit**

*Note: there is no copayment for laboratory or x-ray services that are performed as part of an encounter with a physician or for lead testing, mammography or pap smears.**

Medical Equipment & Supplies (Including Hearing Aids)

Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) are covered when medically necessary. Also covered are supplies and equipment needed to deliver enteral nutrition.

Charges & Caps:

No copayments for disposable supplies.

\$2 per item/\$5 per item (equipment)

Hearing aids will be covered twice every 5 years.

Mental Health– Inpatient

Inpatient mental health services are covered for 365 days per confinement, including partial day treatment services. Coverage includes: rooms, meals, general nursing services, prescribed drugs, and ER services leading directly to admission. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital are covered. **FAMIS will not cover services received while a child is admitted to a freestanding psychiatric facility or Institute for Mental Disease (IMD).** Services must be pre-authorized.

3.36 FAMIS Covered Services

Charges & Caps:
\$15 per confinement/\$25 per confinement

Services in a substance abuse treatment facility are covered by FAMIS.

Charges & Caps:
\$15 per confinement/\$25 per confinement

Mental Health and Substance Abuse Services – Outpatient

Medically necessary outpatient individual, family, and group mental health and substance abuse clinic services are covered. Emergency counseling services, intensive outpatient services, day treatment, and substance abuse case management services are provided by DMAS, not the MCO.

Charges & Caps:
\$2 per visit/\$5 per visit

Mental Health Rehabilitative Services – Community-based

Community rehabilitation mental health services, including intensive in-home services, therapeutic day treatment, mental health crisis intervention, mental health case management. These services are currently done outside of MCO, but will be transition to the MCO with the roll out of Medallion 4.0 which will be completed by December 2018.

Organ Transplantation

FAMIS covers organ transplants when medically necessary or per industry standards for all eligible individuals, including but not limited to: transplants of tissues; autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for children with lymphoma or myeloma. FAMIS also covers: kidney (with dialysis dependent kidney failure), heart, pancreas, single lung, and liver transplants. FAMIS will not cover experimental or investigational transplants.

Charges & Caps:
\$15 per confinement and \$2 per outpatient visit/\$25 per confinement and \$5 per outpatient visit
Services to identify donor limited to \$25,000 per member

Out of State Medical Coverage

For FAMIS Fee-For-Service enrollees: FAMIS covers emergency services while an enrolled child is temporarily outside of Virginia, if the provider of care agrees to participate in Virginia's FAMIS/Medicaid program and to bill DMAS for the services provided. FAMIS does not cover medical care provided while the enrollee is outside of the United States.

For FAMIS MCO enrollees: MCOs cover emergency services while an enrolled child is temporarily outside of Virginia, if the provider of care agrees to bill the MCO and accepts the MCO reimbursement for the services provided. The provider should contact the enrollee's MCO. MCOs do not cover medical care provided to the enrollee while outside of the United States

Physician Services

FAMIS covers all symptomatic visits provided by physicians or physician extenders within the scope of their license. Cosmetic services are not covered, unless for medically necessary physiological reasons. This includes services while: admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.

Charges & Caps:
Inpatient physician care – no charge
Outpatient physician visit in office or hospital
Preventive Care (well child visits/annual check-up) no charge
Primary Care or Specialty Care \$2 per visit/\$5 per visit
Maternity Care - no charge

Pregnancy Related Services

FAMIS covers services to pregnant teens, including prenatal services.

Charges & Caps:
Maternity Care – no charge

Prescription Drugs

Prescriptions are covered when medically necessary, including those prescribed by an outpatient mental health provider. No DESI drugs are allowed. Over the counter prescriptions are not covered by FAMIS. Check with the MCO to learn which prescriptions are available at retail pharmacies and which are available through mail service.

Charges & Caps:

Retail – up to 34 day supply: \$2 per prescription/\$5 per prescription

Retail – 35-90 day supply: \$4 per prescription/\$10 per prescription

Mail service up to 90 day supply: \$4 per prescription/\$10 per prescription

[If generic is available, enrollee pays the copayment plus 100% of the difference between the allowable charge for the generic drug and the brand name drug.]

Private Duty Nursing and Skilled Nursing Facility Care

FAMIS covers medically necessary private duty nursing when provided by an RN or LPN. The RN/LPN may not be a relative or member of the enrollee's family. The provider must explain why the services are required and what medically skilled services will be provided. Private duty nursing must be pre-authorized. Medically necessary skilled nursing care services that are provided in a skilled nursing facility are covered.

Charges & Caps:

\$ 2 per visit/\$5 per visit for private duty nursing

\$15 per confinement/\$25 per confinement in a skilled nursing facility

Capped at a maximum of 180 days per confinement in a skilled nursing facility

Prosthetics/Orthotics

FAMIS covers prosthetic services and devices (at a minimum: artificial arms, legs and their necessary supportive attachments) and medically necessary orthotics (braces, splints, ankle/foot orthotics, etc.) It also covers orthotics deemed necessary as part of an approved intensive rehabilitation program.

Charges & Caps:

\$2 per item/\$5 per item

Rehabilitation Hospitals – Inpatient

Rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health are covered.

Charges & Caps:

\$15 per confinement/\$25 per confinement

School-based Services for Special Education Students

Physical therapy, occupational therapy, speech language pathology, psychiatric and mental health services, and skilled nursing provided in a school setting are covered. (Note: These services are reimbursed by DMAS only.)

Charges & Caps:

There are no copayments for these services.

Second Opinions

Second opinions are covered when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. Must be made by a qualified health care professional within the network, or if necessary, outside of the network. May require pre-authorization.

Charges & Caps:

\$2 per visit/\$5 per visit

Substance Abuse Services-Inpatient

Inpatient substance abuse services in a substance abuse treatment facility are covered.

Charges & Caps:

\$15 per confinement/\$25 per confinement

Substance Abuse Services – Outpatient (See Mental Health and Substance Abuse Services – Outpatient)**Telemedicine Services**

Telemedicine is defined as the real time, or near real time, exchange of information for diagnosing and treating medical conditions. Telemedicine is made possible through audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. A physician or nurse practitioner must be present at the main (hub) or satellite (spoke) sites for a telemedicine service to be reimbursed and the recipient must be present for the encounter. DMAS currently recognizes three telemedicine projects. The MCO shall provide coverage for telemedicine services at least to the extent covered by DMAS.

3.38 FAMIS Covered Services

Therapy Services

FAMIS covers physical therapy, occupational therapy, speech-language pathology, and audiology services that are medically necessary to treat or promote recovery from an illness or injury. The MCO is not required to cover those services rendered by a school clinic when included in a child's IEP. The school district will bill DMAS for school – based services.

Charges & Caps:

\$2 per visit/\$5 per visit

FAMIS also covers renal dialysis, chemotherapy/radiation therapy, intravenous therapy, and inhalation therapy.

Charges & Caps:

Inpatient: \$15 per confinement/\$25 per confinement

Outpatient: \$2 per visit/\$5 per visit

Vision Services

FAMIS covers diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine eye exams shall be allowed once every 2 years. Routine refractions are limited to once every twenty-four months. Covers eyeglasses (one pair of frames and one pair of lenses) or contacts prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist.

Charges & Caps:

Routine eye exam \$2/\$5

Reimbursement by plan: Eyeglass frames (one pair) \$25; Contacts \$100

Eyeglass lenses (one pair) – Single vision \$35, Bifocal \$50, Trifocal \$88.50

Well Baby and Well Child Care (including Hearing Services)

FAMIS covers routine well baby and well child care visits with health assessments, physical exams, routine lab work, and age appropriate immunizations as recommended by the American Academy of Pediatrics Advisory Committee. The following lab services are covered: blood lead testing, Hemoglobin (HGB), Hematocrit (HCT) or FEP (max. of 2, any combination), Tuberculin Test (max. of 3 covered), Urinalysis (max. of 2 covered), pure tone audiogram for ages 3-5 (max. of 1), machine vision test (max. of 1). Well child visits rendered in the home, office or other outpatient provider location are covered at birth and follow the American Academy of Pediatrics Periodicity Schedule. Coverage also includes the newborn hearing test administered prior to discharge from the hospital.

Charges & Caps:

There are no copayments for well baby or well child checkups.

FAMIS DOES NOT COVER THE FOLLOWING SERVICES

- Abortions (elective)
- Court Ordered Services
- Temporary Detention Orders
- EPSDT
- Experimental and Investigational Procedures
- Inpatient Mental Health Services Rendered by a Freestanding Psychiatric Hospital
- Non-emergency Medical Transportation, unless covered as an extra benefit added by the MCO

PART IV: Medicaid for Pregnant Women and FAMIS MOMS

Once Approved

A woman approved for **Medicaid for Pregnant Women** will receive a *Notice of Action on Benefits* stating that she has been approved for "MA-PG." (An example of this form is located on page 2.39.)

A woman approved for **FAMIS MOMS** will receive a *Notice of Action on Benefits* stating that she has been approved for "FAMIS MOMS." (An example of this form is located on page 2.39.)

In a separate mailing, she will receive a permanent blue and white plastic ID card from DMAS. This card enables her to receive services from any Medicaid/FAMIS MOMS provider while her permanent benefits delivery method is determined. (A sample of this card can be seen on page 3.1.)

Selecting a Provider

The six MCOs providing services to Medicaid for Pregnant Women/FAMIS MOMS enrollees are listed on page 3.1.

Medicaid for Pregnant Women

The enrollee will receive a letter from DMAS about the managed care enrollment process and a comparison chart of the six MCOs. The letter directs her to call the **Managed Care HelpLine** at **(800) 643-2273** Monday through Friday between 8:30AM and 6PM to select her MCO. She can also go online to www.virginiamanagedcare.com to make her choice. **Note:** The HelpLine has access to **interpreter services**, if English is not the recipient's primary or preferred language. (Sample enrollment letter and MCO comparison chart on pages 3.7-3.8 and the enrollment process is charted on page 3.6)

If she does not respond to the letter by the date indicated, she will be assigned to the MCO listed in the letter. After initial enrollment into the MCO, she still has **90 days to change to another MCO**.

FAMIS MOMS

The enrollee will receive information on choosing her MCO in her *Notice of Action*. It directs her to call the **Cover Virginia Call Center** to select her MCO. A list of available health plans is included with the Notice. She is also informed that if she does not call by the indicated deadline, she will be assigned to an MCO. In either case, she will **have an additional 90 days after initial enrollment to switch** to another one. (This enrollment process is charted on page 3.30)

Once the MCO is chosen, either actively by the enrollee or assigned by DMAS, she will receive an ID card and welcome packet from her MCO. This card will be used during her entire enrollment period.

Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, she must inform her local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in Section 5. If the problem is with her MCO card, she will need to call her MCO.

The enrollee should report the loss or theft of her DMAS ID card to the local DSS or Cover Virginia Call Center immediately. If the MCO card is lost or stolen, she should report this to her MCO. These cards should never be lent to anyone.

It is the enrollee's responsibility to show her MCO ID card and her DMAS ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid/FAMIS MOMS program. The provider uses the information on the card(s) to verify enrollment prior to delivering services. Failure to present the card(s) at the time of service may result in the enrollee being held responsible for any incurred expenses.

Covered Services Overview *(A detailed listing of Services is on pages 3.19-24.)*

The Medicaid for Pregnant Women and FAMIS MOMS programs provide a comprehensive package of benefits for pregnant women. The coverage is basically the same as FAMIS Plus coverage for children, although certain services are not available to participants over age 21 (i.e. EPSDT, orthodontia, and eyeglasses). In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, they also cover services such as non-emergency transportation to medical appointments, behavioral health and substance abuse treatment services, case management and health education for new mothers and babies with potential health risks, smoking cessation services, and treatment for substance abuse. MCOs may provide additional "added benefits" such as health education, 24-hour nurse advice line access, and disease management programs. Routine dental care was added to the benefits package for pregnant women in March 2015 and in January 2016 DMAS began paying for breast pumps and breast-feeding supports.

Cost Sharing

There are **no** copayments for services provided to Medicaid for Pregnant Women or FAMIS MOMS enrollees.

Period of Coverage and Reporting Requirements

When a pregnant woman is determined to be eligible for **Medicaid for Pregnant Women**, coverage goes back to the **first day of the month** in which she applied. If she requested **retroactive coverage**, by answering the question on the Application about help paying for medical bills in the last **3 months**, the program may retroactively pay for outstanding medical

bills for up to three months prior to her application. For example, if a signed application is received in March and ultimately results in enrollment, the recipient's outstanding medical bills may be covered for December, January, and February, if she was determined eligible for Medicaid during that time and requested retroactive coverage.

FAMIS MOMS coverage begins the **first day of the month in which the application was received**, so only outstanding medical bills incurred during that month may be covered retroactively.

Once enrolled in Medicaid for Pregnant Women or FAMIS MOMS, the enrollee is **covered for the duration of her pregnancy and 60 days postpartum regardless of any changes in income or insurance status**.

Note: It is important for recipients to report a **change of address** to LDSS or the Cover Virginia Call Center, because DMAS/CPU/DSS mail is not forwarded even if the woman has a forwarding order on record with the Post Office. This information may also be reported on the CommonHelp website if the enrollee has linked her case.

After the 60 day postpartum period, a Medicaid for Pregnant Women enrollee may be eligible for LIFC or the New Health Coverage for Adults. At the end of a FAMIS MOMS recipient's enrollment if her income is above 138% of FPL, she may be eligible to purchase subsidized coverage through the Federal Health Insurance Marketplace and/or for family planning services through the Plan First program. Coming off of state-sponsored health insurance coverage opens a Special Enrollment Period for her to shop on the Marketplace. If her income drops below 138% of FPL, due to the change in family size, she may also be eligible for the New Health Coverage for Adults. *(For more information on Plan First see pages 3.43-3.44)*

Coverage of the Newborn

A **child** born to a woman enrolled in Medicaid for Pregnant Women or FAMIS MOMS is **automatically enrolled in FAMIS Plus (or FAMIS) for one year once she calls her local DSS or the Cover Virginia Call Center to report the birth**. She will report the name of the child, the gender, the race, and the date of birth. This information may also be reported via the CommonHelp website. The hospital or the pregnant woman's MCO may also report the birth to the local DSS on the family's behalf.

Special Note: A baby born to a teen enrolled in FAMIS/FAMIS Plus can also be deemed eligible and automatically enrolled in FAMIS Plus/FAMIS Plus for one year. The teen must follow the same procedure mentioned above for reporting the birth.

A renewal is required in order to retain health coverage at the child's first birthday. The family will receive a renewal application in the mail about 45 days before the child turns 1, the family should check it over, correct/add any needed information and return it. If determined to be still eligible, a *Notice of Action* will be mailed indicating coverage has been renewed for a year.

Note: This child's coverage should remain active until the renewal application is processed, even if it is past the child's first birthday.

PART V: Plan First

Plan First

Plan First began in January 2008. It is a **limited coverage** Medicaid program that pays for birth control and family planning services for women and men with incomes up to 205% FPL. The income guidelines for this program are on page 2.11.



Who is Eligible?

US citizen or qualified legal immigrant* men and women who are residents of Virginia, whose incomes fall within the program guidelines, and who do not qualify for any other full coverage Medicaid program. Medicaid for Pregnant Women and FAMIS MOMS enrollees may be eligible for Plan First coverage at the end of their pregnancy coverage.

**Lawful permanent residents (LPRs) may be eligible after the first five years of residence in the US, if they have worked 40 qualifying work quarters.*

How to Apply

People wishing to apply for Plan First use the same Application to apply for coverage as for Medicaid/FAMIS. They may also apply over the phone via the Cover Virginia Call Center, online via CommonHelp, or via paper application mailed or delivered to their local DSS. It may take DSS or Cover Virginia CPU up to 45 days to make an eligibility determination of eligibility.

The applicant must pay close attention to answering the question re: evaluation for Plan First (**Step 2: Person 1 Question 8** or **Step 2: Person 2 Question 9**). Check "Yes" if he/she needs health coverage, and if between the ages of 19 and 64. **Do not check** any of the boxes under question 8a/9a.

Term of Coverage

Once enrolled, the man or woman is enrolled for up to one year unless any changes of circumstances happen (i.e. increase in income, moving out of state). Annual renewal of coverage is required to retain ongoing coverage. This procedure is the same as that detailed for other programs in this section.

Covered Services

- Family planning education and birth control counseling
- Pap smears for women to screen for cervical cancer, if appropriate
- Sexually transmitted infection (STI) testing

- Lab services for family planning and STI testing
- Sterilizations - tubal ligation for women and vasectomies for men (the enrollee must be age 21 or over and wait 30 days after signing the consent form for these services)
- Prescription and over-the-counter contraceptives (with a doctor's order), including implants, ring, patch, IUDs, birth control pills, diaphragms, and Depo Provera injections and condoms
- Non-emergency transportation to a family planning service or to pick up a prescription for birth control

The following services are **not** covered:

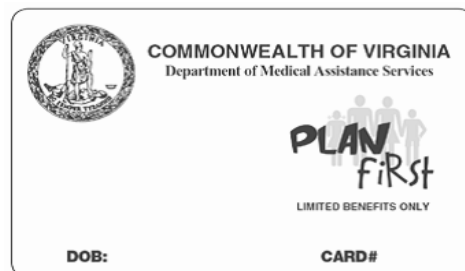
- Medical exams for women/men who do not want or no longer need pregnancy prevention services
- Treatment for any medical problems (including STIs or other reproductive health problems)
- Repeat Pap tests due to a problem or Pap tests for women who do not need birth control
- Vaccinations, mammograms, hysterectomies, and treatment for infertility
- Abortions
- Emergency transportation - ground or air ambulance

Cost Sharing

There are **no** copayments for Plan First family planning services.

How to Access Services

The enrollees are issued a green and white Plan First ID card (pictured at right) and can see any provider **who takes Medicaid and provides family planning services**. Information on how to access Plan First services can be found at: <https://coverva.org/planfirst/>



PART VI: FAMIS *Select* and HIPP

FAMIS *Select*

FAMIS *Select* is the name for the “premium assistance” component of FAMIS. The program has been streamlined and simplified to be more easily understood by families and employers, and to allow a greater number of families to participate. The program is also open to self-employed families that get their insurance through private insurance plans.

FAMIS *Select* is a “rebate” program. **ONCE A CHILD HAS BEEN ENROLLED IN FAMIS**, the family can select this option that allows them to cover their children with health insurance offered through an employer or a private company, and be reimbursed for a portion of the cost of coverage for the FAMIS children.

If a family decides to participate in FAMIS *Select*, they will fill out an additional **online application form accessed on coverva.org**, and once approved, they will sign up for their employer/private plan. Once they send in their pay stub (cancelled check for a private plan) as proof of payment, the family will be reimbursed up to \$100 per FAMIS enrolled child per month.

For example: a FAMIS *Select* family of five (mother, father and three FAMIS children) would receive \$300 per month toward the cost of family coverage. *Note: FAMIS Select will not reimburse an amount greater than the actual cost of the coverage, so if the total cost paid for insurance was only \$200, then this family would only receive \$200.*

The FAMIS *Select* option may allow a family to afford family coverage that truly does cover the entire family, including family members not otherwise eligible for FAMIS (i.e. an uninsured spouse, a child over age 19). It may also allow the entire family to see the same providers who all participate in the employer/private plan.

It is important to note that **under FAMIS *Select* any deductibles, co-insurance and copayments required by the employer/private plan are the responsibility of the family.** Over time these can add up to a significant financial outlay. FAMIS has only small copayments for most services and no copayments at all for preventive care. Also, the family will be **limited to the services provided by their employer/private plan** and use that plan’s participating providers.

While it may seem like a “deal” to cover the family through FAMIS *Select*, it make more sense in the long run to have children on “regular” FAMIS and just add coverage for a spouse through work. Families will need to consider this carefully when deciding whether to participate in FAMIS *Select*.

If at any time a family in FAMIS *Select* drops the private/employer coverage, the family should notify the FAMIS *Select* Office and the eligible children will revert to regular FAMIS coverage. Children enrolled in this program need to renew their FAMIS Coverage every 12 months in order to stay enrolled.

Health Insurance Premium Programs (HIPP)

The Virginia Department of Medical Assistance Services offers two programs for Medicaid members without Medicare coverage, the first is known as HIPP and the second is HIPP for Kids.

HIPP is the premium assistant program for adults. It may be available to people with Medicaid and may help pay for part or all of their health insurance premiums. To be eligible:

- A household member must have Medicaid full coverage
- The person must have or be able to get insurance through his/her employer
- The health insurance available must meet program criteria, including cost effectiveness

The cost of the insurance available must be less than Medicaid would pay for his/her care. HIPP does not provide premium assistance for: indemnity plans, plans paying limited amounts for services; plans limited to temporary periods and that are not comprehensive; high deductible health plans; and family plans where there are three or more members on the health plan who are not full coverage Medicaid eligible.

HIPP for Kids is the premium assistance program that may be available to children under the age of 19 who are also eligible for Medicaid. It pays for their entire health insurance premium. Cost sharing may apply to non-covered copayments, deductibles, and other expenses not covered by the primary insurer. To be eligible:

- A household member must be eligible for Medicaid and be under the age of 19
- The parent(s) must be able to get insurance through his/her employer and the employer must pay at least 40% of the total cost of the health insurance premium
- The health insurance available must meet program criteria

The insurance available must provide comprehensive medical coverage. HIPP for Kids does not provide premium assistance for: indemnity plans, plans paying limited amounts for services; plans limited to temporary periods or that are not comprehensive; high deductible health plans; and non-medical insurance, such as vision or dental plans.

To contact DMAS for information regarding these programs or to submit an application, people should send an email to HIPPcustomerservice@dmass.virginia.gov, send a fax to the HIPP Unit at (804) 452-5447, or send a letter to:

Virginia Department of Medical Assistance Services
Health Insurance Premium Payment Programs Unit
600 E. Broad Street, 12th Floor
Richmond, VA 23219
Phone: (804) 225-4236 or (800) 432-5924 (in Virginia)

Application forms and additional information are available on the web at:
<http://www.dmas.virginia.gov/#/hipp>

PLEASE DO NOT DISCARD THIS PAGE

18 PAGE RENEWAL FORM
FOR MEDICAL ASSISTANCE
Note: the actual form has QR
codes on the bottom of every
page.

Commonwealth of Virginia Department of Social Services

Local social services address below **MUST** show in window of return envelope.

County/City: King William County (101)
PO BOX 187
172 COURTHOUSE LANE
KING WILLIAM, VA 23086

Phone:
Date: MM/DD/YYYY
Case Number:
Correspondence #:

HEAD OF HOUSEHOLD
NAME
ADDRESS
CITY, STATE ZIP

Worker User ID:AAA###
Worker Name: FI LNAME

Medical Assistance (Medicaid & FAMIS) Renewal Form

For Families and Children Medical Assistance:

Contact Cover Virginia at 855-242-8282 (TTY:1-888-221-1590) or
local department of social services at the phone number
listed in the right corner above.

For Aged, Blind, Disabled and Long Term Care

Medical Assistance: Contact your local department of social
services at the phone number listed in right corner above.

**It is time to renew your
Medical Assistance
coverage.**

**How to complete this
renewal form**

- **By mail:** Complete this form and mail it to your local department of social services at the address at the top of this form. TO ENSURE THE RENEWAL FORM IS MAILED PROPERLY, PLEASE RETURN THIS PAGE ALONG WITH THE REST OF THE RENEWAL FORM AND INSERT THE ENTIRE PACKED WITH THE LOCAL AGENCY ADDRESS DISPLAYED IN THE WINDOW OF THE STAMPED RETURN ENVELOPE.
- In person: Visit your local department of social services. Contact your local department of social services for office hours.
- Go to coverva.org or contact your local department of social services for information about obtaining assistance with this form.

1. Please answer all of the questions on the form.
2. Please read the information about you and each member of your household. Add any missing information. If any information has changed, print the right information.

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You do not need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you
- Parent of your child(ren) living with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 21)

Questions? Call Cover Virginia Call Center at 1-855-242-8282
M to F 8am until 7pm Sat 9am until noon

Case #
Case Name
Correspondence #

- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes.

3. If you are Aged (65 or older), Blind or Disabled, please be sure to complete Section 11 in addition to the other relevant sections.
4. Please **sign** and date the form at the end of Section 12.
5. **Please return this from by** .If you do not return the form by this deadline, you may lose your Medical Assistance coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get Medical Assistance now,
- those who do not get Medical Assistance now but would like to apply, **and**
- others who live in the household and do not get Medical Assistance

If you have questions about what we might need, contact Cover Virginia (phone listed at bottom of page) or your local department of social services.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (DHS) If the information does not match, we may ask you to send more information.

If you do not qualify for Medical Assistance

If you do not qualify for Medical Assistance, we will check to see if you qualify for other kinds of health coverage. We may send your information to the Health Insurance Marketplace so they can see if you qualify for advanced premium tax credits or other coverage.

1

Your contact information

Review your contact information here.

Correct only wrong or missing information here.**Home address:**

Name (first,middle,last & suffix)

Mailing address:**Home address**

Apartment#

City (home)

State

Zip code

Phone:
Home:
Other:**Mailing address**

Apartment#

City (mailing)

State

Zip code

Best phone number to reach you:

☐

Home

☐

Cell

☐

Work

Phone Number:

Other phone number, if you have one :

☐

Home

☐

Cell

☐

Work

Phone Number:

Email address:

If you have an email address and would like to provide it to us:

2

We need information about who files tax returns.

Review your tax information here.

Correct any wrong or missing tax information here.**Person filing tax return:****If this person filed a joint
return, name of the spouse:****If this person had dependents,
names of the dependents:**Will anyone in the household file a **federal tax return next year** to report income earned this year?☐Yes **If yes**, answer all of the questions below ☐ No **If no**, answer the question marked with asterisk (*) below.**Person filing tax return:** Name (first,middle,last & suffix)**If this person is filing a joint return, write the name of the spouse:****If this person will claim dependents, write the names of the dependents:****Person filing tax return:** Name (first,middle,last & suffix)**If this person is filing a joint return, write the name of the spouse:****If this person will claim dependents, write the names of the dependents:**

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the filer and the dependents. Answer only if different than what you reported above.

Name of filer: _____

Name of dependents: _____

3

These are the people in your household who get Medical Assistance and need to renew**Person 1**This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write this person's Social Security number here: _ _ _ - _ - - _ _ _ _

If the person is no longer living in the household, check here. ☐

Date left household: _____

Immigration status on file (if applicable):

☒ You need to provide the information below. ☐ You do not need to provide the information below unless there are any changes.If this person has eligible immigration status, check here ☐ and provide the document type: _____

and ID number: _____ See Appendix C for more information about eligible immigration status.

Person 2This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write this person's Social Security number here: _ _ _ - _ - - _ _ _ _

If the person is no longer living in the household, check here. ☐

Date left household: _____

Immigration status on file (if applicable):

☒ You need to provide the information below. ☐ You do not need to provide the information below unless there are any changes.If this person has eligible immigration status, check here ☐ and provide the document type: _____

and ID number: _____ See Appendix C for more information about eligible immigration status.

[IF THERE ARE MORE PEOPLE ON ASSISTANCE, THEIR INFORMATION WOULD PRINT HERE AS WELL]

4

Tell us about the other people living in your household, and the other people listed on your tax return**List the people who you did not tell us about in Section 3.****Other person:**This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write the Social Security number

if this person is applying for health insurance: _ _ _ - _ - - _ _ _ _

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If the person is no longer living in the household, check here ☐

Date left household: _____

Date of birth (month/ day / year): _____

This person is: ☐ Male ☐ FemaleIf this person wants health insurance, check here ☐ and fill out Section 5.**Other person:**This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write the Social Security number

if this person is applying for health insurance: _ _ _ - _ - - _ _ _ _

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If the person is no longer living in the household, check here ☐

Date left household: _____

Date of birth (month/ day / year): _____

This person is: ☐ Male ☐ FemaleIf this person wants health insurance, check here ☐ and fill out Section 5.**Questions?** Call Cover Virginia Call Center at 1-855-242-8282

M to F 8am until 7pm Sat 9am until noon

3.50 RENEWAL FORM

Tell us about other people in your household who want to apply for Medical Assistance

Tell us about anyone in your household who wants to apply for Medical Assistance. **Do not answer** these questions for people **who already have Medical Assistance**. *If more than one person is applying make a copy of this page.*

Name of person applying: Name (first, middle, last & suffix) _____ Social Security Number: ____ - ____ - ____
(You may choose not to include)

Relationship to all household members: _____

Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes *If yes*, answer all of the questions below.
☐ No *If no*, go to "Tell us more information about this person".

If this person **is not** a U.S. citizen or U.S. national, but has eligible immigration status, check here. ☐

and write the document type: _____ and ID number: _____

See Appendix C for more information about eligible immigration status.

If this person has lived in the U.S. since **1996**, check here. ☐

If this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military, check here. ☐

Tell us more information about this person

If this person lives with at least one child who is 18 years or younger, and is the main person taking care of this child, check here. ☐

If this person is 18 years or younger and has a parent living outside of the household, check here. ☐

If this person wants help paying for medical bills from the last three months, check here. ☐

Is this person pregnant? ☐ Yes ☐ No What is the expected due date? _____ How many babies are expected? _____

Tell us about ethnicity and race. You may choose not to answer these questions.

What is this person's ethnicity? Check all that apply:

- ☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican ☐ Cuban
☐ Hispanic ☐ Unknown

What is this person's race? Check all that apply:

- ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Korean
☐ Vietnamese ☐ Other Asian ☐ Black or African American ☐ Native Hawaiian ☐ Unknown
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ White ☐ Japanese

Tell us about other health insurance

If anyone who is renewing or applying for Medical Assistance is enrolled in some other type of health insurance, list him or her below.

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Marketplace ☐ Other insurance _____
☐ Premium Assistance (HIPP or FAMIS Select)

List everyone who is on this policy:

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Marketplace ☐ Other insurance _____
☐ Premium Assistance (HIPP or FAMIS Select)

List everyone who is on this policy:

If anyone on this form is offered health insurance through a job, check ☐
 here. If this is a state employee benefit plan, check here. ☐
 Do you want to apply for health insurance? ☐

Managed Care Organization (MCO)**FAMIS Enrollees**

For FAMIS enrollees renewing their FAMIS coverage: this is the time each year you are able to change Managed Care Organization (MCO) plans without a special reason. If you wish to change your child's FAMIS MCO now, please check which MCO for each child enrolled in FAMIS. If you do not request a change, your child will remain with the same FAMIS MCO until next year. If you need assistance with changing your child's FAMIS MCO or you need to change to your child's MCO after you complete your renewal, call Cover Virginia at 1-855-242-8282.

Each person with MCO listed below:

Person	Current MCO	Change MCO here (Select from list below)

To Change MCO in the table above, Enter an MCO from list below:

Valid MCOs for Locality: [AVAILABLE MCOS LISTED HERE]

Please complete for any new person for whom you are requesting an MCO.

Person	MCO (Select from list above)

Medicaid Enrollees

Medicaid enrollees will receive a separate letter in the mail to notify you about open enrollment and your opportunity to change MCO plans. Different regions of the state have different open enrollment periods when you can change your Medicaid MCO.

Questions? Call Cover Virginia Call Center at 1-855-242-8282

M to F 8am until 7pm Sat 9am until noon

3.52 RENEWAL FORM

Tell us more about the people listed on this form

If anyone who is renewing or applying for health insurance has a physical, mental, emotional, or developmental disability, write his or her name here.

Name (first,middle,last & suffix):

Name (first,middle,last & suffix):

If anyone who is renewing or applying for health insurance lives in a medical facility or nursing home, write his or her name here.

Name (first,middle,last & suffix):

Name (first,middle,last & suffix):

If anyone who is renewing or applying for health insurance is between the ages of 18 and 26 and was on Medicaid and in foster care in Virginia at age 18, write his or her name here.

Name (first,middle,last & suffix):

Name (first,middle,last & suffix):

If anyone listed on this form is pregnant (whether renewing or applying for health insurance or not), write her information below.

Name (first,middle,last & suffix):

How many babies are expected ?

What is the expected due date?

Name (first,middle,last & suffix):

How many babies are expected ?

What is the expected due date?

If anyone who is renewing or applying is an American Indian or Alaska Native, check here ☐ and fill out Appendix A.

Provide the information below for anyone in your household who is working. If someone has more than one job, tell us about **all jobs**. Make a copy of this page if you need more space. **Cross out any information that is not correct** about members of your household. Write in the new information.

Person who has the job: Name (*first,middle,last & suffix*)

If you are unemployed, check here ☐

Employer phone number:

Employer name and address:

City:

State:

Zip code:

Is this person still employed at this job? ☐ Yes ☐ No

If No, date when they left the job:

How often are wages or tips paid? ☐ Weekly ☐ Bi - Weekly ☐ Semi - monthly ☐ Monthly ☐ Irregular ☐ Annual

☐ Contractual/Single Payment Covering More than One Month

How much does this person get paid (before taxes)? \$

Average hours worked each week:

If anyone in your household has a **new job** or has **changed jobs**, list him or her below.

Name (first,middle,last & suffix)

Date when job began:

Employer name and address:

City:

State:

Zip code:

Employer phone number:

How often are wages or tips paid? ☐ Weekly ☐ Bi - Weekly ☐ Semi - monthly ☐ Monthly ☐ Irregular ☐ Annual

☐ Contractual/Single Payment Covering More than One Month

How much does this person get paid (before taxes)? \$

Average hours worked each week:

If anyone in your household has a **new job** or has **changed jobs**, list him or her below.

Name (first,middle,last & suffix)

Date when job began:

Employer name and address:

City:

State:

Zip code:

Employer phone number:

How often are wages or tips paid? ☐ Weekly ☐ Bi - Weekly ☐ Semi - monthly ☐ Monthly ☐ Irregular ☐ Annual

☐ Contractual/Single Payment Covering More than One Month

How much does this person get paid (before taxes)? \$

Average hours worked each week:

If any household member's income changes from month to month, tell us this person's name and what you think he or she will be making this year.

Name (*first,middle,last & suffix*):

What do you expect his or her income to be this year? Amount: \$

Name (*first,middle,last & suffix*):

What do you expect his or her income to be this year? Amount: \$

If anyone in your household is **self-employed**, we need to know about their work. See Appendix C for more information about deductions.

Name (*first,middle,last & suffix*):

Type of work:

How much net income will this person get from self-employment this month? Amount: \$

Net income means the profits left over after business expenses are paid. For more information about business expenses, see Appendix C.

Name (*first,middle,last & suffix*):

Type of work:

How much net income will this person get from self-employment this month? Amount: \$

Net income means the profits left over after business expenses are paid. For more information about business expenses, see Appendix C.

Questions? Call Cover Virginia Call Center at 1-855-242-8282

M to F 8am until 7pm Sat 9am until noon

3.54 RENEWAL FORM

Provide us with any other work details which may be helpful below:

Name (*first,middle,last & suffix*):

Work details:

Name (*first,middle,last & suffix*):

Work Details:

Cross out any information that is not correct about members of your household. Write in the new information.

Income	How much?	How often?
Income Type:	\$	<input type="checkbox"/> Annual <input type="checkbox"/> Bi - Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Semi- Monthly <input type="checkbox"/> Irregular <input type="checkbox"/> Contractual/Single Payment Covering More than One Month
Name (<i>first,middle,last & suffix</i>):		

Income Type:	How much?	How often?
	\$	<input type="checkbox"/> Annual <input type="checkbox"/> Bi - Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Semi- Monthly <input type="checkbox"/> Irregular <input type="checkbox"/> Contractual/Single Payment Covering More than One Month
Name (<i>first,middle,last & suffix</i>):		

If anyone in your household has deductions, tell us what kind.

Deductions	How much monthly?
Deduction Type:	
Name (<i>first,middle,last & suffix</i>):	\$

Deduction Type:	How much monthly?
Name (<i>first,middle,last & suffix</i>):	\$

Questions? Call Cover Virginia Call Center at 1-855-242-8282

M to F 8am until 7pm Sat 9am until noon

3.56 RENEWAL FORM

Case #
Case Name
Correspondence #

1. Does your spouse or your child(ren) under age 21 live with you? ☐ No ☐ Yes If yes, tell us their names and their relationship to you:

2. List all the money received by you or your spouse during the past month. List Social Security benefits, VA benefits, wages, retirement benefits, disability benefits, unemployment, etc. Attach proof of the amount received. Proof of SSA, SSI, or unemployment is not required.

Who received money?

Source

Amount

_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

3. If you or your spouse who lives with you are working, do either of you have expenses related to work? ☐ Yes ☐ No

If yes, list what kind of expenses you have and attach proof. _____

4. List changes in your health insurance, including company name, policy number, coverage, what the change was and the date of change:

5. List all resources owned by you or your spouse such as checking/savings accounts, annuity or trust fund, certificate of deposit (CD), stocks, bonds, life insurance, burial funds, vehicles, pension plan, IRA, other retirement fund.

_____ \$ _____

6. Have you or your spouse transferred any real or personal property within the last year? ☐ Yes ☐ No If yes:

What? _____ Value _____ Date _____

Long Term Care (LTC) Questions – Answer these additional questions if you are receiving LTC services.

1. Name of nursing facility, state institution or community-based care provider: _____

2. If married or separated, spouse's name: Name (*first,middle,last & suffix*) _____

Spouse's Social Security Number: ____ - ____ - ____ Spouse's

address, if different: _____

Spouse's Telephone Number: _____

Spouse's Shelter Expenses: (Attach Current Verification)

Rent/Mortgage: \$ _____ Utilities ☐ Yes ☐ No

Homeowner's/Renter's Insurance: \$ _____ Real Estate Taxes: \$ _____

Maintenance Charges for Condominium: \$ _____

3. Dependent's Income: (Attach Current Verification)

Social Security: \$ _____ SSI: \$ _____

Civil Service: \$ _____ VA: \$ _____
Retirement/Pension: \$ _____ Disability: \$ _____
Wages: \$ _____ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.): \$ _____

4. Medical Expenses: (Attach Premium Notice or Statement)

Does the patient have:

Medicare? Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No

Other health insurance? ☐ Yes ☐ No If yes:

Company: _____ Policy #:

Coverage Type: _____ Premium Amount: \$

Company: _____ Policy #: _____

Coverage Type: _____ Premium Amount: \$ _____

Medical expenses other than insurance premiums? ☐ Yes ☐ No

What? _____ Amount: \$ _____

Renewal of coverage in future years

Read the statement below and check one box.

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medical Assistance Program or Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my Medical Assistance renewal. I understand that I can opt out at any time.

If this had already been selected on initial application, it would give the date the authorization ends and the opportunity to continue or stop it.

Yes, renew my eligibility automatically for the next:

- ☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use information from tax returns to renew my coverage

Your rights and responsibilities

Read the statements below.

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell my local department of social services if anything changes and is different from what I wrote on this form. I can call 1-855-242-8282 or visit coverva.org or CommonHelp at <https://commonhelp.virginia.gov> to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- If you think there was a mistake, you can appeal the decision. To appeal means to tell someone at the state that you think the action is wrong, and ask for a fair review of the action. You can find out how to appeal by calling the Department of Medical Assistance Services at 804-371-8488, or you can visit the website at www.dmas.virginia.gov and click on Client Services on the left, and then select Appeals Information or go to coverva.org.
- I understand that if I do not qualify for Medical Assistance my local department of social services will check to see if I qualify for other kinds of health coverage. My local department of social services may send my information to another program so they can see if I qualify.
- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for Medicaid or FAMIS because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months.

Other Request for Information:

1. All Medical Assistance applicants 19-64 years old will be evaluated for Plan First (family planning services only) if they do not qualify for full Medical Assistance benefits unless they tell us not to below. Applicants under 19 years and 65 years or older will be evaluated for Plan First by request below.

List the names in the space provided.

DO NOT evaluate these applicants for Plan First coverage: _____

Evaluate these applicants for Plan First coverage: _____

2. I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). List anyone you are applying for who is incarcerated: _____

Consent to Exchange Information

The Virginia Department of Social Services (VDSS) would like to use some of the personal information that you have provided on your application about you and your dependents to create your User Profile. VDSS is asking for permission to share your User Profile electronically with the state agencies listed below. Each agency will be told when you make a change to the information in your User Profile. This will allow you to save time by only providing User Profile information once when visiting these agencies.

Questions? Call Cover Virginia Call Center at 1-855-242-8282
 M to F 8am until 7pm Sat 9am until noon

Case #
 Case Name
 Correspondence #

RENEWAL FORM 3.59

Legal Notice

The data being shared

Your User Profile will only be created if you agree to share it and you are eligible for assistance. Your User Profile will contain first name, last name, middle initial, suffix (Jr., Sr., etc.), current home address, date of birth, Social Security Number and Medicaid identification number (if applicable), email address, home phone, driver's license ID and cell phone number. However, you can share your User Profile without sharing your Social Security number; this will not affect your eligibility. Your Medicaid identification number will only be shared with VDSS and your local department of social services. Because the User Profile is based on your application for assistance, the agencies named below also will know that you are receiving assistance.

Agencies Included and Allowed Use

Below are the agencies that will get your information. The reasons they have requested your User Profile and what they will be allowed to do with your User Profile are listed.

Sharing your User Profile will allow them to update the information in their computers, saving taxpayer dollars. It may save you a visit to one of these agencies because your information has been changed electronically.

The Department of Motor Vehicles (DMV) would like a copy of your User Profile when it changes. DMV can change your address for cars you own or driver's license/identification card information they have for you. They will send you a card automatically through the mail to complete this update.

The Virginia Information Technologies Agency (VITA) operates an electronic system known as Enterprise Data Management (EDM). EDM contains data that you have already provided to DMV for your driver's license or identification card. If you give permission to share your User Profile, EDM will match the DMV data and your User Profile, and share this information with your local department of social services and DMV. If the data does not match, DMV or your local department of social services may contact you to confirm the information. Email address, home phone number, cell phone number and Medicaid identification number may be reviewed by a local department of social services worker inside EDM to identify possible duplicate User Profiles.

If you choose not to share your User Profile

Your information will remain only with the Department of Social Services. Choosing not to share your User Profile will not affect your eligibility for assistance.

Social Security Number

Including your Social Security Number (SSN) in your User Profile is your choice. The SSN is used to match your User Profile with DMV data in EDM easily. Your SSN is kept confidential.

Dependents

This request is for your own User Profile and for the User Profile of any person who is your legal dependent, including your children under age 18, any person for whom you serve as legal guardian, or any other person for whom you have the authority to agree to share.

To stop sharing of your User Profile

You can stop sharing your User Profile at any time by going to www.commonhelp.virginia.gov and changing your decision to share. You can also change your decision to share your User Profile by visiting your local department of social services.

How long consent to share lasts

Your permission to share your User Profile will remain active for one (1) year from the date you approve, unless you change your decision to share sooner. Your agreement for any minor child who turns 18 will be stopped on the date of the child's 18th birthday. That individual then will be asked to agree to share his information.

You will be asked to share your information every time you make a change to the information that is used in your User Profile.

Giving Consent

- ☐ My User Profile can be shared with the specified agencies, but do not include Social Security Number when creating my User Profile.
- ☐ Share my User Profile with the specified agencies. Include Social Security Number when creating my User Profile.
- ☐ Do not allow my User Profile to be shared.

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

- ☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ☐ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)

☐ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.

If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with:

Secretary of the Virginia State Board of Elections
Washington Building
1100 Bank Street
Richmond, VA 23219-3497
804-864-8901

If you want an authorized representative or Certified Application Counselor/ Navigator/Broker or want to change the authorized representative or Certified Application Counselor/ Navigator/Broker you have now, fill out Appendix B.

All new individuals applying for Medical Assistance who are 18 years old or older MUST sign this form below.

Name	Signature	Date

SIGN AND DATE BELOW - By signing this form you agree to the information provided on this form.

Signature of Recipient or Authorized Representative

Date

If you are an authorized representative, check here ☐

Questions? Call Cover Virginia Call Center at 1-855-242-8282
M to F 8am until 7pm Sat 9am until noon

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RENEWAL FORM 3.61

Appendix A

Tell us about your American Indian or Alaska Native family member(s):

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (first, middle, last & suffix):

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

How much income? \$

How often?

☐ Weekly ☐ Semi-Monthly ☐ Irregular
☐ Annual ☐ Monthly ☐ Bi-Weekly
☐ Contractual/Single Payment Covering
More than One Month

2. Name (first, middle, last & suffix):

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties.
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
- Money from selling things that have cultural significance.

How much income? \$

How often?

☐ Weekly ☐ Semi-Monthly ☐ Irregular
☐ Annual ☐ Monthly ☐ Bi-Weekly
☐ Contractual/Single Payment Covering
More than One Month

Questions? Call Cover Virginia Call Center at 1-855-242-8282
M to F 8am until 7pm Sat 9am until noon

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3.62 RENEWAL FORM

Appendix B

You can choose an authorized representative

An *authorized representative* is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.

Do you want an authorized representative? ☐ Yes ☐ No

If yes, you want an authorized representative, answer the questions below.

We show that you chose this person as your authorized representative:

Do you still want this person to be your representative?

☐ Yes ☐ No

If yes, has any of his or her information changed?

☐ Yes ☐ No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information here:

Name of authorized representative and/or Organization:

Address: Apartment # City State Zip code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other
Number:

Relationship to Applicant:

Please indicate the duties that you would like to authorize for this person.

- ☐ Apply for benefits
- ☐ Receive benefits
- ☐ Receive requests for information needed to determine eligibility
- ☐ Receive letters regarding actions taken on your case
- ☐ Other

I Allow the Authorized Representative above to view my data. ☐ Yes ☐ No

Do you want to add another authorized representative? ☐ Yes ☐ No

If yes, make a copy of this page and complete the information.

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your Signature:

Date:

You can choose one certified application counselor/ navigator/ broker

Complete this section if you would like to authorize a Certified Application Counselor or Navigator or Broker to be able to access confidential information related to your medical assistance case.

Do you want a certified application counselor/navigator/broker? ☐ Yes ☐ No

If yes, you want a certified application counselor/ navigator/ broker, answer the questions below.

We show that you chose this person as your certified application counselor/navigator/broker:

Do you still want this person to be your certified application counselor/navigator/broker?

☐ Yes ☐ No

If yes, has any of his or her information changed?

☐ Yes ☐ No

Name of Organization:
ID Number (if applicable):

If your certified application counselor/ navigator/ broker's information has **changed**, or if you would like a **different** certified application counselor/ Navigator/broker, please write the new information here:

Name:

Name of Organization: ID Number (if applicable):

Questions? Call Cover Virginia Call Center at 1-855-242-8282
M to F 8am until 7pm Sat 9am until noon

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RENEWAL FORM 3.63

Appendix C

Eligible immigration status list

If you see the person's status below, go back to the question and check the Yes box.

<ul style="list-style-type: none"> • Lawful Permanent Resident (LPR or Green Card holder) • Asylee • Refugee • Cuban or Haitian entrant • Paroled into the U.S. • Conditional entrant granted before 1980 • Battered spouse, child and parent • Victim of Trafficking and his/her spouse, child, sibling or parent • Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT) • Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau) • Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS) • Deferred Enforced Departure (DED) • Family Unity beneficiary • Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance • Lawfully Residing Non-Citizen 	<ul style="list-style-type: none"> • Applicant for Special Immigrant Juvenile Status • Applicant for Adjustment to LPR Status • Applicant for Asylum • Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Registry Applicants (with Employment Authorization) • Order of Supervision (with Employment Authorization) • Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization) • Applicant for Legalization under IRCA (with Employment Authorization) • Legalization under the LIFE Act (with Employment Authorization) • Lawful Temporary Resident • Member of a federally-recognized Indian tribe or American Indian • Born in Canada • Resident of American Samoa • Administrative order staying removal issued by the Department of Homeland Security (DHS)
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Immigration document types

Eligible non-citizens applying for health coverage also need to list their immigration document.

Below are some common types. If the document you have is not listed, you can still write its name. If you are not sure, or you have an eligible status but no document, call Cover Virginia at 1-855-242-8282 (TTY 1-888-221-1590) or your local department of social services so we can help.

<ul style="list-style-type: none"> • Permanent Resident Card (I-551, also known as Green Card) • Temporary I-551 Stamp (on passport or I-94, I-94A) • Immigrant Visa (with temporary I-551 language) • Employment Authorization Card (EAD or I-766) • Arrival/Departure Record (I-94 or I-94A) • Arrival/Departure Record in foreign passport (I-94) • Foreign passport • Reentry Permit (I-327) 	<ul style="list-style-type: none"> • Refugee travel document (I-571) • Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) • Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) • Notice of Action (I-797) • Other document with an Alien Number or I-94 number, or other documents showing you have an eligible immigration status listed above
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Self-employment expenses

You can subtract the business expenses listed below from your gross income to get an amount for your net self-employment income.

<ul style="list-style-type: none"> • Car and truck expenses (for travel during the workday, not commuting) • Depreciation • Employee wages and fringe benefits • Property, liability, or business interruption insurance • Interest (including mortgage interest paid to banks, etc.) • Legal and professional services • Rent or lease of business property and utilities • Commissions, taxes, licenses and fees 	<ul style="list-style-type: none"> • Advertising • Contract labor • Repairs and maintenance • Certain business travel and meals • Deductible self-employment taxes • Cost of self-employed health insurance • Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan
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Questions? Call Cover Virginia Call Center at 1-855-242-8282

M to F 8am until 7pm Sat 9am until noon

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Case #

Case Name

Correspondence #