CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

AGENDA

June 20, 2024, 1:00-3:30 PM

This meeting will be held virtually via WebEx.

To Join Meeting Remotely: https://covaconf.webex.com/covaconf/j.php?MTID=m996be742aff4248ba8d5ff38dfd92f38
Meeting # (Access Code): 2428 437 7674 | **Meeting Password:** McB3iTdbw33
Dial in (Phone): +1-517-466-2023 (US Toll) | +1 866-692-4530 (US Toll Free)
Remote Conference Captioning Link: https://www.streamtext.net/player?event=HamiltonRelayRCC-0606-VA4143

I. Welcome and Announcements 1:00

II. CHIPAC Business 1:05-1:20
   A. Review/approval of minutes from March 7 meeting
   B. Committee membership and leadership updates and actions

III. SFY 25-26 Biennial Budget Update 1:20-1:35
   Truman Horwitz, Director, DMAS Budget Division

IV. Medicaid Continuous Coverage Unwinding Lookback 1:35-2:05
   Irma Blackwell, Benefit Programs Manager, Virginia Department of Social Services (VDSS)
   Frank Smith, Associate Director Senior, VDSS
   Jessica Annecchini, Senior Policy Advisor - Administration, DMAS Director's Office

V. 2022-23 Maternal and Child Health Focus Study Highlights 2:05-2:35
   Laura Boutwell, Director, DMAS Quality and Population Health Division

VI. CHIPAC and Children's Coverage Overview 2:35-3:05
   Emily Roller, Senior Management Analyst, DMAS Policy Division
   Sara Cariano, Director, DMAS Eligibility Policy and Outreach Division
   Freddy Mejia, CHIPAC Chair

VII. Agenda for September 5, 2024 CHIPAC Meeting 3:05-3:15

VIII. Public Comment 3:15-3:30

Reasonable accommodations will be provided upon request for persons with disabilities or limited English proficiency. Please notify the DMAS Civil Rights Coordinator at (804) 482-7269, or at civilrightscoordinator@dmas.virginia.gov, at least five (5) business days prior to the meeting to make arrangements.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

DRAFT
Meeting Minutes
3/7/24

A quorum of the full Committee attended the meeting in person.
The Webex link was also made available for members of the public to attend virtually.

The following CHIPAC members were present:

• Freddy Mejia (Vice Chair)	The Commonwealth Institute for Fiscal Analysis
• Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
• Michael Muse	Virginia League of Social Services Executives
• Emily Roller	Virginia Health Care Foundation
• Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services
• Kelly Cannon	Virginia Hospital and Healthcare Association
• Heidi Dix	Virginia Association of Health Plans
• Martha Crosby	Virginia Community Healthcare Association
• Sarah Bedard Holland	Virginia Health Catalyst
• Kenda Sutton-El	Birth in Color
• Sarah Stanton	Joint Commission on Health Care
• Irma Blackwell	Virginia Department of Social Services

The following CHIPAC members sent a substitute:

• Jennifer Macdonald (Marcus Allen)	Virginia Department of Health

The following CHIPAC members were present virtually:

• Shelby Gonzales	Center on Budget and Policy Priorities
• Emily Moore	Voices for Virginia's Children (remote participation due to illness)

I. **Welcome** – Freddy Mejia, CHIPAC Chair, called the meeting to order at 1:02 pm. Meija welcomed committee members and members of the public.

Meija introduced DMAS Director Cheryl Roberts for special remarks and Medicaid updates. The word of the year for DMAS is SOAR (Service, Operations, Accountability, Results). Updates included initial budget rate increases for EPSDT. Governor is making maternity a priority along with behavioral health. He held a Maternal Health Roundtable last week to discuss the issue with statewide agencies, community organizations, providers, and other stakeholders. Rural health will also be a focus. For the first time, both VDH and DMAS Directors are Maternal and Child Health advocates and have great synergy. DMAS has posted the Managed Care Re-Procurement Notice of Intent to Award (NOIA) and DMAS is currently in the protest period.

Meija welcomed DMAS Chief Deputy Jeff Lunardi and DMAS Chief Medical Officer Dr. Lisa Stevens.

II. **CHIPAC Business**

A. **Review and approval of minutes from Dec 7 meeting** – Committee members reviewed draft minutes from the December 7 meeting. Kenda Sutton-El made a motion to approve the minutes; Kelly Cannon seconded, and the minutes were approved by majority vote.

B. **Membership items** – The memberships of Michael Muse and Shelby Gonzales are expiring.

A motion to approve Laura Harker to the CHIPAC committee was made by Kelly Canon and Emily Roller seconded. The Committee voted to approve the membership of Laura Harker.

A motion to approve Tiffany Gordon to the CHIPAC committee was made Sarah Beddard Holland and Martha Crosby seconded. The Committee voted to approve the membership of Tiffany Gordon.

Irma Blackwell, Jennifer MacDonald, Heidi Dix, and Dr. Susan Brown have renewed their memberships.

Dr. Susan Brown was re-hired by Elevance to help build a NICU program.

III. **2024 General Assembly Session Update**

Will Frank, Senior Advisor for Legislative Affairs at DMAS gave a General Assembly update, noting that it is technically not done. GA is set to adjourn on Saturday 3/9. He noted that just under 3,000 bills were introduced and DMAS was assigned about 40 lead bills.

This session DMAS had four main categories of bills: new Medicaid benefits, changes to rules for paid family caregivers (Legally Responsible Individuals), eligibility changes for waiver recipients, and pharmacy changes.

The presentation provided a list of new benefit proposals that were introduced this session. Additionally, there was an overview of Legally Responsible Individuals (LRI) including legislation that has been introduced around the provisions of allowing reimbursement for LRI who provide care to their children or spouses. The legislation would allow 40 hours per member if there are two Medicaid members in the household, and the LRI would provide Proof of Services if another provider wasn't found.

Pharmacy legislation included proposed changes to drug costs and purchasing. There was legislation related to a statewide centralized pharmacy, Prescription Drug Affordability Board, and changing payment structures for long-acting injectables.

Waiver and screening bills include seeking CMS approval to disregard SSDI when determining financial eligibility for DD waivers, increasing time a DD waiver slot can be retained from 150 days to up to 365 days, and greater flexibility for nursing facilities and PACE programs to conduct LTSS screenings in certain circumstances.

Other legislation includes a bill to require timeliness of lien settlements when DMAS has a claim for reimbursement against the settlement of a member, and also creating a new provider type (BH technicians and BH technician assistants).

IV. 2024 Budget Update

Truman Horowitz, DMAS Budget Division Director shared information about the 2024 budget in a presentation for the Committee. The presentation covered look-back expenditure data from the last 5 years, and compared this year against both the forecast and expenditures. The presentation included data through January for each of the years posted, showing the year-over-year change from this point last year to today. There is about an 11% increase in FAMIS expenditures year after year between 2023 and 2024. This is because enrollment is up on average by 10% from this time last year in FAMIS. As redeterminations are occurring by individuals, there are many cases and members being moved to Medicaid Expansion, or out of Medicaid, but some children are moving to CHIP/FAMIS. There was also a 30% increase in dental rates in 2023 impacting FAMIS and MCHIP expenditures over the last two years.

The MCHIP MCO category has a decrease in enrollment by 11%, and pharmacy rebates were $1.26m higher in FY23 than 24, but FY24 is more in line with history. Looking at fund type we see decreasing FMAP associated with PHE unwinding, which requires the general fund to pick up more of the burden. That is why the general fund expenditures are higher than they were last year.

The presentation reviewed forecasted to actual expenditures for FY2024, noting the variance is primarily attributable to higher enrollment in FAMIS. There is a large variance in FAMIS FFS because of redeterminations made at household level earlier in the fiscal year. When members enter Medicaid the first time they enter Fee-For-

Service first, which is why there is a one-time spike in FFS that we are seeing. MCHIP is also seeing a slightly higher enrollment than anticipated, driving a very small variance. Overall, spending is trending higher than forecasted, which DMAS is monitoring, and DMAS expects that unwinding-related disenrollments will bring spending down to forecasted levels by end of fiscal year.

Mejia asked about the funding put aside by the Senate and House in case more funding was needed than forecasted in November for contingency; are we seeing similar trends for adults? Lunardi answered that generally yes, it's across all eligibility categories, but looking at breakdown in enrollment children are trending higher.

Mejia asked if unwinding is behind the schedule that was anticipated when the expenditures were forecasted in November. Lunardi responded that it's a combination of multiple factors, including new enrollments vs. disenrollments through unwinding. DMAS Senior Advisor Jessica Annecchini also pointed out that enrollment churn is a factor.

V. Return to Normal Enrollment Update

Jessica Annecchini, DMAS Senior Policy Advisor for Administration, provided an update on the process of unwinding from the federal public health emergency and redetermining Medicaid members' eligibility.

The public-facing DMAS dashboard was refreshed yesterday. Out of those redetermined, 83% remain enrolled and 17% have closed. The 17% figure includes 14% closure and 4% churn. The total amount redetermined is 84.56%. The highest jump in closures occurs between the last week of reporting and the first week of the next month.

Annecchini reviewed closures by eligibility groups. Renewals are completed on an individual basis. One of the trends we have noticed is that the numbers between non-ABD adult group and children were similar; non-ABD adult is the largest group losing coverage.

Annecchini then reviewed procedural vs. non-procedural closures by eligibility grouping through 2/21/24. Non-procedural outweighs procedural, which is good because it means we know why their coverage is ending. With procedural closures, we don't know why they chose not to retain coverage. Some states have started doing disenrollment surveys, which DMAS is learning about during weekly meetings with other states and CMS, and is considering.

Annecchini shared some answers DMAS can provide regarding recently asked questions.

Questions about data-

- Does DMAS have an exact or approximate number of children who transitioned from FAMIS to FAMIS Plus during renewal? There is some data, but not a comprehensive review.
- Is county data showing reason for determination? Some you can see on dashboard.

- Is parental coverage loss is more likely to result in coverage loss for kids? The gap is growing, and Horowitz shared this data in his presentation. DMAS does not have all the data available for every covered group.
- Does DMAS have an estimate on number of renewals that have been submitted but not processed, and separated out by method (online, in person)? Yes, there is data collected about all of this but not necessarily a report pulled together with it from all sources. The best option currently is to submit a FOIA request to see if that is even possible, since some would be DMAS data and some would be DSS data on the eligibility end. There are items on dashboard where there is an asterisk instead of data. If a locality's population is under a certain number, DMAS cannot report the data because of HIPAA regulations. HIPAA trumps FOIA for this data. There may be a different way to aggregate it to go around those limitations.
- How does the unwinding churn rate for children compare to churn rate for children pre-pandemic? DMAS is looking into this with the data team so that we can provide this information at the next meeting. The number of children who transitioned from Medicaid to the marketplace – this would be more of a request for Virginia Insurance Marketplace because they are going to have more recent and thorough data than what DMAS may receive.

Questions about closures-

- *What steps has the state taken to minimize closures for children?* DMAS has waivers allowing flexibilities through the end of this year. DMAS may try to extend some indefinitely as we see which has biggest impact, so that we can make state plan amendments to adopt those. Some we would love to see would be ones around getting updated information without needing outreach if we have an accurate and verifiable source.
- *Does DMAS have data about number of renewal packets that were returned as undeliverable?* VDSS has a team tracking things that come to the home office. A number of returned mail also goes to local offices, so it's hard to track each one. We are trying to share guidance around returned mail and make it more clear in the eligibility manual. There is also a budget item about having a centralized mail room.
- *Children's coverage loss estimates compared to predictions?* We predicted 14% loss and 4% churn. We are on track and will have a churn review out at the next meeting.
- *Will we be doing surveys?* Partly already addressed that we are looking into it, but unfortunately do not have a timeline. If there are any questions that you would like to see on a survey, I can't guarantee the questions will be added, but we would be happy to take those as we are putting that together. Our executive leadership team will review and approve all the questions on the survey. So we are willing to entertain questions related to anything that you might want to know about former members, that will help us to make sure we are giving you not only the responses, but the information you really want to know.

Question from Emily Roller during meeting:

- *In terms of surveys conducted in other states, were there any common top-lines?* Some common answers included ones such as, “I have other coverage.” One thing that states have noted is that they don’t necessarily know if they get employer-sponsored coverage, or where their coverage comes from. Another reason coming up is that they knew they had been ineligible for some time so they were hesitant to respond to unwinding efforts, without realizing they could be transferred to the marketplace. We get uploads of some third-party data within our enrollment system, but not all. It depends on where the coverage comes from and the technology of that company. That is something that other states have noted, that I am hoping we might be able to get a little information on.

Mejia expressed hope that DMAS will be able to do a survey around unwinding and indicated that this could be a critical way to see where families go after their time with Medicaid, and to understand that sooner than the time lag when the census information comes out.

Question from Mejia:

- *For the Churn Report you mentioned there are several different definitions; is the definition for this dashboard 6-months, or is it still TBD?* DMAS wants to expand the timeframe so that individuals could look at three months, six months, or as long as they want to. There is also the difference between just coming back, and “where were you before?” and, “when did you come back?” That is what the dashboard doesn't say right now. For example, you may have redetermined people, but who stayed in full coverage? Who moved to limited? Who aged out that was still able to retain? We have a lot of people in the Children under 19 groups that have aged out, but because of the income limits a majority of them could move to expansion. Knowing they aged-out, they may have their own income now accountable. It is not only a straight number, but, also, what does it mean to churn back in, and where are they going?

Annecchini wrapped up the presentation by indicating that DMAS is looking forward to what we are going to change after unwinding is complete. We are looking at what we want to keep. We know the dashboard has been helpful, so we are looking at making parts of dashboard permanent, as well as other temporary measures taken than were helpful and can be made permanent.

VI. Discussion of agenda items for June 6, 2024, CHIPAC Meeting

Mejia indicated that there may be additional funding in the House and Senate budget, coming out today at 4:00pm, for training for DSS. Additionally, there is funding for improvements to CommonHelp, and the centralized mail location for Medicaid in the House budget.

Mejia announced the June 6, 2024, meeting at DMAS offices. The goal is to have a full conversation about things that people care about, and are interested in learning about when it comes to Children's Health Insurance. By June it will be a different landscape

in terms of unwinding, finalizing the General Assembly and the budget. Mejia asked members if they had suggested agenda items for the June meeting.

Sarah Bedard Holland suggested that there are some opportunities to talk about the integration between some of the pieces of the dental benefit and children's health; one of the new benefits that went into place this year was increasing the age that providers are able to apply fluoride varnish, which positively impacts rate of cavities. This is an inexpensive, easy thing to do for kids that can virtually eradicate cavities. Utilization is 5% so we have massive opportunities to improve.

Kenda Sutton-El wants to discuss exploring the car seat technician program. There is currently no funding for that, hospitals don't do it, and fire departments only have specific days they do it. Some birth centers and doulas are currently doing it as a volunteer service, but are being bombarded with requests and driving all over the state to assist. Mejia indicated that in the past CHIPAC has provided recommendations about things that are important to our CHIPAC members, and things that we would like for the stakeholders to look at and support, if possible. CHIPAC could discuss writing a letter of recommendation around exploring possible avenues for funding this program.

Mejia invited members to submit any additional ideas or requests for the June meeting agenda to the Executive Subcommittee for consideration at their April subcommittee meeting.

VII. Public Comment

Dan Sullivan, member of the public. Sullivan noted that he happens to be a Healthcare Navigator with Enroll Virginia: Senator Deeds summed up the challenge of the Virginia policy operation: "When you have seen one CSB, you have seen one CSB." There are 120 local DSS offices. There may not be one best way to run a local DSS, but there are not 120. That is what we run into all the time. It seems like there is a right way and the Virginia way. The Virginia way is to attempt to delegate responsibility and maintain authority. There are local offices where caseworkers almost never come into the office, or have an office, or work with someone in-person. Richmond City provides paltry support. Virginia likes to say there is no wrong door when submitting Medicaid applications. But if people apply online, the CommonHelp app may sit dormant for weeks and get passed to locals just in time for 45-day deadline for processing. Locals hear they have 45 days for processing, so the bar is low. The 10-day standard for processing Medicaid applications for pregnant members is not able to happen because of lack of staff and untrained staff. There have been challenges to the Medicaid system. Each has offered opportunities for improvement that have been squandered. Responsibility has been delegated. That will never change unless there is leadership from DMAS, and as a starting point, I suggest statewide standardized caseworker and training and testing and job aides. The Medicaid manual is far from a user-friendly. I recommend a requirement for Annual Continuing Education, and development of meaningful key performance indicators for both caseworkers and Departments of Social Services. Thanks. I heard some of this being talked about already here. I would say key is the training. It is just not adequate training, except from the Healthcare Foundation.

Kimberly Dyke-Harsley provided public comment online via chat wish for a Medicaid SPA soon.

VIII. Closing

The meeting was adjourned at 2:21pm

BYLAWS

CHIPAC Bylaws

ARTICLE I – NAME

The name of the committee is the Children's Health Insurance Program Advisory Committee, hereinafter known as the Committee.

ARTICLE II – MISSION OF THE COMMITTEE

The mission of the Committee is to advise the Director of the Department of Medical Assistance Services (DMAS) and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS programs to address the health needs of children.

ARTICLE III – LEGAL BASE AND POWERS AND DUTIES OF THE COMMITTEE

Legal Base: Code of Virginia, § 32.1-351.2:

> *The Department of Medical Assistance Services shall maintain a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee shall consist of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge of and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.*

ARTICLE IV – MEMBERSHIP OF THE COMMITTEE OF THE DEPARTMENT

Section 1. Composition (as stipulated in the Code of Virginia):

The Committee shall consist of no more than 20 members and shall include a member from each of the following appropriate entities:

- The Joint Commission on Health Care,
- The Department of Social Services,
- The Department of Health,
- The Department of Education,
- The Department of Behavioral Health and Developmental Services, and
- The Virginia Health Care Foundation.

Other members may come from various provider associations and children's advocacy groups or may be individuals with significant knowledge of and interest in children's health insurance issues.

Section 2. Terms:

A. Appointments

1. Organizational Members Mandated in the Code of Virginia
   Membership from six organizations is mandated in the Code of Virginia. A representative of a mandated member organization shall serve a term of three years. After three years, that representative may be reappointed at the discretion of the organization, or the organization may appoint another representative to serve on the Committee. If the representative leaves his/her position or can no longer serve on the Committee, the mandated member organization shall appoint another representative to complete his/her term.

2. All Other Committee Members
   The Committee will make recommendations to the Director of DMAS to fill the other fourteen membership positions. The Director of DMAS maintains final authority to invite individuals or groups to serve on the Committee.

   Committee members other than representatives of the mandated member organizations shall serve for a term of two years. Members may serve no more than four consecutive two-year terms. A person appointed to fill a vacancy during a term may serve three additional consecutive terms. If a person cannot complete his/her term, the Committee will recommend appointment of a replacement to the Director of DMAS.

B. Absences

1. Organizational Members Mandated in the Code of Virginia
   If a mandated member organization's representative misses two consecutive meetings of the Committee (without providing a substitute), inquiry shall be made of the organization to ascertain whether they desire to appoint another representative.

2. All Other Committee Members

For all other Committee members who miss two consecutive meetings (without providing a substitute), the Committee may ask the member to resign and recommend a replacement to serve the remainder of the member's term. If a person misses three or more meetings without providing a substitute during his/her term, he/she may be asked to resign and the Committee would then recommend a replacement to serve the remainder of the member's term.

C. Substitutes

1. If a person is unable to attend a meeting, they may send an appropriate substitute in their place. The member is responsible for letting the Chairperson or appropriate DMAS staff know of such substitution, if possible, in a reasonable time frame.

2. The substitute will be understood to have the authority to vote on behalf of the person/organization they are representing on matters before the Committee on the day of the meeting.

Section 3. Authority of Individual Members:

No member of the Committee shall at any time act or purport to act on behalf of or in the name of the Department or the Committee without prior authority from the Committee and the Department.

ARTICLE V – ORGANIZATION

Section 1. Officers of the Committee:

The officers of the Committee shall be a Chairperson and a Vice-Chairperson.

Section 2. Selection of Officers:

A. The Chairperson shall be elected by the Committee from among its membership in odd-numbered years. The Chairperson shall serve for a term of two years. The incumbent shall be eligible to serve an additional consecutive term of two years.

B. The Vice-Chairperson shall be elected by the Committee from among its membership in even-numbered years. She/he shall serve for a two-year term. The Vice-Chairperson shall also be eligible to serve an additional consecutive term of two years.

C. Elections for Chairperson and Vice-Chairperson shall be held in the month of December, with the term of office beginning at the start of the new calendar year. In the case of the Chair being vacant, the Vice-Chairperson shall serve as the temporary Chairperson until the next Committee meeting, at which time a new election shall be held to fulfill the remainder of the original term.

Section 3. Duties of Officers:

A. The Chairperson shall preside at all meetings of the Committee, shall be a member ex officio of all standing subcommittees, and shall perform such other duties as may be imposed by action of the Committee or as set forth in other sections of these policies and procedures.

B. The Vice-Chairperson shall serve in the absence of the Chairperson of the Committee and shall perform such other duties as may be imposed by action of the Committee or as set forth in other sections of these regulations.

Section 3. Executive Subcommittee:

A. The Executive Subcommittee shall consist of the Chairperson, the Vice-Chairperson, Chairpersons of any existing subcommittees, and one or more at-large CHIPAC members appointed at the discretion of the CHIPAC Chair.

B. The Executive Subcommittee shall carry out functions as assigned by the Committee in keeping with the purposes of the Committee. The Executive Subcommittee may assist Department staff in problem solving and decisions.

C. The Executive Subcommittee may be called to meet as needed and at the request of the Chairperson.

Section 4. All other subcommittees:

A. Subcommittees shall be appointed by the Chairperson whenever they are deemed necessary by the Committee. A subcommittee shall be restricted to its assigned task, shall report its recommendations to the Committee, and shall be dissolved when its report is complete and accepted by the Committee unless otherwise provided by the Committee.

B. Subcommittees may invite others with topic expertise who are not serving on the full Committee to participate as advisors or consultants in subcommittees. Only full Committee members or their substitutes will be counted in the quorum and can vote.

C. The chair of any subcommittee must be a member of the full Committee.

ARTICLE VI – MEETINGS OF THE COMMITTEE

Section 1. Regular Committee Meetings:

A. A gathering, whether physical or by electronic means, of three or more Committee members discussing or transacting Committee business is considered a meeting.

B. The Committee shall meet at the call of the Chairperson, but no less than four times a year.

C. Meetings will be held quarterly in March, June, September, and December.

Section 2. Special Meetings:

A. Special meetings may be called by the Chairperson, upon the written request of any three members of the Committee, or by the Director of the Department of Medical Assistance Services.

B. Notice to all Committee members stating the time, place and purpose of the special meeting shall be e-mailed as early as possible, but in no case less than five working days prior to the meeting.

Section 3. Agendas:

A. The agenda for each meeting of the Committee shall be prepared by the Department in consultation with the Chairperson. Copies of the tentative agenda shall be provided in hard copy or electronically to each member at least three working days prior to each regular meeting.

B. Copies of the agenda and materials provided to the Committee members shall be available to the public at the same time they are made available to the Committee members.

Section 4. Meetings to be Public:

A. All regular and special meetings of the Committee shall be open to the public, provided that the Committee may meet in Closed Meeting to consider matters as permitted by the Freedom of Information Act (Va. Code §2.2-3711). Such Closed Meetings shall be held when feasible after all items of business on the agenda have been conducted.

B. Notice of a regular Committee meeting shall be posted publicly at least three working days prior to the meeting.

Section 5. Citizen Participation:

A. Individuals or representatives of groups may speak on agenda topics at a publicly announced time on the agenda during each meeting, provided the Chairperson has approved this request prior to the meeting being called to order. Such individuals or group representatives will be allotted up to ten minutes to present their information to the Committee. At the discretion of the Chairperson or by majority vote of the Committee, such time limit may be extended as appropriate.

B. After the Committee has dispensed with items on the agenda, members of the public will be permitted to speak during a designated public comment period. Each individual/group shall be allotted up to two minutes to make their comment. At the discretion of the Chairperson or by majority vote of the Committee, such time limit may be extended as appropriate.

C. Except in emergencies, the Committee shall not attempt to decide upon any question before examining and evaluating the information any person requests the Committee to consider. The appropriate subcommittee of the Committee shall be given an opportunity to examine and to evaluate all such information and to recommend action before the Committee makes a decision.

Section 6. Quorum:

A majority of the filled Committee member positions shall constitute a quorum for the transaction of business at a full Committee meeting. For a subcommittee meeting, a quorum shall consist of at least half of the subcommittee membership.

Section 7. Voting:

If a quorum exists, an affirmative vote of a majority of the Committee members present is required for the Committee to act. All votes must be recorded and take place in an open meeting.

Section 8. Closed Meetings:

A. A closed meeting may be held within an open meeting under certain conditions. There must be an affirmative vote during an open meeting to hold a closed meeting. The motion to approve the closed meeting must include the following: (1) the subject of the closed meeting, (2) the purpose of the closed meeting, and (3) the reference to the applicable exemption from the open meeting requirements.

B. Following the closed meeting, the Committee must reconvene an open meeting and take a vote to affirm that they restricted their discussion during the closed meeting to only those items specifically mentioned in the closed meeting motion. A decision made during a closed meeting only becomes official once the Committee reconvenes an open meeting and votes on the decision.

Section 9. Remote Participation and All-Virtual Meetings:

A. Remote Participation of Individual Members

Consistent with § 2.2-3708.3 of the Code of Virginia, effective September 1, 2022, an individual member of the Committee may participate remotely instead of attending a meeting in person if, in advance of the public meeting, the member notifies the CHIPAC Chair and DMAS staff of the following:

1. The member has a temporary or permanent disability or other medical condition that prevents the member's physical attendance;
2. A family member's medical condition requires the member to provide care for such family member, thereby preventing the member's physical attendance; or
3. The member's principal residence is more than 60 miles from the meeting location identified in the required notice for the meeting.

The member and the Committee must follow the Procedure for Remote Participation Approval outlined below. When an individual member participates remotely under this process, the Code of Virginia requires that a quorum of the Committee be physically assembled at the primary or central meeting location. Members participating remotely may participate in discussions, make motions, vote, join in closed meetings, and otherwise participate fully as if they were physically present. A separate set of requirements apply to all-virtual meetings, described below under All-Virtual Meetings Policy.

B. Procedure for Remote Participation Approval

1. Request: The member requesting to participate remotely must notify the Chair and DMAS staff on or before the day of the meeting. The member must include the reason for the request for remote participation, citing one of the specific reasons listed above.

2. Approval: Approval shall be granted unless a member's participation would violate this policy or the provisions of § 2.2-3708.3. If a member's participation from a remote location is challenged, then the Committee shall vote whether to allow such participation.

3. Documentation: The following information must be included in the meeting minutes:

a. The fact that the member participated through electronic communication means and the reason as listed in A.1, 2, or 3 above.

b. Notwithstanding the disclosure requirement, the specific medical condition(s) or related clinical information affecting the member requesting remote participation shall not be publicly disclosed.

c. If a member's participation from a remote location is disapproved because such participation would violate this policy, such disapproval shall be recorded in the minutes with specificity.

4. Limitation: There is no limit on the number of times per calendar year an individual member may participate remotely.

5. Consistent Application of Policy: In accordance with § 2.2-3708.3 of the Code of Virginia, this policy shall be applied strictly and uniformly, without exception, to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

The policy for remote participation and procedures for approval shall also apply to meetings of any subcommittee designated by the Committee to perform delegated functions or to advise the Committee.

C. All-Virtual Meetings Policy

Consistent with § 2.2-3708.3 of the Code of Virginia, effective September 1, 2022, the following policy defines the circumstances under which an all-virtual public meeting of the CHIPAC will be allowed. All-virtual meetings may be held at the option of the Chair or by vote of the full Committee. No more than two (2) all-virtual meetings shall be held per calendar year, such meetings must be non-consecutive, and the following requirements must be met.

1. An indication of whether the meeting will be in-person or all-virtual shall be included in the required meeting notice along with a statement notifying the public that the method by which the Committee chooses to meet shall not be changed unless the Committee provides a new meeting notice in accordance with the provisions of § 2.2-3707.

2. Public access to the all-virtual public meeting shall be provided via electronic communication means.

3. The electronic communication means used shall allow the public to hear all members of the Committee participating in the all-virtual meeting and, when audio-visual technology is available, to see the members as well.

4. A phone number or other live contact information shall be provided to alert the Committee if the audio or video transmission of the meeting provided fails. Committee staff shall monitor such designated means of communication during the meeting, and the Committee shall take a recess until public access is restored if the transmission fails for the public.

5. A copy of the proposed agenda and all agenda packets and, unless exempt, all materials furnished to members shall be made available to the public in electronic format at the same time that such materials are provided to members.

6. The public shall be afforded the opportunity to comment through electronic means, including by way of written comments, when public comment is customarily received.

7. No more than two members of the Committee shall be together in any one remote location unless that remote location is open to the public to physically access it.

8. If a closed session is held during an all-virtual public meeting, transmission of the meeting to the public shall resume before the Committee votes to certify the closed meeting as required by subsection D of § 2.2-3712.

9. Minutes shall be taken as required by § 2.2-3707 and shall include the fact that the meeting was held by electronic communication means and the type of electronic communication means by which the meeting was held.

Section 10. Recordings of the Meeting:

A. Typed minutes of each meeting shall be maintained as a public record in the custody of the Department of Medical Assistance Services. These minutes shall be sent to each Committee member and approved at the next full Committee meeting.

B. Draft minutes will be posted on the Department of Medical Assistance Services web site and on a central electronic calendar maintained by the Commonwealth within ten days of the meeting. Approved minutes will be posted within three days of the meeting at which they were approved.

Section 11. Adjourned Meetings:

Meetings may be adjourned as the business of the Committee requires. At the time of adjournment, the time, date, and place of the continuation of the meeting or next meeting shall be determined and announced.

Section 12. Parliamentary Procedure:

Robert's Rules of Order shall prevail except as otherwise provided herein.

ARTICLE VII – REPORTING

The Committee shall, at its discretion, report on the current status of the FAMIS programs and submit recommendations to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

ARTICLE VIII – AMENDMENTS

These bylaws, except those quoted from the enabling statute, may be amended at any meeting of the

Committee by a simple majority.

ADOPTED by the Committee December 8, 2022.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEMBER RESPONSIBILITIES

MISSION OF THE COMMITTEE

The mission of the Children's Health Insurance Program Advisory Committee is to advise the Director of the Department of Medical Assistance Services (DMAS) and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS programs to address the health needs of children.

COMMITTEE MEMBER RESPONSIBILITIES

- Attend all full committee and subcommittee meetings, retreats, and other CHIPAC functions.
- When an absence is unavoidable, it is expected that the member will authorize a knowledgeable substitute to attend and vote on his/her behalf. Please inform the chairperson and DMAS staff in advance of the meeting of the name of the person substituting on the member's behalf.
- Be informed about CHIPAC's mission, bylaws, policies, and projects.
- Review agenda and supporting materials prior to meetings.
- Serve on subcommittees or task forces; offer to take on special assignments and present at meetings.
- Suggest possible nominees to the committee who can make a significant contribution to the work of CHIPAC.
- Keep up to date on developments in CHIP and Medicaid and in the field of maternal and child health.
- Follow conflict-of-interest and Freedom of Information Act (FOIA) policies.

PERSONAL CHARACTERISTICS TO CONSIDER

- Ability to listen, analyze, think clearly and creatively, and collaborate with other committee members.
- Willingness to prepare for and attend all committee meetings, engage in committee discussion, and follow through on projects for the committee.
- Commitment to contributing to and advancing the mission, goals, and work of CHIPAC.

§ 32.1-351.2. Children's Health Insurance Program Advisory Committee; purpose; membership; etc

The Department of Medical Assistance Services shall maintain a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee shall consist of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

The Department of Medical Assistance Services shall enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced price school lunches or for services through the Women, Infants, and Children program (WIC) in order that the eligibility of such children for the Virginia Plan for Title XXI of the Social Security Act may be determined expeditiously.

2000, cc. 824, 848;2002, c. 329;2004, c. 301;2009, cc. 813, 840.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

HISTORY

Children's Health Insurance Program Advisory Committee of Virginia

In 1997, over 100 organizations came together to form the Virginia Coalition for Children's Health to ensure that Virginia would take full advantage of the newly established S-CHIP program, to provide health insurance for the uninsured children of lower income working families. The Coalition worked during the 1998 General Assembly Session to ensure that Virginia adopted a program that provided the best package of benefits for the greatest possible number of uninsured children. Recognizing that legislation alone would not ensure that children enrolled, the Coalition also launched the statewide *SignUpNow* outreach initiative.

At the initiation of the Governor, the 2000 Virginia General Assembly passed legislation that renamed and significantly reshaped the existing CMSIP (Children's Medical Security Insurance Program) into the FAMIS (Family Access to Medical Insurance Security) plan. This legislation required the Department of Medical Assistance Services (DMAS) to maintain an Outreach Oversight Committee composed of representatives from community-based organizations engaged in outreach activities (such as *SignUpNow*), social services eligibility workers, the provider community, health plans, and consumers. The Committee was tasked with recommending strategies to improve outreach activities and to streamline and simplify the application process.

In the 2004 session of the Virginia General Assembly, legislation was passed that eliminated the Outreach Oversight Committee and established the present-day Children's Health Insurance Program Advisory Committee—CHIPAC. The scope of CHIPAC was broadened significantly from that of the Outreach Oversight Committee. CHIPAC is now charged with assessing the policies, operations, and outreach efforts for both FAMIS and FAMIS Plus (children's Medicaid). In addition, the Committee evaluates enrollment, utilization of services, and the health outcomes of children eligible for these programs. CHIPAC has the authority to report on the current status of the programs and make recommendations to the Director of DMAS and the Secretary of Health and Human Resources.

July 15, 2022

The Honorable John Littel
Secretary of Health and Human Resources
1111 East Broad Street, 4th Floor
Richmond, VA 23219
john.littel@governor.virginia.gov

Cheryl Roberts, JD
Acting Director, Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
cheryl.roberts@dmas.virginia.gov

Dear Secretary Littel and Acting Director Roberts:

We, the members of the Children's Health Insurance Program Advisory Committee (CHIPAC), are writing to recommend the below measures for inclusion in the Department of Medical Assistance Services' upcoming budget request package and Governor's 2023 budget. *

CHIPAC is made up of a diverse group of stakeholders committed to promoting maternal and child health in Virginia. Established in 2004 by the General Assembly, CHIPAC's charge includes assessing the policies, operations, and outreach efforts for both FAMIS and FAMIS Plus and evaluating enrollment, utilization of services, and the health outcomes of children eligible for such programs (Code of Virginia §32.1-351.2). Our mission states that we shall advise "on ways to optimize the efficiency and effectiveness of DMAS' programs that address the health needs of children."

The four recommendations below align with this mission by streamlining the administration of the FAMIS Plus and FAMIS programs, reducing the administrative complexities families encounter when applying for and renewing coverage, and expanding coverage to children who currently have no access to affordable and comprehensive health coverage, including a robust mental health benefit package. These steps are even more crucial as Virginia and other states prepare to return to normal Medicaid operations at the conclusion of the federal Public Health Emergency (*PHE*). We encourage the Commonwealth to adopt these recommendations.

** CHIPAC members who are staff of the Joint Commission on Health Care, the Virginia Health Care Foundation, and state agencies provided technical expertise on the options below. They did not support or oppose any specific recommendation.*

12 Month Continuous Eligibility for Children in FAMIS and FAMIS Plus

Continuous eligibility will benefit the state by reducing the administrative complexity and cost associated with the disenrollment and reenrollment process.[i] Many children lose coverage due to a modest increase in household income or for administrative reasons. Often, they are still eligible or regain eligibility within a few months and must reapply. As we anticipate the end of the federal PHE and associated Medicaid Maintenance of Effort requirement, Virginia should take all available steps to ease administrative burden and ensure a smooth transition back to normal operations.

Providing 12 months of continuous eligibility to FAMIS Plus and FAMIS enrolled children also results in better health outcomes due to uninterrupted access to preventative services, primary care, and

treatment. It fosters the development of a patient-physician relationship, allowing the child's health and development to be tracked and medical needs to be identified and addressed earlier.[ii]

Twenty-four states have adopted this option for all Medicaid- and CHIP-enrolled children. An additional nine states have continuous eligibility for a subset of these children.[iii] Virginia currently provides continuous eligibility to pregnant women through 12 months postpartum and to children born to Medicaid/CHIP enrolled individuals until age 1.

Create a State-funded Program to Cover Income-Eligible Children Regardless of Immigration Status

Virginia has adopted the federal option to cover legally residing children in FAMIS and FAMIS Plus. However, per federal rules, children without legally residing status are only eligible for Emergency Medicaid, which covers emergency services only. These children are also prohibited from purchasing private insurance through the Marketplace, even at full cost, and many do not have access to employer plans.[iv] It is estimated that 48% of FAMIS and FAMIS Plus income eligible children in this category are uninsured.[v] As a result, many struggle to access preventative and ongoing health care, leading to long-term negative health outcomes. Conversely, the provision of medical assistance has been shown to decrease infant mortality, improve childhood health, decrease Emergency Department visits and hospitalizations as adults, increase economic security, and improve school attendance and educational achievement.[vi]

Further, only 62% of FAMIS and FAMIS Plus eligible legally residing immigrant children are enrolled, versus 90% of eligible U.S. born children. [vii] Recent analysis of the uninsured by the Virginia Health Care Foundation shows that the uninsured rate among non-citizens ages 0-64 is 26.6%, compared to 5% for citizens. Creating a program for children regardless of immigration status would provide coverage to children with no current option and create a welcome mat for those currently eligible and not enrolled.

The program would also support Virginia's health care safety net, which is currently providing care to ineligible and eligible but unenrolled children through Federally Qualified Health Centers, emergency departments and school divisions. General relief and CSA funds are also used to provide mandatory health care to children without legal status in foster care. A state-funded program covering these children would provide comprehensive coverage and offset the costs currently being absorbed by these other entities.

Merge FAMIS Program with Children's Medicaid, retaining higher CHIP federal match

Virginia currently operates a children's Medicaid program (covering children 0-5 years with income < 143% FPL and 6-21 years with income < 100% FPL); a CHIP-funded Medicaid program ("MCHIP," covering children 6-18 years with income >100% and <143% FPL); and a separate CHIP program called FAMIS ("SCHIP," covering children 0-18 years with income >143% and <200% FPL).

Moving the FAMIS children into MCHIP would reduce the burden of administering separate programs and alleviate compliance challenges associated with administering SCHIP, such as tracking out-of-pocket limits and ensuring compliance with federal mental health parity law. It would also: ensure that all children enrolled in Virginia's medical assistance programs have equal access to benefits, such as non-emergency medical transportation, Early Periodic Screening Diagnosis and Treatment, and complex care services; transition children in FAMIS Select to the more robust premium assistance program available for Medicaid children.; and allow Virginia to collect significant federal drug rebates that are only available under Medicaid.[viii]

Increase Income Limit for FAMIS and FAMIS MOMS (Virginia's CHIP Programs)

Virginia's current income limit for FAMIS and FAMIS MOMS is 205% FPL. Only 2 states, Idaho and North Dakota, have lower limits for children's CHIP coverage. The national median upper income limit for children's CHIP coverage is 255% FPL, 266% FPL in Medicaid Expansion states. More than a third of states, including neighboring states Maryland and West Virginia, cover children at or above 300% FPL.[ix] The Affordable Care Act's Health Insurance Marketplaces offer less robust cost-sharing subsidies for those with incomes ≥200% FPL, resulting in significantly higher deductibles and out-of-pocket maximums. Increasing the FAMIS and FAMIS MOMS income eligibility limits would cover more Virginians and smooth the transition between these coverage types and Marketplace coverage.

Virginia has made great progress toward improving child health since the inception of CHIPAC, much thanks to the efforts of DMAS and the Virginia Department of Social Services. We thank you for your consideration of these items to continue this great work and look forward to our continued partnership with the Administration.

Please don't hesitate to reach out to discuss these recommendations, or any other ways in which CHIPAC can support your work, by contacting Sara Cariano, CHIPAC Chairperson (sara@vplc.org or 804-332-1432).

Sincerely,

Children's Health Insurance Program Advisory Committee (CHIPAC) Members:

Center on Budget and Policy Priorities
Families Forward Virginia
Medical Society of Virginia
The Commonwealth Institute for Fiscal Analysis
VCU Health
Virginia Association of Health Plans
Virginia Chapter of the American Academy of Pediatrics
Virginia Community Healthcare Association
Virginia Hospital and Healthcare Association
Virginia League of Social Services Executives
Virginia Poverty Law Center
Voices for Virginia's Children

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[i] "DMAS Decision Package: Ensure Continuous Eligibility for Children in Medicaid and FAMIS." *Virginia Department of Medical Assistance Services,* Oct. 2021, http://publicreports.dpb.virginia.gov/rdPage.aspx?rdReport=OB_DocView&Param1=72839288

[ii] "Continuous Eligibility for Medicaid and Chip Coverage." *Centers for Medicare and Medicaid Services*, Sep. 2021 https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html

[iii] Brooks, Trisha and Gardner, Allexa. "Continuous Coverage in Medicaid and CHIP." Jul. 2021, https://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf

[iv] Artiga, Samantha and Diaz, Maria. "Health Coverage and Care of Undocumented Immigrants." Jul. 2019, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/

[v] Mejia, Freddy. "Covering All Kids in 2022: 13,000 Children Shouldn't Have to Wait Another Year." Jan. 2022, https://thecommonwealthinstitute.org/the-half-sheet/covering-all-kids-in-2022-13000-children-shouldnt-have-to-wait-another-year/

[vi] Cohodes, Sarah, et al. "The Effect of Child Health Insurance Access on Schooling: Evidence form Public Insurance Expansions." May 2014. https://www.nber.org/system/files/working_papers/w20178/w20178.pdf

[vii] LaCarte, Valerie. "Immigrant Children's Medicaid and CHIP Access and Participation: A Data Profile." Jun. 2022, https://www.migrationpolicy.org/sites/default/files/publications/mpi_chip-immigrants-brief_final.pdf

[viii] "DMAS Decision Package: Migrate Virginia's Children's Program into MCHIP." *Virginia Department of Medical Assistance Services,* Oct. 2021, http://publicreports.dpb.virginia.gov/rdPage.aspx?rdReport=OB_DocView&Param1=72840520

[ix] Mejia, Freddy. "Covering All Kids in 2022: 13,000 Children Shouldn't Have to Wait Another Year." Jan. 2022, https://thecommonwealthinstitute.org/the-half-sheet/covering-all-kids-in-2022-13000-children-shouldnt-have-to-wait-another-year/

Past CHIPAC Recommendations

Date	Recommendation	Response/Outcome
6/7/18	CHIPAC recommends DMAS prepare for anticipated changes to federal immigration policy that would affect children's access to Medicaid and CHIP; requests that Sec. of Health and Human Resources and DMAS Director submit comments during public comment period on DHS Proposed Rule on Public Charge.	CHIPAC letter sent to Secretary and DMAS Director 12/6/18. Secretary Carey responded 12/7 stating that the Governor shares CHIPAC's concerns and has submitted comment to DHS.
9/2017	CHIPAC requests that Secretary of Health and Human Resources and DMAS Director encourage the Governor to urge Virginia's Congressional Delegation to renew CHIP funding before its expiration.	Governor letter to Congressional Delegation: 10/25/17 DMAS Director response: 11/21/17
6/6/16	CHIPAC recommends more training for DSS on ex parte renewals, streamlining the renewal application, and systems changes in place to prevent 1-year-olds being cancelled.	DMAS Director response: 6/27/16
11/17/14	CHIP Reauthorization: CHIPAC supports the reauthorization of the Children's Health Insurance Program.	Legislation reauthorizing CHIP [PUB.L. 114-10] signed by President Obama in April 2015
6/6/13	FAMIS MOMS**:** DMAS should postpone termination of the FAMIS MOMS program to allow for a transition period to better protect pregnant women and infants.	"Based on the budget language and concerns expressed during the legislative process, DMAS determined that it does not have the authority to postpone implementation as this would not meet the intent 'to remove disincentives for subsidized private healthcare coverage through publicly offered alternatives.'"
8/18/11	Immigrant Eligibility: DMAS should support/adopt the federal options to cover legally residing children and pregnant women during the first five years they are in the United States.	Medicaid, FAMIS, and FAMIS MOMS cover all otherwise-eligible legally residing pregnant women and children during the first five years they are in the United States, effective July 1, 2012.

8/11/11	Public Benefits: DMAS should ensure that all children enrolled in other public benefits are enrolled in FAMIS/Medicaid.	"During the past year, the Robert Wood Johnson Foundation 'Maximizing Enrollment' grant project at DMAS, in partnership with DSS, has worked to connect children enrolled in other programs such as SNAP to FAMIS Plus coverage, and we intend to continue this important work. Through increased awareness among eligibility workers in local departments of social services, we have seen a decrease in the number of children who are eligible but unenrolled in health coverage… The information gap between public programs was a motivating factor behind Secretary Hazel's vision for the new customer portal, CommonHelp, for programs under the Health and Human Resources Secretariat. With improved customer access and increased coordination between programs, citizens are able to apply once and be informed about a range of public programs for which they qualify."
8/11/11	Income Eligibility: DMAS should increase the FAMIS income eligibility limit to 225% FPL.	"DMAS continues to work with Secretary Hazel to identify policy actions that best support the health of children in low-income families given the economic challenges facing the Commonwealth. The General Assembly did not increase the FAMIS income eligibility limit this year."
4/10/09	DMAS should reconsider developing an action plan for expanding provider capacity in response to enrollment increases caused by the economic downturn.	"DMAS has implemented the Affordable Care Act's requirement that Medicaid reimburse family medicine, general internal medicine, pediatric medicine, and related subspecialists at Medicare levels in CY 2013 and CY 2014. The increase in payment for primary care is paid entirely by the federal government with no matching payments required of states."

		"DMAS continues to move forward with plans to develop new coordinated care models and expands existing managed care delivery models, which would necessarily include network development and may serve to promote other reforms to encourage provider participation. The entire state is now served by Medicaid/FAMIS MCOs."
4/10/09	Prenatal Care: DMAS should consider evaluating the reliability and validity of its prenatal care utilization data with the aim of producing quality data which can be used by DMAS to accurately evaluate utilization rates.	"MCH staff worked in collaboration with HCS staff to ensure that solid methodologies were utilized by the EQRO for the Prenatal Care Study. DMAS contracted External Quality Review Organization (EQRO) utilized data from the Virginia Birth Registry for the analysis of the rates published in the 2013 *Improving Birth Outcomes Through Adequate Prenatal Care* study."
4/10/09	Immunization: DMAS should consider evaluation of the possible causes of below-average immunization rates, including but not limited to possible problems in the coding and billing practices used by providers.	"Due to our intense focus on improving immunization rates, we have seen significant improvements in our rates. DMAS continues to partner with our contracted MCOs to further improve rates and with VDH to improve the Virginia Immunization Registry. Monitoring Immunization rates is a key quality measure evaluated by NCQA for all Virginia MCOs to maintain accreditation. DMAS has selected immunization rates at 2 years of age as a quality measure on which to evaluate MCOs under a new pay for performance plan."
4/10/09	Goal Setting: DMAS should consider formally adopting a goal to attain and surpass national norms for well-child visit rates, access-to-PCP rates, immunization rates, and prenatal care utilization rates.	"DMAS sets goals for measures reported in the agency's strategic plan and in Virginia's CHIP Annual Report to CMS and reports against these goals. DMAS' 2011-2015 Medicaid/CHIP Managed Care Quality Strategy includes goals to reach the 75th percentile in NCQA's Quality Compass by 2016 for well-child visits, immunization rates, and timeliness of prenatal care."

4/10/09	CHIPRA: CHIPAC requests the opportunity to discuss opportunities, help set priorities and be kept informed about DMAS' specific actions to implement Children's Health Insurance Program Reauthorization Act (CHIPRA) provisions.	"DMAS staff provides updates and information on proposed implementations related to CHIPRA at the CHIPAC quarterly meetings. As a result of implementing two additional enrollment and retention strategies and increasing Medicaid enrollment of children, CMS awarded DMAS a CHIPRA Performance Bonus of $19,973,322 for FFY 2012."

CHIPAC Quarterly Enrollment Dashboard

Table 1 - CHIP and Medicaid Child Enrollment

PROGRAM	INCOME	# Enrolled as of 05-01-24	# Enrolled as of 06-01-24	Net Increase This Month	% of Total Child Enrollment
FAMIS (separate CHIP program) *Children 0-18 years*	> 143% to 200% FPL	99,647	98,006	-1,641	13%
CHIP-Medicaid Expansion *Children 6-18 years*	> 100% to 143% FPL	90,201	92,496	2,295	12%
Total CHIP (Title XXI) Children		**189,848**	**190,502**	**654**	**25%**
FAMIS Plus* *Children 0-5 years* *Children 6-18 years*	≤ 143% FPL ≤ 100% FPL	570,939	569,519	-1,420	73%
Adoption Assistance & Foster Care *Children < 21 years*	FPL N/A	14,782	14,681	-101	2%
Other Medicaid Children** *Children < 21 years*	FPL N/A	29	27	-2	0%
Total MEDICAID (Title XIX) Children		**585,750**	**584,227**	**-1,523**	**75%**
TOTAL CHILDREN		**775,598**	**774,729**	**-869**	**100%**

* *Children under 19 enrolled in a Medicaid Families & Children Aid Category. This count does not include the CHIP Medicaid Expansion group.*

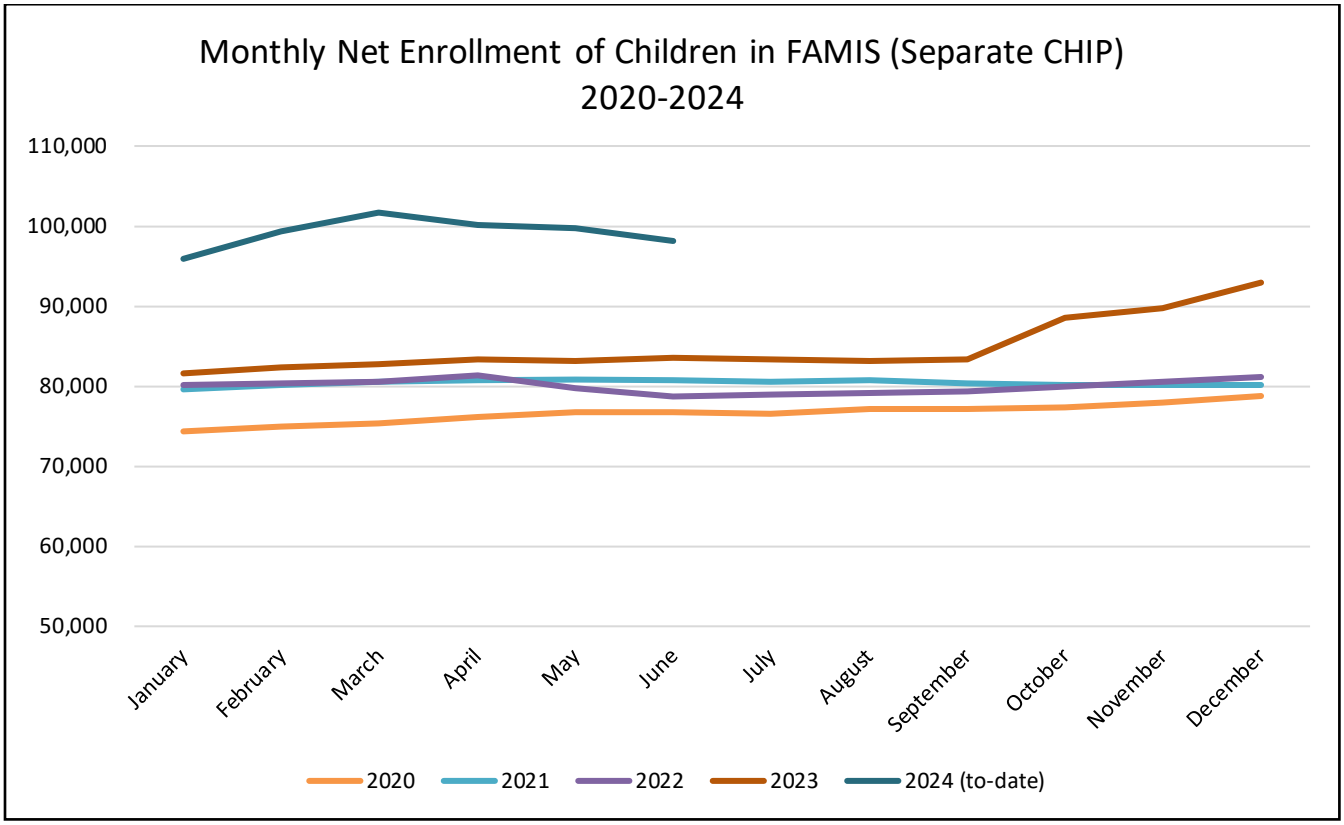
** *This includes children under 21 enrolled in Medicaid under the care of the Juvenile Justice Department or in an intermediate care facility (ICF-MR).*

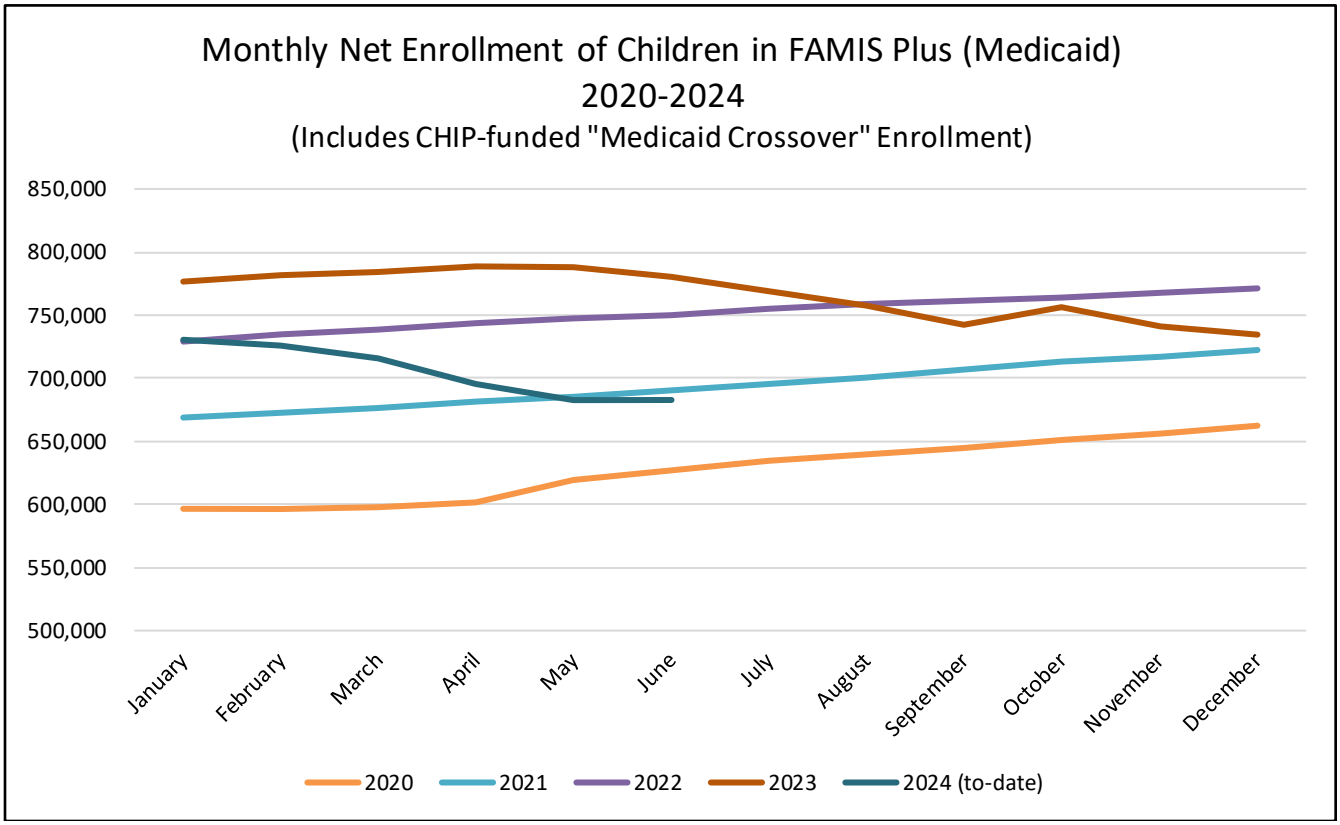
Table 2 - CHIP Premium Assistance Enrollment

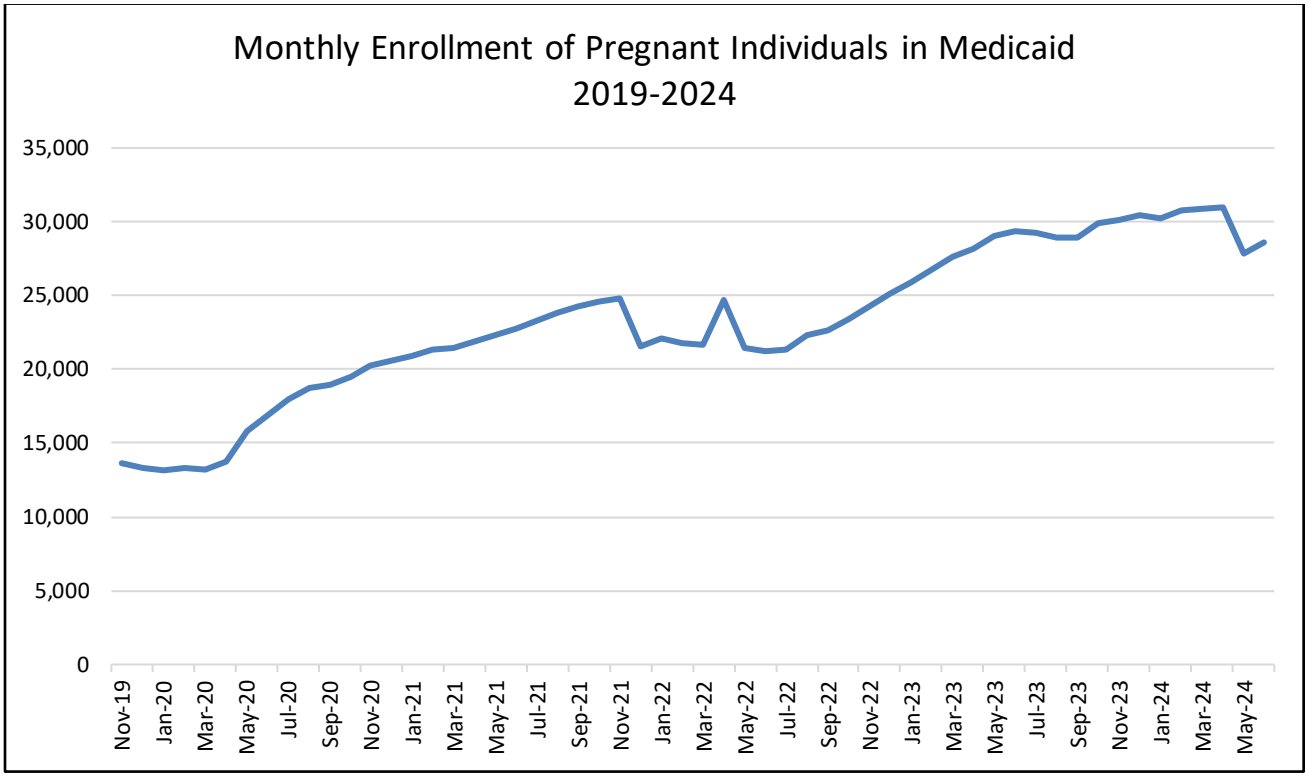
PROGRAM	INCOME	# Enrolled as of 05-01-24	# Enrolled as of 06-01-24	Net Increase This Month
FAMIS *Select* *FAMIS Children < 19 years*	> 143% to 200% FPL	32	30	-2

Table 3 - Pregnant & Postpartum Members Enrollment

PROGRAM	INCOME	# Enrolled as of 05-01-24	# Enrolled as of 06-01-24	Net Increase This Month	% of Total Pg Enrollment
FAMIS MOMS Pregnant & Postpartum	> 143% to 200% FPL	3,667	3,843	176	10%
FAMIS Prenatal Coverage	≤ 200% FPL	4,315	4,394	79	12%
Medicaid Pregnant & Postpartum	≤ 143% FPL	27,896	28,652	756	78%
TOTAL Pregnant & Postpartum Members		**35,878**	**36,889**	**1,011**	**100%**


Monthly Net Enrollment of Children in FAMIS (Separate CHIP)
2020-2024
110,000
100,000
90,000
80,000
70,000
60,000
50,000
January
February
March
April
May
June
July
August
September
October
November
December
2020
2021
2022
2023
2024 (to-date)


Monthly Net Enrollment of Children in FAMIS Plus (Medicaid)
2020-2024
(Includes CHIP-funded "Medicaid Crossover" Enrollment)
850,000
800,000
750,000
700,000
650,000
600,000
550,000
500,000
January
February
March
April
May
June
July
August
September
October
November
December
2020
2021
2022
2023
2024 (to-date)


Monthly Enrollment of Pregnant Individuals in Medicaid
2019-2024
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22
May-22
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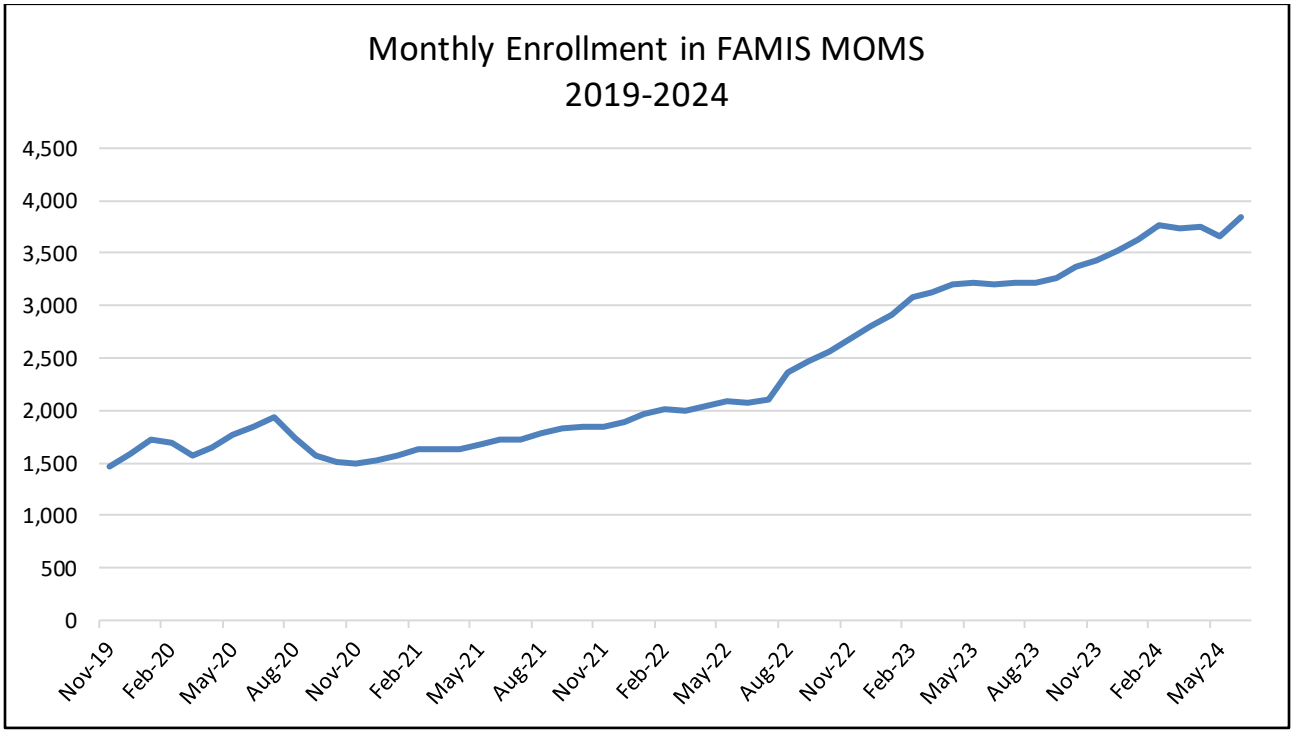
Jan-24
Mar-24
May-24


Monthly Enrollment in FAMIS MOMS
2019-2024
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Nov-19
Feb-20
May-20
Aug-20
Nov-20
Feb-21
May-21
Aug-21
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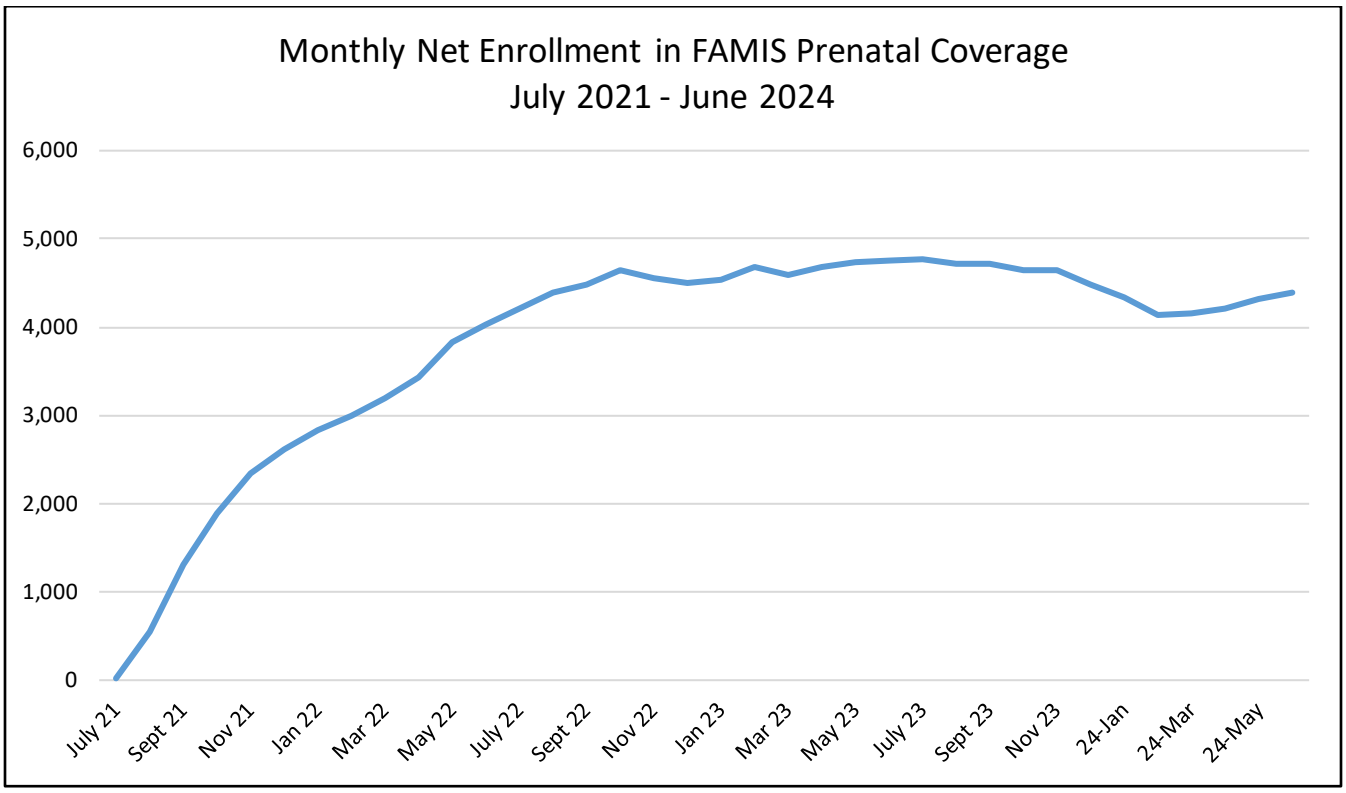
Feb-23
May-23
Aug-23
Nov-23
Feb-24
May-24


Monthly Net Enrollment in FAMIS Prenatal Coverage
July 2021 - June 2024
6,000
5,000
4,000
3,000
2,000
1,000
0
July 21
Sept 21
Nov 21
Jan 22
Mar 22
May 22
July 22
Sept 22
Nov 22
Jan 23
Mar 23
May 23
July 23
Sept 23
Nov 23
24-Jan
24-Mar
24-May

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

CHIPAC Candidate Biographical Sketch – Victoria Richardson

Victoria Richardson is an attorney specializing in healthcare law and public benefits at the Virginia Poverty Law Center (VPLC). She is a graduate of the University of Maryland Francis King Carey School of Law with a specialty certificate in healthcare law and policy. Prior to working with VPLC, she worked with the Social Security Administration on adult and children's disability cases at hearing offices in Baltimore, Maryland and Charlottesville, Virginia.

Notably, her connection to healthcare law and policy became personal in November 2020 when her son George was born prematurely with congenital heart disease. After multiple surgeries, he required a tracheostomy to help him breath and a feeding tube for nourishment and growth. She experienced the shortfalls of the American healthcare system firsthand as his caregiver and wants to use her lived experience and expertise to improve access to care for all Virginians.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

CHIPAC Candidate Questionnaire

The mission of Virginia's CHIP Advisory Committee (CHIPAC) is to advise the Director of DMAS and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS' programs that address the health needs of children (FAMIS/CHIP and FAMIS Plus/Medicaid).

1. Please describe the experience and qualifications you will bring to the CHIPAC, including those specifically related to children's health/health insurance. Please also include examples of your commitment to supporting and improving public medical assistance programs.

   I have a specialty certificate in Health Law and Policy from the University of Maryland Francis King Carey School of Law. While in law school I participated in multiple internships regarding healthcare access. Specifically, I worked with Catholic Charities during the 2012 Maryland legislative session advocating to maintain funding for safety net programs. I participated in service-learning trips during my winter breaks in 2012 and 2013 working with the Mississippi Center for Justice to develop "know your rights" pamphlets on privacy rights, housing rights, and employment rights for individuals living with HIV/AIDS. I created and presented a training regarding mental health parity laws for Maryland Medicaid Matters while a student attorney with the Drug Policy and Public Health Strategies Clinic. After law school I worked with the Social Security Administration Department of Hearing Operations writing hearing decisions and doing legal research and analysis for Administrative Law Judges regarding disability claims for adults and children; I worked there for ten years. I currently work at the Virginia Poverty Law Center (VPLC) on healthcare and public benefits issues. I started working with VPLC in December 2023. I have assisted with VPLC's legislative priorities in the 2024 session especially regarding "Cover All Kids" and a bill to expand access to hearing aids and hearing screenings for adult Medicaid recipients.

2. What motivates you to participate in CHIPAC? What are your goals and priorities as a member of the Committee?

I am particularly interested in increasing access to healthcare for children because early intervention is crucial for bridging the gaps between children of different socioeconomic backgrounds and making sure they have equal opportunities in life. On a personal note, I have three children and my second son was born prematurely with serious congenital heart defects. Because of complications from his first open heart surgery, he required breathing support via a tracheostomy, and he needed a feeding tube for nourishment. Having access to Medicaid (in addition to our private insurance) was crucial in getting him access to private duty nursing, durable medical equipment, specialty care, speech therapy, and physical therapy. Our family struggled every day to make sure he had the care and resources he needed but I was always aware that we benefitted from privileges that other families did not have. This experience opened my eyes to the strengths and weaknesses in the healthcare system. As a member of the Committee, I would be particularly interested in ensuring continuity of care for children, because gaps in coverage lead to prolonged setbacks in progress. I am also concerned about increasing trust and communication between families, medical providers, and medical assistance programs and increasing focus on the social determinants of health.

CHIPAC

Children's Health Insurance Program Advisory Committee of Virginia

Quarterly Meeting

June 20, 2024

CardinalCare
Virginia's Medicaid Program

Real-time Remote Captioning

Remote conference captioning is being provided for this event.

- The link to view live captions for this event will be pasted in the chat.
- You can click on the link to open up a separate window with the live captioning.

Meeting Notice – Public Access

This meeting is being held virtually.

- There will be a public comment period at the close of the meeting (~3:15pm).
- This meeting is being recorded.

Roll Call

Please indicate your presence either by coming off mute, or via the chat.

Organization	Name
Joint Commission on Health Care*	Sarah Stanton
Virginia Department of Health*	Jennifer Macdonald
Virginia Department of Education*	Alexandra Javna
Virginia Department of Behavioral Health and Developmental Services*	Hanna Schweitzer
Virginia Health Care Foundation*	Kim Bemberis (sub)
Virginia Department of Social Services*	Irma Blackwell
Virginia Hospital and Healthcare Association	Emily Lafon (sub)
Center on Budget and Policy Priorities	Laura Harker

** Member organizations required per Code of Virginia*

Roll Call

Please indicate your presence either by coming off mute, or via the chat.

Organization	Name
Virginia League of Social Services Executives	Robin Zuk (sub)
The Commonwealth Institute for Fiscal Analysis	Freddy Mejia, *Chair*
Voices for Virginia's Children	Emily Moore
Virginia Association of Health Plans	Heidi Dix
Virginia Chapter of the American Academy of Pediatrics	Dr. Susan Brown
Virginia Community Healthcare Association	Martha Crosby
Birth in Color	Kenda Sutton-EL
Virginia Health Catalyst	Sarah Bedard Holland

CardinalCare
Virginia's Medicaid Program

Budget Update

Truman Horwitz, Budget Division Director

DMAS

Overview

- Expenditure comparison
- Tracking to the forecast
- Signed Budget Update

Expenditure Comparison
In Millions

Five Year Look-back (Through April)

	Actuals through April - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	157.1	161.2	179.0	209.9	242.1	32	15.3%
FAMIS FFS	10.7	8.2	20.4	21.5	22.8	1	6.0%
FAMIS Dental	18.6	18.0	17.8	24.4	30.0	6	23.1%
FAMIS Total	**186.4**	**187.4**	**217.2**	**255.8**	**294.9**	**39**	**15.3%**

	Actuals through April - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	130.2	143.0	163.5	187.6	179.0	(9)	-4.6%
MCHIP FFS	6.6	6.5	5.9	3.8	6.0	2	60.2%
MCHIP Dental	19.4	19.9	20.3	30.1	32.5	2	8.0%
MCHIP Total	**156.2**	**169.4**	**189.7**	**221.5**	**217.6**	**(4)**	**-1.8%**
Title XXI Total	**342.6**	**356.8**	**406.9**	**477.3**	**512.5**	**35.2**	**7.4%**
Fund Type							
General	57.4	86.2	113.0	138.6	157.7	19	13.8%
FAMIS Trust Fund	12.6	12.7	10.3	7.0	12.7	5.6	80.0%
Federal	272.73	257.95	283.59	331.69	342.10	10.41	3.1%
Title XXI Total	**342.6**	**356.8**	**406.9**	**477.3**	**512.5**	**35.2**	**7.4%**

Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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FAMIS MCO enrollment is up about 12% from this time last year. Additionally, prenatal programs saw growth, resulting in more Kick payments.

Federal	272.73	257.95	283.59	331.69	342.10	10.41	3.1%
Title XXI Total	**342.6**	**356.8**	**406.9**	**477.3**	**512.5**	**35.2**	**7.4%**

Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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FAMIS Total	**186.4**	**187.4**	**217.2**	**255.8**	**294.9**	**39**	**15.3%**

Dental rates **increased** by 30% in FY23.

	Actuals through April - MCHIP					FY23 vs. FY24	
					FY 2024	**Change**	**Change**
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	179.0	(9)	-4.6%
MCHIP FFS	6.6	6.5	5.9	3.8	6.0	2	60.2%
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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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FAMI						1	6.0%
FAMI						6	23.1%
FAMIS Total	**186.4**	**187.4**	**217.2**	**255.8**	**294.9**	**39**	**15.3%**

Enrollment **decreased** by 5.4% in MCHIP Managed Care.

	Actuals through April - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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Expenditures	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	Change	% Change
FAMIS MCO	157.1	161.2	179.0	209.9	242.1	32	15.3%
FAMI						1	6.0%
FAMI						6	23.1%
FAMI						**39**	**15.3%**

Pharmacy rebates were $4.5m **higher** in FY23 than FY24, but FY24 seems more in line with history.

	Actuals through April - MCHIP					FY23 vs. FY24	
Expenditures	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	Change	Change
MCHIP MCO	130.2	143.0	163.5	187.6	179.0	(9)	-4.6%
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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

	Actuals through April - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	157.1	161.2	179.0	209.9	242.1	32	15.3%
FAMI						1	6.0%
FAMI						6	23.1%
FAMIS Total	**186.4**	**187.4**	**217.2**	**255.8**	**294.9**	**39**	**15.3%**

Reflects the decreasing enhanced FMAP.

	Actuals through April - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	130.2	143.0	163.5	187.6	179.0	(9)	-4.6%
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Title XXI Total	**342.6**	**356.8**	**406.9**	**477.3**	**512.5**	**35.2**	**7.4%**

Expenditure Comparison
In Millions

Five Year Look-back (Through April)

	Actuals through April - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	157.1	161.2	179.0	209.9	242.1	32	15.3%
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FAMIS Dental	18.6	18.0	17.8	24.4	30.0	6	23.1%
FAMIS Total	**186.4**	**187.4**	**217.2**	**255.8**	**294.9**	**39**	**15.3%**

Reflects the timing of a reclass of GF more in line with history.

						FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	130.2	143.0	163.5	187.6	179.0	(9)	-4.6%
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Title XXI Total	**342.6**	**356.8**	**406.9**	**477.3**	**512.5**	**35.2**	**7.4%**

Expenditure Comparison – Another way to Look at the Data

In Millions

FY 2024 Compared Against the Forecast

Expenditures	YTD Nov Forecast	YTD FY2024	Variance	Comments
FAMIS MCO	229.60	242.07	5%	Avg Enrollment above forecast
FAMIS FFS	21.19	22.83	8%	Avg Enrollment above forecast
FAMIS Dental	27.45	29.97	9%	Avg Enrollment above forecast
FAMIS Total	**278.24**	**294.87**	**6%**	**Avg Enrollment above forecast**
MCHIP MCO	166.28	179.00	8%	Avg Enrollment above forecast
MCHIP FFS	6.06	6.05	0%	
MCHIP Dental	33.11	32.55	-2%	
MCHIP Total	**205.44**	**217.59**	**6%**	**Avg Enrollment above forecast**
Title XXI Total	**483.69**	**512.46**	**6%**	**Avg Enrollment above forecast**

Signed Budget Highlights

- Signed biennial budget included impacts to many of DMAS' levers.
- Some highlights include:
  - Rate increases: Dental, CD/AD PCAs, DD, DME Rates.
  - Slots: DD, GME.
  - Medicaid Reserve Funding.
  - New FTEs to support: Cardinal Care, TPL, E&E.

- See the appendix slides for the full list of budget changes.

Summary

- Financial data shows a variance from forecast due to slower unwinding.
- Lessons from FY24 will be incorporated into FY25/26 forecast

Appendix Slides

- Full summary of Budget Changes

Caboose Budget Changes

Item	Summary
Aligning Virginia TPL with CMS requirements	Aligns Virginia Medicaid with new CMS requirements prohibiting TPL providers from denying claim because it did not receive prior-approval with the TPL provider's rules.
MCO Re-procurement	Document all changes, legal authority, and fiscal impact by June 1, 2024
Adds $2.8M coverage assessment appropriation	Allows DMAS to increase cost allocation for Dentaquest, Acentra, FAS to MedEX
Adds $1.7M coverage assessment appropriation	Allows DMAS to cost allocate MES modules (AIMS, EDWS, ISS, PRSS) to MedEX

Biennium Budget Changes

Item	Summary
Removes $500K each year from TDO fund	GA is removing TDO GF for other priorities since it is underused
Remove obsolete supplemental payment language	PRD will review supplemental payments with Mercer to remove unnecessary language
Develop change-in-scope policy for FQHCs	Complete by January 1, 2025, allow providers to submit CIS by October 1, 2024
Supplemental Payments (many)	Adds 5 FTEs, adds specific requirements for quality measures (DMAS approval, quarterly and annual reporting to DMAS), requires analysis of all supplemental payment quality measures and report to GA by November 15, 2024.
Adds $1M for 10 OBGYN GME slots	$1M for 10 OBGYN GME residency slots each year

Biennium Budget Changes

Item	Summary
Increase CD facilitation service rate	Adds $10.9M each year to increase CD management training, initial comprehensive visit, routine visit, and reassessment visit
Increase DME rate for enteral products ONLY (no resp.)	Increase to 100% of Medicare rural or non-rural if rural does not exist
Increase peer mentoring service rate	Adds $17K each year to increase rate for peer mentoring services
Increase dental rates 3%	3% rate increase for dental services
50% rate increase to Grafton	Provides $1.8M annually to Grafton for rate increase

Biennium Budget Changes

Item	Summary
2% rate increase for CD/AD PCAs	FY25: authorizes 2% rate increase for CD/AD PCAs FY26: authorizes ANOTHER 2% increase for CD/AD PCAs (cumulative 4% raise)
MCO re-procurement	Allows implementation by July 1, 2024
Collaborative Care Guidelines	Deliver BH in primary care practices
Weight loss Rx—PA required	Requires PA for weight loss drugs
Weight loss Rx—restriction	Restricted to: • BMI>40, or • BMI>37 plus at least one comorbidity: hypertension, Type 2 diabetes, or dyslipidemia, or Traditional weight-loss drug excluding GLP-1s

Biennium Budget Changes

Item	Summary
Medicaid Forecast Contingency	Provides $95M in FY25 in case there are more Medicaid members than expected based on Nov.1 forecast.
Permanently implements telehealth delivery for DD waivers	Permanently enshrine telehealth services for DD waivers
DD Waiver SLOTS: 3,440	FY25: • 387 each quarter FIS, 43 each quarter CL • total = 1,548 FIS, 172 CL FY26: • Additional 387 each quarter FIS, additional 43 each quarter CL • total = 1,548 FIS, 172 CL Total over biennium: 3,096 FIS, 344 CL for 3,440 total

Biennium Budget Changes

Item	Summary
DD Waiver RATES: 3% each year	FY25: 3% rate increase to DD waiver providers FY26: ANOTHER 3% increase to DD waiver providers (cumulative 6% increase in FY26)
Requirements for Medicaid CD Facilitators	Removes Associate/Bachelor degree requirements for CD services facilitators
NF VBP	Adds $40M in FY25 and $40M in FY26 to inflate NF VBP program
NSGONF supplemental payments	Adds $3.7M to five NSGONFs supplemental payments
Annual inflation for PRTFs	Annually inflates rate
CHKD supplemental payment	Adds $16M annually to CHKD supplemental payment

Biennium Budget Changes

Item	Summary
DMAS to report to DSS if TPL available for child	The Department of Medical Assistance Services, in cooperation with the Department of Social Services' Division of Child Support Enforcement (DSCE), shall identify and report third party coverage where a medical support order has required a custodial or noncustodial parent to enroll a child in a health insurance plan. The Department of Medical Assistance Services shall also report to the DCSE third party information that has been identified through their third party identification processes for children handled by DCSE.

Biennium Budget Changes

Item	Summary
Align outpatient rehab reimbursement with industry standards	Updates reimbursement for outpatient rehab to RBRVS
Bravo 2.0	
USPTF Prevention Services for Adults	
Modify EFRC	Removes December meeting, adds focus on enrollment trends
TPL Activities	17 FTE to execute TPL, create TPL dashboard
Transfer 1 FTE from DBHDS to DMAS	Implement DD waiver rates review and changes
Add 3 FTEs to replace E&E contractors	No additional funding, need to attrition wage/contractors in E&E to fund
Fiscal Agent Services (MMIS) replacement	Un-allots funding until DMAS provides DPB with itemized documentation of cost for replacement

Biennium Budget Changes

Item	Summary
Add 3 FTE for Cardinal Care Oversight	FY25 & 26: 3 FTE with 590K GF, 590K NGF
Improve eligibility determination	Improve efforts to determine if individuals applying to Medicaid and CHIP are eligible for alternate healthcare coverage. No funding, report due October 1.
DSH Workgroup	Workgroup evaluate how DSH needs to change in response to MedEX 2019. Report due October 1, 2024.
Evaluate Medicaid Eligibility Determination Process	Hire vendor to do a comprehensive analysis of current and proposed Medicaid eligibility determination process
Increase Medicaid Eligibility Determination	
Centralize Mail Operations	

CardinalCare
Virginia's Medicaid Program

Unwinding and Beyond

DMAS and VDSS Collaboration
Jessica Annecchini, DMAS
Frank Smith, VDSS
Irma Blackwell, VDSS

DMAS

Medicaid Continuous Coverage Requirements: Background

The end of the continuous coverage requirement, or "unwinding" has represented the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA).

- **The Families First Coronavirus Relief Act required states to maintain enrollment of Medicaid members (enrolled as of March 18, 2020) to receive the additional 6.2 % increase until the end of the month in which the federal Public Health Emergency (PHE) ended.**

- **In December 2022, the Consolidated Appropriations Act (CAA) 2023 was signed into effect decoupling the PHE from the continuous coverage requirement effective March 31, 2023. Additionally, the CAA:**
  - Allowed states 12 months to initiate all renewals, with an additional two months to complete redeterminations. Virginia initiated unwinding renewals in March 2023; February 2024 will be the 12th month of initiations.
  - Stepped down the enhanced federal match rate beginning April 1 and completely phasing out the enhanced match effective December 31, 2023.
  - Virginia received a total of $3.067 billion in enhanced funding beginning in March 2020 through the end of calendar year 2023.
  - Virginia was one of 44 states required to submit a mitigation plan prior to unwinding, which was approved by the Centers for Medicare and Medicaid Services on March 29, 2023.

Medicaid Continuous Coverage Requirements: Preparation

Health Human Resources (HHR) agencies acted early in the PHE to implement flexibilities and protect needed coverage during the PHE to allow access to services. In a parallel effort, the DMAS and DSS began planning in mid-2020 for the eventual unwinding of those flexibilities. Virginia has been named a leader in the country for innovative and thorough outreach, education, and communication to all stakeholders.

Unwinding Taskforce: Convened by Secretary Littel in January 2022 to include DMAS and DSS leaders and the Office of the Attorney General. In July 2022, the taskforce was expanded to include Senate and House Finance and Department of Planning and Budget staff.

Cover Virginia: Expanded operations to include a redetermination call center and processing services through the end of unwinding. Implemented new permanent units dedicated to pregnant women and application assisters/advocates.

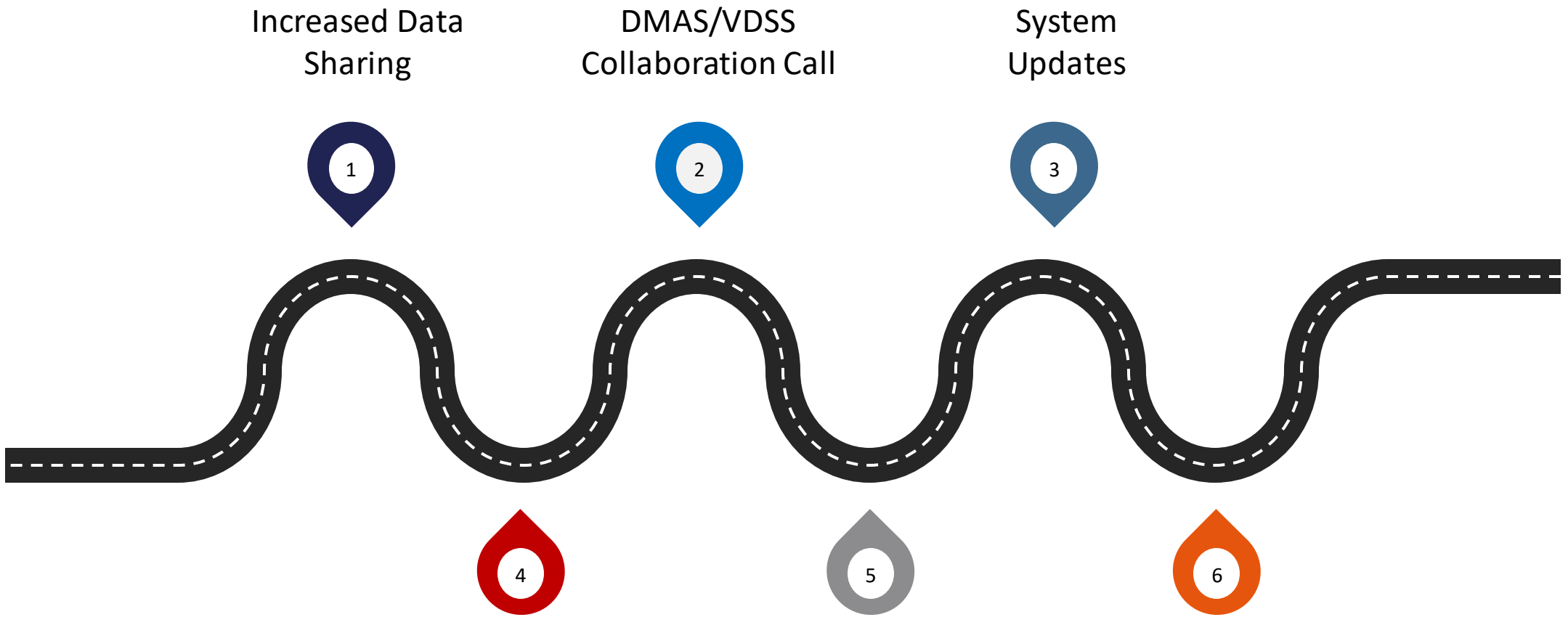
Outreach and Education: Launched outreach campaigns through radio, television, social media, and 3 websites. Development of 4 stakeholder toolkits, 18 outreach templates, 60 provider memos. Engagement through speaking events to include 8 public townhalls to nearly 1000 different stakeholder groups.

25 System Updates: Increased the number of successful "no touch" actions at application, change, and renewal to promote consistency, reduce local worker burden, and allow a stronger focus on high-risk populations which require manual processing.

Training and Information Sessions: eLearning and webinars held for over 3,000 local agency staff. Expanded learning opportunities through existing Virginia Health Care Foundation partnership to increase assistance resources, added trainings for aged and disabled populations.

Managed Care Organization Collaboration: Executed agreement with the six health plans to solidify plans for four round of targeted member outreach across all modalities. Implemented new data sharing processes to include addresses, closures, and closure reason.

How Did We Collaborate?



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Virginia's Medicaid Program

Preparations to Resume Normal Enrollment:
Local Agency Planning and Partner Collaboration

23 System Updates:

- Increased the number of successful "no touch" actions at application, change, and renewal to promote consistency, reduce local worker burden, and allow a stronger focus on high-risk populations which require manual processing.
- Increased reporting to meet federal requirements and to allow monitoring of progress throughout the unwinding period.

Training and Information Sessions:

- Developed an eLearning that refreshed local agency staff on renewal processing.
  - Over 3,000 Local Agency staff have completed this training.
- Hosting subject-matter expert led webinars that focus on Q&A with local agency staff to assist in preparing them for the work.
  - Over 2,000 Local Agency staff have attended these webinars, and this series will continue until the end of April 2023.

Managed Care Organization (MCO) and Virginia Insurance Marketplace collaboration:

- Executed agreement with the health plans to solidify plans for four round of targeted member outreach across all modalities.
- Implemented new data sharing processes to include addresses, closures, and closure reason.
- Collaboration with the State Corporation Commission to ensure the smooth transition of individuals no longer eligible for coverage to other health coverage through referrals to the new Virginia Insurance Marketplace beginning In November 2023.

Preparations to Resume Normal Enrollment:
Local Agency Planning and Partner Collaboration

Data Updates:

- DMAS and VDSS data teams worked together to share information in both systems (VaCMS for eligibility, MMIS for enrollment) to align numbers
- The data alignment included aligning dates as well as enrollment between systems
- The data allowed us to produce a calendar spreading renewals over the 12 months of initiation as best as possible.
- This data also led Virginia to take a time-based approach rather than a population-based approach to unwinding

Mitigation Planning: CMS had states participate in two rounds of mitigation planning:

- Many states, including Virginia, had mitigation plans for ensuring all members receive an ex parte review. As of March 2023, Virginia did not put non-MAGI members through the ex parte process – to mitigate, Virginia performed a back end ex parte attempt, meaning after the renewal form was sent but prior to procedural closure.
  - In August 2023 system changes were put in place to track the ex parte attempt date and negate closure if an ex parte renewal was not attempted.
  - In May 2024 system changes were put in place to put all members through the automated ex parte process.
- In summer of 2023, CMS had states evaluate if they were truly performing renewals at the individual level. Virginia did run eligibility for members separately, however, in the automated process all members were run at the same time and if one failed, all failed.
  - In September 2023 system changes were put in place to complete the ex parte process at the individual level. Individuals who were reinstated due to a possible improper procedural closure were re-evaluated and those eligible renewed. All members were re-attempted through the individual process that were part of the backlog in November 2023.

Preparations to Resume Normal Enrollment:
Local Agency Planning and Partner Collaboration

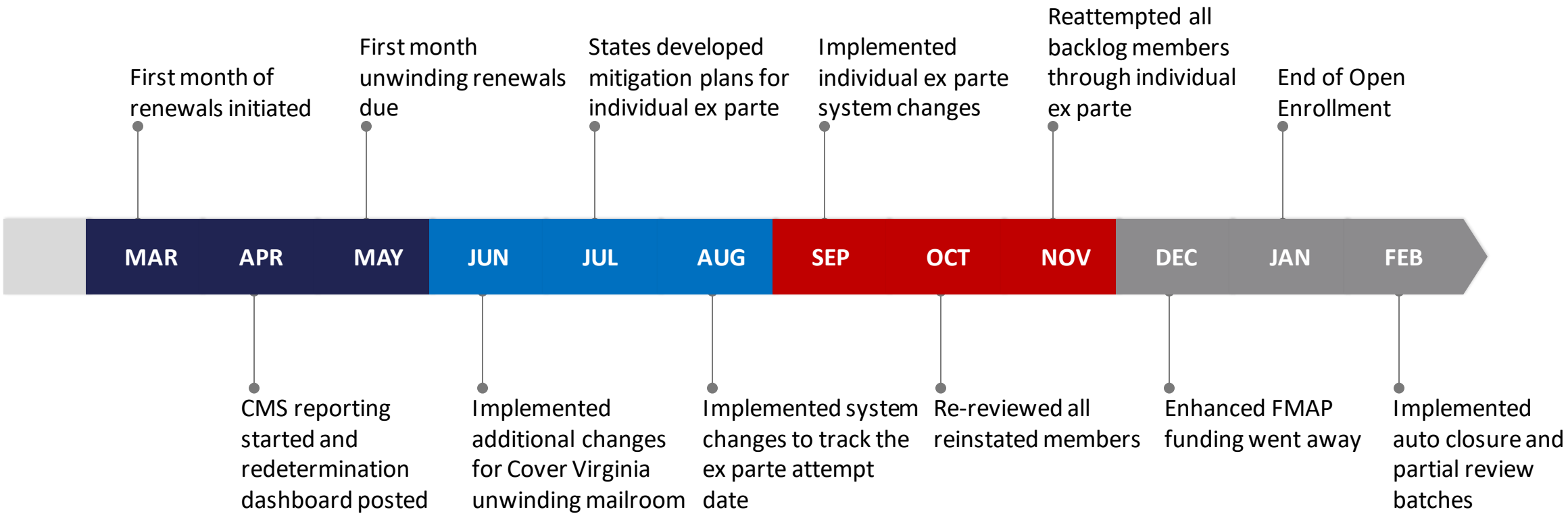
Reporting Updates:

- CMS directed states to return additional data regarding renewals before unwinding that has been announced as remaining permanent. Virginia worked with the VaCMS vendor for "ad-hoc reports" to meet the need during unwinding and are working on the permanent system changes as the reporting has become permanent.
- In addition, multiple reports were gathered during the PHE and in preparation to track populations that would need to be renewed during unwinding, as well as those that had non-financial changes and would need to be re-evaluated to move coverage groups as part of their redetermination.

Other Changes:

- During the PHE, there were several policy updates that assisted to streamline enrollment processes:
  - Removal of 40 work quarter requirement for Lawful Permanent Residents
  - Implementation of FAMIS Prenatal Care (PC), coverage for pregnant individuals regardless of immigration status
  - Extension of the postpartum period from 60 days to 12 months (exception: FAMIS PC)
- To assist with unwinding, CMS provided states with 1902(e)14 waiver opportunities to reduce burden due to the increased workload. Virginia adopted several flexibilities, including but not limited to:
  - Grace period for appeals exceeding 90 days
  - Verbal consent for application assisters
  - Collaboration with health plans to take address updates

What Did the Unwinding Year Look Like



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Virginia's Medicaid Program

What Did We Look at During Unwinding?

- Collaboration with health plans:
  - Health plans provided outreach stats to DMAS
  - Health plans wanted to continue to receive procedural closure information
- Enrollment trends:
  - Largest drops in enrollment aligned with largest enrollment groups (non-ABD adults and children under 19)
  - Saw a larger gap between non-ABD adults and children under 19 groups after the individual ex parte changes were put into place
- Ex Parte Rates:
  - Average 46.3% success rate
  - Pre PHE success rates were 50%
  - As predicted, months with older renewals were less successful than more recently renewed members
- Dashboard Trends:
  - Saw highest closures at beginning of month
  - Moving monthly to weekly allows us to track the higher vs. lower processing weeks

System Changes During Unwinding

- Auto Closure Batch
  - This nightly batch process denies a request for assistance or closes coverage if an individual hasn't returned information in a specified amount of time.
    - For applications, denials occur if a checklist was sent and it is more than 45 days past the due date. For renewals, closures occur if the renewal packet was sent more than 95 days ago, and the renewal is more than 30 days overdue.
    - Because the closures are for a procedural reason, the individual is afforded a 90 day reconsideration period.
- Partial Review Batch
  - Notice Batch – This monthly batch process runs to send letters to individuals in certain coverage who gain Medicare or turn 65; the letter includes an Appendix D to gather resource information.
  - Eligibility Batch – This monthly batch processes changes to individuals aging out of coverage, those that gained Medicare while in certain covered groups, or individuals who have met the end of their postpartum period.
- Both batches have outcome reports generated and posted for worker action.

Churn Analysis

Action item from previous meeting

DMAS performed a churn analysis to compare CY2019 with April 2023-April 2024 in May of 2024

- Assumptions:
  - Churn members must have a gap in coverage of at least one day
  - Definition of time to reinstatement is how long it took for them to come back to coverage (when the action was taken), not their actual enrollment date
  - This does not look at if there were multiple instances of churn or if the member is still enrolled today
    - We only look at the first instance that someone churned back into coverage
    - We did perform a point in time analysis for all members that churned within six months and are still enrolled today (from the unwinding cohort) and that is a 3.5% churn rate.

Churn Analysis

Observations of 2019:

- Children accounted for the highest proportion of reinstated members at 38%, followed by non-ABD adults at 34%, and Limited Benefits Individuals at 13%. Collectively, these three groups constituted 84% of the total reinstated members.
- A notable 57% of members were reinstated within the initial three months after closure, underscoring the significant role of this early period in the reinstatement process.
- Additionally, 21% of members were reinstated after one year of closure, indicating that reinstatements continue to occur beyond the immediate post-closure period.
- Approximately 51% of reinstated members returned to the same aid category they were previously in, while 49% shifted to a different aid category upon reinstatement.
- Procedural closures accounted for 30% of the total closed members who were reinstated, while non-procedural closures accounted for the remaining 70%.

Observations of Unwinding:

- NBD adults, Children, and Limited Benefits collectively constituted 87% of the total reinstated members. Among these, NBD adults accounted for the highest proportion at 39%, followed by Children at 35%, and Limited Benefits Individuals at 14%.
- A noteworthy 81% members were reinstated within the initial three months after closure, indicating the critical role of this early period in the reinstatement process.
- Approximately 58% of reinstated members returned to the same aid category they were previously in, while 42% shifted to a different aid category upon reinstatement.
- Procedural closures accounted for 42% of the total closed members who were reinstated, while non-procedural closures accounted for the remaining 58%.
- Note: there is not enough data on 12 months to be able to fully compare 2019 to unwinding as non-procedural closures started in April 2023, and procedural in May 2023.

Churn Analysis

Churn Mapping - 2019		Total Closed members	Total Reinstated members	Percentage of Reinstated members of the total Closed members in that group	Reinstated within Three Months			Reinstated within Six Months			Reinstated within Twelve Months			Reinstated more than Twelve Months		
Eligibility Category	Closure Type				Totals	Same Eligibility Category	New Eligibility Category	Totals	Same Eligibility Category	New Eligibility Category	Totals	Same Eligibility Category	New Eligibility Category	Totals	Same Eligibility Category	New Eligibility Category
Children	Total Closures	345,480	115,082	33%	64,339	36,767	27,572	16,177	7,350	8,827	12,941	5,192	7,749	21,625	6,959	14,666
	Procedural closure	66,520	42,666	64%	23,923	14,724	9,199	6,174	3,395	2,779	4,842	2,339	2,503	7,727	2,890	4,837
	Non Procedural Closure	278,960	72,416	26%	40,416	22,043	18,373	10,003	3,955	6,048	8,099	2,853	5,246	13,898	4,069	9,829

Churn Mapping - Unwinding		Total Closed members	Total Reinstated members	Percentage of Reinstated members of the total Closed members in that group	Reinstated within Three Months			Reinstated within Six Months			Reinstated within Twelve Months			Reinstated more than Twelve Months		
Eligibility Category	Closure Type				Totals	Same Eligibility Category	New Eligibility Category	Totals	Same Eligibility Category	New Eligibility Category	Totals	Same Eligibility Category	New Eligibility Category	Totals	Same Eligibility Category	New Eligibility Category
Children	Total Closures	480,868	70,272	15%	56,833	34,081	22,752	9,699	4,825	4,874	3,703	1,323	2,380	37	14	23
	Procedural closure	86,705	33,133	38%	27,543	17,846	9,697	4,263	2,435	1,828	1,327	512	815			
	Non Procedural Closure	394,163	37,139	9%	29,290	16,235	13,055	5,436	2,390	3,046	2,376	811	1,565	37	14	23

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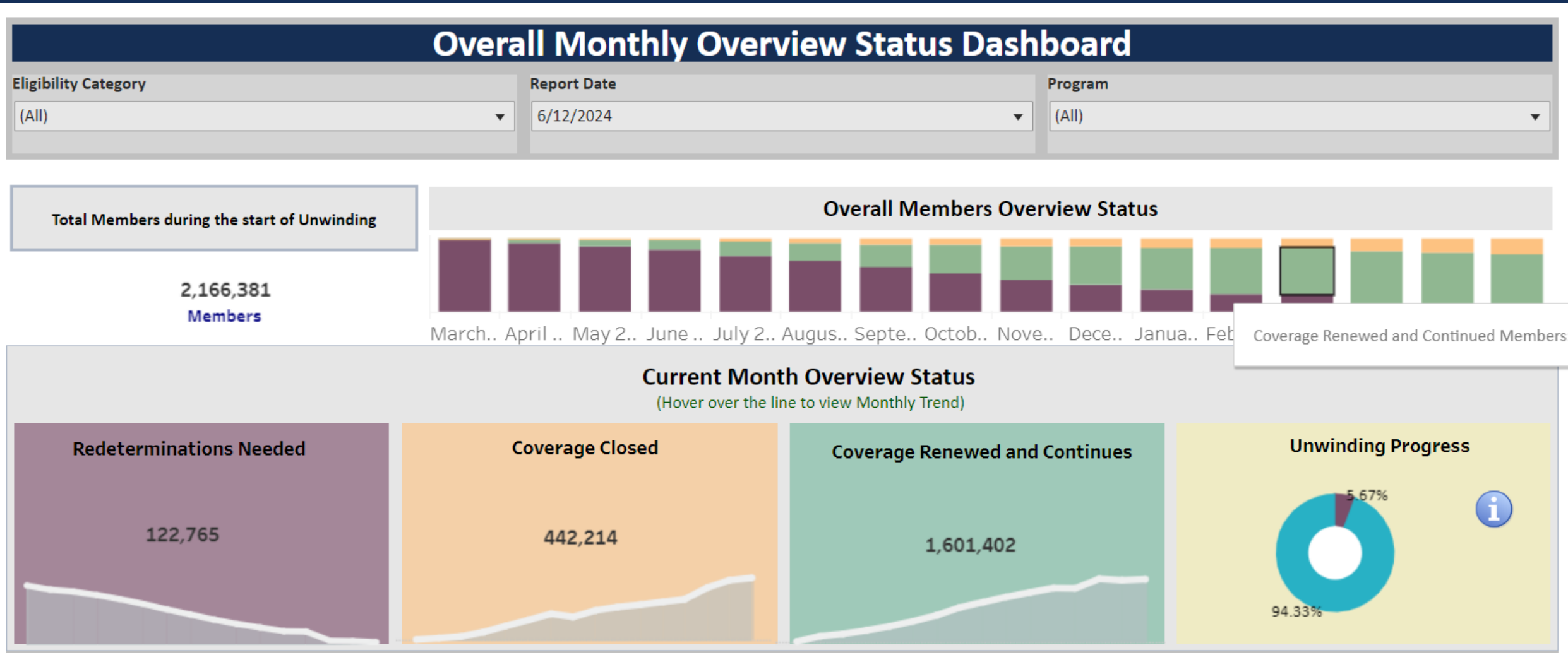
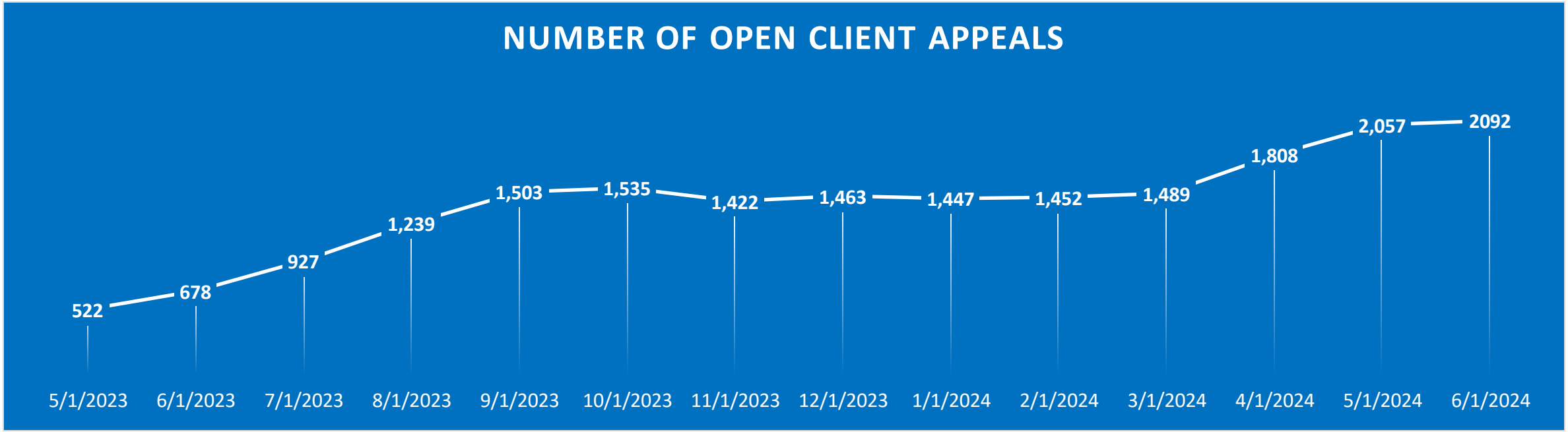
Where Are We Now?



DMAS Updates: Appeals Division Updates

The DMAS Appeals Division has seen a dramatic increase in phone calls and member appeal requests, which DMAS expected as we have entered the second month post procedural closures. Calls have tripled, and appeal requests have doubled in relation to previous months.



- Prior to May 2023, our appeals call volume averaged 163/week, and as of the week of 06/10/2024, Appeals received 435 calls, and 438 the week prior. 77% of eligibility client appeals are from renewal actions.
- The appeals staff prepared for this increase by hiring and training additional staff (ARPA funded) that has allowed the division to maintain zero overdue client appeals during unwinding.

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Medical Assistance Unwinding Backlog Plan

As mentioned, the Local Departments of Social Services (LDSS), CoverVA and the Virginia Case Management System (VaCMS) automated ex parte process has successfully redetermined over 1 million Medical Assistance cases since the Unwinding period began.

Undoubtedly, lots of hard work, lots of good work and so much work that is worthy of celebrating and recognizing!

Layout of the Overall Plan

Medical Assistance Unwinding Backlog Plan

Virginia's Initiative to Eliminate the Unwinding Redetermination Backlog – May 2024

To ensure the timely completion of all Medical Assistance Unwinding redeterminations, the Division of Benefit Programs, in partnership with the VDSS Division of Local Engagement and Support and the VDSS Office of Continuous Quality Improvement, has implemented strategic initiatives aimed at reducing the remaining Medicaid backlog.

These efforts include ongoing initiatives and the introduction of additional measures to help us focus on the immediate task at hand, as well as stay engaged relative to our long-term goals to obtain and sustain timeliness and accuracy measures.

Medical Assistance Unwinding Backlog Plan

In order to successfully complete the remaining MA Redeterminations and shorten the timeline for that completion, we are focusing on the following areas:

- VDSS Monthly Calls with the LDSS
- Ongoing Medical Assistance Compliance Activities
- VDSS Medical Assistance FUSION Page and Ongoing Communication Strategies
- Assistance from the VDSS Medical Assistance Processing Team
- Medical Assistance Engagement Meetings
- Prioritizing Agencies for Intensive Support from the Office of Continuous Quality Improvement

Monthly Engagement Calls with the LDSS

VDSS Monthly Calls with the LDSS

Due to overwhelming requests and successful outcomes, the Medical Assistance teams have decided to continue with the Monthly Calls with the LDSS –

Monthly calls will continue to provide support by way of:

- ✓ Continued case processing support
- ✓ Policy and procedural guidance
- ✓ Best practices for a variety of topics
- ✓ Systems processing steps and assistance with trending issues
- ✓ Training content/delivery
- ✓ Medicaid Policy Transmittal highlights and more

The monthly calls are specifically designed for staff who are responsible for processing, maintaining or assisting with Medical Assistance applications, renewals and changes.

These calls are made possible and supported by VDSS, DMAS, CoverVA and of course the LDSS.

Ongoing and Frequent Communication Platforms and Strategies

VDSS will continue to engage with the LDSS via various ways - We often refer to this as “layered” communication strategies.

- ✓ Presence during monthly and quarterly local agency roundtables
- ✓ Supervisor’s and manager’s meetings
- ✓ VLSSE monthly and board meetings
- ✓ BPRO committee meetings/conferences
- ✓ Local and state conferences/meetings
- ✓ Broadcasts/Listserv messages
- ✓ Regional distribution lists
- ✓ Management distribution lists
- ✓ Partner agency connections, such as DMAS
- ✓ MA FUSION (Intranet) Pages

VDSS MA Processing Support

Assistance from the VDSS Medical Assistance Processing Team

- The VDSS MA central processing team has been in place since Medicaid Expansion and currently consists of 10 team members who are responsible for processing both current as well as overdue applications and redeterminations for Medical Assistance, for Local Agencies with the largest Unwinding backlog.
- This team also completes special projects, at the request of DMAS, related to processing Medical Assistance cases. This team performs all of the same duties as staff at the LDSS.
- The expectation is that this group will consistently assist with a small number of agencies based on backlog, vacancy rates and total MA caseload.
- This strategy proved to be effective when VDSS stood up the VDSS Processing Team which averaged 30 team members during its lifecycle and completed 19,477 MA Redeterminations from October 2023 through March 2024.

LDSS Focused Engagement Meetings

Medical Assistance Unwinding Engagement Meetings

- Meetings are currently being held to help promote continued communication, support and dialog between state and local agencies - to foster collaboration, cooperation, training opportunities, policy and procedural guidance discussions, systems and technical items of note and various additional solutions – and, of course, to help with specialized efforts to process the remaining Unwinding redeterminations.

- These meetings are intended to drive positive change, promoting transparency and strategic enhancement within the MA program and will be a vital part of Virginia's timeliness and accuracy efforts.

What Does the End of Unwinding Look Like?

- Eventually we will remove the unwinding dashboard once we have completed most of the redeterminations
  - We are considering changes to other existing dashboards to incorporate some of the information we've put in the redetermination dashboard, including closure and churn data
- We will continue to monitor the backlog as renewals continue and collaborate for plans to assist with the workload as necessary
- The flexibilities put in place through 1902(e)14 waivers are allowed through June 20, 2025, and CMS is considering making some permanent
- Reporting has become permanent, and will continue to be posted publicly

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Reminders for Ongoing Work

Renewals are a normal annual process that will not stop after unwinding!

While there was a great focus on renewals, the applications and changes must continue to be processed timely and accurately.

The collaboration between DMAS and VDSS does not stop:

- Collaboration calls continue
- DMAS continues to participate in VDSS/LDSS calls
- System improvements, policy changes, and opportunities to speak with the local agencies continue

Final Eligibility Rules are being implemented!

Thank you to all partners across the Commonwealth who are working to support the efforts to ensure a smooth transition back to normal processing.

2022–23 Medicaid and CHIP Maternal and Child Health Focus Study

Considering Births During Calendar Year 2022

March 2024

Objectives

- Study purpose and Methodology
- Findings
  - Demographic findings
  - Study indicator results
- Study Limitations and Conclusions
- Recommendations

Background Information

- External Quality Review (EQR) Focus Study
  - Annual EQR study, with trends over three years
  - Current results for calendar year (CY) 2022 births
- Four 2022–23 study questions:
  - To what extent do women with births paid by Virginia Medicaid receive early and adequate prenatal care?
  - What clinical outcomes are associated with Virginia Medicaid-paid births?
  - What maternal health outcomes are associated with Virginia Medicaid-paid births?
  - What health disparities exist in birth and maternal health outcomes for births paid by Virginia Medicaid?

Study Indicators

Study Indicators	Stratifications

• **Birth Outcomes**
  • *Births With Early and Adequate Prenatal Care*
  ○ *Births With Inadequate Prenatal Care*
  ○ *Births With No Prenatal Care*
  • *Preterm Births (<37 Weeks Gestation)*
  • *Newborns With Low Birth Weight (<2,500g)*
• **Maternal Health Outcomes**
  • *Postpartum Emergency Department (ED) Utilization*
  • *Postpartum Ambulatory Care Utilization*
  • *Prenatal Maternal Depression Screening*
  • *Postpartum Maternal Depression Screening*
  • *Most or Moderately Effective Contraceptive (MMEC) Within 3 Days of Delivery*
  • *MMEC Within 90 Days of Delivery*
  • *Long-Acting Reversible Contraceptive (LARC) Within 3 Days of Delivery*
  • *LARC Within 90 Days of Delivery*
	• **Key Demographic Characteristics**
	  • Race/Ethnicity
	  • Region of Residence
	• **Medicaid Program Characteristics**
	  • Medicaid Program
	  • Managed Care Program
	  • Delivery System
	  • Managed Care Organization (MCO)

Birth Outcomes Study Indicator Results

Overall Birth Outcomes Study Indicator Findings Among Singleton Births, CY 2020–CY 2022

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
Births With Early and Adequate Prenatal Care	76.4%	22,245	71.9%	23,780	72.7%	25,535	72.1%
*Births With Inadequate Prenatal Care**	*NA*	4,651	15.0%	5,106	15.6%	5,454	15.4%
*Births With No Prenatal Care**	*NA*	534	1.7%	685	2.1%	1,072	3.0%
Preterm Births (<37 Weeks Gestation)*	9.4%	3,168	9.8%	3,327	10.1%	3,446	9.6%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	2,979	9.2%	3,074	9.3%	3,279	9.1%

** a lower rate indicates better performance for this indicator.*
NA indicates there is not an applicable national benchmark for this indicator.

Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Medicaid Delivery System and MCO, CY 2022

	Births With Early and Adequate Prenatal Care		Births With Inadequate Prenatal Care*		Births With No Prenatal Care		Preterm Births (<37 Weeks of Gestation)*		Newborns With Low Birth Weight (<2,500 grams)*	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Delivery System										
FFS	1,980	61.0%	715	22.0%	216	6.7%	359	10.9%	313	9.5%
Managed Care	23,555	73.2%	4,739	14.7%	856	2.7%	3,087	9.5%	2,966	9.1%
MCO										
Aetna	3,316	74.9%	655	14.8%	79	1.8%	397	8.9%	376	8.4%
HealthKeepers	7,356	73.7%	1,383	13.9%	289	2.9%	953	9.4%	916	9.1%
Molina	1,748	70.8%	384	15.5%	81	3.3%	256	10.3%	233	9.4%
Optima	4,719	74.1%	911	14.3%	167	2.6%	645	10.0%	656	10.1%
UnitedHealthcare	2,536	70.4%	586	16.3%	130	3.6%	310	8.5%	308	8.5%
VA Premier	3,880	73.0%	820	15.4%	110	2.1%	526	9.7%	477	8.8%

** a lower rate indicates better performance for this indicator.*

Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Managed Care Region of Residence, CY 2022

	Births With Early and Adequate Prenatal Care		Births With Inadequate Prenatal Care*		Births With No Prenatal Care		Preterm Births (<37 Weeks of Gestation)*		Newborns With Low Birth Weight (<2,500 grams)*	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Managed Care Region of Residence										
Central	7,052	76.5%	1,026	11.1%	325	3.5%	970	10.4%	927	9.9%
Charlottesville/Western	3,235	75.1%	705	16.4%	67	1.6%	375	8.6%	386	8.9%
Northern & Winchester	6,389	65.1%	2,014	20.5%	414	4.2%	826	8.3%	705	7.1%
Roanoke/Alleghany	2,355	73.4%	437	13.6%	34	1.1%	292	9.1%	302	9.4%
Southwest	776	78.5%	137	13.9%	12	1.2%	78	7.8%	62	6.2%
Tidewater	5,652	72.7%	1,125	14.5%	217	2.8%	892	11.3%	887	11.2%

** a lower rate indicates better performance for this indicator.*


FAMIS MOMS Program

Distribution of Singleton Births Among Women in FAMIS MOMS by Delivery System, CY 2020–CY 2022

Overall Births	CY 2020		CY 2021		CY 2022	
	Number	Percent	Number	Percent	Number	Percent
FFS	264	12.6%	259	14.5%	267	14.7%
Managed Care	1,827	87.4%	1,526	85.5%	1,550	85.3%
Total FAMIS MOMS Singleton Births	**2,091**	**100.0%**	**1,785**	**100.0%**	**1,817**	**100.0%**

FAMIS MOMS Study Findings

- Exceeded national benchmarks for the following study indicators:
  - *Births With Early and Adequate Prenatal Care*
  - *Preterm Births (<37 Weeks Gestation)*
  - *Newborns With Low Birth Weight (<2,500 grams)*

Overall Study Indicator Findings Among Singleton Births by FAMIS MOMS, CY 2020–CY 2022

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
Births With Early and Adequate Prenatal Care	76.4%	1,564	76.8%	1,382	78.1%	1,391	77.4%
*Births With Inadequate Prenatal Care**	*NA*	261	12.8%	219	12.4%	230	12.8%
*Births With No Prenatal Care**	*NA*	11	0.5%	12	0.7%	27	1.5%
Preterm Births (<37 Weeks Gestation)*	9.4%	163	7.8%	161	9.0%	150	8.3%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	150	7.2%	145	8.1%	137	7.5%

** a lower rate indicates better performance for this indicator.*
NA indicates there is not an applicable national benchmark for this indicator.

FAMIS MOMS Study Groups

Study Population

Women enrolled in FAMIS MOMS on the date of delivery, with continuous enrollment in any Medicaid program or combination of programs for **120 or more days** (counting the date of delivery)

Comparison Group

Women enrolled in FAMIS MOMS on the date of delivery, with continuous enrollment in any Medicaid program or combination of programs for **fewer than 120 days** (counting the date of delivery)

FAMIS MOMS Findings by Comparison Group and Study Population, CY 2022

Overall Births (FAMIS MOMS)	National Benchmark	Comparison Group			Study Population		
		Denom	Number	Percent	Denom	Number	Percent
Births With Early and Adequate Prenatal Care	76.4%	392	296	75.5%	1,404	1,095	78.0%
*Births With Inadequate Prenatal Care**	*NA*	392	59	15.1%	1,404	171	12.2%
*Births With No Prenatal Care**	*NA*	392	*S*	*S*	1,404	19	1.4%
Preterm Births (<37 Weeks Gestation)*	9.4%	399	52	13.0%	1,417	98	6.9%^
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	399	46	11.5%	1,417	91	6.4%^

**a lower rate indicates better performance for this indicator.*

NA indicates there is not an applicable national benchmark for this indicator.

^indicates the study population rate is statistically different from the comparison group rate.

S indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11).

Maternal Health Outcomes Study Indicator Results

Overall Maternal Health Outcomes Study Indicator Findings Among Singleton Births, CY 2021–CY 2022

Study Indicator	CY 2021		CY 2022	
	Number	Percent	Number	Percent
Postpartum ED Utilization*	4,627	14.0%	5,929	16.5%
Postpartum Ambulatory Care Utilization	17,024	51.5%	21,067	58.7%
Prenatal Maternal Depression Screening	1,638	5.0%	1,932	5.4%
Postpartum Maternal Depression Screening	2,251	6.8%	2,821	7.9%
MMEC Within 3 Days of Delivery	—	—	3,869	10.8%
MMEC Within 90 Days of Delivery	—	—	14,412	40.2%
LARC Within 3 Days of Delivery	—	—	860	2.4%
LARC Within 90 Days of Delivery	—	—	4,640	12.9%

**a lower rate indicates better performance for this indicator.*
— indicates the study indicator is new for CY 2022; therefore, rates are not available for CY 2021.

Please note, Postpartum ED Utilization and Postpartum Ambulatory Care Utilization calculates the number of postpartum women who utilized the ED or ambulatory care, respectively, within 90 days of delivery. Postpartum Maternal Depression Screening calculates the number of women who received a screening for depression on or between 7 and 84 days after delivery.

Overall Study Indicator Findings Among Singleton Births by MCO, CY 2022

	Postpartum ED Utilization*		Postpartum Ambulatory Care Utilization		Prenatal Maternal Depression Screening		Postpartum Maternal Depression Screening		MMEC Within 3 Days of Delivery		MMEC Within 90 Days of Delivery		LARC Within 3 Days of Delivery		LARC Within 90 Days of Delivery	
	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate
MCO																
Aetna	728	16.3%	2,625	58.7%	242	5.4%	293	6.6%	513	11.5%	1,938	43.4%	116	2.6%	618	13.8%
HealthKeepers	1,727	17.1%	6,298	62.4%	475	4.7%	950	9.4%	1,072	10.6%	4,258	42.2%	179	1.8%	1,402	13.9%
Molina	401	16.1%	1,403	56.4%	108	4.3%	258	10.4%	276	11.1%	978	39.3%	74	3.0%	340	13.7%
Optima	1,157	17.9%	3,626	56.1%	450	7.0%	698	10.8%	749	11.6%	2,716	42.0%	172	2.7%	755	11.7%
UnitedHealthcare	549	15.1%	2,146	59.0%	91	2.5%	143	3.9%	441	12.1%	1,456	40.0%	83	2.3%	490	13.5%
VA Premier	1,057	19.4%	3,610	66.4%	547	10.1%	393	7.2%	675	12.4%	2,456	45.2%	163	3.0%	784	14.4%

** a lower rate indicates better performance for this indicator.*

Overall Maternal Health Outcomes Study Indicator Findings Among Singleton Births by Managed Care Region of Residence, CY 2022

	Postpartum ED Utilization*		Postpartum Ambulatory Care Utilization		Prenatal Maternal Depression Screening		Postpartum Maternal Depression Screening		MMEC Within 3 Days of Delivery		MMEC Within 90 Days of Delivery		LARC Within 3 Days of Delivery		LARC Within 90 Days of Delivery	
	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate	Num	Rate
Managed Care Region of Residence																
Central	1,668	17.9%	5,864	62.8%	530	5.7%	622	6.7%	840	9.0%	3,820	40.9%	233	2.5%	1,275	13.7%
Charlottesville/ Western	672	15.4%	2,535	58.1%	554	12.7%	417	9.6%	529	12.1%	1,909	43.8%	138	3.2%	618	14.2%
Northern & Winchester	1,292	13.0%	6,071	60.9%	188	1.9%	483	4.8%	874	8.8%	3,701	37.1%	*S*	*S*	1,263	12.7%
Roanoke/ Alleghany	584	18.1%	1,808	56.1%	163	5.1%	107	3.3%	479	14.9%	1,366	42.4%	168	5.2%	461	14.3%
Southwest	235	23.7%	644	64.9%	47	4.7%	17	1.7%	152	15.3%	478	48.1%	*S*	*S*	92	9.3%
Tidewater	1,461	18.5%	4,097	51.8%	446	5.6%	1,171	14.8%	989	12.5%	3,109	39.3%	287	3.6%	921	11.6%

** a lower rate indicates better performance for this indicator.*
S indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the values for the second smallest population were also suppressed, even if the values were 11 or more.

Postpartum ED Analysis

Count and Percentage of Postpartum ED Visits, CY 2022

Number of ED Visits per Member	Count of ED Visits	Percentage of ED Visits
1 ED Visit	4,404	74.3%
2 ED Visits	1,043	17.6%
3 ED Visits	284	4.8%
4 ED Visits	116	2.0%
5 ED Visits	37	0.6%
6 ED Visits	18	0.3%
7 ED Visits	11	0.2%
8 or More ED Visits	16	0.3%

Postpartum ED Visits by Postpartum Period, CY 2022

Timing of First ED Visit	Num	Rate
Total ED Visits	5,929	100.0%
Less than 7 days of delivery	1,147	19.3%
Between 7 and 14 days after delivery	1,137	19.2%
Between 15 and 30 days after delivery	1,069	18.0%
Between 31 and 60 days after delivery	1,444	24.4%
Between 61 and 90 days after delivery	1,132	19.1%

Postpartum ED Visits by Kotelchuck Index Score, CY 2022

Adequacy of Prenatal Care	Denom	Num	Rate
Total	35,889	5,929	16.5%
Births With Early and Adequate Prenatal Care	25,526	4,239	16.6%
Births With Intermediate Prenatal Care	3,349	558	16.7%
Births With Inadequate Prenatal Care	5,454	865	15.9%
Births With No Prenatal Care	1,072	189	17.6%
Births Missing Prenatal Care Information	488	78	16.0%

Postpartum ED Visits by Completion and Timing of Postpartum Follow-up Visits, CY 2022

Timing of Postpartum Visit	Num	Rate
Postpartum Visit Timing With No ED Visit		
No Postpartum Visit	15,634	52.2%
Postpartum Visit Within Less Than 7 Days of Delivery	1,191	4.0%
Postpartum Visit Between 7 and 14 Days After Delivery	1,939	6.5%
Postpartum Visit Between 15 and 30 Days After Delivery	2,004	6.7%
Postpartum Visit Between 31 and 60 Days After Delivery	8,084	27.0%
Postpartum Visit Between 61 and 84 Days After Delivery	1,108	3.7%
Postpartum Visit Timing With ED Visit		
No Postpartum Visit	2,831	47.7%
Postpartum Visit Within Less Than 7 Days of Delivery	278	4.7%
Postpartum Visit Between 7 and 14 Days After Delivery	524	8.8%
Postpartum Visit Between 15 and 30 Days After Delivery	493	8.3%
Postpartum Visit Between 31 and 60 Days After Delivery	1,579	26.6%
Postpartum Visit Between 61 and 84 Days After Delivery	224	3.8%

Study Limitations and Conclusions

Study Limitations (Part 1)

- Study indicator and stratification results may be influenced by the accuracy and timeliness of the birth registry data and administrative Medicaid eligibility, enrollment, and demographic data used for calculations.
- Study used the Healthy People 2030 goals, using data derived from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), for the *Births with Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study indicators. Federal Fiscal Year (FFY) 2022 Centers for Medicare & Medicaid Services (CMS) Core Set benchmarks were used for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator.
- Study results are not comparable to Healthcare Effectiveness Data and Information Set (HEDIS®)[1] indicator results due to differing methodologies.
- HSAG developed the maternal health outcomes study indicators; therefore, comparisons to any applicable national benchmarks cannot be made. Further, due to billing practices or providers, the maternal depression screening results are likely more representative of data completeness, rather than actual performance.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Study Limitations (Part 2)

- COVID-19 may have impacted the CY 2020 study indicator results given the public efforts put in place during CY 2020 to mitigate the spread of COVID-19 (e.g., social distancing, stay at home orders). Additionally, researchers found that women who were pregnant during the early stages of the COVID-19 pandemic had increased fears and stress about delivering in a hospital, especially when a support person could not be in the hospital for the delivery or go to prenatal visits with the mother. Further, COVID-19 may have also impacted women's ability to get timely and frequent prenatal care. As a result, caution should be exercised when comparing CY 2021 and CY 2022 study indicator results to those for CY 2020.

Overall Study Conclusions

Overall results for the *Births With Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* continue to underperform in comparison to national benchmarks for all three measurement periods

Rates for the *Newborns With Low Birth Weight (<2,500 grams)* indicator outperformed the national benchmark for all three measurement periods

Approximately 17 percent of postpartum women utilized ED services. Women who received no prenatal care had the highest rates of *Postpartum ED Utilization.*

Approximately 39 percent of women who had an ED visit after delivery had the visit in the first 14 days after delivery, and approximately 24 percent had the visit between 31 and 60 days of delivery, and the amount of prenatal care received did not impact ED utilization in the postpartum period.

Approximately 59 percent of postpartum women utilized ambulatory care services. Women who were continuously enrolled for more than 180 days had higher rates of *Postpartum Ambulatory Care Utilization*.

Variation in study indicator results exist when reviewing the results with different stratifications, including geography or delivery system.

Past and Current DMAS Activities (Part 1)

- Partnership for Petersburg
  - In July 2023, DMAS mailed out more than 200 prenatal and postpartum care flyers to pregnant members residing in Petersburg to raise awareness of prenatal and postpartum care, MCO extended benefits services, and contact information of local OB/GYNs and Federally Qualified Health Centers (FQHCs) in Petersburg.
  - DMAS and MCOs tracked prenatal and postpartum care for its Petersburg members on a bimonthly basis to identify the percentage of women with a prenatal or postpartum visit.
  - MCOs, Conexus, and DentaQuest participated in over 150 Petersburg area events, and MCOs invested more than $4 million to support the Petersburg community. Events included area mobile health clinics and resource fairs that focus on pregnant and postpartum members to facilitate OB visits, increase access to doula services and increase education.
  - DMAS and MCOs worked directly with members, helping them access community doula services in Petersburg.
  - The Urban Baby Beginnings Petersburg Maternal Health Hub opened on April 11, 2023, which represents a community-based model of care which can help address factors that contribute to maternal and infant morbidity and mortality.
  - DMAS partnered with Bon Secours Southside OB/GYN Office to host weekend clinic hours on November 11, 2023. DMAS worked with MCOs to fill the allocated slots ranging from annual check-ups, prenatal and postpartum visits. Director Cheryl Roberts met with lead provider Dr. Daphne Bazile to share their experiences and future opportunities for weekend clinic hours.

Past and Current DMAS Activities (Part 2)

- All pregnant full-benefit Medicaid and FAMIS MOMS members receive a full year of postpartum benefits. Benefits include family planning, dental care, community doula services, lactation services (including breast pumps and supplies), behavioral health and substance use disorder screening and treatment services, non-emergency medical transportation and more. Pregnant and postpartum members may also receive various added benefits from their Cardinal Care MCO.
- Maternal Health
  - Improving health outcomes for all pregnant and postpartum women remains a top priority for DMAS, with a focus on reducing racial disparities and maternal mortality. Working across the agency, and with input from sister agencies, providers, members, and contracted MCOs, DMAS is implementing best practices in the following areas to improve wellbeing for all Medicaid members:
    - Eligibility and Enrollment: Streamline enrollment for pregnant women/newborns
    - Outreach and Information: Engage internal and external stakeholders and share information with members
    - Connections: Engage providers, community stakeholders, hospitals, and agencies
    - New and Improved Services and Policies: Collaborate on Virginia initiatives to enhance services
    - Oversight: Use data and reports to evaluate and improve programs

Past and Current DMAS Activities (Part 3)

- Doula Services
  - DMAS conducts quarterly Virginia Task Force meetings that assist with the promulgation of regulations and implementation of the doula certification process and serves as an informational resource for policy-related matters for VDH. Priorities for the group include establishing a workforce and professional development committee to ensure continued training and professional development for doulas.
  - As of August 2023, 124 doulas obtained state certification, 84 doulas completed Medicaid enrollment, and 76 doulas contracted with an MCO.

Past and Current DMAS Activities (Part 4)

- Child Health
  - DMAS assisted with the enrollment of Early Intervention (EI) providers in the Provider Services Solution portal (PRSS).
  - DMAS conducts quarterly EI meetings to engage MCOs, key stakeholders, Virginia's Local Lead Agencies (LLAs), and EI providers to share information about the EI community.
  - DMAS is implementing measures to increase awareness and enhance Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit services amongst providers, MCOs, and Virginia Medicaid members.
  - Working with the MCOs, DMAS participated in an Infant Well Child Affinity Group to increase well-child visits. The Affinity Group initiated interventions with different providers in the target regions of Roanoke/Alleghany, Northern & Winchester, Tidewater, Petersburg, and Southwest.
  - DMAS as well as seven other states received technical assistance from Mathematica to analyze interventions that had an impact on infant well-child visit rates and quality of care and access to members. The initiative started in March 2021 and concluded in December 2023.


EQRO Recommendations

EQRO Recommendations

- DMAS and MCOs should investigate factors contributing to women's ability to access timely prenatal care and implement targeted improvement efforts.
- DMAS and MCOs should continue to investigate factors contributing to women's ability to access timely prenatal care and implement targeted improvement, including through the performance improvement project (PIP) and Performance Withhold Program (PWP).
- DMAS and MCOs should work with hospitals and providers to leverage the Virginia Postpartum LARC toolkit and to assess how many members are using contraceptives prior to becoming pregnant.
- DMAS should consider investigating the utilization of ED services in the postpartum period to understand the factors contributing to why women are seeking care in the ED instead of an outpatient setting.
- DMAS should continue to ensure that women of childbearing age are seeing their primary care provider prior to pregnancy to discuss steps that can be taken (e.g., taking prenatal vitamins, using services [registered dietician, community support groups] that can help women reach a healthy weight before pregnancy).
- DMAS and the MCOs should investigate the reasons why women are not having a postpartum visit (e.g., transportation issues, appointment availability).
- DMAS should continue to work on reassessing the performance threshold for MCOs to earn back a portion of their quality withhold for the *Prenatal and Postpartum Care—Postpartum Care* indicator to incentivize MCO performance.
- DMAS should consider working with the MCOs and providers to promote the use of, and provide trainings related to, standardized maternal depression screening tools during the perinatal period.

Questions?

Thank you!

Health Services Advisory Group, Inc.

CardinalCare
Virginia's Medicaid Program

CHIPAC History and Mission

Emily Roller, Senior Management Analyst
Policy Division

DMAS

Agenda

- CHIPAC History
- CHIPAC Charge
- Member Organizations
- Member Responsibilities; Electronic Meetings and Remote Participation
- CHIPAC's Mission and Advisory Role
- Children's Medicaid/FAMIS Eligibility and Benefits 101
- Examples of Prior CHIPAC Recommendations

CHIPAC History

1997

Balanced Budget Act of 1997 creates the **Children's Health Insurance Program (CHIP).**

Virginia Coalition for Children's Health established, advocates for **CMSIP, Virginia's first CHIP program.**

2000

Virginia General Assembly passes legislation establishing **Family Access to Medical Insurance Security (FAMIS)** program.

Outreach Oversight Committee established to recommend strategies for improving outreach and application processes.

2004

CHIP Advisory Committee (CHIPAC) established, replacing Outreach Oversight Committee.

Committee's **scope is broadened** to include assessing policies, operations, and outreach efforts for both FAMIS and FAMIS Plus (children's Medicaid), and evaluating enrollment, utilization of services, and health outcomes.

CHIPAC Charge

Code of Virginia, § 32.1-351.2. Children's Health Insurance Program Advisory Committee; purpose; membership; etc.

*[DMAS] shall maintain a Children's Health Insurance Program Advisory Committee to **assess the policies, operations, and outreach efforts** for FAMIS and FAMIS Plus and to **evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs**… The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.*

Member Organizations

- **Maximum of 20 members**
- Required members:
  - Joint Commission on Health Care
  - Department of Social Services (VDSS)
  - Virginia Department of Health (VDH)
  - Department of Education (VDOE)
  - Dept of Behavioral Health and Developmental Services (DBHDS)
  - Virginia Health Care Foundation
- **Other members:** "various provider associations and children's advocacy groups, and other individuals with significant knowledge and interest in children's health insurance."

Member Responsibilities, Electronic Meetings and Remote Participation Policy

- **Attendance at quarterly meetings is required** for members.
  - If unable to attend, please **designate a substitute** and notify DMAS staff with that person's contact information.
- Two meetings a year are **all-virtual meetings**. These meetings are held in June and December.
- The other two meetings—March and September—are **in-person meetings**. Members may participate remotely under certain circumstances; permission to attend remotely must be requested in advance.

CHIPAC's Mission and Advisory Role

- CHIPAC's mission is to advise the DMAS Director and Secretary of Health and Human Resources on ways to **optimize the efficiency and effectiveness** of DMAS' children's programs.
- CHIPAC strives to make **timely, actionable recommendations**, and works with DMAS to ensure meeting content is geared towards providing the Committee the opportunity to help shape the agency's decision-making.

CardinalCare
Virginia's Medicaid Program

Overview: Eligibility for Children and Pregnant Women

Sara Cariano, Director
Eligibility Policy and Outreach Division

DMAS

Medicaid/FAMIS Eligibility: Children and Pregnant Virginians

- **Immigration status**: U.S. citizens or lawfully residing noncitizens*

  **Exception: Otherwise-eligible pregnant individuals can be covered by FAMIS Prenatal regardless of immigration status.*

- **Virginia residency**

- FAMIS, FAMIS MOMS, FAMIS Prenatal: no other "creditable" health insurance at application or renewal

- Meet **income** guidelines (Modified Adjusted Gross Income):

Household Size	Children's or Pregnant Women's Medicaid (148% FPL)	FAMIS, FAMIS MOMS, FAMIS Prenatal (205% FPL)
1	$1,858	$2,573
2	$2,521	$3,492
3	$3,185	$4,411
4	$3,848	$5,330
5	$4,512	$6,250
6	$5,176	$7,169
7	$5,839	$8,088
8	$6,503	$9,007
Each additional family member add:	$664	$920

Medicaid/FAMIS Benefits for Children

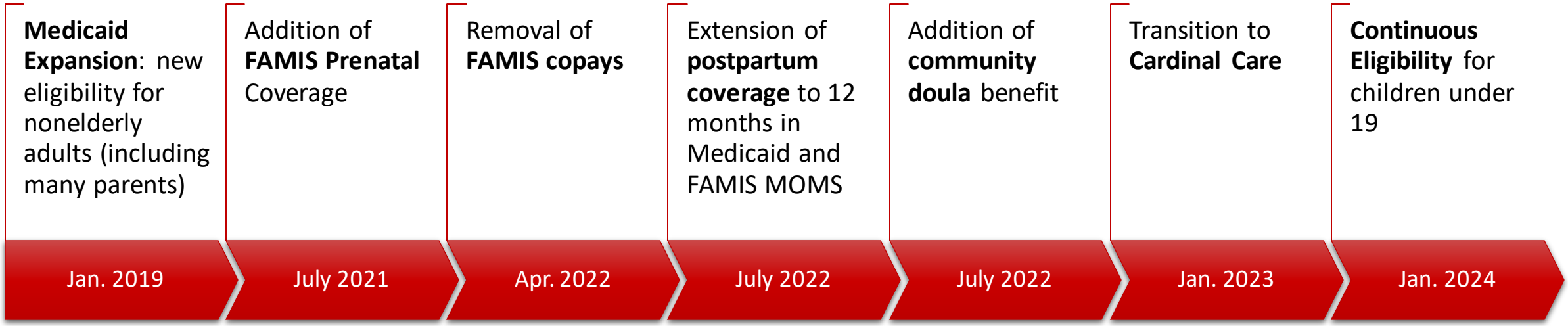
- Dental care
- Doctor visits
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT; comprehensive preventive and treatment services)*
- Emergency care
- Hospital visits
- Mental health care
- Prescription medicine
- Tests and X-rays
- Vaccinations
- Vision care
- Well-baby and well-child check-ups

**Covered in FAMIS prior to a child's enrollment into Managed Care, and ongoing in FAMIS Plus.*

Medicaid/FAMIS Benefits for Pregnant Virginians

- Dental care
- Doctor visits (including postpartum visits, general, and specialty care)
- Emergency care
- Hospital visits
- Mental health care
- Prescription medicine
- Tests and X-rays
- Vaccinations
- Smoking cessation
- Substance use disorder treatment
- Breast pumps and supplies, and lactation consultant services
- Birth control, including long-acting reversible contraception (LARC)

Key Recent Children's and Pregnant Women's Coverage Changes/Expansions



CardinalCare
Virginia's Medicaid Program

Recent CHIPAC Recommendations

Freddy Mejia, The Commonwealth Institute

Chair, CHIPAC

DMAS

Recent CHIPAC Recommendations to DMAS

Timeframe	Recommendation/Request
Summer 2022	Implement 12-Month Continuous Eligibility for children (*later implemented at the federal level*); Create a state-funded program to cover children regardless of immigration status; Merge FAMIS with children's Medicaid (*to enable FAMIS-eligible children to access additional benefits, including EPSDT, while retaining higher CHIP federal match*); Increase FAMIS and FAMIS MOMS income limits.
Summer 2018	Prepare for anticipated changes to federal immigration policy that would affect children's access to Medicaid/FAMIS; Secretary of Health and Human Resources and DMAS Director should submit comments during public comment period on DHS Proposed Rule on Public Charge.
Fall 2017	Secretary of Health and Human Resources and DMAS Director should encourage the Governor to urge Virginia's Congressional Delegation to renew CHIP funding before its expiration.
Summer 2016	Deploy additional training for DSS on *ex parte* renewals; streamline the renewal application; and implement systems changes to prevent 1-year-olds being cancelled.
Summer 2011	Adopt federal options to cover legally residing children and pregnant women during the first five years they are in the United States.