



# Virginia CARTS FY2020 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:

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5. Job title:

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Include city, state, and zip code.

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#### 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 the 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

3b. What's the maximum premium a family would be charged each year?

\$

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

3b. What's the maximum premium fee a family would be charged each year?

\$

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.

☒ Managed Care

☐ Primary Care Case Management

☒ 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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 women?

☐ 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.

Through a Medicaid Disaster SPA and other federal and state authorities, DMAS has enabled emergency flexibilities during the COVID-19 public health emergency, 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 for the timeframe 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 and treatment in compliance with federal mandate. Outreach is being conducted largely through electronic/remote modalities.

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. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

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 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 your Pregnant Women State Plan expansion?  
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 women?

☐ 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.

Through a CHIP Disaster SPA and other federal and state authorities, DMAS has enabled emergency flexibilities during the COVID-19 public health emergency, including accommodations for extended application and renewal processing timelines. No closures or adverse actions will be taken on enrollees 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 for the timeframe 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 and treatment in compliance with federal mandate. Outreach is being conducted largely through electronic/remote modalities. \* NOTE: Federal continuity of coverage requirements do not apply to lawfully residing non-citizen pregnant women and children under age 19. Additionally, the continuity of coverage requirements do not apply for coverage in a separate CHIP program. In Virginia, this includes FAMIS MOMS pregnant women whose sixty (60) day postpartum period has ended, and FAMIS children turning 19. Individuals who meet these requirements and have reached age 19 or who have reached the end of their pregnancy period are re-determined and enrolled in other coverage or, if no longer eligible, referred to Marketplace coverage.

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 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	122,903	125,752	2.318%
Separate CHIP	119,931	113,687	-5.206%

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

We believe several factors are involved in the year-over-year decline in separate CHIP (FAMIS) enrollment (unduplicated number ever enrolled). On a monthly basis, our enrollment numbers for FAMIS, and all children's enrollment categories, trended upward for most of FY2020. The drop in unduplicated number of children ever enrolled in FAMIS likely indicates fewer transitions from Medicaid into FAMIS, and a greater proportion of newly enrolled children qualifying for Medicaid and the Medicaid-CHIP expansion group (at lower income eligibility ranges) than for FAMIS due to recessionary impacts. In compliance with the continuous coverage provision of the Families First Coronavirus Response Act (FFCRA), children enrolled in Medicaid and Medicaid expansion CHIP are remaining enrolled in their current category regardless of changes in circumstance, rather than moving to separate CHIP. (One exception being that a Medicaid child could transition to an adult category upon turning 19 if eligible and if the category provided equivalent or better coverage.) With the resumption of ex parte batch runs in the late summer, FAMIS children found eligible for Medicaid children's coverage at renewal are enrolled in Medicaid, but Medicaid children would remain in a Medicaid category and would not transition to FAMIS. In addition, consistent with CMS guidance in summer 2020, DMAS is ensuring FAMIS (separate CHIP) children are being reevaluated timely upon turning 19. The child who is "aging out" is then enrolled in other coverage if eligible, but unlike in Medicaid, if the 19-year-old is not eligible for other coverage then they would not remain in FAMIS.

## 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.

<b>Year</b>	<b>Number of uninsured children</b>	<b>Margin of error</b>	<b>Percent of uninsured children (of total children in your state)</b>	<b>Margin of error</b>
<b>2015</b>	55,000	7,000	2.9%	0.4%
<b>2016</b>	54,000	6,000	2.8%	0.3%
<b>2017</b>	51,000	6,000	2.6%	0.3%
<b>2018</b>	48,000	5,000	2.5%	0.3%
<b>2019</b>	40,000	5,000	2.1%	0.3%

<b>Percent change between 2018 and 2019</b>
<b>NaN%</b>

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

Virginia has seen an increase in both adult and children's enrollment during the COVID-19 public health emergency. Even prior to that, Virginia was experiencing increases in children's enrollment and decreases in children's uninsuredness, in contrast to nationwide trends. We attribute this partly to the Commonwealth's recent Medicaid expansion -- applications for the new adult coverage are sometimes resulting in other family members, including children, enrolling. We also believe our outreach efforts have been successful, among other factors.



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).

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## 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 and employer presentations, attendance at workshops, enhancing community partnerships, health fair attendance, and materials distribution. Their efforts were greatly impacted by the COVID pandemic, but they quickly adapted to a new virtual world, which forced them to think of new and innovative ways to continue their outreach. In November 2019, DMAS launched a new Spanish-language website, Cubre Virginia, to mirror the English-language Cover Virginia website. The [www.coverva.org](http://www.coverva.org) website continued support of the Federal Health Insurance Marketplace in Virginia during Open Enrollment and beyond. The Spanish language website also added a Marketplace page in December 2019. 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](http://coverva.org) and [cubrevirginia.org](http://cubrevirginia.org). During the reporting period, DMAS promoted FAMIS on the Cover Virginia and FAMIS Facebook pages and through the Cover Virginia Twitter account. Also in FFY 2020, DMAS continued to partner with a digital engagement organization to help grow subscriptions among consumers. Staff also managed the 19th annual Back to School (BTS) campaign, preparation for which begins in February. This year's campaign was adapted to include a greater online presence and to extend the length of the BTS Flyer distribution through the end of the calendar year. (Please see additional information about the BTS campaign in item #3 below.)

☐ 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?

Virginia continues to conduct targeted outreach to rural communities and immigrant communities, with a special focus on the Spanish-speaking population. We offer our print materials in Spanish and 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. Additionally, in September 2020, a new family-oriented Spanish-language television ad was aired on statewide Spanish TV stations. During FFY 2020, the percentage of children covered by our separate CHIP program who reported as Spanish speakers averaged 7%. This number has increased by 0.5 percentage points over the last year as bilingual outreach staff continued to conduct extensive outreach to Latino communities, especially in Central and Northern Virginia and in the Roanoke Valley. Recent outreach campaigns have also encompassed the rural far Southwest counties of Virginia, targeting the uninsured through grassroots outreach to churches, schools, employers, and other local organizations.

☐ No

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

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

For 19 years, the most effective outreach strategy employed by DMAS has always been the annual FAMIS Back-To-School (BTS) campaign. This year, we adapted our outreach strategies in response to the COVID-19 public health emergency. Working in close partnership with the Virginia Department of Education, we made our outreach more flexible and virtual than in previous years. 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 partnered with School Lunch Program directors to include language about FAMIS directly on the letter sent to families. We also built separate BTS pages on the [coverva.org](http://coverva.org) website specifically to reach parents and school personnel, and we added a page on the Spanish language [cubrevirginia.org](http://cubrevirginia.org) website to make applying for coverage more streamlined. Again this year, we were also able to include a banner placed across the BTS flyers announcing that parents might also be eligible for the new adult coverage. And we continued outreach for the Medicaid expansion, including two separate advertising campaigns in October 2019 through March 2020 and from June through September 2020 that included messaging geared toward families.

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

Our most successful strategies tap into the existing relationships that schools -- and, specifically, school nurses -- have with families and children and utilize that opportunity to share information about our programs. Funding for regular media advertising is not secure enough to be able to build on it from one year to the next; there was no media campaign targeted exclusively toward FAMIS during the reporting period. FFY2020 has been an atypical year and it is therefore not feasible to rely on usual methods of outreach.

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).

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## 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 data?

Data are 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).

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# 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?

This question should only be answered in respect to Separate CHIP.

☐ 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 worked to continue 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 2020?

Don't include applicants being considered for redetermination - this 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 this 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
<b>Total denials</b>	
<b>Denied for procedural reasons</b>	
<b>Denied for eligibility reasons</b>	
<b>Denials for other reasons</b>	

## 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 2020?

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 this data?

Due to limitations in the data captured through our application process and the single steamlined 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
<b>Children screened for redetermination</b>	
<b>Children retained after redetermination</b>	
<b>Children disenrolled after redetermination</b>	

Table: Disenrollment in CHIP after Redetermination

	Percent
<b>Children disenrolled after redetermination</b>	
<b>Children disenrolled for procedural reasons</b>	
<b>Children disenrolled for eligibility reasons</b>	
<b>Children disenrolled for other reasons</b>	

## 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 2020?

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 this data?

Due to limitations in the data captured through our renewal processes, 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
<b>Children screened for redetermination</b>	
<b>Children retained after redetermination</b>	
<b>Children disenrolled after redetermination</b>	

Table: Disenrollment in Medicaid after Redetermination

	Percent
<b>Children disenrolled after redetermination</b>	
<b>Children disenrolled for procedural reasons</b>	
<b>Children disenrolled for eligibility reasons</b>	
<b>Children disenrolled for other reasons</b>	

## Part 5: Tracking a CHIP cohort (Title XXI) 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 2020 (the second quarter of FFY 2020). 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 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). 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 2020. 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 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

#### 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 2020 weren't enrolled in CHIP in December 2019.

☒ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

719

967

1127

581

July - September 2020 (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

581

731

889

463

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

133

229

232

115

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

119

208

212

102

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

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

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 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

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 (Title XIX) 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 2020 (the second quarter of FFY 2020). 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 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). 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 2020. 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 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

#### 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 2020 weren't enrolled in Medicaid in December 2019.

☒ 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 2020 weren't enrolled in CHIP or Medicaid in December 2019.

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 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1

10411

Ages 1-5

5782

Ages 6-12

6541

Ages 13-16

3229

July - September 2020 (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

10120

Ages 1-5

5516

Ages 6-12

6248

Ages 13-16

3062

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

26

45

52

32

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

13

17

25

17

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

265

222

245

139

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

116

132

76

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

January - March 2021 (12 months later)

Next year you'll report this data. Leave it blank in the meantime.

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 2021 (18 months later)

Next year you'll report this data. Leave it blank in the meantime.

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



2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

☒ Families ("the shoebox method")

2a. What information or tools do you provide families with so they can track cost sharing?

The FAMIS handbook instructs the member to maintain records of their costs. A tracking sheet is included with instructions on how to use and submit it.

☐ Health plans

☐ States

☐ Third party administrator

☐ Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

Once DMAS has verified that the co-pay maximum has been met, the MCO and the enrollee are notified that for the remainder of the year, no co-pays are to be charged. The MCO is required to issue a new ID card showing \$0 co-pay. MCO systems are adjusted to recognize this change.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

0

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

☐ Yes

☒ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

☐ Yes

☒ No

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

Virginia charges no premium or enrollment fee. DMAS has temporarily suspended FAMIS co-payments for the duration of the COVID-19 public health emergency. We are not actively monitoring the impact of the suspension of co-payments on utilization; however, we are tracking the impact of the pandemic on utilization.

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

N/A

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).

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## 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)]

☒

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 wraparound 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

☐ N/A

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

☐ N/A

7. How many children were enrolled in the premium assistance program on average each month in FFY 2020?

45

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

\$ 0



Ends at

\$ 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

\$ 0



Ends at

\$ 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 2020?

We continue to see a decline in 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 2020?

Virginia has continued to work with CMS on the updated demonstration evaluation plan for FAMIS Select after securing a 10-year renewal of our CHIP 1115 waiver in November 2019.

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

Data are not available for items 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).

  

## 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 2020?

89

7. How many cases have been found in favor of the beneficiary in FFY 2020?

27

8. How many cases related to provider credentialing were investigated in FFY 2020?

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

10. How many cases related to provider billing were investigated in FFY 2020?

309

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

185

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

2051

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

35

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?

In #7 above, the 27 cases found in favor of the beneficiary include administrative resolutions. 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).

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## 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 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
2062	8950	16307	21307	26510	18237

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 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
13	2182	8779	13783	16821	10069

#### 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 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	8426	13186	2067	15605	8843

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?

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
13	3314	7317	532	9718	6325

#### 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 2020?

2920



### 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).

## 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.

1. Did you collect the CAHPS survey?

☒ Yes

1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?

☒ Yes

☐ No

☐ No

## Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.

This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

**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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2. Which CHIP population did you survey?

- ☐ Medicaid Expansion CHIP
- ☒ Separate CHIP
- ☐ Both Separate CHIP and Medicaid Expansion CHIP
- ☐ Other

3. Which version of the CAHPS survey did you use?

- ☐ CAHPS 5.0
- ☒ CAHPS 5.0H
- ☐ Other

4. Which supplemental item sets did you include in your survey?

Select all that apply.

- ☐ None
- ☒ Children with Chronic Conditions
- ☐ Other

5. Which administrative protocol did you use to administer the survey?

Select all that apply.



NCQA HEDIS CAHPS 5.0H



HRQ CAHPS



Other

6. Is there anything else you'd like to add about your CAHPS survey results?

## Part 3: 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 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.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service 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

## **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 this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Maximize the percentage of Medicaid and CHIP-eligible children 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's children's Medicaid and CHIP participation rate (based on American Community Survey data)

4. Numerator (total number)

92.2

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Estimated number of uninsured Medicaid and CHIP-eligible children in Virginia

6. Denominator (total number)

100

**Computed:** 92.2%

7. What is the date range of your data?

**Start**

mm/yyyy

01

/

2018

**End**

mm/yyyy

12

/

2018

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?

This is a newly identified goal/metric for the CHIP Annual Report

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

Since the implementation of Virginia's adult Medicaid expansion in January 2019, DMAS has made efforts -- including targeted advertising and outreach campaigns -- to maximize the impact of new adult enrollment on enrollment of eligible children and entire families.



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

Please note that we are reporting Virginia's Medicaid and CHIP participation rate as a percentage from a secondary source that uses American Community Survey data, rather than as a raw numerator and denominator. Source: Haley, J., et al., "Progress in Children's Coverage Continued to Stall Out in 2018: Trends in Children's Uninsurance and Medicaid/CHIP Participation," (District of Columbia: The Urban Institute, October 2020). The latest ACS data that we are able to report at this time are from 2018, which pre-dates the adult Medicaid expansion. Enrollment across the children's programs has seen robust growth since the launch of the adult Medicaid expansion in January 2019. Therefore we anticipate that we will see progress on this goal as we track the metric in the coming years.

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 children

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

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 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)

66.08

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

The national HEDIS Medicaid 50th percentile for the Combo 3 vaccination measure

6. Denominator (total number)

70.68

**Computed:** 93.49%

7. What is the date range of your data?

**Start**

mm/yyyy

01

/

2018

**End**

mm/yyyy

12

/

2018

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?

Although this is a newly identified metric for this report, DMAS has tracked and reported on this HEDIS metric for some time. Please note that DMAS believes the magnitude of changes to Virginia's Medicaid and FAMIS managed care programs in 2018 necessitates a break in trending for HEDIS measures from previous years. A number of major changes and innovations occurred in the Virginia Medicaid and CHIP programs in 2018, including the phased rollout of the Medallion 4.0 managed care program. Children's data from the Medallion and Commonwealth Coordinated Care Plus (CCC+) programs were also combined for the first time.

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 onset of the COVID-19 public health emergency dramatically affected children's preventive (well visits, immunizations, etc.) and other health care utilization, particularly in the early months. In partnership with the MCOs and through strategies such as vaccination drives, provider incentives and training, extended office hours, data sharing, significant direct outreach to members, and other initiatives, we are working 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 try to work within the CARTS form. It would be helpful in future years if there were other options for input of the metrics.

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 to match what's in your CHIP State Plan.

To conduct effective outreach to encourage enrollment in health insurance plans

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Please see below

2. What type of goal is it?

- ☐ New goal
- ☐ Continuing goal
- ☒ Discontinued goal

2a. Why was this goal discontinued?

Virginia is retiring this objective and associated goals because we feel it is duplicative of objective #1 and is not sufficiently focused on outcomes. In our recent strategic plan, DMAS has shifted our focus toward quality measures, so we will replace this metric with an access measure based on member feedback reported in our CAHPS survey. This incorporates a more timely metric and one that is based on consumer input. DMAS will amend our CHIP State Plan to reflect the change.



Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

see above

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

see above

6. Denominator (total number)

**Computed:**

7. What is the date range of your data?

**Start**

mm/yyyy

 / 

**End**

mm/yyyy

 / 

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?

see above

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

see above

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

see above

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?

Increase access to care

1. Briefly describe your goal for this objective.

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?

Surveyed family members of enrolled FAMIS children. Numerator is the 2020 FAMIS Program "Getting Needed Care" CAHPS composite measure (General Child)

4. Numerator (total number)

89.6

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

2019 NCQA National Average for "Getting Needed Care" CAHPS composite measure (General Child)

6. Denominator (total number)

89.0

**Computed:** 100.67%

7. What is the date range of your data?

**Start**

mm/yyyy

07

/

2019

**End**

mm/yyyy

06

/

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?

This is a newly identified goal/metric for the CHIP Annual Report

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 try to work within the CARTS form. It would be helpful in future years if there were other options for input of the metrics.

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).

  

**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 the Medallion managed care program. The contract requires each MCO to complete federal- and state-mandated quality improvement activities, such as participation in a quarterly collaborative; reporting of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data; measure validation activities; and participation in a performance incentive award program. Contracted MCOs are required to be accredited by the National Committee for Quality Assurance (NCQA). All plans have quality improvement programs, disease management programs, and provider relations operations. The MCOs are encouraged to report all HEDIS measures for the Medicaid product as part of their QI program; the MCOs are also required to meet HEDIS specifications for data collection. Measures combine Medicaid and CHIP population data. DMAS has 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 Initiative also 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 a rapid cycle performance improvement project, and (3) comprehensive review of MCO compliance with federal and state operational standards once every three years. The contracted EQRO conducts these activities using CMS published protocols. DMAS is committed to the continuation of the Managed Care Compliance Program to ensure appropriate service delivery to FAMIS members. The Compliance Program aims to detect issues, collaborate with MCOs, and enforce the Medallion 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. Also, in alignment with goals and objectives of managed care quality improvement in Virginia, the Performance Incentive Awards (PIA) initiative was designed to provide a financial incentive to MCOs to improve the quality, efficiency, and overall value of healthcare for members. For the PIA program, DMAS selected six measures representing two measurement domains (i.e., administrative and HEDIS measures). The measures were consistent in Year 1, Year 2, and Year 3. The first

domain, administrative measures, included the following measures: • Assessments of Foster Care Population • MCO Claims Processing • Monthly Reporting Timeliness and Accuracy The second domain, HEDIS measures, included the following measures: • Childhood Immunization Status - Combination 3 • Controlling High Blood Pressure • Prenatal and Postpartum Care - Timeliness of Prenatal Care 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 this data become available?

The agency contracts for a comprehensive birth outcomes study that looks at timeliness and adequacy of prenatal care, birth weight, and gestational age for the FAMIS MOMS population and their newborns, along with Medicaid pregnant women and newborns. The most recent year's study incorporates a new measure, percentage of women with early elective deliveries ( $\geq 37$  completed weeks of gestation) and  $< 39$  completed weeks of gestation. In addition, for the first time, the 2018-19 study includes detailed breakdowns by race, geographic region, managed care plan, and other disaggregated data.

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

The birth outcomes study referenced above is a focused study that includes women served by the FAMIS MOMS program and their infants (who at birth are deemed eligible for FAMIS or Medicaid, as applicable). Previous years' analyses have demonstrated that women who participate in the FAMIS MOMS program have birth outcomes (e.g., rates of preterm and low birthweight births) that compare favorably to those of similar populations. The 2018-19 Birth Outcomes Focused Study is attached.

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).

Browse...

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

## Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

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 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

\$ 363,569,690

2021

\$ 366,989,805

2022

\$ 387,602,282

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$ 77,225,361

\$ 77,401,175

\$ 81,397,662

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
<b>Managed Care</b>	363569690	366989805	387602282
<b>Fee for Service</b>	77225361	77401175	81397662
<b>Other benefit costs</b>			
<b>Cost sharing payments from beneficiaries</b>			
<b>Total benefit costs</b>	440795051	444390980	468999944

## Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

This includes wages, salaries, and other employee costs.

2020

\$ 2,758,460

2021

\$ 2,822,841

2022

\$ 3,037,786

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

\$ 610,961

2021

\$ 625,221

2022

\$ 672,828

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

\$ 19,216,084

2021

\$ 19,664,576

2022

\$ 21,161,936

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

\$ 5,997,124

2021

\$ 6,137,094

2022

\$ 6,604,403

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

\$ 498,877

2021

\$ 510,521

2022

\$ 549,394

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020

2021

2022

\$

\$

\$

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 2020	FFY 2021	FFY 2022
<b>Personnel</b>	2758460	2822841	3037786
<b>General administration</b>	610961	625221	672828
<b>Contractors and brokers</b>	19216084	19664576	21161936
<b>Claims processing</b>	5997124	6137094	6604403
<b>Outreach and marketing</b>	498877	510521	549394
<b>Health Services Initiatives (HSI)</b>			
<b>Other administrative costs</b>			
<b>Total administrative costs</b>	29081506	29760253	32026347
<b>10% administrative cap</b>	48977227.89	49376775.56	52111104.89



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 2020	FFY 2021	FFY 2022
<b>Total program costs</b>	469876557	474151233	501026291
<b>eFMAP</b>	76.50	65	65
<b>Federal share</b>	359455566.11	308198301.45	325667089.15
<b>State share</b>	110420990.89	165952931.55	175359201.85

8. What were your state funding sources in FFY 2020?

Select all that apply.

☒

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 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

144376

2021

158633

2022

174298

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

Round to the nearest whole number.

2020

\$ 209

2021

\$ 224

2022

\$ 239

	FFY 2020	FFY 2021	FFY 2022
<b>PMPM cost</b>	209	224	239

## 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 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020

151982

2021

166665

2022

182766

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020

\$ 36

2021

\$ 32

2022

\$ 28

	FFY 2020	FFY 2021	FFY 2022
PMPM cost	36	32	28

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

--

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).

Browse...

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

The COVID-19 public health emergency and associated uncertainty in the economic forecast presented challenges to the development of Virginia's budget for the 2020-2022 biennium. Funding for a number of new projects and policy changes that were included in the General Assembly's initial budget in early 2020 were later unallotted by the Governor after the onset of the public health emergency. Subsequently, some of these items were reallocated in a special session of the General Assembly that occurred during the late summer and fall. Uncertainty around funding and approval for several key projects has, in some cases, made project planning more challenging and caused delays in implementation. However, DMAS continues to uphold our central mission of providing high quality healthcare to those we serve, and we have ensured that the necessary adaptations and flexibilities are in place for us to continue to provide essential benefits to our members without disruption, which is more important than ever during this unprecedented public health crisis.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

The initial onset of the public health emergency necessitated a transition to remote work for most agency employees and required the rapid deployment of policy changes to comply with federal COVID-19 legislation and guidance. Along with these transitions and changes, there was also an increase in application volume.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

The DMAS workforce as well as many of our key contractors and the local departments of social services that perform enrollment functions moved to almost entirely remote work with minimal disruption in program operations. DMAS acted quickly to ensure that all necessary federal flexibilities were in place to respond to the public health emergency. The agency also adapted quickly and effectively to online modes of outreach and communication.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

FAMIS will continue to operate with the flexibilities activated under Virginia's CHIP Disaster SPA until wind-down / end of the PHE. DMAS will ensure that all necessary changes and provisions are made to ensure that the agency executes all current and forthcoming federal directives such as COVID-19 treatment and vaccination requirements.

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.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).