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

Children and Adults Health Programs Group

July 26, 2022

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

Dear Ms. Olson:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs) VA-20-0015, submitted June 30, 2020, with additional information received on July 20, 2022, and VA-22-0011, submitted on June 7, 2022 have been approved. VA-20-0015 was effective on October 24, 2019. The effective dates for VA-22-0011 are described below.

Through VA-20-0015, Virginia has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that behavioral health services be delivered in a culturally and linguistically appropriate manner. Virginia demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Virginia is making several new behavioral health services available in CHIP through VA-22-0011. Effective July 1, 2021, the state added intensive outpatient services, partial hospitalization, and assertive community treatment to its CHIP state plan. Effective December 1, 2021, Virginia also added crisis stabilization, multi-systemic therapy, and functional family therapy to its CHIP state plan.

VA-22-0011 also makes technical updates in section 4 of the CHIP state plan to include an updated hardship exception analysis for coverage of children of state employees and in section 9 to reflect updates to the strategic objectives and performance goals.

Your Project Officer is Ms. Ticia Jones. She is available to answer your questions concerning this amendment and other CHIP-related matters. Ms. Jones' contact information is as follows:

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

Sincerely,

Amy Lutzky
Deputy Director

SPA #VA-18-0012
Purpose of SPA: Compliance with Mental Health Parity and Addiction Equity Act - Effective and implementation date 07/01/17;
Removal of Outpatient Behavioral Health Co-payments – Effective and implementation date: 07/01/19

SPA #VA-19-0010
Purpose of SPA: Update for SFY 2019; Managed Care Final Rule Compliance Assurances; Technical Updates
Effective and implementation date: 07/01/18

SPA #VA-20-0001
Purpose of SPA: CHIP Disaster Relief – Temporary Waiver of Co-payments; Flexibilities Related to Processing and Renewal Requirements for State or Federally Declared Disaster Area
Effective date: 01/01/2020
Implementation date: 03/12/2020

SPA #VA-20-0015
Purpose of SPA: Update for SFY2020; SUPPORT Act Section 5022 Compliance
Effective and implementation date: 10/24/19

SPA #VA-21-0010
Purpose of SPA: Health Services Initiative – Poison Control Centers
Effective and implementation date: 7/1/21

SPA #VA-21-0027
Purpose of SPA: Extend coverage for unborn children whose mothers are uninsured pregnant women up to 200% FPL not otherwise eligible for Medicaid, FAMIS MOMS, or FAMIS, regardless of immigration status requirements; Fund a Health Services Initiative to provide fee-for-service health services up to 60 days postpartum to mothers covered under the unborn child option, called FAMIS Prenatal.
Effective and implementation date: 07/01/21

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

On May 29, 2020, a Tribal notification letter was sent to representatives of each of Virginia's seven federally recognized Indian Tribes, as well as to contacts at

the newly established Indian Health Program (IHP) office, describing the provisions of CHIP SPA #VA-20-0015 and notifying Tribal and IHP leadership of the 30-day Tribal comment period. Tribal members and IHP contacts were invited to provide input on the SPA, and contact information was provided for submitting any comments to DMAS. There was no formal response by Tribal or IHP officials regarding this CHIP SPA. Virginia does not anticipate that this SPA will have a direct impact on the Tribes or IHP.

As of January 1, 2015, dependents of state employees able to access employer-sponsored dependent health insurance coverage under a Virginia state employee health insurance plan are eligible to enroll in FAMIS, if they otherwise qualify. See approved template effective January 1, 2015: CS10 (Eligibility – Children Who Have Access to Public Employee Coverage). The Commonwealth performed an analysis of public employee coverage costs for 2019-20~~2018-19~~, and confirms that the previously approved Hardship Exception still applies. See attachment, Hardship Exception Analysis 2019-20 ~~2018-19~~.

See approved templates effective January 1, 2014: CS13 (Eligibility - Deemed Newborns); CS19 (Non Financial - Social Security Number); and CS23 (Other Eligibility Standards).

Effective July 1, 2021, the Commonwealth provides coverage through the unborn child option for uninsured pregnant women with income up to and including 200% FPL who are not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of immigration status requirements. The household for this coverage will be based on the pregnant woman, and the "unborn child" or children will be counted as if born and living with the mother in determining household size.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

Please see approved template effective January 1, 2014: CS19 (Non-Financial - Social Security Number).

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility

See SPA page CS27 for a description of continuous eligibility for the unborn child population (i.e., FAMIS Prenatal).

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☒ Other (Describe)

Secretary-approved coverage through a modified Title XIX look-alike (a fee-for-service component) is the coverage~~delivery system~~ provided for newly eligible children on a temporary basis until they are enrolled in a MCO.

Secretary-approved coverage modeled after the state employee plan is the~~provides~~ coverage ~~using~~ provided for children enrolled in managed care. This plan is modeled after the Key Advantage Plan, which was~~. This plan is~~ the PPO option for state employees ~~that was~~ offered statewide in June 2000. Section 6.2 of the State Child Health Plan has been amended on occasion after its initial establishment to include additional benefits, beyond those originally offered in the 2000 Key Advantage Plan, for FAMIS children in managed care.~~Several enhanced benefits are added to the plan. The services under the Key Advantage Member Handbook are briefly outlined in the checklist in § 6.2. The enhanced benefits that are provided in addition to the Key Advantage Plan are listed at the end of this checklist. This coverage is provided for children enrolled in a MCO.~~

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR 457.490)

If the state elects to cover the new option of targeted low-income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)

COVERED SERVICES FOR FAMIS CHILDREN

The FAMIS program has two separate health care services delivery systems and benefit packages.

Newly enrolled children initially receive coverage in fee-for-service (FFS) on a temporary basis prior to enrollment in a managed care organization (MCO). During this period, FAMIS children receive the same benefits as the Medicaid state plan, including the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

FAMIS children enrolled in managed care receive Secretary-approved coverage modeled after the state employee benefit plan in effect in June 2000, Virginia's Key Advantage State Employee Benefit Plan. Benefits offered under the managed care plans are, is summarized in the checklist below (6.2.1 - 6.2.31). ~~The additional coverage provided is listed separately at the bottom of the checklist.~~

Behavioral health benefits are summarized separately in 6.2.1-BH – 6.2.31-BH, pursuant to the SUPPORT Act.

~~NOTE: The FAMIS program has two separate health care services delivery systems, described immediately below and at 6.2.1.A – 6.2.31.A.~~

COVERED SERVICES FOR FAMIS PRENATAL (UNBORN CHILD POPULATION)

Effective July 1, 2021, Virginia provides coverage through the unborn child option for uninsured pregnant persons in households with income up to 200% FPL not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of the pregnant individual's immigration status. The FAMIS Prenatal program's coverage is the same as that provided under the FAMIS MOMS CHIP 1115 Demonstration, which reflects the Medicaid state plan covered benefits for pregnant women, with the exception of long-term services and supports (LTSS). Benefits to the "unborn child" population are delivered through the same delivery and utilization control systems as those used for FAMIS MOMS. Pregnant persons who are receiving services under FAMIS Prenatal on the basis of the "unborn child" shall continue to be eligible to receive services through the end of the month in which the 60th postpartum day occurs, regardless of any subsequent changes in household income. FAMIS Prenatal enrollees are not eligible for the FAMIS Select premium assistance program.

Through Virginia's Medicaid and CHIP managed care organizations (MCOs), DMAS utilizes bundled capitated payment arrangements for coverage of services including prenatal, labor and delivery, and postpartum services. Virginia considers all services delivered to the mother through managed care during the pregnancy through 60 days postpartum to support the health of the "unborn child" who at birth may be eligible as a targeted low-income child. Virginia's comprehensive maternal health benefits plan in Medicaid and CHIP is based on a recognition that beyond traditional limited prenatal and postpartum services, the new mother's access to full-scope health services substantially improves the newborn's access to health care. Adequately addressing the birthing person's health needs in the critical postpartum period is essential to supporting the newborn's physical, social, and emotional health.

Accordingly, DMAS claims CHIP federal financial participation (FFP) under this State Plan for managed care costs for the covered population through 60 days postpartum.

For FAMIS Prenatal participants who are not enrolled in managed care during the postpartum period, Virginia will utilize a Health Services Initiative as described in Section 2.2 to claim CHIP FFP for postpartum services paid through fee-for-service.

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

365 days per confinement; includes ancillary services.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

Outpatient services include emergency services, surgical services, and professional provider services in a physician's office or outpatient hospital department. Facility charge for outpatient department of a hospital or hospital emergency room, separate from physician or diagnostic services.

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

Physician services include services while admitted in the hospital, or in a physician's office, or outpatient hospital department.

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

Surgical services include services provided in Sections 6.2.1, 6.2.2,

and 6.2.3.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Clinic services include services provided in Sections 6.2.2 and 6.2.3.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

Covered for outpatient prescription drugs. Mandatory generic program.

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

Optional - May be covered at the discretion of the health plan.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

Outpatient diagnostic tests, x-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

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

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

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

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

~~**11.** ☒ Outpatient mental health services, other than services described in 6.2.19, but including services~~

~~furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)~~

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

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

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

~~1. Intensive in-home services to children and adolescents under age 19 - shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment, individual and family counseling, and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.~~

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

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

~~4. Case Management - Case management services for youth at risk of serious emotional disturbance and who meet the definition of Seriously Emotionally Disturbed. Case management services assist youth at risk of serious emotional disturbance and with a diagnosis of Serious Emotional Disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include: Assessment and planning, linking the individual directly to services and supports, assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources, coordinating services and service planning, enhancing community integration, making collateral contacts, follow up and monitoring, and education and counseling.~~

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

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

6.2.10~~12~~. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). (Section 2110(a)(12))

Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses are covered when medically necessary with certain limitations.

6.2.11~~13~~. ☒ Disposable medical supplies. (Section 2110(a)(13))

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

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

6.2.12~~14~~. ☒ Home and community-based health care services (Section 2110(a)(14))

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

6.2.13~~15~~. ☒ Nursing care services (Section 2110(a)(15))

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

6.2.14~~16~~. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2110(a)(16))

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

6.2.15~~17~~. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

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

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

6.2.16~~18~~. ☐ Vision screenings and services (Section 2110(a)(24))

6.2.1719. ☐ Hearing screenings and services (Section 2110(a)(24))

~~**6.2.20.** ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))~~

~~**Effective 7/1/10, medically necessary inpatient substance abuse treatment services are covered for 365 days per confinement. This coverage does not include services furnished in a state-operated mental hospital or in an IMD.**~~

~~**This coverage does not include residential services or other 24-hour therapeutically planned structural services.**~~

~~**6.2.21.** ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))~~

~~**As of 4/1/17, outpatient substance abuse treatment services include outpatient, intensive outpatient, partial hospitalization, medication-assisted treatment, and case management. Peer support services (as discussed in section 6.2.11 C) are effective 7/1/17. There is no visit limit on medically necessary outpatient substance abuse treatment services (effective 7/1/10).**~~

6.2.1822. ☒ Case management services (Section 2110(a)(20))

The State may elect to offer benefits for an approved, alternative treatment plan for a recipient who would otherwise require more expensive services. These services will be offered on a case-by-case basis. Effective October 1, 2011, targeted case management is provided by a certified Early Intervention Case Manager and reimbursed directly by DMAS for children from birth up to age three years who are in need of early intervention services.

6.2.1923. ☐ Care coordination services (Section 2110(a)(21))

6.2.2024. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Medically necessary services used to treat or promote recovery from an illness or injury are covered with limitations.

6.2.2125. ☒ Hospice care (Section 2110(a)(23))

Hospice services include a program of home and inpatient care provided directly under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services are available if the enrollee is diagnosed with a terminal illness with a life expectancy of six months or fewer. Effective 3/23/10, hospice care is available concurrently with care related to

the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.

Guidance: See guidance for section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.2226. ☐ EPSDT consistent with the requirements of sections 1905(r) and 1902(a)(43) of the Act.

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.2327. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

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

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

6.2.2428. ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))

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

6.2.2529. ☒ Medical transportation (Section 2110(a)(26))

Professional ambulance services under certain conditions are covered when used locally to or from a covered facility or provider's office. Ambulance services if prearranged by the Primary Care Physician and authorized by the Company if, because of enrollee's medical condition, the enrollee cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the enrollee's condition suddenly becomes worse and must go to a local hospital's emergency room.

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

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

6.2.2630. ☐ Enabling services (such as transportation, translation, and outreach services (Section 2110(a)(27))

6.2.2731. ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

Enhanced Services Provided Beyond Secretary-approved coverage modeled after the state employee plan:

The services described above are the services included in the Key Advantage State Employee Benefit Package in effect in June 2000. FAMIS Secretary-approved coverage modeled after the state employee plan will include all of the Key Advantage benefits plus the additional benefits listed below:

1. **Well-child care from age 6 through 18 including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization**

Practice (ACIP). (Well-child care from birth through age 5 is covered under Key Advantage.)

2. **The following services for special education students, when provided in a school setting pursuant to a student's Individualized Education Program (IEP), are covered under this State Plan: physical therapy, occupational therapy, and speech-language therapy; audiology; skilled nursing; psychiatric and psychological services; personal care; medical evaluations; and specialized transportation. Assessments are covered as necessary to determine special education and related services needed in the IEP. The Department of Medical Assistance Services (DMAS) reimburses Local Education Agencies (LEAs) directly for services provided pursuant to the IEP.**

3. **Blood lead testing.**

~~*Coverage offered for Secretary-approved coverage through the fee-for-service program is summarized in the checklist below.*~~

~~**6.2.1.A** ☒ Inpatient services (Section 2110(a)(1))~~

~~**A. Payment based upon DRG shall be made for medically necessary stays in acute general care facilities within the limits of coverage prescribed with the Title XIX State Plan and state regulations.**~~

~~**B. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all children within the limits of coverage prescribed in the Title XIX State Plan and state regulations.**~~

~~**C. Payment will not be made for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.**~~

~~**D. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services shall be limited to procedures that are not experimental. Transplants are covered when determined medically necessary and preauthorized.**~~

~~**E. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.**~~

~~**F. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be limited to 48 hours unless additional days are medically justified. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be limited to 24 hours unless additional days are medically justified.**~~

~~**6.2.2.A** ☒ Outpatient services (Section 2110(a)(2))~~

~~**A. Outpatient hospital means preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished to outpatients, by or under the direction of a physician or dentist, except in the case of nurse mid-wife services.**~~

~~**B. Are furnished by an institution that is licensed or formally approved by the Virginia Department of Health and except in the case**~~

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

~~C. Emergency hospital services provided without limitation.~~

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

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

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

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

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

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

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

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

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

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

~~A. Medical surgical services - Medically necessary surgical services are covered. Elective surgery is defined as procedures not medically necessary to restore or materially improve a body function. Elective and cosmetic surgical procedures are not covered unless performed for physiological reasons and require preauthorization.~~

~~B. See physician services above for organ transplantation. Breast reconstruction/prostheses following mastectomy and breast reduction may be covered if preauthorized following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized for all medically necessary indications. Such procedures shall be considered non-cosmetic.~~

~~6.2.5.A ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))~~

~~Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided to outpatients by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients and are furnished by or under the direction of a physician or dentist.~~

~~6.2.6.A ☒ Prescription drugs (Section 2110(a)(6))~~

~~A. Drugs for which Federal Financial Participation is not available pursuant to the requirements of §1927 of the Social Security Act shall not be covered. Legend drugs, with the exception of the drugs or classes of drugs provided for in Supplement 5 of the Medicaid State Plan are covered. Coverage of drugs used for weight loss requires prior authorization. Prescriptions for recipients for specific multiple source drugs shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies "brand necessary." The number of refills shall be limited pursuant to the Drug Control Act, *Code of Virginia* Title §54.1-3411.~~

~~B. Coverage includes home infusion therapy which is covered consistent with limits and requirements set out within home health services.~~

~~C. Effective June 1, 2004, pursuant to § 1927 of the Act and 42 CFR § 440.230, the Department shall require the prior authorization of legend drugs when both institutionalized and non-institutionalized FAMIS enrollees are prescribed high numbers of legend drugs. Over-~~

~~the-counter drugs and legend drug refills shall not count as a unique prescription for the purposes of prior authorization as it relates to the threshold program.~~

~~Prior authorization shall be required for non-institutionalized FAMIS enrollees whose current volume of prescriptions meet the identified threshold limits as defined by the agency's guidance documents for pharmacy utilization review, limitations, and the prior authorization program. All recipients subject to these prior authorization limits shall be given advance notice of such limits and shall be advised of their rights to appeal. Such appeals shall be considered and responded to pursuant to 12 VAC 30-110-10 et. seq.~~

~~Prior authorization shall consist of prospective and retrospective drug therapy review by a licensed pharmacist to ensure that all predetermined clinically appropriate criteria, as established by the department, have been met before the prescription may be dispensed. Prior authorization shall be obtained through a call center staffed with appropriate clinicians, or through written or electronic communications (e.g., faxes, mail). Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization shall be provided. The dispensing of 72-hour emergency supplies of the prescribed drug may be permitted and dispensing fees shall be paid to the pharmacy for such emergency supply.~~

~~Exclusion of protected institutions from pharmacy threshold prior authorization: For the purposes of threshold prior authorization, nursing facility residents do not include residents of the Commonwealth's mental retardation training centers. For the purposes of threshold prior authorization, non-institutionalized recipients do not include recipients of services at Hiram Davis Medical Center.~~

~~6.2.7.A ☒ Over-the-counter medications (Section 2110(a)(7))~~

~~Non-legend drugs shall be covered for insulin, syringes and needles, and diabetic test strips and family planning supplies. Designated non-legend drugs which are prescribed by licensed prescribers to be used as less expensive therapeutic alternatives to covered legend drugs are also covered. Designated categories of non-legend drugs for recipients in nursing homes are covered.~~

~~**6.2.8.A** ☒ Laboratory and radiological services (Section 2110(a)(8))~~

~~**Services must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.**~~

~~**Effective 08-01-03, prior authorization of the following specific high-cost non-emergency outpatient procedures is required: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) Scans and Positron Emission Tomography (PET) Scans.**~~

~~**6.2.9.A** ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))~~

~~**A. Family planning services and supplies for individuals of child-bearing age must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts. Family planning services shall be defined as those services which delay or prevent pregnancy. Such services shall not include services to treat infertility or services to promote fertility.**~~

~~**B. Pregnancy-related and postpartum services shall be covered for any medical condition that may complicate pregnancy if otherwise covered under the Title XXI state plan. Enhanced prenatal care services include nutrition, patient education, homemaker services, blood glucose meters (including test strips).**~~

~~**6.2.10.A** ☒ Inpatient mental health services, other than services described in 6.2.20, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))~~

~~**Inpatient mental health services will be offered in general acute care hospitals. Inpatient acute mental health services other than those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services. Effective 07-01-10, medically necessary inpatient mental health services are covered for 365 days per confinement. Effective 12-01-13, these services are managed by the contracted BHSA.**~~

~~**6.2.11.A** ☒ Outpatient mental health services, other than services described in 6.2.21, but including services furnished in a state-operated mental hospital and~~

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

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

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

~~**Community Mental Health Services:**~~

~~**1. Intensive in-home services to children and adolescents under age 19 - Shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment, individual and family counseling, and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the residence with the child present.**~~

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

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

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

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

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

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

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

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

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

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

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

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

Prosthetic devices (artificial arms and legs, and their necessary supportive attachments; implants and breasts) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license. This service when provided by an authorized vendor must be medically necessary and preauthorized for the minimum applicable component necessary for the activities of daily living.

6.2.13.A ☒ Disposable medical supplies (Section 2110(a)(13))

Medical supplies, equipment and appliances suitable for use in the home. All medically necessary medical supplies, equipment, and appliances are covered for recipients. Unusual amounts, types and duration of usage must be authorized by DMAS. When cost-effective, payment may be made for rental of the equipment in lieu of purchase. Prosthetics which are preauthorized shall be covered. Supplies, equipment that are not covered are: space conditioning equipment, equipment and supplies for any hospital or nursing facility resident, except for ventilators and associated supplies for nursing facility residents; furniture or appliances not defined as medical equipment; items that are only for the recipient's comfort and convenience.

6.2.14.A ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))

A. Home Health Services: Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area. Effective 08-01-2003, home health services are limited to five visits without prior authorization in each state fiscal year. Service extensions beyond the initial five visits must be prior-authorized. Limits are per recipient, regardless of the number of providers rendering services. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

B. Home Health Aide services provided by a home health agency. Home health aides must function under the supervision of a professional nurse. Home health aides must meet the federal certification requirements. Patient may receive up to 32 visits annually.

6.2.15.A ☒ Nursing care services (See instructions) (Section 2110(a)(15))

Intermittent or part-time nursing service provided by a home health agency; Nurse mid-wife services allowed under licensure

requirements of Virginia and federal law; skilled nursing services provided in schools to special education students.

Private duty nursing services are not covered.

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

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

6.2.17.A ☒ Dental services (Section 2110(a)(17))

A. Routine diagnostic, preventive or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; routine amalgam and composite restorations; stainless steel crowns, prefabricated steel post, temporary (polycarbonate crowns) and stainless steel bands; crown recementation; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization.

C. All covered dental services not referenced above require preauthorization by DMAS. The following services are also covered through preauthorization: medically necessary full banded orthodontics, tooth guidance appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns and bridges.

D. Routine bases under restorations and inhalation analgesia are not covered.

E. Examinations prophylaxis, fluoride treatment (one each six months); space maintenance appliance; bitewing x-ray - two films each 12 months; routine amalgam and composite restorations once each three years; dentures once each five years; extractions, orthodontics, tooth guidance appliances, permanent crowns and bridges, endodontics, patient education and sealants - one time.

F. Limited oral surgery procedures, as defined and covered by Medicare when preauthorized.

~~**G. Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.**~~

~~**6.2.18.A** ☒ Vision screenings and services (Section 2110(a)(24))~~

~~**6.2.19.A** ☒ Hearing screenings and services (Section 2110(a)(24))~~

~~**6.2.20.A** ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))~~

~~**Effective 12-01-13 these services are managed by the contracted BHSA.**~~

~~**Residential treatment for pregnant women. The treatment facility shall not be an institution for mental disease.**~~

~~**6.2.21.A** ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))~~

~~**Group and individual counseling, outpatient, intensive outpatient, partial hospitalization, and case management services are covered for members with a documented substance use diagnosis as of 4-1-17. Peer support services (as discussed in section 6.2.11.C) were added on 7/1/2017. Services must be rendered by a certified or licensed provider. Effective 12-01-13 these services are managed by the contracted BHSA.**~~

~~**6.2.22.A** ☒ Case management services (Section 2110(a)(20))~~

~~**Targeted case management for high risk pregnant women and infants up to age 2; individuals with mental retardation; children with serious emotional disturbance and youth at risk for serious emotional disturbance; and children with behavioral disorder or emotional disturbances who are referred to treatment foster care by the Family Assessment and Planning Team of Comprehensive Services Act for Youth and Family. Effective October 1, 2011, targeted case management is provided by a certified Early Intervention Case Manager and reimbursed directly by DMAS for children from birth up to age three years who are in need of early intervention services.**~~

~~**6.2.23.A** ☐ Care coordination services (Section 2110(a)(21))~~

~~**May be a component of another service.**~~

~~**6.2.24.A** ☒ Physical therapy, occupational therapy, and services for individuals with~~

~~speech, hearing, and language disorders (Section 2110(a)(22))~~

~~**Effective 08-01-03, home health and outpatient rehabilitation services are limited to five visits for each rehabilitative therapy without prior authorization in each state fiscal year. Service extensions beyond the initial five visits must be prior-authorized.**~~

~~**A. Under home health, physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility covered as ordered by a physician in consultation with a physical therapist who has been licensed by the Board of Medicine. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If the physician determines that additional services are needed, the provider shall request prior authorization.**~~

~~**B. Physical therapy and related services:**~~

~~**1. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient services, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.**~~

~~**2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine or a physical therapy assistant who is licensed by the Board of Medicine and under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.**~~

~~**C. Occupational therapy: Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a provider who provides rehabilitation services. Services shall meet all of the following conditions: services shall be directly and specifically related to an active written plan of care designed by a physician after consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board; shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified occupational therapist. The amount, frequency and**~~

~~duration of the services shall be reasonable.~~

~~D. Services for individuals with speech, hearing and language disorders. Services must be provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitative services. Services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Speech/Language Pathology, or, if exempt from state licensure, meets the requirements in 42 CFR 405.1719(c). The services shall be of a level of complexity and sophistication or the patient's condition be of a nature that the services can only be performed by or under the direction of a qualified speech-language pathologist. The amount, frequency and duration of the services shall be reasonable.~~

~~6.2.25.A ☒ Hospice care (Section 2110(a)(23))~~

~~Hospice care services described in the Title XIX state plan for medical assistance. Effective 3/23/10, hospice care is available concurrently with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.~~

~~6.2.26.A ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act.~~

~~Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act §1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the Virginia Title XIX State Plan subject to the requirements and limits of Title XXI.~~

~~6.2.27.A ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))~~

~~A. Intensive physical rehabilitation in facilities certified as rehabilitative hospitals or rehabilitation hospitals which meet the requirements to be excluded from the Medicare PPS system and in CORFs. An intensive physical rehabilitation program provides intensive skilled rehabilitation, nursing, physical therapy, occupational therapy, and speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation.~~

~~B. Optometrist: Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of VA and by regulations of the Boards of Medicine and of Optometry, are covered. Routine refractions are limited to once in 24 months except as may be authorized by DMAS.~~

~~C. Podiatrists: Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by State law. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.~~

~~D. Nursing facility services in a Medicaid certified facility (other than in an IMD).~~

~~E. Nurse-midwife services: defined as those services allowed under the licensure requirements of the state statute and as specified in the Social Security Act.~~

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

~~6.2.28.A ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))~~

~~6.2.29.A ☒ Medical transportation (Section 2110(a)(26))~~

~~Transportation services are provided to ensure that recipients have necessary access to and from providers of all covered medical services. Transportation to both emergency and nonemergency services is covered.~~

~~6.2.30.A ☐ Enabling services (such as transportation, translation, and outreach services~~

~~(See instructions) (Section 2110(a)(27))~~

~~**6.2.31.A** ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))~~

~~**The following services for special education students, when provided in a school setting pursuant to a student's Individualized Education Program (IEP), are covered under this State Plan: physical therapy, occupational therapy, and speech-language therapy; audiology; skilled nursing; psychiatric and psychological services; personal care; medical evaluations; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; and specialized transportation. Assessments are covered as necessary to determine special education and related services needed in the IEP. The Department of Medical Assistance Services (DMAS) reimburses Local Education Agencies (LEAs) directly for services provided pursuant to the IEP.~~**

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☒ **American Academy of Pediatrics/ Bright Futures**
☐ Other Nationally recognized periodicity schedule (please specify:)
☐ Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

FAMIS children are enrolled in fee-for-service on a temporary basis prior to enrollment in a MCO, and during this period, they receive the same benefits as the Medicaid state plan, including EPSDT.

FAMIS children enrolled in managed care receive Secretary-approved coverage modeled after the state employee benefit plan in effect in June 2000, Virginia's Key Advantage State Employee Benefit Plan. Behavioral health services are outlined in detail in the checklist below.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Virginia currently mandates, throughout delivery systems and covered populations, coverage for age-appropriate, routine, and standardized validated developmental and behavioral health screenings, including for all FAMIS enrollees, consistent with the Bright Futures/American Academy of Pediatrics (AAP) guidelines and periodicity schedule. These requirements are outlined in the managed care contracts. Primary care providers are given discretion, within the scope of AAP guidance, on the specifics of evidence-based screening tools used. DMAS guidance regarding

developmental and behavioral health screenings is outlined in the EPSDT section of the DMAS provider manuals. This guidance also applies to FAMIS well child coverage. To facilitate the use of age-appropriate validated behavioral health screening tools, MCOs are required to educate and train providers on the use of these tools and provide updated versions of the tools as they become available. DMAS provides information and updates regarding developmental and behavioral health screenings in provider manuals and on the agency's website. DMAS will provide updated information through a policy transmittal to providers and MCOs describing the requirements of Section 5022 of the SUPPORT Act, including the use of age-appropriate validated behavioral health screening tools in primary care settings.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Psychosocial treatment, including psychotherapy, group therapy, family therapy, and other types of counseling services, is covered for the treatment of mental health and substance use disorder conditions. Medically necessary outpatient mental health and substance use disorder services (American Society of Addiction Medicine [ASAM] Level 1) other than services furnished in a state-operated mental hospital are covered without limitations.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Tobacco cessation services are covered, including both counseling and pharmacotherapy. Coverage includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. All FDA-approved tobacco cessation products are covered. At least two quit attempts and five tobacco cessation counseling sessions per quit attempt are covered; these limits can be exceeded when medically necessary.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

Medication Assisted Treatment for opioid use disorder is covered. All FDA-approved medications to treat opioid use disorder are covered as well as psychotherapy and substance use disorder counseling. There is no visit limit on medically necessary outpatient substance use disorder treatment.

6.3.2.3.2- BH ☒ Alcohol Use Disorder

Medication Assisted Treatment for alcohol use disorder is covered. All FDA-approved medications to treat alcohol use disorder are covered as well as psychotherapy and substance use disorder counseling. There is no visit limit on medically necessary outpatient substance use disorder treatment.

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.2.5- BH ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Intensive in-home services to children and adolescents under age 19 are time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis intervention, individual and family counseling, and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☐ Mental Health ☒ Substance Use Disorder

As of 4/1/17, intensive outpatient services (ASAM Level 2.1) are covered for substance use disorder treatment. There are no visit limits on medically necessary outpatient substance use disorder treatment services. Medication assisted treatment shall be provided onsite or through referral.

6.3.2.9- BH ☐ Psychosocial rehabilitation
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Therapeutic Day Treatment (TDT) is an intensive outpatient service that is covered for the treatment of mental health conditions. TDT provides evaluation, medication, education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☐ Mental Health ☒ Substance Use Disorder

Partial Hospitalization (ASAM Level 2.5) is covered for substance use treatment. There is no visit limit on medically necessary outpatient substance use treatment services. Medication assisted treatment shall be provided onsite or through referral.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital and inpatient substance use disorder treatment services rendered in a psychiatric unit of a general acute care hospital are covered for 365 days per confinement. The following services are not covered: (1) services furnished in a state-operated mental hospital, (2) services furnished in an IMD, and (3) residential services or other 24-hour therapeutically planned structural services.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☐ Residential Treatment
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Residential Treatment services are not provided under the CHIP state plan. Children in need of mental health or substance use disorder Residential Treatment services may receive them for stays less than 30 days, through state-

only funds. For stays longer than 30 days, the child is assessed for Medicaid eligibility.

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

ASAM defines detoxification as "withdrawal management." Withdrawal management, as defined by ASAM, means services to assist a member's withdrawal from the use of substances. This service may be offered in all ASAM Levels of Care.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Crisis Intervention services are covered, effective 8-1-2003. Crisis intervention provides immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. A unit equals 15 minutes and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

6.3.6- BH ☐ Continuing care services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.7- BH ☒ Care Coordination
Provided for: ☐ Mental Health ☒ Substance Use Disorder

The substance use disorder outpatient benefit, including Preferred Office-Based Addiction Treatment (OBAT) and Opioid Treatment Programs, requires Substance Use Disorder (SUD) Care Coordination that includes integrating

behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring member progress and tracking member outcomes; linking members with community resources to facilitate referrals and respond to social service needs, or peer supports; and tracking and supporting members when they obtain medical, behavioral health, or social services outside the practice. SUD Care Coordination services are considered duplicative of SUD Case Management services (6.3.8-BH), so these benefits are provided only to individuals with a primary SUD diagnosis who are not already receiving SUD Case Management.

6.3.7.1- BH ☐ Intensive wraparound
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.7.2- BH ☐ Care transition services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

SUD Case Management services for substance use disorders are covered and cannot be billed concurrently with SUD Care Coordination (6.3.7- BH).

6.3.9- BH ☒ Other

Behavioral Therapies
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Behavioral Therapies - As of 07-01-16, behavioral therapies are covered. Behavioral therapies are systematic interventions provided by licensed practitioners within their scope of practice, defined under state law or regulations, to individuals younger than

19 years of age, usually in the individual's home. Behavioral therapy includes, but is not limited to, applied behavior analysis. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual's family is trained to effectively manage the individual's behavior in the home and community settings using behavioral modification strategies. Behavioral therapy services must be preauthorized and based on a medical necessity determination.

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☒ Substance Use Disorders

☒ InterQual
☒ Mental Health ☐ Substance Use Disorders

☒ MCG Care Guidelines
☒ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☒ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☒ Substance Use Disorders

The Virginia Department of Medical Assistance Services manuals describe the criteria for psychiatric services, community mental health and rehabilitation services (CMHRS), and Addiction and Recovery Treatment Services (ARTS).

☒ Plan-specific criteria (please describe)
☒ Mental Health ☒ Substance Use Disorders

The plans are required to use a standardized assessment tool to determine medical necessity for behavioral health services. DMAS does not specify which standardized assessment tools the MCOs must use; however, MCOs must use assessment tools that meet an acceptable practice standard. These include InterQual, Milliman, and MCG. If MCOs use plan-specific criteria, the criteria shall not be more restrictive than the State Plan program.

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Contracted managed care organizations must use the Department's service authorization criteria or other medically sound, evidence-based criteria in accordance with national standards in making medical necessity determinations. MCOs may choose assessment tools listed in Section 6.4.1-BH. To facilitate the use of validated assessment tools for the treatment of behavioral health conditions, MCOs are required to educate and train providers on the use of these tools and provide updated versions of the tools as they become available. DMAS will require MCOs to submit a plan, as well as updates to the plan in the future, that details the use of validated assessment tools for the treatment of behavioral health conditions.

To engage in community mental health services, providers must complete a comprehensive needs assessment on members, which can be done by completing the DLA-20, a validated outcomes measurement and monitoring tool that helps persons with mental illness manage their treatment, which can reduce the need for specialized, high-cost services. The use of the DLA-20 is included in the DMAS service manuals.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

CHIP Budget Plan

	Federal Fiscal Year Costs – FFY2020	Federal Fiscal Year Costs – FFY2021
Enhanced FMAP rate	**79.755%**	**65.0%**
Benefit Costs		
Insurance payments		
Managed care	$364,487,613	$367,151,620
per member/per month rate @ # of eligible	$206.45 @ 147,126 avg elig/mo	$196.71 @ 155,536 avg elig/mo
Fee for Service	$80,255,664	$80,404,628
Cost of Proposed SPA changes		
Total Benefit Costs	**$444,743,277**	**$447,556,248**
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	**$444,743,277**	**$447,556,248**
Administration Costs		
Personnel	$2,288,222	$2,342,226
General administration	$506,810	$518,771
Contractors/Brokers (e.g., enrollment contractors)	$15,940,295	$16,316,500
Claims Processing	$4,974,787	$5,092,197
Outreach/marketing costs	$413,833	$423,600
Health Services Initiatives		
Other		
Total Administration Costs	**$24,123,947**	**$24,693,294**
10% Administrative Cap	$49,415,920	$49,728,472
Federal Share (multiplied by enh-FMAP rate)	**$373,945,055**	**$306,962,202**
State Share	$94,922,170	$165,287,339
TOTAL PROGRAM COSTS	$468,867,224	$472,249,541

Funding:

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

The 1997 General Assembly established the Virginia Children's Medical Security