

FINAL REPORT

Congressionally Mandated Evaluation of the Children's Health Insurance Program: A Case Study of Virginia's FAMIS Program

October 2012

Sarah Benatar

Margo Wilkinson

Ian Hill

The Urban Institute

Submitted to:

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
200 Independence Avenue, SW
Washington, DC 20201
Project Officer: Rose Chu
Contract Number: HHSP23320095642WC/HHSP23337021T

Submitted by:

Mathematica Policy Research
220 East Huron Street
Suite 300
Ann Arbor, MI 48104-1912
Telephone: (734) 794-1120
Facsimile: (734) 794-0241
Project Director: Mary Harrington
Reference Number: 06873.703

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ACKNOWLEDGEMENTS

The authors would like to thank the many State officials and stakeholders in Virginia who gave so freely of their time and insights during our site visit; this case study would not have been possible without their assistance. We are also indebted to the many parents who took the time to participate in our focus groups, tell us of their experiences, and share their honest opinions about how well the *FAMIS* program is meeting the needs of their children. Finally, we are grateful to our federal project officers, Rose Chu and Wilma Robinson at ASPE/DHHS, for their ongoing guidance, assistance, and advice.

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I. BACKGROUND AND RECENT HISTORY

Virginia's Title XXI Children's Health Insurance Program (CHIP) is a combination program comprising a separate component—*Family Access to Medical Insurance Security* or *FAMIS*—and a slightly smaller Title XXI funded Medicaid Expansion called *FAMIS Plus*. The separate *FAMIS* program is modeled on the state employee health plan, and designed to look like private insurance. In recent years, it has enjoyed bipartisan political support, widespread provider acceptance, and broad consumer appreciation.

FAMIS came to be after the state's initial effort, which involved establishing a Medicaid “look-a-like” program called Children's Medical Security Insurance Plan (CMSIP) in 1998 following the passage of the Balanced Budget Act of 1997 and the creation of the State Children's Health Insurance Program (SCHIP, now referred to as CHIP). CMSIP was a program that some claimed at the time was “designed to fail,” – with a burdensome application process and poor outreach. In short order, low enrollment, widespread challenges with the application process, and the failure of Virginia to use its full federal funding allotment led child advocates in the state to press for changes to the program. *FAMIS* was rolled out to replace CMSIP in 2001. Specific changes to the program included: shortening the “crowd out” waiting period from 12 to 6 months, so that children would not have to be uninsured for as long a period after dropping private insurance and qualifying for CHIP; eliminating the state's child support enforcement requirement to qualify; eliminating monthly premiums¹; and utilizing a Central Processing Unit (CPU) to process *FAMIS* applications instead of local Department of Social Service Offices. When Governor Mark Warner came into office in 2002, his support for the program—coupled with additional scrutiny—led to further improvements including, simplifying the application processes, seamlessly transitioning children who age-out of Medicaid into CHIP, and a concerted focus on improving enrollment statewide.

Today, *FAMIS* covers about 91,000 kids from birth to age 19 living in families with incomes between 134 and 200 percent of the federal poverty level (FPL)². *FAMIS Plus* covers about 80,000 children ages 6 to 19 with family incomes between 100 and 133 percent of FPL. Virginia also has a small premium assistance program (*FAMIS Select*), that provides subsidies to about 350 children with access to employer sponsored insurance, and a program for pregnant women called *FAMIS MOMS*. *FAMIS* and *FAMIS Plus* are administered by the Virginia Department of Medical Assistance Services (DMAS), and housed within the division of Maternal and Child Health. All applications are processed by a contracted private vendor—Xerox State Healthcare—which acts as the “Central Processing Unit” (CPU) for CHIP. Virginia has a joint application for children and pregnant women. Applications are also processed by local Departments of Social Service and forwarded to Xerox for determination in cases where the applicant is CHIP eligible.

¹ The initial change in 2001 to implement *FAMIS* (8/1/01) included new monthly premiums; but In 2002 all monthly premiums were eliminated.

² CARTS Report of unduplicated ever-enrolled member counts in 2010.

Several of the most substantial changes to *FAMIS* occurred prior to this evaluation's study period, which covers 2006—the end of the previous Congressionally Mandated CHIP Evaluation—to the present, with a particular focus on changes made by states in response to the CHIP Reauthorization Act (CHIPRA) of 2009. More recent changes in Virginia have centered on eligibility and enrollment policies and simplification of enrollment and renewal processes. These efforts led to Virginia being awarded a CHIPRA performance bonus in 2011. In addition, just this year, Virginia expanded its managed care delivery system statewide to include all CHIP enrollees.

While Virginia's *FAMIS* program enjoys widespread support, there has been little political will to expand the program beyond its upper income limit of 200 percent of poverty. Attempts to increase overall *FAMIS* eligibility to 225 percent have been proposed several times in recent years, but failed to pass in the legislature each time. This resistance is consistent with the conservative nature of the state, but has also been attributed to uncertainties surrounding implementation of the Affordable Care Act. In turn, Virginia continues to have some of the lowest eligibility thresholds in the nation for both CHIP and Medicaid. The state has however, implemented a handful of small, somewhat surprising, eligibility expansions in the last few years including increasing upper income eligibility limits for *FAMIS MOMS* to 200 of the FPL in 2009³ and, through a Section 1115 waiver, extending coverage to via the CHIPRA option to lawfully residing immigrants in 2012. Furthermore, a proposal to cut eligibility to 175 percent FPL in 2010, however, was also defeated.

This case study is based primarily on a site visit to Virginia conducted in June and July 2012 by staff from the Urban Institute.⁴ Virginia was one of 10 states selected for study in the second Congressionally-mandated evaluation of the Children's Health Insurance Program (CHIP) called for by the CHIP Reauthorization Act of 2009 (CHIPRA), and overseen by the Assistant Secretary for Planning and Evaluation (ASPE). The report focuses primarily on changes to the state programs that have occurred since 2006, with particular focus on state responses to provisions of CHIPRA. The site visit included interviews with more than 30 key informant, including state CHIP and Medicaid officials, legislative staff, health care providers and associations, health plans and associations, children's advocates, and community-based organizations involved in outreach and enrollment. (See Appendix A for a list of site visitors and key informants). In addition, three focus groups were conducted – in Richmond, Alexandria, and Fairfax –with parents of children enrolled in *FAMIS*, and with parents of children who were eligible for CHIP, but not enrolled. Findings from these focus groups are included throughout the report and serve to augment information gathered through stakeholder interviews.

³ *FAMIS MOMS* eligibility increased incrementally over the years; up to 150% FPL in 2005; 166% FPL in 2006; 185% FPL in 2007; and 200 % FPL in 2009.

⁴ Since our site visit was conducted, in part, before the Supreme Court ruled on the constitutionality of the Affordable Care Act, this case study report largely reflects the *FAMIS* program and policy developments prior to the ruling. Where relevant, updates have been made to the extent possible.

The remainder of this case study report will describe recent *FAMIS* program developments and their perceived effects in the key implementation areas of: eligibility, enrollment, and retention; outreach; benefits; service delivery, quality, and access; cost sharing; crowd out; financing; and preparation for health care reform. The report concludes with cross-cutting lessons learned about the successes and challenges associated with administering Virginia's CHIP program.

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II. ELIGIBILITY, ENROLLMENT, AND RETENTION

Virginia has placed great emphasis on leveraging technological innovations to improve enrollment and renewal processes for *FAMIS*. With virtually no political will for eligibility expansions in the state, and severe budget reductions to outreach efforts, a focus on streamlining enrollment and renewal has been critical in enabling Virginia to continue to grow its CHIP program.

Eligibility Policies. As mentioned above, Virginia’s separate CHIP program, *FAMIS*, extends coverage to children from birth to age 19 in families with incomes between 134 and 200 percent of FPL. Children ages 6 to 19 between 100 and 133 percent of FPL are covered through the state’s Title XXI Medicaid expansion program, *FAMIS Plus* (see Table II.1). Virginia’s CHIP and Medicaid eligibility thresholds are among the lowest in the nation.

Table II.1. Eligibility Rules, By Age and Income (as % FPL) for Medicaid and CHIP

	Age Categories		
	Infants	1 to 5	6 to 18
Medicaid	133%	133%	100%
M-CHIP	N/A	N/A	133%
S-CHIP (<i>FAMIS</i>)	200%	200%	200%

Also as noted above, two small CHIP expansions have occurred in Virginia over the last several years, including an increase in upper income eligibility thresholds for *FAMIS MOMS*, which extends coverage to pregnant women with incomes between 134 and 200 percent of poverty. In addition, the state has extended *FAMIS* coverage to legal resident immigrant children and pregnant women without requiring a five year waiting period. There was an effort by the state legislature in 2010 to reduce eligibility thresholds for *FAMIS* to 175 percent of poverty, but that effort was thwarted, owing in part to Maintenance of Effort (MoE) provisions that were instituted with the passage of the Affordable Care Act.

In recent years, Virginia has implemented several eligibility policies aimed at removing barriers to enrollment. (Current eligibility policies are highlighted in Table II.2.) The state has for a long time required no asset test for either CHIP or Medicaid, and has eliminated the need for a face-to-face interview with an eligibility worker when applying for either program. The state does not have presumptive eligibility for either Medicaid or CHIP, and offers a “modified” 12-month continuous eligibility for *FAMIS* only, but does not have continuous eligibility for Medicaid or *FAMIS Plus*. The state’s version does not, however, meet the CHIPRA definition of continuous eligibility because coverage can still be revoked if income exceeds 200 percent of FPL during those 12 months. Proof of income is requested with the application, but the state also uses available data sources to verify income. Residency can be self-declared, and citizenship is verified through a data match against Social Security Administration (SSA) records. While Virginia’s eligibility policies are not the most progressive nationally, the state has worked to remove barriers to enrollment by simplifying both eligibility requirements and modernizing its enrollment processes, as discussed in the following section. Overall, Medicaid and CHIP eligibility policies in Virginia are well-aligned, facilitating the state’s screen and enroll process.

Table II.2. CHIP and Medicaid Eligibility Policies

	CHIP	Medicaid	Details
Retroactive Eligibility	Yes	Yes	Medicaid may be authorized for up to three months before the date of application; CHIP may be authorized for an eligible child who was born within 3 months prior to the FAMIS application month
Presumptive Eligibility	No	No	
Continuous Eligibility	Yes, 12 months	No	Children covered under CHIP get 12 months continuous coverage unless the family's income exceeds the program's income eligibility guideline
Asset Test	No	No	
Income Test	Self-declaration with internal verification	Self-declaration with internal verification	For renewals only
Citizenship Requirement	Self-declaration with internal verification	Self-declaration with internal verification	SSA data match to verify citizenship
Identity Verification	Yes	Yes	A child's social security number
Redetermination Frequency	12 months	12 months	

Enrollment Processes. Virginia has concentrated considerable resources and effort on implementing technological advances to ease enrollment in FAMIS, *FAMIS Plus* and Medicaid in recent years, implementing a “no-wrong door” approach that allows families to apply however they encounter the system. Innovations have differed somewhat, however, for *FAMIS*—where the enrollment process is administered by the CPU, and *FAMIS Plus*/ Medicaid – where the enrollment process is administered by local DSS offices. From the start, the state has used a web-based eligibility determination system and the functionality to prepopulate renewal applications for the *FAMIS* (see Table II.3). More recently, in 2010 and 2011, Virginia became one of the first states to employ the following enhancements with its CHIP and Medicaid enrollment and renewal processes:

- Telephonic signature⁵ (*FAMIS* only);
- E-signatures (*FAMIS*, *FAMIS Plus* and Medicaid);
- Administrative verification of income; (primarily for renewals)
- Administrative renewal with income attestation (*FAMIS* only);
- Ex Parte renewal (*FAMIS Plus* and Medicaid only)
- Automatic enrollment of deemed newborns (*FAMIS* only);

⁵ Telephonic signature allows applicants to certify verbally that they agree to terms and conditions. This verbal confirmation is recorded and saved.

- SSA matching for citizenship and identity (*FAMIS*, *FAMIS Plus* and Medicaid); and
- E-submission of verification documents (*FAMIS* only).

FAMIS applicants have the option to submit a paper application, an application by telephone with the assistance of a customer service representative, or an on-line application. Medicaid and *FAMIS Plus* applicants can apply in person, or through a new web portal called “Common Help”, which will screen applicants for several social service assistance programs (including medical assistance, TANF, SNAP, energy assistance and childcare assistance). With recent enhancements to the web and telephone systems for *FAMIS* applications, Virginia has begun to move away from paper as evidenced by the large jump in the number of web and telephone applications submitted for *FAMIS*, up from 48 percent of applications in 2010 to 78 percent of applications in 2012.

Application processing and eligibility determination are handled by the state’s CPU that has been under contract with DMAS since 2001. Formerly Benova, ACS, and now Xerox State Healthcare, Virginia’s CPU employs 57 full time employees dedicated to *FAMIS*, including 16 eligibility workers, 18 call center representatives who answer questions and create telephone applications, and additional staff who do quality monitoring, training, and oversee all IT functions. Xerox has Spanish and English speakers on staff, and utilizes a translation service for families with other language needs. The CPU functions in a paperless environment, scanning all applications and verification documents submitted, and creating electronic records for all communication.

In addition to these staff focused on *FAMIS*, there are 10 co-located DMAS staff who can finalize eligibility determination for applications that are found to be Medicaid eligible. During busy enrollment months—typically around the state’s “Back to School” campaign—the CPU hires temporary staff to manage additional work volume. This flexibility was touted as one of the benefits to utilizing a contractor to process applications rather than a government agency that would have a harder time hiring temporary staff. Per its agreement with DMAS, the CPU is obligated to complete its review all *FAMIS* applications within 12 business days of receipt, and all *FAMIS* MOMS applications within eight days. The CPU currently averages six days for *FAMIS* MOMS and between 10 and 12 days for all other *FAMIS*

Focus Group Findings: Enrollment

Focus group participants felt that the enrollment process was straightforward. Parents enrolled their children in *FAMIS* through the mail, or at their local Social Services office. Along with their application, parents were required to submit documentation, including pay stubs and employment verification.

“She started out with regular Medicaid...because I was working, I went through the VIEW program...and next thing I know, she was on FAMIS.”

“I went to social services [and] signed for several things.”

“It was an easy process. The only thing was just to get your pay stub and verifications from work.”

“It’s self-explanatory.”

Parents who received application assistance had mixed reviews of their experiences.

“It has moments where it’s inconvenient depending on the caseworker...just depending on the day of the week and what mood they’re in, if they wanted to work or not wanted to work.”

“[The] first time...the social worker [came to] my home... it’s easy.”

“The only difficult part was that you had to go during work hours [to the Social Services office] so it’s like you have to take off from work to come here.”

applications. Applications for the *FAMIS* Select premium assistance program go through the traditional *FAMIS* processes initially and are then referred to a *FAMIS Select* coordinator, as will be discussed further, below.

Virginia first implemented SSA data matching for CHIP and Medicaid in 2010, and was among the first states to do so. In addition the *FAMIS* application does request proof of income, but when it is not provided, the state is able to use state employment databases to look up and verify income information.

Table II.3. Current CHIP Application Requirements and Procedures

Form	
Joint Application with Medicaid	Yes
Length of Joint Application	6 pages; 4 pages of application, 2 pages rights/responsibilities
Languages	English, Spanish
Application Requirements	
Age	Yes – self-declared
Income	Yes – the state may make attempts to verify income administratively but documentation must be submitted with the application
Deductions	Yes – working expenses, dependent care and a portion of child support received (for Medicaid and <i>FAMIS MOMS</i> only)
Social Security Number	Yes – self declared
Citizenship	Yes – SSA data match to verify citizenship
Enrollment Procedures	
Express Lane Eligibility	No
Mail-In Application	Yes
Telephone Application	Yes
Online Application	Yes
Hotline	Yes
Outstationed Application Assistors	Yes
Community-Based Enrollment	No

Numerous stakeholders in Virginia expressed positive opinions of the CPU and the efficiency it has brought to the application process for *FAMIS*. In some cases, this efficiency was contrasted with that of Medicaid (which also applies to *FAMIS Plus*), for which eligibility is determined at the local level by autonomous county-administered Departments of Social Service. The systems employed by the CPU are nimble in a way that the Medicaid eligibility systems are not. Utilizing an outside vendor for enrollment and eligibility determination was cited as a particular strength of the program that ought to be considered as implementation of the Affordable Care Act takes place. In addition to the flexibility afforded by utilizing a third party, DMAS emphasized its ability to implement oversight and enforce sanctions if contractual standards are not met. From the DSS perspective, the CPU was viewed as less than transparent, noting that if a *FAMIS* application is forwarded to the CPU, DSS no longer has the ability to track the status. The CPU can transfer Medicaid and *FAMIS Plus* eligible applicants to co-located DSS workers, but once applications are passed along to the local DSS offices, the CPU is no longer able to track the application.

Virginia embraced application assistance early on in response to reported difficulties with the application process for CMSIP, as well as the 12-month waiting period between having private coverage and being eligible for the program. Virginia's application assistance program, "SignUpNow" is currently overseen by the Virginia Health Care Foundation (VHCF). Initially administered and supported by the Virginia Health and Hospital Association (VHHA), VHHA transferred the program and funding for it to VHCF in 2002/2003. Application assistance is coupled with "Project Connect", which has been characterized as the outreach arm, but has a role in application assistance. Today, the programs are funded in part by DMAS, and in part by available grant programs. VHCF currently employs 16.5 FTEs to train staff at local health organizations, school nurses, and others in the rules and regulations of the *FAMIS* program as well as strategies for reaching families. Over time, DMAS supported the development of online training modules through VHCF to promote training throughout the state, and have also developed toolkits and resource manuals to share with those who do the application assistance. This project is described in greater detail in the section on Outreach below.

Renewal Processes and Procedures. *Renewal Processes and Procedures.* Virginia has also made several improvements to its *FAMIS* renewal processes in recent years. (Current renewal policies are outlined in Table II.4.) In particular, the state implemented administrative renewals for its separate CHIP program in October 2010. The state now sends pre-populated, one-page renewal forms to families that require only a signature attesting to the fact that the presented income information is correct and has not changed. At the time of our visit, DMAS reported that 60 percent of renewals were occurring administratively. To audit the process, DMAS regularly samples 5 percent of administrative renewals to verify that self-attestations are valid.

Adoption of this process was lauded by consumers and advocates alike. Several focus group participants acknowledged how much easier the renewal process had been during their past cycle, and advocates were pleased to see the removal of additional barriers to keeping folks enrolled.

Virginia's choice to implement administrative renewal also contributed to the state's ability to qualify for a CHIPRA performance bonus in 2011. Ex parte renewals, in which the state relies on data available through other public programs or data banks, rather than from the enrollee, to confirm continued eligibility; already existed on the Medicaid side, and DMAS decided that extending administrative

Focus Group Findings: Renewal

Parents are required to send income documentation and indicate if there have been any changes to the information displayed on the pre-printed renewal application. Overall, parents reported being satisfied with the renewal process, although there were inconsistencies from parents who received assistance with renewal.

"It's pretty simple I think. They sent it to you, and they just say if anything changes, you write down what changes. And you still need to send...your check stubs."

"Just give them proof of your income and make sure that everything is the same."

"Mine comes from [Social Services]. So...[I] get the paperwork together, and I take it back to Social Services."

"I think [the Social Services worker] is not good, because he sent the paper, and I fill it out and I sent it into Human Services Office...but after 15 days...my social workers sends me other paper."

"The [health clinic] helped me to renew online."

"One parent had a lapse in coverage after she was unable to complete the renewal process."

"I didn't renew on time...We were changing homes...[and] they had the old address...I didn't know [it was time to renew]."

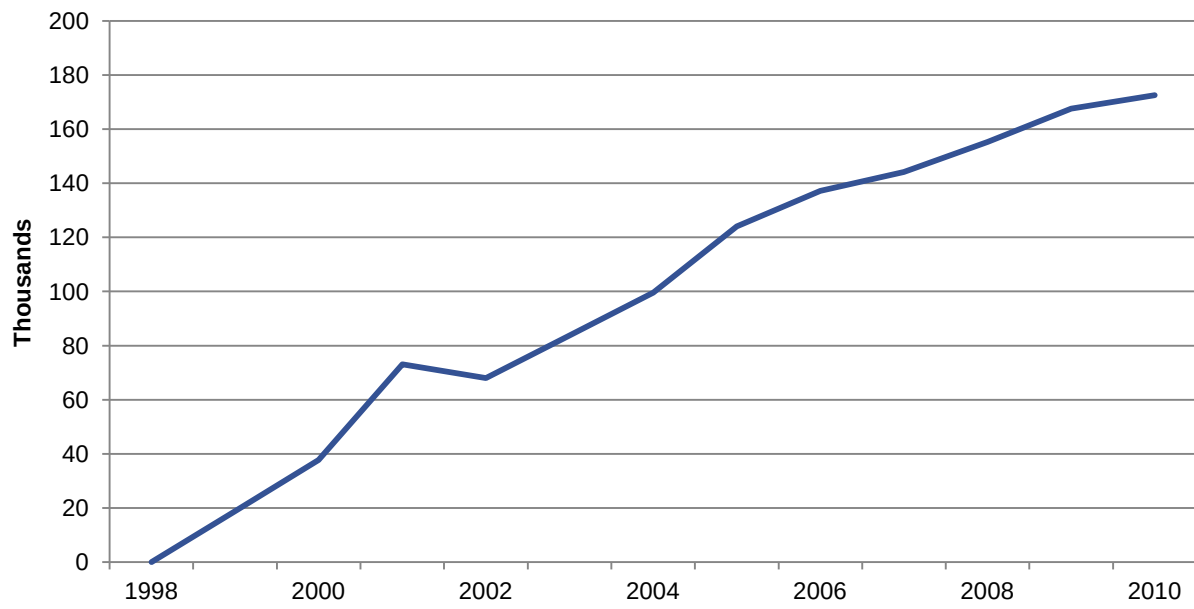
renewal to CHIP would be a fairly easy change to make. The state needed to implement two more simplification measures to qualify for the bonuses, as they already had just three in place (joint application, elimination of asset test, elimination of in-person interviews), and achieve adequate enrollment growth to qualify for a bonus. In addition to administrative renewal, the state implemented the CHIPRA premium assistance program in Medicaid to meet the final criteria necessary. The state's 2011 CHIPRA performance bonus amounted to \$26,729,489.

Table II.4. Renewal Procedures in Virginia CHIP and Medicaid as of January 2012

	Renewal Requirements	
	CHIP	Medicaid
Passive/Active	Active	Passive
Ex-Parte	Administrative	Ex-parte
Rolling Renewal	No	Yes
Same Form as Application	No	No
Preprinted/Pre-populated Form	Yes	No
Mail-In or Online Redetermination	A renewal packet is sent in the mail with a PIN and Family ID number to go online to submit a prepopulated renewal application. In addition, families can renewal over the phone or return the prepopulated form in BRE.	If an eligibility worker is unable to renew coverage with information they already have, participants will receive a notice asking them to complete a form. Recently, families were also given the option to renew online through the new DSS CommonHelp web portal.
Income Documentation Required at Renewal	No, if there was a change in income, the applicant indicates on the online renewal form and signs	Families may be asked to supply proof of income or resources at renewal
State Administratively Verifies Income	Yes	Yes
Other Verification Required	No	No

Discussion. Virginia has implemented several enrollment and eligibility changes in recent years to help streamline the process, and remove potential barriers for families seeking health coverage. In light of fairly restrictive eligibility thresholds, and severe cuts to outreach in the state (discussed below), these changes have helped contribute to continued growth in the state's CHIP program. Committed to technological advancements, in particular, the state has worked hard to improve its systems for data sharing, transfer, and tracking. Families have received these changes favorably, as DMAS notes a steep uptick in online applications, and focus group participants comment with appreciation on the ease of renewals, in particular.

Figure II.1. Number of Children Ever Enrolled in CHIP in Virginia (1998-2010)



Source: SEDS

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III. OUTREACH

Virginia's outreach efforts have followed two primary tracks that have worked in tandem. On the one hand, the state has typically committed public funds in support of media buys and back-to-school campaigns. On the other hand, community-based efforts have focused on application assistance and received funding from a combination of private philanthropies and DMAS. Together, the two complementary strategies have promoted statewide awareness of *FAMIS* while simultaneously providing individualized assistance for those who need it.

Since 2009, DMAS' outreach budget has been chipped away, leaving the agency with no budget for television ads. DMAS has, however, retained its CHIP marketing and outreach manager and two staff positions, and preserved funding that it has historically set aside for VHCF's outreach and application assistance efforts: "Project Connect" and "SignUpNow". Funding to VHCF has not been as high in recent years as it had been in the past, but DMAS clearly values these efforts and works to maintain what funding it can to support outreach workers.

The state also continues to promote its "Back to School" campaign (though with fewer resources), which entails sending letters—signed by the superintendents of schools and the head of the Department of Education—to each school principal. Letters and *FAMIS* flyers are then included in the first day packets distributed to school children. The state consistently sees an increase in applications in September and October of each year, which has been attributed to the success of the Back-to-School campaign.

Furthermore, DMAS outreach staff manage the famis.org website as well as the Children's Health Insurance Program Advisory Committee (CHIPAC)—a 20-member advisory committee that evaluates outreach, enrollment, quality, and utilization for CHIP and Medicaid and makes recommendations to DMAS Director as well as Virginia's Secretary of Health and Human Resources.

Meanwhile VHCF, with funding support from DMAS, focuses its efforts at the community level. The Outreach component of VHCF's efforts is called "Project Connect," and the training/assistance component, as noted above, is called "SignUpNow." VHCF won \$988,154 during the first CHIPRA Outreach grant award cycle in 2010. This helped the organization to fund 10 additional

outreach workers for twenty months. In addition, VHCF also receives money from the Anthem BCBS Foundation, and other regional foundations to fund outreach workers. Funding for "Project Connect" outreach workers and "SignUpNow" trainers has vacillated through the years,

Focus Group Findings: Outreach

Focus group participants heard about *FAMIS* from a variety of sources including State and local agencies, schools, friends and family members, and advertisements.

"It came in a school packet."

"My sister-in-law, she has her kids with FAMIS. That's how I heard."

"[I was told by a] social worker with the Early Intervention [program]."

"[My children] started out as something else, and then they switched over to FAMIS."

and is expected to dip significantly in the coming months as CHIPRA outreach grant funds run out.

Project Connect grants are given to local agencies such as the Partnership for Healthier Kids in Fairfax and STOP in Norfolk, which assist families with enrollment and renewal, and are expected to meet pre-specified quarterly goals. DMAS works with VHCF to ensure that the Project Connect outreach grantees are meeting their goals. Grantees are selected based on need (i.e., reaching a community with significant numbers of eligible but not enrolled children). If goals are not met consistently, grants can—and have been—revoked. On the “SignUpNow” side, VHCF has both an online training module for anyone interested in being trained on application assistance, and hosts eight in-person “SignUpNow” trainings each year; during each workshop VHCF trains approximately 50 people on application assistance. “SignUpNow” and “Project Connect” are viewed as potential models for the Navigator program in Virginia, under the Affordable Care Act.

Virginia has seen significant cuts to its outreach budget and has scaled back state-supported marketing efforts, but continues to support community based outreach efforts aimed at reaching families directly. DMAS reports that these budget cuts do not seem to have significantly affected program enrollment, perhaps because of the ongoing work of community-based partners.

IV. BENEFITS

The benefit package offered to families enrolled in *FAMIS* is benchmarked to the State Employees Health Plan, which covers a broad range of standard benefits, including physician's visits, hospitalization, prescription drugs, and emergency room visits. Children enrolled in the Medicaid expansion portion of the program (*FAMIS Plus*) receive the full Medicaid benefit package required by federal law, including EPSDT. Although informants reported that the benefits package for the separate CHIP program has slowly evolved since 2001 to more closely resemble that of Medicaid, many informants still felt that the Medicaid package was richer and more comprehensive than that of *FAMIS*. In particular, the *FAMIS* package does not include the full protections for coverage guaranteed by EPSDT, or non-emergent transportation, a gap noted by several informants. Furthermore, certain benefits for serious mental health disorders are not covered by *FAMIS* (such as community-based residential care), but are covered by Medicaid (and *FAMIS Plus*).

Since 2005, there have been few significant changes to the benefits covered under *FAMIS* and *FAMIS Plus*. The most notable change came in 2005 when the state carved out dental services into a separate program called Smiles For Children. The new program offers families covered under CHIP the same dental benefits as those enrolled in Medicaid—including all medically necessary dental services and orthodontic procedures—at no cost to the family. The state did not have to make any significant changes to its dental benefits when CHIPRA passed in 2009.

Focus Group Findings: Benefits

While parents expressed general satisfaction with the benefits covered under *FAMIS*, some noted gaps in dental coverage and prescription drug coverage..

"My kid was sick when he was six months old with eczema... [so I went to] this dermatologist...I had to pay for the cream \$150 myself."

"I had to put them on my...dental insurance at work in order to get what I needed done. And then my youngest, they won't pay for her braces."

"I went to refill a prescription and they said it wasn't covered anymore. And it was just regular asthma medication, and I thought it was strange because I had just been there...and gotten the prescription...but then the refill they said no...I would have to either pay for it or go get a different prescription."

Several changes have also been made to the mental health benefits offered under *FAMIS*. Notably, in 2009 mental health parity was established and hospital stay/visit limits were adjusted to conform with CHIPRA provisions and an early intervention program was implemented for children in Medicaid and CHIP that allowed the state to better identify children receiving early intervention services. However, several informants still reported coverage of mental health services as a weakness in the *FAMIS* benefit package. One key informant expressed concern that modeling the *FAMIS* benefits package off of a "static benchmark" may create difficulties in the future as things "evolve and change." For example, despite establishing mental health parity through CHIPRA, there are still important gaps in coverage for mental health services. In particular, as rates of autism rise and new behavioral health treatments are introduced to cope with autism, families and officials have found it difficult to discern what services are covered under *FAMIS*.

Overall, however, consumers, advocates, and providers were very satisfied with the CHIP's benefits coverage. Despite a few exceptions, many reported that *FAMIS* provided comprehensive benefits similar to those of Medicaid and private insurance.

V. SERVICE DELIVERY, ACCESS, AND QUALITY OF CARE

Virginia's service delivery networks for Medicaid and *FAMIS* share considerable overlap. The state implemented Medicaid managed care in 1996 for most of the state, and moved CHIP enrollees into the same network of health plans. CHIP and Medicaid administrators tout this compatibility as a primary strength of the program, promoting comparable quality and access for participants, easing transitions for families that shift from one program to the other, and reducing administrative burdens for the state.

Service Delivery and Payment Arrangements. In 2012, Virginia implemented statewide managed care for its Medicaid and CHIP programs.⁶ While Virginia has been shifting *FAMIS* enrollees to managed care over the course of several of years, the very rural southwestern portion of the state remained fee-for-service until just this year.

The state has risk based managed care contracts with six health plans, all of which accept both Medicaid and *FAMIS*. The three managed care organizations (MCOs) with the greatest market share are Anthem HealthKeepers Plus, Virginia Premier Health Plan, and Optima Family Care. Amerigroup and Majestacare are new additions to Virginia's managed care market, and CareNet is the smallest of the health plans that participate in the state. Amerigroup and Virginia Premier focus exclusively on Medicaid and *FAMIS*—their only line of business—while the others carry a blend of private and public customers. Anthem HealthKeepers Plus is the largest MCO in the state, with nearly 45 percent of the *FAMIS* market share, and approximately one-third of the Medicaid market share statewide. Additional plans have expressed interest in entering the Virginia market in anticipation of a possible Medicaid Expansion under the ACA.

None of the MCOs currently operates in all parts of the state, but Anthem has plans to expand statewide by the end of 2012 and this will likely result in an additional boost to its market share. In each region there are at least two managed care plans from which enrollees can choose, though a large majority of Medicaid patients (over 80 percent) are auto-assigned a plan. In certain regions, to entice managed care participation, the state has promised new MCO entrants a pre-specified percentage of the market share. A few respondents commented that even the minimum requirement of two plans per region is inadequate in certain pockets of the state due to provider shortages in rural areas; beneficiaries reportedly have to sometimes travel quite a distance to get care from a provider accepting new patients. Advocates would like to see greater oversight of managed care plans in Virginia to ensure that they aren't being paid for treating Medicaid and *FAMIS* members who are unable to gain access through their networks. DMAS' oversight includes not only network analysis of each plan for adequacy, but constant review of complaints/issues that are reviewed for access issues.

The state sets rates for MCOs based on actuarial analysis conducted by an independent accounting firm; MCOs can then negotiate directly with the providers with whom they contract. Rates for *FAMIS* are not strictly comparable since Medicaid rates are blended for children and

⁶ *FAMIS* remains fee-for-service for the residents of Tangier Island, an isolated fishing community that would experience access hardships if shifted to managed care.

pregnant women. Capitation rates in 2012 for *FAMIS* were \$115 PMPM, while Medicaid rates ranged from \$157 to \$272 PMPM.

Managed care plans are responsible for all medical care and basic behavioral health services, but dental care and certain aspect of mental health care are carved out of plans' responsibilities. Medicaid and CHIP beneficiaries have historically experienced difficulty accessing dental care but the state increased dental reimbursement in 2006, which resulted in significant dental provider participation increases and, thus, access improvements.

While basic mental health services are covered by MCOs in Virginia, services for children with serious emotional disturbance are carved out in both Medicaid and *FAMIS*. The scope of mental health benefits covered for CHIP kids, however, is much more limited than for Medicaid. To assist with some of the disparities, Virginia implemented targeted case management for children identified through early intervention, which has helped families navigate a complicated (and not particularly generous) system. Some informants interviewed cited the mental health service provision in CHIP as being fairly problematic, and an area in need of scrutiny and improvement.

Access to Care. In general, children enrolled in *FAMIS* are perceived to have broad access to care, though certain exceptions exist. Access in less populous rural or mountainous communities can be particularly problematic, where provider supply is limited and residents often have to travel long distances to obtain care. In addition, several informants mentioned shortages among certain pediatric subspecialties, noting however that these shortages persist in the private market as well.

Generally in Virginia, ensuring adequate access is the responsibility of the managed care organization, and DMAS has specified contract language designed to ensure that MCOs are held accountable for helping *FAMIS* members identify an appropriate and available provider within a reasonable distance. In some areas of the state MCOs have utilized telemedicine to help address access issues.

Dental access had historically been a particular problem for the state, as it has been for other states. In attempt to address these challenges, Virginia worked closely with the state dental association to improve dental access which

Focus Group Findings: Access to Care

Parents were mostly satisfied with access to primary care providers, including their ability to switch providers if needed.

"I went through the referral service...you can either call them or go online and search for doctors within your area."

"I have changed [providers]...because I didn't agree with the opinion of the doctor...so that caused me to switch."

"I think there was a lot of [choice]."

"I didn't know you had to call...to change [your primary care provider]...But [the office] just called the same day I was at the appointment...they fixed it."

However, parents reported more mixed experiences accessing dental, specialty, and developmental providers.

"It was easy [finding a dentist]."

"I think it was harder for me to find a dentist because we tried a couple of dentists before we got to [our current dentist]."

"The dentists, they treat normal teeth [but] my son he [has] eight cavities and they say to me...it's a one hour drive [to dental specialist]."

"I need to make appointment for him for...occupational therapy, [and] we need to wait almost one year."

"Not as many specialists accept this type of insurance as regular pediatricians. So it's like you have two to choose from."

included hiring a dental benefits administrator. DMAS has contracted with a dental benefits administrator and worked closely with the state's dental association to recruit providers to participate with Medicaid and *FAMIS*. Like with MCOs, DMAS has required that the dental benefits manager be accountable for ensuring that patients have reasonable access to a provider. The state has witnessed significant improvements in dental care access and utilization. Dental access continues to improve overall. Access in medically underserved areas continues to be a challenge.

Children in *FAMIS* with serious mental disturbance may also experience significant access challenges, as the benefits available to *FAMIS* recipients are far more limited than they are in Medicaid. Gaining access to adequate community treatment facilities, in particular, was cited as challenging for *FAMIS* recipients, who instead are often cared for in acute care settings.

In moving toward statewide managed care for Medicaid and *FAMIS* members, Virginia has shifted considerable responsibility for access concerns to the MCOs with whom they contract. The managed care contracts have specific access standards and oversight is provided in this area. At times it has been found that there is a lack of certain provider types within the state for services. Child advocates in Virginia expressed concern that there is insufficient oversight and enforcement of MCO policies, and subsequently access issues persist in certain portions of the state.

Quality of Care. Virginia requires that the MCOs with which it contracts are NCQA accredited, systematically reviews several quality measures on a quarterly basis, and monitors annual HEDIS scores closely. Individual MCOs identify the specific measures they would like to focus on, such as increasing immunization rates. Health plans are assessed on their progress meeting the goals of their quality improvement plans as well as their overall quality scores, based largely on HEDIS measures. All contracted MCOs and DMAS come together quarterly to share their quality success stories, an exercise that was praised by health plans, which noted how unusual such transparency is amidst steep competition.

The shift to managed care has improved quality of care through access to disease management programs and individual case management. All health plans are required to contact all new enrollees to determine their medical needs. Enrollees that have complex needs or require assistance are referred to a case manager for individualized assistance. In addition, outreach staff are deployed to meet new members and provide education on appropriate use of services. Other plans have implemented financial incentives for providers in response to meeting quality improvement goals.

Focus Group Findings: Quality

Although some parents encountered long wait times at their primary care provider's office, they were satisfied with the quality of care their children received and felt that providers were sensitive to their culture. However, parents reported mixed experiences with the dentist serving their children.

"I am happy with my pediatric doctor. He is really good."

"For me it's hard. Every time I bring my child...I've got to wait...for like a minimal of 45 minutes...but the time that the doctor brings to my child is really considerate."

"When I go to doctor...there's one interpreter from Spanish."

"I'm thinking about switching [dentists]. They're not that good...they're not that friendly, and they seem like they're in a rush."

"I think I have the best dentist...all the kids love to go there."

Discussion. There are some changes afoot in Virginia on the service delivery side, as statewide managed care for CHIP recipients rolls out. These changes have been prompted in part by concerns about capacity as the Affordable Care Act rolls out in the state. The network overlap for Medicaid and CHIP will help families navigate utilization seamlessly. Nonetheless, access concerns remain, particularly in less densely populated portions of the state. While the state and its MCOs have worked hard to implement quality assurance and improvement some stakeholders call for additional oversight of the plans to ensure children enrolled in FAMIS are having their needs met.

VI. COST SHARING

Cost sharing for families enrolled in *FAMIS* is limited to copayments that are tied to family income level; there are no premium requirements. Under the original separate CHIP program (CMSIP), all families were required to pay both monthly premiums and copayments. When *FAMIS* was first implemented in 2001, there were no monthly premiums for families under 150 percent of federal poverty level, but for those with incomes between 151 and 200 percent of poverty, families were required to pay premiums of \$15 per child per month, up to a maximum of \$45 per family. Several informants reported that, at the time, these premiums were perceived to erect barriers for enrollment and retention for low-income families. Due to the confluence of several factors, including the work of advocacy groups and the high administrative costs of premium collection, monthly premiums for all *FAMIS* participants were eliminated just a year later, in 2002.

Key informants interviewed for this evaluation felt that copayments for families enrolled in *FAMIS* are more appropriate than premiums because families are more satisfied when “paying for a [specific] service.” No copayments are required for preventive services—including well-child visits, immunizations, dental, and pregnancy related services—but copayments are imposed for other services, and amounts vary by income level. Families with incomes under 133 percent of poverty enrolled in the Medicaid expansion face no copayments (as required by law), while families above 133 percent are split into two copayment groups. As illustrated in Table VI.1, families with incomes between 134 percent and 150 percent of poverty pay slightly lower copayments and have a lower annual copayment limit per family than those families who fall between 151 percent and 200 percent of federal poverty level.

Table VI.1. Cost Sharing in Virginia's *FAMIS* Programs

Program	Income Level	Premium/Child/Month	Sample Copayments
Medicaid	<133% of the FPL: ages 0-5 <100% of the FPL: ages 6-18	\$0	\$0
<i>FAMIS Plus</i> (Medicaid Expansion)	100-133% of the FPL, ages 6-18	\$0	\$0
<i>FAMIS</i> Co-pay Status 1*	134–150% of the FPL, ages 6-18	\$0	\$2: doctor's visit, outpatient hospital service, prescription (34 day supply), emergency room use \$10: inappropriate emergency room visits \$15: inpatient hospital service \$180 yearly co-pay limit/family

Table VI.1 (Continued)

Program	Income Level	Premium/Child/Month	Sample Copayments
<i>FAMIS</i> Co-pay Status 2*	151-200% of the FPL, ages 6-18	\$0	\$5: doctor's visit, outpatient hospital service, prescription (34 day supply), emergency room service \$25: inappropriate emergency room visits, inpatient hospital service \$350 yearly co-pay limit/family

*No cost sharing charged to American Indians and Alaska Native enrollees

Providers are expected to collect copayments from *FAMIS* participants at the point of service. However, one informant acknowledged that some providers do not collect copayments because it can “cost more to bill the co-pay than to collect it.” Families are responsible for keeping track of their annual copayment total; if a family exceeds the yearly limit, they can send their receipts to the *FAMIS* Central Processing Unit to have copayments waived for the remainder of the coverage year. Overall, informants expressed satisfaction with the current levels of cost sharing in *FAMIS* and did not feel that copayments acted as a barrier to service use or access.

VII. CROWD OUT

Key informants interviewed for this case study asserted that crowd out has never been a major concern in Virginia given the relatively restrictive income eligibility threshold for *FAMIS*. Several noted that because *FAMIS* only covers children in families up to 200 percent of poverty, the program effectively targets the “working poor” who are less likely to be offered insurance through their employers that they can afford.

However, despite the low income eligibility threshold, Virginia, like other states, has enacted significant crowd-out prevention provisions during the history of *FAMIS*. At implementation, the legislature implemented a 12-month waiting period during which a child had to be uninsured before they could enroll in the program. Over time, this waiting period was reduced by the legislature twice; once in 2001 to six months, and again in 2003 to four months. However, a child may be exempted from the waiting period if any of the following circumstances apply:

- The parent/stepparent changed jobs or stopped working;
- The employer stopped paying part of the cost for family coverage;
- The insurance was cancelled by an insurance company not related to unpaid/late payments;
- COBRA coverage was dropped;
- The insurance was dropped by a family member other than the parent or stepparent living in the home with the child;
- The insurance was dropped because the cost was more than 10% of a family’s current gross income or was more than 10 percent of the family’s gross monthly income at the time the insurance was dropped;
- The child’s prior coverage was through Medicaid, HIPP, *FAMIS*, or *FAMIS Select*;
- The prior health insurance did not have doctors in the area where the child lives; or
- The child is pregnant at the time the family applies for *FAMIS*.

In addition to the current four-month waiting period, the CPU monitors the health insurance status of all applicants by reviewing a series of questions included on the application regarding present and previous coverage. These questions inquire whether a child already has health insurance or if has had coverage in the past 4 months; if so, families are asked to indicate the reason their coverage ended. Finally, upon completion of the *FAMIS* application, every applicant is run through the MMIS system to screen for active insurance or previous coverage under Medicaid or *FAMIS*. If an applicant is found to have active insurance, *FAMIS* coverage is denied. Few families in Virginia, however, are subjected to the waiting period crowd-out prevention strategy, as the majority of applicants either do not have access to employer-sponsored insurance or meet one of the waiting period exceptions. As a result, key informants all agreed that crowd out is not a contentious issue in the state today.

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VIII. FINANCING

With the passage of CHIPRA, funding for the program was extended through Federal Fiscal Year (FFY) 2013. The Affordable Care Act extended that funding for two more years, through FFY 2015. CHIPRA set new total annual allotments for the program and also revised the formula for calculating state-specific allotment amounts. This new method for determining allotments was designed to account for states' actual and projected spending, adjusting for inflation and child population growth, rather than focusing on each state's share of uninsured/uninsured-low-income children, as was previously the case. Drafters of the rule changes believed that it would lead to more appropriate distribution of CHIP funds at the beginning of each year and avoid the need for massive re-allocations of funds from states unable to spend their allotment at the end of each year.

During the first several years of the program, Virginia received larger federal allotments than it could spend. However, from 2003 to 2009, *FAMIS* outspent its federal allotment as enrollment more than doubled, but was able to use carryover funds from the previous years' allotments to meet the needs of the program. Between 2008 and 2009, as a result of CHIPRA's new allotment formula, the state saw an 81 percent increase in federal funding—from \$90.3 million to \$175 million. Throughout the program's history, the state's share of funding for *FAMIS* has remained relatively constant increasing from 34 percent originally to 35 percent today. Virginia's CHIP Allotments and Expenditures from 2006-present can be seen in Table VIII.1.

Table VIII.1. CHIP Allotments and Expenditures (in millions of dollars)

FFY	Federal Allotment	Federal Expenditures	Federal Matching Rate
2006	\$72.3	\$95.9	65
2007	\$94.1	\$110.7	65
2008	\$90.3	\$131.3	65
2009	\$175.9	\$148.4	65
2010	\$184.5		65
2011	\$175.2		65
2012	\$184.0		65

Virginia funds its share of *FAMIS* through a combination of state appropriations, foundation grants, and tobacco settlement funds. But, like many states, Virginia has faced serious budget deficits in recent years, which have threatened enrollment and eligibility levels in *FAMIS*. In 2010, Governor Robert McDonnell proposed freezing enrollment for *FAMIS* to cut program costs. In the same year, the House of Delegates passed legislation to reduce eligibility to 175 percent of the federal poverty level. However, maintenance of effort requirements prevented these reductions and forced the state to maintain current eligibility levels.

Virginia continues to look for ways to cut costs in both the CHIP and Medicaid programs. Although informants reported that CHIP is viewed more favorably by legislators than Medicaid, given its significantly higher federal matching rate and smaller size, the program has still experienced sharp cuts in the last several years. In 2010, drastic cuts to the DMAS budget led to

a hiring freeze and a sharp decrease in outreach funding. In addition, the legislature has chosen not to raise provider payments with inflation during the last four years.

In an attempt to offset budget cuts, DMAS has worked diligently to qualify for CHIPRA performance bonus funds. The state met both the eligibility simplification and enrollment criteria in FFY 2011, and was awarded \$26.7 million, the second largest amount in the country. Unfortunately, key informants noted that none of the money was directly returned to *FAMIS*; instead, it was funneled to the General Fund, potentially preventing further cuts.

IX. PREPARATION FOR HEALTH REFORM

Virginia has a complex relationship with the Affordable Care Act (ACA) which several informants noted has resulted in a lack of clarity regarding what preparations should be pursued. On one hand, Virginia's Attorney General was the first to file a suit against the federal government challenging the constitutionality of the Affordable Care Act's individual mandate. On the other hand, the state has made considerable progress planning for Affordable Care Act implementation, despite political and legal opposition. Among its accomplishments, Virginia has been and continues to be busy planning the state's health insurance exchange, developing a modernized enrollment and eligibility system, and paying considerable attention to capacity issues that are likely to arise.

Governor McDonnell formed the Virginia Health Reform initiative (VHRI) in 2010 lead by Dr. William Hazel, the state's Secretary of Health and Human Resources. The VHRI is tasked with planning for implementation of the Affordable Care Act and considering any changes the state may want to make that go above and beyond what is mandated in the legislation. A committee composed of legislators, business leaders, health care providers, advocates, and state administrators, the VHRI has focused on six strategic areas including:

1. Medicaid expansion, the essential health benefits package, and the relationship between Medicaid and the Exchange;
2. Technology: ranging from telemedicine to payer claims databases;
3. Provider capacity constraints;
4. Service delivery and payment reform;
5. Insurance considerations; and
6. Employers.

In the past year, the VHRI has been primarily focused on planning the state's health benefits exchange, and preparing the Commonwealth to submit a Level one establishment grant. The Governor has decided not to submit a level one establishment grant to date, despite the Supreme Court decision upholding the Affordable Care Act. At the time of our visit Virginia's was described as "ready to act" on the exchange, but still awaiting legislative approval.

In addition, Virginia has been focused on developing a more modern eligibility and enrollment system. Expectations are that the new eligibility system will look very different from what is currently implemented in local agencies and more akin to what *FAMIS* has accomplished with the CPU. At the time of our visit, the state had released an RFP to develop a new eligibility and enrollment system that would ultimately meet the needs of both Medicaid and CHIP. Virginia was a Robert Wood Johnson Maximizing Enrollment (MaxEnroll) grantee. And while MaxEnroll activities in Virginia focused on streamlining enrollment and renewal through implementation of simplified and automated processes, the state has also engaged in the development and design of a state health insurance exchange and development of the Executive Support System (ESS), data warehouse tool, to collect and analyze data from multiple programs.

Virginia Governor Robert McDonnell has signaled that he is still weighing whether or not the state will implement a Medicaid expansion. If, however, Virginia goes ahead with a Medicaid expansion, the effects are expected to be significant. Since the state's current Medicaid eligibility criteria for adults is quite restrictive—Virginia covers low-income parents up to 30 percent FPL and does not cover childless low-income adults—the state anticipates a large increase in newly eligible low-income adults.

So while the constitutionality and financial viability of the Affordable Care Act had been questioned by Virginia officials, the state has engaged in planning to prepare to implement the Affordable Care Act “the Virginia way.” Despite the uncertainty around the Affordable Care Act's implementation, with creative and informed people at the table, the state has made considerable progress, and should be in a good position to take action when called upon to do

X. CONCLUSIONS & LESSONS LEARNED

Virginia's CHIP program has rebounded from being a program that was "designed to fail" to one that is robust in meeting the healthcare needs of children up to 200 percent of poverty. Despite fairly restrictive eligibility criteria, Virginia has worked diligently to streamline the enrollment and renewal processes and ease the burden on families, pleasing consumers, child advocates and politicians alike. Furthermore, community-based outreach and enrollment efforts have consistently worked to grow enrollment throughout the state, targeting communities of particular need. Given the popularity of the program, *FAMIS* has remained mostly insulated from threats to curtail the program with the exception of one proposal to implement an enrollment freeze and an unsuccessful legislative effort to reduce the upper income eligibility threshold for *FAMIS* to 175 percent of poverty in 2010.

Recent expansion of managed care statewide is generally viewed as a positive development for the program, improving access and promoting quality improvement initiatives. Furthermore, the fact that *FAMIS* and Medicaid share the same service delivery system ensures seamlessness for families transitioning between the programs. Access to dental and mental health services continues to lag behind access to medical care, but has made significant strides in recent years. While *FAMIS* does not cover some of the benefits available to children on Medicaid, the program's benefit package was characterized by most informants as quite adequate.

Focus Group Findings: Implications of Having Health Insurance

Parents were unanimous in their appreciation of having coverage for their children. Many contrasted their experiences with *FAMIS* to periods when their children were uninsured or when they were covered under private insurance.

"[Having health insurance] makes it easier."

"Peace of mind...because there [isn't anything] worse than having a kid that's sick...and you don't [have] the money for cough medicine."

"Financially, it makes a major difference...it adds up when you don't have FAMIS."

"[Not having health insurance was] horrible...especially when you had to take them to the emergency room."

"[You] just crossed your fingers and toes that nothing happened. Thank God it didn't."

"Private insurance is crazy. It's like they won't pay for this. They won't pay for that. FAMIS is a blessing."

The future of CHIP in Virginia under health care reform remains unknown, but the state is leveraging several lessons from the program in planning for Affordable Care Act implementation. In particular, expectations are that the modernized enrollment and eligibility system under development will be modeled closely on the *FAMIS* enrollment process which has been such a success.

- ***Simplified and streamlined enrollment and eligibility policies work.*** Virginia has worked diligently to simplify and streamline its enrollment and eligibility policies; from implementing e-signatures and telephonic signatures, to adopting administrative renewals. Families and advocates alike remarked at the positive impact of these changes, and voiced appreciation for the ease of enrolling and staying enrolled in the program.

- ***Contracting enrollment processes with a Central Processing Unit vendor promotes flexibility that benefits the program and its beneficiaries.*** Virginia’s use of a CPU to administer the enrollment process for FAMIS has been a huge success, according to many stakeholders. In particular, informants noted the CPU’s ability to quickly adjust for changes in eligibility policy, the efficiency with which applications are processed, and the ability of the company to seamlessly adopt technological advances. Many held this system up as a model upon which to base a modernized eligibility and enrollment system for Virginia under the Affordable Care Act.
- ***Community-based application assistance has been effective in enrolling harder to reach populations.*** Virginia has a long history of utilizing community based application assistors to enroll hard-to-reach populations, and has been very thoughtful in its deployment of funds to support this effort. In turn, uninsurance rates for children have decreased considerably over the years and, despite cuts in outreach budgets, the program continues to grow.
- ***Strong benefits coverage and access to care can be achieved through contracts with a broad range of health plans.*** The FAMIS benefits package was described as nearly equivalent to Medicaid’s, with a few notable exceptions. Furthermore, Virginia has constructed a statewide managed care network that –though still new in certain regions – appears to be providing adequate access to care for children. Overlap between the Medicaid and CHIP service delivery networks (which are equivalent) was also hailed as a benefit to enrollees who tend to shift between programs with some frequency. Nonetheless, additional oversight of MCOs was called for by some to ensure that kids enrolled in these programs are indeed having their needs met.
- ***Given its many strengths, FAMIS was not dramatically impacted by CHIPRA provisions.*** As illustrated in Table X.1, the state has complied with all mandatory changes, and has adopted several additional and optional provisions, related to the coverage of legal immigrant children and pregnant women.

Despite comparatively restrictive eligibility policies, Virginia has focused efforts on streamlining its enrollment and renewal processes, and been very successful in easing the process for families. The Central Processing Unit approach to enrollment promises to be a model for the state as additional decisions are made about implementation of the Affordable Care Act, but for the now this conservative state remains in a “wait and see” mode. Lastly, while state funded, broad-based outreach has been eliminated in Virginia, strong community based efforts have continued to make great strides enrolling harder to reach populations. Virginia’s CHIP program may not be the most progressive in the nation, but backed by strong leadership and innovative policies, the state has demonstrated significant achievements over the last decade.

Table X.1. Virginia's Compliance with Key Mandatory and Optional CHIPRA Provisions

Provision	Implemented in Virginia?
Mandatory CHIPRA provisions	
Mental health parity required for States that include mental health or substance abuse services in their CHIP plans by October 1, 2009	Yes
Requires States to include dental services in CHIP plans	Yes
Medicaid citizenship and identity documentation requirements applied to Title XXI, effective January 1, 2010	Yes
30-day grace period before cancellation of coverage	Yes
Apply Medicaid prospective payment system to reimburse FQHCs and RHCs effective October 1, 2009	Yes
Optional CHIPRA provisions	
Option to provide dental-only supplemental coverage for children who otherwise qualify for a State's CHIP program but who have other health insurance without dental benefits	No
Option to cover legal immigrant children and pregnant women in their first 5 years in the United States in Medicaid and CHIP	Yes, for Pregnant women in both Medicaid and CHIP and for Children in both Medicaid and CHIP
Bonus payments for those implementing five of eight simplifications	Yes, in 2011; no asset test, no in-person interview, joint application with Medicaid, ex parte/administrative renewal, , premium assistance
Contingency funds for States exceeding CHIP allotments due to increased enrollment of low-income children	No
\$100 million in outreach funding	Two grantees have received CHIPRA outreach funds
Quality initiatives, including development of quality measures and a quality demonstration grant program	In the Federal FY 2010 CARTS report, 3 voluntary quality performance measures were reported

FQHC = Federally qualified health center; RHC = rural health clinic.

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APPENDIX A

SITE VISITORS AND KEY INFORMANTS

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Site Visitors

Urban Institute

Sarah Benatar

Fiona Adams

Margo Wilkinson

Key Informants: Richmond

Virginia Department of Medical Assistance Services

Rebecca Mendoza

Kate Paris

Janice Holmes

Cynthia B. Jones

Steve Ford

Keith Hare

Molly Carpenter

Karen Packer

Tammy Woodlock

Shelagh Greenwood

Virginia State Senate

Joe Flores

Virginia Healthcare Foundation

Debbie Oswalt

Virginia Health Plan Association

Doug Gray

Xerox State Healthcare

Jenness Vaccarella

Virginia Poverty Law Center

Jill Hanken

Virginia Premier Health Plan

Jim Parrott

Linda Hines

Anthem Blue Cross Blue Shield

Lori White

Lynn Vogel

Virginia Community Healthcare Association

Neal Graham

Virginia Health and Hospital Association
Paul Speidell

Key Informants: Prince William County

Prince William County Department of Social Services
Donna Patton
Amy Swift
Lisa Tatum
Suzy Van Ryan

Alexandria Neighborhood Health Services
Eduardo Mantilla-Torres

Greater Prince William Community Health Center
Frank Principi

Partnership for Healthier Kids
Jill Christiansen

Balsamo Arnoldson and Rees MDs
Dr. William Rees

APPENDIX B
APPLICATION

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Health Insurance for Children and Pregnant Women

This application is for Virginia's health insurance programs for children and pregnant women.
FAMIS and FAMIS Plus cover children. FAMIS MOMS and Medicaid cover pregnant women.



Application: ☐ New ☐ Renewal
Family ID # _____
Case Worker _____

Step 1

Tell us who is completing the application, where you live, and where you get your mail:

First Name	MI	Last Name	Phone Numbers	Preferred Language (See instructions)
			H () W () Other ()	
Address	Apt. No.	City	State	ZIP
(Street)				
(Mailing)				
City/County of Residence				

Step 2

Tell us if anyone applying for health insurance is pregnant:

Proof of pregnancy and due date are required. See instructions.

First Name	MI	Last Name	Expected Due Date
			(Month/Day/Year)

Step 3

Tell us about **all** the children and pregnant women under 21 living in your home:

If there are more than four children in the home, please complete steps 3 and 4 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (First, MI, Last)				
Relationship to You				
Date of Birth & Sex	____/____/____ ☐ M ☐ F	____/____/____ ☐ M ☐ F	____/____/____ ☐ M ☐ F	____/____/____ ☐ M ☐ F
Child's Parent, Stepparent or Spouse Living in the Home (First, MI, Last)	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required
	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required
	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required	☐ Mother ☐ Father ☐ Stepparent ☐ Spouse Name: _____ (SS#) _____ Not Required

FAMIS 1 (Revised 11/09)

Step 4

Tell us about the children under 19 and pregnant women under 21 applying for insurance:

	Child 1 <i>continued</i>	Child 2 <i>continued</i>	Child 3 <i>continued</i>	Child 4 <i>continued</i>
Child's Full Name (First, MI, Last)				
Applying for Health Insurance for Child?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If you are applying for insurance for this child, answer the questions below. If you are not applying for this child, you may go to Step 5.				
Is Child a U.S. Citizen?	☐ YES ☐ NO If Yes , please provide City/County and State of Birth: _____ If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____	☐ YES ☐ NO If Yes , please provide City/County and State of Birth: _____ If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____	☐ YES ☐ NO If Yes , please provide City/County and State of Birth: _____ If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____	☐ YES ☐ NO If Yes , please provide City/County and State of Birth: _____ If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____
Child's SS# or date of application for SS#	(SS#) _____	(SS#) _____	(SS#) _____	(SS#) _____
Child Attends School?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child's Race (See codes below)	Race Code # _____	Race Code # _____	Race Code # _____	Race Code # _____
	RACE CODES: 1 White; 2 Black/African American; 3 American Indian/Alaskan Native; 4 Asian; 5 Spanish American/Hispanic; 6 Native Hawaiian or Other Pacific Islander; 7 Asian & White; 8 Black/African American & White; 9 Other or Unknown; or A Asian & Black/African American			
Child's Ethnicity	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	☐ YES ☐ NO If Yes , please provide: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason# _____ Other _____	Reason# _____ Other _____	Reason# _____ Other _____	Reason# _____ Other _____
REASONS CHILD'S HEALTH INSURANCE ENDED: (See Instructions) 1 Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. 2 Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. 3 Insurance company discontinued coverage because child is uninsurable. 4 Cost of insurance exceeded 10% of monthly income (before taxes). 5 Insurance stopped/dropped by someone other than parent or stepparent living with child. 6 Stopped/dropped a COBRA policy. 7 Other.				

Step 5

Tell us about pregnant women 21 and over applying for insurance:

If not applying for an adult pregnant woman, you may go to Step 6.

Full Name (First, MI, Last)		Applying for Health Insurance for a Pregnant Woman? ☐ YES ☐ NO	
Her Date of Birth month / day / year	Her Relationship to You:		Provide Full Name of Husband if Living in the Home:
Is the Pregnant Woman a US Citizen? ☐ YES ☐ NO	If Yes , please provide City/County and State of Birth: _____	If No , please provide: Alien/INS # _____ Country of Birth: _____ Date Entered U.S.: _____	SS#: _____ Race: (See codes below) Race Code# _____ Ethnicity: Hispanic/Latino ☐ YES ☐ NO
RACE CODES: 1 White; 2 Black/African American; 3 American Indian/Alaskan Native; 4 Asian; 5 Spanish American/Hispanic; 6 Native Hawaiian or Other Pacific Islander; 7 Asian & White; 8 Black/African American & White; 9 Other or Unknown; or A Asian & Black/African American			
Does Pregnant Woman Have Health Insurance Now? ☐ YES ☐ NO		If Yes , please provide: Type of Policy _____ Policy ID # _____ Company Name _____	

Step 6

Tell us about household income:

Complete the section below for each parent, stepparent, child, pregnant woman, and spouse living in the home and receiving income. List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write **"NONE"** in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

May we have your permission to get information from all employers, if necessary, about dates of employment and earnings? ☐ YES ☐ NO

Person Receiving Income	Employer's Name or Source of Income	How Often is Income Received?	How Much Gross Income is Received?
_____ (First Name, MI, Last Name)	_____ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	\$ _____
_____ (First Name, MI, Last Name)	_____ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	\$ _____
_____ (First Name, MI, Last Name)	_____ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	\$ _____
_____ (First Name, MI, Last Name)	_____ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	\$ _____

FAMIS Select: FAMIS offers help with private health insurance premiums through **FAMIS Select**.

If your child is approved for FAMIS you may choose to enroll your child in a private or employer health insurance plan instead of FAMIS.

FAMIS Select may help you pay for it.

☐ If my child is approved for FAMIS, I would like more information about **FAMIS Select**.

You are almost done. Turn the page over, complete the application, and remember to sign it.

Step 7

Tell us about childcare or adult daycare expenses:

Do you pay someone to provide childcare or adult daycare while you work? ☐ YES ☐ NO

	Person 1	Person 2	Person 3	Person 4
Full Name of person in daycare	_____	_____	_____	_____
How much do you pay? _____	_____	_____	_____	_____
How often? _____	_____	_____	_____	_____

Step 8

Tell us about medical bills in the last 3 months:

If a child is eligible for FAMIS Plus, a pregnant woman is eligible for Medicaid, or a newborn is eligible for FAMIS, you may be able to get help with medical/dental services in the last 3 months. Did any child or pregnant woman you are applying for receive medical/dental services in the last 3 months?

☐ YES ☐ NO

If **Yes**, list names of the children or the pregnant woman and the months in which they received medical/dental services.

(Note: Dental services are only covered for children.)

You must provide proof of household income for the months that the child or pregnant woman received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS.**

Step 9

Tell us if you have authorized someone else to follow up on this application:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____ and/or (organization name) _____

Address _____ City _____ State _____ Zip _____

Telephone _____

to receive eligibility and enrollment information relating to my child(ren) or the pregnant woman on this application. I also authorize FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

Step 10

Signature: ***We cannot process this application unless it is signed.***

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all the information I have given on this application is true and correct to the best of my knowledge and belief. I understand that the information provided on this application can be used to establish identity for children under age 16. I also understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, health insurance coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

SIGNATURE (REQUIRED)

DATE

Application Instructions & Rights and Responsibilities

This Application May Be Used For: FAMIS or FAMIS Plus (children's Medicaid) for Children and FAMIS MOMS and Medicaid for Pregnant Women

How do I apply?

To get started, simply call our toll-free number **1-866-87FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS at PO Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off, or faxed to the **local Department of Social Services** in the city or county in which you live. You may also apply online at **www.famis.org**.

For a child or a pregnant woman under 21:

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse. Children and pregnant women 18 and over or children emancipated by a court may apply for themselves.

For a pregnant woman over 21:

An adult pregnant woman may apply for herself. The adult husband of a pregnant woman, guardian, or an adult relative if the pregnant woman cannot sign for herself may apply on her behalf.

Step 1 Information on person completing application: Complete this section listing your name, address, city/county of residence and phone number. If we may call you at work, include that phone number. Please tell us the language you speak. Write the name of the language in the space provided, such as: English, Spanish, Vietnamese, Farsi, Korean, Kurdish, Arabic, Urdu, Russian, or any other language.

Step 2 Information on pregnant applicant: Complete this section if you are applying for insurance for someone who is pregnant. Write her name and expected due date. Attach proof of pregnancy from her health care provider to the application.

Step 3 Information on all children and pregnant women under 21: Provide information on all children and pregnant women under 21 who live in the home with you even if they are not applying for **FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid for pregnant women**. Although you can only apply for children under age 19 and pregnant women on this form, we need information on all children under 21 living in your home to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete steps 3 and 4 on the Additional Child Form or on another application and attach it to this one. For each child under age 21 in the home please write the child's name, your child's relationship to you, the child's date of birth and check if the child is male or female. Write the name of the child's parents, stepparent, and spouse living in the home and check their relationship to the child. The Social Security Number (SSN) of the parent, stepparent and spouse is helpful, but not required information. If you are applying for a pregnant woman under age 21, include all of the same information.

Step 4 Information about children under 19 and pregnant women under age 21 applying for insurance:

Write the **name** of each person under 21 at the top of the same column again. Check whether you are **applying for health insurance** for each child or pregnant woman under 21. Answer all the questions in the column, if you are applying for health insurance for this person.

If the child or pregnant woman under age 21 is a **U.S. citizen** check yes. If the child or pregnant woman is a U.S. citizen you will be asked to provide proof of the child's or pregnant woman's citizenship and identity. The easiest way to do this is to include the child's or pregnant woman's Social Security number on the application. If they are **legal immigrants**, provide the child's Alien/INS #, country of birth and the date they entered the U.S. Some legal immigrants may qualify for these health insurance programs. You must provide a copy of the front and back of the child's/pregnant woman's Resident Alien Card or other proof of immigration status with this application. We do not need

information on the immigration status of any adults in your family if they are not applying for health insurance. The INS (now known as USCIS) cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Tell us if the child is currently **attending school**.

Enter the correct code number for the person's **Race**. Codes are listed below the question on the application. Then check yes or no if they are of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus or a pregnant woman's eligibility for Medicaid but may affect eligibility for FAMIS and FAMIS MOMS. Tell us if the person has **health insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless they are pregnant. If the child had **health insurance during the past 4 months**, tell us about the policy. Please list the type of policy, name of insurance company, the policy number of the previous health insurance, and the date that it ended. There are some exceptions to this four month waiting period. Read the **reasons for ending health insurance** listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation about the exceptions to the four month waiting period, or more information on what to include with the application, call **1-866-87FAMIS** or go to **www.famis.org**. **This rule does not apply to FAMIS Plus.**

If you are applying for a pregnant woman, you do not need to provide information about health insurance in the last four months and may skip to the next step.

Step 5 Pregnant Women 21 and over applying for insurance: Write the **full name** of the pregnant woman and check if applying for health insurance. Include her date of birth, her relationship to you (self, spouse, daughter, etc.), and her husband's full name, if he resides in the home.

If the pregnant woman is a **U.S. citizen** check yes. If the pregnant woman is a U.S. citizen you will be asked to provide proof of her citizenship and identity. If the woman is a **legal immigrant**, provide the woman's Alien/INS #, country of birth and the date the woman entered the U.S. Some adults who are legal immigrants may qualify for these health insurance programs. **You must provide a copy of the front and back of the woman's Resident Alien Card or other proof of immigration status with this application.**

A **Social Security Number** is required for all pregnant women applying for health insurance.

Enter the correct code number for the **Race and Ethnicity** of the pregnant woman. Codes are listed below the question on the application. Then check yes or no if the woman is of Hispanic/Latino ethnic origin.

Check if the woman currently has health insurance. If yes, indicate the type of policy, company name and policy identification number.

Step 6 Household Income: In some situations we may need to contact employers to get information about dates of employment and earnings. If you agree to let us do this in order to process this application, check yes.

For each parent, stepparent, pregnant woman, spouse, and child under 21 who lives in the home and receives income, list their **name and the source of income**. If the income is from a job, list the name of the employer. If the income is from another source (such as child support, unemployment compensation, Social Security, etc) write the type or source of the income. Check yes if the person works for a **State government**.

For each type of income listed, check how often it is received (**each week, every two weeks, twice a month, once a month, or yearly**) and write the gross amount of income received each time. **Be sure to write the amount of income before any taxes** or other deductions are taken (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To **provide proof of income from a job**, please attach a copy of all paycheck stubs for the month before you apply showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much (gross pay) the employee was paid for each pay period for that month or you may call 1-866-87FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or provide business records for last month.

You must also provide proof of other types of income received. Examples of **proof of other income** include:

- Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, a signed statement from the absent parent stating how much they pay each month, or a recent court order;
- Social Security (SSA or SSI) or Veteran's benefits — the current year award letter from the Social Security Administration or the VA;
- Unemployment compensation — a print out from the Employment Commission of all payments for the last month, benefits award letter, or a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call **1-866-87FAMIS** or your **local Department of Social Services**.

FAMIS Select: If your child(ren) are approved for FAMIS, you may choose to enroll them in a private or employer sponsored health insurance plan. FAMIS Select can help with the premiums. If you are interested in this program check the box and we will mail you additional information if your child is approved for FAMIS.

Step 7 Childcare or Adult Daycare Expenses: Certain child and adult daycare expenses may help a person qualify for FAMIS Plus or Medicaid for pregnant women. Tell us if you **pay for childcare or adult daycare while** you work. If the answer is yes, write the **name** of each person in daycare and how much you pay for their care and how often you pay it. (For example: \$50 a week or \$200 a month.) You can even report this expense if you are paying a relative to care for the children. The adult daycare expenses must be for an incapacitated spouse or parent of the person applying for health insurance.

Step 8 Medical Bills in the Last 3 Months: If a child qualifies for FAMIS Plus or a pregnant woman qualifies for Medicaid, you may be able to get help with **medical and dental bills for the past 3 months (dental bills are only covered for children)**. If your baby was born in the last three months, FAMIS may also be able to help with the newborn's medical bills. Tell us if a child or pregnant woman applying for insurance had any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or pregnant woman who has medical bills and the **month** in which they received the medical or dental service. You will also have to show proof of family income for that month so we can determine if they would have qualified for FAMIS Plus, Medicaid, or FAMIS at the time the medical care was received. If a child older than three months qualifies for FAMIS or a pregnant woman qualifies for FAMIS MOMS, medical bills will only be covered from the first day of the month in which the signed application was received by FAMIS or at the local Department of Social Services.

DO NOT SEND MEDICAL OR DENTAL BILLS. We cannot pay for bills sent from individuals. If the child or pregnant woman qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the FAMIS Plus child, Medicaid pregnant woman, or FAMIS newborn during that time.

Step 9 Release of Information: If you would like someone else to be able to receive information about this application, **clearly print the person's name** or the name of an **organization, the address, and phone number** in this section. We will not release any information about this application to anyone except you or your spouse living in the home, unless you tell us who you want to be able to receive this information.

Step 10 Signature: Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an application without a signature.

Final checklist:

- ☐ Did you answer all the questions?
- ☐ Did you attach proof of all of last month's income?
- ☐ Did you attach any other necessary documents?
- ☐ Did you sign the application?

Mail to FAMIS at PO Box 1820, Richmond, VA 23218-1820 or fax to FAMIS at 1-888-221-9402 or drop it off at your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES (Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law. I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects eligibility for or receipt of FAMIS, FAMIS Plus (children's Medicaid), FAMIS MOMS, or Medicaid for pregnant women. This includes timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole reason is for lack of funding for FAMIS or FAMIS MOMS.
- Receive services from the Division of Child Support Enforcement (DCSE) and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus. I also understand that if an adult pregnant woman is found eligible for Medicaid, has children, and is separated or divorced from her husband, she may be required to cooperate with DCSE to receive benefits.

I further understand and agree that:

- This application could lead to enrollment in FAMIS or FAMIS Plus for the children or FAMIS MOMS or Medicaid if the person applying is pregnant. I understand that they will be enrolled in the appropriate program based on eligibility rules.
- The State and its contractors may contact other State and Federal agencies to verify any information that affects eligibility for coverage of the children or pregnant woman applied for on this application.
- The State and its contractors may exchange information on this application and medical, health, or other information relating to the child(ren)'s or pregnant woman's coverage with other agencies and contractors to assist with application, enrollment, administration, quality control, and quality assurance. This includes companies offering health insurance to the child(ren) or pregnant women.
- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by the child(ren) or pregnant women.
- Each provider of medical services to the child(ren) or pregnant woman may release any medical or other information necessary for the provider to be paid.

As an enrollee in FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid, I understand:

- I may be responsible for paying a co-payment for some FAMIS medical services received by my child(ren);
- I may be responsible for paying co-payments for non-pregnancy related services for the pregnant woman enrolled in FAMIS MOMS or Medicaid;
- That FAMIS Plus cases for children and Medicaid for pregnant women cases, will be maintained by the local Department of Social Services where the person lives;
- That FAMIS and FAMIS MOMS cases will be maintained by the FAMIS Central Processing Unit (CPU);
- That for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months; and
- I must report any changes in the information provided on this application to the FAMIS at 1-866-873-2647 or my local Department of Social Services agency.

FAMIS and FAMIS Plus must be renewed at least **every 12 months**. It is very important that you report any change in your address to the agency that is managing the case. If we do not have a correct address, we will not be able to notify you when it is time to renew coverage and the child will be cancelled from the program.

Help us keep your children covered — tell us if you move!

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