

**FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

**Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- C Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- C Provide *consistency* across States in the structure, content, and format of the report, **AND**
- C Build on data *already collected* by HCFA quarterly enrollment and expenditure reports, **AND**
- C Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: Commonwealth of Virginia  
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).



(Signature of Agency Head)

SCHIP Program Name (s) Virginia Children's Medical Security Insurance Program

SCHIP Program Type  Medicaid SCHIP Expansion Only  
 Separate SCHIP Program Only  
 Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date DECEMBER 20, 2000

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## **SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS**

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*This sections has been designed to allow you to report on your SCHIP program-s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).*

### **1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.**

*Note: If no new policies or procedures have been implemented since September 30, 1999, please enter NC=for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.*

- |  |                     |
|--|---------------------|
| 1. Program eligibility   | <i>NC – see #15</i> |
| 2. Enrollment process  | <i>NC – see #15</i> |
| 3. Presumptive eligibility   | <i>NC – see #15</i> |
| 4. Continuous eligibility  | <i>NC – see #15</i> |
| 5. Outreach/marketing campaigns  | <i>NC – see #15</i> |
| 6. Eligibility determination process   | <i>NC – see #15</i> |
| 7. Eligibility redetermination process   | <i>NC – see #15</i> |
| 8. Benefit structure   | <i>NC – see #15</i> |
| 9. Cost-sharing policies   | <i>NC – see #15</i> |
| 10. Crowd-out policies   | <i>NC – see #15</i> |
| 11. Delivery system  | <i>NC – see #15</i> |
| 12. Coordination with other programs (especially private insurance and Medicaid) | <i>NC – see #15</i> |
| 13. Screen and enroll process  | <i>NC – see #15</i> |
| 14. Application  | <i>NC – see #15</i> |

15. Other – Awaiting federal approval of FAMIS application under Title XXI.

*The year 2000 session of the Virginia General Assembly enacted legislation that directed the Virginia Department of Medical Assistance Services (DMAS) to amend the Virginia Children's Medical Security Insurance Plan (VCMSIP) as authorized under Title XXI of the Social Security Act. This action revises and renames the VCMSIP program as the Family Access to Medical Insurance (FAMIS) Plan. The aim of FAMIS is to diminish the stigma of a public welfare program, simplify and expedite the eligibility determination and enrollment process, and increase access to a broader array of providers through private-sector health insurance programs. The Commonwealth of Virginia maintains that these actions will improve public perception and acceptance of the program, thereby increasing enrollment.*

*The FAMIS Plan will be for individuals up to the age of 19, and:*

- *Changes eligibility criteria to include children in families with gross income at or below 200% of the Federal Poverty Level (FPL)*
- *Changes the 12-month required waiting period, if previously insured, to six (6) months*
- *Implements cost sharing for all eligible children in a family – above 150% of FPL cost sharing shall not exceed 5% of family's gross income (premiums and co-pays); at or below 150% of FPL cost sharing shall not exceed 2.5% of family's gross income and shall be limited to nominal co-payments*
- *Provides comprehensive health care benefits, including: well-child and preventive services; medical; dental; vision; mental health; substance abuse services; physical therapy, occupational therapy; speech language pathology; and skilled nursing services for special education students*

*The benefits delivery system of FAMIS includes:*

- *No pre-assignment process nor fee-for-service program for initial enrollment*
- *Health plan mechanisms for delivery of benefits can include HMOs, preferred provider organizations, indemnity, or other entities*

*The FAMIS program subsidizes employment-based coverage by:*

- *Enabling participants who have access to employer-sponsored health insurance coverage to enroll in the employer's plan if DMAS determines that it is cost effective to provide premium assistance on their behalf*
- *Providing supplemental benefits for eligible children covered under employer plans as needed to be equivalent to those available through the comprehensive health care benefits package under FAMIS*

*Eligibility and enrollment processes for the FAMIS program include:*

- *Establishing a centralized processing site for FAMIS in order to respond to inquiries,*

*distribute applications and program information, receiving and processing applications, determining eligibility for the program, and enrollment into the health plans*

- *Allowing local social service agencies, contracting health plans, providers, and others to provide application assistance*

*Outreach activities for the FAMIS program include:*

- *The DMAS Board, in consultation with the establishment of the Outreach Oversight Committee, shall develop a comprehensive, statewide outreach plan. The plan shall include strategies for improving outreach and enrollment in those localities where enrollment is less than the statewide average and enrolling uninsured children of former Temporary Assistance to Needy Families recipients*
- *The Outreach Oversight Committee shall be composed of representatives from community-based organizations engaged in outreach activities, social services eligibility workers, the provider community, health plans, and consumers*
- *The Committee shall make recommendations regarding state-level outreach activities, the coordination of regional and local outreach activities, and procedures for streamlining and simplifying the application process, brochures and other printed materials.*

*Until the FAMIS plan is approved by HCFA, the original VCMSIP program is in effect, with no changes in eligibility, enrollment, coordination, or other program features as reported in March 2000.*

**1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.**

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

*The total VCMSIP enrollment for FFY00 is 27,879. These are children enrolled anytime during FFY00 including enrollees carried over from the previous fiscal year, as well as reenrollees during the period. This is an increase of 8,931 over the enrollment for FFY99 reported in the March 2000 evaluation report to HCFA. VCMSIP provided creditable coverage to these children enrolled during these periods. The eligibility characteristics of FFY00 VCMSIP enrollees compared to last year's is as follows:*

	<i>FFY00</i>	<i>FFY99</i>
<i>Total number of enrollees</i>	<i>27,879</i>	<i>18,948</i>
<i>Average number of days eligible</i>	<i>189 days</i>	<i>188.7 days</i>
<i>Average age on day of CMSIP enrollment</i>	<i>8.96 years</i>	<i>9.2 years</i>
<i>% of VCMSIP disenrollees (enrolled anytime in FFY00 and not enrolled as of 10/1/00)</i>	<i>14.76%</i>	<i>NA</i>
<i>% of Medicaid disenrollee comp. group (enrolled anytime in FFY00 and not enrolled as of 10/1/00)</i>	<i>31.1%</i>	<i>NA</i>
<i>% of VCMSIP disenrollees with subsequent Medicaid eligibility</i>	<i>4.3%</i>	<i>21%</i>

<i>% enrollees 0-6 years of age</i>	<i>37%</i>	<i>34%</i>
<i>% enrollees 7-12 years of age</i>	<i>39%</i>	<i>41%</i>
<i>% enrollees 13-18 years of age</i>	<i>24%</i>	<i>25%</i>
<i>% White enrollees</i>	<i>51.8%</i>	<i>57.8%</i>
<i>% Black</i>	<i>31.8%</i>	<i>27.7%</i>
<i>% Hispanic</i>	<i>12.6%</i>	<i>10.9%</i>
<i>% Asian</i>	<i>3.4%</i>	<i>3.2%</i>
<i>% Native American</i>	<i>0.1%</i>	<i>0.1%</i>

*As shown above, the VCSMIP program over the last year has increased enrollment of minority populations. In the other categories, the population characteristics of the two fiscal years are remarkably similar except in one regard: the percentage of children who disenrolled from the VCMSIP program with subsequent Medicaid eligibility (4.3% in FFY00 versus 21% in FFY99). One explanation for this may be start-up in the first year of the VCMSIP program where uninsured children who were Medicaid eligible enrolled in VCMSIP (through the joint application form) and then later were redetermined for Medicaid as their documentation materials were verified.*

*In addition to the information from the computer eligibility files, information from the VCMSIP enrollment broker for the FFY00 period indicates the following, based on 7,775 records:*

- 4041, or 52%, of the children enrolled were not previously insured*
- 3046, or 39%, of the children were previously insured through Medicaid*
- 688, or 9%, of the children had other previous insurance coverage*
- 37% of the new enrollees were between the ages of 0-6; 40% between the ages of 7-12; and 23% between the ages of 13-18. These figures correspond closely with the computer eligibility files of 37%, 39%, and 24%, respectively.*

*In addition, the enrollment broker data indicates that the majority (69%) of new enrollees heard about the program through their local Social Service Departments, although other outreach strategies were also successful, including: brochures (9%); media (7%); relatives (5%); and other (10%).*

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

*During FFY00, DMAS enrolled approximately 4,000 additional Medicaid children. This is based on information from the DMAS computer eligibility files for the number of children enrolled in FFY99 and FFY00, and reported in DMAS reports. Since the inception of the VCMSIP program in October 1998, there has been a net increase of about 10,000 Medicaid children.*

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

*Virginia has made progress in reducing the number of uninsured children over the past decade. A 1993 Virginia Health Access Survey showed that approximately 14 percent of the children were uninsured. A similar survey was conducted in 1996 for the Virginia Health Care Foundation resulting in estimates of the number of uninsured children of approximately 12 percent. A report from the American Academy of Pediatrics projected that 13% (227,000) of Virginia's 1.8 million children would not have health insurance in the year 2000. Last year, an updated Virginia Children's Health Access Survey was conducted by Virginia Commonwealth University. Survey findings indicate that some form of health insurance covered most of the children in the responding households, with 10% of children having no insurance.*

*Public and private entities within the Commonwealth of Virginia offer many programs aimed toward reducing the number of uninsured low-income children in the state. A sample of these programs is listed below:*

- *A state-wide information and referral help-line that refers callers to private and public providers of a wide range of health and social services for women, infants, and teens*
- *Newborn screening programs for metabolic conditions, sickle cell disease, and hearing loss*
- *Child health primary care programs that improve the access of low-income children to comprehensive primary care services*
- *Early intervention services for children 0-2 years old at risk of developmental delays*
- *Children's AIDS Network Designed for Interfaith Involvement, is a case management of support services for women and their children affected by HIV/AIDS*
- *Children's Specialty Services (CSS) Program, a state-wide specialized medical-surgical care program for medically indigent handicapped children*
- *Child Health Investment Partnership (CHIP), a public-private program for low-income children through the age of six*
- *Arlandia Health Center, which provides primary and preventive care for medically indigent Hispanic women and children*
- *INOVA Health System, a school-based initiative that links uninsured children with available health insurance*
- *Blue Ridge Medical Center provides "insurance passports" for uninsured residents*

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

No, skip to 1.3

Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

**1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).**

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter a NC (for no change) in column 3.

*In general, the state Medicaid agency utilizes enrollment data, survey data, data generated by contractor review of services, and administrative data to measure the success of reaching the VCMSIP performance goals. See Table 1.3.*



<b>Table 1.3</b>		
<p>(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)</p>	<p>(2) Performance Goals for each Strategic Objective</p>	<p>(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)</p>
	<p><i>Reduce percentage of uninsured children</i></p>	<p>Data Sources: <i>Periodic statewide child health access surveys</i></p> <p>Methodology: <i>Survey conducted that asks about child's health insurance status</i></p> <p>Progress Summary: <i>NC from March 2000 evaluation: see 1.2.3 narrative in previous section</i></p>
<p><b>OBJECTIVES RELATED TO SCHIP ENROLLMENT</b></p>		

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<i>To conduct effective outreach to encourage enrollment in health insurance plans</i>	<i>Obtain the active participation of community-based organizations</i>	<p><b>Data Sources:</b> <i>Records/reports of outreach campaign</i></p> <p><b>Methodology:</b> <i>Contacts tracked with all entities involved in outreach</i></p> <p><b>Progress Summary:</b> <i>Broad-based outreach campaign including state agencies, all licensed and temporary day care facilities, grocery stores, pharmacies, restaurants, hospitals, schools, Head Start programs, retail stores, non-profits such as United Way, Action Alliance for Virginia's Children and Youth, and other organizations. DMAS sponsored training sessions for these organizations on VCMSIP. Virginia was also awarded a Robert Wood Johnson (RWJ) Foundation grant to enable the VCMSIP program further active participation by community-based organizations. Each RWJ pilot program collaborates with other</i></p>
		<i>community-based organizations to recruit and train volunteers as outreach workers to recruit and enroll eligible children into VCMSIP. The outreach workers also provide assistance in completing the VCMSIP application. The RWJ pilots participate in community events to market and promote participation in VCMSIP. The RWJ – VCMSIP Program is collaborating with state agencies (DMAS and DSS programs) and non-profit organizations to simplify the application.</i>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	<i>Utilize various strategies for informing parents about VCMSIP</i>	<p><b>Data Sources:</b> <i>Administrative records of outreach campaign</i></p> <p><b>Methodology:</b> <i>Strategies tracked in outreach campaign</i></p> <p><b>Progress Summary:</b> <i>DMAS has a contract with the Virginia Department of Social Services for outreach services. VDSS has implemented a four-tier outreach approach: federal, state, local, and grassroots. The <b>Federal tier</b> includes a partnership with the Health Care Financing Administration (HCFA) and the Department of Agriculture. At the <b>State level</b>, a media campaign has been launched including radio, television, newspaper, outdoor, and transit advertising. VDSS has formed partnerships with community-based organizations, faith-based organizations, child advocacy groups, hospitals, free clinics, HMOs, and other agencies. VDSS hosts and coordinates a VCMSIP Outreach Coordinating Committee made up of partners and stakeholders to continuously collaborate and improve upon outreach strategies. State outreach workers developed marketing materials in conjunction with a public relations firm. Mail campaigns target the eligible population and local outreach workers and the local Departments of Social Services. The state is a partner with and equips the 122 local Departments of Social Services to conduct outreach. <b>On a grassroots level</b>, volunteer community outreach workers are recruited from churches, schools, and other community agencies. The volunteers are trained on how to reach out to families and enroll eligible children</i></p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	<i>Distribute information and applications to parents of school-aged children and pre-school children</i>	<p><i>into VCMSIP. The volunteers seek eligible children/families through churches, health clinics, school events, community fairs, depot stations, libraries, Head Start programs, day care centers, and other settings. The RWJ-VCMSIP pilot programs are recruiting and training lay volunteers to do outreach of eligible families and to assist the families in completing the VCMSIP application.</i></p> <p><b>Data Sources:</b> <i>Administrative records of outreach campaign; DMAS Quarterly Reports on the Status of VCMSIP</i></p> <p><b>Methodology:</b> <i>Strategies tracked in outreach campaign</i></p> <p><b>Progress Summary:</b> <i>During FFY00, almost 2000 VCMSIP packets were distributed to all school principals along with a letter of support from the superintendent of schools and the Governor. 1.4 million copies of CMSIP applications were also distributed to the schools. All licensed and temporary day care facilities, including Head Start facilities, received CMSIP information. In addition, thousands of brochures, flyers, tear-off pads and posters printed in both English and Spanish were distributed to public and private elementary, middle, and high-schools statewide.</i></p>
<b>OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT -</b>		

<b>Table 1.3</b>		
<b>(1)</b> Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	<b>(2)</b> Performance Goals for each Strategic Objective	<b>(3)</b> Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<i>To reduce the number of uninsured children</i>	<i>Increase the number of Medicaid eligible children enrolled in Medicaid</i>	Data Sources: <i>DMAS eligibility computer file</i>  Methodology: <i>Tracking the increase in the number of children enrolled in Medicaid</i>  Progress Summary: <i>Approximately 4000 in FY00 and 6,000 in FFY99</i>
<b>OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED) -</b>		
<i>To improve the health status of children</i>	<i>Increase the number of children with a usual source of care</i>	Data Sources: <i>1999 Child Health Access survey and Consumer Assessment of Health Plans Survey (CAHPS)</i>  Methodology: <i>1999 Child Access Survey provides a statewide benchmark of children with a usual source of care; CAHPS addresses the experience of Medicaid enrolled children</i>  Progress Summary: <i>CAPHS results are expected shortly</i>
<b>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE) -</b>		

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<i>To improve the health status of children</i>	<i>Increase the percentage of children with immunizations</i>	<p><i>Data Sources: DMAS and Virginia Department of Health</i></p> <p><i>Methodology: Children under age of 3</i></p> <p><i>Progress Summary: Study on the Medicaid and CMSIP population was completed in August 2000. Study reported a substantial improvement in immunization rates between 1997 and 1999</i></p>
	<i>Increase the number of children treated for asthma</i>	<p><i>Data Source: DMAS data and encounter data</i></p> <p><i>Methodology: Tabulation of statistical measures for analyzing childhood asthma such as ER visits/1000; hospital discharges/1000; hospital days/1000 and average hospital length of stay</i></p> <p><i>Progress Summary: Project design is in development</i></p>

**1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**

*Despite successes in the VCMSIP program, there are constraints in meeting the program goals. The intersecting roles of state, county, and local social services officials in administering CMSIP add an additional layer of complexity, and may constrain a coordinated outreach and enrollment program. Outreach funds are part of a limited budget for overall administrative expenses for CMSIP, so outreach activities are also limited.*

*The paperwork involved in completing an original or redetermination application and obtaining the necessary verifications for Medicaid or VCMSIP can be extensive for caseworkers, community advocates, and clients. Partnerships with community-based organizations have helped with outreach, application completion, and program enrollment.*

*The VCMSIP Program delivery system parallels the Medicaid program's delivery system. Maintaining an adequate network of physicians willing to accept Medicaid/VCMSIP patients is a challenge, and physicians fluent in the languages spoken by their clientele are chronically in short supply in areas of the state with non-English speaking populations.*

**1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.**

NA

**1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**

*The Commonwealth of Virginia's Joint Commission on Health Care (JCHC), in conjunction with the Virginia Health Care Foundation, is seeking to acquire funding from the 2001 Virginia General Assembly to conduct a health access survey as a follow-up to their 1996 survey. This will provide a more current estimate of the number of uninsured, low-income children in the state.*

*DMAS anticipates the proposed FAMIS plan will use numerous strategies to overcome previous barriers in meeting performance goals and will devise methods to assure that recipients receive quality services that are appropriate to their needs. These include:*

*Barriers to Participation:*

- *The central eligibility processing system planned in FAMIS should result in improvements in facilitating and monitoring the initial application and subsequent redetermination process, including the receipt of required verifications.*
- *FAMIS will reduce the waiting period for previously insured children from 12 months to 6 months.*

*Enhance Outreach:*

- *A comprehensive statewide outreach plan is needed and required by FAMIS statute, and may include: methods for tracking data on outreach, enrollment, and redeterminations; use of focus groups for evaluating outreach material and methods; direct linkage with free reduced school lunch program participants; support for hospital-based and community-based outreach and application assistance activities*

*Maximize Provider Participation*

- *FAMIS will collect data on provider participation, the effect of required copayments on provider participation, and the impact of marketing efforts to enlist providers*

*Enhance Health Insurers Quality Assurance Programs*

- *Verification that the health insurers develop and maintain quality assurance and quality improvement programs, which meets standards and reporting requirements set out by the Commonwealth*
- *Verification that health insurers have sufficient network providers and procedures to ensure that children have access to routine, urgent, and emergency services*
- *Verification that health insurers maintain a member complaint system and provide access to a grievance process to appeal a plan action*
- *Health insurers will be required to submit a quality improvement plan which meets NCQA standards, as well as results of HEDIS or other measures of utilization and quality of health care*
- *Health insurers will be required to demonstrate their ability to monitor network capacity throughout their service area for routine, urgent, and emergency care. The Commonwealth will establish standards and reporting requirements for access to routine, urgent, and emergency care.*

**1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.**

*Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program, Department of Medical Assistance Services, January 4, 2000.*

*Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program, Department of Medical Assistance Services, April 1, 2000.*

*Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program, Department of Medical Assistance Services, July 1, 2000.*

*Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program,  
Department of Medical Assistance Services, October 1, 2000.*

## SECTION 2. AREAS OF SPECIAL INTEREST

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*This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.*

### 1. Family coverage:

*Virginia does not offer family coverage*

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults \_\_\_\_\_

Number of children \_\_\_\_\_

3. How do you monitor cost-effectiveness of family coverage?

### 2.2 Employer-sponsored insurance buy-in:

*The Commonwealth of Virginia has proposed a program that includes an employer-sponsored insurance buy-in, the Family Access to Medical Insurance (FAMIS) Plan. See Section 1.1 #15 for a description of the plan.*

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults \_\_\_\_\_

Number of children \_\_\_\_\_

### 2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

*As part of the application for the VCMSIP, each application includes a declaratory statement that the child for whom the application is being filed is not covered under any*

*group health insurance plan. The application includes a question about health insurance in the past. If the child has been covered under a health insurance plan within the past 12 months, the child is ineligible for VCMSIP, unless the reason for dropping the coverage is approved by the state.*

*National data (Center for Studying Health System Change, 2000) indicates that while the proportion of low-income children with public coverage has increased over the last two years, the percentage with private insurance coverage has decreased, resulting in little change in the overall percentage of children who are uninsured. Possible factors for this include increasing private insurance premiums (resulting in dropping coverage or a lower “take-up” rate of enrolling in ESHI), substitution of public for private coverage, and changes in the characteristics of low-income persons.*

*The 12-month waiting period under the VCMSIP program is not intended to discourage application for VCMSIP but rather to insure that the publicly subsidized program is not substituting for or contributing to the erosion of private health insurance coverage. The proposed FAMIS program, which includes an employer-based program, reduces the waiting period to six (6) months (see Section 1.1 #15 above), and provides subsidies to families to purchase dependent coverage through employment-sponsored health insurance programs.*

2. How do you monitor and measure whether crowd-out is occurring?
  - *Each application for VCMSIP includes a declaratory statement that the child for whom the application is being filed is not covered under any group health plan.*
  - *A recipient must report a change when it occurs*
  - *A change in eligibility is effective on the first of the month following the month the child is determined to be ineligible*
  - *If no change is reported, eligibility will be reevaluated annually*
3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

*The 12-month waiting period for previously privately insured children before becoming eligible for VCMSIP is the maximum allowable under the rules specified by HCFA. Although there is no definitive data to suggest that the 12-month waiting period has been effective in preventing crowd-out, using the maximum allowable timeframe suggests a greater disincentive to move from private to public insurance and an overall lower level of substitution. Private and public reports suggest that estimates on crowd-out vary widely by state, and that, in the long run, about 40 percent of SCHIP participants would have had some other type of coverage (GAO, 1999). Other experts suggest that because of the significant economic burden to near-poor families to purchase employment-based coverage, some substitution may need to be tolerated to ensure that children receive needed health insurance (Shenkman et al, 1999).*

*Virginia's waiting period of twelve months of being uninsured after participating in employment-sponsored health insurance can be waived if a family claims "good cause" for the discontinuation of a child's health insurance coverage and documents that the health insurance was discontinued for specific reasons. Good Cause exists where: 1) the child's coverage was discontinued by the insurance company for reasons of uninsurability; 2) the family member carrying the insurance stopped or changed employment and no family member has access to employer sponsored dependent health insurance; 3) the employer of the family member carrying the insurance coverage dropped employer sponsored dependent health insurance coverage for all employees and no other family member has access to employer-sponsored dependent health insurance.*

*The proposed Virginia FAMIS plan would reduce the waiting period from 12 months to six (6 months), and subsidize an existing employer-sponsored health insurance (ESHI) program that offers family coverage and where the employer makes a contribution for family coverage. The FAMIS application is requesting an exemption to the federal requirement that participating employers be required to contribute at least 60% towards the cost of family coverage. This exception is requested based on average employer family health coverage contribution rates in Virginia, which are typically lower than 50% .*

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

*The Department of Social Services reports case denial information for VCMSIP, which includes insurance status, to DMAS. DMAS officials monitor this information.*

*See above answer for discussion about effectiveness of crowd-out policies.*

#### **2.4 Outreach:**

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

*Since its inception, the VCMSIP program has utilized a comprehensive marketing and outreach effort, including: a private enrollment broker, coordination with other state agencies; coordination with other community-based organizations; coordination with the business community (particularly through the RWJ Covering Kids initiative); coordination with Health Care Associations and Providers; a Telephone Call Center; as well as the use of billboards, brochures, direct mail, television and print advertisements to provide client education and outreach. The activities found most effective, as recorded by Department of Social Services eligibility workers and private health insurance enrollment brokers are: brochure availability and dissemination in community-based organizations, home visits by*

*VCMSIP representatives, a telephone hotline, public transportation ads, community sponsored events, and education activities in schools, adult education sites, at social service agencies, and at the workplace. Continued coordination with state public and private programs, such as Medicaid, Maternal and child health, public/teaching hospital indigent care clinics, school-based programs, community-based programs, and local government health programs also contributed to the effectiveness in reaching low-income, uninsured children.*

*In June of 1999, the Robert Wood Johnson Foundation awarded the Commonwealth of Virginia funding of almost one million dollars for three pilot programs to conduct innovative SCHIP outreach for three years. The three pilots represent a grassroots approach for statewide outreach. The goal of the three pilots is to enroll children into the SCHIP program by identifying and overcoming enrollment barriers and developing effective community tailored outreach mechanisms. The Nelson County Rural Health Outreach Program serves the tri-county area of Buckingham, Nelson, and Amherst counties. The Nelson County Rural Health Outreach pilot employs a one-on-one approach, utilizing a mobile van to take health services to their community. The Cross-Over Ministry, Inc., is a health clinic located in the southside of Richmond that serves low-income families. The Cross-Over program incorporated SCHIP outreach by training lay volunteers to assist and facilitate applicants with the enrollment process. As of June, the Cross-Over program no longer participated under the grant and the Success by Six program has taken its place. Agape Community Development Corporation is a faith-based outreach program that works within a large network of churches in the Hampton Roads area to train outreach workers within each faith-based congregation. In addition, the three pilots collaborate with local agencies and community-based organizations to reach eligible families.*

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

*The state has utilized focus groups, call center data, presentation evaluations, and a public relations firm to evaluate media effectiveness. The current enrollment numbers reflects the effectiveness of the outreach, bringing together the results of call center statistics, feedback from workers, evaluations of presentations, and survey responses. See Table 1.3 for a detailed narrative of specific outreach activities. Increases in minority enrollment from FFY99 to FFY00 (see Section 1.2) indicate that the outreach has been effective.*

*The FAMIS plan includes in statute a requirement for a comprehensive statewide outreach plan, which will be coordinated with its centralized eligibility processing system. Elements of the plan will include methods for tracking data on outreach, enrollment, and redeterminations, as well as provide direct linkage with other public and private organizations working to increase children's health and health insurance coverage.*

3. Which methods best reached which populations? How have you measured effectiveness?

*The outreach strategies that have been most effective are those that involve face-to-face interaction. One-on-one facilitation in the application and enrollment process has proven highly effective, particularly when the outreach worker is a trusted member of the community. Community involvement is instrumental to the program's success, and fostering public/private partnerships like the RWJ Covering Kids Project is particularly noteworthy.*

## **2.5 Retention:**

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

*Like many states, Virginia has taken significant steps to simplify enrollment and coordination for their child health coverage programs. These include: a joint application (1 of 28 states); no asset test (1 of 42 states); no face-to-face interview (1 of 40 states); and annual redetermination (1 of 39 states). The VCMSIP program attempts to simplify as much as possible the eligibility criteria and the eligibility process, and in turn, these administrative improvements spill over into streamlining the Medicaid program to the extent that it shares outreach techniques and application procedures. (Source: Kaiser Commission on Medicaid and the Uninsured. Making It Simple...2000)*

*The percentage of VCMSIP disenrollees over the FFY00 was 14.7%, which is lower than the comparison Medicaid population of 31.1% (see Section 1.2). Both groups of disenrollees were enrolled at some point in FFY00 but not enrolled as of October 1, 2000. There are many reasons for the higher percentage of Medicaid disenrollment, including the volatility of income eligibility in the Medicaid population and the general decline in Medicaid enrollment. However, the stigma associated with Medicaid can also serve as a barrier to participation in a state-supported children's health insurance program for low-income children (Struber, 2000). With that awareness, the proposed FAMIS program provides a premium subsidy for families who are eligible to insure their children under an employer-sponsored health plan.*

*In addition, the proposed FAMIS program includes mechanisms for identifying and enrolling uninsured children of former Temporary Assistance to Needy Families (TANF) recipients. This is important because of the decline in Medicaid enrollment after the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which ended the automatic link to Medicaid for low-income families who received cash assistance. The SCHIP program provided for new outreach efforts to capture eligible children who had lost health insurance during welfare reform, and Virginia's FAMIS program acknowledges that need.*

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

*Reenrollment activities are locally determined and executed, but many localities in Virginia utilize the following mechanisms to encourage reenrollment:*

- Follow-up by caseworkers/outreach workers
- Renewal reminder notices to all families
- Targeted mailing to selected populations, specify population –

*HMOs perform targeted mailings to those individuals who lose eligibility to let them know that they could be eligible for coverage. Postcards are mailed to people identified as having lost their eligibility. Advocacy groups try and target in their outreach those who may have lost eligibility. Local Departments of Social Services also have the discretion to follow-up with these children. Finally, the numerous, ongoing general outreach efforts can encourage children to reenroll.*

- Information campaigns
- Simplification of re-enrollment process, please describe \_\_\_\_\_

*Common application form for Medicaid and VCMSIP, no face-to-face interview required, applications can be downloaded from the internet and mailed in, program flexibility in the application process.*

- Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe \_\_\_\_\_

*The enrollment broker tracks disenrollment*

- \_\_\_\_ Other, please explain \_\_\_\_\_

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.  
*Yes*

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

*Retention efforts are locality-dependent, but like outreach, strategies that have been most effective pertain to individualized attention and assistance in meeting the redetermination deadline and providing the necessary documentation to maintain participation in the program.*

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

*This data is from the eligibility computer files, and the categorical descriptions are used for the Medicaid program and therefore do not correspond in all cases with the National Academy for State Health Policy categories. The reasons most frequently cited are failure*

*to meet financial eligibility and obtained private insurance.*

## **2.6 Coordination between SCHIP and Medicaid:**

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

*The Medicaid and VCMSIP programs share a common application for enrollment and redetermination, and include the same verification and interview requirements. The application is a double-sided, one-page joint application, and evaluates those who qualify for Medicaid as well as VCMSIP.*

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

*All applications, whether original or for redetermination, undergo eligibility review and determination at the local Department of Social Services after the completed application is received. Applicants are first evaluated, through the common application form, for the state Medicaid program. If they are ineligible because of income level, they are evaluated for eligibility for the VCMSIP program. Program enrollees are required to report changes in their income or program eligibility to the eligibility worker, whereupon an additional determination is made about the appropriateness of moving from the VCMSIP program to the Medicaid program or the reverse. During the annual redetermination process, resubmission of health information, income, and other documents determine which program is appropriate for the applicant. In FFY00, only 4.3% of VCMSIP disenrollees were eligible for Medicaid (see Section 1.2).*

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

*VCMSIP enrollees have the same regional managed care program options as the Medicaid eligibles in their geographic area: MEDALLION, the primary care case management (PCCM) program and Medallion II, the HMO program.*

## **2.7 Cost Sharing:**

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

*Although the VCMSIP program allows for cost-sharing on a sliding fee scale for children with incomes between 150% and 185% FPL, there has been no cost-sharing to date.*

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

NA

## **2.8 Assessment and Monitoring of Quality of Care:**

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

*DMAS uses a variety of mechanisms to measure the quality of care received by VCMSIP enrollees, including: focused studies; client satisfaction surveys; complaint/grievance/disenrollment reviews; plan site visits; case file reviews; independent peer review; HEDIS performance measurement; HMO Quality Assurance Committee; DMAS Quality Assurance Workgroup; Case Management meetings; reports from the DMAS HMO Clinical Coordinator and the Special Needs Liaison; and independent assessments. A more detailed explanation of these activities is contained in Table 4.5.1 of the March 2000 report.*

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

*Internal and external quality assurance initiatives that were implemented as part of Virginia's federal 1915(b) waiver programs were extended to the VCMSIP program, and continue to be utilized. These include: annual household recipient surveys and biannual managed care program assessments; the use of preventive services may be evaluated through measures of well-child screening rates, the rate of acute and ambulatory care, and the adequacy of services for special-needs children. Enrollment data, survey data, contractor review of services data, and administrative data are used to measure effectiveness.*

*Currently available information on quality of care includes immunization and prenatal care reports, the household survey report on access and quality measures, DMAS Surveillance and Utilization Review Subsystems (SURS) reports on low and high utilization of services, complaint and appeals tracking reports, and enrollment broker disenrollment reports. The DMAS SURS regularly assesses the extent to which primary care practitioners are meeting contractual obligations, particularly with regard to early and periodic screening, diagnosis and treatment (EPSDT) services (immunizations, physical examinations, eye and hearing tests, laboratory tests, dental check-ups, other services).*

*DMAS also has numerous quality of care process activities such as the quality assurance mechanisms within DMAS, DMAS Quality Assurance Workgroup, Case Management meetings, and reports from the DMAS HMO Clinical Coordinator and Special Needs Liaison. These are coupled with independent assessments for specific programs (e.g., Medallion II) and ensure assessment and monitoring of quality of care.*

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

*Information available in the future on quality of care includes SURS reports on primary care practitioners meeting contractual obligations, client satisfaction surveys, and HEDIS measures for comparison of HMOs. A well-child study is planned for completion by 2002. With the exception of the encounter data, information should be available in early 2001. The encounter data information should be available by the end of 2001.*

*The proposed FAMIS plan will use numerous methods to assure that recipients receive quality services, including: verification that the health insurers develop and maintain quality assurance and quality improvement programs; verification that health insurers have sufficient network providers and procedures to ensure that children have access to routine, urgent, and emergency services; verification that health insurers maintain a member complaint system and provide access to a grievance process to appeal a plan action; adherence to overall quality standards established by the Commonwealth of Virginia; and adequate performance measurements to include submission of a quality improvement plan which meets NCQA standards. The DMAS contract for health plan services stipulates that immunization rates for two year- olds be reported annually.*

## SECTION 3. SUCCESSES AND BARRIERS

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*This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.*

### **3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.**

*Note: If there is nothing to highlight as a success or barrier, Please enter NA=for not applicable.*

*As mentioned above in Section 1.4, despite successes in the VCMSIP program, there are constraints in meeting the program goals.*

#### 1. Eligibility –

***Barriers:** The paperwork involved in completing an original or redetermination application and obtaining the necessary verifications for Medicaid or VCMSIP can be extensive for caseworkers, community advocates, and clients.*

***Successes:** Virginia has taken significant steps to simplify enrollment and coordination for their child health coverage programs. These include: a joint application; no asset test; no face-to-face interview; and annual redetermination. The VCMSIP program attempts to simplify as much as possible the eligibility criteria and the eligibility process, and in turn, these administrative improvements spill over into streamlining the Medicaid program.*

#### 2. Outreach –

***Barriers:** The intersecting roles of state, county, and local social services officials in administering CMSIP add an additional layer of complexity, and may constrain a coordinated outreach and enrollment program. Outreach funds are part of a limited budget for overall administrative expenses for CMSIP, so outreach activities are also limited.*

***Successes:** Continued to build broad public and private community partnerships, including the RWJ Covering Kids Project.*

#### 3. Enrollment – *The 12-month waiting period for previously insured children may present a barrier to enrollment. Partnerships with community-based organizations have helped with outreach, application completion, and program enrollment.*

#### 4. Retention/disenrollment – *Despite the eligibility and enrollment simplification measures in VCMSIP and Medicaid, once children are enrolled they can lose coverage when they reach a new age category or when redeterminations are required. Procedures that facilitate contacting families and assisting them in redetermination of eligibility may ensure lower rates of disenrollment.*

#### 5. Benefit structure – *The benefit structure's strength is its comprehensiveness, but keeping it as*

*a purely public program may be a barrier. Having a benefit structure that parallels what is in the private sector would remove any welfare stigma and invite participation by the private sector.*

6. Cost-sharing – *There currently is no cost-sharing in the VCMSIP program*
7. Delivery systems – *The VCMSIP Program delivery system parallels the Medicaid program’s delivery system. Maintaining an adequate network of physicians willing to accept Medicaid/VCMSIP patients is a challenge, and physicians fluent in the languages spoken by their clientele are chronically in short supply in areas of the state with non-English speaking populations.*
8. Coordination with other programs – *DMAS has coordinated with public, not-for-profit, and for-profit firms in the development and implementation of VCMSIP. DMAS continues to work with these organizations as to common programmatic interests for meeting the health insurance needs of low-income children.*
9. Crowd-out – *The 12-month waiting period is a safeguard against supplanting private insurance with a public program, however it is also seen as a barrier by some.*

10. Other

*Acknowledging some of the strengths and barriers associated with the VCMSIP program, an alternative plan was developed for the Commonwealth of Virginia that retained the program flexibility under VCMSIP but added an employer-sponsored health insurance subsidy for those children whose parents have access to family health coverage at their workplace. DMAS believes the FAMIS program will reduce the stigma that may accompany participation in a state supported children’s health insurance program. The proposed FAMIS changes include:*

- *Coverage of eligible children from birth through age 18 in families with income at or below 200% of FPL*
- *Simplified eligibility determination based on gross income*
- *Centralized eligibility processing*
- *Comprehensive benefits including well-baby and preventive services*
- *A health care delivery which utilizes private insurance programs or other DMAS authorized entities*
- *Subsidizes health insurance premiums of eligible children with access to employer-sponsored health insurance (ESHI), which may enable coverage of entire families*
- *Children who do not have access to ESHI will be covered directly under the state-administered plan through private insurers, health care providers, or HMOs.*

## SECTION 4. PROGRAM FINANCING

*This section has been designed to collect program costs and anticipated expenditures.*

**4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.**

*Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00.*

	(\$000)	(\$000)	(\$000)
	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
<b>Benefit Costs</b>			
<b>Insurance payments</b>			
<b>Managed care</b>	<i>6,077</i>	<i>13,808</i>	<i>26,722</i>
per member/per month rate X # of eligibles	<i>86.05x6,098</i>	<i>88.62x12,984</i>	<i>93.65x23,777</i>
<b>Fee for Service</b>	<i>19,268</i>	<i>27,867</i>	<i>43,987</i>
<b>Total Benefit Costs</b>			
<b>(Offsetting beneficiary cost sharing payments)</b>			
<b>Net Benefit Costs</b>	<i>25,345</i>	<i>41,675</i>	<i>70,709</i>
<b>Administration Costs</b>			
<b>Personnel</b>		<i>63</i>	<i>126</i>
<b>General administration</b>			
<b>Contractors/Brokers (e.g., enrollment contractors)</b>		<i>2,092</i>	<i>4,155</i>
<b>Claims Processing</b>		<i>165</i>	<i>178</i>
<b>Outreach/marketing costs</b>		<i>750</i>	<i>750</i>
<b>Other</b>	<i>2,701</i>		
<b>Total Administration Costs</b>	<i>2,701</i>	<i>3,070</i>	<i>5,209</i>
<b>10% Administrative Cost Ceiling</b>	<i>2,701</i>	<i>3,070</i>	<i>5,209</i>
<b>Federal Share (multiplied by enhanced FMAP rate)</b>	<i>18,558</i>	<i>29,666</i>	<i>50,121</i>
<b>State Share</b>	<i>9,488</i>	<i>15,079</i>	<i>25,797</i>
<b>TOTAL PROGRAM COSTS</b>	<i>28,046</i>	<i>44,745</i>	<i>75,918</i>

**4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.**

NA

**4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?**

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify) \_\_\_\_\_

**A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.**

*No change is anticipated in the sources of the non-Federal share of plan expenditures.*

## SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

**5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information.** If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
<b>Program Name</b>		<i>Virginia Children's Medical Security Insurance Plan</i>
<b>Provides presumptive eligibility for children</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
<b>Provides retroactive eligibility</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
<b>Makes eligibility determination</b>	<input type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
<b>Average length of stay on program</b>	Specify months _____	Specify months <u>8.7 MO FY99</u>
<b>Has joint application for Medicaid and SCHIP</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
<b>Has a mail-in application</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
<b>Can apply for program over phone</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <i>Requires signature</i> <input type="checkbox"/> Yes
<b>Can apply for program over internet</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <i>Can download but must be signed</i> <input type="checkbox"/> Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
<b>Requires face-to-face interview during initial application</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<b>Requires child to be uninsured for a minimum amount of time prior to enrollment</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> <i>Applicable when coverage terminated within 12 months prior to application.</i> What exemptions do you provide? <i>3 GOOD CAUSE*</i>
<b>Provides period of continuous coverage <u>regardless of income changes</u></b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
<b>Imposes premiums or enrollment fees</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____
<b>Imposes copayments or coinsurance</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<b>Provides preprinted redetermination process</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

See Section 2.3.3 for explanation of "Good Cause" exemptions

**5.2 Please explain how the redetermination process differs from the initial application process.**

*The redetermination process varies somewhat based on locality. Eligibility verifications and requirements are the same as in the initial application, but during the redetermination process localities may choose more vigorous contact and follow-up procedures.*

## SECTION 6: INCOME ELIGIBILITY

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*This section is designed to capture income eligibility information for your SCHIP program.*

**6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or  
Section 1931-whichever category is higher

133 % of FPL for children under age 6  
100% of FPL for children aged 6-19  
\_\_\_\_% of FPL for children aged \_\_\_\_\_

Medicaid SCHIP Expansion

\_\_\_\_% of FPL for children aged \_\_\_\_\_  
\_\_\_\_% of FPL for children aged \_\_\_\_\_  
\_\_\_\_% of FPL for children aged \_\_\_\_\_

State-Designed SCHIP Program

185% of FPL for children aged birth through age 18  
\_\_\_\_% of FPL for children aged \_\_\_\_\_  
\_\_\_\_% of FPL for children aged \_\_\_\_\_

**6.2 As of September 30, 2000, what types and amounts of disregards and deductions does each program use to arrive at total countable income?** Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter a NA.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) \_\_\_\_ Yes   x   No  
 If yes, please report rules for applicants (initial enrollment).

<b>Table 6.2</b>			
	Title XIX Child Poverty- related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	<i>first \$90 of earned income</i>	\$	<i>first \$90 of earned income</i>
Self-employment expenses	<i>Business expenses</i>	\$	<i>Business expenses</i>
Alimony payments Received	<i>Disregard first \$50 monthly</i>	\$	<i>Disregard first \$50 monthly</i>
Paid	NA	\$	NA
Child support payments Received	<i>Disregard first \$50 monthly</i>	\$	<i>Disregard first \$50 monthly</i>
Paid	NA	\$	NA
Child care expenses	*	\$	*
Medical care expenses	NA	\$	NA
Gifts	<i>\$30/quarter</i>	\$	<i>\$30/quarter</i>
Other types of disregards/deductions (specify)	\$	\$	\$

*\*Full-time employment up to \$175 per month for child age 2 or older; disregard up to \$200 per month child under 2; and part-time employment up to \$120 per month per child*

*time employment up to \$120 per month per child*

**6.3 For each program, do you use an asset test?**

Title XIX Poverty-related Groups	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____
Medicaid SCHIP Expansion program	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____
State-Designed SCHIP program	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____
Other SCHIP program _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test _____

**6.4 Have any of the eligibility rules changed since September 30, 2000?**  Yes  No

## SECTION 7: FUTURE PROGRAM CHANGES

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*This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.*

### **7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001( 10/1/00 through 9/30/01)?** Please comment on why the changes are planned.

*The 2000 Virginia General Assembly directed the Virginia Department of Medical Assistance Services (DMAS) to amend the Virginia Children's Medical Security Insurance Plan (VCMSIP) as authorized under Title XXI of the Social Security Act enacted legislation. This action revises and renames the VCMSIP program as the Family Access to Medical Insurance (FAMIS) Plan. The aim of FAMIS is to diminish the stigma of a public welfare program, simplify and expedite the eligibility determination and enrollment process, and increase access to a broader array of providers through private-sector health insurance programs, including subsidizing employment-sponsored health insurance (ESHI). The Commonwealth of Virginia maintains that these actions will improve public perception and acceptance of the program, thereby increasing enrollment. The plan is still awaiting approval from HCFA.*

*The following section describes future changes in both the existing VCMSIP program as well as the proposed FAMIS program.*

1. Family coverage – *Family coverage is not offered in VCMSIP. With FAMIS, if employer-sponsored health insurance is available through a parent, DMAS may provide premium assistance for the child. This may also result in coverage of the parents but this is considered incidental.*

2. Employer sponsored insurance buy-in – *No Change in VCMSIP*

*The FAMIS program subsidizes employment-based coverage by:*

- *Enabling participants who have access to employer-sponsored health insurance coverage to enroll in the employer's plan if DMAS determines that it is cost effective to provide premium assistance on their behalf*
- *Providing supplemental benefits for eligible children covered under employer plans as needed to be equivalent to those available through the comprehensive health care benefits package under FAMIS*

*The benefits delivery system of FAMIS includes:*

- *No pre-assignment process nor fee-for-service program for initial enrollment*
- *Health plan mechanisms for delivery of benefits can include HMOs, preferred provider organizations, indemnity, or other entities*

3. 1115 waiver – *The Commonwealth of Virginia does not plan on applying for an 1115 waiver*

4. Eligibility including presumptive and continuous eligibility – *No Change in VCMSIP*

*Eligibility and enrollment processes for the FAMIS program include:*

- *Establishing a centralized processing site for FAMIS in order to respond to inquiries, distribute applications and program information, receiving and processing applications, determining eligibility for the program, and enrollment into health plans*
- *Allowing local social service agencies, contracting health plans, providers, and others to provide application assistance*
- *There is no presumptive eligibility*
- *The duration of eligibility is 12 months, unless the parent or caretaker reports a change affecting eligibility. The recipient must report changes when they occur.*

5. Outreach – *No Change in VCMSIP*

*Outreach activities for the FAMIS program include:*

- *The DMAS Board, in consultation with the establishment of the Outreach Oversight Committee, shall develop a comprehensive, statewide outreach plan. The plan shall include strategies for improving outreach and enrollment in those localities where enrollment is less than the statewide average and enrolling uninsured children of former Temporary Assistance to Needy Families recipients*
- *The Outreach Oversight Committee shall be composed of representatives from community-based organizations engaged in outreach activities, social services eligibility workers, the provider community, health plans, and consumers*
- *The Committee shall make recommendations regarding state-level outreach activities, the coordination of regional and local outreach activities, and procedures for streamlining and simplifying the application process, brochures and other printed materials*

6. Enrollment/redetermination process - *No Change in VCMSIP*

*The FAMIS Plan will be for individuals up to the age of 19, and:*

- *Changes eligibility criteria to include children in families with gross income at or below 200% of the Federal Poverty Level (FPL)*
- *Changes the 12-month required waiting period, if previously insured, to six (6) months*
- *Implements cost sharing for all eligible children in a family – above 150% of FPL cost sharing shall not exceed 5% of family's gross income (premiums and co-pays); at or below 150% of FPL cost sharing shall not exceed 2.5% of family's gross income and shall be limited to nominal co-payments*
- *Provides comprehensive health care benefits, including: well-child and preventive services; medical; dental; vision; mental health; substance abuse services; physical therapy, occupational therapy; speech language pathology; and skilled nursing services for special education students*
- *The duration of eligibility is 12 months, unless the parent or caretaker reports a change*

*affecting eligibility. The recipient must report changes when they occur. If no change is reported, eligibility will be redetermined annually.*

7. Contracting - *No Change in VCMSIP*

*For FAMIS, DMAS is considering issuing Request for Proposals to address the following areas:*

- *Centralized processing unit: A centralized processing site for FAMIS in order to respond to inquiries, distribute applications and program information, receiving and processing applications, determining eligibility for the program, and enrollment into the health plans*
- *Health Benefits Programs: For selecting and contracting with managed care entities for the delivery of services to children in FAMIS*
- *Outreach: For a firm to assist with development of a statewide marketing plan. The plan will be directed toward informing the target market, stimulating interest and promoting enrollment in the program.*

8. *Other – In the FAMIS program, the Commonwealth will develop and use separate applications for the FAMIS and Medicaid programs. A central site will receive FAMIS applications from numerous sources, including: mail, telephone, Internet or fax. Local social service agencies, as well as providers and health plans, may provide applications and assist families with completing FAMIS applications; however, eligibility processing will occur at the central site. If a child appears to be eligible for Medicaid, the contract staff will transfer the application and/or automated data to Medicaid state agency staff co-located at the central site, who will initiate follow-up contact and assist families with completing the Medicaid application and eligibility determination process. On-going case maintenance for Medicaid cases may be handled through the local DSS in the locality where the child resides or by Medicaid staff at the central site.*

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*[end]*