Table of Contents

State Name: Virginia

State Plan Amendment (SPA) #: 18-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street
Suite 9400
Philadelphia, Pennsylvania 19107

Region III/Division of Medicaid and Children's Health Operations

SWIFT #060820184012

September 5, 2018

Dr. Jennifer S. Lee
600 East Broad Street
Suite 1300
Richmond, VA 23219

Dear Dr. Lee:

We have reviewed Virginia's proposed Federal Medical Assistance Payment (FMAP) State Plan Amendment (SPA), 18-007, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 7, 2018. This SPA describes the methodology used by the state for determining the appropriate FMAP rates, including the increased FMAP rates, available under the provisions of the Affordable Care Act applicable for the medical assistance expenditures under the Medicaid program associated with enrollees in the new adult group adopted by the state and described in Title 42 of the Code of Federal Regulations (CFR) §435.119.

Based on the information provided, Virginia SPA 18-007 is approved with an effective date of January 1, 2019. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have any additional questions or need further assistance, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-007

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 435

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 0
b. FFY 2020 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: New pages: Supplement 18 to Attachment 2.6A, Pages ~~1-7~~ Pages 1-6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: Medicaid Expansion - FMAP Claiming

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2019
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted] /S/

13. TYPED NAME: Jennifer S. Lee, M.D.

14. TITLE: Director

15. DATE SUBMITTED: 6/7/18

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 7, 2018

18. DATE APPROVED: September 5, 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS

06/08/2018 Section 8 Pen and Ink change correction Page numbers are 1-6 as confirmed by Emily McClellan.

Instructions on Back

Save

State Plan Under Title XIX of the Social Security Act

Virginia

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP

RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 02/11/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	**Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan.**	**No**	**No**	**No**	**No**
Disabled Persons, non-institutionalized	**Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan.**	**No**	**No**	**No**	**No**
Disabled Persons, institutionalized	**Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan.**	**No**	**No**	**No**	**No**
Children Age 19 or 20	**Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan**	**No**	**No**	**No**	**No**
Childless Adults	**Attachment A, Column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan.**	**No**	**No**	**No**	**No**

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ☒ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ☒ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

Attachment A: Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan**

VIRGINIA

2/11/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives**			no	new SIPP conversion	SIPP
	Dollar standards by family size					
	1	*	$270			
	2	*	$390			
	3	*	$491			
	4	*	$611			
	5	*	$693			
	6	*	$779			
	7	*	$873			
	8	*	$973			
	add-on	$72.53	$96			
2	**Noninstitutionalized Disabled Persons** FPL %	80%	82%	n/a	new SIPP conversion	SIPP
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	**Children Age 19-20**	n/a	n/a	n/a	n/a	n/a
5	**Childless Adults**	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable.

* The converted standards for medically needy parents/caretaker relatives are a weighted average of three regional standards. The original add-on amount is identical across the three regions.

**The contents of this table will be updated automatically in case of modifications to the CMS and approved MAGI Conversion Plan

Attachment E: Transition Methodologies

The Virginia Department of Medical Assistance Services (DMAS) is committed to making a smooth transition of coverage for those enrolled in two limited benefit Medicaid programs, Plan First and the Governor's Access Plan (GAP). All individuals currently enrolled in GAP and many individuals currently enrolled in Plan First will be eligible for full Medicaid upon expansion of eligibility to individuals with incomes up to 133 percent of the federal poverty level (FPL).

Plan First

Plan First is Virginia's limited benefit family planning program. The Plan First program uses MAGI to determine eligibility for the program, and it covers individuals with incomes at or below 200 percent of the federal poverty limit. The program provides its enrollees with an annual physical exam for family planning purposes, which includes a PAP test (if appropriate) and sexually transmitted infection (STI) screening; family planning education and counseling; birth control methods provided by a clinician or obtained with a prescription; sterilizations for individuals over age 21 (if chosen by the enrollee); and non-emergency transportation to family planning services. Plan First covers only these family planning services – it does not cover any other acute medical or behavioral health services. Individuals enrolled in Plan First are served with a fee-for-service (FFS) model.

A large proportion of those individuals currently enrolled in Plan First will be eligible for full Medicaid benefits upon expansion.

The Virginia Department of Social Services (VDSS) eligibility and enrollment system, the Virginia Case Management System (VaCMS) contains MAGI-based household income data for each Plan First enrollee from their most recent eligibility determination. DSS would use this most recent eligibility determination information to administratively transfer individuals identified as eligible for expanded Medicaid to a new aid category established for expansion enrollees with expansion coverage beginning on January 1, 2019. Once expansion coverage begins on January 1, 2019, enhanced FMAP will be claimed only for expenses associated with individuals enrolled in the new expansion aid categories. Individuals remaining in the Plan First aid categories will continue to have FMAP claimed for their expenditures at the applicable FMAP rates (90% for family planning services, 50% for any other services).

Medicaid enrollees will be sent a consumer notice informing them of the change in covered benefits under the new adult group and who to contact with any questions.

Governor's Access Plan (GAP)

GAP is a section 1115 demonstration waiver that provides limited benefits to individuals who have a household income at or below 100% FPL and have a diagnosis of a serious mental illness (SMI). GAP covers mental health and substance use disorder services, medical doctor visits, prescription drugs, access to a 24-hour crisis line, recovery navigation services, and case management. GAP does not cover most inpatient services or Emergency Department services. Individuals enrolled in GAP are served with a FFS model. These individuals are identified by their aid category in the DMAS' CHAMPS system. Aid category 087 is a unique aid category

that is only applied to individuals enrolled in the GAP program. As a result of the GAP program's eligibility criteria, all individuals enrolled in GAP will be eligible for full Medicaid benefits upon expansion. All GAP enrollees will be converted to the VDSS VaCMS system and administratively transferred to a new aid category established for expansion enrollees with expansion coverage beginning on January 1, 2019. Once expansion coverage begins on January 1, 2019, enhanced FMAP will be claimed for expenses associated with individuals enrolled in the new expansion aid categories.

Medicaid enrollees will be sent a consumer notice informing them of the change in covered benefits under the new adult group and who to contact with any questions.