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State/Territory Name: Virginia

State Plan Amendment (SPA) #: VA-18-0012

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Children and Adults Health Programs Group

May 10, 2021

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-18-0012 submitted on June 27, 2018 with additional information provided on April 22, 2021, has been approved. This amendment proposes to demonstrate compliance with the Mental Health Parity and Addiction Equity Act. This SPA has an effective date of July 1, 2017, except for the changes noted below.

Through this SPA, Virginia implements mental health parity requirements to ensure that treatment limitations and financial requirements applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that financial requirements (FRs) and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of section 2705(a) of the Public Health Service Act, in the same manner that such requirements apply to a group health plan. The state provided the necessary assurances and supporting documentation that the state's application of FRs, quantitative treatment limits (QTLs), and non-quantitative treatment limitations to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

The state took the following actions to come into compliance with parity regulations, which have effective dates that vary from the overall effective date of the SPA:

- Removal of FRs applicable to outpatient MH/SUD benefits, effective July 1, 2019,
- Revisions to state regulations to remove all QTLs applicable to MH/SUD benefits, effective March 5, 2020, and
- Updates to provider manuals related to removing FRs and QTLs, which will be effective no later than August 2021.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Page 2 - Ms. Cindy Olson

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 Amy
Lutzky/

Amy Lutzky
Deputy Director

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Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101(a)(1)); (42 CFR 457.70):

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

1.1.2 Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

1.1.3 A combination of both of the above. (Section 2101(a)(2))

Effective 09/01/02.

1.2 Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan Effective Date: 10/26/98; Implementation Date: 10/26/98

Amendment Effective Dates: Amend. 1: 07/01/01. Amend. 2: 12/01/01. Amend. 3: 7/01/01. Amend. 4: 09/01/02. Amend. 5: 08/01/03. Amend. 6: Withdrawn.

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Amend. 7: delete ESHI premium assistance program and exempt pregnant children from waiting period 08/01/05; allow for disease management in fee-for-service program 07/01/06. Amend. 8: Changes to the CHIP State Plan to outline coverage of school services and to add language regarding private funding. Amend. 9: FAMIS MOMS to 200% FPL and MCO opt in 07/01/09; Medicaid Expansion Immigrants 04/01/09. Amend. 10: Translation for Dental Care 07/01/09; Hospice Concurrent with Treatment 03/23/10; Early Intervention and prospective payment for FQHCs and RHCs 10/01/09; Citizenship Documentation 01/01/10; Mental Health Parity and No Cost Sharing for Pregnancy-Related Assistance 07/01/10. Amend. 11: Administrative Renewal Process 10/01/10; Virginia Health Care Fund 07/01/10. Amend. 16: Behavioral Therapies added 07/01/16. Amend. 17: Temporary Adjustments to Enrollment and Redetermination for Individuals Living or Working in a Declared Disaster Area at the Time of a Disaster Event 01/01/17.

Amendment Implementation Dates: Amend. 1: 08/01/01; Amend. 2: 12/01/01; Amend. 3: 12/01/01; Amend. 4: 09/01/02; Amend. 5: 08/01/03; Amend. 6: Withdrawn; Amend. 7: 07/01/06; Amend. 8: 07/01/07, and 02/14/09 implementation date of language regarding the RWJ Grant funding and private funding; Amend. 9: 07/01/09, and Medicaid Expansion Immigrants: 04/01/09; Amend. 10: Translation for Dental Care: 07/01/09; Hospice Concurrent with Treatment: 03/23/10; Early Intervention and prospective payment for FQHCs and RHCs: 10/01/09; Citizenship Documentation: 01/01/10; and Mental Health Parity, No Cost Sharing for Pregnancy-Related Assistance, and Virginia Health Care Fund: 07/01/10. Amend. 11: Administrative Renewal Process: 10/01/10; and Virginia Health Care Fund: 07/01/10. Amend. 12: Discontinue primary care case management: 05/01/12; Expand eligibility under lawfully residing option: 07/01/12; Add coverage for early intervention case management: 10/01/11; and Discontinue Virginia Health Care Fund funding: 07/01/12. Amend. 13: Outreach Procedures 07/01/12; and Performance Plan: 07/01/12. Amend. 14: Delivery system change (Sec. 6 and 12) Behavioral Health Service Administrator: 01/01/14. Amend. 16: Behavioral Therapies 07/01/16. Amend. 17: Temporary Adjustments to Enrollment and Redetermination for Individuals Living or Working in a Declared Disaster Area at the Time of a Disaster Event 01/01/17.

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Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-13-15 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
VA-14-0020 Effective/Implementation Date: January 1, 2015		CS13	Eligibility - Deemed Newborns	Incorporate under section 4.3
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
		CS10	Eligibility – Children Who Have Access to Public Employee Coverage	Supersedes language in regard to dependents of public employees in Section 4.1.9
VA-14-0002 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
VA-14-0025 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within subsection 4.4.1
VA-13-0018 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
VA-13-19 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR

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Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-13-19-01 Effective/Implementation Date: July 3, 2014		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9
		CS23	Other Eligibility Standards	Supersedes the current section 4,1.6, 4.1.7, 4.1.8, 4.1.9
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4

SPA #15

Purpose of SPA: Update for SFY 2015

Effective date: 07/01/14

Implementation dates:

Remove waiting period for eligibility: 07/03/14; Allow eligibility for dependents of state employees: 01/01/15

SPA #16

Purpose of SPA: Update for SFY 2016

Effective date: 07/01/15

Implementation date:

Benefits - add Behavioral Therapy services: 07/01/16

SPA #17

Purpose of SPA: Temporary Adjustments to Enrollment and Redetermination for Individuals Living or Working in a Declared Disaster Area at the Time of a Disaster Event.

Effective date and implementation date: 01/01/17

SPA #VA-17-0012

Purpose of SPA: Update for SFY 2017

Effective date: 7/1/16

SUD amendments (not including peer supports) have an implementation date of 04/01/17.

All other items (including peer supports) have an implementation date of 07/01/17.

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SPA #VA-18-0012

Purpose of SPA: Compliance with Mental Health Parity and Addiction Equity Act - Proposed effective and implementation date: 07/01/17;

Removal of Outpatient Behavioral Health Co-payments - Proposed effective and implementation date 07/01/19

SPA #VA-19-0010

Purpose of SPA: Update for SFY 2019; Managed Care Final Rule Compliance Assurances; Technical Updates

Effective and implementation date: 07/01/18

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2110(a)(9))

Maternity service including routine prenatal care is covered. Pre-pregnancy family services include coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives. Contraceptive drugs and devices eligible for reimbursement are oral contraceptives, Depo-Provera, cervical caps, diaphragms, intrauterine devices and transdermal implants.

- 6.2.10.** Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services. (Section 2110(a)(10))

Inpatient acute mental health services other than those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services.

Effective 07-01-10, medically necessary inpatient mental health services are covered for 365 days per confinement.

- 6.2.11.** Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

Effective 07-01-10, medically necessary outpatient mental health services (including, but not limited to those listed below) are covered without limitations.

A. Outpatient mental health services, other than services furnished in a state-operated mental hospital.

B. Effective 08-01-2003, the following community mental health services are covered under this state plan.

1. Intensive in-home services to children and adolescents under age 19 - shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment, individual and family

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counseling, and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.

2. **Therapeutic day treatment** - provides evaluation, medication, education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy. The service shall be provided two or more hours per day in order to provide therapeutic interventions. One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

3. **Crisis Intervention** - Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. A unit equals 15 minutes and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

4. **Case Management** - Case management services for youth at risk of serious emotional disturbance and who meet the definition of Seriously Emotionally Disturbed. Case management services assist youth at risk of serious emotional disturbance and with a diagnosis of Serious Emotional Disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include: Assessment and planning, linking the individual directly to services and supports, assisting the individual directly for the purpose of

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locating, developing or obtaining needed service and resources, coordinating services and service planning, enhancing community integration, making collateral contacts, follow up and monitoring, and education and counseling.

5. Behavioral Therapies - As of 07-01-16, behavioral therapies are covered. Behavioral therapies are systematic interventions provided by licensed practitioners, within their scope of practice defined under state law or regulations, to individuals younger than 19 years of age, usually in the individual's home. Behavioral therapy includes, but is not limited to, applied behavior analysis. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual's family is trained to effectively manage the individual's behavior in the home and community settings using behavioral modification strategies. Behavioral therapy services must be preauthorized and based on a medical necessity determination.

C. Peer Support Services - As of 07-01-17 peer support services are covered. Peer Support Services extend existing comprehensive behavioral health and substance use treatment services to help facilitate recovery from even the most serious mental health and substance use disorders. Peer support providers are self-identified individuals who are in successful and ongoing recovery from mental health and/or substance use disorders. Peer support providers shall be sufficiently trained and certified to deliver services. Peer Support Services are delivered by peers (trained/certified individuals with lived experience with mental health and/or substance use disorders) who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an individual's community to support and assist a member with staying engaged in the recovery process. A Peer Support service called Family Support Partners shall be provided to individuals under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their caregiver.

- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). (Section 2110(a)(12))

Durable medical equipment, prosthetic devices, hearing aids, and

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eyeglasses are covered when medically necessary with certain limitations.

- 6.2.13.** Disposable medical supplies. (Section 2110(a)(13))

Medically necessary disposable medical supplies provided in an inpatient or outpatient setting are covered.

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

- 6.2.14.** Home and community-based health care services (Section 2110(a)(14))

Includes coverage of up to 90 visits per calendar year. Includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy.

- 6.2.15.** Nursing care services (Section 2110(a)(15))

Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations.

- 6.2.16.** Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2110(a)(16))

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

- 6.2.17.** Dental services (Section 2110(a)(17))

Coverage includes diagnostic, preventive, primary, prosthetic and complex restorative services. Coverage does not include routine bases under restorations.

Coverage shall include full-banded orthodontics and related services to correct abnormal and correctable malocclusion for enrollees. Post-treatment stabilization retainers and follow-up visits are included in the orthodontic services. Effective 12/1/02, the benefit limits for orthodontic services increased to mirror

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of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare.

C. Emergency hospital services provided without limitation.

D. Coverage of outpatient observation beds. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient precertification and admission.

6.2.3.A Physician services (Section 2110(a)(3))

A. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function. Elective and cosmetic surgical procedures are not covered unless performed for physiological reasons and require prior approval by DMAS.

B. Routine physicals and immunizations are not covered except when the services are provided under the EPSDT Program and when a well child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

C. Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 19 years of age when the need for such services has been identified through an EPSDT screen.

D. Physician visits to inpatient hospital patients are limited to medically necessary days of inpatient hospitalization.

E. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine.

F. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions.

G. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Experimental or investigational procedures are not covered.

6.2.4.A Surgical services (Section 2110(a)(4))

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including community-based services (Section 2110(a)(11))

Effective 07-01-10, medically necessary outpatient mental health services (including, but not limited to those listed below) are covered without limitations. Outpatient mental health services are managed by the contracted BHSA.

Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, medically necessary psychiatric services shall be covered for individuals younger than 19 year of age when the need for such services has been identified through an EPSDT screen.

Community Mental Health Services:

1. Intensive in-home services to children and adolescents under age 19

- Shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child.

These services provide crisis treatment, individual and family counseling, and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the residence with the child present.

2. Therapeutic day treatment for children and adolescents - Provides evaluation, medication, education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy. The service shall be provided two or more hours per day in order to provide therapeutic interventions. One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

3. Day Treatment / Partial Hospitalization - Day treatment / partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These

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services include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.

4. **Psychosocial Rehabilitation** - Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

5. **Crisis Intervention** - Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. A unit equals 15 minutes and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

6. **Mental Health Crisis Stabilization** - Crisis stabilization services for non-hospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation.

7. **Mental Health Support** - Mental health support services shall be defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services may be authorized for six consecutive months. This program shall provides the following services: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

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8. Intensive Community Treatment - Medical psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community.

9. Case Management - Case management services for youth at risk of serious emotional disturbance and who meet the definition of Seriously Emotionally Disturbed. Case management services assist youth at risk of serious emotional disturbance and with a diagnosis of Serious Emotional Disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include: Assessment and planning, linking the individual directly to services and supports, assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources, coordinating services and service planning, enhancing community integration, making collateral contacts, follow up and monitoring, and education and counseling.

10. Behavioral Therapies - As of 07-01-16, behavioral therapies are covered. Behavioral therapies are systematic interventions provided by licensed practitioners within their scope of practice, defined under state law or regulations, to individuals younger than 19 years of age, usually in the individual's home. Behavioral therapy includes, but is not limited to, applied behavior analysis. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual's family is trained to effectively manage the individual's behavior in the home and community settings using behavioral modification strategies. Behavioral therapy services must be preauthorized and based on a medical necessity determination.

6.2.12.A Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

Durable medical equipment, hearing aids, and eyeglasses are covered when medically necessary with certain limitations. Prosthetic devices for the replacement of missing arms, legs and breasts and the provision of any internal (implant) body part shall be covered.

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6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

International Classification of Disease (ICD)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

State guidelines

Other (Describe): Conditions noted in ICD-10-CM, Chapter 5, “Mental, Behavioral, and Neurodevelopmental Disorders” are classified under MH/SUD with the following exceptions: The conditions listed in subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09) are categorized as MED/SURG; the conditions listed in subchapter 8, “Intellectual disabilities” (F70 to F79) are categorized as MED/SURG; and the conditions listed in subchapter 9, “Pervasive and specific developmental disorders” (F80-F89) are categorized as MED/SURG.

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

Yes

No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

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Yes

No

FAMIS children access the EPSDT benefit during the time they are temporarily in fee-for-service prior to being enrolled in a MCO. FAMIS children in managed care do not receive the EPSDT benefit; therefore DMAS is not seeking deemed parity on the basis of EPSDT for its separate CHIP population.

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

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All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

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All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

Inpatient: All covered services or items (including medications) provided to a member when a physician (or other qualified provider as applicable) has written an order/certification for a >24-hour admission to a facility.

Outpatient: All covered services or items (including medications) provided to a member in a setting that does not require a physician (or other qualified provider as applicable) order/certification for a >24-hour admission, and does not meet the definition of emergency care.

Emergency Care: All covered services or items (including medications) provided in an

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emergency department setting or to stabilize an emergency/crisis, when provided in a setting other than an inpatient setting.

Pharmacy/Prescription Drugs: Covered medications, drugs, and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

6.2.3.1.1 MHPAEA The State assures that:

The State has classified all benefits covered under the State plan into one of the four classifications.

The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

Yes

No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

Mental health / substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

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Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii)).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit: _____)

No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on any mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on any mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

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6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).

The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits (457.496(c)(3)).

- The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state’s methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit

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on any mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on any mental health or substance use disorder benefits (§457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with §§457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

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Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify: _____)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (§457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the

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State applies QTLs to mental health or substance use disorder benefits.
(§457.496(d)(3)(i)(E))

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

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

Yes

No

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

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in §457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in §457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

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

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is

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no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification.
(§457.496(d)(2)(i))

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

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

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Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

- The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- State
- Managed Care entities
- Both**

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both**

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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 until further notice. Effective September 1, 2002, the FAMIS program no longer charges premiums.

8.2.2. Deductibles:

None.

8.2.3. Coinsurance or copayments:

Co-payments shall not be imposed on any of the children covered under

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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.

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

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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.

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.

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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)) **Not applicable.**

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

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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

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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))

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.