DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

DEC 3 0 2013

Ms. Rebecca Mendoza, MA
Director, Division of Maternal and Child Health
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Mendoza:

Virginia's request to amend its existing section 1115 demonstration project, entitled the "FAMIS MOMS and FAMIS *Select*," (Project No. 21-W-00058/3), submitted June 26, 2013, has been approved by the Centers for Medicare & Medicaid Services (CMS). This amendment approval is effective January 1, 2014.

This demonstration currently covers uninsured pregnant women, including those pregnant women lawfully residing, with income up to and including 200 percent of the federal poverty level (FPL), under the *FAMIS MOMS* program. In addition, this demonstration provides uninsured children in families with income from 133 percent up to and including 200 percent of the FPL with the option to elect Children's Health Insurance Program (CHIP) coverage through employer-sponsored insurance under a premium assistance delivery system model under the *FAMIS Select* program.

Under this demonstration amendment, the Commonwealth will begin to phase out the FAMIS MOMS program on January 1, 2014. New applications for pregnant women in FAMIS MOMS will not be accepted after December 31, 2013. Pregnant women enrolled in FAMIS MOMS on or prior to December 31, 2013, will retain eligibility for the duration of their coverage period, including up to 60 days post-partum. Any application received for pregnancy coverage on or after January 1, 2014, will be evaluated for Medicaid and Marketplace coverage according to federal rules.

As specified in the expenditure authority under Demonstration Population 1, Virginia will continue to receive title XXI funds for pregnant women in *FAMIS MOMS* from January 1, 2014 until December 31, 2014. This permits the Commonwealth to continue to claim title XXI funds for coverage of pregnant women during the phase out of the program. Under existing approval, Virginia will continue to have authority to cover children under a premium assistance delivery model in *FAMIS Select* through June 30, 2016.

Our approval of this demonstration amendment is subject to the limitations specified in the enclosed approved waiver authority, special terms and conditions (STCs), and title XXI requirements not applicable. These documents specify the agreement between the Virginia Department of Medical Assistance Services and CMS. The Commonwealth may deviate from the Medicaid and the Children's Health Insurance Program (CHIP) state plan requirements only to the extent those

requirements have been specifically listed as waived. All requirements of the CHIP and Medicaid programs as expressed in law, regulation, and policy statement not expressly identified as waived in the waiver authorities shall apply to the FAMIS MOMS and FAMIS *Select* demonstration.

This approval is also conditioned upon compliance with the enclosed STCs which set forth in detail the nature, character, and extent of federal involvement in this demonstration and the Commonwealth's obligations to CMS. This award letter is subject to our receipt of your written acceptance of the award, including the waiver authorities and the STCs, within 30 days of the date of this letter.

Your title XXI project officer is Ms. Ticia Jones, who may be reached at (410) 786-8145 and through email at Ticia.Jones@cms.hhs.gov. Ms. Jones is available to answer any questions concerning your section 1115 demonstration and other CHIP-related issues. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Jones at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-0 1-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communication regarding program matters should be submitted simultaneously to Ms. Jones and Mr. Francis McCullough, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS Philadelphia Regional Office. Mr. McCullough's contact information is as follows:

Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Division of Medicaid and Children's Health Operations
The Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, P A 191 06

We appreciate your cooperation throughout the review process, and look forward to successful implementation of this demonstration. If you have additional questions, please contact Mr. Eliot Fishman, Director of the Children and Adults Health Programs Group within the Center for Medicaid and CHIP Services, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Cindy Mann
Director

Enclosures

cc: Mr. Francis McCullough, ARA, Philadelphia Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AUTHORITIES

NUMBER: **21-W-00058/3 (Title XXI)**

TITLE: **Virginia FAMIS MOMS and FAMIS *Select* Section 1115 Demonstration**

AWARDEE: **Virginia Department of Medical Assistance Services**

Costs Not Otherwise Matchable Authority

All requirements of the Medicaid and Children's Health Insurance Program (CHIP) programs not identified as not applicable in this list, shall apply to the demonstration expenditures listed below. These requirements apply to Demonstration Population 1 until December 31, 2014, and to Demonstration Population II from the period beginning July 1, 2013, through June 30, 2016.

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which are not otherwise included as expenditures under section 1903 or section 2107(e)(2)(A) shall, for the period of this demonstration in accordance with the Special Terms and Conditions (STCs), be regarded as matchable expenditures under the state's title XXI plan:

- **Demonstration Population I**: Until December 31, 2014, expenditures for extending health insurance coverage through the CHIP program for those uninsured pregnant women with incomes up to and including 200 percent of the Federal Poverty Level (FPL), including lawfully residing pregnant women. Coverage for this population will be applicable only for periods when Medicaid coverage of lawfully residing pregnant women is also in effect.
- **Demonstration Population II:** Expenditures for extending health insurance coverage for those children, with family incomes from 133 percent up to and including 200 percent of the FPL, who are eligible for Virginia's title XXI Separate child health assistance program and not eligible under the Medicaid State plan, who choose premium assistance under the FAMIS *Select* demonstration.

For these populations, all CHIP and Medicaid rules not expressly waived or identified as not applicable shall apply.

The following title XXI requirements are not applicable for the Virginia FAMIS MOMS and FAMIS *Select* section 1115 demonstration.

Title XXI Requirements Not Applicable to Demonstration Populations I and II.

1. General Requirements, Eligibility and Outreach **Section 2102**

The Commonwealth's Child Health Insurance Plan (CHIP) does not have to reflect the demonstration populations, and eligibility standards do not have to be limited by the general principles in section 2102(b) of the Act. To the extent other requirements in section 2102 of the Act duplicate Medicaid or other CHIP requirements for these or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration populations do not include individuals otherwise eligible for Medicaid.

2. Cost Sharing **Section 2103(e)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration population 2 to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored insurance plans.

3. Cost-Sharing Exemption for American Indian/ Alaskan Native (AI/AN) Children **Section 2102(b)(3)(D) 42 CFR Section 457.535**

To the extent necessary to permit the Commonwealth to impose cost sharing on AI/AN children who elect to enroll in the premium assistance program.

4. Benefit Package Requirements **Section 2103**

To permit the Commonwealth to offer a benefit package that does not meet the requirements of section 2103 at 42 CFR section 457.4 10(b)(1) for the demonstration populations.

5. Federal Matching Payment and Family Coverage Limits **Section 2105**

Federal matching payment in excess of the 10-percent cap for expenditures related to the demonstration population and limits on family coverage are not applicable to the demonstration population.

Waiver Authority

Under the authority of section 1115(a) of the Act, the following exceptions to Medicaid and CHIP requirements are granted:

Newborn deeming **Section 1902(a)(46) and 2102(b)(2)**

To enable the Commonwealth to consider children who are born to individuals eligible under the demonstration as pregnant women on the date of the child's birth, or eligible targeted low-income children under the approved State plan on the date of the child's birth, to have applied and been determined otherwise eligible for Medicaid or CHIP, as appropriate, on the date of birth, and to remain eligible until attaining the age of 1, unless, after a reasonable opportunity period, the Agency fails to obtain evidence to satisfy satisfactory documentation of citizenship under 42 CFR 435.407(c)(1) and (2) and

identity under 42 CFR 435.407(e) and (f). This does not permit waivers of either section 1903(x) of the Act or section 2105(c) which requires States to obtain satisfactory documentary evidence of citizenship or nationality during the reasonable opportunity period for individuals in Medicaid or CHIP.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

AWARDEE: Virginia Department of Medical Assistance Services

DEMONSTRATION NUMBER: No. 21-W-00058/3

TITLE: FAMIS MOMS and FAMIS *Select*

I. PREFACE

The following are STCs for the Virginia FAMIS MOMS and FAMIS *Select* programs, a Children's Health Insurance Program section 1115 demonstration. The parties to this agreement are the Virginia Department of Medical Services (Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the Commonwealth's obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration renewal is approved for the period of July 1, 2013 through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits; Cost Sharing; Program Design; General Financial Requirements for demonstration populations 1 and 2.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the CMS Central Office Project Officer and the Associate Regional Administrator at the addresses shown on the award letter.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Virginia FAMIS MOMS and FAMIS *Select* demonstration was initially approved on June 30, 2005, and implemented August 1, 2005. The demonstration provides coverage for uninsured children through age 18, and services to pregnant women without creditable coverage in families with incomes through 200 percent of the federal poverty level (FPL). Coverage of lawfully residing pregnant women shall be consistent with the guidance set forth in the State Health Official letter (SHO #10-006) dated 07/01/2010. Coverage for this population will be applicable only for periods when Medicaid coverage of lawfully residing pregnant women is also in effect. Effective October 1, 2013, the Commonwealth has amended its FAMIS MOMS and FAMIS *Select* waiver program to use the modified adjusted gross income (MAGI)-based methodology in eligibility determinations for all new applications received through December 31, 2013. The

Commonwealth will continue to provide health care benefits that are identical to those provided to pregnant women under the Medicaid state plan.

Beginning January 1, 2014, Virginia's Title XXI waiver is amended to phase out the FAMIS MOMS program. New applications for FAMIS MOMS will not be accepted after December 31, 2013. Women enrolled in FAMIS MOMS on or prior to December 31, 2013, shall retain eligibility for the duration of their coverage period. Any application received for pregnancy coverage on or after January 1, 2014, will be screened for Medicaid under pregnant women eligibility. If the applicant's income is above 143 percent of the FPL, the application will be evaluated for Federally Facilitated Marketplace (FFM) coverage under federal rules.

The authority under this demonstration for Virginia to continue to receive title XXI funds for FAMIS MOMS enrollees will expire December 31, 2014.

Effective July 1, 2010, Virginia began deeming infants born to FAMIS children and FAMIS MOMS eligible for Medicaid or CHIP coverage, as appropriate. These infants are deemed eligible on the date of birth and remain eligible until attaining the age of 1, unless, after a reasonable opportunity period, the Agency fails to obtain evidence to satisfy satisfactory documentation of citizenship under 42 CFR 435.407(c)(1) and (2), and identity under 42 CFR 435.407(e) and (f).

The FAMIS *Select* premium assistance program will continue with no changes. Wrap-around coverage will continue to be provided for immunizations only.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The Commonwealth must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the Commonwealth must adopt, subject to CMS approval, an allotment neutrality agreement for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

   b) If mandated changes in the federal law require Commonwealth legislation, the changes must take effect on the day such Commonwealth legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The Commonwealth must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the Commonwealth, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

   b) An up-to-date CHIP allotment neutrality worksheet;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) If applicable, a description of how the evaluation's design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** No later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the demonstration extension request, the Commonwealth must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

9. **Demonstration Summary and Objectives:** The Commonwealth must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

10. **Special Terms and Conditions (STCs):** The Commonwealth must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

11. **Waiver and Expenditure Authorities:** The Commonwealth must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

12. **Quality:** The Commonwealth must provide summaries of External Quality Review Organization reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

13. **Draft Report with Evaluation Status and Findings**: The Commonwealth must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

14. **Demonstration Phase-Out.** The Commonwealth may suspend or terminate this demonstration in whole, or in part, at any time prior to the date of expiration. The Commonwealth must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the Commonwealth elects to phase out the demonstration, the Commonwealth must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out

activities. Consistent with the enrollment limitation requirement in paragraph ten, a phase-out plan shall not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the Commonwealth, FFP shall be limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

15. **Enrollment Limitation During Demonstration Phase-Out.** If the Commonwealth elects to suspend, terminate, or not renew this demonstration as described in paragraph nine, during the last 6 months of the demonstration, individuals who would not be eligible for Medicaid or CHIP under the current Medicaid or CHIP state plan must not be enrolled unless the demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the Commonwealth in writing that the demonstration will not be renewed.

16. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the Commonwealth has materially failed to comply with the terms of the project. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the suspension or termination, together with the effective date.

17. **Finding of Non-Compliance.** The Commonwealth does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

18. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and XXI. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the Commonwealth an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

19. **Adequacy of Infrastructure.** The Commonwealth must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

20. **Public Notice and Tribal Consultation, and Consultation with Interested Parties.** Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must continue to comply with the State Notice Procedures set forth in 59 Fed.

Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the Commonwealth. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this demonstration. In the event that the Commonwealth conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.

21. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. GENERAL REPORTING REQUIREMENTS

22. **Quarterly and Monthly Enrollment Reports.** Each quarter the Commonwealth will continue to provide CMS with an enrollment report, by demonstration population, which shows the end of the quarter actual and unduplicated ever-enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. In addition, the Commonwealth will provide monthly enrollment data in the written report format agreed to by CMS and the Commonwealth.

23. **Monitoring Calls.** CMS and the Commonwealth will hold monthly monitoring calls to discuss issues associated with the continued operation of the demonstration.

24. **Annual Reports.** The Commonwealth must continue to submit an annual report documenting accomplishments; budget updates; quantitative and any case-study findings; policy and administrative issues; and, progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses no later than 6 months after the end of its operational year. Within 30 days of receipt of comments from CMS, the Commonwealth shall submit a final annual report.

25. **Final Report.** No later than 3 months after the end of the demonstration, a draft final report must be submitted to CMS for comments. CMS' comments shall be taken into consideration by the Commonwealth for incorporation into the final report. CMS' document entitled, *Author's Guidelines: Grants and Contracts Final Reports* is available to the Commonwealth upon request. The final report is due no later than 90 days after the receipt of CMS' comments.

26. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the Commonwealth must submit a final

plan for the overall evaluation of the demonstration described in paragraph 3, within 60 days of receipt of CMS' comments. The Commonwealth must implement the evaluation design and report its progress in the quarterly reports. The Commonwealth must submit to CMS a draft evaluation report 120 days after the expiration of the current demonstration period. CMS shall provide comments within 60 days of receipt of the report. The Commonwealth must submit the final report no later than 60 days after the receipt of the comments from CMS.

V. ELIGIBILITY AND ENROLLMENT

27. **Screening for Medicaid.** Applicants for the demonstration will continue to be screened for Medicaid eligibility. Demonstration applicants eligible for Medicaid will be enrolled in Medicaid and receive the full Medicaid benefit package.

28. **Prenatal Coverage.** Beginning January 1, 2014, Virginia's Title XXI waiver is amended to phase out the FAMIS MOMS program. New applications for FAMIS MOMS will not be accepted after December 31, 2013. Women enrolled in FAMIS MOMS on or prior to December 31, 2013, shall retain eligibility for the duration of their coverage period. Any application received for pregnancy coverage on or after January 1, 2014, will be screened for Medicaid under pregnant women eligibility. If the applicant's income is above 143 percent of the FPL, the application will be evaluated for FFM coverage under federal rules.

29. **Enrollment in Premium Assistance.** CMS has given approval through this demonstration renewal for children eligible for Virginia's Separate CHIP program and not eligible under the Medicaid state plan as of March 31, 1997, to continue to choose to receive coverage through premium assistance for private or employer-sponsored insurance. Such enrollment is to be voluntary and based on informed choice regarding all implications of choosing premium assistance, including the possibility of reduced benefits and increased cost sharing, and that the title XXI cost-sharing limit of 5 percent on annual, aggregate cost sharing will not apply. Virginia will ensure that enrollees are annually notified that they may choose direct coverage at any time. In the case of title XXI-eligible children, Virginia will inform families that all age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) are covered. Families will continue to be told that this coverage is a factor to consider in choosing private or employer-sponsored insurance. The Commonwealth shall provide information as to where children may receive immunizations and well-baby and well-child services in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled. In the case of title XXI eligibles, whose employer or private insurance does not include immunizations, the Commonwealth has an established mechanism in effect to reimburse providers for the cost of immunizations.

30. **Enrollment Limits.** There is no enrollment cap for FAMIS MOMS and FAMIS *Select*. Enrollment in a private- or employer-sponsored plan is voluntary and the

child may continue to elect to switch to direct Commonwealth coverage at any time.

VI. BENEFITS

31. **Prenatal Coverage.** CMS has extended its approval of the FAMIS MOMS benefit package as outlined in attachment C of the demonstration proposal as the Medicaid prenatal benefit package. If changes are made in the benefit package, the Commonwealth must submit the proposed change to CMS for review and approval before modifications can be implemented by the Commonwealth.

32. **Premium Assistance.** For children who choose to receive coverage through premium assistance, CMS has extended its approval of the benefit packages available through the private or employer-sponsored insurance company as the benefit package to be delivered. (Refer to the discussion in V. 28. Concerning immunizations and well-baby and well-child services.)

33. **Cost Effectiveness.** Consistent with 2105(c)(3) of the Social Security Act, cost-effectiveness for the purchase of employer-sponsored insurance shall be determined relative to the amount of expenditures (determined on an individual or aggregate basis) under the state child health plan, including administrative expenditures, that the state would have made to provide comparable coverage to the targeted low-income child or family involved (as applicable).

VII. COST SHARING

34. **Prenatal Coverage.** The cost-sharing requirements for the FAMIS MOMS demonstration are consistent with those described in the title XIX state plan, with cost-sharing limits consistent with those described in the title XXI state plan. There are no premiums or enrollment fees. However, copayments will continue to apply to services that are not pregnancy-related and were approved as specified in Attachment E of the demonstration proposal.

35. **Premium Assistance.** For children who choose to receive coverage through premium assistance, cost-sharing requirements will continue to be set by their private or employer-based coverage.

VIII. PROGRAM DESIGN

36. **Concurrent Operation.** The Commonwealth's title XXI state plan, as approved, will continue to operate concurrently with this section 1115 demonstration.

37. **Maintenance of Coverage and Enrollment Standards for Children**

a) The Commonwealth shall, throughout the course of the demonstration renewal, include a review of enrollment data to provide evidence that children are not denied

enrollment and continue to s how that it has continued procedures to enroll and retain eligible children for CHIP.

b) The Commonwealth's established monitoring process ensures that expenditures for the renewal will not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriate state match.

The Commonwealth may also, for demonstration population 1, which is eligible for continued coverage during the 3-year renewal period only by virtue of the demonstration:

- Lower the federal poverty level used to determine eligibility, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS FOR DEMONSTRATION POPULATIONS 1 AND 2

In order to continue to track title XXI expenditures under this demonstration, the Commonwealth reports demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual. title XXI demonstration expenditures will continue to be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the state will continue to be required to identify the program code and coverage (children or adults).

37. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the Commonwealth must continue to identify separately, on the Form CMS-21, net expenditures related to dates of service during the operation of the demonstration.

38. The standard CHIP funding process will continue to be used during the demonstration. Virginia will continue to estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the Commonwealth provides updated estimates of expenditures for the demonstration population. CMS will continue to make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the Commonwealth, and include the reconciling adjustment in the finalization of the grant award to the Commonwealth.

39. The Commonwealth will continue to certify Commonwealth/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

40. Virginia continues to be subject to a limit on the amount of federal title XXI funding that it may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the Commonwealth's available allotment, including currently available reallocated funds.

Should the Commonwealth expend its available title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the approved title XXI separate child health program or demonstration until the next allotment becomes available.

41. Total federal title XXI funds for the Commonwealth's CHIP program (i.e., the approved title XXI state plan and this demonstration renewal) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the state plan population. Demonstration expenditures are limited to remaining funds.

42. Total expenditures for outreach and other reasonable costs to administer the title XXI state plan and the demonstration renewal that are applied against the Commonwealth's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

43. If the Commonwealth exhausts the available title XXI federal funds in a federal fiscal year during the renewal period of the demonstration, the Commonwealth will continue to provide coverage to the approved title XXI state plan separate child health program population and the demonstration population(s) with Commonwealth funds.

44. All federal rules shall continue to apply during the period of the demonstration that state or title XXI federal funds are not available. The Commonwealth is not precluded from closing enrollment or instituting a waiting list with respect to the demonstration populations. Before closing enrollment or instituting a waiting list, the Commonwealth will provide a 60-day notice to CMS.

ATTACHMENT C

(Benefit Package Description)

FAMIS MOMS:

Duration of Coverage – Women with family income between 133 and 200 percent of the FPL will be eligible for comprehensive health benefits for the duration of their pregnancy and for sixty days after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Covered Services – Women enrolled in FAMIS MOMS will receive the same package of benefits as provided to pregnant women covered by Virginia's Medicaid program.

Service Delivery System – Health care services will be delivered primarily through one of the Managed Care Organizations contracted by DMAS to provide Medicaid and FAMIS benefits. The five MCOs currently under contract to DMAS cover 104 of the 135 localities in Virginia. In those areas of the state where there is no contracted MCO, primarily in the far southwest part of Virginia, health care benefits will be provided on a fee-for-service basis.

FAMIS *Premium*:

Duration of Coverage – Children enrolled in FAMIS are guaranteed 12 months of coverage. Children receiving premium assistance and enrolled in an employer's health plan or a private insurance plan will likewise be guaranteed 12 months of coverage. The premium assistance will continue as long as the child remains enrolled in the private plan, the family chooses to participate in FAMIS *Premium*, the child resides in the Commonwealth of Virginia, and the family income remains below 200 percent of the FPL. If the family chooses to drop employer coverage for the child and requests coverage through FAMIS, the child will be enrolled in the direct coverage program FAMIS for the remaining months of the 12-month coverage period. Eligibility for FAMIS *Premium* will be re-determined every 12 months.

Covered Services – The specific benefit package and co-pay requirements will vary dependent on the employer/private plan and may or may not meet regulatory requirements for cost-sharing and benchmark-equivalency. However, it should be noted that Virginia insurance law, through a variety of mandated benefits requirements, provides for a fairly rich benefit package for all insurance plans licensed in the Commonwealth. Moreover, DMAS administrative records indicate that to date each of the employer sponsored health insurance plans submitted by families in conjunction with their application for its ESHI program met or exceeded regulatory requirements for benchmark equivalency.

Wrap-around or supplemental coverage will be offered by the state only as necessary for childhood immunizations.

Immunizations – Immunizations are the only wrap-around benefit to be included in FAMIS *Premium*. Because of mandated benefits described above, it is anticipated that very few children in FAMIS *Premium* will not have coverage for immunizations through private/employer plans. However, as a fail-safe measure, children in FAMIS *Premium* will be issued a FAMIS ID card to be used for any immunizations covered by FAMIS but not covered by their employer-sponsored

or other health insurance plan. Use of this card will allow the State to use Title XXI funds to reimburse providers directly at the state rate for any immunizations provided to FAMIS *Premium* children. Like other children covered through SCHIP, children enrolled in FAMIS *Premium* will not qualify for the Vaccines for Children Program. However, all local health departments are Medicaid/FAMIS providers and therefore a child in FAMIS *Premium* could use the FAMIS ID card to receive immunizations at these sites or from any participating provider.

Service Delivery System – The service delivery system utilized by the employer's health plan will provide benefits to children enrolled in FAMIS *Premium*. In this way, some children covered under Title XXI will have access to health care providers outside of the Medicaid provider network. Based on conversations with callers interested in premium assistance, it is believed that some families will choose FAMIS *Premium* over FAMIS because it will allow their child access to a particular specialist or health care network.