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

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101(a)(1)); (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

Effective 09/01/02.

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

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

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

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

Original Plan Effective Date: 10/26/98; Implementation Date: 10/26/98

Amendment Effective Dates: Amend. 1: 07/01/01. Amend. 2: 12/01/01. Amend. 3: 7/01/01. Amend. 4: 09/01/02. Amend. 5: 08/01/03. Amend. 6: Withdrawn.

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

Amendment Implementation Dates: Amend. 1: 08/01/01; Amend. 2: 12/01/01; Amend. 3: 12/01/01; Amend. 4: 09/01/02; Amend. 5: 08/01/03; Amend. 6: Withdrawn; Amend. 7: 07/01/06; Amend. 8: 07/01/07, and 02/14/09 implementation date of language regarding the RWJ Grant funding and private funding; Amend. 9: 07/01/09, and Medicaid Expansion Immigrants: 04/01/09; Amend. 10: Translation for Dental Care: 07/01/09; Hospice Concurrent with Treatment: 03/23/10; Early Intervention and prospective payment for FQHCs and RHCs: 10/01/09; Citizenship Documentation: 01/01/10; and Mental Health Parity, No Cost Sharing for Pregnancy-Related Assistance, and Virginia Health Care Fund: 07/01/10. Amend. 11: Administrative Renewal Process: 10/01/10; and Virginia Health Care Fund: 07/01/10. Amend. 12: Discontinue primary care case management: 05/01/12; Expand eligibility under lawfully residing option: 07/01/12; Add coverage for early intervention case management: 10/01/11; and Discontinue Virginia Health Care Fund funding: 07/01/12. Amend. 13: Outreach Procedures 07/01/12; and Performance Plan: 07/01/12. Amend. 14: Delivery system change (Sec. 6 and 12) Behavioral Health Service Administrator: 01/01/14

List continues after table below.

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-13-15 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS13	Eligibility – Targeted Low Income Children Eligibility - Deemed Newborns	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate under section 4.3

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-14-0020 Effective/Implementation Date: January 1, 2015		CS15 CS10	MAGI-Based Income Methodologies Eligibility – Children Who Have Access to Public Employee Coverage	Incorporate within a separate subsection under section 4.3 Supersedes language in regard to dependents of public employees in Section 4.1.9
VA-14-0002 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
VA-14-0025 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within subsection 4.4.1
VA-13-0018 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
VA-13-19 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS23	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Other Eligibility Standards	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR Supersedes the current section 4.1.9 Supersedes the current section 4,1.6, 4.1.7, 4.1.8, 4.1.9

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-13-19-01 Effective/Implementation Date: July 3, 2014		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
VA-21-0021 Effective/Implementation Date: July 1, 2021	MAGI Eligibility & Methods	CS9	Coverage from Conception to Birth	
	Non-Financial Eligibility	CS27	Continuous Eligibility	

SPA #15
Purpose of SPA: Update for SFY 2015
Effective date: 07/01/14
Implementation dates:
Remove waiting period for eligibility: 07/03/14; Allow eligibility for dependents of state employees: 01/01/15

SPA #16
Purpose of SPA: Update for SFY 2016
Effective date: 07/01/15
Implementation date:
Benefits - add Behavioral Therapy services: 07/01/16

SPA #17
Purpose of SPA: Temporary Adjustments to Enrollment and Redetermination for Individuals Living or Working in a Declared Disaster Area at the Time of a Disaster Event.
Effective date and implementation date: 01/01/17

SPA #VA-17-0012
Purpose of SPA: Update for SFY 2017
Effective date: 7/1/16
SUD amendments (not including peer supports) have an implementation date of 04/01/17.
All other items (including peer supports) have an implementation date of 07/01/17.

SPA #VA-18-0012
Purpose of SPA: Compliance with Mental Health Parity and Addiction Equity Act - Effective and implementation date 07/01/17;
Removal of Outpatient Behavioral Health Co-payments – Effective and implementation date: 07/01/19

SPA #VA-19-0010
Purpose of SPA: Update for SFY 2019; Managed Care Final Rule Compliance Assurances; Technical Updates
Effective and implementation date: 07/01/18

SPA #VA-20-0001
Purpose of SPA: CHIP Disaster Relief – Temporary Waiver of Co-payments; Flexibilities Related to Processing and Renewal Requirements for State or Federally Declared Disaster Area
Effective date: 01/01/2020
Implementation date: 03/12/2020

SPA #VA-20-0015 - PENDING
Purpose of SPA: Update for SFY2020; SUPPORT Act Section 5022 Compliance
Proposed effective and implementation date: 10/24/19

SPA #VA-21-0010
Purpose of SPA: Health Services Initiative – Poison Control Centers
Effective and implementation date: 07/01/21

SPA #VA-21-0027
Purpose of SPA: Extend coverage for unborn children whose mothers are uninsured pregnant women up to 200% FPL not otherwise eligible for Medicaid, FAMIS MOMS, or FAMIS, regardless of immigration status requirements; Fund a Health Services Initiative to provide fee-for-service health services up to 60 days postpartum to mothers covered under the unborn child option, called FAMIS Prenatal.
Effective and implementation date: 07/01/21

SPA #VA-22-0010
Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost-sharing in CHIP.
Effective and implementation date: 03/11/21

SPA #VA-22-0011
Purpose of SPA: Enhanced Behavioral Health Services, Hardship Exception Analysis, and Updated Performance Objectives
Proposed effective date: 07/01/21
Proposed implementation date:
For Mental Health Intensive Outpatient Services, Mental Health Partial Hospitalization, Assertive Community Treatment, and updates to Sections 4 and 9 (Hardship Exception Analysis and Strategic Objectives and Performance Goals): 07/01/21
For Multi-systemic Therapy, Functional Family Therapy, and Crisis Intervention and Stabilization services under Section 6.3.5.1- BH: 12/01/21

1.4- TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

On May 4, 2022, a Tribal notification letter was sent to representatives of each of Virginia's seven federally recognized Indian Tribes, as well as to contacts at the Indian Health Program (IHP) office, describing the provisions of CHIP SPA #VA-22-0011 and notifying Tribal and IHP leadership of the 30-day Tribal comment period. Tribal members and IHP contacts were invited to provide input on the SPA, and contact information was provided for submitting any comments to DMAS. There was no formal response by Tribal or IHP officials regarding this CHIP SPA. Virginia does not anticipate that this SPA will have a direct impact on the Tribes or IHP.

As of January 1, 2015, dependents of state employees able to access employer-sponsored dependent health insurance coverage under a Virginia state employee health insurance plan are eligible to enroll in FAMIS, if they otherwise qualify. See approved template effective January 1, 2015: CS10 (Eligibility – Children Who Have Access to Public Employee Coverage). The Commonwealth performed an analysis of public employee coverage costs and confirms that the previously approved Hardship Exception still applies. See attachment, Hardship Exception Analysis 2021-22.

See approved templates effective January 1, 2014: CS13 (Eligibility - Deemed Newborns); CS19 (Non Financial - Social Security Number); and CS23 (Other Eligibility Standards).

Effective July 1, 2021, the Commonwealth provides coverage through the unborn child option for uninsured pregnant women with income up to and including 200% FPL who are not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of immigration status requirements. The household for this coverage will be based on the pregnant woman, and the "unborn child" or children will be counted as if born and living with the mother in determining household size.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

Please see approved template effective January 1, 2014: CS19 (Non-Financial - Social Security Number).

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility

See SPA page CS27 for a description of continuous eligibility for the unborn child population (i.e., FAMIS Prenatal).

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when

toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

As of 4/1/17, intensive outpatient services (ASAM Level 2.1) are covered for substance use disorder treatment. There are no visit limits on medically necessary outpatient substance use disorder treatment services. Medication assisted treatment shall be provided onsite or through referral.

As of 7/1/2021, Mental Health Intensive Outpatient Services (IOP) is covered for mental health and co-occurring mental health and substance use disorder treatment. Mental Health IOP is a non-residential, rehabilitative benefit that includes skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. MH-IOP is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent service components and treatment modalities. Treatment focuses on symptom reduction, crisis and safety planning, promoting stability and independent living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. This service is provided to individuals who do not require the intensive level of care of inpatient, residential, or partial hospitalization service, but require more intensive services than outpatient services and would benefit from the structure and safety available in the MH-IOP setting.

6.3.2.9- BH ☐ Psychosocial rehabilitation
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Therapeutic Day Treatment (TDT) is an intensive outpatient service that is covered for the treatment of mental health conditions. TDT provides evaluation, medication, education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations,

etc.); and individual, group and family psychotherapy.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Partial Hospitalization (ASAM Level 2.5) is covered for substance use treatment. There is no visit limit on medically necessary outpatient substance use treatment services. Medication assisted treatment shall be provided onsite or through referral.

Effective 7/1/2021, Mental Health Partial Hospitalization (MH-PHP) is covered for mental health and co-occurring mental health and substance use disorder treatment. MH-PHP services are short-term, non-residential interventions that are more intensive than outpatient services and that are required to stabilize an individual's psychiatric condition. The service is delivered under physician direction to individuals at risk of psychiatric hospitalization or transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a medical necessity for the service arising from behavioral health disorders that result insignificant functional impairments in major life activities. This service includes assessment, assistance with medication management, individual and group therapy, skills restoration, and care coordination for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital and inpatient substance use disorder treatment services rendered in a psychiatric unit of a general acute care hospital are covered for 365 days per confinement. The following services are not covered: (1) services furnished in a state-operated mental hospital, (2) services furnished in an IMD, and (3) residential services or other 24-hour therapeutically planned structural services with the exception of Residential Crisis Stabilization (effective 12/1/21).

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential

treatment services are provided).

6.3.4.1- BH ☐ Residential Treatment
Provided for: ☐ Mental Health ☐ Substance Use Disorder

With the exception of Residential Crisis Stabilization (see 6.3.5.1), Residential Treatment services are not provided under the CHIP state plan. Children in need of mental health or substance use disorder Residential Treatment services may receive them for stays less than 30 days, through state-only funds. For stays longer than 30 days, the child is assessed for Medicaid eligibility.

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

ASAM defines detoxification as "withdrawal management." Withdrawal management, as defined by ASAM, means services to assist a member's withdrawal from the use of substances. This service may be offered in all ASAM Levels of Care.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

~~**Crisis Intervention services are covered, effective 8-1-2003. Crisis intervention provides immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. A unit equals 15 minutes and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.**~~
Effective 12/1/2021, Mobile Crisis Response shall provide immediate behavioral health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing an acute behavioral health crisis requiring immediate

clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Mobile Crisis Response is provided in a variety of settings including community locations where the individual lives, works, attends school, participates in services and socializes, and includes temporary detention order preadmission screenings.

Effective 12/1/2021, Community Stabilization services provide intensive, short term behavioral health care to non-hospitalized individuals who recently experienced an acute behavioral health crisis. The goal is to address and stabilize the acute behavioral health needs at the earliest possible time to prevent decompensation while a comprehensive array of services is established.

Effective 12/1/2021, Residential Crisis Stabilization services serves as a diversion from inpatient hospitalization by offering psychiatric stabilization in licensed crisis services provider units of fewer than 16 beds. Residential Crisis Stabilization shall not be provided in facilities that meet the definition of an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010. Residential Crisis Stabilization provides short-term, crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress. This service is also available as a 23-hour option.

6.3.6- BH ☐ Continuing care services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.7- BH ☒ Care Coordination
Provided for: ☐ Mental Health ☒ Substance Use Disorder

The substance use disorder outpatient benefit, including Preferred Office-Based Addiction Treatment (OBAT) and Opioid Treatment Programs, requires Substance Use Disorder (SUD) Care Coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring member progress and tracking member outcomes; linking members with community resources to facilitate referrals and respond to social service needs, or peer supports; and tracking and supporting members when they obtain medical, behavioral health, or social services outside the practice. SUD Care Coordination services are considered duplicative of SUD Case Management services (6.3.8-BH), so these benefits are provided only to individuals with a primary SUD diagnosis who are not already

preauthorized and based on a medical necessity determination.

Assertive Community Treatment
Provided for: ☒ Mental Health ☐ Substance Use Disorder

As of 7/1/2021 Assertive Community Treatment provides long term needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community.

Multi-systemic therapy
Provided for: ☒ Mental Health ☒ Substance Use Disorder

As of 12/1/2021 Multi-systemic therapy (MST) is an intensive, evidence-based treatment provided in home and community settings to youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes an emphasis on engagement with the youth's family, caregivers and natural supports and is delivered in the recovery environment. MST is a short-term and rehabilitative intervention that is used as a step-down and diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and community.

Functional Family Therapy
Provided for: ☒ Mental Health ☒ Substance Use Disorder

As of 12/1/2021 Functional Family Therapy (FFT) is a short-term, evidence-based treatment program for at-risk youth who have been referred for behavioral or emotional problems and/or substance use disorders by the juvenile justice, behavioral health, school or child welfare systems.

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)

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

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

~~**Objective One: To reduce the number of uninsured children.**~~
~~**Objective Two: To improve the health care status of children.**~~
~~**Objective Three: To conduct effective outreach to encourage enrollment in health insurance plans.**~~
Objective 1: Reduce the number of uninsured children
Objective 2: Increase enrolled children's access to care
Objective 3: Improve the health care status of enrolled children

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))
~~**See Section 9.3.**~~
Objective 1 performance goal:
Maximize the percentage of Medicaid and CHIP-eligible children in Virginia who are insured

Objective 2 performance goal:
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey "Getting Needed Care" composite metric for the FAMIS program (general child population) will meet or exceed the National Committee for Quality Assurance (NCQA) national average for this metric

Objective 3 performance goal:
Maintain childhood immunization status (Combo 3) percentage among Virginia's Medicaid and CHIP-enrolled children that meets or surpasses the national HEDIS Medicaid 50th percentile

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

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

CHIP Budget Plan

	Federal Fiscal Year Costs – FFY 2021	Federal Fiscal Year Costs – FFY 2022
Enhanced FMAP rate	**69.34%**	**69.34%**
Benefit Costs		
Insurance payments		
Managed care	$376,687,621	$390,952,645
per member/per month rate @ # of eligible	$202.68 @ 154,875 avg elig/mo	$197.57 @ 164,903 avg elig/mo
Fee for Service	$69,355,181	$75,484,543
Cost of Proposed SPA changes	*$20,535*	*$208,974*
Total Benefit Costs	**$446,063,338**	**$466,646,163**
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	**$446,063,338**	**$466,646,163**
Administration Costs		
Personnel	$4,296,425	$3,622,107
General administration	$137,894	$116,252
Contractors/Brokers (e.g., enrollment contractors)	$19,645,330	$16,562,021
Claims Processing	$3,256,968	$2,745,791
Outreach/marketing costs	$535,334	$451,314
Health Services Initiatives	$203,700	$5,950,173
Other		
Total Administration Costs	**$28,075,651**	**$29,447,657**
10% Administrative Cap	$49,562,593	$51,849,574
Federal Share (multiplied by enh-FMAP rate)	$328,767,975	$343,991,455
State Share	$145,371,014	$152,102,365
TOTAL PROGRAM COSTS	**$474,138,989**	**$496,093,820**

Funding:

State funding comes from state General Funds and the Family Access to Medical Insurance Security (FAMIS) Plan Trust Fund.

The 1997 General Assembly established the Virginia Children's Medical Security