Virginia CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Virginia

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

Family Access to Medical Insurance Security (FAMIS)

Who should we contact if we have any questions about your report?

4. Contact name:

Hope Richardson

5. Job title:

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7. Full mailing address:

Include city, state, and zip code.

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8. Phone number:

804-418-4468

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Managed care and fee for service. Enrollees may designate a managed care organization / health plan at application. If they do not, they begin in fee for service and transition to an assigned MCO. Children with third party liability (TPL) or in a waiver prior to Medicaid enrollment remain in FFS.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

N/A

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Managed care and fee for service. Enrollees may designate a managed care organization / health plan at application. If they do not, they begin in fee for service and transition to an assigned MCO.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

Certain flexibilities implemented at the onset of the COVID-19 federal public health emergency remain in place, including accommodations for extended application and renewal processing timelines. No closures or adverse actions will be taken on Medicaid enrollments through the end of the emergency unless a death is reported, an enrollee moves from Virginia permanently, or an enrollee requests closure of coverage. Appeals flexibilities include an extension of the time frame to file client appeals; an extension of provider appeal timeframes; automatic continuation of coverage during client appeals when the action involves a denial, reduction, or termination of existing eligibility or service; hearings conducted by telephone; and client appeal reschedule requests automatically granted when the appellant misses a scheduled hearing. DMAS has also issued guidance around allowances for 90-day fills on prescriptions and streamlined service authorization processes. Virginia Medicaid and CHIP are providing full coverage of COVID-19 testing, vaccination, and treatment in compliance with federal mandate.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No
- ( ) N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ◉ Yes
- ○ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ○ No
- ◉ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ◉ Yes
- ○ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

FAMIS copayments have been suspended throughout the PHE, and DMAS has submitted a CHIP SPA to permanently remove FAMIS copays effective 7/1/22. Also effective 7/1/22, Virginia implemented 12 months postpartum continuous coverage across Medicaid and CHIP pregnant populations--including CHIPRA-214 populations--under 1115 demonstration authority. Certain flexibilities implemented at the onset of the COVID-19 federal public health emergency remain in place, including accommodations for extended application and renewal processing timelines. No closures or adverse actions will be taken on enrollments through the end of the emergency unless a death is reported, an enrollee moves from Virginia permanently, or an enrollee requests closure of coverage. (For CHIP/ FAMIS, exceptions are children turning 19 and pregnant individuals after 12 months postpartum.) Appeals flexibilities include an extension of the time frame to file client appeals; an extension of provider appeal timeframes; automatic continuation of coverage during client appeals when the action involves a denial, reduction, or termination of existing eligibility or service; hearings conducted by telephone; and client appeal reschedule requests automatically granted when the appellant misses a scheduled hearing. DMAS has also issued guidance around allowances for 90-day fills on prescriptions and streamlined service authorization processes. Virginia Medicaid and CHIP are providing full coverage of COVID-19 testing, vaccination, and treatment in compliance with federal mandate.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7:

"Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	117,272	94,581	-19.349%
Separate CHIP	103,959	79,116	-23.897%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

On a monthly basis (average monthly enrollment over the course of the year) our enrollment numbers have grown year-over-year for our Medicaid expansion CHIP program and have remained stable for our separate CHIP program. We will review the SEDS data; it is possible that there is an error or that updates are needed.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	55,000	7,000	2.9%	0.4%
2016	54,000	6,000	2.8%	0.3%
2017	51,000	6,000	2.6%	0.3%
2018	48,000	5,000	2.5%	0.3%
2019	40,000	5,000	2.1%	0.3%
2020	Not Available	Not Available	Not Available	Not Available
2021	38,000	4,000	1.9%	0.2%

Percent change between 2019 and 2021
-9.52%

1. What are some reasons why the number and/or percent of uninsured children has changed?

Between 2019 and 2021, the estimated number of uninsured children in Virginia has declined by 2,000. The percentage of uninsured children in Virginia has declined by 0.2 percentage points. Virginia's numbers reflect a nationwide trend: Compliance with the maintenance of effort policy during the COVID-19 public health emergency has led to high rates of insuredness for children in our state. These numbers have remained steady as individuals remain enrolled as the PHE has been extended.

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

◉ Yes

1a. What are you doing differently?

During the reporting period, and using their unique knowledge of their respective localities, staff conducted outreach through community outreach and engagement presentations, attendance at workshops, enhancing community partnerships, community event attendance, and materials distribution. Outreach and engagement for specific populations has greatly increased over the past year. Targeted outreach was done for the following populations and programs: non-citizens; pregnant women newly eligible for FAMIS Prenatal Coverage (Virginia's new unborn child coverage) launched in July 2021; Hispanic community (two bilingual outreach team members engage the Latinx/Hispanic communities across the Commonwealth); Afghan evacuees, particularly pregnant women and children; and promoting new adult dental coverage launched in July 2021 to current and potential members. Virginia continues to conduct outreach and engage immigrant communities, with a special focus on the Spanish-speaking population. We offer our print materials in Spanish and five other languages not including English, as well as some other FAMIS informational materials in 15 languages. The Cover Virginia website is available in 48 languages as a translation through Google Translate. In November 2019, DMAS implemented Cubre Virginia, a full-service Spanish language website that mirrors the coverva.org website, including a FAMIS page. Bilingual outreach staff continue to conduct extensive outreach to and engage with Latino communities, especially in Central and Northern Virginia. Recent outreach campaigns have targeted the under- and uninsured through grassroots outreach to faith-based organizations, schools, employers, food pantries, regional coalitions, and other local organizations and agencies. The Cover Virginia website continued support of the Federal Health Insurance Marketplace in Virginia during Open Enrollment and beyond. DMAS ensured that all of the Marketplace materials also supported enrollment in Virginia's FAMIS program. FAMIS also has its own pages on coverva.org and cubrevirginia.org. During the reporting period, DMAS promoted FAMIS on the Cover Virginia and FAMIS Facebook pages and through the Cover Virginia Twitter account. DMAS also continued to partner with a digital engagement organization to help grow subscriptions among consumers.

○ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

◉ Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

Ways we have measured effectiveness of outreach efforts include website analytics, the number and types of stakeholders engaged, events attended, and volume of materials distributed by community outreach and member engagement team (COMET) staff. We are currently working to revamp our internal monthly marketing and enrollment report to better reflect current and potential enrollment. This work will inform the development of a strategic plan that will enable us to better track and measure the impact of outreach efforts.

○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

For 21 years, the most effective outreach strategy employed by DMAS in reaching children has always been the annual FAMIS Back-To-School (BTS) campaign. This year, we continued to adapt our outreach strategies in response to the COVID-19 public health emergency. Working with the Virginia Department of Education, we made our outreach flexible and virtual. We shipped 1.3 million flyers to every public school in the state (1,800-plus, including elementary, middle, and high schools) with a request that flyers be distributed through the end of the calendar year instead of just included as a single distribution in first day of school packets. We expanded the campaign to more digital components to include social media assets, automated calling scripts, and videos for partners to use at their disposal. Again this year, we included a banner placed across the BTS flyers announcing that parents might also be eligible for adult coverage. Several campaigns were launched in calendar year 2021, including the 40 Quarters campaign and mailing, FAMIS Prenatal Coverage, and New Adult Dental Coverage campaigns. Targeted mailings have been the most effective in reaching these populations.

4. Is there anything else you'd like to add about your outreach efforts?

Community outreach and engagement efforts have grown significantly over the past year. Outreach and engagement to immigrant populations has been a continued topic of conversation, but has taken off with better messaging, print materials available in more languages, a mirror-image Spanish Cover Virginia website, and ads also running in Spanish on social media. The Community Outreach and Member Engagement Team (COMET) was reimagined when the new Outreach and Community Engagement Manager was hired in May 2021. The newly configured team has been able to modernize, streamline, and develop innovative approaches to outreach across the Commonwealth. The Manager has hired an Outreach and Community Engagement Specialist (Bilingual) and has implemented a plan that has six community outreach coordinators in the Central, Tidewater, Northern, Allegany/Roanoke and Southwest regions as well as an additional graphic designer to support the outreach team's efforts anticipating the wind-down of the federal public health emergency. These roles, in addition to key statewide partnerships that include application assistance, targeted outreach and engagement, and system navigation, will continue to help the division to increase outreach efforts and reach more current and potential Medicaid and FAMIS members.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

_____ %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

Data not available for #3 above.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- ○ Yes
- ◉ No
- ○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ◉ Yes
- ○ No

3. Do you send renewal reminder notices to families?

◉ Yes

3a. How many notices do you send to families before disenrolling a child from the program?

If the child's enrollment is closed for any reason other than excess income, one Notice of Eligibility is sent to the household within Advance Notice timeframes. If the child is ineligible due to excess income, an initial notice is sent explaining the reason they are no longer eligible and giving the household at least 10 calendar days to turn in additional information for a Medically Needy evaluation. Once the timeframe for verifications has passed, the household will receive another notice once the CHIP coverage is closed and to provide results of the evaluation for Medically Needy. The second notice is sent within Advance Notice timeframes due to the negative action taken to close the existing coverage.

3b. How many days before the end of the eligibility period did you send reminder notices to families?

On average, 70% of MAGI renewal applications are completed through the ex parte renewal process, meaning there is no action required on behalf of the individual to renew coverage. If the annual renewal cannot be completed through the ex parte process, the individual is mailed a paper renewal packet two months prior to the month in which the eligibility period ends. Enrollees have up to 90 days after the end of the enrollment period to furnish necessary information and have an eligibility determination completed without having to file a new application.

○ No

4. What else have you done to simplify the eligibility renewal process for families?

In collaboration with the Virginia Department of Social Services (VDSS), DMAS continues to make system improvements in order to increase the success rate of ex parte renewals. Additionally, in collaboration with VDSS, external stakeholders, and member input through Virginia's Medicaid Member Advisory Committee, DMAS revised the renewal form. The renewal form was reviewed to ensure all federal and state requirements were met and further improvements were made to streamline and simplify the readability and flow of the renewal form.

5. Which retention strategies have you found to be most effective?

DMAS and VDSS partners are working to ensure that we maximize the number of renewals that can be completed automatically through the ex parte process. This has proven to be one of the most effective strategies for ensuring retention. Additionally, improvements to the Medicaid renewal form included more prominently highlighting how renewals can be completed: online, by mail, or in person. Previously, the renewal forms did not provide information for renewing online or telephonically. Finally, DMAS has formed a pilot partnership with one of the state's health plans to remind individuals whose renewal was completed through the ex parte process that their renewal is due beginning the month prior to the renewal due date. This outreach includes automated reminder calls, postcards, and text messages.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

While a formal evaluation has not been conducted, VDSS runs and monitors monthly reports on the percentage of renewals that successfully complete the automated ex parte process. Virginia has been unable to measure the success of the new renewal forms and the health plan outreach pilot due to the public health emergency (PHE). After the PHE, DMAS plans to monitor trends and impact of the implemented improvements to measure any retention strategy successes.

7. Is there anything else you'd like to add that wasn't already covered?

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

5. Did you have any limitations in collecting these data?

Due to limitations in the data captured through our application process and the single streamlined application, we are unable to report on #1-4 at this time.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	
Denied for procedural reasons	
Denied for eligibility reasons	
Denials for other reasons	

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in CHIP after redetermination?

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

Due to limitations in the data captured through our application process and the single streamlined application, we are unable to report on #1-4 at this time.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting these data?

Due to limitations in the data captured through our application process and the single streamlined application, we are unable to report on #1-4 at this time.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
703	455	541	334

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
522	349	423	265

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	<11	<11	<11

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	<11	<11	<11

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
176	104	114	65

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
142	81	79	51

9. Is there anything else you'd like to add about your data?

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
10165	3270	3739	1985

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
9737	3008	3499	1838

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
34	34	24	19

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
28	17	12	<11

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
395	231	218	128

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
128	59	67	38

9. Is there anything else you'd like to add about your data?

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- ○ Yes
- ◉ No

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- (●) Yes
- ( ) No

1. Under which authority and statutes does your state offer premium assistance? Check all that apply.

- [ ] Purchase of Family Coverage under CHIP State Plan [2105(c)(3)]
- [ ] Additional Premium Assistance Option under CHIP State Plan [2105(c)(10)]
- [x] Section 1115 Demonstration (Title XXI)

2. Does your premium assistance program include coverage for adults?

- ( ) Yes
- (●) No

3. What benefit package is offered as part of your premium assistance program, including any applicable minimum coverage requirements?

This only applies to states operating an 1115 demo.

The benefit package is that of the private or employer-sponsored plan, with wrap-around coverage for immunizations. (Note: The FAMIS Select program provides $100 in premium assistance per FAMIS-eligible child per month, up to the total cost of the monthly premium, if the family chooses to cover their FAMIS-eligible child/ren with a private or employer-sponsored health plan instead of FAMIS. The reimbursement is paid to the family member who chooses to provide the insurance. Thus any adult coverage is incidental coverage only.)

4. Does your premium assistance program provide wrap-around coverage for gaps in coverage?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No

5. Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?
This only applies to states operating an 1115 demo.

- ( ) Yes
- (●) No
- ( ) N/A

6. Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?
This only applies to states operating an 1115 demo.

- ○ Yes
- ◉ No

7. How many children were enrolled in the premium assistance program on average each month in FFY 2022?

47

8. What's the average monthly contribution the state pays towards coverage of a child?

$ 100

9. What's the average monthly contribution the employer pays towards coverage of a child?

$

10. What's the average monthly contribution the employee pays towards coverage of a child?

$

Table: Coverage breakdown

Child

State	Employer	Employee
100		

11. What's the range in the average monthly contribution paid by the state on behalf of a child?

Average Monthly Contribution

Starts at		Ends at
$ 0	→	$ 100

12. What's the range in the average monthly contribution paid by the state on behalf of a parent?

Average Monthly Contribution

Starts at		Ends at
$ 0	→	$ 0

13. What's the range in income levels for children who receive premium assistance (if it's different from the range covering the general CHIP population)?

Federal Poverty Levels

Starts at		Ends at
	→	

14. What strategies have been most effective in reducing the administrative barriers in order to provide premium assistance?

The application process does not require detailed information on employer-sponsored or private insurance benefit plans and cost-sharing, which has made applying simpler for families. Providing reimbursement to families after they demonstrate proof of having paid the premium has made it unnecessary to contact employers or insurers, and has eliminated the need for recovery of overpayments.

15. What challenges did you experience with your premium assistance program in FFY 2022?

We continue to see low participation in FAMIS Select. The decrease over time is thought to be due to changes in employer-sponsored insurance - fewer employers offering insurance; more restrictive requirements or employee eligibility; higher employee costs - that make the FAMIS program a more attractive choice for children's coverage.

16. What accomplishments did you experience with your premium assistance program in FFY 2022?

Virginia's revised Section 1115 demonstration evaluation plan for FAMIS Select was approved November 3, 2021.

17. Is there anything else you'd like to add that wasn't already covered?

Data are not available for #9 and #10 above.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

The annual program integrity plan lays out the specific planned investigative activities for the fee-for-service program for each fiscal year. Methods and procedures are laid out in the policy manuals for each investigative unit for staff activities, and in the contracts for activities conducted by contract auditors. Prevention activities in the program integrity division are defined in our service authorization contract, as well as the policies of our prior authorization division that oversees that contract. Fraud and patient abuse referrals are executed according to a memorandum of understanding with our state's Medicaid fraud control unit on standard forms used by all staff, contractors, and managed care partners. These forms contain all fields required by federal law.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  The managed care organization contracts require that each MCO have in place written policies and procedures for ensuring protections against actual or potential fraud and abuse. These plans are submitted to DMAS annually. DMAS conducts oversight of the adequacy of these plans through annual review of each MCO's Program Integrity Plan. In addition, staff evaluate quarterly Program Integrity Activity reports, as well as reports on individual audits to ensure progress toward completing the annual plan. Program integrity and managed care policy staff review these plans to ensure that each MCO has adequate planned program integrity activities based on an evaluation of risk.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

207

7. How many cases have been found in favor of the beneficiary in FFY 2022?

81

8. How many cases related to provider credentialing were investigated in FFY 2022?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

10. How many cases related to provider billing were investigated in FFY 2022?

1057

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

98

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

1361

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

14

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ◉ Yes

    15a. How do you provide oversight of the contractors?

    The Program Integrity Division does utilize contractors to provide recipient and provider auditing functions. The detailed duties, responsibilities and reporting required are written in a request for proposal, vendor response and contract amendments. DMAS has assigned staff members (contractor monitors) for each contract to assure contractual standards are met. Each contract is closely monitored by DMAS staff to include weekly meetings with the contractors. Contractors are continually reviewed for cost effectiveness, productivity and ROI, as well as monitoring to ensure that completion deadlines and reporting requirements are met.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

- ○ Yes
- ◉ No

17. Is there anything else you'd like to add that wasn't already covered?

Data are not available for #8 and 9 above.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
2000	7135	14586	20400	25079	19567

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	441	5140	10579	13481	9709

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	1502	6834	11726	13698	8786

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	460	2873	6682	8772	6279

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

2717

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- (●) Yes

  1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database? Please note this is a requirement for FFY 2022.

  - (●) Yes
  - ( ) No

- ( ) No

Part 2: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

FAMIS Prenatal Coverage

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Coverage of 60 days postpartum fee-for-service health services for CHIP unborn child population

4. How many children do you estimate are being served by the HSI program?

1244

5. How many children in the HSI program are below your state's FPL threshold?

1244

Computed: 100%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

We are measuring the number of individuals served in the FAMIS Prenatal Coverage HSI and the cost of health services provided through the HSI during the reporting period.

7. What outcomes have you found when measuring the impact?

An estimated 1,244 individuals were served in the program in the first full year of implementation (FY22). Annual expenditures for the HSI were $434,481.

8. Is there anything else you'd like to add about this HSI program?

Claims lag may affect the completeness of the data on program costs.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Virginia Poison Control Centers

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

All children in Virginia can receive assistance from the poison control centers.

4. How many children do you estimate are being served by the HSI program?

33546

5. How many children in the HSI program are below your state's FPL threshold?

10567

Computed: 31.5%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

- Number and percentage of calls to the poison centers involving children - Percentage of pediatric cases safely managed at site of exposure - Estimated number of annual pediatric Emergency Department visits averted and annual cost savings to Virginia

7. What outcomes have you found when measuring the impact?

In 2021, Virginia's poison control centers responded to 70,402 calls for assistance. Of those calls, 61,778 were human poisonings and 33,546 (54.3%) involved children. The Virginia Poison Control Network safely managed 75% of the pediatric cases at the site of exposure (outside of a health care facility). Virginia estimates that in 2021, approximately 25,153 pediatric ED visits were averted, resulting in an estimated cost savings to the Commonwealth of approximately $26 million.

8. Is there anything else you'd like to add about this HSI program?

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Maximize the percentage of Medicaid and CHIP-eligible children in Virginia who are insured.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Virginia children's Medicaid and CHIP participation rate - the percentage of children eligible for Medicaid and CHIP who are enrolled/insured (Urban Institute analysis of 2019 American Community Survey data from the Integrated Public Use Microdata Series)

4. Numerator (total number)

93

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

The denominator in the original measure is the number of Medicaid and CHIP-eligible children in Virginia. Please see additional information below.

6. Denominator (total number)

100

Computed: 93%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Due to issues affecting US Census data during the COVID-19 pandemic, updated ACS data for 2020 are not available. Virginia is reporting the most recent Medicaid and CHIP participation rate currently available based on 2019 ACS data. As indicated in Section 2, the percentage of uninsured children in Virginia (of total children in the state) is 1.9% (an estimated 38,000 children).

10. What are you doing to continually make progress towards your goal?

Virginia continues to comply with PHE Maintenance of Effort, which has led to sustained high enrollment and a very low uninsurance rate for children and other populations during the past three years.

11. Anything else you'd like to tell us about this goal?

We are reporting Virginia's Medicaid and CHIP children's participation rate as a percentage derived from a secondary source that calculates this rate using ACS/IPUMS data. This is not DMAS' calculation. Source: Haley, J., et al., "Uninsurance Rose Among Children and Parents in 2019" (District of Columbia: The Urban Institute, July 2021). The latest update for the children's participation rate that we are able to report as this time is from 2019, prior to the current reporting period for this CHIP Annual Report (FFY2022).

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase enrolled children's access to care

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey "Getting Needed Care" composite metric for the FAMIS program (general child population) will meet or exceed the NCQA national average for this metric

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Surveyed family members of enrolled FAMIS children. Numerator is the 2022 FAMIS Program "Getting Needed Care" CAHPS composite measure (General Child)

4. Numerator (total number)

83

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Survey sample

6. Denominator (total number)

100

Computed: 83%

7. What is the date range of your data?

Start

mm/yyyy

07 / 2021

End

mm/yyyy

06 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Virginia first identified this as a goal in the 2020 CHIP Annual Report. Last year we reported SFY2021 data, and the metric was 83.0%. The SFY2022 metric increased to 83.3%.

10. What are you doing to continually make progress towards your goal?

Please see information below regarding our managed care Quality Improvement program.

11. Anything else you'd like to tell us about this goal?

NOTE: Because the "Getting Needed Care" measure is a composite score, we have adapted this metric to conform to input requirements for CARTS.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Improve the health care status of enrolled children

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

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

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

The percentage of Medicaid and FAMIS-enrolled children who received Combo 3 vaccination

4. Numerator (total number)

64

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

Sample size

6. Denominator (total number)

100

Computed: 64%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2020

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Virginia's average this year was 64.03%, compared to the national benchmark (HEDIS 50th percentile) of 69.9%. Last year, Virginia's average was 64.28%, compared to the national benchmark of 71.05%. DMAS has tracked and reported on this HEDIS measure for some time; in 2018, Virginia incorporated this measure into the CHIP Annual Report.

10. What are you doing to continually make progress towards your goal?

DMAS continues to work closely with the managed care organizations (MCOs) to improve children's vaccination rates. The COVID-19 public health emergency has continued to affect children's utilization. In partnership with the MCOs and through strategies such as vaccination drives, provider incentives and training, extended office hours, data sharing, direct outreach to members, and other initiatives, we continue to work to ensure that Virginia Medicaid and FAMIS-enrolled children remain on track with their immunizations and receive recommended preventive care.

11. Anything else you'd like to tell us about this goal?

NOTE: Because the HEDIS metric is a weighted average that is not simply derived from a single numerator and denominator, we have adapted this metric to work within the CARTS form.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

DMAS prioritizes quality improvement as a fundamental component of Virginia's Medicaid managed care program. The Managed Care Organizations (MCOs) that are contracted with the state are required to complete federal- and state-mandated quality improvement activities such as reporting the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, measure validation activities, and participation in a quarterly collaborative. Contracted MCOs are also required to be accredited by the National Committee for Quality Assurance (NCQA). Each MCO has quality improvement and disease management programs, in addition to provider relation operations focused on improving the quality of care received by Medicaid members. The MCOs are required to report all HEDIS measures for the Medicaid product as part of their Quality Improvement (QI) program and meet HEDIS specifications for data collection. The HEDIS measures combine Medicaid and CHIP population data. DMAS' Quality and Population Health Unit (QPH) has also created a Quality Collaborative in which the contracted MCOs share their challenges and successes in quality measurement and improvement. Virginia's Medicaid Managed Care quality oversight assures compliance with federal mandates for external quality review organization (EQRO) activities, including (1) validation of a sample of each MCO's performance measures annually, (2) implementation of performance improvement projects, and (3) comprehensive reviews of MCO compliance with federal and state operational standards, that occurs every three years. The contracted EQRO conducts these activities adhering to CMS published protocols. DMAS' QPH Unit also evaluates the Child Welfare Foster Care and Medicaid and CHIP Maternal and Child Health populations through studies completed by the EQRO. In addition, QPH monitors and conducts an annual analysis on the HEDIS measure rates to include the following measures: (1) Childhood Immunization Status - Combination 3, (2) Prenatal and Postpartum Care - Timeliness of Prenatal Care, (3) Well Child Visits in the First 30 Months of Life. DMAS is committed to the continuation of the Managed Care Compliance Program to ensure appropriate service delivery to CHIP members. The Compliance Program aims to detect issues, collaborate with MCOs, and enforce the contract requirements. The Compliance program was designed to identify and respond to program compliance issues and remedy contractual violations if necessary in four

major areas: deliverables, quality, systems and reporting and contracts. Finally, the Children's Health Insurance Program Advisory Committee (CHIPAC) monitors FAMIS program data related to enrollment, access, utilization, and retention, and continues to be actively interested in improving utilization of preventive services for children.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

The agency contracts for a comprehensive maternal and child health / birth outcomes study that looks at timeliness and adequacy of prenatal care, birth weight, and gestational age for the FAMIS / FAMIS MOMS populations and their newborns, along with Medicaid pregnant women and newborns. Starting with the 2018-19 study, the report includes detailed breakdowns by race, geographic region, and managed care plan.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

The birth outcomes study referenced above is a focused study that includes women in FAMIS / FAMIS MOMS and their infants (who at birth are deemed eligible for FAMIS or Medicaid, as applicable). Previous years' analyses have demonstrated that individuals enrolled in FAMIS MOMS have birth outcomes (e.g., rates of preterm and low-birthweight births) that compare favorably to those of similar populations.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 401,158,280	**$** 430,603,354	**$** 448,366,728

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 73,960,821	**$** 87,610,603	**$** 90,097,853

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	$	$

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	$	$

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	401158280	430603354	448366728
Fee for Service	73960821	87610603	90097853
Other benefit costs			
Cost sharing payments from beneficiaries			
Total benefit costs	475119101	518213957	538464581

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$ 2,851,423	**$** 3,350,742	**$** 3,098,467

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 91,516	**$** 107,542	**$** 99,445

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 13,038,082	**$** 15,321,210	**$** 14,167,690

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 2,161,563	**$** 2,540,079	**$** 2,348,839

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 355,287	**$** 417,502	**$** 386,069

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 1,340,005	**$** 2,995,250	**$** 3,042,959

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel	2851423	3350742	3098467
General administration	91516	107542	99445
Contractors and brokers	13038082	15321210	14167690
Claims processing	2161563	2540079	2348839
Outreach and marketing	355287	417502	386069
Health Services Initiatives (HSI)	1340005	2995250	3042959
Other administrative costs			
Total administrative costs	19837876	24732325	23143469
10% administrative cap	Not Available	57579328.56	59829397.89

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	Not Available	542946282	561608050
eFMAP	65	65.46	65
Federal share	Not Available	355412636.2	365045232.5
State share	Not Available	187533645.8	196562817.5

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 171,439	**$** 180,767	**$** 180,491

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 195	**$** 199	**$** 207

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	195	199	207

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 172,049	**$** 181,410	**$** 181,126

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 36	**$** 40	**$** 41

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	36	40	41

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

FAMIS children are enrolled in fee for service only while awaiting assignment to a managed care plan. All children are counted in the "eligible children" count because children enrolled in managed care may also access some FFS carved out services (primarily Medicaid expansion CHIP children).

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Over the last three years, uncertainty caused by the COVID-19 public health emergency and its economic impact have at times made project planning and implementation challenging. DMAS continues to uphold our central mission of providing high quality healthcare to our members, and we have ensured that the necessary adaptations and flexibilities are in place for us to continue to provide critical coverage to low-income children and families without disruption.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

During the ongoing public health emergency, DMAS is working with our managed care plans to ensure that children are receiving essential health care including well visits and scheduled immunizations. We are also focusing attention on meeting the needs of children and youth with behavioral health conditions. DMAS continues to track federal legislation and guidance and ensure efficient deployment of policy directives related to pandemic recovery. We have spent much of the year developing and updating Virginia's plan for the PHE unwinding in order to be fully prepared for transitions at the end of the PHE.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

FFY2022 was the first full year of implementation for several exciting additions to Virginia's CHIP program. In July 2021, DMAS implemented new coverage for previously ineligible pregnant individuals through our unborn child option CHIP SPA. Virginia also established the state's first Health Services Initiatives, both effective in July 2021. The first HSI funds Virginia's Poison Control Centers. The second HSI funds fee-for-service costs through 60 days postpartum for FAMIS Prenatal Coverage members.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

In November 2021, Virginia's Section 1115 waiver amendment was approved to extend 12 months continuous postpartum coverage for our members, including CHIP pregnant women in our FAMIS MOMS program. This coverage expansion, implemented July 1, 2022, aims to reduce maternal mortality and severe morbidity and address racial disparities in maternal health. In addition, effective July 1, 2022, Virginia removed co-payments in FAMIS. Co-payments have been suspended for the duration of the PHE, and our recently submitted CHIP SPA makes the change permanent. Both the extension of postpartum coverage and the removal of co-payments were directives from Virginia's Governor and General Assembly.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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