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State/Territory Name: Virginia

State Plan Amendment (SPA) #: VA-22-0021

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

December 23, 2022

Cindy Olson
Director
Eligibility and Enrollment Services Division
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Olson:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) VA-22-0021, submitted on November 4, 2022, has been approved. Through this SPA, Virginia permanently removes copayments for all health care services for CHIP enrollees. This SPA has an effective date of July 1, 2022.

Your title XXI project officer is Ms. Ticia Jones. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-8145
E-mail: Ticia.Jones@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

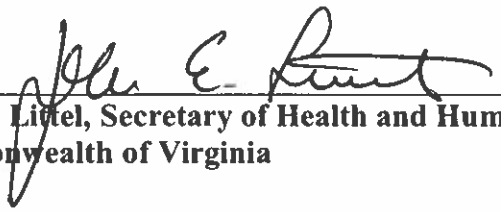
Sarah deLone
Director

STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: **Virginia**
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act (42 CFR 457.40(b)),



John E. Littel, Secretary of Health and Human Resources
Commonwealth of Virginia

10/4/22
Date Signed

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name:	**John E. Littel**	Title:	**Secretary of Health and Human Resources**
Name:	**Cheryl J. Roberts**	Title:	**Acting Director, Department of Medical Assistance Services**
Name:	**Cindy Olson**	Title:	**CHIP Director**

*Disclosure. In accordance with the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10393 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SPA #VA-22-0011
Purpose of SPA: Enhanced Behavioral Health Services, Hardship Exception Analysis, and Updated Performance Objectives
Effective date: 07/01/21
Implementation date:

- **For Mental Health Intensive Outpatient Services, Mental Health Partial Hospitalization, Assertive Community Treatment, and updates to Sections 4 and 9 (Hardship Exception Analysis and Strategic Objectives and Performance Goals): 07/01/21**
- **For Multi-systemic Therapy, Functional Family Therapy, and Crisis Intervention and Stabilization services under Section 6.3.5.1- BH: 12/01/21**

SPA #VA-22-0021
Purpose of SPA: Removal of Co-Payments
Effective and implementation date: 07/01/22

1.4- TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

On October 4, 2022, a Tribal notification letter was sent to representatives of each of Virginia's seven federally recognized Indian Tribes, as well as to contacts at the Indian Health Program (IHP) office, describing the provisions of CHIP SPA #VA-22-0021 and notifying Tribal and IHP leadership of the 30-day Tribal comment period. Tribal members and IHP contacts were invited to provide input on the SPA, and contact information was provided for submitting any comments to DMAS. There was no formal response by Tribal or IHP officials regarding this CHIP SPA. Virginia does not anticipate that this SPA will have a direct impact on the Tribes or IHP.

the license.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

Coverage of chiropractic and vision services with benefit limitations. ~~**Effective 12/1/02, the vision co-payments levels for each FPL decreased and levels for frames and trifocal lenses increased.**~~

Effective 10/1/09, coverage for early intervention services was expanded to include all certified Early Intervention Professionals and Early Intervention Specialists.

6.2.24. ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))

Premiums for private health care insurance coverage are covered in the FAMIS Select program through a CHIP Section 1115 Demonstration waiver, as outlined in Section 4.4.

6.2.25. ☒ Medical transportation (Section 2110(a)(26))

Professional ambulance services under certain conditions are covered when used locally to or from a covered facility or provider's office. Ambulance services if prearranged by the Primary Care Physician and authorized by the Company if, because of enrollee's medical condition, the enrollee 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 enrollee's condition suddenly becomes worse and must go to a local hospital's emergency room.

For coverage of ambulance services, the following three conditions must be met: (a) The trip to the facility or office must be to the nearest one recognized by the health plan administrator as having services adequate to treat the condition; (b) The services received in that facility or provider's office are covered services; and (c) If the health plan administrator requests it, the attending provider must explain why transportation could not occur in a private car or by any other less expensive means.

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☐☒ Yes

~~**Cost sharing as described below applies to FAMIS children. Cost sharing does not apply to the FAMIS Prenatal population.**~~

8.1.2. ☒☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

None. Effective April 15, 2002, Virginia temporarily suspended premiums ~~until further notice~~. Effective September 1, 2002, the FAMIS program ~~no longer charges~~ permanently removed premiums.

8.2.2. Deductibles:

None.

8.2.3. Coinsurance or copayments:

Co-payments are removed for all FAMIS populations effective July 1, 2022.~~Co-payments shall not be imposed on any of the children covered under the Secretary-approved coverage offered through fee-for-service.~~

~~In Secretary-approved coverage modeled after the state employee plan, no co-payments are required for well-baby and well-child and other preventive services. Effective 7/1/10, no co-payments are required for pregnancy-related services. Effective 7/1/19, no co-payments are required for outpatient mental health and substance use disorder services.~~

~~In the event of a federally declared or Governor-declared disaster and at the Commonwealth's discretion, the Commonwealth may temporarily waive co-payments for FAMIS beneficiaries who reside and/or work in the State or federally declared disaster area.~~

~~Copayments for Secretary-approved coverage modeled after the state employee plan are:~~

~~Description of Service~~	~~≤ 150% FPL~~	~~> 150% FPL~~
~~Outpatient~~	~~$2 per visit~~	~~$5 per visit~~
~~Prescription Drugs~~	~~$2 per prescription~~	~~$5 per prescription~~
~~Inpatient~~	~~$15 per admission~~	~~$25 per admission~~
~~Non-Emergency use of Emergency Room~~	~~$10 per visit~~	~~$25 per visit~~
~~Poverty Levels~~	~~≤ 150% FPL~~	~~> 150% FPL~~
~~Maximum Yearly Co-Payment Limit Per Family~~	~~$180~~	~~$350~~

~~Income levels are provided as a percentage of Federal Poverty Level (FPL) based on gross income.~~

~~Total cost-sharing for each year (or 12-month eligibility period) is limited to: (1) for a family with an annual income equal to or less than 150% of the FPL, the lesser of (a) 2.5% of a family's income, and (b) $180.00; and (2) for a family with an annual income greater than 150% of the FPL, the lesser of (a) 5% of a family's income, and (b) $350.00.~~

~~The co-payment and coinsurance maximums are set at thresholds that are well below the maximum allowable per CMS for families with annual incomes equal to or below 150% of FPL and for those with annual incomes above 150% of FPL. The maximum yearly co-payment limit for families in FAMIS with annual incomes at or below 150% FPL is $180.00 per year. Families enrolled in FAMIS and receiving benefits through FAMIS contracted health plans are advised of the amount of maximum allowable cost-sharing that they may be responsible for during the year. Families are required to submit documentation to DMAS or its contractor, showing that the co-payment cap is met for the year. Once the cap is met, DMAS or its contractor will issue a new card excluding families from paying additional co-pays.~~

~~Enrollees are not held liable for any additional costs, beyond the standard co-payment amount, for emergency services furnished outside of the individual's managed care network. Only one co-payment charge is imposed for a single office visit.~~

~~The proposed cost sharing caps to be applied toward copayments and/or coinsurance ($180 and $350) were included in the Plan document.~~

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

~~Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:~~

~~COVID-19 Vaccine:~~

- ~~The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(c)(2) of the Act.~~

~~COVID-19 Testing:~~

- ~~The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(c)(2) of the Act.~~

~~COVID-19 Treatment:~~

- ~~The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section~~

~~2103(e)(11)(B) and 2103(e)(2) of the Act.~~

~~Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:~~

- ~~The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(e)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.~~

8.2.4. Other

None.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(A)) (42 CFR 457.505(b))

~~The public is notified of FAMIS' cost-sharing requirements, including differences based on income and plans, in the outreach and enrollment materials including:~~

- ~~The DMAS and Cover Virginia websites;~~
- ~~FAMIS Member Handbook;~~
- ~~Managed care organization member handbooks; and~~
- ~~Outreach grantees.~~
- ~~The public also has the opportunity to become involved during the regulatory process. Implementing regulations must go through a mandatory 60-day comment period consistent with the Code of Virginia.~~
- ~~The Children's Health Insurance Program Advisory Committee (CHIPAC) provides an opportunity for public education and input.~~

~~Effective April 15, 2002, Virginia temporarily suspended premiums until further notice. FAMIS families were notified by letter, informing them of the suspension of premiums and copies of such letters were posted on the DMAS web site. Effective September 1, 2002, the FAMIS program no longer charges premiums.~~

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☐☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☐☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3. ☐☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☐☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☐☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐☒ Yes (Specify: inpatient, emergency, pharmacy)

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health

plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☒ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☒ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☒ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical

benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐☒ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

~~8.5.~~ Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

~~8.6.~~8.5.

~~**Virginia has structured the cost sharing levels to make it highly unlikely that any family will exceed the allowable cost sharing.**~~

~~**Virginia ensures that the annual aggregate cost sharing for all FAMIS enrollees in a family does not exceed 5% of a family's income as required by §2103(e)(3)(b) of Title XXI. Co-payments are capped at levels that are extremely unlikely to exceed the upper limit. Total cost-sharing for each year (or 12-month eligibility period) is limited to: for a family with an annual income equal to or less than 150% of the FPL, the lesser of (a) 2.5% of a family's income or (b) $180; and for a family with an annual income greater than 150% of FPL, the lesser of (c) 5% of the family's income or (d) $350. In 2018, the federal poverty level for a family of one is $12,140: 5% of that amount is $607 and 2.5% of that amount is $304. Virginia's cost-sharing caps are well below these amounts and are designed not to exceed 2.5% or 5% of a family's income, respectively.**~~

~~As mentioned earlier, families under the Secretary-approved coverage offered through the fee-for-service program are not subject to any cost-sharing.~~

~~Families are required to submit documentation to DMAS or its contractor, showing that the co-payment limit is met for the year. Once the cap is met, the managed care organization will issue a new card excluding families from paying additional co-pays.~~

~~Finally, Title XXI requires that cost-sharing for families with incomes below 150 percent of FPL not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The maximum co-payment for a service costing over $50 is $3 under Medicaid law and was established in 1978. Virginia's co-payment for families under 150% of FPL is $2, which is well below the $3 federal cap.~~

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

~~No cost-sharing will be charged to American Indians and Alaska Natives. The application form requests information regarding race, ethnicity, and AI/AN status on each child for whom application for child health insurance is made. The applicant's statement on the application form is sufficient to exempt an AI/AN child from any cost-sharing obligations. The FAMIS automated eligibility determination system codes the case records for children listed on the application form as Alaska Natives or American Indians and the automated record will exempt such children from any cost-sharing obligations.~~

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

~~Not applicable.~~

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect

to payment of premiums. (Section 2103(e)(3)(C)) ~~Virginia's program does not have premiums.~~

8.7.1.1. ☐☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☐☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☐☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☐☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

Abortion only if necessary to save the life of the mother.

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

CHIP Budget Plan

	Federal Fiscal Year Costs – FFY 2022
Enhanced FMAP rate	**69.34%**
Benefit Costs	
Insurance payments	
Managed care	$391,161,620
per member/per month rate @ # of eligible	$197.67 @ 164,903 avg elig/mo
Fee for Service	$75,484,543
Cost of Proposed SPA changes	0
Total Benefit Costs	**$466,646,163**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$466,646,163**
Administration Costs	
Personnel	$3,622,107
General administration	$116,252
Contractors/Brokers (e.g., enrollment contractors)	$16,562,021
Claims Processing	$2,745,791
Outreach/marketing costs	$451,314
Health Services Initiatives	$5,950,173
Other	
Total Administration Costs	**$29,447,657**
10% Administrative Cap	$51,849,574
Federal Share (multiplied by enh-FMAP rate)	$343,991,455
State Share	$152,102,365
TOTAL PROGRAM COSTS	**$496,093,820**

Funding:

State funding comes from state General Funds and the Family Access to Medical Insurance Security (FAMIS) Plan Trust Fund.

The 1997 General Assembly established the Virginia Children's Medical Security Insurance Plan (CMSIP) Trust Fund in anticipation that a children's health insurance

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For coverage of ambulance services, the following three conditions must be met: (a) The trip to the facility or office must be to the nearest one recognized by the health plan administrator as having services adequate to treat the condition; (b) The services received in that facility or provider's office are covered services; and (c) If the health plan administrator requests it, the attending provider must explain why transportation could not occur in a private car or by any other less expensive means.

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Section 8. Cost Sharing and Payment (Section 2103(e))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☐ Yes
8.1.2. ☒ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

None. Effective April 15, 2002, Virginia temporarily suspended premiums. Effective September 1, 2002, the FAMIS program permanently removed premiums.

8.2.2. Deductibles:

None.

8.2.3. Coinsurance or copayments:

Co-payments are removed for all FAMIS populations effective July 1, 2022.

8.2.4. Other

None.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(A)) (42 CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3. ☐ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☐ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the

State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify: inpatient, emergency, pharmacy)

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same

type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☐ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

Abortion only if necessary to save the life of the mother.

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

CHIP Budget Plan

	Federal Fiscal Year Costs – FFY 2022
Enhanced FMAP rate	**69.34%**
Benefit Costs	
Insurance payments	
Managed care	$391,161,620
per member/per month rate @ # of eligible	$197.67 @ 164,903 avg elig/mo
Fee for Service	$75,484,543
Cost of Proposed SPA changes	0
Total Benefit Costs	**$466,646,163**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$466,646,163**
Administration Costs	
Personnel	$3,622,107
General administration	$116,252
Contractors/Brokers (e.g., enrollment contractors)	$16,562,021
Claims Processing	$2,745,791
Outreach/marketing costs	$451,314
Health Services Initiatives	$5,950,173
Other	
Total Administration Costs	**$29,447,657**
10% Administrative Cap	$51,849,574
Federal Share (multiplied by enh-FMAP rate)	$343,991,455
State Share	$152,102,365
TOTAL PROGRAM COSTS	**$496,093,820**

Funding:

State funding comes from state General Funds and the Family Access to Medical Insurance Security (FAMIS) Plan Trust Fund.

The 1997 General Assembly established the Virginia Children's Medical Security Insurance Plan (CMSIP) Trust Fund in anticipation that a children's health insurance