Federal Fiscal Year 2001
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:

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

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
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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 Insurance Program & Family Access to Medical Insurance Security Plan***

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
_X_Separate SCHIP Program Only
_____Combination of the above

Reporting Period: ***Federal Fiscal Year 2001 (10/1/2000-9/30/2001)***

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Submission Date: ***December 20, 2001***

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 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, 2000, 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.

A. Program eligibility
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

B. Enrollment process
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

C. Presumptive eligibility NC

D. Continuous eligibility
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

E. Outreach/marketing campaigns
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

F. Eligibility determination process
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

G. Eligibility redetermination process
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

H. Benefit structure
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

I. Cost-sharing policies
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

J. Crowd-out policies
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

K. Delivery system
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

L. Coordination with other programs (especially private insurance and Medicaid)
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

M. Screen and enroll process
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

N. Application
NC 10/1/00 – 7/31/01; see below narrative for changes with FAMIS program after 8/1/01

O. Other

See below narrative for changes with FAMIS program after 8/1/01

The year 2000 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 revised and renamed 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 speed-up 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 joins a handful of states that have decided to form partnerships with employers to expand access to health care coverage in the belief that these actions will improve public perception and acceptance of the program, thereby increasing enrollment. Under the premium assistance program, Virginia will reimburse parents of FAMIS-eligible children for part of the cost of health insurance premiums paid on behalf of children.

Components of the FAMIS Plan:

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

- *Applications and eligibility determinations are handled at a centralized site instead of at local Department of Social Services offices throughout the State.*
- *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, benchmarked to the PPO option offered to State employees, which includes: well-child and preventive services; medical; dental; chiropractic, family planning, vision; mental health; substance abuse services; physical therapy, occupational therapy; speech language pathology; organ transplantation, home health, hospice, and skilled nursing services for special education students*

**Ineligible children include members of families employed by a state agency or local government entity that contributes to the cost of dependent health care coverage; members of families who have access to employer-sponsored dependent health insurance coverage under any Virginia State Employee Health Insurance Plan; inmates of public institutions; inpatients in an Institution for Mental Disease (IMD); and those who have discontinued insurance within past six months (without good cause).*

The benefits delivery system of FAMIS includes:

- *One or more approved managed care entities (MCEs) in 118 localities will provide the delivery system for the new FAMIS benefit package*
- *The MCE's network of providers includes doctors, hospitals, clinics, drug stores, medical supply companies, and other medical service providers*
- *MCEs offer a Primary Care Provider (PCP) to manage health care services for the FAMIS enrollees*

- *FAMIS enrollees will be asked to select or will be assigned a plan at the point of eligibility*
- *Children who are enrolled in VCMSIP will be automatically enrolled in FAMIS*

The FAMIS program subsidizes employment-based coverage by:

- *Enabling participants who have access to employer-sponsored health insurance coverage (and whose employers pay a minimum of 40% of the cost of family 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*
- *If cost of ESHI is equal/less than FAMIS, parents may be covered as well as children*

Eligibility and enrollment processes for the FAMIS program include:

- *Establishing a centralized processing unit (CPU) for FAMIS in order to provide "one-stop shopping" for potential enrollees, which will respond to inquiries, distribute applications and program information, receive and process applications, and determine eligibility for the program*
- *Establishing a toll-free Call Center within the CPU and co-locating Medicaid eligibility staff at the site*
- *Eliminating the requirement for applicants to go to the Department of Social Services, but allowing local social service agencies, contracting health plans, providers, and others to provide application assistance*

Outreach activities for the FAMIS program include:

- *Maintaining an Outreach Oversight Committee composed of representatives from community-based organizations engaged in outreach activities, social services eligibility workers, the provider community, health plans, and consumers*
- *Coordination of publicity, enrollment, and service delivery with existing local providers and programs such as health care services and providers, and schools*
- *Coordination with SignUpNow, a project of the Virginia Coalition for Children's Health, a private sector initiative supporting community based efforts to increase the enrollment of eligible children in the state's health insurance programs (SCHIP and Medicaid), by providing: workshops and training, technical assistance, comprehensive information and resources, coordination and support to a network of community and state-level workers, specific case-by-case assistance for local workers helping families, and advocacy for program improvements and effective local outreach.*
- *Statewide information meetings for enrollees*
- *Statewide agency/community group training meetings*

The FAMIS plan was approved by HCFA (now called CMS) on December 22, 2000 (Virginia Title XXI Program Fact Sheet, HCFA, 2001), and implementation of the first phase began in

August 2001. Phase I components included: inaugurating a simplified eligibility process; establishing the central processing unit (CPU); launching the employer-sponsored health insurance (ESHI) component; and beginning the outreach, marketing, and enrollment activities. Phase II, scheduled to be implemented throughout November and December of 2001, includes: cost-sharing, a new benefit package, and a new benefit delivery system.

The following table describes the differences between the VCMSIP Program and the newly approved FAMIS program.

Changes to Virginia's Health Insurance Programs for Children effective 8/1/01

	VCMSIP	***FAMIS***
Family Income	*185% of FPL after certain deductions*	*200% of FPL based on gross income*
Eligibility Determined by	*Local Dept. of Social Services*	*Central Processing Unit*
Covered Services	*Almost identical to Medicaid benefits*	*Modeled after state employees health care plan (eff. 12/01)*
Effective Date	*Coverage is effective on the first day of the month of application*	*same*
Provider Network	*Medicaid Medallion & Medallion II Programs*	*FAMIS Managed Care Entities (MCEs) (eff. 12/01)*
Cost to Families	*None*	*Co-payments for services other than preventive medical services for all and monthly premiums for those over 150% FPL (eff. 11/01)*
Current Insurance	*Children with current insurance are not eligible*	*same*
State Employees	*Children of parents with access to state's family coverage are not eligible*	*same*
Waiting Period	*12 months since last insurance*	*6 months since last insurance*
Cooperation with Child Support Enforcement	*Child is not eligible if parent refuses to cooperate*	*Encouraged but not required*
Employer Sponsored Health Insurance	*Not an option*	*If family chooses to purchase employer's health care plan, and it is cost effective for the state- FAMIS may be used to pay for cost of employee's premium*

Until August 1, 2001, the original VCMSIP program remained in effect, with no changes in eligibility, enrollment, coordination, or other program features as reported in the FY01 Annual Report.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Because of the roll-out of the FAMIS program in August of 2001 and the data and system disruptions that came as a result of moving the application processing unit from Social Services to a centralized separate private contractor, we calculated the number of insured children in the Commonwealth of Virginia for FFY01 only through 07/31/01, which reflects enrollment for the VCMSIP program. The total VCMSIP enrollment for eleven months of FY01 is 69,108. These are children enrolled anytime during the eleven months including distinct enrollees carried over from the previous fiscal year, as well as reenrollees during the period. This suggests an increase of 41,229 children over the last fiscal year, although it should be noted that the preparatory actions readying the system for the transition to FAMIS may have caused initial data reporting duplications or inaccuracies. Other DMAS reports indicate a figure closer to 59,000 for total enrollees ever enrolled from 10/1/99, with a current enrollment of approximately 35,000 children (JCHC report, September 10, 2001; HCFA 21 Summary), which still indicates a sizeable increase from the previous year's enrollment figures. VCMSIP provided creditable coverage to these children enrolled during these periods. The eligibility characteristics of the VCMSIP population through August 31, 2001 follows:

VCMSIP enrollee population eligibility characteristics	*FFY01*[1]	*FFY00*[2]	*FFY99*
Total number of enrollees ever enrolled (10/1/99 – 08/31/01)	*69,108*	*27,879*	*18,948*
Average number of days eligible (among all ever enrolled)	*293 days*	*189 days*	*188.7 days*
Avg age on day of CMSIP enrollment among all ever enrolled	*8.77 years*	*8.96 years*	*9.2 years*
% of VCMSIP disenrollees (enrolled anytime between October 1, 1999 and August 30, 2001 but not enrolled in VCMSIP August 31, 2001)	*18.8%*	*14.76%*	*NA*
% of Medicaid disenrollee comparison group (% of all individuals 18 years and younger and enrolled anytime between between October 1, 1999 and August 30, 2001 but not enrolled in VCMSIP August 31, 2001))	*41.67%*	*31.1%*	*NA*
% of VCMSIP disenrollees with subsequent Medicaid eligibility	*7.11%*	*4.3%*	*21%*
% of VCMSIP enrollees with prior Medicaid eligibility	*66.03%*	*63.5%*	*65.3%*
% enrollees 0-6 years of age	*39%*	*37%*	*34%*
% enrollees 7-12 years of age	*38%*	*39%*	*41%*
% enrollees 13-18 years of age	*23%*	*24%*	*25%*
% White enrollees	*48.9%*	*51.8%*	*57.8%*
% Black	*34.3%*	*31.8%*	*27.7%*
% Hispanic	*13.1%*	*12.6%*	*10.9%*
% Asian	*3.2%*	*3.4%*	*3.2%*
% Native American	*0.1%*	*0.1%*	*0.1%*

[1] *Data calculated only through 08/31/01 because of reporting and system changes with the onset of the FAMIS program in August 2001.*

[2] *Figures reported in last year's annual report. FY00 total number of enrollees ever enrolled recalculated at 34,894 (MMIS, 11/01), which may indicate enrollees captured late in the last fiscal year and not reported at that time because of the lag in data entry.*

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. Those enrolled in the VCMSIP program with subsequent Medicaid eligibility (7.1% in FFY01 versus 4.3% in FFY00) may be a reflection of the economic downturn that began mid-year.

In addition to the information from the computer eligibility files, information from the VCMSIP enrollment broker for the FFY01 period indicates the following, based on 6300 records:

- *44%, of the children enrolled were not previously insured*
- *56%, of the children were previously insured through Medicaid*
- *37% of the new enrollees were between the ages of 0-6; 39% between the ages of 7-12; and 24% between the ages of 13-18. These figures correspond closely with the computer eligibility files of 39%, 38%, and 23%, respectively.*

In addition, the enrollment broker data indicates that the majority (79%) of new enrollees heard about the program through their local Social Service Departments, although other outreach strategies were also successful, including: brochures (6%); media (4%); relatives (4%); and other (7%).

B. 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.

Last year, in FFY00, the total number of Medicaid enrollees ever enrolled from October 1, 1999 through September 30, 2000 was 377,045 (HCFA64). During FFY01, the total number of Medicaid enrollees ever enrolled from October 1, 2000 through September 30, 2001 was 390,279, an increase of over 13,000 children. In addition, DMAS eligibility files indicate that between July 2000 and July 2001 the daily total enrolled Medicaid population increased by 27% (160,000 to 220,000). This may indicate that more children became Medicaid eligible as the economy softened or that more eligible children were enrolled as a shadow effect of the increased outreach for the VCMSIP/FAMIS program during the FFY01 year. Because children move in and out of the Medicaid program throughout the year, which is reflected in the high disenrollment rate in the Medicaid program (almost 42%), it is unclear how many children have been enrolled in Medicaid as a direct result of SCHIP outreach. However, since the inception of the VCMSIP program in Virginia, there has been a net increase of at least 10,000 new Medicaid children (DMAS report to the JCHC, May and September 2001).

C. 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. The Kaiser Commission on Medicaid and the Uninsured (October 2001) reports that 12.8% of Virginia's children are uninsured. A 2001 follow-up Health Access Survey by the Virginia Health Care Foundation found that 14% of children 0-17 were uninsured, representing a slight increase in the number of uninsured children in the Commonwealth, and matching the national average (Academy for Health Services Research & Policy 2001). This increase in the number of uninsured children mirrors the overall experience of the rest of the state with regard to the number of uninsured Virginians – a two percent increase, or nearly 300,000 individuals. The increase in the number of uninsured Virginians, including uninsured children, is believed to be the result of new population growth in the state. Many of the children of the newly arrived families may be in income categories ineligible for either the Medicaid or the VCMSIP program. The VHCF survey reports that individuals above 200 percent FPL represent an increasing share of the uninsured population in Virginia (50% in 2001 compared to 34% in 1996), a population ineligible for state supported children's insurance.

The Virginia CMSIP Program began October 26, 1998. There were 1,420 children enrolled by the end of the 1998 calendar year, 19,569 by December 1999, and 29,967 by the end of 2000. This represents a 73% increase in VCMSIP enrollment over the last calendar year, exceeding the national average of 67% during the same time, and suggests evidence of progress in the Commonwealth of Virginia in reducing the numbers of uninsured children. (Source: Kaiser Commission, 2001).

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*

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

__X__ 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 2001 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 and 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 "NC" (for no change) in column 3.*

Table 1.3 (1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
To reduce the number of uninsured children	*Increase the number of Medicaid eligible children enrolled in Medicaid*	Data Sources: *DMAS eligibility computer file, federal reports* Methodology: *Tracking the number of children enrolled in Medicaid* Progress Summary: *During FFY01, the total number of Medicaid enrollees ever enrolled was 390,279, an increase of over 13,000 children from FY00. DMAS eligibility files indicate that between July 2000 and July 2001 the daily total enrolled Medicaid population increased by 27% (160,000 to 220,000). Over 10,000 new, unduplicated Medicaid children have received insurance since the inception of VCMSIP*
	Enroll 63,200 children in VCMSIP/FAMIS by the end of FFY02	Data Sources: *DMAS eligibility computer file, enrollment broker records* Methodology: *Count VCMSIP/FAMIS participants on file* Progress Summary: *The total VCMSIP enrollment for eleven months of FY01 is 69,108, representing an increase of 41,229 children from the previous fiscal year. It should be noted that the changes in recording the enrollment in the existing information management system during the transition to FAMIS in August 2001 might have caused initial data reporting duplications or inaccuracies. Other DMAS reports indicate a figure closer to 59,000 for total enrollees ever enrolled from 10/1/99, with a current enrollment of approximately 35,000 children. The state expects to meet or exceed the goal of enrolled children.*
	Reduce percentage of uninsured children	Data Sources: *Periodic statewide child health access surveys* Methodology: *Survey conducted measuring child health insurance status* Progress Summary: *See 1.2.C narrative in previous section*
Objectives Related to SCHIP Enrollment		
To conduct effective outreach to encourage enrollment in health insurance plans	*Obtain the active participation of community-based organizations*	Data Sources: *Records/reports of outreach campaign* Methodology: *Contacts tracked with all entities involved in outreach (e.g., community-based, other state agencies, business community, school districts)* Progress Summary: *A broad-based outreach campaign continues for the VCMSIP/FAMIS program, 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 continues to sponsor training sessions for these organizations on VSMCIP and FAMIS.* *The RWJ – VCMSIP/FAMIS Covering Kids program demonstration pilots have as their goals to increase public awareness, coordinate outreach efforts among volunteers to recruit and assist eligible families to apply for children's health insurance, simplify the enrollment process, and collect data to identify effective outreach strategies. The Blue Ridge Medical Center (BRMC), a federally qualified community health center, leads the rural outreach pilot for a five county area in central Virginia. BRMC's Rural Health Outreach Program (RHOP) uses its health depots as one approach to outreach and enroll eligible children from the five rural counties. Through the health depots, which are located at various community sites, RHOP staff and trained volunteers recruit and assist families with eligible children to enroll in Virginia's children's health insurance program and Medicaid. Strong linkages with the schools in the five county area are established by RHOP for identifying and enrolling eligible children in VCMSIP/FAMIS and Medicaid. Another outreach approach RHOP uses is recruiting and training faith-based communities to lead faith-based outreach efforts and assist families in applying for health insurance for their children. Follow up contacts are made*

Table 1.3 (1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		with families to determine outcomes of the applications, encourage accessing medical services, and determine if additional assistance is needed. *As the urban pilot for the Virginia Covering Kids project, Success By 6 conducts outreach efforts in Richmond, Petersburg, Chesterfield County, and Henrico County. Throughout the pilot area, SB6 recruits and trains volunteers from community health care providers, local public schools, and faith-based communities to identify, recruit and assist families with eligible children to apply for health care coverage for their children.* *Each RWJ pilot program collaborates with other community-based organizations to recruit and train volunteers as Outreach Workers to recruit and enroll eligible children into VCMSIP and FAMIS. The Outreach Workers also provide assistance in completing the VCMSIP or FAMIS applications. The RWJ pilots participate in community events to market and promote participation in VCMSIP/FAMIS. The RWJ – VCMSIP Program is collaborating with state agencies (DMAS and DSS programs) and non-profit organizations to simplify the application and to develop an electronic application. The computerized application program is being pilot tested with the afore-mentioned RWJ Demonstration Projects.*
	Utilize various strategies for informing parents about VCMSIP/FAMIS	Data Sources: *Administrative records of outreach campaign* Methodology: *Strategies tracked in outreach campaign* Progress Summary: *Until January 2001, DMAS had a contract with the Virginia Department of Social Services for outreach services for the VCMSIP program. VDSS implemented a four-tier outreach approach: federal, state, local, and grassroots. The* ***Federal tier*** *included a partnership with the Health Care Financing Administration (HCFA) and the Department of Agriculture. At the* ***State level****, a media campaign was launched including radio, television, newspaper, outdoor, and transit advertising. VDSS formed partnerships with community-based organizations, faith-based organizations, child advocacy groups, hospitals, free clinics, HMOs, and other agencies. VDSS coordinated 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 targeted the eligible population and local outreach workers within the 122 local Departments of Social Services. VDSS fostered partnerships among local community based organizations and the local DSS offices to facilitate the enrollment and outreach process.* ***On a grassroots level****, volunteer community outreach workers were recruited from churches, schools, and other community agencies. The volunteers were trained on how to reach out to families and enroll eligible children into VCMSIP. The volunteers sought eligible children/families through churches, health clinics, school events, community fairs, depot stations, libraries, Head Start programs and day care centers. The RWJ-VCMSIP pilot programs described in the above section recruited lay volunteers to do outreach of eligible families and to assist the families in completing the VCMSIP application.* *DMAS transferred responsibility of VCMSIP outreach from DSS to DMAS, in preparation for the transition to FAMIS, in early 2001. Since then, DMAS Outreach staff has been working with the FAMIS Outreach Oversight Committee, the Virginia Coalition for Children's Health "Sign-up Now" coordinator, other public-private community partners, and a public relations firm to continue the effective outreach campaign begun under DSS and to develop additional outreach plans and strategies for FAMIS outreach. A media campaign began in August and continued to use various media (radio, TV, newspapers, transit and outdoor signage) to alert the public about VCMSIP/FAMIS.*
	Distribute information and applications to parents of school-aged children and pre-school children	Data Sources: *Administrative records of outreach campaign, DMAS quarterly reports on the Status of VCMSIP/FAMIS* Methodology: *Strategies tracked in outreach campaign* Progress Summary: *During FFY01, thousands of brochures, flyers, tear-off pads, and*

Table 1.3 (1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		posters printed in both English and Spanish were distributed to the public statewide. The VCMSIP Call Center volume doubled during the spring of 2001 when the media campaign was airing statewide (from approximately 1000 calls/month to over 2200 calls/month). In addition to receiving calls and mailing out applications for the VCMSIP/FAMIS programs, DMAS outreach staff are working directly with elementary, middle, and high schools throughout the state to reach families with uninsured children.
Objectives Related to Increasing Medicaid Enrollment		
To reduce the number of uninsured children	*Increase the number of Medicaid eligible children enrolled in Medicaid*	Data Sources: *DMAS eligibility computer files, HCFA-64 reports* Methodology: *Tracking the increase in the number of children enrolled in Medicaid* Progress Summary: *DMAS eligibility files indicate that between July 2000 and July 2001 the daily total enrolled Medicaid population increased by 27% (160,000 to 220,000). This may indicate that more children became Medicaid eligible as the economy softened or that more eligible children were enrolled as a shadow effect of the increased outreach for the VCMSIP/FAMIS program during the FFY01 year. Because many children move in and out of the Medicaid program throughout the year, it is unclear how many children have been enrolled in Medicaid as a direct result of VCMSIP and/or FAMIS outreach. However, since the inception of the VCMSIP/FAMIS program in Virginia, there has been a net increase of at least 10,000 new Medicaid children.*
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
To improve the health status of children	*Increase the number of children with a usual source of care*	Data Sources: *1999 Child Health Access survey (state) and Consumer Assessment of Health Plans Survey (CAHPS) (federal)* Methodology: *1999 Child Access Survey provides a statewide benchmark of Medicaid managed care children with a usual source of care; CAHPS addresses the experience of Medicaid enrolled children* Progress Summary: *Results of the Child Access Survey includes satisfaction with health plans but a need for better communication with the Medicaid population with regard to using Medicaid services in a timely and appropriate way.*
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
To improve the health status of children	*Increase the number of children with immunizations*	Data Sources: *DMAS and Virginia Department of Health* Methodology: *Children under 35 months of age* Progress Summary: *In 1998, the Virginia Department of Health conducted a retrospective survey of kindergarteners (looking at the status of 4 and 5-year-old children when they were 2-years-old) to measure statewide progress towards the Year 2000 immunization goal of 90% for children by the age of two years. 70% of children had received the optimal 4-3-1 (four doses of DTP, three doses of polio, and one dose of MMR), up from 64% the preceding year. The National Immunization Survey (NIS) collects information on the immunization coverage of children 19 months to 35 months of age across the U.S. CDC provides state-specific immunization level estimates through NIS. In 1998, NIS estimated that 73% (+/- 4.7%) of children between the ages of 19 and 35 months in Virginia had received their primary series of shots (4-3-1) (VDH, Office of Epidemiology, 2001).*
	Increase the number of children treated for asthma	Data Sources: *Virginia Department of Health* Methodology: *Tabulation of statistical measures* Progress Summary: *In 1999, hospitalizations for asthma in Virginia totaled more than 11,000 (15.5/10,000 population), – a 11.5% increase in the number of asthma hospitalizations from*

Table 1.3 (1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		the year before (13.9/10,000 population). Children have a rate of hospitalization for asthma nearly twice of that for adults. Preschool children have the highest rate at 47.1/10,000 population with disparities among different races and localities. Low-income and minority children have the highest asthma-related hospitalization rates in Virginia. In May of 2001, VDH announced that it is partnering with the Virginia Asthma Coalition to address asthma-related health concerns in the Commonwealth of Virginia. (VDH Epidemiology Bulletin, March/April 2001).

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

Despite many 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 VCMSIP add an additional layer of complexity, and may constrain a coordinated outreach and enrollment program. Because of the ten percent cap on administrative expenditures by the federal government, outreach funds and 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. (This was simplified for FAMIS.) 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 clients are chronically in short supply in areas of the state with non-English speaking populations.

It is too early to evaluate the barriers and restraints in meeting the performance goals of the FAMIS program. See section 1.6 below for a description of the performance expectations of the FAMIS program.

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 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:

Overcoming 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 (see section 1.1.O for a more detailed description of the CPU and its functions).*
- *FAMIS will reduce the waiting period for previously insured children from 12 months to 6 months.*

Enhancing Outreach:

- *A comprehensive statewide outreach plan is needed and required by FAMIS statute, and includes: 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 (see Section 1.1.O for more information on the outreach effort under FAMIS)*

Maximizing 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*

Enhancing 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, documentation of accreditation by NCQA, JCAHO, or other nationally accrediting organization, 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 1, 2001

Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program, Department of Medical Assistance Services, April 1, 2001

Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program, Department of Medical Assistance Services, July 1, 2001

Quarterly Report on the Status of the Virginia Children's Medical Security Insurance Program, Department of Medical Assistance Services, October 1, 2001

SECTION 2. AREAS OF SPECIAL INTEREST

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

2.1 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.

VCMSIP does not offer family coverage. However, the FAMIS program, which was implemented in August of 2001, offers an employer-sponsored health insurance (ESHI) component. Under the FAMIS plan, families that have access to health insurance through their employer have the option of enrolling family members in the employer's health plan if it doesn't cost the State any more than it would have cost to cover the children by a FAMIS provider.

Families with children that are eligible for FAMIS can be covered under ESHI as long as the following conditions are met: 1) the employer must pay at least 40% of the cost of the health insurance for the family; 2) The cost of covering children under ESHI has to be equal to or less than the cost of covering the children under FAMIS; 3) The family must apply for the full premium contribution from the employer.

Some families may pay a premium based on their total family income and the number of children enrolled in the program. The monthly premium is $15 per child enrolled. The highest premium any family will pay is $45 per month, which covers three or more children. Depending on income, some families may not pay a monthly premium. (See table in previous Section 1.1.O)

ESHI participants are not required to pay a co-payment. They may have other cost sharing obligations and deductibles up to the capped amounts allowed for non-ESHI FAMIS families.

Families who have dropped insurance coverage for their children without "good cause" must wait six months before being eligible for coverage. This is because FAMIS is designed for uninsured children and is not designed to "crowd-out" or supplant creditable, private health insurance. (See table in previous Section 1.1.O)

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults

_____Number of children

Because the FAMIS ESHI program did not become effective until August 2001, there is very limited and/or incomplete data for FY01.

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

See 2.1.A above, and Section 1.1.O for a description of the plan.

2.2 Employer-sponsored insurance buy-in:

A. 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).

See 2.1.A above, and Section 1.1.O for a description of the plan.

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

VCMSIP does not have an employer buy-in component. Because the FAMIS ESHI program did not become effective until August 2001, there is very limited and/or incomplete data for FY01.

2.3 Crowd-out:

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

Crowd out emerged as one of the most contentiously debated issues during the development of the national SCHIP legislation. Policymakers were divided between the belief that aggressive policies were needed to prevent crowd out, and the belief that such policies were unnecessary and could deter enrollment. Most agreed that expanding coverage to uninsured children would require some displacement of private financing by public financing (Bilheimer 2001). Mechanisms such as waiting periods, monitoring applications, verifying insurance status, and cost sharing were used to deter supplanting private health insurance with publicly subsidized SCHIP programs. The original SCHIP in Virginia, VCMSIP, utilized some of these strategies to prevent crowd-out.

As part of the application for the VCMSIP, each application included a declaratory statement that the child for whom the application is being filed was not covered under any group health insurance plan. The application included a question about health insurance in the past. If the child had been covered under a health insurance plan within the past 12 months, the child was ineligible for VCMSIP, unless the reason for dropping the coverage was considered "good cause" and approved by the state. The 12-month waiting period under the VCMSIP program was not intended to discourage application for VCMSIP but rather to insure that the publicly subsidized program was not substituting for or contributing to the erosion of private health insurance coverage.

The newly implemented FAMIS program, which includes an employer-based program, reduces

the waiting period to six (6) months (see Section 1.1.O above), and provides subsidies to families to purchase dependent coverage through employment-sponsored health insurance programs. Subsidizing employer-based coverage, as in the FAMIS program, seeks to broaden the goals of capitalizing on private sector resources already supporting health insurance and thus strengthen the foundation of ESHI in the state.

National studies now suggest that the pressures to increase enrollment and reduce the number of uninsured children have begun to outweigh concerns about crowd out (Dubay 2001). There is a recognition that some degree of crowd out seems inevitable under a large expansion of public coverage but that using shorter waiting periods in conjunction with premium assistance models to facilitate ESHI buy-ins may mitigate some of the effects of crowd-out while promoting access to health insurance (Lutzky & Hill, 2001). Virginia joins Massachusetts, Mississipppi, Maryland, New Jersey, and Wyoming in offering SCHIP-supported ESHI buy-ins to expand child health coverage (Burueau of National Affairs, 2/10/01).

B. How do you monitor and measure whether crowd-out is occurring?

VCMSIP Program:

- *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*

FAMIS Program

- *FAMIS is not available to children who have had other "creditable" health insurance within the last six months unless there was "good cause" for stopping that insurance. The three allowable "good cause" exceptions for not waiting six months are:*
  1. *The insurance company dropped the child for reasons of uninsurability*
  2. *The employer dropped family coverage for all the company's employees and no one else in the household can cover the child with ESHI*
  3. *The person carrying coverage lost or changed jobs and the new employer does not provide subsidized coverage, and no one else in the household can cover the child with ESHI*
- *When participating in the ESHI program under FAMIS, a family choosing the ESHI option may find that other non-FAMIS eligible family members are also covered by the policy at no cost to them*
- *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*

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

VCMSIP Program

Although researchers have long been interested in measuring the level of "crowding out of private coverage" associated with Medicaid, no specific prevention mechanism had ever been required and the topic has remained a source of contention for decades (Ryan, NHPF, 2001). The debate escalated as the federal SCHIP legislation was being developed, since the program targeted working families with incomes higher than the Medicaid population. Many states, like Virginia, enacted a twelve-month waiting period because of the concern that families would drop private coverage in order to enroll in the lower cost SCHIP program. Under the original VCMSIP program, Virginia's waiting period of twelve months of being uninsured after participating in employment-sponsored health insurance reflected the national concern about crowd out, but included language allowing earlier participation if a family claimed "good cause" for the discontinuation of a child's health insurance coverage and documented 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 steady growth in the VCMSIP program since its inception suggests that the twelve-month waiting period was not a large barrier to enrollment.

However, national studies now suggest that the pressures to increase enrollment in Medicaid and SCHIP and reduce the number of uninsured children have begun to outweigh concerns about crowd out. There is recognition that some degree of crowd out seems inevitable under a large expansion of public coverage and that states, like Virginia, can use shorter waiting periods and "good cause" reasons to promote ESHI buy-ins and promote access to health insurance (Lutzky & Hill, 2001).

The Virginia FAMIS plan reduces the waiting period from 12 months to six (6 months), and subsidizes an existing employer-sponsored health insurance (ESHI) program that offers family coverage where the employer contributes at least 40% of the premium for family coverage. The FAMIS program was built on the belief that subsidies to employers to assist families in purchasing offered job-based coverage for themselves and their dependents could turn partially insured families into totally insured families, a notion that is shared by health policy experts (Hanson 2001). Because of the importance of the ESHI component, the FAMIS amendment requested and was granted an exemption to the federal requirement that participating employers be required to contribute at least 60% towards the cost of family coverage. This exception was requested based on average employer family health coverage contribution rates in Virginia, which are typically lower than 50%. In this way, it is hoped that Virginia's premium assistance model under the FAMIS program to facilitate ESHI buy-ins may mitigate some of the effects of crowd-out and promote health coverage for children (Source: Revised State Children's Health Insurance Program, TN No.:00-100, 7/1/2000).

D. 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.

Crowd-out raises many questions, including: 1) How much crowd out is acceptable in a public program; 2) What policy measures are effective at controlling crowd-out; 3) Are all rationales for substituting public for private coverage equal when determining a program's cost effectiveness; and 4) How might policymakers rank the priorities of efficiency and equity to improve health status? These questions came up in prior Medicaid expansions and then in the SCHIP program. Estimates on the extent to which crowd-out occurs vary greatly, with some studies suggesting it accounts for 15 percent and others putting it as high as 50% (RWJ, 2001). Limited data and methodological differences in the way coverage substitutions are defined make it difficult to know which type of calculation is most accurate.

Different research methodologies are used to measure the effects of crowd out. These include:

- *Cross-sectional studies estimate crowd out by examining the changes in insurance status of specific populations following public health insurance coverage expansions,*
- *Longitudinal studies estimate crowd out by examining the insurance status of the same individuals over a period of time following a Medicaid coverage expansion, and*
- *Qualitative case-studies or firm-level insurance data have evaluated the employer response to Medicaid expansion programs and may be the most applicable to the SCHIP program.*

Controversy over crowd-out analyses stems from widely divergent estimates reported by different studies, with estimates ranging from four percent (longitudinal study) to almost 50 percent (cross-sectional study). This difference is due, in part, with how crowd-out is defined, what population is used, what type of data are used, and what controls are included in the analysis (RWJ 2001).

Assessing the policy implications of crowd-out is not straightforward because crowd-out can have both negative and positive effects, such as supplanting private coverage (negative) and providing access to a program of continuous, comprehensive health care that was previously unaffordable (positive). As with many public policy issues, crowd out is about trade-offs. Although some degree of substitution seems inevitable, policymakers need to determine the greater priority – limiting the displacement of private health coverage or making significant strides in reducing uninsurance (Feder 2001). Many health policy analysts believe that it is still too early to modify federal or state policies relating to crowd out until more is learned about the rate of substitution as coverage is extended to "higher" low- income families (Lutzky & Hill, 2001). In the meantime, many states, like Virginia, are finding that they can do more to help the nation's uninsured by working with the private sector through subsidizing premiums for employees and encouraging family coverage at the workplace.

2.4 Outreach:

A. 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 programs, 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 pilot projects represent a grassroots approach for statewide outreach. The goal of the pilots is to enroll children into the SCHIP program by identifying and overcoming enrollment barriers and developing effective community tailored outreach mechanisms. (See Section 1.1.O and Table 1.3 in the above sections)

In early 2001, DMAS transferred responsibility of the VCMSIP outreach from DSS to DMAS in preparation for the transition to the FAMIS program. Until FAMIS became operational in August 2001, DMAS staff continued to promote the VCMSIP program through media, community events, presentations, outreach training, coalition building, local outreach facilitation, call center support, and information dissemination. The FAMIS Outreach Oversight Committee consists of community organizations, social service eligibility workers, and members of the provider, health plan, and consumer groups. The outreach program promotes coordination of publicity, enrollment, and service delivery through actions of the Central Processing Unit (CPU), schools, private/public partnerships, and case management providers.

B. 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 demonstrate the effectiveness of the outreach, and reflect 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 FFY01 (See Section 1.2) also indicate that the outreach has been effective.

The FAMIS plan includes in statute a requirement for a comprehensive statewide outreach plan, and the current outreach effort is coordinated with FAMIS' centralized eligibility processing system. Elements of the plan include methods for tracking data on outreach, enrollment, and

redetermination, as well as direct linkage with other public and private organizations working to increase children's health and health insurance coverage.

C. 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 the program's success, and fostering public/private partnerships like the RWJ Covering Kids Project, the SignUpNow project sponsored by the Virginia Coalition for Children's Health, United Way's Insurance for Children Project, Employer-based enrollment, and school-based programs, are particularly noteworthy. The successes of these types of programs mirror the national experience that link effective outreach strategies to increased coverage of uninsured children (Cunningham 2001; Felland 2001; Worthlin Worldwide 2001).

2.5 Retention:

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

The percentage of VCMSIP disenrollees since its inception is approximately 19%, much lower than the comparison Medicaid population of 42% (see Table 1.2). There are many reasons for this disparity, including the volatility of income eligibility in the Medicaid population. 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 (Hill 2000). With that awareness, the newly enacted FAMIS program mirrors private insurance by providing a premium subsidy for eligible families to insure their children under an employer-sponsored health plan.

FAMIS facilitated enrollment in the program by greatly simplifying the application verification and eligibility determination process and time frame. Although the FAMIS program does not share an application with the Medicaid program, a change from VCMSIP, FAMIS applications are mailed to a central processing site for initial Medicaid screening and a FAMIS eligibility determination. Medicaid eligibility staff are co-located at the central site. Applicants are not required to have a face-to-face interview or contact.

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

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

Under VCMSIP, HMOs performed targeted mailings to those individuals who lost eligibility to let

them know that they could be eligible for coverage. Postcards were mailed to people identified as having lost their eligibility. Advocacy groups targeted in their outreach those who may have lost eligibility. Local Departments of Social Services also used their discretion to follow-up with those children. Finally, the numerous, ongoing general outreach efforts encouraged children to reenroll. Under the FAMIS program, similar efforts will be made to contact families who disenroll but may be eligible except that the activities will be coordinated through the CPU in cooperation with community organizations and other state agencies.

__X__ Information campaigns
__X__ Simplification of re-enrollment process, please describe

Simplification efforts include: the common application form for Medicaid and VCMSIP (through 7/31/01); the integration of Medicaid and FAMIS enrollment procedures at the CPU; the lack of a requirement for a face to face interview; and the ability to complete applications by telephone, fax, mail, or electronic means.

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

The enrollment broker tracks disenrollment

____ Other, please explain

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

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

Retention efforts for VCMSIP were locality-dependent, but like outreach, strategies that were

2.6 Coordination between SCHIP and Medicaid:

A. 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 shared a common application for enrollment and redetermination, and included the same verification and interview requirements. The application was a double-sided, one-page joint application, and evaluated those who qualify for Medicaid as well as VCMSIP.

Although the FAMIS program uses a separate application from the Medicaid program the processing of the applications via a centralized processing unit should offset any enrollment barriers caused by the dual applications. A recent GAO study (2001) reports that application transfers took less time if the SCHIP and Medicaid program offices were geographically close or co-located. The Commonwealth of Virginia utilizes a call center and a mail-in application, both of which address specific questions about health insurance coverage or available coverage. FAMIS applications are taken over the phone or they can be mailed to a central processing unit (CPU) site for Medicaid screening and a FAMIS eligibility determination. Medicaid eligibility staff is co-located at the central site in order to assist in the coordination between the two programs. Applicants are not required to have a fact-to-face interview or contact.

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

In the VCMSIP program, all applications, whether original or for redetermination, experienced eligibility review and determination at the local Department of Social Services after the completed application was received. Applicants were first evaluated through the common application form for the state Medicaid program. If they were ineligible because of income level, they were evaluated for eligibility for the VCMSIP program. Program enrollees were required to report changes in their income or program eligibility to the eligibility worker, whereupon an additional determination was made about the appropriateness of moving from the VCMSIP program to the Medicaid program or the reverse. The application process could take up to 45 days. During the annual redetermination process, resubmission of health information, income, and other documents determined which program was appropriate for the applicant. Since the inception of the program, only 7% of VCMSIP disenrollees were eligible for Medicaid (see Table 1.2).

The FAMIS program has the same process as described above except the CPU would be responsible for determining Medicaid or SCHIP eligibility during the redetermination stage or if the family reported changes in their income. If changes were noted and an enrollee's program eligibility changed, the enrollee would be instructed to send in a revised application to the CPU for FAMIS or to either the CPU or the local DSS office for the Medicaid program.

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

VCMSIP enrollees had the same three regional managed care program options as the Medicaid eligibles in their geographic area: MEDALLION, the primary care case management (PCCM) program; Options, a voluntary MCO; or Medallion II, the mandatory MCO Program.

The FAMIS program benefit program will be delivered through approved managed care entities (MCEs). Recent research suggests that states that have similar delivery systems for their Medicaid and SCHIP programs are less likely to experience disruptions in care (AHRQ 2001). However, rather than a Medicaid look-alike benefit plan in the VCMSIP program, FAMIS program benefits are patterned after the state employees' PPO health plan option, with the addition of physical therapy, occupational therapy, speech language pathology, and skilled nursing services for special needs children. The State will provide supplemental coverage for children in the premium assistance program if the employer plan does not provide services included in the benchmark plan. This phase of FAMIS began in December 1, 2001.

2.7 Cost Sharing:

A. 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.

Under the FAMIS program, all families with incomes above 150% of the FPL will pay a monthly premium of $15 per child with a maximum of $45 per family per month. Families at or below 150% of the FPL are subject to co-payments ranging from $2 to $15 per inpatient admission. For families with incomes above 150% FPL, co-payments range from $5 to $25. Total co-payments for non-premium assistance families are limited to $180 per year for families with incomes at or below 150% FPL, and $350 for families with incomes above 150% FPL. Families not enrolled in the premium assistance program will track the amount they spend on co-payments and notify the State when the out-of-pocket cap is met. A new card will then be issued excluding families from additional co-payments. Families enrolled in the premium assistance program will not be subject to co-payments – providers will bill the state directly for co-payment charges. Native American children are not subject to cost sharing. Premiums and co-payments will be phased in to the FAMIS program in November and December of 2001.

B. 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?

See above description and cost-sharing and dates of implementation.

2.8 Assessment and Monitoring of Quality of Care:

A. 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 and FAMIS 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.

B. 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 in FAMIS as well. 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 draft 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 assurance mechanisms within DMAS, including the: 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.

In addition, the Commonwealth of Virginia will use numerous methods to assure that FAMIS recipients receive quality services that are appropriate to their needs, including: verification that health insurers develop and maintain quality assurance and quality improvement programs (including documentation of national accreditation and quality performance measures); verification that health insurers have sufficient network providers and procedures to ensure that children have access to routine, urgent, and emergency services; and verification that health insurers maintain a member complaint system and provide access to a grievance process to appeal a plan action.

C. 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, client satisfaction surveys, case file information from encounter data validation, HEDIS measures for comparison of HMOs. This information is available from the managed care division at DMAS, which tracks quality assurance for the Medicaid, VCMSIP, and FAMIS programs.

The 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 and documentation of accreditation by NCAQ, JCAHO, or other nationally recognized accrediting organization. In addition, the Commonwealth will require all health insurers to develop and maintain a Quality Improvement Program (QIP), 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

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 2001 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.

A. Eligibility

VCMSIP
The paperwork, which could take up to 45 days, 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. The VCMSIP Child Support Enforcement requirement was an additional component that may affect participation. Virginia has taken some steps to simplify enrollment and coordination for their child health coverage programs. These include: no asset test; no face-to-face interview; and annual redetermination.

FAMIS
National studies have detailed the deterrent effects of the enrollment systems in SCHIP programs. Around 10 percent of low-income children nationally had parents who cited problems related to administrative hassles such as language, transportation, or provision of documents as the primary reason they didn't apply for or inquire about coverage (Kenney 2001). Recognizing those barriers, eligibility improvements under the FAMIS program include: reducing the eligibility waiting period from 12 months to six months; the encouragement but not the requirement that parents cooperate with the Division of Child Support Enforcement (CDSE); a simpler FAMIS application; the use of gross income (rather than income disregards) in calculating eligibility; a centralized, separate, private contractor (CPU) for application process and assistance; accepting applications by phone, mail, fax; or internet, with no face-to-face contact with anyone required.

B. Outreach

VCMSIP
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.*

FAMIS

The FAMIS program combines an Outreach Oversight Committee, made up of community organizations, social service eligibility workers, the provider community, health plans, and consumers) with a private public relations firm in order to publicize the new program statewide. Outstationing of workers will be a key element in successful outreach efforts; there are currently 67 outstationed sites in Virginia. In addition, SignUpNow, a project of the Virginia Coalition for Children's Health, will provide FAMIS application assistance and outreach.

C. Enrollment

The 12-month waiting period for previously insured children under the VCMSIP program may have presented a barrier to enrollment. Partnerships with community-based organizations have helped with outreach, application completion, and program enrollment.

The FAMIS program has reduced the waiting period from 12 months to six months and encourages but not require that parents cooperate with the Division of Child Support Enforcement (CDSE). The use of a simpler FAMIS application and income calculations in conjunction with the institution of a private contractor (CPU) for application process and assistance should expedite enrollment for the new program.

D. Retention/disenrollment

Despite the eligibility and enrollment simplification measures in VCMSIP, FAMIS and Medicaid, once children are enrolled they can lose coverage when they reach a new age category or when redeterminations are required. Community-based groups and internal procedures that facilitate contacting families and assisting them in redetermination of eligibility may ensure lower rates of disenrollment. The disenrollment rate for VCMSIP is half of the Medicaid disenrollment rate (see Table 1.2), which may indicate some income stability for that population or the effects of retention efforts on the part of DMAS and community partners.

E. Benefit structure

The strength of the benefit structure in VCMSIP was its comprehensiveness, but keeping it as a purely public program was considered a potential barrier. The FAMIS program incorporates a benefit structure that parallels what is in the private sector, which may help to remove any welfare stigma associated with a public program and in turn invite greater participation from working families.

F. Cost-sharing

The VCMSIP program had no cost sharing. The FAMIS program has modest cost sharing based on family income (see 2.7.A above). While it is too early to assess the consequences of cost-sharing on consumer behavior under FAMIS, national qualitative information suggests that cost-sharing (if indexed to "higher income" low-income families) will be beneficial in two ways: it will deter employees from substituting public for private dependent coverage (crowd-out) and it will not create barriers to enrollment (RWJ 2000; Hill 2000).

G. Delivery system

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

The FAMIS program's delivery system utilizes various approved health plans and networks, called managed care entities (MCEs). The MCE will be utilizing the same provider networks that are used for the State Medallion II program, with an emphasis on pediatric services. The challenges are the same as outlined above for VCMSIP.

H. 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 in developing common programs for meeting the health insurance needs of low-income children. (See the Outreach section above in 3.1.B)

I. Crowd-out

In the VCMSIP program, the 12-month waiting period was a safeguard against supplanting private insurance with a public program, however it was seen as a potential barrier to access to health coverage. The FAMIS program addresses that potential barrier by reducing the waiting period to six months and by working with private employers through a premium assistance program. The modest cost-sharing aspects of the FAMIS program reduce the incentive to drop private health insurance coverage and supplant it with a public program.

J. 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. Evidence from other states suggests that targeted effort with certain sectors of the employer market

might result in increased enrollment of low-income workers' children in SCHIP (Gugenheim 2001). In addition, DMAS believes the FAMIS program will reduce the stigma that may accompany participation in a state supported children's health insurance program. The FAMIS changes include:

- *Coverage of eligible children from birth to 19 in families with income at or below 200% of FPL*
- *Simplified eligibility determination based on gross income*
- *Centralized eligibility processing to reduce length of application process*
- *Comprehensive benefits including well-baby and preventive services*
- *Health care delivery through the centralized system, which utilizes commercial 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 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	11,752,812	37,459,024	55,324,138
per member/per month rate X # of eligibles	87.68 x 134,041	107.41 x 348,734	117.79 x 469,701
Fee for Service	27,406,584	15,743,557	11,941,763
Total Benefit Costs	39,159,396	53,202,581	67,265,901
(Offsetting beneficiary cost sharing payments)	0	1,527,478	2,099,235
Net Benefit Costs	39,159,396	51,675,103	65,166,666
Administration Costs			
Personnel	74,013	302,012	414,679
General administration	35,826	10,000	13,730
Contractors/Brokers (e.g., enrollment contractors)	308,331	3,191,730	4,382,419
Claims Processing	153,677	240,000	329,533
Outreach/marketing costs	1,600,543	966,800	1,327,469
Other			
Total Administration Costs	2,172,390	4,710,542,	6,467,830
10% Administrative Cost Ceiling	4,351,044	5,741,678	7,420,741
Federal Share (multiplied by enhanced FMAP rate)	27,402,974	37,383,682	47,493,671
State Share	13,928,812	19,001,962	24,140,825
TOTAL PROGRAM COSTS	41,331,786	56,385,645	71,634,496

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

NA

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__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**
Program Name		*Virginia Children's Medical Security Insurance Plan (10/1/00-7/31/01)* *Family Access to Medical Insurance Security Plan (8/1/01-present)*
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	X-*VCMSIP*____State Medicaid eligibility staff X-*FAMIS*_____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months	Specify months _*9.7 MO* (10/1/99-8/31/01)
Has joint application for Medicaid and SCHIP	_____No _____Yes	*X-FAMIS*_____*No* *X-VCMSIP*___Yes
Has a mail-in application	_____No _____Yes	_____No __X_FAMIS Yes
Can apply for program over phone	_____No _____Yes	__*X – VCMSIP* No - *Requires signature* __*X – FAMIS*__No - *Requires signature*
Can apply for program over internet	_____No _____Yes	__X__No - Can download but must be signed _*X – FAMIS* No Can download but must be signed
Requires face-to-face interview during initial application	_____No _____Yes	__X__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months What exemptions do you provide?	_____No __X__Yes, specify number of months *12 for VCMSIP; 6 for FAMIS* What exemptions do you provide? *3 GOOD CAUSE* *(See Section 2.3.C)*

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage regardless of income changes	_____No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	___X_No _____Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	_____No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	*X-VCMSIP* No *X-FAMIS* Yes, how much? *See 2.7.A above* Who Can Pay? ___ Employer _X_ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	_____No _____Yes	*X-VCMSIP* No *X-FAMIS* Yes, how much? *See 2.7.A above*
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	*X-VCMSIP* No *X-FAMIS* Yes, we send out form to family with their information and: _X_ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

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

VCMSIP
The redetermination process varied somewhat based on locality. Eligibility verifications and requirements were the same as in the initial application, but during the redetermination process localities had the opportunity to choose more vigorous contact and follow-up procedures.

FAMIS
Sixty days prior to the 12-month enrollment anniversary date, a renewal notification including an application form preprinted with the family's information will be sent to the enrollee. Eligibility verifications and requirements are the same as in the initial application. The family will be asked to check that all the information provided on the application is correct, to make any needed changes, and to return it to the Central Processing Unit (CPU) in the postage-paid envelope. In the event that the family returns the application and additional information is still needed, the CPU will contact them to request the needed information. If this form is not returned within 15 days, a reminder notice will be sent. If it is not returned within 30 days, the FAMIS CPU will make at least two attempts via telephone and one attempt via mail to contact the family and remind them of the need to forward the updated application.

SECTION 6: INCOME ELIGIBILITY

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

6.1 As of September 30, 2001, 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 _____

Separate SCHIP Program

200_% of FPL for children aged __birth to age 19_
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, 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 "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).

The VCMSIP program used Medicaid methodology to determine income. The FAMIS program uses gross income (earned and unearned income) and allows no income disregards, but raises the income eligibility from 185% to 200% FPL.

	Title XIX Child Poverty-related Groups	Separate SCHIP Program – VCMSIP Up to 7/31/01	Separate SCHIP Program – FAMIS** 7/31/01-present
Earnings	*first $90 of earned income*	*first $90 of earned income*	*Gross income – no income disregards*
Self-employment expenses	*Business expenses*	*Business expenses*	*Gross income – no income disregards*
Alimony payments Received	*Disregard first $50 monthly*	*Disregard first $50 monthly*	*Included in gross income – no income disregards*
Paid	*NA*	*NA*	*NA*
Child support payments Received	*Disregard first $50 monthly*	*Disregard first $50 monthly*	*Included in gross income – no income disregards*
Paid	*NA*	*NA*	*NA*
Child care expenses	*	*	*Gross income – no income disregards*
Medical care expenses	*NA*	*NA*	*NA*
Gifts	*$30/quarter*	*$30/quarter*	*Gross income – no income disregards*
Other types of disregards/deductions (specify)	*$*	*$*	*$*

**Medicaid and VCMSIP only: Full-time employment up to $75 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*
***Medicaid income methodology will continue to be used for current VCMSIP children who transition into FAMIS if they do not meet FAMIS income limit*

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

Title XIX Poverty-related Groups
__X_No___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program
____No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program
_X__No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____
____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes ___ No

VCMSIP transitioned into FAMIS August 1, 2001. See Section 1.1.O above

SECTION 7: FUTURE PROGRAM CHANGES

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 2002 (10/1/01 through 9/30/02)? 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 revised and renamed 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 speed-up 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 believes that these actions will improve public perception and acceptance of the program, thereby increasing enrollment. The plan was approved by HCFA (now CMS) on December 22, 2000 and began phase-in implementation on August 1, 2001.

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

A.Family coverage- *Family coverage is not offered in VCMSIP. With FAMIS, if employer-sponsored health insurance (ESHI) is available through a parent, DMAS may provide premium assistance for the child. This may also result in coverage of the parents, but the primary purpose of FAMIS is to cover uninsured children.*

B. 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 (effective December 2001):

- *One or more managed care entities (MCEs) in each locality will provide the delivery system*
- *FAMIS enrollees will be asked to select a plan or will be assigned a plan at the point of eligibility*
- *During the transition, VCMSIP enrollees will receive package with benefits, cost sharing, and delivery system choices*

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

D. 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, and determining eligibility for the program*
- *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.*

E. Outreach–*No change in VCMSIP*

Outreach for the FAMIS program includes:

- *The DMAS Board, in consultation with the established Outreach Oversight Committee, has developed a comprehensive, state-wide plan. The plan includes strategies for improving outreach and enrollment in those localities where enrollment is less than the statewide average and enrolling uninsured children of former TANF recipients*
- *The Outreach Oversight Committee is 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 that application and enrollment processes.*
- *Outstationing of outreach workers will be a key element in successful outreach efforts; there are currently 67 outstationed sites in Virginia*
- *Other strategies will include the coordination with school districts and other agencies and organizations, a toll-free hotline number, the use of a simplified application, and direct-marketing techniques*

F. Enrollment/redetermination process - *No change in VCMSIP*

The FAMIS Plan will be for individuals 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.*

G. Contracting - *No change in VCMSIP*

The FAMIS plan provides "one stop shopping" through a centralized processing unit (CPU) that oversees:

- *Distribution of applications and materials*
- *The receipt and processing all applications*
- *The maintenance of a toll-free Call Center for inquiries*
- *Friendly customer service*
- *The co-location and coordination with Medicaid eligibility staff*
- *Education to FAMIS and VCMSIP enrollees about program changes*
- *Administration of a monthly premium remittance process to include verifying and monitoring program eligibility*
- *Administration and monitoring of the premium remittance and copayment structure in accordance with specified program limits*

H. Other

In the FAMIS program, the Commonwealth uses 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 will be handled either through the Central Processing Unit or the local DSS in the locality where the child resides.

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