OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR 457.40(b))**

Bill Hazel, MD, Secretary of Health and Human Resources

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	Bill Hazel, MD	Position/Title: Secretary of Health and Human Resources
Name:	Cynthia B. Jones	Position/Title: Director, Department of Medical Assistance Services
Name:	Rebecca Mendoza	Position/Title: Director, Division of Child Health Insurance

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above. (Effective 09/01/02)

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan - Effective Date: 10/26/98 Implementation Date: 10/26/98
Effective date: Plan: 10/26/98; Amend. 1: 7/01/01; Amend. 2: 12/01/01; Amend.

3: 7/01/01; Amend. 4: 09/01/02; Amend. 5: 08/01/03; Amend. 6: Withdrawn; Amend.7: [(delete ESHI premium assistance program and exempt pregnant children from waiting period 8/01/05; allow for disease management in fee-for-service program 7/01/06)]; Amend. 8: Changes to the CHIP State Plan to outline coverage of school services and to add language regarding private funding; Amend. 9 FAMIS MOMS to 200% FPL and MCO opt in: 07/01/09, and Medicaid Expansion Immigrants: 04/01/09; Amend. No. 10: Translation for Dental Care: 7/1/09; Hospice Concurrent with Treatment: 3/23/10; Early Intervention and prospective payment for FQHCs and RHCs: 10/01/09; Citizenship Documentation: 01/01/10; Mental Health Parity and No Cost Sharing for Pregnancy-Related Assistance: 07-01-10. Amend. No. 11: Administrative Renewal Process: 10/01/10; and Virginia Health Care Fund: 07/01/10.

Implementation date: 10/26/98; Amend. 1: 8/01/01; Amend. 2: 12/01/01; Amend. 3: 12/01/01; Amend. 4: 09/01/02; Amend. 5: 08/01/03; Amend. 6: Withdrawn; Amendment 7: 7/01/06; Amend. 8: 07/01/07, and 02/14/09 implementation date of language regarding the RWJ Grant funding and private funding; Amend. 9: 07/01/09, and Medicaid Expansion Immigrants: 04/01/09; Amend. No. 10: Translation for Dental Care: 7/1/09; Hospice Concurrent with Treatment: 3/23/10; Early Intervention and prospective payment for FQHCs and RHCs: 10/01/09; Citizenship Documentation: 01/01/10; and Mental Health Parity, No Cost Sharing for Pregnancy-Related Assistance, and Virginia Health Care Fund: 07-01-10. Amend. No. 11: Administrative Renewal Process: 10/01/10; and Virginia Health Care Fund: 07/01/10. Amend. No. 12: Discontinue primary care case management: 5/1/12; Expand eligibility under lawfully residing option: 7/1/12; Add coverage for early intervention case management: 10/1/11; and Discontinue Virginia Health Care Fund funding: 7/1/12.

SPA #13, Purpose of SPA Update for SFY 2013
Proposed effective date: 7/1/12

Proposed implementation date:
Update description of outreach procedures (Sec. 5) to reflect changes initiated 7/1/04 – 7/1/12.
Revise performance plan (Sec. 9.3) 7/1/12

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

The Virginia Health Care Foundation conducted two surveys of health access in Virginia. The latest survey was conducted in the Spring of 1997 for the year 1996 of a representative sample of 1,861 households representing 4,694 individuals. The Department of Medical Assistance Services (DMAS) used estimates derived from this survey and census data for its planning purposes rather than from the national Current Population Survey. DMAS' administrative data were used to estimate Medicaid insured children.

HEALTH INSURANCE STATUS OF VIRGINIA
CHILDREN 0-18, BY POVERTY LEVEL 1996

	Insured			Uninsured			
Poverty Level	Medicaid	Private	Total Insured	Medicaid Eligible	Other Uninsured	Total Uninsured	Total Children
Under 100%	206,550	2,430	208,980	34,020	0	34,020	243,000
100% to 125%	33,450	3,570	37,020	10,980	9,000	19,980	57,000
125% to 150%	31,500	4,860	36,360	12,920	12,720	25,640	62,000
150% to 175%	37,500	9,140	46,640	22,080	17,280	39,360	86,000
175% to 200%	6,000	44,000	50,000	2,000	33,000	35,000	85,000
200% to 250%	0	57,000	57,000	0	20,000	20,000	77,000
Above 250%	0	979,000	979,000	0	40,000	40,000	1,019,000
Totals	315,000	1,100,000	1,415,000	82,000	132,000	214,000	1,629,000

DMAS assumes that insured/uninsured individuals are evenly distributed by age below 100% of poverty. Above 100% of poverty more of the uninsured are ages 6-18. Virginia Medicaid covers children 0 through 5 up to 133% and covers children ages 6 through 18 up to 100% of poverty. Effective 9/01/02, Virginia's Medicaid Program was expanded through Title XXI to cover additional targeted low-income children ages 6 through 18 with family income equal to or less than 133% of FPL.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

In Virginia, determinations of eligibility for Medicaid (Title XIX) are made by the local Departments of Social Services and by Medicaid State agency staff co-located at the Title XXI Central Processing Unit. Applicants have the option of mailing in both their application for assistance and needed verifications, so that no face-to-face interview is required. Virginia also has eligibility workers outstationed in selected hospital sites and local health departments to identify potentially eligible and enroll eligible Medicaid (Title XIX) participants.

Determinations of eligibility for the state child health insurance program, The Family Access to Medical Insurance Security (FAMIS) Plan (Title XXI), are completed at a Central Processing Unit or Local Department of Social Services (LDSS). The Central Processing Unit screens applicants for Medicaid eligibility prior to completing a FAMIS eligibility determination. LDSS determines eligibility for Medicaid first and then determines FAMIS eligibility for children denied Medicaid due to excess income. Families may apply by mail, by phone, fax or web; there is no requirement for a face-to-face interview.

In addition, many community groups have trained volunteers to help parents of potential Medicaid (Title XIX) and FAMIS (Title XXI) eligible individuals by answering questions and helping to complete applications and gather verifications needed to process cases.

Virginia's Title XXI program is known as the Family Access to Medical Insurance Security Plan (FAMIS). The FAMIS program replaced Virginia's original Title XXI program in August 2001. FAMIS was designed to 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. These actions were taken to improve public perception and acceptance of the program, thereby increasing enrollment. In September 2002, the FAMIS program was revised again to provide for better coordination with the Medicaid program and to simplify the application process.

FAMIS provides comprehensive health benefits for children from birth through age 18 who are not covered under health insurance and are not members of a family employed by a state agency or local government entity that contributes to the cost of dependent health care coverage. A mail-in application is used which addresses specific questions about other current and prior health insurance coverage A family may call a toll-free number and begin the application process. The FAMIS Central Processing Unit mails a preprinted Child Health Insurance application which can be completed, signed, and returned via mail or fax to the Central Processing Unit for Medicaid screening and FAMIS eligibility determination. If it appears the child is eligible for Medicaid, the application is forwarded to the outstationed Medicaid staff located at the Central Processing site or to the LDSS in the city or county where the family resides for Medicaid eligibility determination. Child Health Insurance applications may also be submitted to any LDSS for determination of eligibility of Medicaid and FAMIS.

Expenditures for children who meet Medicaid eligibility criteria are claimed at the Commonwealth's regular Medicaid FMAP. Effective 9/01/02, the Commonwealth began claiming enhanced funding for optional targeted low-income children who qualify under the Medicaid expansion. Expenditures for the children determined eligible under the Family Access to Medical Insurance Security Plan are claimed at the State's enhanced FMAP.

No Entitlement: In accordance with § 2102(b)(4) of the Social Security Act (42 U.S.C. § 1397bb(b)(4)) and § 32.1-353 of the Code of Virginia, the Family Access to Medical Insurance Security Plan shall not create any individual entitlement for payment of medical services or any right or entitlement to participation.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Virginia currently has no health insurance programs that involve a public-private partnership.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

The FAMIS program coordinates with the Virginia Department of Health, including Children's Specialty Services and the Maternal and Child Health programs, with State teaching hospitals serving indigent families, and with local government health delivery programs which serve low income children. The Commonwealth's goal is to provide all targeted low-income children with an accessible and comprehensive system of care that secures a medical home for children. This coordination is directed to ensuring that FAMIS does not supplant or replace existing programs. Rather, the goal of coordination is the close cooperation between these programs to enhance the health care resources available to low income children. DMAS, the single State agency that administers the Medicaid program, also administers FAMIS. Thus, Virginia ensures that the plan is closely coordinated with Medicaid in identifying and facilitating enrollment in the respective programs.

DMAS is responsible for the coordination of outreach and education efforts for all children whether they qualify for Medicaid or for FAMIS. Community-based organizations participating in this effort direct families to the appropriate program and assist them with applying for either FAMIS or Medicaid. Public programs that have established networks serving families who would meet either FAMIS or Medicaid's income eligibility requirements are used as a resource in reaching eligible children.

DMAS has developed an interagency committee specifically to address the health care needs of children, pregnant women, and special needs populations. The group meets periodically to discuss issues of mutual concern, solicit support, and cooperation, and share creative approaches to serving these unique populations. Information regarding FAMIS as well as Medicaid is routinely shared and discussed with these individuals. A part of this group effort is the identification and coordination of Title V children. In addition, through its many other committees comprised of non-agency membership (e.g., Board of Directors, Managed Care Advisory Committee, Provider Advisory Council), DMAS solicits input and advice from public and private entities on its programs.

DMAS shall issue a settlement notice at the time of the reconciliation that denotes the amount due to or from the LEA provider. If the interim payments exceed the FFP of the certified costs of an LEA's Medicaid, Medicaid Expansion, or FAMIS services, DMAS will recoup the overpayment using the methods outlined in the Virginia Medicaid State Plan, Attachment 4.19-B, Pages 9a of 15 through 9f of 15 and subsequent revisions to this section. If the FFP of the certified costs exceeds interim payments, DMAS will pay the difference to the LEA provider.

At the end of each settlement, interim rates for each LEA provider will be determined by dividing total medical services cost and special transportation service cost by an estimate of the number of units of service. For the initial interim rates or for new providers, interim rates will be based on pro forma cost data. Interim rates are provisional in nature pending completion of the cost report.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to CMS' Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.

If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Prior to May 1, 2012, the Commonwealth of Virginia's Title XXI State Plan utilized two Secretary-approved benefit packages within FAMIS. One Secretary-approved coverage is a modified Medicaid look-alike component offered through a fee-for-service program and a Primary Care Case Management (PCCM) Program previously approved and continually provided under the State's original Title XXI program, Virginia Children's Medical Security Insurance Plan (VCMSIP). The group of children receiving services through a PCCM program is comprised of children who transitioned into FAMIS from either VCMSIP or Medicaid with a prior primary care case management (PCCM) history. Such children are initially assigned to the PCP with whom they had a previous relationship. The PCCM program was discontinued May 1, 2012. The other Secretary-approved coverage is modeled after the state employee plan in effect in June 2000, provided under the current Title XXI State Plan, approved by the Centers for Medicare and Medicaid Services (CMS) December 22, 2000 and delivered by contracted (Managed Care Organizations) MCOs.

Newly eligible and enrolled FAMIS recipients are assigned to the fee-for-service program until they are enrolled into managed care. All geographic areas will be covered by two or more MCOs beginning July 1, 2012. In preparation for this expansion, the Commonwealth discontinued the PCCM program effective May 1, 2012.

Financing

Effective October 1, 2009, the Commonwealth reimburses for services provided by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs), applicable to CHIP, in the same manner it reimburses for services provided in the Title XIX (Medicaid) program as described in the Virginia State Plan for Medical Assistance, Attachment 4.19-B, Supplemental payments are made to FQHCs and RHCs for services reimbursed by MCOs as also described in the Virginia State Plan for Medical Assistance, Attachment 4.19-B. Coverage under the fee-for-service/PCCM components (modified Medicaid look-alike component) will be reimbursed on a fee-for-service basis by the Department.

The managed care organizations (MCOs) are at risk for all services provided. The plans have the discretion in reimbursing and contracting with providers and must ensure services are provided and a sufficient network exists. FAMIS rates are actuarially sound rates, and are established in a manner consistent with CMS regulations promulgated pursuant to the Balanced Budget Act of 1997. A managed care savings factor shall be applied to determine the final rates. The savings factor shall be determined annually.

PRIMARY CARE CASE MANAGEMENT

Secretary-approved coverage through the PCCM Program was provided through a Primary Care Case Management (PCCM) delivery system. The PCCM delivery system manages and delivers health care for enrollees and is reimbursed on a fee-for-service basis. This program is administered in conjunction with the State's MEDALLION Primary Care Case Management program. The MEDALLION and FAMIS PCCM delivery system was discontinued May 1, 2012.

FEE-FOR-SERVICE

Coverage under the modified Medicaid look-alike component is based on the fee-for-service program and providers are reimbursed by the Department. Children newly eligible for FAMIS receive services through the fee-for-service delivery system until they are enrolled in an MCO. Effective September 1, 2012, all localities shall have at least two MCOs.

COVERAGE PROVIDED UNDER MCOs

The second benefit package is Secretary-approved coverage modeled after the state employee plan in effect in June 2000, provided under the current Title XXI State Plan through contracted MCOs.

Secretary-approved coverage modeled after the state employee health plan provides a comprehensive array of health care benefits for eligible enrollees. DMAS has contracted with various managed care health insurers that meet certain requirements and standards in order to provide a comprehensive health benefits plan to FAMIS enrollees on a regional basis. The plans have the discretion in reimbursing and contracting with providers and must ensure services are provided and a sufficient network exists.

Effective July 1, 2009, children who are assigned to a MCO in an area where there is only one contracted MCO may request reassignment to the traditional fee-for-service delivery and payment system.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

A. FFS/PCCM Utilization Controls.

Utilization controls for providers offering Secretary-approved coverage through the fee-for-service and the PCCM Program component are administrative mechanisms that are designed to ensure that children use only health care that is appropriate, medically necessary, and approved by DMAS. DMAS relies on the utilization controls already established and operational in the Title XIX program for eligibles under Title XXI. Administrative mechanisms to be employed include the following: prepayment reviews, prior authorizations and internal reviews, post payment and SURS reviews.

Managed Care Organization Utilization Controls

Managed care organizations providing the Secretary-approved coverage modeled after the State employee plan in effect in June 2000 are required by contract to manage service utilization and have in place a process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. The utilization program may include drug formulary decisions and criteria. The UM program must demonstrate that enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interest of the enrollees. The MCO's UM program reflects standards for utilization management from the most current nationally accepted standards. The program must have mechanisms to detect over-

utilization and/or under-utilization of care, including, but not limited to, provider profiling and disease management programs. MCOs must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.

For more information on utilization controls, please refer to the current Title XXI State Plan § 7 - Quality and Appropriateness of Care.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan:

State wide.

4.1.2. ☒ Age:

From birth through age 18.

4.1.3. ☒ Income:

Effective September 1, 2002, the Commonwealth's Medicaid program was expanded under Title XXI to provide coverage for children from age 6 through age 18 who live in families with income in excess of 100% of FPL, but less than or equal to 133% FPL. The income limit prior to this date was less than or equal to 100% FPL for children age 6 through 18. All Medicaid income disregards, deductions and methodologies used for the Poverty Level group of Medicaid eligible children in the State's Title XIX plan apply to this expanded group. The Commonwealth claims enhanced funding for optional targeted low-income children who qualify under the Medicaid expansion. Regular FMAP is claimed for those children who do not meet the definition of optional targeted low-income child.

The Family Access to Medical Insurance Security Plan, Virginia's separate Title XXI plan, was also revised to cover children from birth through age 18 in families with gross incomes at or below 200% of the FPL, but in excess of 133% of the federal poverty level. Formerly, FAMIS covered children from birth through age 5 in families with gross income in excess of 133% of the FPL but at or below 200% of the FPL and children from age 6 through 18 in families with gross incomes in excess of 100% of the FPL but at or below 200% of the FPL.

The former Title XXI program, CMSIP, covered children up to 185% of the FPL and used the same income methodologies applied under the Virginia State Plan for Medical Assistance that are applied to children in the poverty income related groups.

Children who were enrolled in CMSIP on the date of FAMIS implementation, August 2001, were automatically enrolled in FAMIS. The income methodology for these children is protected. In the event that their gross family income exceeds the FAMIS limits, their eligibility will be determined using the income requirements of the CMSIP program for as long as they remain continuously eligible.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):

Eligible children must be Virginia residents.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage:

Any child covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91(a) and (b)(1)) shall not be eligible for the program.

4.1.8. ☒ Duration of eligibility:

Children enrolled in FAMIS are eligible for coverage as of the first day of the month in which a signed application is received at either the local department of social services in the locality where the child resides or at the FAMIS Central Processing Unit. Effective 08-01-06, if a child enrolled in FAMIS is born within the three months prior to the month in which a signed application is received, coverage is effective retroactive to their date of birth if they would have met all eligibility criteria during that time.

Effective 08-01-03, enrollment is for 12 continuous months, unless one of the following events occurs before the annual renewal: 1)

an increase in gross monthly income to above 200% FPL; 2) a child moves out of state; 3) a child turns age 19; 4) the family requests cancellation; or 5) the family applies for Medicaid and the child is determined eligible for Medicaid. Families must report the following changes before the annual renewal: 1) an increase in gross monthly income or change in family size resulting in a family income above 200% FPL; or 2) an enrolled child moving out of the Commonwealth of Virginia. If none of the above changes is reported, eligibility will be renewed annually.

4.1.9. ☒ Other standards (identify and describe):
Children are not eligible for the Family Access to Medical Insurance Security Plan: (1) if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Virginia State Employee Health Insurance Plan, (2) if they are inmates of public institutions, (3) if they are inpatients in an institution for mental disease, or (4) if their parent or other authorized representative does not meet the requirements on assignment of rights to benefits or cooperation with the agency in identifying and providing information to assist the Commonwealth in pursuing any liable third party.

Effective 01-01-10, upon signing the declaration of citizenship or nationality required by § 1137(d) of the Social Security Act, the applicant or recipient is required under § 2105(c)(9) to furnish satisfactory documentary evidence of U.S. citizenship or nationality and documentation of personal identity unless citizenship or nationality has been verified by the Commissioner of Social Security or unless otherwise exempt. Applicants who otherwise meet eligibility requirements are enrolled and are permitted a reasonable opportunity to provide the required verification.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1)"lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost

of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible children as specified below who are lawfully residing in the United States including the following:

A child shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section
210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the

Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age 19.

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, which the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

Effective September 1, 2002, the State intensified efforts to enroll children in health care coverage through both its FAMIS and Medicaid programs. The Medicaid income

limits for poverty level children were increased to 133% of the federal poverty level for children ages 6-19, thereby creating a single income limit for all poverty level children. A Title XIX State Plan Amendment effective September 1, 2002 was submitted to expand this income limit. Note: Children with income in excess of 100% FPL but equal to or less than 133% FPL who are currently enrolled in FAMIS became Medicaid eligible effective on this date. Families of these children were notified of this change, the different benefit package available to Medicaid recipients, and the fact that their children's cases would be transferred to and maintained by the local department of social services in the locality where they reside.

Instead of having a separate application form for each program, Medicaid and FAMIS, a single child health insurance application form was implemented. The single application form is accepted at the FAMIS Central Processing Unit and at any local department of social services in the Commonwealth. In addition to the single application form, children in families who apply at local departments of social services for Medicaid using a multi-program application form and who are determined to be ineligible for Medicaid will also have their eligibility for FAMIS determined by the local department. A supplement has been developed for use with the multi-program application form to collect information not applicable to Medicaid but necessary to determine FAMIS eligibility.

The Commonwealth continues to contract with a private entity to operate a Central Processing Unit for receipt and review of applications, for conducting a screen for Medicaid eligibility and for making FAMIS eligibility determinations for those children who do not appear to be eligible for Medicaid. The Central site receives applications from numerous sources. Families are able to apply by mail, by phone, by fax or on the FAMIS.org website. Effective July 2010, new and renewal applications made through the FAMIS.org website can be signed with an electronic signature. Effective January 2011, new and renewal applications can be signed over the telephone with an electronically recorded signature. Contract staff at the Central Processing Unit review documentation and input data from the single application form into an automated system that screens the data for potential Medicaid eligibility. If a child appears potentially eligible for Medicaid, the contract staff transfers the application to Medicaid State staff co-located at the Central Processing Unit. State Medicaid staff reviews the case for Medicaid and determines if the child or his family has an active case with a local department of social services (Medicaid, Food Stamps or TANF). If the child or family has an active case, the State Medicaid staff transfers the application to the local department of social services in the city or county where the child resides for a complete eligibility determination and enrollment in the Medicaid program. If the child or family does not have an active case with a local department of social services, State Medicaid staff complete the Medicaid eligibility determination and enroll eligible children in the Medicaid program. Approved cases

are then transferred to the local department of social services in the city or county where the child resides for on-going case maintenance.

Local departments of social services accept applications by mail, by fax or in person. Eligibility staff at the local agencies process child health applications received for Medicaid eligibility and, if eligible, enroll the child or children in the Medicaid program. If the child is found ineligible for Medicaid because of excess income, local departments of social services then complete a FAMIS eligibility determination. Children eligible for FAMIS are enrolled in the FAMIS program and their cases are transferred to the FAMIS Central Processing Unit for ongoing case maintenance. The family is not required to file a new application.

FAMIS eligibility staff and eligibility workers at the local departments of social services evaluate applications for children determined not to be Medicaid eligible and having family income at or below 200% of the FPL and notify applicants of their eligibility. Children determined to be FAMIS-eligible have their cases maintained at the central site. Children determined to be Medicaid-eligible have their cases maintained at the local department of social services in their locality of residence.

FAMIS cases are reviewed annually to determine continued eligibility. Effective 08-01-03, enrollment is for 12 continuous months, unless one of the following events occurs before the annual renewal: 1) an increase in gross monthly income to above 200% FPL; 2) a child moves out of state; 3) a child turns age 19; 4) the family requests cancellation; or 5) the family applies for Medicaid and the child is determined eligible for Medicaid. Families must report the following changes before annual renewal: 1) an increase in gross monthly income or change in family size that results in family income above 200% FPL; or 2) an enrolled child moves out of the Commonwealth of Virginia. Medicaid cases are reviewed in accordance with established Medicaid policy. At the time of redetermination and/or renewal, a child found ineligible for either Medicaid or FAMIS will have his eligibility automatically determined in the other program.

Beginning in July 2010, recipients up for renewal receive a renewal packet in the mail with a PIN and Family ID number which gives them the option to log into the FAMIS.org website and view/submit a renewal application prepopulated with family information, including income information from the most recent eligibility determination. All recipients have an option to send additional information and upload pay stubs or other verification documents through the website. New applications can be signed electronically via the website.

On October 1, 2010, the FAMIS CPU implemented an administrative renewal process. Additional fields were added to both the paper and the electronic renewal

prepopulated application to allow the recipient to attest that the income has not changed from the previous reporting period. In addition, there is a section for families to report any changes in income. If the responsible person does not confirm or reports a change in income source, the CPU attempts to electronically verify the household income through the Department of Social Service's SPIDeR data warehouse. Only if the CPU cannot electronically verify household income is a notice sent to request documentation of the unverified income. When the Central Processing Unit (CPU) cannot verify income either though electronic means or other documentation, a letter is sent to the family requesting the verification. If the CPU does not receive the requested verifications, a letter is sent notifying the family that coverage will be canceled in accordance with the procedure described in Section 12.1.

Application options expanded with the addition of telephonic signature capability. Effective January 1, 2011, new applicants may obtain application assistance and sign the application over the telephone.

No Entitlement: In accordance with § 2102(b)(4) of the Social Security Act and § 32.1-353 of the Code of Virginia, the Family Access to Medical Insurance Security Plan shall not create any individual entitlement for payment of medical services or any right or entitlement to participation.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

The child health insurance application asks for employer information and whether children currently have health insurance. Children with health coverage or those who have access to the State Employee Insurance Plan are ineligible for FAMIS.

As described in § 4.3 above, all applications for child health insurance coverage are screened for completeness of information, the presence of other health insurance, verification of income, health coverage or access to the State Employee Health Insurance Plan, and Medicaid eligibility. If it appears that the child is Medicaid eligible, the case is referred for a Medicaid eligibility determination.

Applications received by the Central Processing site are screened for potential Medicaid eligibility first. If it appears that the child is Medicaid eligible, the case is referred for Medicaid eligibility determination. The State utilizes a screening process that consists of applying the Medicaid disregards to the gross family income and comparing the remainder to the Medicaid income limit for the family size. The single child health application collects all income and child care expense information needed to determine potential Medicaid eligibility. Individuals who are identified as potentially Medicaid eligible will not be enrolled in Title XXI without a full Medicaid determination and finding of ineligibility. Applications received at local departments of social services have full Medicaid eligibility determinations completed. If a child is determined ineligible for Medicaid, a FAMIS eligibility determination is then conducted.

At the time of a renewal of eligibility, the child's insurance status and Medicaid eligibility is reviewed to ensure continued eligibility for enrollment in FAMIS.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Child health applications received at the FAMIS Central Processing Unit are screened for Medicaid eligibility and, if found to be potentially eligible for Medicaid, are transferred directly by the FAMIS staff to Medicaid eligibility workers co-located at the FAMIS Central Processing Unit. In accordance with procedures described in §4.3 above, Medicaid workers, either at the Central Processing Unit, or at local departments of social services complete a Medicaid eligibility determination on all applications, those screened as potentially eligible for Medicaid by the FAMIS staff, as well as those received at local departments of social services directly from applicants.

The Commonwealth tracks applications that are referred by the Central Processing Unit for a Medicaid eligibility determination to monitor the

accuracy of the Medicaid screening and the number of children enrolled in Medicaid through an application filed at the FAMIS Central Processing Unit.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Applications filed on behalf of children determined to be ineligible for Medicaid by Medicaid eligibility staff co-located at the Central Processing Unit or by Medicaid staff at local departments of social services undergo a FAMIS eligibility determination. A single child health insurance application form and process facilitates this eligibility determination and enrollment of children in the appropriate program, either Medicaid or FAMIS.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.
Only uninsured children shall be eligible for FAMIS. The single child health application form requests information on health insurance coverage the child may have or had within the past four months. Each application and redetermination of eligibility documents inquiry about health insurance within the past 4 months. If the child has been covered under a health insurance plan within 4 months of application for or receipt of FAMIS services, the child will be ineligible, unless they are pregnant at the time of application or unless good cause for discontinuing the coverage is demonstrated.

Good Cause: A child shall not be ineligible for FAMIS if health insurance was discontinued within the four month period prior to the month of application if one of the following good cause exceptions is met:

1. The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage.
2. The employer stopped contributing to the cost of family coverage and no other family member's

employer contributes to the cost of family health insurance coverage.

3. The child's coverage was discontinued by an insurance company for reasons of uninsurability, *e.g.*, the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums.
4. Insurance was discontinued by a family member who was paying the full cost of the insurance premium under the COBRA policy and no other family member contributes to the cost of family health insurance coverage.
5. Insurance on the child was discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent, or step-parent, e.g., the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc.
6. Insurance on the child was discontinued because the cost of the premium exceeds 10% of the family's gross monthly income or exceeded 10% of the family's gross monthly income at the time the insurance was discontinued.
7. Other good cause reasons as may be established by the DMAS Director.

Staff at the central site reports information to DMAS, which will monitor the trends in health insurance coverage for children enrolling in FAMIS to determine the degree substitution is occurring. Assignment of rights to medical support is a condition of eligibility.

4.4.4.2. □ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4 If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

American Indian and Alaska Native children are eligible for the Family Access to Medical Insurance Security Plan on the same basis as any other children in the Commonwealth. Virginia has no federally recognized Indian tribes; however, ongoing communication will occur with Indian tribes in Virginia to ensure that Indian families understand the program and can access the provider network to secure covered services.

No cost sharing is imposed on American Indian and Alaska Native children.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Pursuant to the 2004 amendment to § 32.1-351.2 of the Code of Virginia, DMAS has established the Children's Health Insurance Advisory Committee. The Committee consists of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources. The Committee is staffed by DMAS Marketing and Outreach staff.

The Commonwealth is broadening its outreach focus to child health insurance, which includes FAMIS and Medicaid. With assistance and advice from the Outreach Oversight Committee, DMAS will create a comprehensive outreach plan that includes specific strategies for: (i) improving outreach and enrollment in those localities where enrollment is less than the statewide average, and (ii) enrolling eligible children in either the FAMIS or Medicaid programs.

Virginia works with community based organizations that have expertise in providing translation services to reach eligible families with limited English speaking abilities. All outreach material is available in both English and Spanish. DMAS will continue to provide these community-based organizations with the support and tools needed to reach these families.

DMAS coordinates a comprehensive marketing and outreach effort. The marketing and outreach efforts promote FAMIS and Medicaid and may include the following:

Coordination with Other State Agencies -- Assistance is sought from other agencies, including Virginia's Department of Education, Department of Health, Department of Social Services, and State Employment Commission with referrals for potential new enrollees. These agencies are supplied with enrollment information and outreach materials. Utilizing the same criteria as the School Lunch Program, school systems are a primary vehicle for sending information home to parents about the FAMIS program. In addition, State agencies are routinely educated and trained about the

program and are provided with informational fact sheets and brochures.

Coordination with other Community Based Organizations -- The Commonwealth actively encourages participation of a wide range of organizations, including, but not limited to, those organizations that target high concentrations of uninsured children. DMAS has partnered with a network of Community Based Organizations (CBO) to promote and facilitate enrollment of children in the FAMIS and Medicaid programs. DMAS will continue to build coalitions and infrastructure at the state and local level that will provide awareness and application assistance in both FAMIS and Medicaid. DMAS continues to work closely with its contractor, the Virginia Health Care Foundation, in coordinating local outreach efforts through Community-Based Organizations. Virginia works with community based organizations that have expertise in providing translation services to reach eligible families with limited English speaking abilities. All outreach materials are available in both English and Spanish. DMAS continues to provide these community-based organizations with the support and tools needed to reach these families.

Coordination with the Business Community -- DMAS will contact Virginia businesses and business associations to request their cooperation in enrolling employees' children, sponsorship opportunities, advertising partnerships, and support of the State's child health insurance programs. These groups will be provided with materials outlining the importance and benefits of the program so that they can make informed decisions on their ability and level of participation.

Coordination with the Health Care Associations and Providers -- The Commonwealth partners with health care associations and requests their cooperation in performing outreach for Virginia's child health insurance programs. Outreach information is provided to health care associations and health care providers so that they can distribute FAMIS and Medicaid information to their members.

Central Processing Unit – The Commonwealth, through a contractor, provides a call center with a toll-free helpline number to be located at the Central Processing Unit. The call center serves as a distribution point for applications, assists callers with completing applications, serves as a source for answering questions, and provides eligibility status. DMAS continues to coordinate outreach efforts in conjunction with the call center and works to develop better outreach evaluation methods. It is required that the contractor responsible for operating the call center provides translation services for non-English speaking callers. This requirement may be met through an arrangement with a contracted service that provides interpretation services in 148 of the most commonly spoken languages around the world. Translation services are available during the call center hours of operation and must be accessible via a toll-free number. Callers requiring translation services are not required to hang up and call

another number. A translator is conferenced in the call providing a three-way conversation between the call center representative, the translator, and the caller if a bilingual operator is not available.

The call center also allows for applicants to complete an application over the phone and telephonically "sign" their application. This allows for a higher completion rate of applications and better customer service. The call center also allows for applicants to upload any necessary documentation via the famis.org website which can be more convenient for applicants and also reduces the reliance on paper at the central processing unit. The central processing unit has also developed a reminder service for FAMIS enrollees that will contact them via text message to remind them of upcoming renewals and other important information. All of these enhancements are incorporated into the FAMIS marketing materials and seen as an effective way to reach potentially eligible individuals in the Commonwealth.

Robert Wood Johnson Foundation – In 2009, the Virginia Department of Medical Assistance Services (DMAS) was one of eight states awarded a Maximizing Enrollment grant from the Robert Wood Johnson Foundation to increase enrollment and retention of eligible children in CHIP and Medicaid. The bulk of the work under the grant has been accomplished by the hard work and dedication of the grant's four workgroups. These groups are made up of staff from DMAS, the state and local Departments of Social Services, as well as internal and external stakeholders who support the mission of enrolling eligible children in our programs. The workgroups cover the following topics: Data Analysis, Retention, Reaching Eligible Children, and Improving Communication. The grant has also provided detailed data analysis on the number and geographic location of uninsured low-income children in the Commonwealth which has greatly informed outreach efforts by DMAS.

The Commonwealth has not received any gifts or in-kind contributions from the business community to support the Commonwealth's Child Health Insurance Program. Any gifts, donations, or in-kind contributions that have been provided have been given directly to the outreach efforts (as described above) or have been provided directly to the grantees providing/supporting the outreach efforts. As stated above, none of these funds are used to draw-down the Title XXI federal match.

Virginia currently has no health insurance programs that involve a public-private partnership.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☒ Other (Describe)

A child will receive Secretary-approved coverage modeled after the state employee plan if the child lives in an area in which there is a contracted MCO to offer Secretary-approved coverage modeled after the state employee plan.

Secretary-approved coverage through a modified Title XIX look-alike (a fee-for-service component or the PCCM Program) is the delivery system provided in geographic areas not served by a contracted MCO until such time as a system to offer the Secretary-approved coverage modeled after the state employee plan is implemented.

Secretary-approved coverage modeled after the state employee plan provides coverage using the Key Advantage Plan. This plan is the PPO option for state employees that was offered statewide in June 2000. Several enhanced benefits are added to the plan. The services under the Key Advantage Member Handbook are briefly outlined in the checklist in § 6.2. The enhanced benefits that are provided in addition to the Key Advantage Plan are listed at the end of this checklist.

For children in families receiving the Secretary-Approved coverage through the fee-for-service program or PCCM program, Virginia provides a Title XIX look-alike program with benefits that are essentially the same as the state's Title XIX Plan.

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

Secretary-approved coverage modeled after the state employee, Virginia's Key Advantage State Employee Benefit Plan in effect in June 2000, is summarized in the checklist below **(6.2.1 --6.2.28)**. The additional coverage provided is listed separately at the bottom of the checklist.

NOTE: The FAMIS program has two separate health care services delivery systems, described immediately below and at 6.2.1.A – 6.2.28.A, below.

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

365 days per confinement; includes ancillary services.

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

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

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

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

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

Surgical services include services provided in §§ 6.2.1, 6.2.2, and 6.2.3.

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

Clinic services include services provided in §§ 6.2.2 and 6.2.3.

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

Covered for outpatient prescription drugs. Mandatory generic program.

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

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

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

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

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

Maternity service including routine prenatal care is covered. Prepregnancy family services include coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives. Contraceptive drugs and devices eligible for reimbursement are oral contraceptives, depo provera, cervical caps, diaphragms, intrauterine devices and Norplant.

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

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

Includes 30 days total for inpatient hospital care and partial day services per benefit period. Effective 07-01-10, medically necessary inpatient mental health services are covered for 365 days per confinement.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

Effective 07-01-10, medically necessary outpatient mental health services (including, but not limited to those listed below) are covered without limitations. These services are subject to prior authorization by DMAS.

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

B. Effective 08-01-2003, the following community mental health services are covered under this state plan and reimbursed directly by DMAS to providers:

1. Intensive in-home services to children and adolescents under age 19 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.

2 Therapeutic day treatment provides evaluation; medication; education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy. The service shall be provided two or more hours per day in order to provide therapeutic interventions. Services are limited annually to 780 units: one unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

3. Crisis Intervention - Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention activities, are limited annually to 720 units per year (a unit equals 15 minutes) and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the–individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other than (a) services furnished in a state-operated mental hospital, (b) services furnished in IMDs, or (c) residential services or other 24-hour therapeutically planned structural services.

Inpatient rehabilitation in a substance abuse treatment facility up to 90 days, maximum lifetime benefit. Effective 7/1/10, medically necessary inpatient substance abuse treatment services are covered for 365 days per confinement.

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

Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. Substance abuse services and psychiatric services are limited to no more than a combined total of 50 medically necessary visits for treatment with a licensed mental health or substance abuse professional each calendar year. Effective 7/1/10, there is no visit limit on medically necessary outpatient substance abuse treatment services.

6.2.20. ☒ Case management services **(Section 2110(a)(20))**

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

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

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

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

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

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

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

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

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

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

Premiums for private health care insurance coverage will be covered as outlined in § 3.1.

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

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

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

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

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

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

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

1. Well-child care from age 6 through 18 including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP). (Well-child care from age birth through age 5 is covered under Key Advantage.)

2. Physical therapy, occupational therapy, services for individuals with speech, hearing and language disorders, psychology/psychiatry services and skilled nursing services, medical evaluation services covered as physicians' services, transportation, personal care services and assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP s for special education students are covered under this state plan. The Department reimburses the school divisions directly for the services provided pursuant to the student's Individualized Education Program (IEP).

3. Blood lead testing.

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

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

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

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

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

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

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

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

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

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

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

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

C. Emergency hospital services provided without limitation.

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

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

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

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

C. Psychiatric services are limited to an initial availability of 26 sessions without prior authorization during the first year of treatment. An additional extension of up to 47 sessions during the first treatment year must be prior authorized by DMAS. The availability is further restricted to no more than 26 sessions each succeeding year when approved by DMAS. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 19 year of age when the need for such services has been identified through an EPSDT screen.

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

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

F. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the

service is medically justified or meets one of the exceptions.

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

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

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

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

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

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

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

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

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

C. Effective June 1, 2004, pursuant to § 1927 of the Act and 42 CFR § 440.230, the Department shall require the prior authorization of legend drugs when both institutionalized and non-institutionalized FAMIS enrollees are prescribed high numbers of legend drugs. Over-the-counter drugs and legend drug refills shall not count as a unique prescription for the purposes of prior authorization as it relates to the threshold program.

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

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

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

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

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

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

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

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

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

6.2.9.A ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

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

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

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

Inpatient mental health services will be offered in general acute care hospitals.

6.2.11.A ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

Effective 07-01-10, medically necessary outpatient mental health services (including, but not limited to those listed below) are covered without limitations. These services are subject to prior authorization by DMAS.

A. Psychiatric services are limited to an initial availability of 26 sessions without prior authorization during the first year of treatment. An additional extension of up to 47 sessions during the first treatment year must be prior authorized by DMAS. The availability is further restricted to no more than 26 sessions each succeeding year when approved by DMAS. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 19 year of age when the need for such services has been identified through an EPSDT screen.

B. Community Mental Health Services:

1. Intensive in-home services to children and adolescents under age 19 - Shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.

2. Therapeutic day treatment for children and adolescents - Provides evaluation; medication; education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy. The service shall be provided two or more hours per day in order to provide therapeutic interventions. Services are limited annually to 780 units: one unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

3. Day Treatment/Partial Hospitalization - Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.

4. Psychosocial Rehabilitation - Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

5. Crisis Intervention - Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention activities, are limited annually to 720 units per year (a unit equals 15 minutes) and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the-individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

6. Mental Health Crisis Stabilization - Crisis stabilization services for non-hospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. The maximum limit on this service is up to eight hours (with a unit being one hour) per day up to 60 days annually.

7. Mental Health Support - Mental health support services shall be defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services may be authorized for six consecutive months. This program shall provides the following services: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition. The yearly limit for mental health support services is 372 units.

8. Intensive Community Treatment- Medical psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. The annual unit limit shall be 130 units.

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

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

Prosthetic devices for the replacement of missing arms, legs and breasts and the provision of any internal (implant) body part shall be covered. Prosthetic devices (artificial arms and legs, and their necessary

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

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

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

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

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

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

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

Intermittent or part-time nursing service provided by a home health agency; Nurse mid-wife services allowed under licensure requirements of Virginia and federal law; skilled nursing services provided in schools to special education students.

Private duty nursing services are not covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

Group and individual counseling. If medically necessary, additional sessions may be preauthorized. Services must be rendered by a certified or licensed provider. Community substance abuse treatment services are covered in accordance with the Community Health Services model described in Section6.2.11A.

Day treatment for pregnant women.

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

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

6.2.21.A Care coordination services **(Section 2110(a)(21))**

May be a component of another service.

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

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

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

physician determines that additional services are needed, the provider shall request prior authorization.

B. Physical therapy and related services:

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

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

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

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

services can only be performed by or under the direction of a qualified speech-language pathologist. The amount, frequency and duration of the services shall be reasonable.

6.2.23.A ☒ Hospice care **(Section 2110(a)(23))**

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

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

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

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

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

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

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

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

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

6.2.26.A ☒ Medical transportation **(Section 2110(a)(26))**

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

6.2.27.A ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

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

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

2. Physical therapy, occupational therapy, services for individuals with speech, hearing and language disorders, psychology/psychiatry services and skilled nursing services, medical evaluation services covered as physicians' services, transportation, personal care services and assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP s for special education students are covered under this state plan. The Department reimburses the school divisions directly for the services provided pursuant to the student's Individualized Education Program (IEP).

The Department reimburses the school divisions directly for these services.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above. **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

The families of targeted low-income children who have access to health insurance through their employer may be eligible for premium assistance

for the purchase of their employer-sponsored health insurance if certain conditions are met. However, the goal of the FAMIS Plan is to provide coverage for eligible children under their parents' employer-sponsored plan. Any coverage of individuals not eligible for FAMIS is incidental.

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The Commonwealth will use numerous methods to assure that FAMIS recipients receive quality services that are appropriate to their needs. These methods may include the following:

- 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.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

Health insurers are required to follow standards established by the Commonwealth in the development and maintenance of their quality improvement programs.

7.1.2. ☒ Performance measurement

A. Submission of a quality improvement plan.
B. Adherence to NCQA, JCAHO, or other nationally recognized accrediting organization.
C. Results of HEDIS or other.
D. CAHPS Survey.
E. Clinical focus studies.

7.1.3. ☒ Information strategies

Each managed care organization will establish a system to monitor compliance with access standards set forth by DMAS and a data management system to meet DMAS data collection requirements. DMAS annually requires managed care organization to report the percentage of children who received all expected well-child care visits according to the benefits schedule, during the period that each child was enrolled and the percent of two-year old children who have received each immunization specified in the most current ACIP recommendations.

7.1.4. ☒ Quality improvement strategies

Health insurers may perform the following:

A. Documentation of current MCHIP quality certification or documentation of a comparable accreditation
B. Develop and maintain a Quality Improvement Program (QIP) which meets standards and reporting requirements set out by the Commonwealth.
C. Cooperate and show compliance with the DMAS Quality Improvement Program, which may require calculation and reporting of performance measures and the implementation of performance improvement projects as well as cooperate with DMAS or a designated agent in conducting quality reviews. Managed care organizations are required to have a written utilization management (UM) program that reflects the National Committee for Quality Assurance standards to include mechanisms to detect under-utilization and/or over-utilization of care. Managed care organizations must show implementation of an approved system to monitor and address complaints and grievances.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

Each MCO and PCCM provider will meet the requirements by the contract with DMAS to ensure access to well baby care, well adolescent care, and childhood immunizations. By contract MCOs and PCCM providers are responsible for arranging and administering covered services to enrollees and ensuring that the

delivery system provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. The MCO and PCCM provider provides or otherwise arranges care by providers specializing in early childhood youth services. MCOs and PCCM providers provide services as established by recognized clinically approved guidelines for standards of care. MCOs and PCCM providers ensure that immunizations are rendered in accordance with the most current Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics Advisory Committee recommendations.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Health insurers are required to demonstrate their ability to monitor network capacity throughout their service area for routine, urgent, and emergency care. The Commonwealth establishes standards and reporting requirements for access to routine, urgent, and emergency care. The health plans are solely responsible for arranging for and administering covered services to enrollees and ensuring that its delivery system provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. The health plan must include in its network or otherwise arrange care by providers specializing in early childhood, youth services.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

The State's Disease Management program monitors and promotes appropriate and timely treatment for enrollees with chronic, complex or serious medical conditions.

The State monitors complaints pertaining to access to care received by DMAS, the Central Processing Unit, the MCOs or the PCCM providers with regard to access to care.
Children with special health care needs are not considered a separate population or as a special population under the FAMIS State Plan. MCOs and PCCM providers provide access to all covered services, including specialty service to any child regardless of the medical condition

Each provider must arrange to provide care according to established appointment standards and meet requirements determined by the contract for the monitoring and reporting access to services, timeliness of services, appropriateness of services for all enrollees including those with chronic, complex or serious medical conditions. The MCO or PCCM provider is responsible for the provision of services regardless if a medical condition and/or diagnosis was present prior to being assigned the enrollee, thus the MCO or PCCM provider will manage all pre-existing conditions. The health plans provide access to all covered services, including specialty services, to any child regardless of medical condition. MCOs cover and pay for services furnished in facilities or by practitioners outside the plan's network if the needed medical services or necessary supplementary resources are not available in the plan's network.

MCOs and PCCM providers are not permitted to refuse an assignment or disenroll a patient or otherwise discriminate against a patient based on physical or mental handicap or type of illness or condition.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Prior authorization of health decisions will be made in accordance with State law consistent with the standards set by the regulations governing managed care health insurance plans.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES
8.1.2. NO, **skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

No cost-sharing will be charged to American Indians and Alaska Natives.

8.2.1. Premiums:

None.

8.2.2. Deductibles:

None.

8.2.3. Coinsurance or copayments:

Co-payments shall not be imposed on any of the children covered under the Secretary-approved coverage offered through the fee-for service program and the PCCM program.

No co-payments are required for well-baby and well-child and other preventive services, and families for Secretary-approved coverage modeled after the state employee plan. Effective 7/1/10, no co-payments are required for pregnancy-related services.

Income levels are provided as a percentage of Federal Poverty Level ("FPL") based on gross income. The FPL reflects changes made effective February 13, 2004.

Copayments for Secretary-approved coverage modeled after the state employee plan are:

Description of Service	≤ 150% FPL	> 150% FPL
Outpatient	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient	$15 per admission	$25 per admission
Non-Emergency use of Emergency Room	$10 per visit	$25 per visit
Poverty Levels	**≤ 150% FPL**	**> 150% FPL**
Maximum Yearly Co-Payment Limit Per Family	$180	$350

Total cost-sharing for each year (or 12-month eligibility period) is limited to: (1) for a family with an annual income equal to or less than 150% of the FPL, the lesser of (a) 2.5% of a family's income, and (b) $180.00; and (2) for a family with an annual income greater than 150% of the FPL, the lesser of (a) 5% of a family's income, and (b) $350.00.

The co-payment and coinsurance maximums are set at thresholds that are well below the maximum allowable per CMS for families with annual incomes equal to or below 150% of FPL and for those with annual incomes above 150%. The maximum yearly co-payment limit for families in FAMIS with annual incomes at or below 150% FPL is $180.00 per year. Families enrolled in FAMIS and receiving benefits through FAMIS contracted health plans are advised of the amount of maximum allowable cost-sharing that they may be responsible for during the year. Families are required to submit documentation to DMAS or its contractor, showing that the co-payment cap is met for the year. Once the cap is met, DMAS or its contractor will issue a new card excluding families from paying additional co-pays.

Enrollees are not held liable for any additional costs, beyond the standard co-payment amount for emergency services furnished outside of the individual's managed care network. Only one co-payment charge is imposed for a single office visit.

The proposed cost sharing caps to be applied toward copayments and/or coinsurance ($180 and $350) were included in the Plan document.

No cost-sharing will be charged to American Indians and Alaska Natives.

8.2.4. Other

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**
The public is notified of FAMIS' cost-sharing requirements, including differences based on income and plans, in the outreach and enrollment materials.

- Web site;
- Handbook;
- The public also has the opportunity to become involved during the regulatory process. Implementing regulations must go through a mandatory 60-day comment period consistent with the Code of Virginia;
- Outreach Oversight Committee;

- Managed care organization member handbooks; and
- Outreach grantees.

No cost-sharing is charged to American Indians and Alaska Natives. The application form requests racial information on each child for whom application for child health insurance is made. No cost-sharing is imposed on those children who are reported to be Native American or Alaska Native. The applicant's statement on the application form is sufficient to exempt the child from any cost-sharing obligations. The FAMIS automated eligibility determination system codes the case records for children listed on the application form as Alaska Natives or American Indians and the automated record will exempt such children from any cost-sharing obligations.

FAMIS accommodates the federal requirement that Native American families are exempt from any cost-sharing provisions under CHIP. The FAMIS application inquires as to a child's race. If a family declares that a child is a Native American or Alaska Native, the family will be exempt from cost-sharing obligations.

Virginia has no federally recognized Indian tribes; however, ongoing communication will occur with Indian tribes in Virginia to ensure that Indian families understand the program and can access the provider network to secure covered services.

Effective April 15, 2002, Virginia temporarily suspended premiums until further notice. FAMIS families were notified by letter, informing them of the suspension of premiums and copies of such letters were posted on the DMAS web site. Effective September 1, 2002, the FAMIS program no longer charged premiums.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Virginia has structured the cost sharing levels to make it highly unlikely that any family will exceed the allowable cost sharing levels.

Virginia ensures that the annual aggregate cost sharing for all FAMIS enrollees in a family does not exceed 5% of a family's income as required by § 2103(e)(3)(b) of Title XXI. Co-payments are capped at levels that are extremely unlikely to exceed the upper limit. The tables below demonstrate that the maximum cost sharing for families under the Secretary-approved coverage modeled after the state employee plan falls within the required caps: For families with income equal to or below 150% of FPL, cost-sharing is capped at slightly less than 2.5% of income for a family of one at 100% of FPL. For families with income above 150% of FPL, cost-sharing is capped at slightly less than 5% of income for a family of one at 150% of FPL. (As mentioned earlier, families under the Secretary-approved coverage offered through the fee-for-service program are not subject to any cost-sharing.)

Table 1: Aggregate Cost Sharing for Families under Secretary-approved coverage modeled after the state employee plan

Poverty Levels	*100%	135%	150%	175%	200%
Maximum Yearly Co-Payments Limit	N/A	$180	$350	$350	$350
Total Cost Sharing by Enrollees	N/A	$180	$350	$350	$350

Poverty Levels	*100%	135%	150%	175%	200%
FPL for family of one	$9,310	$12,569	$13,965	$16,293	$18,620
2.5% ≤ 150% of FPL 5% > 150% at FPL	$ $233	$314	$698	$815	$931

*Used for comparative purposes only.

* Figures in this column are for illustration purposes and are rounded.

Families are required to submit documentation to DMAS or its contractor, showing that the co-payment is met for the year. Once the cap is met, the managed care organization will issue a new card excluding families from paying additional co-pays.

Finally, Title XXI requires that cost-sharing for families with incomes below 150 percent of FPL not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The maximum co-payments for a service costing over $50 is $3 under Medicaid law and was established in 1978. Virginia's co-payment for families under 150% of FPL is $2, which is well below the $3 federal cap.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

No cost-sharing will be charged to American Indians and Alaska Natives. The application form requests racial information on each child for whom application for child health insurance is made. No cost-sharing is imposed on those children who are reported to be Native American or Alaska Native. The applicant's statement on the application form is sufficient to exempt the child from any cost-sharing obligations. The FAMIS automated eligibility determination system codes the case records for children listed on the application form as Alaska Natives or American Indians and the automated record will exempt such children from any cost-sharing obligations.

Virginia has no federally recognized Indian tribes; however, ongoing communication will occur with Indian tribes in Virginia to ensure that Indian families understand the program and can access the provider network to secure covered services.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Not applicable.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** *(Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

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

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).
(Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Objective One: To reduce the number of uninsured children
Objective Two: To improve the health care status of children
Objective Three: To conduct effective outreach to encourage enrollment in health insurance plans.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

See § 9.3.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: **(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))**

With the FAMIS program well established after 10 years, Virginia re-assessed the performance goals for the program. While program managers continue to monitor enrollment on a monthly basis, a decision was made to focus on quality measures rather than enrollment targets.

All of Virginia's Medicaid/CHIP managed care organizations (MCOs) are required to be accredited by the National Committee for Quality Assurance (NCQA). As such, they must calculate Healthcare Effectiveness Data and Information Set (HEDIS) scores on an annual basis. These measures of care are calculated using technical specifications set forth by the NCQA. In addition, each MCO is required to conduct the CAHPS Child Survey annually. Virginia contracts with the same MCOs for Medicaid and FAMIS services. All perfomance measures are monitored based on the combined Medicaid-CHIP population.

The MCOs are encouraged to calculate all Medicaid HEDIS measures that pertain to children. In addition, DMAS has directed the MCOs to consider the following Medicaid HEDIS performance measures as a priority for SFY 2013 (July 1, 2012 – June 30, 2013). Each MCO must assure annual improvement these measures until such time that the MCO is performing at least at the 50th percentile as reported by Quality Compass. Thereafter, each MCO is to at least sustain performance at the Medicaid 50th percentile. An MCO is required to develop a detailed, written corrective action plan for any priority measure with a score that are below the 50th percentile or

that has decreased by more than five (5) percentage points from the previous year (not as a result of a change in HEDIS specifications). The statewide goal is to attain the 75th percentile among national scores of Medicaid MCOs reporting by 2015.

- Childhood Immunization Status (Combo 2) and each vaccine reported separately as well.
- Childhood Immunization Status (Combo 3) and each vaccine reported separately as well.
- Lead Screening in Children
- Well-Child Visits in the First 15 Months of Life and each number of visits listed separately.
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visit
- Comprehensive Diabetes Care (all age categories set forth by the HEDIS technical specifications for these diabetes measures: HbA1c Testing, HbA1c Control, Eye Exams, LDL Screenings, LDL Control, BP Control <140/90
- Asthma – Appropriate Use of Medication (all age categories set forth by the HEDIS technical specifications)

The Child Health Insurance Program Advisory Committee (CHIPAC) continues to monitor progress on the following measures based on HEDIS specifications and make recommendations for improvement:

- Well Child Visits for child and adolescent age groups
- Access to Primary Care Provider for child and adolescent age groups
- Immunizations at 2 years of age for combinations 2 and 3

The DMAS agency strategic plan was modified to include two performance measures and goals for the CHIP population for SFY 2013-2014, beginning July 1, 2012, using NCQA's HEDIS technical specifications:

- At least one comprehensive Well Child Visit among adolescent (ages 12-21) managed care enrollees.
- Percentage of two year olds in managed care who are fully immunized

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☒ Immunizations (HEDIS)
9.3.7.2. ☒ Well child care (HEDIS)
9.3.7.3. ☒ Adolescent well visits (HEDIS)
9.3.7.4. ☒ Satisfaction with care (CAHPS)
9.3.7.5. ☐ Mental health
9.3.7.6. ☒ Dental care (EPSDT)
9.3.7.7. ☒ Other, please list:

Lead screening (HEDIS)
Comprehensive diabetes care (HEDIS)
Asthma (HEDIS)

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

DMAS complies with subsection 10.1 in assessing the operation of FAMIS and submitting a report to the Secretary by January 1 following the end of the fiscal year. This includes the reduction in the number of uninsured low-income children and the results of the program assessment.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

In order to accomplish public involvement in the administration, outreach, and access to the FAMIS program, ongoing meetings are held with several advocacy, retail, business, and community organizations to seek direction and request involvement. These organizations include the Virginia Coalition for Children's Health, Virginia Association of Health Plans, the Covering Kids & Families Statewide Coalition, the Virginia Hospital and Healthcare Association, the Virginia Poverty Law Center, and the Virginia League of Social Services Executives, as well as other advocacy organizations that represent the interests of the uninsured. Meetings are also held with other state agencies to seek their assistance. Ongoing meetings are held with legislators, with legislative commissions, and with local human service directors to review and discuss FAMIS.

The Department held five Town Hall meetings during the Spring 2002 across the State to hear ways to improve the FAMIS program. These meetings were attended by approximately 200 persons. To ensure public involvement, DMAS advises and consults with the Joint Commission on Health Care and provide quarterly reports on enrollment, benefit levels, and outreach efforts.

The public also has the opportunity to become involved during the regulatory process. Implementing regulations must go through a mandatory 60-day comment period consistent with the Code of Virginia.

Another method for insuring ongoing public involvement is the Outreach Oversight Committee. 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 meets quarterly to discuss strategies to improve outreach activities. The Committee may offer recommendations regarding state-level outreach activities, the coordination of regional and local outreach activities, and procedures for streamlining and simplifying the application process, brochures, other printed materials, forms, and applicant correspondence.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Virginia has no federally recognized Indian tribes; however, ongoing communication occurs with Indian tribes in Virginia to ensure that Indian families understand the program and can access the provider network to secure covered services.

No cost-sharing will be charged to American Indians and Alaska Natives. The application form requests racial information on each child for whom application for child health insurance is made. The applicant is requested to indicate if the child is White, Black, Hispanic, Other, Native American, Alaska Native or Asian/Pacific Islander. No cost sharing is imposed on those children who are reported to be Native American or Alaska Native.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

In accordance with the CHIP state plan approved December 22, 2000, the group of children receiving services through a primary care case management (PCCM) program included only those children living in a locality not served by a managed care organization (MCO) who transitioned into FAMIS from either CMSIP or Medicaid with a prior PCCM history. FAMIS MCO coverage has expanded incrementally over the years since 2000 in conjunction with the expansion of Medicaid MCOs. Prior to each expansion, notification was sent by letter to all affected members, and Medicaid Memorandum was sent to all PCCM providers. This Memorandum was also posted on the DMAS website.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including:
- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

CHIP Budget Plan - with proposed SPAs

	Federal Fiscal Year Costs – FFY 2013	**Federal Fiscal Year Costs – FFY 2014**
Enhanced FMAP rate	**65%**	**65%**
Benefit Costs		
Insurance payments		
Managed care	$179,437,357	$224,425,199
per member/per month rate @ # of eligibles	$142.73 @ 104,762 avg elig/mo	$171.98 @ 108,747 avg elig/mo
Fee for Service	$100,488,694	$102,699,921
Total Benefit Costs	**$279,926,051**	**$327,125,120**
(Offsetting beneficiary cost sharing payments)	$0	$0
Net Benefit Costs	**$279,926,051**	**$327,125,120**
Administration Costs		
Personnel	$1,095,276	$1,150,040
General administration	$669,483	$723,041
Contractors/Brokers (e.g., enrollment contractors)	$8,149,958	$9,127,953
Claims Processing	$978,147	$1,027,055

Outreach/marketing costs	$794,253	$833,966
Other		
Cost of Proposed SPA changes	**$0**	**$0**
Total Administration Costs	**$11,687,117**	**$12,862,055**
10% Administrative Cost Ceiling	$31,102,895	$36,347,236
Federal Share (multiplied by enh-FMAP rate)	**$189,548,559**	**$220,991,664**
State Share	$102,064,609	$118,995,511
TOTAL PROGRAM COSTS	$291,613,168	$339,987,175

Funding:

State funding comes from four sources: state General Funds, Family Access to Medical Insurance Security Plan Trust Fund, Virginia Health Care Fund, and a private grant. A Robert Wood Johnson Foundation (RWJF) grant was awarded to Virginia to increase enrollment and retention of eligible children in Virginia's health insurance programs, known as FAMIS and FAMIS Plus (children's Medicaid). The grant is for $1 million and the original award dates were February 15, 2009 - February 14, 2013. Grant funding has been extended through August 14, 2013.

The 1997 General Assembly established the Virginia Children's Medical Security Insurance Plan Trust Fund (the fund was renamed the Family Access to Medical Insurance Security Plan Trust Fund in legislation enacted in 2000) in anticipation that a children's health insurance program would be enacted by the 1998 General Assembly. The Assembly directed that the Fund be used to pay in part the Commonwealth's share of expenditures under the new children's health insurance program. Income to the Fund is derived from increased health insurance premium tax revenue. In 1997, the Commonwealth repealed a partial tax exemption enjoyed by the Blue Cross and Blue Shield Companies which no longer provide insurance of last resort as a result of HIPAA reforms. Payments into the trust fund are approximately $14 million a year. The remainder of the Commonwealth's share is paid from state General Funds.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Attributes of Population	Number of Children with Creditable Coverage XIX OTHER CHIP	Number of Children without Creditable Coverage	**TOTAL**
Income Level			
< 100%			
< 133%			
< 185%			
< 200%			
> 200%			
Age			
0 – 1			
1 – 5			
6 – 12			
13 - 18			
Race and Ethnicity			
American Indian or			
Asian or Pacific			
Black, not of Hispanic			
Hispanic			
White, not of			

Location			
MSA			
Non-MSA			

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

For reviews involving adverse eligibility actions taken by the Department of Medical Assistance Services ("DMAS"), the local department of social services, or the Central Processing Unit ("CPU), the following procedures shall apply.

1. DMAS, the local department of social services, and/or the CPU must send written notification of adverse actions affecting an individual's request for or receipt of FAMIS coverage. Adverse actions include:
   a. Denial of eligibility;
   b. Failure to make a timely determination;
   c. Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

2. The written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, the standard and expedited time frames for review, and the circumstances under which enrollment may continue pending review. The notice must be sent to applicants/enrollees within 10 days after the date of denial or at least 10 days prior to suspension or termination of enrollment.

3. To be considered timely, a request for review shall be received by DMAS no later than 30 calendar days from the date of the DMAS, the local department of social services, or CPU notice of adverse action.

4. A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change in eligibility or enrollment that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.
5. A request for review shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under review.

6. All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.

7. All applicants/enrollees shall have an opportunity to:

    a) Represent themselves or have representation of their choosing during the review process;
    b) Timely review their files and other applicable information relevant to review of the decision;
    c) Fully participate in the review process, including an opportunity to present supplemental information during the review process; and
    d) Receive continued coverage if the enrollee requests a review prior to the effective date of the suspension or termination of the enrollment.

8. If an expedited review decision is not mandated, a request for review shall result in a written final decision within 90 calendar days of receipt of the request for review unless the applicant, enrollee, or authorized representative requests or causes a delay. An expedited review decision will be mandated whenever the State receives, from the managed care organization or the primary health provider, information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. If an expedited review decision is mandated, then a request for review shall result in a written final decision within 3 business days after the State receives, from the managed care organization or the primary health provider, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, unless the applicant, enrollee, or authorized representative requests or causes a delay.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

For reviews involving health services matters for FAMIS enrollees receiving services through Managed Care Organizations (MCOs), the following procedures shall apply.

1. The MCO shall provide a written notification within 10 days after a decision is made and provide the opportunity for external review whenever an enrollee's request for covered services is delayed, denied, reduced, suspended, or terminated, in whole or in part including a determination about the type or level of services; or whenever there has been the failure to approve, furnish or provide payment for health services in a timely manner.

2. Written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, and the standard and expedited time frames for review. In addition, it shall inform the enrollee about his or her opportunity to file a grievance or a request for review with the MCO, and include the phone number and name of the contact person at the MCO's office.

3. The MCO shall comply with the Department's hearing process, no more or less, and in the same manner as is required for all other FAMIS evidentiary hearings.

4. The MCO shall have written policies and procedures which describe the informal and formal grievance and review process and how it operates, and the process must be in compliance with federal and State regulations. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action.

5. A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

6. The MCO shall offer an internal grievance review procedure. The MCO shall issue grievance decisions within fourteen (14) days from the date of initial receipt of the grievance and after all pertinent information has been received. The decision must be in writing and shall include but not be limited to:

   a. The decision reached by the MCO;
   b. The reasons for the decision;
   c. The policies or procedures which provide the basis for the decision; and
   d. A clear explanation of further review rights and the time frame for filing a request for review.

7. The enrollee may request an external review of any formal grievance decision by the MCO. An external review organization shall manage the external review procedure. The external review organization provides an independent external review, because the external review organization is the State or a contractor other than the contractor responsible for the matter subject to external review. If an enrollee wishes to file an appeal with the external review organization, the appeal must be filed within 30 days of the enrollee's receipt of notice of the final decision from the MCO.

8. The MCO shall provide to the external review organization all information necessary for any enrollee appeal within the time frame established by the Department.

9. All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.

10. All applicants/enrollees shall have an opportunity to:

    a. Represent themselves or have representation of their choosing during the review process;
    b. Timely review their files and other applicable information relevant to review of the decision;
    c. Fully participate in the review process, whether the review is in person or in writing, including an opportunity to present supplemental information during the review process; and
    d. Receive continued coverage if the enrollee requests a review prior to the effective date of the reduction or termination of services or payment for services.

11. Unless an expedited review decision is mandated, the external review organization shall complete the external review process and issue a decision within ninety (90) calendar days of the date an enrollee requests an internal review. If the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, then the external review organization must complete the external review process and issue a decision within seventy-two (72) hours of the time an enrollee requests external review.

12. The MCO shall comply with the external review decision. The external review organization's decision in these matters shall be final and shall not be subject to appeal by the MCO.

13. The external review organization's decision must be in writing and shall include but not be limited to:

    a. The decision reached by the external review organization;
    b. The reasons for the decision;
    c. The policies or procedures which provide the basis for the decision.

For reviews involving health services matters for FAMIS enrollees receiving services through fee-for-service, the following procedures shall apply.

1. The State or its contractor shall provide a written notification within 10 days after a decision is made and provide the opportunity for external review whenever an enrollee's request for covered services is delayed, denied, reduced, suspended, or terminated, in whole or in part including a determination about the type or level of services; or whenever there has been the failure to approve, furnish or provide payment for health services in a timely manner.

2. Written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, and the standard and expedited time frames for review.

3. A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

4. The external review must be conducted by the State or a contractor other than the contractor responsible for the matter subject to external review.

5. If an enrollee wishes to request an external review, the request must be filed within 30 days of the enrollee's receipt of notice of the final decision from the State or its contractor.

6. All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.

7. All applicants/enrollees shall have an opportunity to:
   a. Represent themselves or have representation of their choosing during the review process;
   b. Timely review their files and other applicable information relevant to review of the decision;
   c. Fully participate in the review process, whether the review is in person or in writing, including an opportunity to present supplemental information during the review process; and
   d. Receive continued coverage if the enrollee requests a review prior to the effective date of the reduction or termination of services or payment for services.

8. Unless an expedited review decision is mandated, the external review process shall be completed and a written decision shall be issued within ninety (90) calendar days of the date an enrollee requests an external review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, then the external review process must be completed and a written decision must be issued within seventy-two (72) hours of the time an enrollee requests external review, unless the applicant, enrollee, or authorized representative requests or causes a delay.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

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