2003 REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) STUDY

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Preface

The provisions of the following resolution and bills were considered in completing this review of Family Access to Medical Insurance Security (FAMIS):

- SJR 90 requires review of regulatory, statutory, and administrative provisions
- SB 428/HB 1087 requires FAMIS coverage of mental health services of day health and rehabilitation services
- HB 332 requires FAMIS coverage of mental health services of intensive in-home services and 24-hour emergency response
- HB 1086 requires simplification of the application process
- HB 1088 limits the annual enrollment fee paid by FAMIS families
- HB 1089 provides for 12-month continuous eligibility for children enrolled in Medicaid or FAMIS.

A copy of the resolution and six bills are included in Appendix A.

Virginia's first State Children's Health Insurance Program (SCHIP) funded under Title XXI of the Social Security Act was the Children's Medical Security Insurance Plan (CMSIP). CMSIP which began accepting applications in October 1998 was a stand-alone program for children whose family incomes were $\leq$185 percent of the federal poverty guidelines.

Virginia's second SCHIP Family Access to Medical Insurance Security or FAMIS was initiated on August 1, 2001. Legislation introduced in 2000 implemented a number of changes in the program. The most significant changes involved increasing family income levels from 185 to 200 percent of federal poverty guidelines and changing the benchmark for health benefits from Medicaid benefits to benefits provided by private, commercial managed-care organizations.

Virginia has failed to meet its own projections for SCHIP enrollment; as of 2001 58 percent of the projected enrollment had been reached (36,740 of 63,200) and approximately $89 million of $210 million in federal funding had been expended.

Actions Taken by JCHC

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the provision of Child Health Insurance in Virginia. These policy options are listed on pages 39-42. A summary of public comments received regarding the proposed Options are included in Appendix D.

The Commission approved for introduction during the 2003 General Session an Omnibus bill and budget amendment to incorporate changes in eligibility and benefits (that should apply both to Medicaid coverage for children and to FAMIS whenever possible) to effectuate the following changes:

- Establish a single, umbrella program that incorporates both Medicaid for medically indigent children and FAMIS retaining the program name of FAMIS with the Medicaid portion being known as FAMIS Plus.
- Require use of a single application to determine eligibility for both Medicaid coverage for children and FAMIS. (This would put in statute what is current practice.)
- Include within FAMIS, coverage for the community-based mental health and mental retardation services provided for children enrolled in Medicaid (under State Plan Options).
- Reduce the waiting period from six to four months between the time that a child was covered by private health insurance and when eligibility for FAMIS can be established.
- Allow coverage for prenatal care and delivery for children within FAMIS using the wording that care will be provided for children from conception to birth.
- Amend the language that authorizes cost-sharing within the FAMIS Plan to require a $25 per year per family enrollment fee and specify that the co-payment amounts shall not be reduced below the co-payment amounts required as of January 1, 2003.

(Approval of an Omnibus bill included accepting Options I, IV, VI, and VIII to recommend that none of the FAMIS-related bills carried over from the 2002 Session be reported.)

TABLE OF CONTENTS

I.
Authority for the Study/Organization of Report

The provisions of a study resolution (Senate Joint Resolution 90) and six bills (Senate Bill 428 and House Bills 332, 1086, 1087, 1088, and 1089) were referred to the Joint Commission on Health Care (JCHC) to be considered in completing a comprehensive study of the Family Access to Medical Insurance Security (FAMIS) program. SJR 90 required a JCHC study of FAMIS to be submitted by November 30, 2002 to the chairmen of the Senate Finance Committee and the House Appropriations Committee and to the Governor. SJR 90 reads, in part:

> [T]he Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services [(DMAS)] and various advocacy groups, [shall] review the regulatory, statutory, and administrative provisions of the FAMIS program. As part of its study, the Joint Commission on Health Care shall review the JLARC findings and assess the degree to which the JLARC recommendations have been implemented. The Joint Commission on Health Care also shall identify further actions to improve the program's effectiveness and efficiency, and to increase enrollment.

SJR 90 was left in the Senate Rules Committee which indicated that a study resolution was not required in order for JCHC to undertake the study.

Six additional bills were referred to JCHC to consider in its review of the FAMIS program. Figure 1 summarizes the provisions of each of the bills. All of the bills, except HB 332, were continued to 2003 with the understanding that the bills' provisions would be considered within the JCHC study. HB 332 was passed by indefinitely.

Appendix A contains a copy of SJR 90 as well as the six bills (Senate Bill 428 and House Bills 332, 1086, 1087, 1088, and 1089) described in Figure 1. The substitute language for SB 1089, the language considered in completing this study, is shown in Appendix A.

Figure 1

2002 General Assembly Bills to Be Considered in Study of FAMIS Program

Bill	Bill Provisions
SB 428 **HB 1087**	Amends *Code of Virginia* § 32.1-351 to require the FAMIS Plan include for "covered persons with mental retardation or related conditions [the mental health services of] day health and rehabilitation services providing individualized activities, supports, training, supervision, and transportation" as provided for within the *State Plan for Medical Assistance Services* (which defines the services provided within the State Medicaid program). **SB 428 was referred to JCHC by letter from the Chairman of the Senate Committee on Education and Health. HB 1087 was referred to JCHC by verbal request of the Chairman of the House Committee on Health, Welfare, and Institutions.**
HB 332	Amends *Code of Virginia* § 32.1-351 to include within the FAMIS Plan the mental health services of "intensive in-home services including crisis treatment; individual family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and twenty-four hour emergency response" as provided for within the *State Plan for Medical Assistance Services.* **Referred to JCHC by verbal request of the Chairman of the House Committee on Health, Welfare, and Institutions.**
HB 1086	Amends *Code of Virginia* § 32.1-325 to require simplification of the "Medicaid application process and verification requirements for children to provide consistency with the procedures used by" the FAMIS Plan and to "provide for the automatic filing of a [FAMIS] application...for children who have been denied or terminated from the Medical Assistance Services program." **Referred to JCHC by verbal request of the Chairman of the House Committee on Health, Welfare, and Institutions.**
HB 1088	Amends *Code of Virginia* § 32.1-351 to limit the annual enrollment fee paid by FAMIS enrollees (who have income in excess of 150 percent of the federal poverty guideline) to no more than $100 per family. **Referred to JCHC by verbal request of the Chairman of the House Committee on Health, Welfare, and Institutions.**
HB 1089	Amends *Code of Virginia* §§ 32.1-325 and 32.1-351 to provide for 12-month continuous eligibility for children enrolled in Medicaid or enrolled in FAMIS. (Note that this description contains the language of the bill substitute that was drafted but not formally adopted.) **Referred to JCHC by verbal request of the Chairman of the House Committee on Health, Welfare, and Institutions.**

Appendix B contains the letter from the Chairman of the Senate Committee on Education and Health requesting JCHC to report back to the Committee regarding the provisions of SB 428. The letter states:

> Thank you for including this provision in the Commission's study plan for the coming year. I appreciate your assistance on this matter and respectfully request, on behalf of the members of the Senate Committee on Education and Health, that the Joint Commission on Health Care advise the Senate Committee on Education and Health of its recommendations on these mental health issues.

Organization of Report

This report is presented in five major sections. This section discussed the authority for this study of the Family Access to Medical Insurance Security program. Section II provides an overview of the federal State Children's Health Insurance Program. The development of Virginia's child health insurance programs is presented in Section III. Section IV reviews the current operation of FAMIS. Section V provides a series of policy options the Joint Commission on Health Care may wish to consider in an effort to enhance the operation of the FAMIS program.

II.
Background on the Federal Initiative: State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP), initiated in 1997, was only the second major federal effort to provide health care coverage for low-income children. (The first effort, the establishment of the Medicaid program in 1965, also provided health care coverage for adults.) SCHIP was a significant initiative undertaken the fact that an estimated 10 million children in America lacked health insurance in 1997. SCHIP was designed to benefit children whose family income was too high to be eligible for Medicaid coverage but too low to afford private health insurance. SCHIP was enacted as Title XXI of the *Social Security Act*. Initial funding of more than $24 billion was allocated over a 5-year period to support SCHIP coverage "making it the largest federal expansion of health insurance coverage since the passage of Medicaid...." (Subsequent Congressional authorizations have increased the federal funding for a 10-year period to $40 billion.)

Federal Requirements for SCHIP Plans

Title XXI delineates certain, general parameters for recipient eligibility for SCHIP plans. These parameters include:

- only children under age 19 may be enrolled in SCHIP (unless a specific waiver has been granted to allow the children's parents to purchase their health insurance through SCHIP by paying the full cost themselves);
- children who are confined within a state institution cannot be enrolled in SCHIP;
- children who are eligible for Medicaid or for the state's employee health insurance through a parent cannot be enrolled in SCHIP;
- children cannot have health insurance at the time of application (although no minimum "waiting period" is specified in the federal legislation between health insurance coverage and eligibility for SCHIP coverage); and

- family income cannot exceed the higher of 200 percent of the federal poverty guideline or 50 percentage points above the amount the particular state allowed for Medicaid coverage as of June 1, 1997.

Figure 2 shows the federal poverty guidelines (FPGs) for federal fiscal year (FFY) 2002.

Figure 2

2002 Federal Poverty Guidelines

Family Size	48 Contiguous States	Alaska	Hawaii
1	$8,860	$11,080	$10,200
2	$11,940	$14,930	$13,740
3	$15,020	$18,780	$17,280
4	$18,100	$22,630	$20,820
5	$21,180	$26,480	$24,360
6	$24,260	$30,330	$27,900
7	$27,340	$34,180	$31,440
8	$30,420	$38,030	$34,980
Add for each additional family member	$3,080	$3,850	$3,540

Source: U.S. Department of Health and Human Services.

While Title XXI provides for general requirements for SCHIP plans, the legislation also provides a great deal of freedom for states in designing their SCHIP plans. To understand the significance of the freedom provided, the constraints placed on states in designing their Medicaid programs are discussed in the following section.

Medicaid Program Requirements on States. Medicaid is an entitlement program which means that anyone who meets the categorical, income, resource, and if appropriate functioning criteria is eligible for Medicaid services regardless of the Commonwealth's ability to "afford" those services. Categorical eligibility for Medicaid involves being a member of a family with children or being pregnant, aged (65 years of age or older), blind, or disabled. Thus, single adults and couples (who have no children) who are not aged, blind or disabled are not eligible for Medicaid regardless of how little income they may have. Functioning criteria must be met in order to receive certain types of services such as long-term care but generally does not apply to the eligibility of children to receive

Medicaid health services. As a National Conference of State Legislatures (NCSL) publication notes, Medicaid is designed to provide services to the "poorest of poor children as well as their parents, pregnant women, and several categories of low-income people with significant illnesses and disabilities."

Within Medicaid there are restrictions on the cost sharing that may be required by states. "Cost sharing" involves requiring program participants to assist in paying for services through such mechanisms as premiums, deductibles, co-payments and enrollment fees. Medicaid regulations do not allow states to require cost sharing for services received by children (aged 18 and under) whose eligibility is based on low family income.

States Are Allowed to Adopt One of Three General Types of SCHIP Programs. The NCSL website describes the federal requirements for SCHIP-program design, as follows:

> States were allowed to use SCHIP funds in three ways:
>
> - to expand Medicaid to cover older children or children from families with incomes too high for them to qualify for regular Medicaid (a "Medicaid expansion" plan);
> - to create an entirely new program (called a "state-designated" or "private" plan) with a benefit package consistent with provisions of Title XXI...; or
> - both expand Medicaid and create a separate private plan, for different populations (a "combination" plan).
>
> In Medicaid expansion states, all Medicaid rules apply. Delivery is through the same providers and systems, Medicaid restrictions on cost-sharing apply, and the state may not "cap" enrollment (i.e. turn away applicants that qualify for eligibility) after a certain number of children have enrolled or after the state has exhausted its funds.
>
> In state-designed plans – or state-designed portions of combination plans – the program is not required to accept enrollees if the program's capacity has been reached or if the state has expended all available funds. At the state's election, however, it can continue to enroll kids in the program after spending its full SCHIP allotment, and still receive some money from the federal government. The federal contribution for these kids, however, will only be at the regular Medicaid match rate....In other words, in these states SCHIP is not an entitlement. In states that design their own SCHIP programs, service delivery, quality assurance mechanisms, enrollment procedures, benefits and even the name of the program may be different from those of Medicaid. Alternatively, several "state designed"

programs are virtually identical to the Medicaid program in all respects except that they are not entitlements and may be capped. These programs are sometimes called "Medicaid look alike" programs.

According to the Centers for Medicare and Medicaid (CMS) as of May 2002: 15 states established Medicaid-expansion programs through SCHIP, 16 states (including Virginia) established separate "private" child health programs, and 19 states established combination programs (Figure 3).

Figure 3
SCHIP Programs Established by the 50 States

Medicaid-Expansion	Separate Program	Combination Program
Alaska	Arizona	Alabama
Arkansas	Colorado	California
Hawaii	Delaware	Connecticut
Idaho	Georgia	Florida
Louisiana	Kansas	Iowa
Minnesota	Montana	Illinois
Missouri	North Carolina	Indiana
Nebraska	Nevada	Kentucky
New Mexico	Oregon	Massachusetts
Ohio	Pennsylvania	Maryland
Oklahoma	Utah	Maine
Rhode Island	Vermont	Michigan
South Carolina	**Virginia**	Mississippi
Tennessee	Washington	North Dakota
Wisconsin	West Virginia	New Hampshire
	Wyoming	New Jersey
		New York
		South Dakota
		Texas

Source: Centers for Medicare and Medicaid, May 2002.

As noted previously, SCHIP plans that are designed as an expansion of a state's Medicaid program are subject to the same guidelines, restrictions, and service-provision obligations as that state's Medicaid program. Conversely, "private" and "combination" SCHIP plans are allowed to have benefit packages that are equivalent to:

- the state's Medicaid program,
- the state employee's health insurance,
- the Federal Employee's Health Benefit Package,

- the health benefit package of the commercial insurance company that insured the largest number of state residents, or
- a health benefit package that a certified actuary determined to be of equal value to any of the previously-described options.

The National Academy for State Health Policy (NASHP) in *How States Have Expanded Medicaid and SCHIP Eligibility*, reports that in federal fiscal year 2000:

- 14.8 million or 20 percent of children in the United States were enrolled in the Medicaid Program
- 3.3 million children were enrolled in a SCHIP program.

NASHP noted that in spite of the number of children enrolled in Medicaid or SCHIP, an estimated 8.4 million children continued to lack health insurance coverage and that 5.6 million of those children had family incomes of no more than 200 percent of the federal poverty guideline.

III.
Development of Virginia's SCHIP Programs

In 1997, before the passage of the federal SCHIP legislation, the Virginia General Assembly passed House Bill 2682 establishing the Virginia Children's Medical Security Insurance Plan. This legislation was in response to a serious gap in health insurance for children. Research indicates that children who lack health insurance are "more likely to lack a usual source of care, to go without needed care, and to experience worse health outcomes than children with coverage" (Kaiser Commission Key Facts on Medicaid and the Uninsured, May 2002). The 1996 Health Access Survey sponsored by the Virginia Health Care Foundation had estimated that 214,000 children under age 19 had no health insurance coverage. These children represented one-quarter of all Virginians who lacked health insurance. Of the 214,000 uninsured children, it was estimated that 71,800 were eligible for VCMSIP and 82,300 children were eligible but not enrolled in Medicaid. The remaining 59,900 uninsured children lived in families whose income was above 200 percent of the federal poverty guidelines.

The Virginia Children's Medical Security Insurance Plan (VCMSIP) was designed to extend health care coverage for children whose families were not eligible for Medicaid but could not afford private health insurance. DMAS was required to develop a proposal for VCMSIP by December 1, 1997. Health insurance coverage under VCMSIP was to be phased in over five years for uninsured and under-insured children whose family incomes were at or below 200 percent of FPG. The VCMSIP Trust Fund was established in the legislation and funding of $3.3 million for FY 1998 and $7.5 million in succeeding fiscal years was anticipated. The funding was expected to result from changes (resulting from Senate Bill 1112 and House Bill 2887) in the premium taxes paid by certain health insurers. VCMSIP was not implemented due to the passage of the federal SCHIP legislation.

A 1998 JCHC study of the provision of health care for the indigent and uninsured in Virginia noted that the provisions of VCMSIP were very similar to many aspects of the federal SCHIP program. Similarities included age and eligibility requirements and approximately the same number of children appeared to be eligible for both VCMSIP and the SCHIP that was being planned for Virginia. There were benefit differences

between the two programs, however. The federal SCHIP program prerequisites were more comprehensive in terms of the levels and types of benefits required than VCMSIP would have provided. As noted previously, VCMSIP was never implemented.

Virginia's First SCHIP was Known as the Children's Medical Security Insurance Plan (CMSIP)

In establishing Virginia's CMSIP program, language in the *1998-2000 Appropriation Act* required a two-component program. Item 334.U.2 of the *Appropriation Act* stated:

> The Virginia Children's Medical Security Insurance Plan shall consist of two components. The existing Medicaid program shall be expanded to cover children ages 0 through 18, in families with income up to 150 percent of the federal poverty level. The second component shall be a Title XXI plan and shall be established for children ages 0 through 18, in families with incomes between 150 and 185 percent of the federal poverty level. Families with children enrolled in the separate, non-Medicaid program shall be required to pay premiums and co-payments on a sliding fee scale. For both components of the program, Medicaid income methodologies and benefits shall be used; however, the Department shall implement Medicaid income methodologies in a manner which streamlines the eligibility determination process. The Department shall promulgate necessary regulations to implement the Virginia Children's Medical Security Insurance Plan to be effective July 1, 1998.

Virginia's plan for CMSIP was submitted on June 12, 1998, to the Health Care Financing Administration (HCFA) (subsequently renamed the Centers for Medicare and Medicaid). HCFA approved Virginia's plan on October 22, 1998 and local social services staff first accepted CMSIP applications on October 26, 1998.

CMSIP was not established as a two-component program that included an expanded Medicaid program. Instead, CMSIP was implemented as a single, stand-alone, non-Medicaid plan for children whose family incomes were at or below 185 percent of FPGs. By establishing a non-Medicaid plan, requirements, such as cost-sharing could be included within CMSIP. Virginia's application to HCFA indicated that cost-sharing requirements would be included at a later date for children whose family incomes were greater than 150 percent of FPGs. Initially, no cost-sharing was required in order to facilitate implementation of the CMSIP program.

Eligibility for CMSIP was determined by staff located in local departments of social services who also determined eligibility for Medicaid coverage. A 12-month waiting period was established. Thus, children who were covered under a health insurance plan within the 12 months prior to application for CMSIP were not eligible for CMSIP unless the "reason for dropping the coverage [was] approved by the state." Examples of acceptable reasons for dropping coverage were given by DMAS in response to a question from HCFA in August 1998. These examples included health care coverage being discontinued because a child had exhausted his/her lifetime benefits, employment was terminated for the person who had qualified the family for employer-sponsored health insurance, or the employer stopped offering health insurance for dependents of employees.

Virginia's Second SCHIP – Family Access to Medical Insurance Security (FAMIS) – Was Initiated on August 1, 2001

Legislation in 2000 (SB 550 and HB 1489) amended *Code of Virginia* § 32.1-351 to modify Virginia's child health program. The new program, Family Access to Medical Insurance Security or FAMIS, included the following changes in statutory provisions:

- reduced the waiting period for previous insurance coverage from 12 to six months
- initiated cost-sharing requirements for children whose gross family incomes exceeded 100 percent of FPG
    - cost sharing not to exceed 2.5% of gross family income for families with income between 100% and 150% of FPG
    - cost sharing not to exceed 5% of gross family income for families with income at or above 150% of FPG
- specified that FAMIS would "provide comprehensive health care benefits...including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act...includ[ing] comprehensive medical, dental, vision, mental health, substance abuse services, physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students"

- authorized DMAS to make premium payments to allow FAMIS enrollees to receive coverage through their employer-sponsored health insurance if "such enrollment is cost-effective" (as defined in the legislation to include that the "employer contributes at least fifty percent towards the cost of dependent or family coverage")
- established a centralized processing unit to determine eligibility for FAMIS (in combination with local departments of social services)
- required an outreach plan and developed an Outreach Oversight Committee.

The family income levels were also increased under the FAMIS program from 185 percent to 200 percent of FPG. Although the statutory basis for the child health program (*Code of Virginia* § 32.1-351) had always provided for children whose family incomes were at or below 200 percent of the FPG to qualify for assistance, *Appropriation Act* language had defined program eligibility limitations to be 185 percent of FPG.

The benchmark for FAMIS health benefits was changed from Medicaid benefits to the types of benefits provided by private, commercial managed-care organizations. It was expected that managed care would be available throughout Virginia and that managed-care benefits (with some enhancements) would be provided for FAMIS enrollees.

Virginia Has Failed to Meet Enrollment Projections for Its Child Health Insurance Programs

Initial projections for the number of uninsured children who would be eligible for Virginia's SCHIP and for Medicaid coverage were estimated based on the results of the 1996 Health Access Survey. The Survey was sponsored by the Virginia Health Care Foundation and conducted by the Virginia Commonwealth University Survey Research Lab. The *1997 Annual Report of the Joint Commission on Health Care* indicated that approximately 71,800 of Virginia's 214,000 uninsured children were expected to be eligible for SCHIP while 82,300 uninsured children were expected to be eligible for Medicaid. (The remaining 59,900 uninsured children were expected to be ineligible for assistance due to family incomes of greater than 200 percent of FPG.)

Virginia's initial CMSIP submission included annual enrollment projections for 1998 through 2001. A comparison of the projected figures with the actual number of children who were enrolled yields the following:

Year	Projected Enrollment	Actual Enrollment	Actual Enrollment/ Projected Total
1998	7,900	1,107	14%
1999	36,340	16,466	45%
2000	53,720	29,515	55%
2001	63,200	36,740	58%

As shown, the number of enrollments increased each year as a percentage of the projected numbers; but the actual number of enrollments failed to reach 60 percent of the enrollment projections by 2001.

During the time that local social services agencies were responsible for CMSIP enrollment, the agencies showed substantial variation in the number of children enrolled compared with the number estimated to be eligible. As of June 19, 2001, the following 10 localities had enrolled at least 75 percent of the number of children projected to be eligible for CMSIP while 15 localities had enrolled less than 25 percent of the projected number of CMSIP-eligible children:

Locality	% of Projected Number Enrolled in CMSIP	Locality	% of Projected Number Enrolled in CMSIP
Arlington	115%	Falls Church	6%
Manassas	103%	Emporia	12%
Prince William	89%	Fairfax City	12%
Highland	87%	Charles City	14%
King & Queen	85%	York	16%
Appomattox	83%	Martinsville	16%
Fairfax	76%	Franklin	20%
Lancaster	76%	Petersburg	20%
Lexington	76%	Salem	20%
Alexandria	75%	Danville	21%
		Portsmouth	22%
		Clarke	23%
		Greensville	23%
		Richmond City	23%
		Prince George	24%

On a statewide basis, 40 percent of the projected number of CMSIP-eligible children had been enrolled when CMSIP was replaced by the FAMIS program.

The number of Medicaid enrollments that resulted from CMSIP outreach is not available because there was little tracking of those enrollments. This problem is noted in the chapter on Virginia's child health program within the 2002 JLARC report, *A Review of Selected Programs in the Department of Medical Assistance Services.* The JLARC report states: "based upon the experience of 12 pilot outreach projects (serving 47 localities), 65 percent of more than 5,500 children assisted by these projects were enrolled in the Medicaid program and the remainder in CMSIP."

Virginia Has Failed to Use Millions in Federal Funding Available for Child Health Insurance

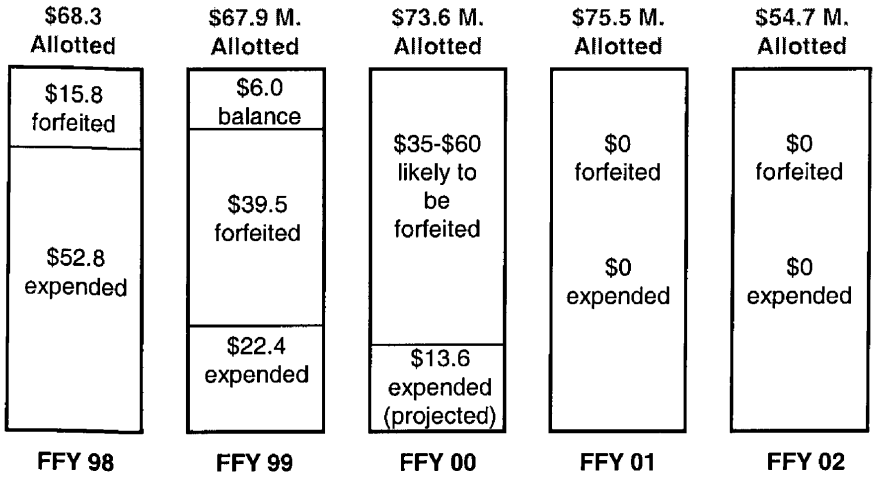
Due to the problems experienced enrolling children in CMSIP, Virginia has failed to expend its federal SCHIP allotments. A number of states experienced problems in the start-up phase of their child health programs. The federal government expected that at the end of the first three-year allocation of SCHIP funds, the unspent funds would be reallocated to the states that had expended their entire allotments. Instead, as explained in the 2002 JLARC report:

> [W]hen the first three-year deadline expired on September 30, 2000, for federal fiscal year (FFY) 1998 allotments, 42 of 50 of the states (including Virginia) had not spent their allocation during the three-year time period (only three percent of the FFY 1998 child health insurance allotments had been spent). Because of this, the federal government allowed the states to retain more than half of their unspent balances. Another three-year deadline expired on September 30, 2001, for the FFY 1999 allocation. In December 2001, the federal government determined that it would redistribute some of the unspent child health insurance dollars to thirteen states that have successfully spent more than their FFY 1999 allotments and allow the remaining states to retain a portion of their unspent dollars for one more year. Funding for the successful states will be provided from a pool of unspent dollars from other states, including Virginia's unspent dollars.

Figure 4, which was developed by DMAS for a May 2002 presentation to JCHC, shows the funding Virginia received and expended in federal child health allotments from FFY 1998 through FFY 2002. It is not yet known how much of the unexpended balance for the FFY 2000

allocation Virginia will be allowed to retain. DMAS expects that $35 to $60 million not be drawn down. Virginia continues to play "catch-up" for failing to expend the federal allocation in the early years of the program.

Figure 4
Federal Allotments and Expenditures
FFY 1998-2002 (in millions)



Source: DMAS Presentation to JCHC on May 30, 2002.

Figure 5 shows the expenditures that were made on Virginia's child health programs (CMSIP and later FAMIS) by the state fiscal year (SFY) in which the expenditure was recorded. The only expenditures that are not included in these figures are the reimbursements that were provided to local departments of social services under the CMSIP program. According to DMAS, those expenditures amounted to several million dollars a year for the first three years of the program.

Relating the expenditures in Figure 5 to the information presented in Figure 4 shows that the $52.8 million federal allotment for FFY 1998 was not expended by Virginia until SFY 2002. DMAS staff confirmed that the federal allotment for 1998 (minus the amount that was not drawn down) was not completely expended until the third month of SFY 2002.

Figure 5
Virginia Child Health Program Expenditures

Funding	SFY 1999	SFY 2000	SFY 2001	SFY 2002
GFs*	$1,387,450	$ 7,652,125	$13,403,999	$17,847,996
NGFs	$2,530,623	$14,225,379	$24,555,058	$32,901,700
TOTAL	**$3,918,073**	**$21,877,504**	**$37,959,057**	**$50,749,696**

*Includes both state general funds and trust funds. The trust fund contributed $15.4 of the $17.8 million shown as GFs SFY 2002.

Source: Department of Medical Assistance Services.

IV.
Review of Virginia's Current FAMIS Program

In Moving from CMSIP to FAMIS, DMAS Expected to Convert from a Medicaid-Based Plan to a Managed Care Plan

When Virginia moved from CMSIP to FAMIS, the goal was to move away from a "Medicaid look-alike program" to a program that was based on health insurance "readily available in the private sector including dental, vision, and well child services." It was expected that a number of families would access health insurance through their employers' plans. The Employer Sponsored Health Insurance (ESHI) option under FAMIS allows a family to access the health insurance sponsored by a family member's employer if the insurance was found to be cost-effective. Thus, ESHI allows an entire family (not just the children) to be enrolled in the employer-sponsored plan.

The expectation that a number of families would access health insurance through their employers' plans has not worked out. Since the initiation of FAMIS in August 2001, 303 families have applied for ESHI coverage. Twenty-nine families currently receive ESHI coverage, 43 families' applications are "pending" and 231 families' applications have been denied or have been approved and subsequently closed. DMAS reports that the top three reasons that families do not enroll in ESHI as being: (1) the required participation rate of 40 percent of cost being borne by the employer is not met, (2) the cost to provide ESHI coverage for a particular family is not cost effective, and (3) the family withdraws the application because the amount of assistance in paying for insurance is considered to be so small.

It was expected that the children who were not covered through ESHI would receive care through a managed-care provider under contract with DMAS. While the ESHI enrollments have not gone as expected, approximately 84 percent of children enrolled in FAMIS are covered by a managed-care organization. Eight managed-care programs – Sentara Family Care, Southern Health, UniCare of Wellpoint, Virginia Premier Health Plan, Trigon Healthkeepers Plus, Trigon Healthkeepers Plus by Peninsula Health Care, and Trigon Healthkeepers Plus by Priority Health Care – have contracts with DMAS to enroll FAMIS children. These eight

programs provide care in all but 32 Virginia localities. The localities that are not covered include:

Counties	Cities and Towns
Alleghany	Bristol
Amherst	Clifton Forge
Appomattox	Covington
Bath	Galax
Bland	Lynchburg
Buchanan	Norton
Campbell	Winchester
Carroll	
Clarke	
Craig	
Dickenson	
Frederick	
Grayson	
Highland	
Lee	
Page	
Rappahannock	
Russell	
Scott	
Shenandoah	
Smyth	
Tazewell	
Warren	
Washington	
Wise	

There Are Three General "Versions" of FAMIS Including Enrollment in One of Eight Managed Care Organizations, Enrollment Through the ESHI Feature, and Provision of Fee-for-Service Care. Fee-for-service based care is provided for families living in the 32 localities in which there is no managed care provider. Figure 6 summarizes the general characteristics of the three versions of FAMIS.

Only the families, who live in localities for which managed care is available or who are enrolled in ESHI, participate in cost-sharing (co-payments). As shown, approximately 84 percent of FAMIS enrollees are subject to cost-sharing requirements. Figure 7 shows the cost-sharing requirements for FAMIS managed-care enrollees. The fee-for-service form of FAMIS does not require cost-sharing and offers basically the same

benefits as the Medicaid program. The Medicaid benefits are defined in the *State Plan for Medical Assistance Services*.

Figure 6

Description of the Three Forms of the FAMIS Program

Description of FAMIS Program	Children Enrolled
FAMIS Managed Care is provided by one of the eight managed care organizations around Virginia. Children who live in a locality in which managed care is available must receive their FAMIS services through that managed care organization. The benchmark for the services is the state's primary employee managed care plan – Key Advantage. Families of children enrolled in FAMIS Managed Care are required to participate in cost-sharing.	35,418 (84%)
FAMIS Fee for Service offers the same benefits as provided under Medicaid (and previously under CMSIP) without any requirement to participate in cost-sharing. Children, previously enrolled in CMSIP who live in a locality that is not served by a managed care organization, are served on a fee-for-service basis but have their care coordinated by a physician. This is known as primary care case management (PPCM). Children, who are new enrollments to FAMIS and live in a locality that is not served by a managed care organization, are not subject to PPCM.	6,826 (16%)
Employer Sponsored Health Insurance allows a family to access the health insurance sponsored by a family member's employer if the "employer contributes at least 40 percent towards the cost of dependent or family coverage...."	49 (<1%)

Source: JCHC staff analysis of DMAS data.

As shown in Figure 7, cost-sharing requirements currently consist of co-payments paid when certain services are received. Some services such as preventive care visits do not have a co-payment requirement.

Administrative and Substantive Changes Have Been Made in the FAMIS Program to Address the Concerns of the General Assembly, FAMIS Recipients, and Child Health Advocates

In an effort to address programmatic and operational problems in the FAMIS program, the General Assembly and the current Administration have implemented changes. The 2002 JLARC report on the development

of Virginia's child health program pointed out a number of the problems. Five town hall meetings held in April 2002 as well as consultation with consumer groups and child health advocates helped to identify additional improvements that have been undertaken.

Figure 7
Comparison of Cost-Sharing Requirements

	FAMIS Managed Care		CMSIP/FAMIS Fee for Service
	150% & Below FPG:	**Above 150% FPG:**	
Co-payments:			
Outpatient Visits	$2/visit	$5/visit	"Under CMSIP, cost-sharing was authorized under the State Plan, but never implemented."
Prescription Drugs	$2/prescription	$5/prescription	
Inpatient Visits	$15/admission	$25/admission	
Inappropriate Use of Emergency Room*	$10/visit	$25/visit	
Preventive Services	None	None	
Maximum per calendar year	**$180 per family**	**$350 per family**	

*"If it is determined that the visit was a non-emergency, the hospital may bill the enrollee only for the difference between the emergency room and the non-emergency co-payments, i.e. $8.00 for ≤ 150% and $20.00 for > 150%. The hospital may not bill for additional charges."

Source: DMAS documents.

Most of the JLARC Recommendations Have Been Implemented. As noted previously, JLARC reviewed the development of Virginia's child health program as part of a larger study of selected programs within DMAS. Figure 8 summarizes the recommendations made in the JLARC report and the current status of those recommendations.

With regard to Recommendation 1, it will be important for DMAS to ensure that Medicaid enrollments that result from FAMIS outreach efforts are counted appropriately. A DMAS representative indicated the Medicaid enrollments that begin with a contact to the CPU are being counted and tracked. However, it would be a new reporting requirement for the staff of the local departments of social services (LDSS) who do not currently determine why a family came in to apply for child health insurance assistance. A DMAS representative indicated: "DMAS and DSS are going through major computer systems changes....The focus should be on enrolling children in either Medicaid or FAMIS, not why they walked in

the door — especially since we have a no wrong door policy. And we know that most people that may come in for FAMIS, will actually qualify

Figure 8

Implementation of Recommendations Made in 2002 JLARC Report

Recommended Action	Implementation Status
1. DMAS should track and report on the number of children who are enrolled in Medicaid following inquiry about FAMIS eligibility.	DMAS has a process for collecting and reporting on the Medicaid enrollments that started with the CPU as possible FAMIS enrollments. However, there is no data field for LDSS staff to report on this information within their computer system.
2. DMAS should implement a telephone or mail survey to use in determining the reasons for children leaving the FAMIS program.	DMAS reported that "[n]o telephone surveys were performed during this quarter."
3. DMAS should update its projections for enrollment of children in Medicaid and FAMIS.	DMAS is working with a consultant to update enrollment projections based on the 2001 Virginia Health Access Survey as well as the results of the 2000 Census.
4. A single eligibility level of 133 percent of the federal poverty guidelines should be set for children up to age 19 rather than simply to age 6. Federal Title XXI funding (at the match rate of 66% federal, 34% state) should be used to fund this Medicaid expansion.	Changed in Item 324.D of the *2002-2004 Appropriations Act.*
5. Coordination between the Medicaid and FAMIS programs should be improved.	DMAS developed "detailed procedures to improve work flow and communication between the CPU and local social services departments" and implemented statewide training of social services staff. Beginning on September 1st additional changes were made including a single application to be used for Medicaid or FAMIS, "uniform verification procedures, and the 'No Wrong Door' policy...."
6. DMAS "should expand the quarterly report...concerning the status of FAMIS to include detailed tracking information on the enrollment and retention of children in FAMIS, the utilization and costs of mental health and health care benefits (those that have been reduced or expanded), how it is implementing the recommendations in this report, and the status of the issues highlighted in this report for ongoing monitoring."	DMAS indicates it "will be easier to track enrollment, retention, and shifts between programs with the September 1 changes because we now have SSNs on children to do these matches. The costs of services are already in the [quarterly] report." In addition the quarterly report for April through June 2002 will address the status of these six JLARC recommendations.

Source: JCHC staff analysis of DMAS information.

for Medicaid." If the Medicaid enrollments that come in to local departments of social services due to the FAMIS outreach are not tracked, Virginia will continue to underestimate the number of uninsured children being reached due to the SCHIP initiative.

With regard to Recommendation 2, it will be important for DMAS to determine the specific reasons that children are leaving the FAMIS program. As discussed later in this report, there are a number of program provisions that Virginia can adopt to provide for better program retention. Knowing why children are leaving the FAMIS program will allow DMAS to tailor program provisions to ensure that children continue to have health insurance coverage.

With regard to Recommendation 3, it will be interesting to see the updated projections. Comparing the estimates contained in the Health Access Survey from 1996 with the 2001 Survey revealed the following:

Estimates based on 1996 Report	**Estimates based on 2001 Report**
214,000 children ages 0 to 18 uninsured	231,220 ages 0 to 17 uninsured
34.0% uninsured families > 200% FPG	49.6% uninsured families > 200% FPG
57.0% of uninsured families work full-time	67.2% of uninsured families work full-time

Similar to the experience on the national level, despite the enrollment of children in Virginia's SCHIP, the number of uninsured children has increased since 1996.

Changes Were Required of FAMIS Through Legislative Action Taken During the 2002 General Assembly Session. Changes were required of FAMIS in *Appropriation Act* language and in two bills that were enacted.

Three changes were included in Item 324 of the *2002-2004 Appropriation Act*. The first change addressed a recommendation of the 2002 JLARC report to expand eligibility for Medicaid coverage to children under age 19 (rather than under age six) whose family income is up to 133 percent of FPG. Previously, children within the same family were covered under Medicaid if they were under age six while the older children were enrolled in FAMIS. It should be noted that the federal government will continue its SCHIP-based participation rate of 65.37 percent (as compared with 50.53 percent for Medicaid for FFY 2003) for the children within this

"Medicaid Expansion" group. (Virginia's SCHIP is now considered to be a combination rather than a separate program as a result of this change.) The second change made through budget language added "affordability" as a calculation that could result in a "good cause" exception to the six-month waiting period for prior insurance coverage. Health insurance costs that exceed "10 percent of the family's countable monthly income" are not considered to be "affordable" for waiting-period purposes. The third change addressed authority to file a FAMIS application on behalf of a child. The list of individuals who are allowed to file a FAMIS application was expanded to include "a parent, legal guardian, authorized representative, or any other adult caretaker relative with whom the child lives." Previously, applications could only be submitted by a parent, legal guardian, or individual as authorized by the parent or legal guardian.

In addition to the budget language, two bills were enacted during the 2002 General Assembly Session that addressed the FAMIS program. HB 790 amended the *Code of Virginia* § 32.1-351 to require the FAMIS Plan to "include a provision allowing a child's application to be filed by a parent, legal guardian, authorized representative or any other adult caretaker relative with whom the child lives." (As noted previously, language was included in the 2002-2004 Appropriations Act to make the same change.) HB 1062 also amended *Code* § 32.1-351 to say: "The Department of Medical Assistance Services shall enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced price school lunches or for services through the Women, Infants, and Children program (WIC) in order that the eligibility of such children for the Virginia Plan for Title XXI of the Social Security Act may be determined expeditiously."

DMAS has taken action on the legislation that was adopted. Programmatic changes that were within the purview of DMAS including the change in Medicaid eligibility, the addition of the "good cause" exception of affordability, and the expansion of the individuals who could apply for a child have been made. In addition, DMAS is coordinating outreach efforts with VDH to inform WIC and other VDH clients about FAMIS and Medicaid and to include descriptions of VDH services on FAMIS' promotional materials. With the start of the 2002-2003 school year, DMAS has worked with DOE so that FAMIS and Medicaid information will accompany the approval letters sent to approximately 430,000 National School Lunch Program recipients.

DMAS Implemented a Number of Programmatic Changes Effective September 1st. One of the significant goals of the current DMAS Director is to ensure better coordination between the FAMIS and Medicaid programs. DMAS found that a large percentage of children who were found to be likely to be eligible for Medicaid coverage and therefore ineligible for FAMIS were not actually enrolled in Medicaid. With the initiation of the FAMIS program, the number of "Medicaid likely" children who attempted to apply for FAMIS began to be tracked. Between August 2001 and May 2002, 13,435 children were referred to local departments of social services to apply for Medicaid coverage. DMAS determined that as of May 2002, only 2,661 or 19.8 percent of those children had been enrolled in Medicaid. This problem is illustrative of the types of difficulties that separating FAMIS and Medicaid eligibility caused.

Beginning September 1st a policy of "No Wrong Door" was implemented. In practice, this means that the CPU which previously focused almost exclusively on determining eligibility for FAMIS can determine eligibility for both FAMIS and Medicaid. Similarly, staff of local departments of social services will be able to determine eligibility for both Medicaid and FAMIS coverage. To facilitate coordination and simplify the application process, a single application was implemented for FAMIS and Medicaid for child health coverage. Child health advocates indicate that having two applications was very confusing for families and individuals who were attempting to help families apply for health care coverage for their children.

Recent changes made in the FAMIS program are shown in Figure 9. DMAS staff indicated that CMS representatives have been very receptive to the changes that reduce program constraints and make it easier for children to access FAMIS and Medicaid benefits. DMAS has promulgated emergency regulations to implement the changes and a new State Plan will be submitted to CMS within weeks. DMAS is also planning to begin contacting the families that were identified as being "Medicaid likely" who have not shown up as Medicaid enrollments in an attempt to enroll the children. The patron of HB 1086 and HB 1088 indicated that the actions recently taken by DMAS have fulfilled the intent of both bills. It was therefore agreed that the provisions of these bills would not be considered in completing this study.

Complementing the programmatic changes initiated, are partnerships and outreach efforts that have been undertaken by DMAS.

An exhaustive listing of those efforts is included in the report in Appendix C. A few examples of some of the efforts that are underway are shown in Figure 10.

Figure 9

Recent Changes Made in the FAMIS Program

Changes that Became Effective Prior to September 1, 2002

Discontinued monthly premiums of $15 per child up to $45 per family.

Increased income levels for Medicaid eligibility for children 6 to 19 from < 100% to < 133% FPG (so that different income levels no longer apply to children of different ages within one family). An estimated 8,000 children will be moved from FAMIS to Medicaid enrollment.

Excluded prior health insurance coverage that cost in excess of 10% of a family's countable income from being counted within the six month waiting period (excluded due to affordability issues).

Expanded authorization to apply for FAMIS on behalf of a child to include "authorized representative or any other adult caretaker relative with whom the child lives."

Changes that Became Effective September 1, 2002

Implemented a single application for FAMIS and Medicaid child health coverage.

Authorized staff of CPU and local departments of social services to determine eligibility for both FAMIS and Medicaid child health coverage.

Clarified that a child is "considered to be uninsured if the child's insurance does not have a network of providers in the area where the child lives."

Eliminated the exclusion of children from FAMIS coverage if they have an absent parent who is eligible for State Employee Health Insurance.

Source: Department of Medical Assistance Services.

DMAS Postponed Action on Other Possible Changes to Allow for Consideration in the Context of this Report

DMAS representatives indicated the recent changes made in the FAMIS program have generally been supported by the General Assembly, child health advocates, and families of children enrolled in FAMIS. Decisions regarding additional changes, for which support was not as obvious, were postponed until they could be reviewed in the context of this report and acted on by the Joint Commission on Health Care. These additional changes include:

Figure 10
Examples of Partnerships and Outreach Efforts Undertaken by DMAS

Participating Entities	Description of Outreach Effort
Department of Social Services	Media campaign promoting both FAMIS and Medicaid coverage as "Children's Health Insurance" options.
Department of Education	David and Lucille Packard Foundation Technical Assistance Grant award (to DMAS and DOE) will be used to fund outreach in the schools that will include training of school nurse coordinators and provision of a variety of promotional materials for use by PTAs, school administrators, and others.
WWBT Channel 12	Call-12 appearances, the first was in August as part of the Back to School campaign.
Virginia Health Care Foundation	VHCF received a second Robert Wood Johnson grant for nearly $1 million (over a four-year period) to fund outreach and promotional activities.

Source: Department of Medical Assistance Services.

- benefit changes that were made in moving from CMSIP to FAMIS.
- reduction in the waiting period for prior health insurance coverage,
- presumptive eligibility, and
- 12-month continuous eligibility.

In Moving from CMSIP to FAMIS, Some Changes in Benefits Were Made

In converting from CMSIP to FAMIS, the benchmark for health benefits changed from Medicaid services to the benefits typically provided in private, commercial managed care plans. Figure 11 shows some of the benefits provided within FAMIS managed care compared with FAMIS fee-for-service benefits. In a number of the examples shown in Figure 11, the managed care benefits are not as generous as the fee-for-service benefits. For example, community-based mental health and mental retardation services are only covered at the discretion of the MCE. Conversely, personal care services and private duty nursing services are covered under FAMIS managed care but are not covered by Medicaid as health care services. Figure 11 also shows changes that will become effective December 1st to enhance dental and vision benefits.

Figure 11
Comparison of Benefits

Benefits	FAMIS Managed Care		FAMIS Fee for Service
Early and Periodic Screening, Diag nostic, and Treatment (EPSDT)	No requirement to cover. Well baby and well child visits are covered.		Covered.
Transportation Services	Limited to ambulance services for "medical emergencies and when medically necessary when used locally to and from a covered facility or provider's office."		Covered.
Dental Complex Services	"Root canals, inlay, onlays, crowns, dentures, bridges, relining dentures, implants, with limits are covered at 50% of approved charge. Annual limit of $1200 for the above services. Orthodontic services covered ($1200) maximum per member per lifetime." ***Effective 12/1/02 the $1200 dental benefit limit will be removed and the orthodontic limit will increase to $2860.***		Covered but may require preauthorization.
Vision Services:	Limited to one routine examination every 24 months and subject to the following co-payments and limitations:		Covered.
Co-payment for visit	Current Limits $25	***As of 12/1/02*** ***$2 <150% FPG*** ***$5 ≥150% FPG***	Covered with no co-payment requirements.
Eyeglass frames	$20	***$25***	
Eyeglass lenses:			
Single vision	$35	***$35***	
Bifocal	$50	***$50***	
Trifocal	$70	***$88.50***	
Contacts	$100	***$100***	
Personal Care Services	Covered.		Not covered except by Medicaid Waiver.
Private Duty Nursing Services	Covered if preauthorized and provided by a RN or LPN who is not related to the enrollee.		Not covered.

Figure 11 (continued)
Comparison of Benefits

Benefits	FAMIS	FAMIS Fee for Service
Temporary Detention Orders	No requirement to cover.	Covered.
Inpatient Mental Health Services	MCE will cover preauthorized inpatient services if services are provided in a psychiatric unit within an acute care hospital or within a state psychiatric hospital with the limitation of only "up to 30 days per calendar year, including partial day treatment services."	Covered within a psychiatric unit within an acute care hospital.
Outpatient Mental Health Services	"The MCE is responsible for covering outpatient mental health and substance abuse clinic services. Psychiatric and substance abuse services are limited to no more than a combined total of 50 medically necessary visits of treatment with a licensed mental health or substance abuse professional each calendar year."	Covered.
Community Rehabilitation Services (State Plan Options)		
Mental Health Community Services	No requirement to cover.	Covered.
Mental Retardation Services	No requirement to cover.	Covered.

Source: Department of Medical Assistance Services.

Senate Bill 428, House Bill 1087, and House Bill 332 (2002) Require FAMIS to Include Community-Based Mental Health Services. SB 428 and HB 1087 are companion bills that would require amending *Code of Virginia* § 32.1-351 to require the FAMIS Plan to provide the mental health services of "day health and rehabilitation services providing individualized activities, supports, training, supervision, and transportation based on a written plan of care for two or more hours per day scheduled multiple times per week" for "covered persons with mental retardation or related conditions...." HB 332 would amend the same section of Title 32.1 to

require the FAMIS Plan to provide the mental health services of "intensive in-home services including crisis treatment; individual family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and twenty-four hour emergency response." All three bills require the defined services to be provided "in the same manner and with the same coverage and limitations" as provided for children covered under the Medicaid or FAMIS fee-for-service program.

Child Health and Mental Health Advocates Support Inclusion of Community-Based Mental Health Services. A number of child health and mental health advocates emphasize the need to provide community-based mental health services. The provision of community-based services would also seem to relate to the requirements of the *Olmstead* Decision. Item 329 of the *2002-2004 Appropriations Act* requires the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services to convene a task force to develop a comprehensive plan implementing the requirements for community-based care as required by *Olmstead*. The plan is to be completed and reported by August 31, 2003.

The Action Alliance for Virginia's Children and Youth provided JCHC staff with an Issue Paper the Alliance developed to explain the importance of including a comprehensive range of community-based mental health services within FAMIS. The Action Alliance Issue Paper cites a 1999 report of the U.S. Surgeon General which estimates that one in five American children has a "diagnosable mental or addictive disorder with at least minimal impairment, and one in ten experiences severe impairment. In Virginia, that translates to as many as 97,000 children and adolescents with serious emotional disturbance, and 5-7% of the total population, or almost 62,000 young people who suffer from extreme impairment." The Action Alliance Issue Paper in discussing the inclusion of community-based mental health services within the FAMIS program stated the following:

> • We recommend that FAMIS benefits be revised to include "Community Mental Health Rehabilitative Services" as defined under Medicaid (formerly known as State Plan Option services), in addition to the limited inpatient and outpatient mental health services currently covered. The full range of services includes the following (the services with an asterisk (*) are those generally used for children and adolescents):

• intensive in-home services*	• intensive community treatment
• therapeutic day treatment*	• crisis stabilization*
• day treatment/partial hospitalization	• mental health support
• psychosocial rehabilitation	• substance abuse treatment for pregnant women
• crisis intervention*	• case management*

Currently, these services are covered by Medicaid and by FAMIS in areas of the state that do not yet have managed care. The services are not covered by FAMIS in areas covered by managed care, and that is what we seek to change.

• The purpose of including these benefits in FAMIS is three-fold. First, including them is a form of mental health parity and sets the example that, in Virginia, we understand that a child's emotional and mental well-being is just as important as his or her physical health. Promoting mental health is a natural extension of promoting health insurance and a medical home for every child. Second, on a very practical level, it will cost the state more to provide services for these children through CSA (all state and local money) than through FAMIS (with the 2-1 federal match). It will certainly cost the state more to deal with the consequences of not serving a child with serious emotional disturbance in the long run if he or she ends up in foster care or in the juvenile justice system. Third, including these benefits in FAMIS creates consistency between Medicaid and FAMIS, as well as between FAMIS within those parts of the state covered by managed care and those that are not. Coverage of these mental health benefits will make services more consistently accessible for the families involved, who frequently fluctuate between Medicaid and FAMIS as their income fluctuates. It will also help the service providers who are trying to help families access needed treatment options.

The Action Alliance representative wanted to emphasize that if mental health care is not provided through FAMIS, Virginia and the children will pay a higher price at a later date. The problems these children have will not go away and the cost to address the problems will typically be higher and more devastating if left to the schools and perhaps the juvenile and criminal justice systems to address.

Virginia May Want to Consider Additional Procedural Changes to Increase Enrollment and Improve Retention in the FAMIS Program

As noted previously, Virginia has taken a number of steps to increase enrollment in both the FAMIS and the Medicaid programs. Since the implementation of FAMIS in August 2001, more than 22,000 additional children have been enrolled, for an average of more than 1,700 new

enrollments each month. For practical reasons, throughout this report descriptive information about the children enrolled in FAMIS has been based on the children enrolled as of June 2002. However, the current number of children enrolled in FAMIS has recently been impacted by redetermination problems that date back as far as December 2001 and by the number of children now eligible for Medicaid through the recent expansion of Medicaid to 133 percent of FPG.

On August 30, 2002, 45,271 children were enrolled in FAMIS. Effective September 1st, approximately 7,500 children were removed from the FAMIS enrollment for failure to return either their annual renewal forms or their redetermination information since December 2001. It should be noted that this large number of children were dropped from FAMIS enrollment all at once because the previous and current administrations wanted to have time to try to keep these children enrolled. DMAS made a minimum of five attempts, including telephone calls, to each family in an effort to prevent the loss of FAMIS coverage for these families. CMS recently advised DMAS that the children could not continue to remain enrolled if their families were not responding to the repeated attempts to contact them. Another approximately 8,000 children were moved on September 1st from FAMIS to Medicaid. These children now qualify for Medicaid because of the *Appropriation Act* language extending Medicaid eligibility from 100 percent to 133 percent of FPG for children 6 to 19 years of age. However, it is important to note that these children have not lost health care coverage and are still funded with FAMIS dollars at the higher match. Considering all of these factors, the estimated number of children enrolled on September 10, 2002 is approximately 30,000 children in FAMIS and 8,000 (Medicaid expansion) for a total of 38,000 enrolled in Virginia's SCHIP.

States have found that making certain procedural changes in child health programs can be very beneficial in terms of increasing enrollment and in retaining families once they have been enrolled. A Kaiser Commission report, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* indicates that states continue to make changes in their child health and in their associated Medicaid programs to simplify both enrollment and renewal procedures. Some of the procedures have been adopted by Virginia such as having a single application form and consistent eligibility requirements for both the child health and the Medicaid programs. Some of the other procedures that have not been adopted may be of interest to Virginia in attempting to increase enrollment

and/or improve retention in FAMIS. The procedures include reducing or eliminating the waiting period related to prior health insurance coverage, allowing for presumptive eligibility under certain circumstances, and allowing for 12-month continuous eligibility.

Reduction in the Waiting Period for Prior Health Insurance Coverage. Federal SCHIP law does not require states to include any waiting period between when a child is covered by private health insurance and when SCHIP eligibility can be established for that child. Federal SCHIP law does require states to "include in their state plans a description of reasonable procedures to ensure that health coverage provided under SCHIP does not substitute for (or "crowd out") private coverage (Kaiser Commission on Medicaid and the Uninsured, *Enrolling Children and Families in Health Coverage: The Promise of Doing More,* June 2002).

Originally 38 states included waiting periods to ensure that crowd-out did not occur. SCHIP regulations were subsequently clarified to indicate that waiting periods were not necessary and could be a barrier to the provision of needed care. Waiting periods are not allowed in SCHIPs designed as Medicaid-expansions unless authorized by an approved waiver.

Figure 12 shows the prevalence and length of the waiting periods imposed by the 50 states as of January 2002. As shown **35 states had no waiting period or a shorter waiting period than Virginia, 14 states had a**

Figure 12
Length of Waiting Period Imposed by the 50 States

Length of Waiting Period	Number of States
No waiting period imposed	17 states
One month	1 state
Two months	2 states
Three months	13 states
Four months	2 states
Six months	14 states
Twelve months	1 state

Source: Kaiser Commission on Medicaid and the Uninsured, *Enrolling Children and Families in Health Coverage: The Promise of Doing More*, June 2002.

waiting period of six months like Virginia, and one state (Alaska) imposed a waiting period of 12 months.

Presumptive Eligibility. Presumptive eligibility involves allowing designated entities to "extend immediate short-term...eligibility...based on preliminary information" while the formal application is being considered. The types of entities typically allowed to confer presumptive eligibility are those that have clients who typically meet the income criteria (such as a local health department) or who are versed in determining eligibility (such as a hospital-based clinic). Presumptive eligibility may also be allowed for certain types of individuals such as pregnant women. Within the SCHIP and Medicaid programs, federal reimbursement is provided for individuals "presumed" to be eligible even if they are never approved for enrollment. The National Academy for State Health Policy (NASHP) in discussing presumptive eligibility notes:

> Presumptive eligibility not only expands eligibility by making children eligible sooner than otherwise possible, it can also be an effective outreach tool, one that enables parents to enroll their child when he or she is in need of care, and when the parents are perhaps most likely to complete an application. Presumptive eligibility allows children, many of whom have multiple unmet needs, to receive services immediately. A potential disadvantage of presumptive eligibility is that families may either not understand that follow-up steps are required to make the child permanently eligible, or they may simply not take the required actions to establish permanent eligibility, resulting in loss of health insurance coverage for the child. This is less likely to occur if the program captures enough information to complete the full application process when the family applies for presumptive eligibility, eliminating the need for follow-up. (NASHP publication *How States Have Expanded Medicaid and SCHIP Eligibility,* January 2002.)

DMAS has indicated that the feasibility of allowing presumptive eligibility for Medicaid and FAMIS to be extended to children who qualify for the school lunch program is being considered. The eligibility requirements for the three programs are similar. The possibility of allowing presumptive eligibility for an unborn child whose mother or family appear to be eligible for FAMIS has also been discussed with DMAS representatives. For the unborn child, the problem is the mother cannot submit the application until the child is actually born. Thus, waiting for approval may delay scheduling of the first office visit with the pediatrician or primary care practitioner.

According to NASHP, **five states that have separate SCHIP programs allow at least one entity to exercise presumptive eligibility for**

applicants (Massachusetts: participating member services; Maine: federally qualified health centers, rural health centers, and family planning agencies; Michigan: participating health plans; New Jersey: federally qualified health centers, local health department, and hospital-based clinics centers; and New York: state contractor). **Nine additional states that have Medicaid expansion SCHIPs allow at least one entity to exercise presumptive eligibility. In 28 states, presumptive eligibility may be extended to pregnant women in determining eligibility for Medicaid.** (NASHP publication *How States Have Expanded Medicaid and SCHIP Eligibility,* January 2002.)

Twelve-Month Continuous Eligibility. HB 1089 would amend Title 32.1 of the *Code of Virginia* to establish 12-month continuous eligibility for children enrolled in Medicaid or enrolled in FAMIS. (It should be noted that the language included in a substitute that was considered in subcommittee but not adopted by the House Committee on Health, Welfare and Institutions was the language JCHC staff was asked to consider in completing this report.)

Virginia, like most states reevaluates families for continued eligibility for Medicaid or FAMIS enrollment once every 12 months. Although eligibility is reevaluated every 12 months, families are required to report material changes in income or assets that occur in that 12-month time period. Failure to report changes is a violation of law and may be considered to be fraud. This can be a burdensome requirement for families as fluctuation in income levels is not uncommon particularly if the families receive hourly wages rather than salaries, work part-time, or have seasonal jobs. The requirement to report any income changes has meant that some families qualify or fail to qualify for Medicaid or FAMIS coverage on a monthly basis. From December 2001 through May 2002, families of approximately 972 children in FAMIS reported changes in income but failed to return the required documentation of those changes. Although DMAS made repeated efforts to contact the families, a number of the children were recently removed from FAMIS enrollment.

Research reported by the Kaiser Commission found that continual changes in eligibility for assistance can negatively affect the continuity of care for the child while increasing the cost of administering the programs. Ensuring that a child will be eligible for services under the same health assistance program for a minimum number of months ensures that care can continue to be provided by the same practitioners for the specified

time period. Continuity of care is particularly important in Virginia when you consider that families sometimes bounce back and forth in terms of their eligibility for Medicaid and FAMIS. Considering the differences in benefits and in some cases health care practitioners available in the Medicaid and the FAMIS managed-care programs, continual changes can be quite disruptive to care. With regard to administrative costs, a study completed by Mathematica Policy Research, Inc. found that "extending children's coverage through the use of 12-month continuous eligibility could reduce Medicaid administrative costs between 2 and 12 percent." Similar cost savings should accrue in administrative costs for SCHIP programs.

Congress, in the Balanced Budget Act of 1997, addressed the issue of fluctuating income levels and assets for families receiving Medicaid coverage for their children by authorizing 12-month continuous eligibility. States may allow 12-month continuous eligibility in their SCHIPs too. According to the National Academy for State Health Policy, **25 states allow continuous eligibility in their separate SCHIPs**: 22 of the states allow 12-month continuous eligibility and 3 of the states allow 6-month continuous eligibility. **Six additional states that have Medicaid-expansion SCHIPs allow continuous eligibility of 12 months (five states) or six months (one state).** (See NASHP publication *How States Have Expanded Medicaid and SCHIP Eligibility,* January 2002.)

Administrative Considerations for the FAMIS Program

While much has been accomplished during the last nine months, many of the changes became effective September 1, 2002 and will need to be carefully monitored and continually adjusted. Moving to a single application and uniform eligibility and verification requirements is expected to address many of the problems experienced in the past year with the implementation of FAMIS. DMAS has ensured that each local department of social services has a contact within the CPU to address questions and problems, and each LDSS has a designated FAMIS contact responsible for addressing questions and problems experienced within his/her agency. DMAS provided training for LDSS staff during the summer regarding the new FAMIS application and program requirements, and the operation of the CPU. However, quality control to ensure the connection between the CPU and the121 local departments of social services will be important.

V.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to recommend with regard to the Family Access to Medical Insurance Security.

With regard to the inclusion of mental health services as addressed in SB 428, HB 1087, and HB 332:

Option I:

Recommend to the Senate Committee on Education and Health that SB 428 not be reported.

Recommend to the House Committee on Health, Welfare and Institutions that HB 1087 not be reported.

Option II:

Recommend to the Senate Committee on Education and Health that SB 428 be reported as introduced and that appropriate budget amendments be introduced to fund community-based mental health services within the Family Access to Medical Insurance Security program.

Recommend to the House Committee on Health, Welfare and Institutions that HB 1087 be reported as introduced and that appropriate budget amendments be introduced to fund community-based mental health services within the Family Access to Medical Insurance Security program.

Option III: **Recommend to the Senate Committee on Education and Health to: (i) amend SB 428 in order to add language (HB 332) requiring the mental health services of "intensive in-home services...and twenty-four hour emergency response" to the bill provisions and subsequently report SB 428, and (ii) introduce budget amendments to fund community-based mental health services within FAMIS.**

Recommend to the House Committee on Health, Welfare and Institutions to: (i) amend HB 1087 in order to add language (HB 332) requiring the mental health services of "intensive in-home services...and twenty-four hour emergency response" to the bill provisions and subsequently report HB 1087, and (ii) introduce budget amendments to fund community-based mental health services within FAMIS.

With regard to addressing the provisions of HB 1086:

Option IV: **Recommend to the House Committee on Health, Welfare and Institutions that HB 1086 not be reported.**

Option V: **Recommend to the House Committee on Health, Welfare and Institutions that HB 1086 be reported as introduced to require consistency and coordination between the Medicaid and FAMIS application process.**

With regard to addressing the provisions of HB 1088:

Option VI: **Recommend to the House Committee on Health, Welfare and Institutions that HB 1088 not be reported.**

Option VII: **Recommend to the House Committee on Health, Welfare and Institutions that HB 1088 be reported as introduced and that appropriate budget amendments be introduced to address reduced cost sharing limits related to the FAMIS program.**

With regard to addressing the provisions of HB 1089:

Option VIII: **Recommend to the House Committee on Health, Welfare and Institutions that HB 1089 not be reported.**

Option IX: **Recommend to the House Committee on Health, Welfare and Institutions that HB 1089 be reported in the form of the Substitute (discussed in Subcommittee but not adopted) and that appropriate budget amendments be introduced to provide for 12-month continuous eligibility for children enrolled in Medicaid or in FAMIS.**

With regard to other legislation:

Option X: **Introduce budget amendment (language and funding) to reduce the waiting period for prior health insurance coverage related to FAMIS eligibility.**

Option XI: **Introduce budget amendment (language and funding) to provide for presumptive eligibility for FAMIS to be allowed for children of pregnant women.**

Option XII: **Introduce budget amendment (language and funding) to provide for presumptive eligibility for FAMIS to be implemented by specific types of health, education, or social services agencies.**

Option XIII: **Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of issues related to provisions of the Medicaid and FAMIS programs.**

APPENDIX A

021304230

SENATE JOINT RESOLUTION NO. 90

Offered January 9, 2002

Prefiled January 9, 2002

Directing the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services, to review regulatory, statutory, and administrative provisions of the Family Access to Medical Insurance Security (FAMIS) Program.

Patrons—Bolling and Puller; Delegate: Brink

Referred to Committee on Rules

WHEREAS, in 1997, Congress authorized the establishment of the State Children's Health Insurance Program (SCHIP) as a means of providing health insurance coverage to low-income uninsured children who are not eligible for Medicaid; and

WHEREAS, the Children's Medical Security Insurance Program (CMSIP) was implemented in Virginia in 1998 as the Commonwealth's SCHIP plan; and

WHEREAS, legislation was passed by the 2000 Session of the General Assembly to convert CMSIP to the Family Access to Medical Insurance Security (FAMIS) Program; and

WHEREAS, the FAMIS legislation implemented a number of significant changes to CMSIP and included program revisions intended to improve the administrative efficiency of the program, make the program more consistent with private health insurance plans, encourage families to take greater responsibility for providing health insurance for their children, and increase enrollment in the program; and

WHEREAS, the FAMIS program was implemented in phases during 2001; and

WHEREAS, while some components of the FAMIS program are operating smoothly, some advocacy groups have expressed concern about certain administrative, regulatory, and operational aspects of the program; and

WHEREAS, enrollment in the program continues to be well below the estimated number of children projected to enroll; and

WHEREAS, a 2001 report by the Joint Legislative Audit and Review Commission (JLARC) made several recommendations for improving the FAMIS program; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Department of Medical Assistance Services and various advocacy groups, review the regulatory, statutory, and administrative provisions of the FAMIS program. As part of its study, the Joint Commission on Health Care shall review the JLARC findings and assess the degree to which the JLARC recommendations have been implemented. The Joint Commission on Health Care also shall identify further actions to improve the program's effectiveness and efficiency, and to increase enrollment.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall submit its written findings by November 30, 2002 to the Chairmen of the Senate Finance and House Appropriations Committees and to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Agreed to By The Senate		**Agreed to By The House of Delegates**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

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Clerk of the Senate Clerk of the House of Delegates

024182564

SENATE BILL NO. 428

Offered January 9, 2002

Prefiled January 9, 2002

A BILL to amend and reenact § 32.1-351 of the Code of Virginia, relating to the Family Access to Medical Insurance Security Plan.

Patrons—Ticer; Delegate: Brink

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-351 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-351. Family Access to Medical Insurance Security Plan established.

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of nineteen, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not 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)); (iv) have been without health insurance for at least six months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan.

B. Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.

The mental health services required herein shall incorporate, in the same manner and with the same coverage and limitations, certain services provided to covered persons with mental retardation or related conditions under the State Plan for Medical Assistance Services and set forth in the Board's regulations as follows: day health and rehabilitation services providing individualized activities, supports, training, supervision, and transportation based on a written plan of care for two or more hours per day scheduled multiple times per week.

D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if

the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this program does not substitute for private health insurance coverage.

F. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance.

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by contacting the local department of social services.

H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

The plan shall also include a provision to request the custodial parent's cooperation with the Commonwealth in securing medical and child support payments. However, such cooperation shall not be a condition of eligibility.

H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care and shall provide quarterly reports on enrollment, policies affecting enrollment, such as the exceptions that apply to the six months' prior coverage limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and other topics.

J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing Administration as Virginia's State Children's Health Insurance Program.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

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Clerk of the Senate Clerk of the House of Delegates

022409696

HOUSE BILL NO. 332

Offered January 9, 2002

Prefiled January 7, 2002

A BILL to amend and reenact § 32.1-351 of the Code of Virginia, relating to the Family Access to Medical Insurance Security Plan.

Patrons—Darner, Baskerville, Christian, Crittenden, Hull, Jones, D.C., Miles, Moran, Petersen, Scott, Spruill and Van Yahres

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Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-351 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-351. Family Access to Medical ~~Insurance Security Plan established.~~

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of nineteen, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not 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)); (iv) have been without health insurance for at least six months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan.

B. Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.

The mental health services required herein shall incorporate, in the same manner and with the same coverage and limitations, certain mental health services provided to children under the State Plan for Medical Assistance Services and set forth in the Board's regulations as follows: intensive in-home services including crisis treatment; individual family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and twenty-four-hour emergency response.

D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or

its designee shall make premium payments to such employer's plan on behalf of eligible participants if the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this program does not substitute for private health insurance coverage.

F. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance.

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by contacting the local department of social services.

H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

The plan shall also include a provision to request the custodial parent's cooperation with the Commonwealth in securing medical and child support payments. However, such cooperation shall not be a condition of eligibility.

H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care and shall provide quarterly reports on enrollment, policies affecting enrollment, such as the exceptions that apply to the six months' prior coverage limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and other topics.

J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated

through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing Administration as Virginia's State Children's Health Insurance Program.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

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Clerk of the House of Delegates Clerk of the Senate

024198648

HOUSE BILL NO. 1086

Offered January 9, 2002

Prefiled January 9, 2002

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, of the Code of Virginia, relating to children's health insurance program.

Patrons—Brink, Amundson, Crittenden, Van Yahres and Watts

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this

subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

9. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

10. A provision for payment of medical assistance for annual pap smears;

11. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

12. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

13. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

16. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

17. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable to the transplant procedure; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient-selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible

terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

18. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

19. A provision for payment of medical assistance for custom ocular prostheses;

20. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; and

21. (For effective date - See note) A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. §§ 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age sixty-five. This provision shall include an expedited eligibility determination for such women.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse

Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Simplify the Medicaid application process and verification requirements for children to provide consistency with the procedures used by the Family Access to Medical Insurance Security Plan.

4. Develop and implement procedures to provide for the automatic filing of an application for the Family Access to Medical Insurance Security Plan for children who have been denied or terminated from the Medical Assistance Services program.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325. (Delayed effective date—See notes) Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians

and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; and

22. (For effective date - See note) A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. §§ 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age sixty-five. This provision shall include an expedited eligibility determination for such women.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each

recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Simplify the Medicaid application process and verification requirements for children to provide consistency with the procedures used by the Family Access to Medical Insurance Security Plan.

4. Develop and implement procedures to provide for the automatic filing of an application for the Family Access to Medical Insurance Security Plan for children who have been denied or terminated from the Medical Assistance Services program.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

024183648

HOUSE BILL NO. 1087

Offered January 9, 2002

Prefiled January 9, 2002

A BILL to amend and reenact § 32.1-351 of the Code of Virginia, relating to the Family Access to Medical Insurance Security Plan.

Patrons—Brink, Amundson, Crittenden, Van Yahres and Watts

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-351 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-351. Family Access to Medical Insurance Security Plan established.

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of nineteen, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not 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)); (iv) have been without health insurance for at least six months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan.

B. Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.

The mental health services required herein shall incorporate, in the same manner and with the same coverage and limitations, certain services provided to covered persons with mental retardation or related conditions under the State Plan for Medical Assistance Services and set forth in the Board's regulations as follows: day health and rehabilitation services providing individualized activities, supports, training, supervision, and transportation based on a written plan of care for two or more hours per day scheduled multiple times per week.

D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if

the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this program does not substitute for private health insurance coverage.

F. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance.

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by contacting the local department of social services.

H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

The plan shall also include a provision to request the custodial parent's cooperation with the Commonwealth in securing medical and child support payments. However, such cooperation shall not be a condition of eligibility.

H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care and shall provide quarterly reports on enrollment, policies affecting enrollment, such as the exceptions that apply to the six months' prior coverage limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and other topics.

J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing Administration as Virginia's State Children's Health Insurance Program.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

027302648

HOUSE BILL NO. 1088

Offered January 9, 2002

Prefiled January 9, 2002

A BILL to amend and reenact § 32.1-351 of the Code of Virginia, relating to children's health insurance annual enrollment fee.

Patrons—Brink, Amundson, Crittenden, Van Yahres and Watts

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-351 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-351. Family Access to Medical Insurance Security Plan established.

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of nineteen, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not 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)); (iv) have been without health insurance for at least six months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan.

B. Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall ~~participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act~~ *pay an annual enrollment fee of no more than $100 per family and nominal copayments*. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.

D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this

program does not substitute for private health insurance coverage.

F. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance.

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by contacting the local department of social services.

H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

The plan shall also include a provision to request the custodial parent's cooperation with the Commonwealth in securing medical and child support payments. However, such cooperation shall not be a condition of eligibility.

H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care and shall provide quarterly reports on enrollment, policies affecting enrollment, such as the exceptions that apply to the six months' prior coverage limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and other topics.

J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to

implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing Administration as Virginia's State Children's Health Insurance Program.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

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Clerk of the House of Delegates Clerk of the Senate

HOUSE BILL NO. 1089

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions

on _____)

(Patron Prior to Substitute--Delegate Brink)

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia, relating to children's health insurance enrollment period and eligibility.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-325. (For effective date--See note) Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and

an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of

Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

9. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

10. A provision for payment of medical assistance for annual pap smears;

11. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

12. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage

where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

13. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

16. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

17. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no

effective alternative medical or surgical therapy available with outcomes that are at least comparable to the transplant procedure; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient-selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

18. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

19. A provision for payment of medical assistance for custom ocular prostheses;

20. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; and

21. (For effective date - See note) A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. §§ 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age sixty-five. This provision shall include an expedited eligibility determination for such women.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed

clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Establish twelve month continuous eligibility for children enrolled in Medicaid in the medically indigent category, as permitted by Title XIX of the Social Security Act, 42 U.S.C. § 1396 (a)(e)(12).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325. (Delayed effective date--See notes) Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be

reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made

for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the

national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; and

22. (For effective date - See note) A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. §§ 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age sixty-five. This provision shall include an expedited eligibility determination for such women.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to

the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia

shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental

Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Establish twelve month continuous eligibility for children enrolled in Medicaid in the medically indigent category, as permitted by Title XIX of the Social Security Act, 42 U.S.C. § 1396 (a)(e)(12).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-351. Family Access to Medical Insurance Security Plan established.

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of nineteen, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Planin the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not 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)); (iv) have been without health insurance for at least six months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended;

and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan. The Department of Medical Assistance Services shall establish twelve month continuous eligibility for children enrolled in FAMIS, as permitted by Title XXI of the Social Security Act.

B. Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.

D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1. The Family

Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this program does not substitute for private health insurance coverage.

F. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance.

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by contacting the local department of social services.

H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications.

Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

The plan shall also include a provision to request the custodial parent's cooperation with the Commonwealth in securing medical and child support payments. However, such cooperation shall not be a condition of eligibility.

H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care and shall provide quarterly reports on enrollment, policies affecting enrollment, such as the exceptions that apply to the six months' prior coverage limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and other topics.

J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing Administration as Virginia's State Children's Health Insurance Program.

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APPENDIX B

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SENATE OF VIRGINIA

WARREN E. BARRY
37TH SENATORIAL DISTRICT
PART OF FAIRFAX AND
PRINCE WILLIAM COUNTIES, AND
PART OF THE CITY OF FAIRFAX
POST OFFICE BOX 1146
FAIRFAX, VIRGINIA 22030-1146

COMMITTEE ASSIGNMENTS:
EDUCATION AND HEALTH, CHAIR
COMMERCE AND LABOR
FINANCE
RULES

May 17, 2002

The Honorable William T. Bolling, Chairman
Joint Commission on Health Care
1001 East Broad Street
Richmond, Virginia 23219

Dear Senator Bolling:

During the 2002 Session, the Senate Committee on Education and Health considered SB 428 (Ticer), which would have required the Department of Medical Assistance Services to incorporate into the Family Access to Medical Insurance Security (FAMIS) Plan certain mental health services that are covered by Medicaid. Under this bill, FAMIS mental health services provided to covered persons with mental retardation or related conditions would be equivalent to those provided to such persons under Medicaid. As you know, the Senate Committee on Education and Health approved a motion to continue this bill to the 2003 Session that included a recommendation that the bill be referred to the Joint Commission on Health Care for consideration in its comprehensive review of the FAMIS program.

Thank you for including this provision in the Commission's study plan for the coming year. I appreciate your assistance on this matter and respectfully request, on behalf of the members of the Senate Committee on Education and Health, that the Joint Commission on Health Care advise the Senate Committee on Education and Health of its recommendations on these mental health issues.

Sincerely,

Warren E. Barry/nes

Senator Warren E. Barry, Chairman
Senate Committee on Education and Health

cc: Members, Senate Committee on Education and Health
E. Kim Snead, Executive Director
Joint Commission on Health Care

Enclosures

APPENDIX C

Department of Medical Assistance Services

VIII. Outreach Efforts to Enroll Eligible Children in FAMIS

The Department of Medical Assistance Services FAMIS Outreach Team and its community partners have been successful this quarter as reflected by the fact that an average of 1,857 new children has been enrolled in FAMIS since January 2002. The major change since the last quarter is that DMAS is moving from outreach focused on FAMIS to one that focused on both child health programs in Virginia: Medicaid and FAMIS. This approach will be intensified in the next quarter as all "Back to School" events and outreach programs will be geared to both programs.

A. Outreach Activities and Partnerships

State Agencies

- Department of Social Services (DSS): DMAS is developing a new media campaign to promote both the FAMIS and Medicaid programs simultaneously. All new materials developed by DMAS will promote both programs as "Children's Health Insurance" options. Outreach staff has begun coordinating outreach efforts with DSS through its regional meetings and local meetings. DMAS has identified specific contact persons for all DSS offices. This person will serve as a central point of contact for the local agency. This person will be charged with the re-ordering of promotional materials for dissemination to potential enrollees. This person will also serve as the central point of contact for the local agency to DMAS outreach staff. DMAS staff will coordinate program changes and updates, and will answer questions as they arise.

- Department of Education (DOE): DOE, in partnership with DMAS, was awarded a David and Lucille Packard Foundation technical assistance grant. DOE and DMAS will use this grant and the best practices from other states, as a framework for the comprehensive school-based outreach efforts. DMAS outreach staff have been developing this comprehensive school-based outreach plan and coordinating activities for the coming school year. School-based outreach will be the primary focus of the identification and enrollment strategy for the coming year. DMAS staff have already coordinated the dissemination of materials to 450,000 Title I students in the beginning of the 2002/2003 school year. By direction of the 2002 General Assembly, and HB 1062, DMAS has been working with DOE to coordinate data sharing for the identification and enrollment of children through the National School Lunch Program (NSLP). DMAS will send out FAMIS and Medicaid information to 430,000 NSLP participant's with their approval letters in early August 2002. These two efforts will reach over 800,000 of our target audience.

  School-based efforts will include coordinating training for more than 120 school nurse coordinators in early August. Once trained and identified, school nurse

coordinators will be able to assist families and direct them to the CPU, local Departments of Social Services, or community outreach workers for one-on-one application assistance. Most importantly, DMAS will have a method for contacting families rather than waiting for them to contact us. Over the course of the school year, DMAS and DOE will place information in report cards, work with Parent/Teacher conferences, Head Start programs, PTA associations and other school administrators to identify and enroll eligible children in FAMIS and Medicaid. All superintendents will receive a memorandum requesting their participation with the school-based outreach efforts. DMAS Outreach will also be furnishing nine school health vans with external promotional signage and program videotapes as they travel throughout the state to promote children's health insurance in Virginia.

Because of similar eligibility requirements between the school lunch programs and the Medicaid and FAMIS programs, DMAS will be determining the feasibility of implementing a presumptive eligibility for these groups.

- Department of Health (VDH): Through HB 1062, the 2002 General Assembly directed DMAS and VDH to coordinate information sharing between the Women's, Infants & Children (WIC) program and FAMIS. DMAS and VDH staff are currently working on an interagency agreement that will enable each agency to share data on these programs, as well as other VDH programs. VDH and DMAS have already agreed to coordinate efforts to inform participants about the possibility of eligibility in the other department's program. DMAS will begin providing materials along with WIC materials to participants through mail-outs, grocery store displays, and other promotional events. DMAS will also participate in the VDH annual Survey on Health in the Commonwealth. Specific questions about health coverage, health care needs, and program perceptions are being developed to include in this year's survey. DMAS will also be drafting a question to be added to licensed childcare providers' enrollment forms. This question will be designed to identify those children enrolled in Child Care facilities who are currently without health insurance.

- Division of Child Support Enforcement (DCSE): DMAS staff in conjunction with DCSE will provide materials and information to Child Support enforcement populations. All DCSE offices have agreed to furnishing and disseminating materials on behalf of the FAMIS and Medicaid programs.

- Department of Professional and Occupational Regulation: DMAS has furnished FAMIS program and promotional materials to the agency for dissemination to contractors and employees. DMAS is working on developing an interagency agreement to coordinate materials being distributed through annual license renewals.

- Virginia Employment Commission (VEC): DMAS staff has coordinated an agreement with VEC for materials to be made available through all local offices. A central contact person for each office coordinates material orders and stocking of materials in their respective offices. DMAS is also a team member of the VEC's Rapid Response team. This team goes into plants and organizations that are anticipating large-scale layoffs. The respective team members discuss their program options and services that are available upon termination of employment. DMAS staff will continue to attend quarterly meetings of local VEC directors to train and update them on program changes. DMAS, in conjunction with the Virginia Employment Commission and Department of Housing and Community Development, has provided materials and staffing for each of the Governor's Crisis Workforce Centers. DMAS will continue to offer support, coordination and program assistance to the VEC and potential Virginia residents needing assistance with our programs.

Business Partners

DMAS' Business Outreach strategy is still under development. DMAS is waiting for Robert Wood Johnson to complete its Business Outreach Toolkit, which will provide strategies that are effective. Some partnerships already formed include:

- WWBT 12: DMAS outreach staff have formed an agreement with WWBT-12 television station to participate in their Call-12 center activities. The first appearance will be in August during the State's Back-to-School campaign. Subsequent appearances will be bi-monthly through the end of 2003.

- Food Lion: DMAS has working agreements with nine (and hopes to get as many as 25) Food Lions to allow informational booths in their stores during the August Back-to-School campaign. Additional agreements are in process for additional booths during Child Health Month in October and throughout the coming year.

- Target: DMAS outreach staff is meeting with the Target Stores Regional Managers in hopes of developing a corporate sponsorship partnership for health fair events and other promotions throughout the state. Target has agreed to allow Outreach staff to set up informational booths outside stores during the coming year and to promote the FAMIS program to employees internally.

- Kmart has agreed to allow DMAS outreach staff to pass out materials during Back-to School campaign and October's Child Health Month.

- Wal-Mart has agreed to allow DMAS staff to set up displays in front of eight stores throughout Virginia. Many stores have also agreed to posters and brochures being available in entrance areas of their store. Some stores have agreed to disseminate materials to their employees.

- Community Pride Stores: DMAS staff will be promoting Virginia's Health Insurance programs outside Community Pride stores around Virginia throughout the year.

Community Partners

DMAS has a variety of community partners who provide additional outreach and application assistance.

- Virginia Health Care Foundation (VCHF): DMAS continues to work closely in with VHCF in a variety of ways. VHCF is the primary source and contractor of community-based outreach. DMAS has continued to fund Project Connect grants for community outreach and application assistance for fiscal year 2003. The $500,000 grant provides funds to 11 sites (Alexandria Neighborhood Health Services, Inc., Central Piedmont Health Services – Martinsville, CHIP of the Roanoke Valley, CHIP/Healthy Families of Chesapeake, Community Memorial Healthcenter, Cumberland Plateau Health District, Johnson Health Center, Partnership for Healthier Kids, Quin Rivers Agency for Community Action, Stafford County Schools Head Start, and United Way – Thomas Jefferson Area.) throughout the State covering, which provides services to approximately 45 percent of local communities. In addition, DMAS has provided VHCF with $75,000 of additional grant money for the Richmond area, which has had difficulty enrolling children in the FAMIS program.

- Robert Wood Johnson Foundation (RWJ): DMAS supported the VHCF as the lead agency for the RWJ Covering Kids and Families grant. The VHCF was awarded the Covering Kids and Families Grant at the end of June. The grant amount is $900,000. There will be three grantees covered by the grant for a four-year period. DMAS will work in support of the VHCF and the grantees to improve outreach efforts in Virginia. DMAS and DOE have incorporate the Back-to-School toolkit developed by RWJ into its school-based campaign. This comprehensive toolkit provides practical and fundamental resources that can be used statewide for outreach and promotional events. This year's statewide Back-to-School campaign will consist of five different media/promotional events throughout the state. The State will partner with local Project Connect grantees and RWJ grantees to create unique and exciting events. The National Campaign kicks off on August 1.

- SignUpNow (SUN): DMAS has continued the contract with SignUpNow through fiscal year 2003 to provide community-based training for the FAMIS and Medicaid programs. SUN will continue to be the state's training coordinator at the local community level and will continue to update other state coalition members of program changes. SUN's additional private funding sources benefit DMAS and the FAMIS and Medicaid programs by

building program awareness and a comprehensive training schedule. SUN's excellent working relationships with VHCF, the Virginia Poverty Law Center and other community-based organizations throughout the state, make this program an invaluable asset to the FAMIS and Medicaid programs.

- Virginia Poverty Law Center (VPLC): DMAS utilizes staff from VPLC as a resource for FAMIS and Medicaid program changes.

- Healthy Families of Virginia: DMAS staff has made presentations to numerous Healthy Families programs throughout the state. DMAS outreach staff will continue to update, train and coordinate through the various Healthy Families programs.

- Bailey's Health Center: DMAS, in conjunction with Fairfax Health Department, local DSS and Medical Care for Children Partnership (MCCP) participated in a Children's Health enrollment fair. Over 1,400 families were sent information on the various programs, and an estimated 600 responded and received various levels of assistance. These types of state and local community partnerships are a viable way to get families the "one-stop shopping" assistance they need.

- United Way Agencies: DMAS has assisted various United Way agencies in promoting Child Health Insurance in their respective areas. The United Way includes DMAS information in its Information and Referral Center. DMAS staff provided technical assistance to the United Way Peninsula and CINCH of Tidewater on how to pool their resources and hire additional dedicated outreach staff to the Tidewater region.

Other Outreach Activities

- Managed Care Organizations: DMAS is working collaboratively with Sentara, UniCare, Virginia Premier, Trigon and CareNet in attending and conducting outreach and enrollment events throughout the state.

- Walkers and Talkers program: The City of Richmond and the Richmond Urban League have asked DMAS to work with them to develop a new "Walkers and Talkers" program in the metropolitan Richmond area. This program is sponsored by the Annie E. Casey Foundation. The purpose of this program is to go door-to-door in select neighborhoods to enroll families in public programs. DMAS will be developing door hangers for promotion of Virginia's child health insurance programs for this program, which is scheduled to begin in the late fall.

Listing of Other Partnerships

Shiloh Baptist Church,
Local Chambers of Commerce,
Stafford County Head Start,
Petersburg Perinatal Network,
National Association of Health Underwriters,
Rural Health Outreach,
CHIP Healthy Families of Chesapeake,
Community Health Associates,
Virginia Cooperative Extension,
Healthy Mothers Healthy Babies,
Virginia Medical Society.

A. Outreach Oversight Committee

The FAMIS Outreach Oversight Committee had its quarterly meeting in June 2002. The meeting was well attended by a variety of State agency staff and community partners. DMAS staff presented an update on FAMIS. The Virginia Health Care Foundation presented an update on its Robert Wood Johnson foundation grant, which will provide funding for additional outreach groups. The next meeting is scheduled for September 25, 2002.

IX. Efforts to Involve Local Children's Health Care and Case Management Programs in the Implementation and Ongoing Operation of the Program.

DMAS continues to have discussions with various organizations that provide outreach and/or services to uninsured children. The Outreach section, above, lists the specific local organizations that provide or take interest in children's health care.

APPENDIX D

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Family Access to Medical Insurance Security Plan (FAMIS)

Organizations/Individuals Submitting Comments

Nineteen organizations and 32 individuals submitted comments in response to the *Review of the Family Access to Medical Insurance Security Plan* as shown:

Organizations

- Action Alliance for Virginia's Children and Youth
- Care Connection for Children
- Charlottesville Regional Success by 6 Initiative
- Children's Hospital of The King's Daughters
- CHIP/Healthy Families Chesapeake
- Consortium for Infant and Child Health
- Cumberland Mountain Community Services Board (2 letters)
- Insurance for Children Project of the United Way-Thomas Jefferson Area
- Minority Health Coalition of South Hampton Roads
- Partnership for Healthier Kids
- Prevent Child Abuse Hampton Roads
- SignUpNow
- United Way of Virginia Peninsula
- Virginia Association of Community Services Boards
- Virginia Coalition for Children's Health (represents 65 organizations)
- Virginia Health Care Foundation Project Connect
- Virginia Hospital & Healthcare Association
- Virginia Poverty Law Center
- Virginia Primary Care Association

Individuals

- Tracy Andersen, Colonial Services Board
- Marsha E. Baker, Children's Hospital
- Bonny Basilone (CSB)
- Linda Beal
- Linda K. Bennington, MSN, CNS, Lecturer, School of Nursing, Old Dominion University
- Sherry Black, Children's Hospital of Richmond
- Larry W. Brooks, Retired School Superintendent
- Carola Bruflat, Women's Health Nurse Practitioner
- Joy Campbell, Quin Rivers Agency for Community Action
- Judith Cash, CHIP of Virginia
- Josie Castaldi, Children's Hospital of Richmond
- Betty Connal, Northern VA Healthy Mothers Healthy Babies Coalition
- Ann V. Deaton, Ph.D, Children's Hospital
- Mat Despard, TAP Head Start, Roanoke
- Sharon Fowler, Colonial CSB
- Lee Goldman, Ph.D., Arlington County CSA Coordinator
- Greg Hammack, Colonial CSB
- Mary Hanrahan
- Virginia Hardin
- Judy Howell, Children's Hospital
- Diana F. Hutchens, Director of SS, Williamsburg
- Cynthia C. Kirkland, Lynchburg Division of Social Services, Assistant Director
- Rachel Lewis, CSA Coordinator
- J. Fletcher Lowe, Va. Interfaith Center for Public Policy
- Regena Mayo
- Mary P. Minor, Child & Family Connection
- Stan Rockwell
- Susan Rosser-Jones (FAPT)
- Rhonda Seltz
- Gail F. Taylor, CSA Coordinator (FAPT)
- Rebecca E. White, CHIP
- Pat Young, Kuumba Community Health and Wellness Center

Policy Options Included in the Issue Brief Evaluating the Family Access to Medical Insurance Security Plan

With regard to the inclusion of mental health services as addressed in SB 428, HB 1087, and HB 332:

Option I:	**Recommend to the Senate Committee on Education and Health that SB 428 not be reported.** **Recommend to the House Committee on Health, Welfare and Institutions that HB 1087 not be reported.**
Option II:	**Recommend to the Senate Committee on Education and Health that SB 428 be reported as introduced and that appropriate budget amendments be introduced to fund community-based mental health services within the Family Access to Medical Insurance Security program.** **Recommend to the House Committee on Health, Welfare and Institutions that HB 1087 be reported as introduced and that appropriate budget amendments be introduced to fund community-based mental health services within the Family Access to Medical Insurance Security program.**
Option III:	**Recommend to the Senate Committee on Education and Health to: (i) amend SB 428 in order to add language (HB 332) requiring the mental health services of "intensive in-home services...and twenty-four hour emergency response" to the bill provisions and subsequently report SB 428, and (ii) introduce budget amendments to fund community-based mental health services within FAMIS.** **Recommend to the House Committee on Health, Welfare and Institutions to: (i) amend HB 1087 in order to add language (HB 332) requiring the mental health services of "intensive in-home services...and twenty-four hour emergency response" to the bill provisions and subsequently report HB 1087, and (ii) introduce budget amendments to fund community-based mental health services within FAMIS.**

With regard to addressing the provisions of HB 1086:

Option IV:	**Recommend to the House Committee on Health, Welfare and Institutions that HB 1086 not be reported.**
Option V:	**Recommend to the House Committee on Health, Welfare and Institutions that HB 1086 be reported as introduced to require consistency and coordination between the Medicaid and FAMIS application process.**

With regard to addressing the provisions of HB 1088:

Option VI:	**Recommend to the House Committee on Health, Welfare and Institutions that HB 1088 not be reported.**
Option VII:	**Recommend to the House Committee on Health, Welfare and Institutions that HB 1088 be reported as introduced and that appropriate budget amendments be introduced to address reduced cost sharing limits related to the FAMIS program.**

With regard to addressing the provisions of HB 1089:

Option VIII:	**Recommend to the House Committee on Health, Welfare and Institutions that HB 1089 not be reported.**
Option IX:	**Recommend to the House Committee on Health, Welfare and Institutions that HB 1089 be reported in the form of the Substitute (discussed in Subcommittee but not adopted) and that appropriate budget amendments be introduced to provide for 12-month continuous eligibility for children enrolled in Medicaid or in FAMIS.**

With regard to other legislation:

Option X:	**Introduce budget amendment (language and funding) to reduce the waiting period for prior health insurance coverage related to FAMIS eligibility.**
Option XI:	**Introduce budget amendment (language and funding) to provide for presumptive eligibility for FAMIS to be allowed for children of pregnant women.**
Option XII:	**Introduce budget amendment (language and funding) to provide for presumptive eligibility for FAMIS to be implemented by specific types of health, education, or social services agencies.**
Option XIII:	**Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of issues related to provisions of the Medicaid and FAMIS programs.**

Overall Summary of Comments

The table on the following page shows the number of commenters who supported six of the Options presented in the *Review of the Family Access to*

SYNOPSIS OF COMMENTS RECEIVED ON OPTIONS

	Option Description	No. of Comments in Support of Option
Option III:	Recommend that SB 428 be amended to incorporate language contained in HB 332 (to add mental health services of "intensive in-home services...and twenty-four hour emergency response to bill provisions); the **amended SB 428 be reported and corresponding budget amendments be introduced** by Senate Committee on Education and Health. Recommend that HB 1087 be amended to incorporate language contained in HB 332; the **amended HB 1087 be reported and corresponding budget amendments be introduced** by House Committee on Health, Welfare and Institutions.	43
Option IX:	Recommend that **HB 1089** (to provide for 12-month continuous eligibility for children enrolled in Medicaid or in FAMIS) **be reported in the form of the drafted Substitute and corresponding budget amendments introduced** by House Committee on Health, Welfare and Institutions.	42
Option XI:	**Introduce budget amendment (language and funding) to provide for presumptive eligibility for FAMIS to be allowed for children of pregnant women.**	41
Option XII:	**Introduce budget amendment (language and funding) to provide for presumptive eligibility for FAMIS to be implemented by specific types of health, education, or social services agencies.**	41
Option X:	**Introduce budget amendment (language and funding) to reduce the waiting period for prior health insurance coverage related to FAMIS eligibility.**	38
Option XIII:	**Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of issues related to provisions of the Medicaid and FAMIS programs.**	5

Medical Insurance Security Plan. No one commented in support of seven of the report Options – Options I, II, IV, V, VI, VII, and VIII. (It should be noted that Option III incorporates the provisions of Option II and changes made in the FAMIS program accomplished the provisions of Options V and VII.)

As shown in the Table, Options III, IX, X, XI, XII, and XII were supported by the largest number of commenters while five commenters supported Option XIII. An additional option, "to establish a single program name for FAMIS and MI Medicaid for children-to streamline and coordinate both programs and improve public understanding and perception" was supported by 42 commenters.

Comments Made by Representatives of Organizations. **Nineteen** organizations (Action Alliance for Virginia's Children and Youth, Care Connection for Children, Charlottesville Regional Success by 6 Initiative, Children's Hospital of The King's Daughters, CHIP/Healthy Families Chesapeake, Consortium for Infant and Child Health, Cumberland Mountain Community Services Board, Insurance for Children Project of the United Way, Minority Health Coalition of South Hampton Roads, Partnership for Healthier Kids, Prevent Child Abuse Hampton Roads, SignUpNow, United Way of Virginia Peninsula, Virginia Association of Community Services Boards, Virginia Coalition for Children's Health, Virginia Health Care Foundation Project Connect, Virginia Hospital & Healthcare Association, Virginia Poverty Law Center and Virginia Primary Care Association) expressed support specifically for Options IX, XI and XII.

Nineteen organizations expressed support "to establish a single program name for FAMIS and MI Medicaid for children-to streamline and coordinate both programs and improve public understanding and perception."

Seventeen organizations (all except Partnership for Healthier Kids and Virginia Hospital & Healthcare Association) commented in support of Option X.

Sixteen commenters (all except Partnership for Healthier Kids, Virginia Coalition for Children's Health and Virginia Hospital & Healthcare Association) commented in support of Option III.

Two organizations (Va. Poverty Law Center and Va. Primary Care Association) stated that Option IV and Option VI were no longer needed due to statutory language no longer being required and administrative changes by DMAS.

Three organizations (SignUpNow, Virginia Poverty Law Center and Virginia Primary Care Association) expressed support for Option XIII.

Summary of Individual Comments

The following description is representative of the comments made by a majority of commenters in support of five report Options and an additional "new" option.

1. Establish a single program name for FAMIS and MI Medicaid for children-to streamline and coordinate both programs and improve public understanding and perception. **(NEW OPTION)**

2. Adopt 12-month continuous coverage for both FAMIS and MI Medicaid for children-to save administrative costs; avoid shifting families between programs due to fluctuating income; and to secure a medical home for the child. **(OPTION IX)**

3. Expedite FAMIS coverage for newborns-current policies make it difficult to secure FAMIS coverage for services needed immediately after birth (particularly for babies born at the end of a month.) **(OPTION XI)**

4. Offer limited "presumptive eligibility" which would allow providers to obtain coverage for services while an application is pending. Money could be SAVED if state providers, such as teaching hospitals and health departments, could utilize presumptive eligibility. **(OPTION XII)**

5. Change mental health coverage in FAMIS so it is uniform with Medicaid coverage. **(OPTION III)**

6. Reduce the waiting period from 6 months to 2 months. **(OPTION X)**

Excerpts from Some Commenters

Action Alliance for Virginia's Children and Youth

Margaret Nimmo Crowe, Senior Program and Policy Director commented on behalf of the Action Alliance for Virginia's Children and Youth. Ms. Crowe commented in support of Options IX, X, XI, XII and the single program name for Medicaid and FAMIS but indicated the Alliance's top priority is the following replacement for Options I, II, and III.

> "Change **mental health** coverage in FAMIS so it is uniform with Medicaid coverage. (Replacement for Options I, II and III) This change would allow children to receive much needed community-based mental health services, such as

crisis intervention, case management, intensive in-home and day treatment services, among others. These are the exact services that are able to keep some children and youth out of more restrictive and costly placements, such as residential care, by keeping them in their homes and communities. They also help children transition back into the community after being treated at a residential facility, helping ensure a successful transition to the home and community environment. These intermediate services are critical for developing a system of care for children and youth in Virginia with mental health needs. At a time when Virginia is trying to conform to the requirements of the Olmstead decision -- providing treatment to individuals in the least restrictive environment -- we should ensure that our state-provided health insurance covers these community-based services.

In addition, if we do not take advantage of the 2-for-1 match of federal dollars, we will end up treating these children in a more costly manner in the future, when they end up in crisis, in the foster care or juvenile justice systems. However, it would be difficult and, I believe, short-sighted, to take money from one of these other systems this year to pay for these benefits in FAMIS. The overall system in Virginia for treating children with mental health problems is fragmented, difficult to access for families, and only treats the "tip of the iceberg" in terms of children with mental health needs. Further depleting any part of the system – either by outright cuts or by taking funds from one program to help another – will only weaken the system as a whole.

Also, covering community-based mental health services for children under FAMIS sends the message to Virginians that we understand that mental health problems are just as real and important as physical health problems. Children with untreated emotional and behavioral problems are less likely to succeed in school than other children, leading to a variety of unwanted social and academic outcomes. It would be unconscionable not to provide health insurance coverage for a child with a broken leg or a disease like diabetes. Certainly we want to provide access to appropriate care for children who suffer from disorders such as depression, bipolar disorder, and other mental and emotional problems.

Finally, many of the programmatic changes to FAMIS and Medicaid in recent months have focused, appropriately, on making the process much simpler for families. The goal is a seamless system so that families do not have to make confusing choices between Medicaid and FAMIS – they have one application, they can apply in a variety of ways (no wrong door), etc. With the current set of mental health benefits, however, families who need these services are further confused by the different benefits in FAMIS and Medicaid. Many families move between the two systems, and every time this happens, their benefits change. The valuable intensive in-home services that were helping keep the child at home are billable through Medicaid, but not through FAMIS. Does this mean that the parent should not take the higher paying job for fear of losing her child's mental health coverage? Certainly we do not want Virginia's parents to have to make such

painful decisions. Changing the mental health coverage in FAMIS will further our goal of a seamless system of health insurance for Virginia's children."

SignUpNow

Linda Nablo, Director commented on behalf of SignUpNow in support of Options III, IX, X, XI, XII, XIII and the single program name for Medicaid and FAMIS. With regard to Option IX, Ms. Nablo stated:

"Option IX - authorizing 12 months continuous coverage in Medicaid and FAMIS.

- *12 month continuous coverage would secure a medical home for each child for a one-year period. Continuity of care, especially during the developmental years, is a key element in proper health care.*

- *Currently, families are required to report all changes to income and family size within 10 days, even if the change does not affect the child's eligibility for insurance. These requirements are costly to administer for caseworkers at DSS and the FAMIS Central Processing Unit. (Administrative savings between 2 and 12 percent have been estimated.)*

- *Current reporting requirements are very burdensome for families with fluctuating income. Families depending on hourly wages or seasonal employment can find themselves constantly reporting their changing income.*

- *Many families move from Medicaid to FAMIS as income rises and many more may move from FAMIS to Medicaid as the economy declines. While these families remain eligible for publicly funded health insurance for their children, shifts between the programs can be disruptive to the child's medical care and confusing to the families as benefits, costs and perhaps even providers change.*

- *12 month continuous coverage may well reduce the problem of children dropping out of the program after one year. With the current system, a family who has failed to report a change in income during the first 12 months could be hesitant to complete the required updated income information at annual renewal time. A different reported income, even if it is still within the eligibility limits, would raise questions about why the family failed to comply with reporting requirements at the time of the change. Some families may opt to drop coverage rather than risk real or perceived reprisal."*

Virginia Hospital and Healthcare Association (VHHA)

Christopher S. Bailey, Senior Vice President commented on behalf of VHHA in support of Options IX, X, XI, XII and an umbrella program for Medicaid and FAMIS. With regard to Options XI and XII Mr. Bailey stated:

> "What is Presumptive Eligibility?
> Presumptive eligibility rules for Medicaid and state child health insurance programs allow states to designate 'qualified entities' who are trained and authorized to conduct a preliminary eligibility screen and immediately enroll qualified individuals for a temporary period. For Virginia currently we recommend that hospital emergency departments, federally qualified health centers, hospital outpatient clinics and other health care safety net providers (who regularly treat people in urgent need of health care services who are eligible for these programs) be designated as such qualified entities. Systems in other states demonstrate that such presumptive eligibility systems can have high accuracy rates; in other words, the vast majority of patients temporarily enrolled are approved when the formal process is completed. And even in those cases where the child is ultimately found ineligible, medical expenses are covered during the temporary enrollment period and the state receives its matching funds for such expenses.
>
> What are the benefits of presumptive eligibility?
> - It allows for coverage to begin immediately for treatment of urgent conditions.
> - It takes full advantage of the opportunity for enrolling eligible children when the family is highly motivated.
> - By speeding enrollment it will provide an opportunity for more routine care and a medical home that will avoid unnecessary emergency and other high cost treatments in the future.
> - It allows providers to be compensated for rendering needed services....
> - Such immediate coverage would offset – with two-thirds federal support – a portion of the indigent care costs being incurred by hospitals and other providers. These costs are otherwise either: a) borne fully by private payors and individuals; or b) in the case of state teaching hospitals and others, covered partially after the fact through disproportionate share hospital payments.
>
> In short, presumptive eligibility is worthy of support as a mechanism for speeding enrollment, assisting families in a times of economic uncertainty and bolstering safety net providers."

Virginia Poverty Law Center (VPLC)

Jill A. Hanken, Staff Attorney commented on behalf of VPLC in support of Options III, IX, X, XI, XII, XIII and a single program name for Medicaid and FAMIS. With regard to the single program name, Ms. Hanken indicated:

> "New Option XIV – I believe there is another significant policy option which should be considered and supported by the JCHC. Now that the application procedures for Medicaid and FAMIS have been streamlined and unified, enrollment and retention in the programs should be improved by using one name to refer to 'Children's Health Insurance.' While some of the eligibility rules and benefits in Medicaid and FAMIS are different, those differences could be 'masked' if a single program name was promoted in the media and in outreach efforts. Families and the public could clearly identify the state funded program that provides excellent health insurance to Virginia's children.
>
> Other states use a single program name as an 'umbrella' program for Medicaid (Medically Indigent Coverage for Children) and Title XXI. I propose that we retain the name FAMIS and add 'FMAIS+' as the designation for Medicaid Medically Indigent Children. This could be accomplished through statutory amendments and altering published material about the programs. The **minimal cost** of this change could be absorbed in current administrative/operating funds used for printing and marketing."

Tracy Andersen

Ms. Andersen, a case manager for a Community Services Board, commented in support of Option X and an alternative version of Option III. With regard to Option III, Ms. Andersen indicated: "As a Case Manager at a Community Service Board, I am always faced with clients who experience problems with their insurance's, benefits, and resources. For this reason, I want to forward to you my support for the suggested improvements and agree that these changes would significantly improve services: I agree with the following: -- To change mental health coverage in FAMIS so it is uniform with Medicaid coverage. This change would allow children to receive much needed community-based mental health services, such as intensive in-home and day treatment services, among others. At a time when Virginia is trying to conform to the requirements of the Olmstead decision – providing treatment to individuals in the least restrictive environment – we should ensure that our state-provided health insurance covers these community-based services. In addition, if we do not take advantage of the 2-for-1 match of federal dollars, we will end up treating these children in a more

costly manner in the future, when they end up in crisis, in the foster care or juvenile justice systems. (replacement for Options I, II and III)."

Sherry Black

Ms. Black, Director of Business Development, Children's Hospital of Richmond, stated: "The red-tape of the system is still not conducive to families in need getting what they should have had all along...access to healthcare coverage for their children. These are children who 1) come out of neonatal intensive care units needing healthcare coverage NOW; 2) belong to families who have social/employment issues such that their income status may fluctuate from Medicaid to FAMIS eligibility ranges. The circumstances of these families are not congruent with the way the FAMIS system is set up. Please put your thinking caps on to make the program accessible to those who need it!"

Lee Goldman

Lee Goldman, Ph.D., Arlington County CSA Coordinator stated: "Due to the current application of the state's Medical Assistance Services program, the state and local governments are losing millions of dollars in potential federal funding. As a result of this loss of Federal monies, there is less money available to serve the children of Virginia." Dr. Goldman recommended, "Restore the community-based mental health services to the FAMIS program. Explore benefit of inclusion of EPSDT in FAMIS – both for additional coverage of those children and the potential for increased Federal match."

Cynthia C. Kirkland

Cynthia C. Kirkland, Assistant Director, Lynchburg Division of Social Services, indicated: "I have reviewed the suggested improvements to the FAMIS program as proposed by the Joint Commission on Health Care. I would agree that these are important changes. It is important, however, for citizens to have access to the program. At this point, access is convoluted at best. I agree that the process must be streamlined. In order to do that, I would encourage disbanding the Central Processing Unit, moving all remaining FAMIS cases and applications back to local agencies, and providing administrative funding to manage the program at the local level. Many of our citizens have been confused, overwhelmed and, ultimately, left out of the program because they could not navigate the system. If we are focused on improving the health of the children of Virginia, the program must be administered on the local level."

Rachel Lewis

Rachel Lewis a Comprehensive Services Act Coordinator commented in support of Option III. Ms. Lewis indicated: "I am a CSA (Comprehensive Services Act) Coordinator for three small localities - I am in full support of the option for FAMIS to cover the same mental health services as Medicaid, including intensive in home and day treatment services. CSA funds are limited for children not in foster care. If we can access some basic community based mental health services for these children, it is easier to maintain them in their biological homes and prevent further costly treatment measures. Thank you for the opportunity to provide input."

Mary P. Minor

Mary P. Minor, Child & Family Connection, stated: "The development of a health coverage plan that is a single application with the decision on funding made as a separate eligibility issue is helpful. The removal of premiums was a vast improvement because this client population is very unsophisticated as to the issues of both preventive health care and treatment then the copay and premium just confused them more. Coverage for unborn children is a new federal requirement so we may need to open FAMIS to similar eligibility. Marketing and recruitment of families through Infant & Toddler Connection and other I&R would be a great means of getting past some of the enrollment issues."

Gail F. Taylor

Gail F. Taylor, Amherst/Nelson CSA Coordinator, indicated: "we have found FAMIS to be less than a resource for our clients. In working with clients who have FAMIS we have found it covers none of the services needed by the children we serve with CSA Pool Funds. The other problem we have run into has been that clients have been changed from Medicaid to FAMIS without knowing it. EX: We had a mother whose child we realized needed residential placement very badly. The mother kept telling us she had Medicaid and after reviewing the services of a number of placements, we took the mother and her child to the Virginia Treatment Center for Children where they established the child was acute. During the intake process, the mother was asked for her Medicaid card and when she produced what she thought was her Medicaid card she was told she had FAMIS and VTCC did not accept FAMIS. This was not the only parent this had happened to and their confusion (and ours) has resulted in lost time and services for these children."

Rebecca E. White

Ms. White commented in support of Options III, IX, X, XI, XII, XIII and a single program name for Medicaid and FAMIS. With regard to Option X, Ms. White stated: "I currently have numerous inquiries involving VA Children, where one parent has been laid-off, therefore creating financial hardships for the other parent with high deductibles and co-pays, not to mention, minimal/no prescription coverage. It is a difficult situation to decide whether to pay the utilities, buy food, or take the child to the doctor or buy the prescription. Children's health should not be a barrier when ones financial situation is not by choice."

JOINT COMMISSION ON HEALTH CARE

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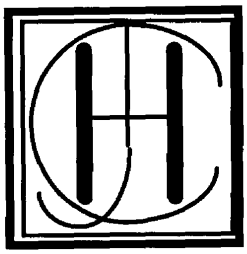

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