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

April 3, 2015

Rebecca Mendoza, M.A.
Director, Maternal & Child Health Division
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 December 22, 2014, has been approved by the Centers for Medicare & Medicaid Services (CMS). This amendment affects only the *FAMIS MOMS* component of the demonstration, which provides coverage for uninsured pregnant women lawfully residing in the United States, with income from 143 of the federal poverty level (FPL) up to and including 200 percent of the FPL. In addition, children born to FAMIS MOMS enrollees are deemed eligible for Medicaid or CHIP coverage, as appropriate, until attaining age one. The effective date of this amendment is April 3, 2015

This amendment expands coverage for FAMIS MOMS to include pregnant women with access to state employee's health benefit coverage in accordance with the hardship exception specified in section 2110(b)(6)(C) of the Social Security Act; thereby aligning with the Commonwealth's coverage of pregnant women with the expansion of CHIP coverage to children of state employees effective January 1, 2015. This amendment also provides comprehensive dental services to pregnant women age 21 and over in FAMIS MOMS, who currently receive emergency dental services only. With the exception of orthodontia, dental coverage will now include a range of type of services, including: diagnostic and preventive, restorative, endodontics, and periodontics. This change is part of the Governor's initiative to improve access to oral health care for pregnant women enrolled in both Medicaid and FAMIS MOMS. With the exception of orthodontia, dental coverage for pregnant women in Medicaid and FAMIS MOMS will be identical to the dental coverage children received in Medicaid and CHIP.

This amendment does not affect the FAMIS *Select* component of the demonstration. The FAMIS Select program provides uninsured children in families with income from 143 percent up to and including 200 percent of the FPL with the option to elect CHIP coverage through employer-sponsored insurance under a premium assistance delivery system model.

This demonstration authorizes waivers of requirements and authority for expenditures under title XXI of the Act, which sets out the federal framework for CHIP. Our approval of this demonstration amendment is subject to the limitations specified in the enclosed approved waiver authorities, expenditure authorities, special terms and conditions (STCs), and list of title XXI requirements not

applicable to the expenditure authorities. These documents specify the agreement between the Virginia Department of Medical Assistance Services and CMS. The Commonwealth may deviate from the Medicaid and 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, Ms. Ticia Jones, 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 (ARA) 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, PA 19106

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,

/s/

Vikki Wachino
Acting Director

Enclosures

cc:
Mr. Francis McCullough, ARA, CMS Region III

CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AND WAIVER 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**

Pursuant to section 1115 of the Social Security Act (the Act), CMS is granting the following list of waiver and expenditure authorities to promote the Children's Health Insurance Program (CHIP) objective of increasing and strengthening overall coverage of low-income individuals in the Commonwealth of Virginia. Specifically, these waiver and expenditure authorities allows Virginia to carry out its objectives of expanding title XXI coverage to uninsured pregnant women through the FAMIS MOMS program and providing health insurance premium assistance through the FAMIS *Select* program.

Costs Not Otherwise Matchable Authority

All requirements of the Medicaid and CHIP programs not identified as not applicable in this list, shall apply to the demonstration expenditures listed below for the period beginning April 3, 2015 through June 30, 2016. These authorities supersede any prior authorities for this demonstration as of April 3, 2015.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the Commonwealth 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, be regarded as matchable expenditures under the state's title XXI plan:

Demonstration Population I: Expenditures for extending health insurance coverage through the CHIP program for uninsured pregnant women from 143 of the federal poverty level (FPL) up to and including 200 percent of the FPL, lawfully residing in the United States. Coverage for this population will be applicable only for periods when Medicaid coverage of lawfully residing pregnant women is also in effect. Effective April 3, 2015, FAMIS MOMS coverage is expanded to include pregnant women with income from 143 percent of the FPL up to and including 200 percent of the FPL with access to state employee's health benefit coverage in accordance with the hardship exception provided in section 2110(b)(6)(C) of the Act.

Demonstration Population II: Expenditures for extending health insurance coverage for those children, with family income from 143 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 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 (Al/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)

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

TITLE: FAMIS MOMS and FAMIS *Select*

AWARDEE: Virginia Department of Medical Assistance Services

I. PREFACE

The following are Special Terms and Conditions (STCs) for the Virginia FAMIS MOMS and FAMIS *Select* programs, a Children's Health Insurance Program (CHIP) 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 FAMIS MOMS (demonstration population 1) and FAMIS *Select* (demonstration population 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

***Current Status*:** The FAMIS MOMS component of the demonstration provides coverage for pregnant women without creditable coverage in families with income up to and including 200 percent of the federal poverty level (FPL). Coverage of lawfully residing pregnant women shall be consistent with the guidance set forth in the CMS 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 April 3, 2015, FAMIS MOMS coverage is expanded to include pregnant women with income from 143 of the FPL up to and including 200 percent of the FPL with access to state employee's health benefit coverage, in accordance with the hardship exception as provided in section 2110(b)(6)(C) of the Social Security Act (the Act); thereby aligning with the Commonwealth's coverage of pregnant women with the expansion of CHIP coverage to children of state employees, which was effective January 1, 2015. FAMIS MOMS coverage is the same as that provided to pregnant women under the Medicaid state plan. Under the demonstration, Virginia is also authorized to

deem infants born to FAMIS MOMS to be 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 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* program provides uninsured children in families with income from 143 percent up to and including 200 percent of the FPL, who would otherwise be eligible for direct CHIP coverage, with the option to elect to receive only premium assistance for employer-sponsored insurance and supplemental immunization benefits.

Historical Background: The Virginia FAMIS MOMS and FAMIS Select demonstration was initially approved on June 30, 2005, and implemented August 1, 2005.

Effective October 1, 2013, the Commonwealth amended the demonstration to use the modified adjusted gross income (MAGI)-based methodology in eligibility determinations for all new applications.

Prior to January 1, 2014, the income eligibility threshold for the FAMIS MOMS program was 210 percent of the FPL. During the period January 1, 2014 through November 30, 2014, the FAMIS MOMS component of this title XXI demonstration was phased-out because the Virginia General Assembly adopted an amendment to the Commonwealth's biennial budget directing the Commonwealth to phase out and eliminate the FAMIS MOMS program when health insurance coverage under the Federally Facilitated Marketplace (FFM) became available on January 1, 2014. New applications for FAMIS MOMS coverage were not accepted after December 31, 2013. However, women enrolled in FAMIS MOMS on or prior to December 31, 2013 retained eligibility for the duration of their coverage period. Any application received for pregnancy coverage beginning January 1, 2014 through November 30, 2014, was screened for Medicaid under pregnant women eligibility and for CHIP. If the applicant was ineligible for Medicaid or CHIP, the application was transferred to the FFM. Beginning on December 1, 2014, enrollment was reopened and new applications accepted for uninsured pregnant women with income up to and including 200 percent of the FPL. This income eligibility threshold aligns with children's coverage levels under the CHIP program.

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 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. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

    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, a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified allotment neutrality worksheet will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state 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 is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to demonstration features, such as eligibility, enrollment, enrollee rights, delivery systems, benefits, evaluation design, cost sharing, sources of non-federal share of funding, 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 or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. 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 STC 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. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. *Public Notice.* The Commonwealth does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues policy guidance to the contrary. However CMS encourages the state to do so in the event it seeks to amend the demonstration that modifies benefits, cost sharing, eligibility, or delivery system changes. CMS will post and accept public comments on all amendments;

    b. *Tribal Consultation Requirements*. If applicable, the Commonwealth must provide documentation of compliance with the tribal consultation requirements outlined in STC 15. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input;

    c. *Demonstration Amendment Summary and Objectives.* The Commonwealth must provide a detailed description of the amendment, including what Virginia intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary;

    d. *Waiver and Expenditure Authorities.* The Commonwealth must provide a list waivers and expenditure authorities that are being requested or terminated, along with the reason, need and the citation along with the programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

    e. *Allotment Neutrality Worksheet.* The Commonwealth must provide an up-to-date CHIP (title XXI funding) allotment neutrality worksheet that identifies the impact of the proposed amendment on the Commonwealth's available title XXI allotment.

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

As part of the demonstration extension request, the Commonwealth must provide documentation of compliance with the transparency requirements at 42 CFR §431.408 and 412 and the public notice requirements outlined in STC 15.

The demonstration extension request must include the following supporting documentation:

a. *Demonstration Summary and Objectives.* The Commonwealth must provide a historical narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was approved, provide evidence of how these objectives have been met, and future goals of the program.

b. *Changes to Demonstration Design*. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

c. *Special Terms and Conditions.* 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.

d. *Waiver and Expenditure Authorities*. The Commonwealth must provide a list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration

e. *Quality***.** The Commonwealth must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

f. *Financial Data*. Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

g. *Evaluation Report.* The Commonwealth must provide an evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

h. *Compliance with Public Notice Process*. Documentation of the Commonwealth's compliance with the public notice process set forth in §431.408 of this subpart, including the post-award public input process described in §431.420(c) of this

subpart, with a report of the issues raised by the public during the comment period and how the Commonwealth considered the comments when developing the demonstration extension application.

Temporary Extension of Demonstration. Upon application from the state or CMS determination that a temporary extension of the demonstration is necessary, CMS will temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. Demonstration Phase-Out. The Commonwealth may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. *Notification of Suspension or Termination.* The Commonwealth must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

b. *Transition and Phase-out Plan.* The Commonwealth must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. *Transition and Phase-out Plan Requirements*. The Commonwealth must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.

d. *Phase-out Procedures*. The Commonwealth must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain

benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

e. *Exemption from Public Notice Procedures 42.CFR Section 431.416(g).* CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

f. *Federal financial participation (FFP).* If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Enrollment Limitation during Demonstration Phase-Out. If the Commonwealth elects to suspend, terminate, or not renew this demonstration as described in STC 9, 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.

11. CMS Right to Amend, Terminate or Suspend. CMS may amend, 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.

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

13. 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.

14. 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.

15. **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 7, 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.

16. **Federal financial participation (FFP).** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the list of waiver or expenditure authorities.

IV. GENERAL REPORTING REQUIREMENTS

17. **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.

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

19. **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.

20. **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.

21. 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

22. FAMIS MOMS eligibility. Effective April 3, 2015, FAMIS MOMS coverage is expanded to include pregnant women with income from 143 of the FPL up to and including 200 percent of the FPL with access to state employee's health benefit coverage in accordance with the hardship exception as provided in section 2110(b)(6)(C) of the Act; thereby aligning with the Commonwealth's coverage of pregnant women to the expansion of CHIP coverage to children of state employees, which was effective January 1, 2015.

The Commonwealth is establishing a dedicated unit within the Cover Virginia call center to assist state employees with an assessment of eligibility for FAMIS and FAMIS MOMS. Immediately prior to and coinciding with the state employee's open enrollment period, the prospective FAMIS MOMS enrollee will receive assistance with completing an application and written notice of projected eligibility, and the FAMIS MOMS application will be pended. If the prospective FAMIS MOMS enrollee decides to drop state employee health coverage for the upcoming plan year, the FAMIS MOMS applicant will be required to provide the Cover Virginia call center with an attestation that the applicant has terminated state employee's coverage and the FAMIS MOMS's applicant's eligibility determination will be finalized. Loss of eligibility under a government sponsored health plan, including FAMIS and FAMIS MOMS is a qualifying mid-year event for state employees. Therefore, during the FAMIS MOMS 60-day postpartum coverage period, the woman will be able to enroll in the state employee health plan.

23. 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.

24. FAMIS *Select* Premium Assistance Enrollment. Children eligible for Virginia's Separate CHIP program and not eligible under the Medicaid state plan as of March 31, 1997, may elect to enroll in FAMIS Select and receive CHIP benefits limited to premium assistance for private or employer-sponsored insurance and immunization benefits. 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 CHIP 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.

25. **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

26. **FAMIS MOMS Coverage**. FAMIS MOMS receive the same benefits as pregnant women under the approved Medicaid state plan. Effective April 3, 2015, Virginia provides comprehensive dental services to pregnant women age 21 and over in FAMIS MOMS. Please see Attachment A for a detailed list of the dental benefits.

    If changes are made in the benefit package, the Commonwealth must submit the proposed change to CMS for review and approval, as outlined in STC 7, before modifications can be implemented by the Commonwealth.

27. **FAMIS *Select* Premium Assistance**. For children who choose to receive premium assistance for employer sponsored insurance, benefits are limited to premium assistance and immunizations, as described in STC 24.

28. **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

29. **FAMIS MOMS Coverage.** The cost-sharing requirements for the FAMIS MOMS demonstration are consistent with those described in the title XIX 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 B of the demonstration proposal.

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

VIII. PROGRAM DESIGN

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

32. Maintenance of Coverage and Enrollment Standards for Children. 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 show that it has continued procedures to enroll and retain eligible children for CHIP.

a. 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.

b. 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.

IX. GENERAL FINANCIAL REQUIREMENTS

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).

33. Claiming Period. 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.

34. **Standard CHIP Funding Process**. 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.

35. **Sources of Non-Federal Share**. The Commonwealth must certify that the matching non-federal shares of funds for the demonstration are state/local monies. Virginia further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The Commonwealth agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the Commonwealth to provide information to CMS regarding all sources of the non-federal share of funding.

36. **Title XXI Limits.** 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.

37. **Administrative Costs**. 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.

38. **Risk.** 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.

39. Enrollment Limits. 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 written notice to CMS.

ATTACHMENT A.

(Benefit Package Description)

FAMIS MOMS:

Duration of Coverage – Women with family income between 143 and 200 percent of the FPL (expansion population) 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. Effective April 3, 2015, pregnant women enrolled in FAMIS MOMS who are 21 years of age and older are eligible to receive comprehensive dental benefits, excluding orthodontics, covered by the ***Smiles for Children*** program. Dental benefits for pregnant women who are 21 years of age and older will be discontinued at the end of the month following their 60th day postpartum. Covered dental services include:

- ☐ Diagnostic (x-rays, exams);
- ☐ Preventive (cleanings);
- ☐ Restorative (fillings);
- ☐ Endodontics (root canals);
- ☐ Periodontics (gum related treatment);
- ☐ Prosthodontics- both removable and fixed (crowns, bridges, partials and dentures);
- ☐ Oral surgery (extractions and other oral surgeries); and
- ☐ Adjunctive general services (all covered services that do not fall into specific dental categories).

Service Delivery System – Health care services will be delivered primarily through one of the Managed Care Organizations (MCO) contracted by DMAS to provide Medicaid and FAMIS benefits. Initially, benefits are provided on a fee-for-service basis until the woman is enrolled in an MCO. Dental services are provided by the contracted ***Smiles for Children*** service provider, DentaQuest.

FAMIS *Select*:

The proposed amendment makes no changes to the FAMIS *Select* program.

ATTACHMENT B.

Cost-sharing Limits for Expansion Populations

FAMIS MOMS: *(Pregnant women from 143-200 % FPL)* Cost-sharing limits for pregnant women enrolled in FAMIS MOMS will be the same as cost-sharing limits in place for children enrolled in FAMIS. There are no monthly premiums or annual enrollment fees associated with participation in FAMIS.

Co-payments for services received by FAMIS MOMS will be identical to co-payments required of pregnant women covered by Medicaid. By policy, there are no co-payments required for pregnancy related services or for medical conditions that may complicate the pregnancy, including dental services. Also, it is a contractual requirement that Managed Care Organization (MCO) not charge pregnant women co-payments for any services. Therefore, the only co-payments that may be charged to a pregnant woman receiving services through Medicaid or FAMIS MOMS would be for non-pregnancy related services delivered through fee-for-service. It is estimated that approximately 90% of all enrollees in FAMIS MOMS will be enrolled in an MCO. Regardless of the delivery system for medical care, all dental services are delivered through DentaQuest.

FAMIS *Select*:
The proposed amendment makes no changes to the FAMIS *Select* program.