COMMONWEALTH of VIRGINIA

Office of the Governor

Terence R. McAuliffe
Governor

June 15, 2015

The Honorable Sylvia Mathews Burwell
U. S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

Attached for your review and approval is an application to extend Virginia's section 1115 demonstration "FAMIS MOMS and FAMIS Select" (No. 21-W-00058/3). I request that your office approve this change as quickly as possible.

Sincerely,

Terence R. McAuliffe

Attachment

cc: Cynthia B. Jones, Director, Virginia Department of Medical Assistance Services
Rebecca Mendoza, CHIP Director, Virginia Department of Medical Assistance Services

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DEMONSTRATION EXTENSION APPLICATION
FAMIS MOMS and FAMIS *Select* (No. 21-W-00058/3)

Historical Summary of the Demonstration Project

Virginia's Title XXI Child Health Insurance Plan (CHIP) covers children with family income from 143% to 200% FPL under a separate child health plan known as the Family Access to Medical Insurance Security Plan (FAMIS). Virginia's Title XXI Health Insurance Flexibility and Accountability **(**HIFA) Demonstration has two objectives. First, it expands Title XXI coverage to uninsured pregnant women with family income up to 200% of the federal poverty level (FPL) who are not eligible for Medicaid through a program known as FAMIS MOMS. Second, it uses Title XXI funds to support a health insurance premium assistance program known as FAMIS *Select*. Children must first be found eligible and enroll in FAMIS before electing coverage through FAMIS *Select*.

By targeting these two populations: uninsured pregnant women not eligible for Medicaid with family income up to 200% FPL and FAMIS-eligible children with access to employer-sponsored or private health insurance, Virginia expects to see the following outcomes:

- A decrease in the rate of uninsurance among pregnant women,
- An increase in participation in premium assistance in CHIP,
- An increase in access to appropriate medical services, and
- An improvement in certain health outcomes of children as reported by participants.

To meet the above outcomes, the future goals of the Demonstration extension are:

- Decrease by 0.25% the rate of uninsurance among pregnant women at delivery (PRAMS data)
- Stabilize the participation in FAMIS *Select* to no fewer than 100 children on average/month
- Increase to 82% the rate of pregnant women in FAMIS MOMS who receive adequate prenatal care (Birth Outcomes Study)
- Reduce to 7.0% the rate of low birthweight among FAMIS MOMS (Birth Outcomes Study)
- Obtain baseline data on the reported health status, and any improvements in health outcomes, of participants in the FAMIS *Select* program.

In June 2013, Virginia received approval to continue operating the FAMIS MOMS program under this HIFA 1115 Demonstration Waiver. The extension included the following agreements:

- Virginia will continue to provide coverage with federal reimbursement at the CHIP rate for pregnant women without creditable insurance coverage in families with income through 200% FPL.
- Virginia will continue to use Medicaid methodology for determining income eligibility.
- Virginia will continue to provide coverage that is identical to coverage provided to pregnant women under the Medicaid State plan.

- Virginia will continue to deem infants born to FAMIS or FAMIS MOMS enrollees for CHIP or Medicaid coverage for the first year of life.

Virginia has expanded health care coverage for pregnant women under Medicaid, and for pregnant women and children under FAMIS, to otherwise eligible lawfully residing immigrants, including those in their first five years of lawful residency in the United States, pursuant to § 214 of the Children's Health Insurance Program Reauthorization Act of 2009.

The Affordable Care Act (ACA) created additional options for subsidized health care coverage for low-income individuals and families effective January 1, 2014. In concert with implementation of the federal health insurance marketplace under the ACA, Virginia received CMS approval to implement modified adjusted gross income (MAGI) eligibility determination methods beginning October 1, 2013 for the FAMIS MOMS population, which was slated to become subject to MAGI-based rules effective January 1, 2014. The conversion of income limits associated with implementing MAGI rules set the upper income limit at 200% FPL (plus a 5% disregard) for FAMIS and FAMIS *Select*, and at 210% FPL for the FAMIS MOMS group. This income eligibility level was in place through the remainder of calendar year 2013.

FAMIS MOMS

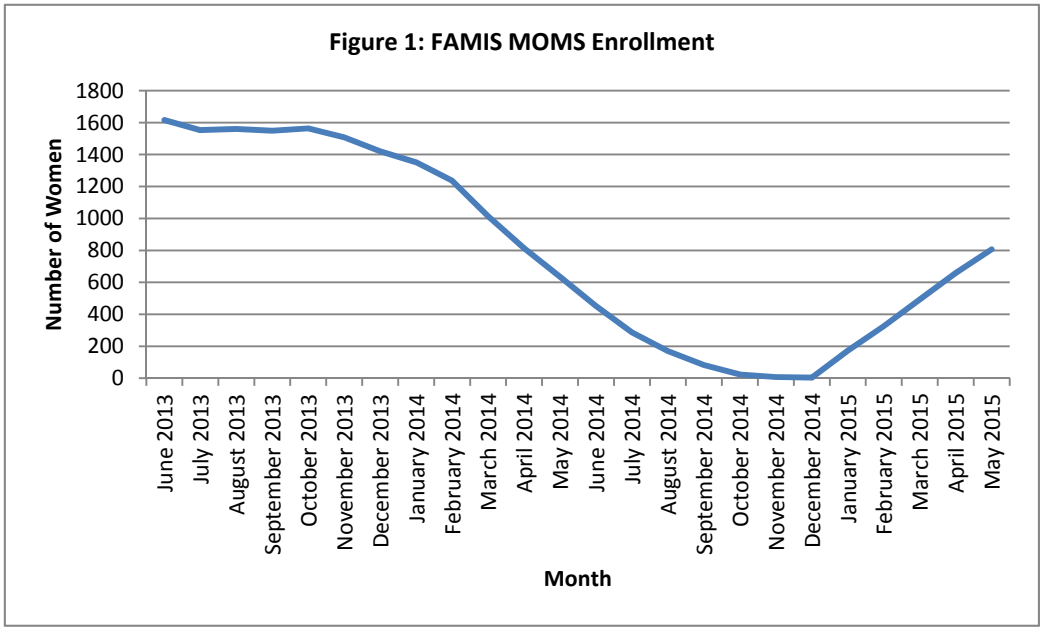
The intent of this program expansion is to provide prenatal care to uninsured women living within the Title XXI income range and likely to give birth to FAMIS eligible children. Virginia implemented the FAMIS MOMS program incrementally beginning August 1, 2005. The first increment expanded eligibility to pregnant women with family income above the Medicaid limit of 133% FPL but less than or equal to 150% FPL. The second increment, implemented September 1, 2006, covered pregnant women with incomes through 166% FPL. Subsequent increments covered pregnant women through 185% FPL (July 1, 2007) and through 200% FPL (July 1, 2009).

Effective July 1, 2010, eligibility requirements were amended to allow enrollment of pregnant women with income below 133% FPL who do not meet eligibility requirements for full Medicaid coverage but do meet the FAMIS MOMS requirements. In addition, infants born to FAMIS children and FAMIS MOMS are deemed eligible for Medicaid or CHIP coverage, as appropriate, on the date of birth and remain eligible until attaining the age of 1, unless, after a reasonable opportunity period, the state fails to obtain satisfactory documentation of citizenship and identity.

In 2013, the Virginia General Assembly adopted an amendment to the biennial budget that directed DMAS to phase out and eliminate the FAMIS MOMS program when Health Benefits Exchange coverage in Virginia became available in order to remove disincentives for subsidized private healthcare coverage through publicly-offered alternatives. Following approval by CMS of an amendment to the waiver, administrative steps were taken to implement this phase out by stopping new enrollment (effective January 1, 2014) while maintaining current cases throughout their benefit period (two months postpartum).

The 2014 General Assembly restored funding to support enrollment in FAMIS MOMS, recognizing that many low-income individuals are not eligible for subsidized coverage through the marketplace due to family circumstances, application difficulties, and enrollment deadlines. The amended state budget for SFY 2015 was passed and signed in late June, 2014. An amendment to the waiver, reinstating enrollment at an upper income level of 200% FPL (plus a 5% disregard), was subsequently submitted to CMS and approved effective November 1, 2014. The Department began enrolling women in FAMIS MOMS again starting December 1, 2014.

DMAS stopped accepting applications for FAMIS MOMS after December 31, 2013. For women with a begin date of coverage prior to January 1, 2014, FAMIS MOMS coverage continued throughout their pregnancy and postpartum periods. Beginning January 1, 2014, pregnant women with family income above the income limit for Medicaid were referred to the Health Insurance Marketplace for health care coverage. Subsequently, FAMIS MOMS enrollment dropped from close to 1,600 on July 1, 2013, to 1,363 on January 1, 2014, and to 814 on April 1, 2014. By July 1, 2014, FAMIS MOMS accounted for only 0.2% of the total CHIP enrollment. Enrollment was reinstated December 1, 2014, and has since been increasing steadily (see Figure 1).



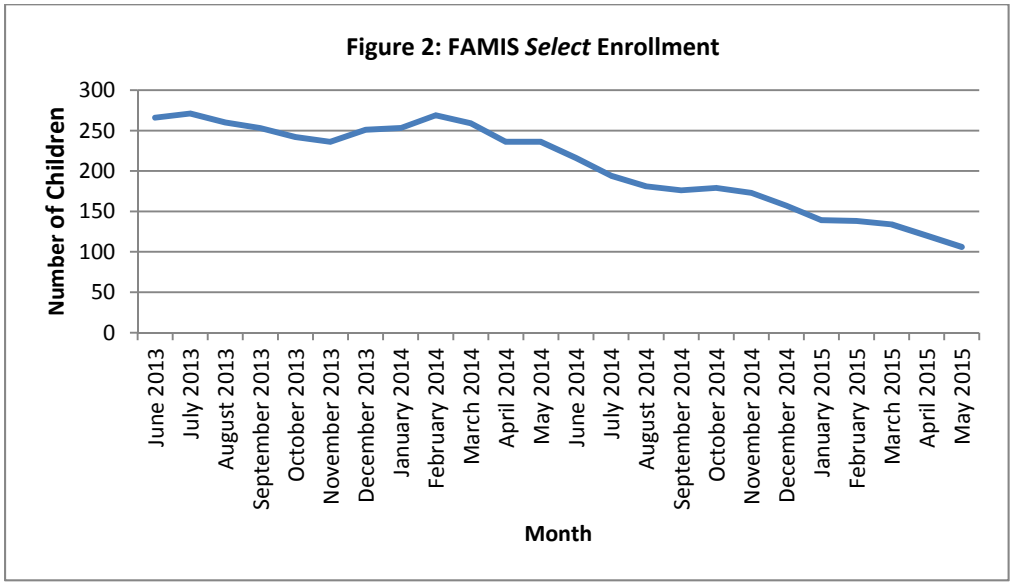
Source: DMAS Recipient File

In April 2015, CMS approved an amendment to the Demonstration adding coverage for dental services to the FAMIS MOMS program, consistent with the addition of these benefits for pregnant women under Medicaid. This amendment also allowed eligibility to be expanded to include pregnant women with access to subsidized health insurance through state employee benefits. While it is evident that some pregnant women are taking advantage of these additional options, the true impact of these changes is not yet apparent.

FAMIS *Select*

Virginia implemented the FAMIS *Select* program beginning August 1, 2005. FAMIS *Select* replaced the former employer-sponsored health insurance (ESHI) program and provides an alternative for families with children enrolled in FAMIS who have access to private or employer-sponsored coverage. All children are first enrolled in FAMIS. For some families, the FAMIS *Select* payment may make health coverage affordable for the entire family. In other cases, it may allow a child to continue to see a doctor or dentist that may not accept FAMIS.

FAMIS *Select* has enrolled more families and proven to be easier to administer than the former ESHI program. In August 2005, 66 children transferred from the ESHI to FAMIS *Select*. Enrollment in FAMIS *Select* has clearly been marked by periods of both growth and decline. At the end of the first year of operation there were 266 children enrolled, more than double the highest ever enrollment in ESHI. Enrollment peaked in year four at 480 children. On average, 327 children have been enrolled monthly since the implementation of the program. Figure 2 shows the enrollment trend during the current Demonstration period. The current decline in participation is likely to be due to changes in employer-sponsored health insurance offerings; the latter is becoming more expensive, with higher employee cost sharing, making family coverage less affordable for lower-income workers.



Source: DMAS Recipient File

Changes Requested

The ACA created additional options for subsidized health care coverage for low-income individuals and families effective January 1, 2014. DMAS continues to monitor the potential impact of the ACA on both the FAMIS MOMS and FAMIS *Select* programs and assess the impact of the ACA as specifics for implementation are developed. Virginia requests that this Demonstration be extended for three additional years as is, with the understanding that an amendment will be requested at a later date if needed to accommodate changes resulting from the ACA.

Waiver and Expenditure Authority

Virginia is requesting the same waiver and expenditure authorities as those approved in the current demonstration. For the FAMIS MOMS and FAMIS Select populations, all CHIP and Medicaid rules not expressly waived or identified as not applicable shall apply. The following title XXI requirements are not applicable for the Virginia FAMIS MOMS and FAMIS *Select s*ection 1115 Demonstration:

1. General Requirements, Eligibility and Outreach — Section 2102

   The Commonwealth's Child Health Insurance Plan (CHIP) does not have to reflect the demonstration populations, and eligibility standards do not have to be limited by the general principles in section 3202(b) of the Act. To the extent other requirements in section 2102 of the Act duplicate Medicaid or other CHIP requirements for these or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration populations do not include individuals otherwise eligible for Medicaid.

2. Cost Sharing — Section 2103(e)

   Rules governing cost sharing under section 2103(e) of the Act shall not apply to the FAMIS *Select* population to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored insurance plans.

3. Cost-Sharing Exemption for American Indian/ Alaskan Native (AI/AN) Children — Section 2102(b)(3)(D) 42 CFR Section 457.535

   To the extent necessary to permit the Commonwealth to impose cost sharing on AI/AN children who elect to enroll in the premium assistance program.

4. Benefit Package Requirements — Section 2103

   To permit the Commonwealth to offer a benefit package that does not meet the requirements of section 2103 at 42 CFR section 457.4 10(b)(1) for the demonstration populations.

5. Federal Matching Payment and Family Coverage Limits Section 2105

Federal matching payment in excess of the 10-percent cap for expenditures related to the demonstration population and limits on family coverage are not applicable to the demonstration population.

Waiver Authority: Under the authority of section 1115(a) of the Act, the following exceptions to Medicaid and CHIP requirements have been granted:

Newborn deeming **Section 1902(a)(46) and 2102(b)(2)**

To enable the Commonwealth to consider children who are born to individuals eligible under the demonstration as pregnant women on the date of the child's birth, or eligible targeted low-income children under the approved State Plan on the date of the child's birth, to have applied and been determined otherwise eligible for Medicaid or CHIP, as appropriate, on the date of birth, and to remain eligible until attaining the age of 1, unless, after a reasonable opportunity period, the Agency fails to obtain evidence to satisfy documentation of citizenship under 42 CFR 435.407(c)(1) and (2) and identity under 42 CFR 435.407(e) and (f). This does not permit waivers of either section 1903(x) of the Act of section 2105(c) which requires states to obtain satisfactory documentary evidence of citizenship or nationality during the reasonable opportunity period for individuals in Medicaid or CHIP.

Quality Assurance

DMAS contracted with the Delmarva Foundation for Medical Care, Inc. as the External Quality Review Organization (EQRO) to conduct annual prenatal care/birth outcomes focused clinical studies. The report of these studies is submitted as a separate document. The aim of the studies was two-fold: 1) to evaluate the adequacy of prenatal care for pregnant women in Medicaid and FAMIS MOMS; and 2) to determine the impact of prenatal care on birth outcomes. Here are the major study findings for births that occurred in calendars years 2011, 2012, and 2013:

- Women in the FAMIS MOMS program received adequate prenatal care at rates that were more favorable than the HEDIS® National Medicaid Managed Care Averages in all years.

- The rate of infants born prematurely (before 37 completed weeks of pregnancy) in the FAMIS MOMS program remained stable and was more favorable than the national rates for all three years.

- Low birth weight rates for FAMIS MOMS remained stable in each of the three years and outperformed the national benchmark in all years.

Financial Data

Historical and projected expenditures and financial analysis are provided in a spreadsheet format as a separate document.

Evaluation

The Demonstration evaluation plan for the renewal period has three components: (1) monitoring the rate of uninsurance, (2) evaluating participation in premium assistance in CHIP, and (3) quality measures on access and outcomes. During the renewal period, the Demonstration evaluation will continue to consider the following hypotheses for the two target populations:

FAMIS MOMS

Hypothesis 1 FAMIS MOMS will result in improved prenatal care for pregnant women between 143-200 percent of the FPL.

Hypothesis 2 FAMIS MOMS will improve birth outcomes thereby decreasing the medical costs incurred for infants born to women in this income range.

Hypothesis 3 FAMIS MOMS will decrease the number of months income eligible babies will go without insurance.

FAMIS *Select*

Hypothesis 1 The number of providers serving as usual sources of care (medical homes) for children in the State's Title XXI program will increase.

Hypothesis 2 There will be no difference in the percentage of children who are up-to-date on immunizations among FAMIS and FAMIS Select children and that both programs result in an increase in the percent of children who are up-to-date on immunizations.

Hypothesis 3 There will be no difference in the percentage of FAMIS and FAMIS Select children who receive appropriate well-child care and that both programs result in an increase in the number of children receiving appropriate well child care.

An interim evaluation report addressing these hypotheses, updated to include activities and findings from the current demonstration extension period, is provided as a separate document. The evaluation in the extension period will include a survey of FAMIS *Select* participants, as recommended in the interim evaluation. Previous program reports are available at Cover Virginia.

Compliance with Public Notice Process

DMAS has complied with the State public notice process for applications for an extension of an existing demonstration project. DMAS has made the following available through the Cover Virginia website: the public notice, including the link to the demonstration page on the CMS website, as well as notice of the public hearings and contact information for comments; proposed demonstration extension application; the EQRO birth outcomes focused study and previous

demonstration evaluation reports. The public notice and proposed demonstration application were also added to the main DMAS website in the *What's New* column. Public hearings, along with links to the demonstration documents, were announced through the Virginia Regulatory Town Hall and Commonwealth Calendar on April 13, 2015. In addition, this information was sent by email to registered public users of the Town Hall, members of the Board of Medical Assistance Services, Children's Health Insurance Program Advisory Committee (CHIPAC), and Joint Commission on Health Care. Information about the public comment period and scheduled hearings was also disseminated through the FAMIS and Cover Virginia Facebook pages. Notice of the renewal application, links to access the Public Notice and draft application, and an invitation for public comments, was published in *The Virginia Register*, the state's administrative record, on May 4, 2015.

Public hearings were held May 7, 2015, at the Virginia Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219 with a conference call option, and June 4, 2015, in conjunction with the CHIPAC quarterly meeting at the Virginia Community HealthCare Association, 3831 Westerre Parkway, Henrico, VA 23233. The public comment period was open through June 5, 2015.

The first public hearing generated no comments. At the second public hearing, two members of the CHIPAC offered comments. The representative from the March of Dimes noted that FAMIS MOMS is a very beneficial program and should be continued. The representative from the Virginia Poverty Law Center asked if the declining participation in FAMIS *Select* should be of concern; she also noted that she had not realized FAMIS *Select* could be used by families with private insurance, in addition to those with employer-sponsored insurance.

Discussion of the latter comment followed, with DMAS staff acknowledging that the FAMIS *Select* enrollment is of concern, reiterating the plan to conduct a survey to better understand families' decision points. Discussion also included the impact of the FFM on participation in FAMIS *Select*, and it was noted that if a child is eligible for CHIP, they will not be covered by insurance offered through the FFM. The consensus of the CHIPAC was that work on general awareness of FAMIS *Select* and outreach would be of benefit.

A motion was made and approved that CHIPAC endorse the waiver renewal, which will be reflected in minutes from the meeting. No additional comments were offered verbally or in writing by others in attendance.

Written comments were submitted to DMAS by Planned Parenthood Advocates of Virginia. These comments are supportive of the three year extension, noting that FAMIS MOMS is a key program helping low income women to access critical health care. The comments also strongly supported the recent amendments to the waiver that added dental services for FAMIS MOMS and allowed state employees and their dependents to access FAMIS MOMS. The

comments encouraged DMAS to assure an adequate network of obstetric providers for women enrolled in FAMIS MOMS over the course of the extension period, and that reimbursement rates for such services be adequate and reasonably cover the costs of services.

Agency Response to Public Comments

DMAS appreciates the comments offered by all stakeholders. DMAS staff agrees with the need to promote awareness of FAMIS *Select*, and will continue to incorporate this in FAMIS outreach efforts.

Prenatal and obstetric care services are provided predominantly through contracted managed care organizations. The rates paid to each MCO are actuarially determined and reviewed annually. The managed care contracts include network adequacy standards, and monitoring for compliance with those standards. Reimbursement rates are negotiated between the managed care organization and providers. DMAS is committed to assuring network capacity and is sensitive to the need to monitor for complaints or changes in utilization that would indicate an issue with access to care.

HIFA Demonstration Waiver Budget Template for States Using CHIP Funds -

VIRGINIA	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
State's Allotment	$175,860,300	$184,454,740	$175,234,257	$184,004,091	$186,575,583	$198,337,665	$247,585,520	$247,585,520	$247,585,520	$247,585,520	$247,585,520
Funds Carried Over From Prior Year(s)	$24,436,278	$51,334,942	$70,948,254	$71,891,110	$78,067,362	$71,562,071	$69,883,820	$115,016,723	$140,150,493	$143,998,082	$132,550,011
SUBTOTAL (Allotment + Funds Carried Over)	$200,296,578	$235,789,682	$246,182,511	$255,895,201	$264,642,945	$269,899,736	$317,469,340	$362,602,243	$387,736,013	$391,583,602	$380,135,531
Reallocated Funds (Redistributed or Retained that are Currently Available)											
TOTAL (Subtotal + Reallocated funds)	$200,296,578	$235,789,682	$246,182,511	$255,895,201	$264,642,945	$269,899,736	$317,469,340	$362,602,243	$387,736,013	$391,583,602	$380,135,531
State's Enhanced FMAP Rate	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	88.00%	88.00%	65.00%	65.00%
COST PROJECTIONS OF APPROVED SCHIP PLAN											
Benefit Costs											
Insurance payments											
Managed care	$97,829,920	$118,175,633	$127,453,131	$140,625,318	$172,944,141	$178,638,196	$184,097,856	$200,084,165	$214,290,141	$229,504,741	$245,799,577
per member/per month rate @ # of eligibles	$110.82* @ 80,256 avg elig/mo	$118.03 @ 83,438 avg elig/mo	$119.77 @ 88,682 avg elig/mo	$121.64 @ 96,337avg elig/mo	$137.06 @ 105,149 avg elig/mo	$139.65 @ 106,600 avg elig/mo	$140.12 @ 109,486 avg elig/mo	$149.64 @ 111,427 avg elig/mo	$157.12 @ 113,656 avg elig/mo	$164.98 @ 115,929 avg elig/mo	$173.22 @ 118,247 avg elig/mo
Fee for Service	$107,227,146	$111,163,125	$116,678,947	$106,258,886	$94,462,053	$100,406,987	$103,818,386	$111,907,829	$119,853,285	$128,362,868	$137,476,632
Total Benefit Costs	**$205,057,066**	**$229,338,758**	**$244,132,078**	**$246,884,203**	**$267,406,194**	**$279,045,183**	**$287,916,243**	**$311,991,994**	**$334,143,426**	**$357,867,609**	**$383,276,209**
(Offsetting beneficiary cost sharing payments)											
Net Benefit Costs	**205,057,066**	**229,338,758**	**244,132,078**	**246,884,203**	**267,406,194**	**279,045,183**	**287,916,243**	**311,991,994**	**334,143,426**	**357,867,609**	**383,276,209**
Administration Costs											
Personnel	$1,147,399	$1,071,337	$969,688	$1,319,331	$1,317,540	$1,347,365	$1,336,661	$1,334,761	$1,334,761	$1,334,761	$1,334,761
General administration	$65,159	$126,061	$212,119	$274,406	$274,406	$274,406	$300,000	$300,000	$300,000	$300,000	$300,000
Contractors/Brokers (e.g., enrollment contractors)	$8,133,472	$8,021,970	$5,224,596	$6,270,703	$6,268,049	$12,387,459	$11,555,598	$8,540,845	$8,540,845	$8,540,845	$8,540,845
Claims Processing	$896,888	$930,099	$969,680	$1,018,164	$1,018,164	$1,018,164	$1,018,164	$1,018,164	$1,018,164	$1,018,164	$1,018,164
Outreach/marketing costs	$633,782	$542,702	$640,966	$676,014	$548,334	$488,518	$5,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Administration Costs	**$10,876,700**	**$10,692,168**	**$8,017,048**	**$9,558,619**	**$9,426,494**	**$15,515,912**	**$19,210,424**	**$14,193,771**	**$14,193,771**	**$14,193,771**	**$14,193,771**
10% Administrative Cap	$22,784,118	$25,482,084	$27,125,786	$27,431,578	$29,711,799	$31,005,020	$31,990,694	$34,665,777	$37,127,047	$39,763,068	$42,586,245
Federal Title XXI Share	$140,356,948	$156,020,102	$163,896,932	$166,687,835	$179,941,247	$191,464,712	$199,632,333	$212,020,747	$226,419,178	$241,839,897	$258,355,487
State Share	$75,576,818	$84,010,824	$88,252,194	$89,754,988	$96,891,441	$103,096,383	$107,494,333	$114,165,018	$121,918,019	$130,221,483	$139,114,493
TOTAL COSTS OF APPROVED SCHIP PLAN	**$215,933,766**	**$240,030,926**	**$252,149,127**	**$256,442,822**	**$276,832,688**	**$294,561,096**	**$307,126,667**	**$326,185,765**	**$348,337,197**	**$372,061,380**	**$397,469,980**
	$10,510.96	$12,029.39									
COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL											
Benefit Costs for Demonstration Population #1 (pregnant women < 200% FPL)											
Insurance payments											
Managed care	$9,765,521	$10,059,822	$12,148,297	$12,992,846	$16,462,052	$11,501,569	$2,826,431	$9,360,655	$16,200,000	$22,113,000	$26,790,750
per member/per month rate @ # of eligibles	$929.08* @ 956 avg elig/mo	$836.27 @ 999 avg elig/mo	$948.42 @ 1,067 avg elig/mo	$916.80 @ 1,181 avg elig/mo	$992.65 @ 1,382 avg elig/mo	$1031.72 @ 929 avg elig/mo	$1323.24 @ 178 avg elig/mo	$1319.89 @ 591 avg elig/mo	$1350 @ 1000 avg elig/mo	$1418 @ 1300 avg elig/mo	$1488 @ 1500 avg elig/mo
Fee for Service	$2,603,713	$2,678,141	$3,075,839	$3,392,566	$3,042,298	$1,092,321	$368,671	$1,333,037	$2,304,000	$3,144,960	$3,810,240
Total Benefit Costs for Waiver Population #1	**$12,369,234**	**$12,737,963**	**$15,224,136**	**$16,385,412**	**$19,504,350**	**$12,593,890**	**$3,195,101**	**$10,693,693**	**$18,504,000**	**$25,257,960**	**$30,600,990**
Benefit Costs for Demonstration Population #2 (children in premium assistance)											
Insurance payments	$496,536	$456,121	$386,394	$367,809	$320,847	$267,103	$280,458	$294,481	$309,205	$324,665	$340,898
Managed care											
per member/per month rate @ # of eligibles											
Fee for Service	$0	$761	$243	$165	$87	$0	$0	$0	$0	$0	$0
Total Benefit Costs for Waiver Population #2	**$496,536**	**$456,882**	**$386,638**	**$367,974**	**$320,933**	**$267,103**	**$280,458**	**$294,481**	**$309,205**	**$324,665**	**$340,898**
Benefit Costs for Demonstration Population #3											
Insurance payments											
Managed care											
per member/per month rate @ # of eligibles											
Fee for Service											
Total Benefit Costs for Waiver Population #3											
Benefit Costs for Demonstration Population #4											
Insurance payments											
Managed care											
per member/per month rate @ # of eligibles											
Fee for Service											
Total Benefit Costs for Waiver Population #4											
Total Benefit Costs	**$12,865,770**	**$13,194,845**	**$15,610,774**	**$16,753,386**	**$19,825,283**	**$12,860,993**	**$3,475,559**	**$10,988,173**	**$18,813,205**	**$25,582,625**	**$30,941,888**
(Offsetting beneficiary cost sharing payments) * Premium Payments will be net of cost sharing											
Net Benefit Costs	**$12,865,770**	**$13,194,845**	**$15,610,774**	**$16,753,386**	**$19,825,283**	**$12,860,993**	**$3,475,559**	**$10,988,173**	**$18,813,205**	**$25,582,625**	**$30,941,888**
Administration Costs											
Personnel	$54,636	$56,275	$57,964	$59,703	$61,494	$31,669	$63,339	$65,239	$67,196	$69,212	$69,212
General administration											
Contractors/Brokers (e.g., enrollment contractors)	$257,575	$260,151	$262,753	$265,380	$268,034	$203,036	$300,000	$300,000	$300,000	$300,000	$300,000
Claims Processing											
Outreach/marketing costs	$60,000	$60,000	$60,000	$60,000	$60,000	$60,000	$500,000	$500,000	$500,000	$500,000	$500,000
Other (specify)											
Total Administration Costs	**$372,212**	**$376,426**	**$380,716**	**$385,083**	**$389,528**	**$294,705**	**$863,339**	**$865,239**	**$867,196**	**$869,212**	**$869,212**
10% Administrative Cap											
Federal Title XXI Share	$8,604,688	$8,821,326	$10,394,468	$11,140,005	$13,139,627	$8,551,204	$2,820,284	$10,431,003	$17,318,753	$17,193,694	$20,677,215
State Share	$4,633,294	$4,749,945	$5,597,021	$5,998,464	$7,075,184	$4,604,494	$1,518,614	$1,422,409	$2,361,648	$9,258,143	$11,133,885
TOTAL COSTS FOR DEMONSTRATION	**$13,237,982**	**$13,571,271**	**$15,991,490**	**$17,138,469**	**$20,214,811**	**$13,155,698**	**$4,338,898**	**$11,853,412**	**$19,680,401**	**$26,451,837**	**$31,811,100**
TOTAL PROGRAM COSTS (State Plan + Demonstration)	**$229,171,747**	**$253,602,197**	**$268,140,616**	**$273,581,291**	**$297,047,499**	**$307,716,793**	**$311,465,564**	**$338,039,177**	**$368,017,598**	**$398,513,217**	**$429,281,080**
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$200,296,578	$235,789,682	$246,182,511	$255,895,201	$264,642,945	$269,899,736	$317,469,340	$362,602,243	$387,736,013	$391,583,602	$380,135,531
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$148,961,636	$164,841,428	$174,291,401	$177,827,839	$193,080,874	$200,015,916	$202,452,617	$222,451,750	$243,737,931	$259,033,591	$279,032,702
Unused Title XXI Funds Expiring (Allotment or Reallocated)											
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$51,334,942	$70,948,254	$71,891,110	$78,067,362	$71,562,071	$69,883,820	$115,016,723	$140,150,493	$143,998,082	$132,550,011	$101,102,829

Demonstration No. 21-W-00058/3
FAMIS MOMS and FAMIS *Select*
Virginia Department of Medical Assistance Services

COMPLANCE WITH SPECIAL TERMS AND CONDITIONS

I. PREFACE

The following documents compliance as of May 2015 with the Special Terms and Conditions (STCs) for the Virginia FAMIS MOMS and FAMIS *Select* programs, a Children's Health Insurance Program section 1115 Demonstration, during the Demonstration renewal period beginning July 1, 2013. The referenced STCs became applicable effective April 3, 2015, superseding previous STCs. The STCs are arranged into the following subject areas: Program Description and Objectives; General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits; Cost Sharing; Program Design; General Financial Requirements for FAMIS MOMS (demonstration population 1) and FAMIS *Select* (demonstration population 2).

II. PROGRAM DESCRIPTION AND OBJECTIVES

Current Status: The Demonstration provides coverage for two populations: (1) pregnant women without creditable coverage in families with incomes through 200 percent of the Federal poverty level (FPL) through the FAMIS MOMS program; and, (2) uninsured children through age 18, through a premium assistance program known as FAMIS *Select*.

The FAMIS MOMS component of the demonstration has continued to coverage for pregnant women without creditable coverage in families with income up to and including 200 percent of the federal poverty level (FPL). Coverage of lawfully residing pregnant women is consistent with the guidance set forth in the CMS State Health Official letter (SHO #10-006) dated 07/01/2010. Coverage for this population is applicable only for periods when Medicaid coverage of lawfully residing pregnant women is also in effect. Effective April 3, 2015, FAMIS MOMS coverage was expanded to include pregnant women with income from 143 of the FPL up to and including 200 percent of the FPL with access to state employee's health benefit coverage, in accordance with the hardship exception as provided in section 2110(b)(6)(C) of the Social Security Act (the Act), thereby aligning coverage for pregnant women with the expansion of CHIP coverage to children of state employees, which was effective January 1, 2015. FAMIS MOMS coverage is the same as that provided to pregnant women under the Medicaid state plan. Under the demonstration, Virginia also deems infants born to FAMIS MOMS to be eligible for Medicaid or CHIP coverage, as appropriate. These infants are deemed eligible on the date of birth and remain eligible until attaining the age of 1, unless, after a reasonable opportunity period, the Agency fails to obtain evidence to satisfy documentation of citizenship under 42 CFR 435.407(c)(1) and (2), and identity under 42 CFR 435.407(e) and (f).

The FAMIS Select program has continued to provide uninsured children in families with income from 143 percent up to and including 200 percent of the FPL, who would otherwise be eligible for direct CHIP coverage, with the option to elect to receive only premium assistance for employer-sponsored insurance and supplemental immunization benefits.

Historical Background: The Virginia FAMIS MOMS and FAMIS *Select* Demonstration was initially approved on June 30, 2005, and implemented August 1, 2005. The Demonstration was most recently renewed July 1, 2013 through June 30, 2016.

Effective October 1, 2013, the Demonstration was amended to use the modified adjusted gross income (MAGI)-based methodology in eligibility determinations for all new applicants. The upper income limit associated with implementing MAGI rules was set at 210% FPL for the FAMIS MOMS group. This income eligibility level was in place through the remainder of calendar year 2013. Beginning January 1, 2014, the waiver was amended to phase out the FAMIS MOMS program subsequent to action by the Virginia General Assembly. New applications for FAMIS MOMS were not accepted after December 31, 2013. Women enrolled in FAMIS MOMS on or before December 31, 2013 retained eligibility for the duration of their coverage period. Any application received for pregnancy coverage on or after January 1, 2014 was screened for Medicaid under pregnant women eligibility, and for CHIP. If the applicant was ineligible for Medicaid or CHIP, the application was referred to the Federally Facilitated Marketplace (FFM).

An amendment was submitted August 20, 2014 seeking approval to reinstate enrollment in FAMIS MOMS, subsequent to General Assembly action; this was approved with an effective date of November 1, 2014. Virginia continued to use MAGI-based methodology for determining income eligibility for FAMIS MOMS, with an upper income level of 200% FPL. Under the Demonstration, FAMIS MOMS continued to provide health care benefits that are identical to those provided to pregnant women under the Medicaid State plan, including the addition of comprehensive dental services as approved in April 2015. Also in April 2015, Virginia began to allow FAMIS MOMS enrollment of state employees and dependents that have access to subsidized health insurance, if otherwise eligible.

The FAMIS *Select* premium assistance program continued with no changes. Wrap-around coverage continued to be provided for immunizations only.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** Virginia complies with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part) were applied to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The Patient Protection and Affordable Care Act [P.L.111-148] (ACA) impacted policy changes that affected the Demonstration during this renewal period. In concert with implementation of the FFM under the ACA, Virginia received CMS approval to use MAGI-based eligibility determination methods beginning October 1, 2013 for the FAMIS MOMS population. The ACA also permitted states to extend eligibility in their CHIP plan to children of state employees who are otherwise eligible. This option was implemented in Virginia by emergency regulation effective January 1, 2015. As a result, Virginia submitted an amendment to the Demonstration to apply the same allowance to the FAMIS MOMS program; this was approved April 3, 2015. A Notice of Intended Regulatory Action has been submitted to similarly amend the FAMIS MOMS regulations. CMS has not notified the Commonwealth of any applicable changes to these Special Terms and Conditions that would require actions to come into compliance with federal law, regulation, or policy.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a) No change in Federal law, regulation, or policy required either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration.
    b) Mandated changes in federal law regarding use of MAGI-based eligibility rules became effective October 1, 21013.

5. **State Plan Amendments.** The required title XIX and title XXI state plan amendments were filed, and approved, to implement MAGI-based rules. A title XXI state plan amendment was also filed, and approved, to expand FAMIS eligibility to dependents of state employees. A title XIX state plan amendment was filed to add comprehensive dental benefits for pregnant women under Medicaid. An amendment to the Demonstration was filed to add the latter changes in eligibility and benefits for FAMIS MOMS. No conforming title XIX or title XXI state plan amendments were required.

6. **Changes Subject to the Amendment Process**. Several changes were made to the Demonstration during the renewal period regarding eligibility and benefits:
    - An amendment was submitted June 26, 2013 notifying CMS of the intent to phase out the FAMIS MOMS program subsequent to action on the part of the General Assembly; this was approved and became effective January 1, 2014, noting that no new enrollment would take place after that date, and that women enrolled on or before December 31, 2013 would continue to receive benefits according to the program parameters.
    - An amendment was submitted August 20, 2014 seeking approval to reinstate enrollment in FAMIS MOMS, subsequent to General Assembly action; this was approved with an effective date of November 1, 2014; enrollment was reinstated December 1, 2013.
    - On December 22, 2014 an amendment was submitted requesting two changes to the Demonstration: (1) adding comprehensive dental benefits to the FAMIS MOMS program; and, (2) allowing pregnant women with access to subsidized health insurance benefits through state employment. This amendment was approved April 3, 2015.

Federal Financial Participation (FFP) has not been applied prior to CMS approval of the above amendments.

7. **Amendment Process.** The amendment process has been implemented as noted above. Amendments have included:
   (a) *Public Notice*. Public notice has included either the legislative process, or has met the requirements of 42 CFR §431.408.

   (b) *Tribal Consultation Requirements*. Virginia has no Federally-recognized Indian tribes, Indian health providers, or urban Indian organizations.

   (c) *Demonstration Amendment Summary and Objectives*. Each approved amendment included an appropriate summary and stated objectives.

   (d) *Waiver and Expenditure Authorities*. Each approved amendment noted the appropriate waiver and expenditure authorities.

   (e) *Allotment Neutrality Worksheet*. Each approved amendment included submission of an appropriate allotment neutrality worksheet.

8. **Extension of the Demonstration.** The Governor of Virginia is submitting a Demonstration extension request to CMS 12 months prior to the expiration date of the Demonstration.

   The Demonstration Extension Application provides documentation of compliance with the following:

   a. **Demonstration Summary and Objectives**: The Demonstration Extension Application provides a historical narrative summary of the Demonstration project, reiterates the objectives set forth at the time the Demonstration was proposed. The Application, and accompanying Interim Evaluation, provide evidence of how these objectives have been met as well as future goals of the program.

   b. **Changes to the Demonstration Design**: The Demonstration Extension Application notes that no changes are being proposed to the demonstration design.

   c. **Special Terms and Conditions (STCs):** This document provides documentation of compliance with each of the STCs.

   d. **Waiver and Expenditure Authorities**: The Demonstration Extension Application notes that Virginia is requesting the same waiver and expenditure authorities as those approved in the current demonstration. For these populations, all CHIP and Medicaid rules not expressly waived or identified as not applicable, appl. The following Title XXI requirements are not applicable for the FAMIS MOMS and FAMIS Select Demonstration:

      i. General Requirements, Eligibility and Outreach Section 2102

The Commonwealth's Child Health Insurance Plan (CHIP) is not required to reflect the demonstration populations, and eligibility standards need not be limited by the general principles in section 3202(b) of the Act. To the extent other requirements in section 2102 of the Act duplicate Medicaid or other CHIP requirements for these or other populations, they do not apply, except that Virginia performs eligibility screening to ensure that the demonstration populations do not include individuals otherwise eligible for Medicaid.

ii. Cost Sharing — Section 2103(e)

Rules governing cost sharing under § 2103(e) of the Act do not apply to the FAMIS Select population to the extent necessary to enable Virginia to impose cost sharing in private or employer-sponsored insurance plans.

iii. Cost-sharing exemption for American Indian/ Alaskan Native (AI/AN) Children — Section 2102(b)(3)(D) 42 CFR §457.535

Virginia is permitted to impose cost sharing on AI/AN children who elect to enroll in the premium assistance program.

iv. Benefit Package Requirements — Section 2103

Virginia is permitted to offer a benefit package that does not meet the requirements of section 2103 at 42 CFR section 457.4 10(b)(1) for the demonstration populations.

v. Federal Matching Payment and Family Coverage Limits — Section 2105

Federal matching payment in excess of the 10-percent cap for expenditures related to the demonstration population and limits on family coverage are not applicable to the demonstration population.

e. Quality: A summary of the most recent focused study conducted by the External Quality Review Organization is provided in the Demonstration Extension Application submittal.

f. Financial Data: Financial data demonstrating historical and projected expenditures for the extension period are provided in a separate document with the Demonstration Extension Application submittal.

g. Evaluation Report: A narrative summary of the evaluation design and status (including evaluation activities and findings to date) is provided as a separate document. No change in evaluation hypotheses is planned for the extension period.

h. Compliance with Public Notice Process: A summary of the public notice process described in §431.408, including a report of the issues raised during the comment period and how Virginia considered the comments in developing the extension application is included in the Demonstration Extension Application.

9. **Demonstration Phase-Out.** Virginia does not plan to suspend or terminate this Demonstration in whole, or in part, prior to the expiration date. During the initial period of the current renewal, Virginia did suspend new enrollment in the FAMIS MOMS component with the intent of phasing out that program. An amendment to this effect, along with a phase-out plan, was submitted to CMS June 26, 2013; this was approved and became effective January 1, 2014. Public notice requirements for the amendment were met through the state legislative and budget process. Since only new enrollment was suspended, and those participants who were enrolled prior to December 31, 2013 had no change in their benefits, there was no need to notify individuals of any loss of benefits or appeal rights. Community partners responsible for outreach and eligibility determinations were notified of the change to the program through broadcasts, websites, memos and manuals.

10. **Enrollment Limitation during Demonstration Phase-Out.** Virginia anticipates that this Demonstration will be extended. Enrollment will be suspended if CMS notifies Virginia in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend**. CMS has not suspended or terminated the Demonstration (in whole or in part).

12. **Finding of Non-Compliance.** CMS has not found that Virginia materially failed to comply with Demonstration requirements.

13. **Withdrawal of Waiver Authority.** CMS has not withdrawn waiver or expenditure authorities.

14. **Adequacy of Infrastructure.** Virginia has made available adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice and Tribal Consultation, and Consultation with Interested Parties.** Virginia has no federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations.

16. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration were requested for this demonstration period prior to the effective date identified in the Demonstration approval letter.

IV. GENERAL REPORTING REQUIREMENTS

17. **Quarterly and Monthly Enrollment Reports.** Each quarter Virginia provides CMS with an enrollment report, by Demonstration population, which shows the end of the quarter actual and unduplicated ever-enrolled figures. These enrollment data are entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. In addition, Virginia provides monthly enrollment data in the written report format agreed to by CMS and the Commonwealth.

18. Monitoring Calls: CMS and the Commonwealth held monitoring calls as needed to discuss issues associated with the continued operation of the Demonstration.

19. Annual Reports. Virginia submitted an annual report for each program, FAMIS MOMS and FAMIS *Select*, on February 13, 2015, for the period July 2013 – June 2014. No comments were received from CMS. An annual report for the period July 2014 – June 2015 has not yet been submitted.

20. Final Report. Virginia proposes to extend the Demonstration so does not plan to submit a final report at this time.

21. Final Evaluation Design and Implementation. Virginia continues to implement the evaluation design and report its progress with program participation in the quarterly reports. Virginia will submit to CMS a draft evaluation report 120 days after the expiration of the current Demonstration period. If comments are received from CMS, Virginia will submit a final report no later than 60 days after the receipt of the comments from CMS.

V. ELIGIBILITY AND ENROLLMENT

22. FAMIS MOMS eligibility: From October 1, 2013 – December 31, 2014, uninsured pregnant women with incomes at or below 210 percent of the FPL, including those who are citizens or lawfully residing immigrants in the United States, not inmates or inpatients in an institution for mental diseases, were eligible to be enrolled in FAMIS MOMS. As of January 1, 2014, new enrollment was closed and new applications were not accepted. Women enrolled in FAMIS MOMS on or prior to December 31, 2013, retained eligibility for the duration of their pregnancy and 60-day post-partum period. On December 1, 2014, enrollment was reopened, and new applications accepted, for uninsured pregnant women with incomes up to 200 percent of the FPL. This income eligibility threshold aligns with children's coverage levels under the CHIP program. Effective April 3, 2015, Virginia expanded eligibility for FAMIS MOMS to state employees and their dependents who otherwise qualify for the program. This change is consistent with that made for dependent children of state employees to be eligible for FAMIS, effective January 1, 2015.

A dedicated unit was established on April 20, 2015 within the Cover Virginia call center to assist state employees with an assessment of eligibility for FAMIS and FAMIS MOMS. Immediately prior to and coinciding with the state employee's open enrollment period, the prospective FAMIS MOMS enrollee received assistance with completing an application and written notice of projected eligibility, and the FAMIS MOMS application was pended. If the prospective FAMIS MOMS enrollee decided to drop state employee health coverage for the upcoming plan year, the FAMIS MOMS applicant was required to provide the Cover Virginia call center with an attestation that the applicant had terminated state employee's coverage and the FAMIS MOMS's applicant's eligibility determination was then finalized. Loss of eligibility under a government sponsored health plan, including FAMIS and FAMIS MOMS is a qualifying mid-year event for state employees. Therefore, during the FAMIS MOMS 60-day postpartum coverage period, the woman will be able to enroll in the state employee health plan.

23. Screening for Medicaid. Virginia continued to screen all applicants for the Demonstration for Medicaid eligibility. Demonstration applicants eligible for Medicaid are enrolled in Medicaid and receive the full Medicaid benefit package.

24. FAMIS *Select* premium assistance enrollment. CMS gave approval through this Demonstration renewal for children eligible for Virginia's Separate CHIP program and not eligible under the Medicaid State plan as of March 31, 1997, to continue to choose to receive coverage through premium assistance for private or employer-sponsored insurance. Such enrollment is voluntary and based on informed choice regarding all implications of choosing premium assistance, including the possibility of reduced benefits and increased cost sharing, and that the title XXI cost-sharing limit of 5 percent on annual, aggregate cost sharing does not apply. Virginia notifies families at enrollment and during the month of May that they may choose direct coverage at any time. In the case of title XXI- eligible children, Virginia continues to inform families that all age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) are covered. Families continue to be told that this coverage is a factor to consider in choosing private or employer-sponsored insurance. Virginia provides information as to where children may receive immunizations in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled. In the case of title XXI-eligibles whose employer or private insurance does not include immunizations, the Commonwealth has an established mechanism in effect to reimburse providers for the cost of immunizations.

25. Enrollment Limits. There is no enrollment cap for FAMIS MOMS and FAMIS *Select*. Enrollment in a private or employer-sponsored plan is voluntary, and the child may elect to switch to direct FAMIS coverage at any time.

VI. BENEFITS

26. FAMIS MOMS Coverage. FAMIS MOMS receive the same benefits as pregnant women under the approved Medicaid state plan. Following submittal of an amendment in December 2014 that became effective April 3, 2015, medically appropriate dental benefits were added to the FAMIS MOMS program following implementation in Medicaid for pregnant women in March 2015. These benefits include:

- Diagnostic
- Preventive
- Restorative
- Endodontics
- Periodontics
- Prosthodontics- both removable and fixed
- Oral surgery (extractions and other oral surgeries)
- Adjunctive general services (all covered services that do not fall into specific dental categories).

Pregnant women enrolled in Medicaid and FAMIS MOMS who are 21 years of age and older are able to receive appropriate benefits, excluding orthodontics, covered by the *Smiles For Children* program. Dental benefits for pregnant women who are 21 years of age and older are discontinued at the end of the month following their 60th day postpartum.

Pregnant women enrolled in Medicaid, FAMIS and FAMIS MOMS who are under age 21 currently are eligible to receive comprehensive children's benefits covered through the Virginia Medicaid *Smiles For Children* dental program which include orthodontia. Dental benefits for children in Medicaid and FAMIS MOMS are discontinued at age 21 and at age 19 for children in FAMIS.

27. FAMIS *Select* Premium Assistance. For children who chose to receive coverage through premium assistance, the benefit package available through the private or employer-sponsored insurance company was the benefit package delivered, along with wrap-around benefits for immunizations, if necessary.

28. Cost Effectiveness. Consistent with 2105(c)(3) of the Social Security Act, cost-effectiveness for the purchase of employer-sponsored insurance has been determined relative to the amount of expenditures under the state child health plan. For the period July 2013 – June 2014, the maximum premium subsidy under FAMIS *Select* was $100 per enrollee per month; the actual average subsidy paid per enrollee was $91.41. The average per enrollee per month cost for FAMIS was $204.80, while the average monthly cost for a FAMIS *Select* enrollee, with administrative and other costs, was $123.51. This amounts to a savings per FAMIS *Select* enrollee of $81.29, and estimated annual aggregate savings of $254,208.

VII. COST SHARING

29. FAMIS MOMS Coverage. The cost- sharing requirements for the FAMIS MOMS Demonstration are consistent with those described in the title XIX State plan. There are no premiums or enrollment fees. Copayments continued to apply to services that are not pregnancy-related as specified in Attachment B of the Demonstration proposal.

30. FAMIS *Select* Premium Assistance. For children who chose to receive coverage through premium assistance, cost-sharing requirements continued to be set by their private or employer-based coverage.

VIII. PROGRAM DESIGN

31. Concurrent Operation. Virginia's title XXI State plan, as approved, continued to operate concurrently with this section 1115 Demonstration.

32. Maintenance of Coverage and Enrollment Standards for Children

a) Virginia continued to review enrollment data to provide evidence that children were not denied enrollment and continued procedures to enroll and retain eligible children for CHIP.

b) Virginia's established monitoring process ensured that expenditures for the renewal did not exceed available title XXI funding (i.e., the title XXI allotment or reallocated

funds) and the appropriate State match.

For Demonstration population 1, Virginia did not employ the option to lower the Federal poverty level used to determine eligibility, or discontinue coverage. Virginia did employ the option to suspend intake into the program, subsequent to legislative action by the General Assembly. This action was reversed during the renewal period and intake into the program reinstated.

IX. GENERAL FINANCIAL REQUIREMENTS FOR DEMONSTRATION POPULATIONS 1 AND 2

Virginia continues to report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual. Title XXI Demonstration expenditures are reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). Virginia continues to identify the program code and coverage (children or adults) on the appropriate waiver forms.

33. Claiming Period. Virginia makes all claims for expenditures related to the Demonstration (including any cost settlements) within 2 years after the calendar quarter in which the Commonwealth made the expenditures. All claims for services during the Demonstration period (including cost settlements) will be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the Commonwealth will continue to identify separately, on the Form CMS-21, net expenditures related to dates of service during the operation of the Demonstration.

34. Standard CHIP Funding Process. The standard CHIP funding process continued to be used during the Demonstration. Virginia continues to estimate matchable CHIP expenditures on the quarterly Form CMS-21B. Virginia provides updated estimates of expenditures for the Demonstration population on a separate CMS-21B. Within 30 days after the end of each quarter, Virginia submits the Form CMS-21 quarterly CHIP expenditure report.

35. Sources of Non-Federal Share. Virginia continues to certify Commonwealth/local monies used as matching funds for the Demonstration and certifies that such funds are not used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-federal funding are compliant with section 1903(w) of the Act and applicable regulations.

36. Title XXI Limits. Virginia has not expended its available title XXI Federal funds for any claiming period.

37. Administrative Costs. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the Demonstration renewal that are applied against Virginia's title XXI allotment have not exceeded 10 percent of total title XXI expenditures.

38. Risk. If Virginia exhausts the available title XXI Federal funds in a Federal fiscal year during this renewal period of the Demonstration, the Commonwealth will continue to provide coverage to the approved title XXI State plan separate child health program population and the Demonstration population(s) with Commonwealth funds.

39. Enrollment Limits. Virginia did close enrollment with respect to Demonstration population 1, for the period January 1 – November 30, 2014. Before closing enrollment, Virginia provided notice to CMS through an amendment to the waiver in June 2013, approved December 30, 2013. Enrollment was reinstated on December 1, 2014, following CMS approval of an amendment to do so.

INTERIM EVALUATION REPORT

Virginia Title XXI Health Insurance Flexibility and Accountability (HIFA) Demonstration: FAMIS MOMS and FAMIS *Select*

Section 1115 Research and Demonstration Project
Project Number **21-W-000 18/10**
Demonstration Period July 1, 2013 through June 30, 2016
Interim Evaluation Period July 1, 2013 through May 31, 2015

Virginia Department of Medical Assistance Services
June 2015

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Virginia Title XXI Health Insurance Flexibility and Accountability (HIFA) Demonstration: FAMIS MOMS and FAMIS *Select*

Project Number 21-W-000 18/10
Demonstration Period July 1, 2013 through June 30, 2016
Interim Evaluation Period July 1, 2013 through May 31, 2015

Executive Summary

Virginia's Title XXI Health Insurance Flexibility and Accountability **(**HIFA) Demonstration has two objectives. First, it expands Title XXI coverage to uninsured pregnant women with family income up to 200% of the federal poverty level (FPL) who are not eligible for Medicaid through a program known as FAMIS MOMS. Second, it uses Title XXI funds to support a health insurance premium assistance program known as FAMIS *Select*. Virginia's HIFA Demonstration was approved for a three year extension for the period July 1, 2013, through June 30, 2016. This evaluation report provides a summary of findings for the initial portion of the extension period.

Virginia continues to compare favorably with the United States population as a whole on rates of insurance coverage while covering a smaller proportion of the population through Medicaid and CHIP. There remains, however, a substantial uninsured population. The uninsurance rate for the Virginia population with income less than 200% FPL is approximately twice that of the population as a whole. Adults in the child-bearing age group are more likely than other age groups to be uninsured. Virginia's HIFA Demonstration continues to target pregnant women and families with children in population groups with high rates of uninsurance.

Under the provisions of the Affordable Care Act, as of January 1, 2014 most women in the FAMIS MOMS income range qualified for health insurance coverage that includes maternity care with a federally subsidized premium through the Health Insurance Marketplace. An amendment to the state's biennium budget directed the Department of Medical Assistance Services (DMAS) to eliminate the FAMIS MOMS program when this subsidized coverage became available. Accordingly, DMAS took steps to phase out FAMIS MOMS beginning January 1, 2014. Subsequently, the Virginia General Assembly reinstated funding to support FAMIS MOMS, recognizing that the Health Insurance Marketplace was not adequately meeting the needs of this population in Virginia. Enrollment in FAMIS MOMS was reinstated in December 2014. By that time, however, there were very few participants from the period before enrollment was suspended. During this time, the number of infants less than one year of age enrolled in FAMIS dropped to an all-time, four-year low. While this aligns somewhat with a decrease in enrollment of children aged one to six years, it may directly reflect the lack of FAMIS MOMS enrollment during most of 2014; by comparison, December enrollment counts for infants under age one for 2011 – 2013 were in the range of 2,500 each year.

Nevertheless, during the initial period of the demonstration extension the FAMIS MOMS program continued to accomplish its goal of providing quality prenatal care to participating uninsured women living within the Title XXI income range and likely to give birth to a FAMIS eligible child. Quality indicators associated with birth outcomes demonstrated that pregnant women served by the FAMIS MOMS program had better results than that of the total population in Virginia. This held true for adequacy of prenatal care, rates of low birth weight, and rates of premature births. These results have remained quite stable over the past five years of the demonstration.

Participation in FAMIS *Select* has continued to decline. This is likely due, at least in part, to the changes in employer-sponsored insurance options. From 2004/05 to 2012/13, the percentage of employers in Virginia offering sponsored health insurance benefits decreased. The combination of reduced offerings, more stringent criteria to be eligible for employer-sponsored insurance, and the employees' choice to take up the offer has contributed to an overall drop in the proportion of Virginia workers with employer-based coverage.

Despite the declining enrollment, the FAMIS *Select* program continued to accomplish its goal of providing a streamlined and cost-effective alternative to the standard FAMIS program. In State Fiscal Year 2014, the average per enrollee per month cost for FAMIS was $204.80, while that for FAMIS Select was $123.51; the difference of $81.29 represents overall annualized savings of $254,208.

The Affordable Care Act provides protection for children who become ineligible for Medicaid as a result of the elimination of income disregards. At their first renewal, children who exceed the MAGI income limit for Medicaid and become ineligible due to the elimination of income disregards are enrolled in FAMIS. These children then have the option to enroll in FAMIS *Select*. Since July 2014, there has been no uninsured waiting period for enrollment in FAMIS. In January 2015, Virginia eliminated the exclusion of state employee dependents from FAMIS eligibility. The latter are now able to enroll in FAMIS if otherwise eligible; this will also allow the option of using FAMIS *Select* to remain in the state sponsored health insurance plan, if families so choose.

In April 2015, changes were approved to the demonstration to allow state employees who otherwise qualify to enroll in FAMIS MOMS, and coverage for dental services was added to the benefit plans for pregnant women in Medicaid and FAMIS MOMS. These changes should enhance participation and quality of care going forward.

The results of this interim evaluation indicate that Virginia's HIFA Demonstration adds value and should be continued. The impact of the Federally Facilitated Marketplace, and employer-sponsored insurance, should continue to be monitored. As opportunities are identified to enhance the demonstration, appropriate amendments should be developed.

Background

Virginia's Title XXI Children's Health Insurance Program (CHIP) covers children with family income from 143% to 200% FPL under a separate child health plan known as the Family Access to Medical Insurance Security Plan (FAMIS). Virginia's Title XXI Health Insurance Flexibility and Accountability **(**HIFA) Demonstration has two objectives. First, it expands Title XXI coverage to pregnant women with family income from the Medicaid income limit of 143% of the federal poverty level (FPL) to 200% FPL through a program known as FAMIS MOMS. Second, it uses Title XXI funds to support a health insurance premium assistance program known as FAMIS *Select*. Children must first be found eligible and enroll in FAMIS before electing coverage through FAMIS *Select*.

By targeting these two populations: pregnant women with family income from 143% to 200% FPL and income eligible children with access to employer-sponsored or other private health insurance, Virginia expects to see the following outcomes:

- A decrease in the rates of uninsurance among pregnant women,
- An increase in participation in premium assistance in CHIP,
- An increase in access to appropriate medical services, and
- An improvement in certain health outcomes of children.

The Department of Medical Assistance Services (DMAS) administers Virginia's HIFA Demonstration. The demonstration was approved most recently for a three year extension for the period July 1, 2013, through June 30, 2016. This report provides interim evaluation findings for the first half of this extension period.

FAMIS MOMS

The intent of this program expansion is to provide prenatal care to uninsured women living within the Title XXI income range and likely to give birth to a FAMIS eligible child. Virginia implemented the FAMIS MOMS program incrementally beginning August 1, 2005. The final increment, implemented July 1, 2009, covers pregnant women with family income through 200% FPL. Effective July 1, 2010, eligibility requirements were amended to allow enrollment of pregnant women with income below 133% FPL who do not meet eligible requirements for full Medicaid coverage but do meet the FAMIS MOMS requirements. Coverage was expanded to otherwise eligible lawfully residing pregnant women July 1, 2012.

In 2013, the Virginia General Assembly adopted an amendment to the biennial budget that directed DMAS to phase out and eliminate the FAMIS MOMS program when Health Benefits Exchange coverage became available in Virginia, in order to remove disincentives for subsidized private healthcare coverage through publicly-offered alternatives. Following approval by CMS of an amendment to the waiver, administrative steps were taken to implement this phase out by stopping new enrollment (effective January 1, 2014) while maintaining current cases throughout their benefit period (two months postpartum).

The 2014 General Assembly restored funding to support enrollment in FAMIS MOMS, recognizing that many low-income individuals are not eligible for subsidized coverage through

the federally facilitated marketplace (FFM) due to family circumstances, application difficulties, and enrollment deadlines. The amended state budget for SFY 2015 was passed and signed in late June, 2014. An amendment to the waiver, reinstating enrollment at an upper income level of 200% FPL (plus a 5% disregard), was subsequently submitted to CMS and approved effective November 1, 2014. The Department began enrolling women in FAMIS MOMS again starting December 1, 2014.

The FAMIS MOMS program provides eligible pregnant women the same comprehensive coverage that pregnant women receive from the Virginia Medicaid program. There is no difference in covered services, service limitations, or pre-authorization requirements. The cost sharing requirements for FAMIS MOMS are consistent with those described in the Medicaid state plan for pregnant women. There are no premiums or enrollment fees, but co-payments apply to services that are not pregnancy-related. The Title XXI cost sharing limits are not applied to FAMIS MOMS. However, consistent with Title XXI requirements, to be eligible for FAMIS MOMS a pregnant woman must be uninsured, a citizen or lawfully residing immigrant, and not be an inmate or an inpatient in an institution for mental diseases.

FAMIS MOMS uses the same health care services delivery systems (fee-for-service [FFS] and managed care organizations) as FAMIS. All pregnant women are initially enrolled under FFS. Over 90% of women transfer to a managed care organization within two months of enrolling.

FAMIS Select

Virginia implemented the FAMIS *Select* program beginning August 1, 2005. FAMIS *Select* replaced the former Employer Sponsored Health Insurance (ESHI) program under the Title XXI state plan and provides an alternative for families with children enrolled in FAMIS who have access to private or employer-sponsored coverage. All children are first enrolled in FAMIS. With FAMIS *Select*, the family of a FAMIS enrolled child may buy into their employer's health insurance program or a private health insurance plan, submit a pay stub or other proof of payment to the FAMIS *Select* program, and be reimbursed $100 per month, per eligible child, not to exceed the total amount of the premium. The child then receives the health care services provided by the private/employer-sponsored health plan, and the family is responsible for any costs associated with that policy. For families with enrolled children who choose to receive coverage through premium assistance, cost sharing requirements are set by their private or employer-based coverage with no FAMIS wrap around benefits other than immunizations. Virginia has established a mechanism to reimburse providers for the cost of immunizations not covered by the employer or private insurance. For some families, the FAMIS *Select* payment may make health coverage affordable for the entire family. In other cases, it may allow a child to continue to see a doctor or dentist that may not accept FAMIS, and gives a family greater choice of providers.

Other factors influencing the demonstration

The number of resident live births in Virginia declined each year from 2007 to 2011 by a total of 5.4% before increasing slightly in 2012. Over the period 2011 – 2013, resident live births have been stable, changing less than 1% each year. This indicates that there should be a continued demand for FAMIS MOMS services.

December 2007 marked the beginning of an economic recession, with health care costs continuing to rise. The recession, which ended in 2009, added considerable stress to the U.S. economy. While almost 59% of private sector employers offered employees health insurance in 2000-2001, by 2012-2013 that figure had dropped to 50%. At the same time, the cost of employer-sponsored coverage, and the employee's share of that cost, increased. It is likely that these changes in employer-sponsored options have increased the number of families who could be eligible to seek assistance through FAMIS MOMS and FAMIS *Select*. However, they have also likely had a negative impact on the use of FAMIS *Select*.

Key informant interviews, a consumer survey, and stakeholder focus groups were conducted in the latter part of 2014 for the Virginia Department of Health (VDH) 2015 Title V Maternal and Child Health Needs Assessment. These groups identified adequate insurance coverage, including lack of Medicaid expansion in Virginia and concerns with the ACA, as the major issue affecting Virginia's maternal and child health population. Other identified high priority topics for the next five-year block grant funding cycle include intended-ness of pregnancy, infant mortality, breastfeeding, and safe sleep.

In November 2008 the State Health Commissioner appointed a group of health professionals and community and civic leaders to work jointly with VDH in the development and implementation of creative and innovative prevention strategies to address Virginia's high infant mortality rate. The work group collaborated on a number of initiatives including promoting the national text4baby health education campaign to reduce premature births among low income women and improve maternal and child health outcomes, and "Healthy Baby Begins with You" training for young women and men in historically black colleges to address preconception health, prenatal health, family planning, and maternal and child health with their peers. Over the course of the last several years, VDH has continued work on a multi-focal strategic plan to reduce infant mortality. The objectives of this plan intersect with those of the Collaborative Improvement and Innovation Network (CoIIN) project to improve birth outcomes under the national Healthy Babies Initiative. VDH is currently leading Virginia's CoIIN project, focusing on smoking cessation, reduction of early elective deliveries, and increasing breastfeeding. DMAS staff has participated throughout this initiative.

Since September 2011 VDH, in collaboration with Virginia's Home Visiting Consortium, has made funds available to support home visiting programs in "at-risk" communities in Virginia. Participating home visiting programs are committed to implementing evidence-based programs including Healthy Families, Parents as Teachers, and the Nurse-Family Partnership. Programs are currently exploring financial sustainability options, including contracting with managed care organizations, and working with Community Service Boards for mental health case management. There is generally increasing interest statewide in home visiting as a strategy to reach high risk pregnant women and families in an effort to improve birth outcomes, inter-conception health, and school readiness.

In June 2013 the Centers for Medicare & Medicaid Services awarded Virginia Commonwealth University a Strong Start grant to evaluate effectiveness of the centering pregnancy model of prenatal care delivery. Centering pregnancy is being tested in several health centers across the Commonwealth, and is available to any pregnant woman receiving the FFS

Medicaid, managed care Medicaid, FAMIS, or FAMIS MOMS benefit who is being served by one of these project sites. Contracted managed care organizations are working with some of the project sites, but it is too early to determine whether or not this initiative has an impact on birth outcomes for FAMIS MOMS.

In an effort to enhance access to health care services for more Virginians, Governor McAuliffe released his plan for *A Healthy Virginia* in September 2014. This plan focuses on ten objectives to expand the reach of public insurance products for a range of services, including outreach to assist eligible individuals and families to access the FFM, enrolling 35,000 more children in Medicaid and FAMIS, allowing state employees to enroll dependents in FAMIS, and adding dental services coverage for pregnant women in Medicaid and FAMIS MOMS.

Evaluation Design

The Demonstration evaluation plan has three components: (1) monitoring the rate of uninsurance, (2) evaluating participation in premium assistance in CHIP, and (3) quality measures on access and outcomes.

Monitoring the Rate of Uninsurance

Data sources used for this component of the evaluation:

- *State Health Access Data Assistance Center (SHADAC):* Health insurance coverage estimates from the Current Population Survey Annual Social and Economic Supplement (CPS), 2006-2012, were obtained from SHADAC. SHADAC, a project of the University of Minnesota, is funded by the Robert Wood Johnson Foundation to help states monitor rates of health insurance coverage and to understand factors associated with uninsurance. The data center is accessible at http://datacenter.shadac.org/ Information about SHADAC is available at http://www.shadac.org/.

- *Title V State Narrative for Virginia 2015* (September 22, 2014) and *Draft Virginia Title V Needs Assessment* (April 2015): The Virginia Department of Health administers the Commonwealth's Title V program, including assessment of the maternal and child health needs of the population. Title V documents may be viewed at https://perf-data.hrsa.gov/MCHB/TVISReports/StateMchApps/StateNarrativeMenu.aspx

- *Virginia Pregnancy Risk Assessment Monitoring System (PRAMS)*: PRAMS is a surveillance project of the Virginia Department of Health and the US Centers for Disease Control and Prevention. PRAMS collects Virginia-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Information about Virginia PRAMS is available at http://www.vahealth.org/prams/.

Evaluating Participation in FAMIS MOMS and FAMIS Select

Data sources used for this component of the evaluation:

- *DMAS Recipient file*: The DMAS Recipient file maintains eligibility and demographic data for individuals enrolled in all DMAS programs funded by Medicaid and CHIP.

- Planalp, C., Sonier, J., Fried, B. 2015. "State-Level Trends in Employer-Sponsored Health Insurance." Minneapolis, MN: State Health Access Data Assistance Center.

- Weldon Cooper Center for Public Service, Demographics & Workforce Group, www.coopercenter.org/demographics, data source United States Census Bureau, Census 2010 and 2013 Population Estimates, University of Virginia, accessed March 2015. The University of Virginia's Weldon Cooper Center for Public Service is a research and training organization focused on the Commonwealth of Virginia.

- *FAMIS Select data base:* The FAMIS *Select* data base is a case maintenance system that includes data about FAMIS *Select* enrollees obtained from the DMAS Recipient file, information from the FAMIS *Select* application, and premium payments records.

Quality Measures on Access and Outcomes

Data sources used for this component of the evaluation:

- *Calendar Year 2013 Improving Birth Outcomes through Adequate Prenatal Care Study*, November 2014, Delmarva Foundation. DMAS contracted with the Delmarva Foundation for Medical Care, Inc. to evaluate the quality of prenatal care provided to women enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs. This report is available at http://dmasva.dmas.virginia.gov/Content_atchs/mc/fs-f11.pdf.

- *Title V State Narrative for Virginia 2015* (September 22, 2014)*:* The Virginia Department of Health reports on health status and health system indicators in its annual report and application for Title V block grant funds.

- Virginia Department of Health, Division of Health Statistics: VDH collects, analyzes, and publishes annual data from vital records, including official birth records. The Division of Health Statistics works as a partner with the National Center for Health Statistics. Statistical reports and tables are available at http://www.vdh.virginia.gov/HealthStats/stats.htm.

- Births: *Final data for 2012, National Vital Statistics Reports; Vol 62 no 9, December 16, 2014* and *Final data for 2013, National Vital Statistics Reports; Vol 64 no 1, January 15, 2015*, National Center for Health Statistics. Reports are available at http://www.cdc.gov/nchs/

- *Issue Brief "Premature Birth: The financial impact on business: March of Dimes, February 2014*. The March of Dimes commissioned an analysis by Truven Health Analytics, Inc. on the costs to business of premature births.

- *FAMIS Select data base:* The FAMIS *Select* data base is a case maintenance system that includes data about FAMIS *Select* enrollees obtained from the DMAS Recipient file, information from the FAMIS *Select* application, and premium payments records.

- *National Survey of Children's Health.* NSCH 2007 and 2011/12. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website retrieved April, 2015.

- *Annual Virginia Immunization Survey, 2013*; Virginia Department of Health Division of Immunization website.

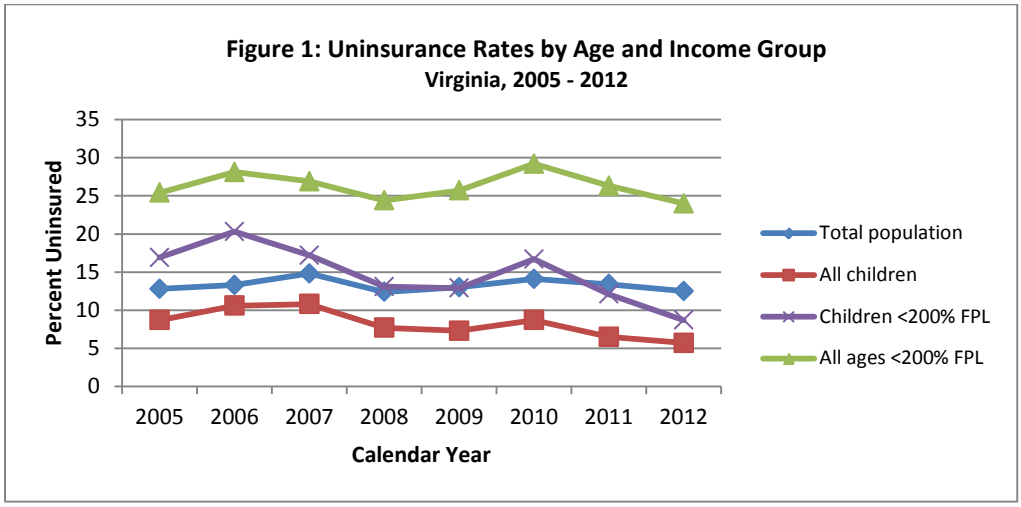
Rate of Uninsurance

Estimates made available through the State Health Access Data Assistance Center (SHADAC) from the Current Population Survey Annual Social and Economic Supplement (CPS), 2006-2012 were used to summarize the rate of uninsurance in Virginia. The data presented in this report are the CPS estimates rather than SHADAC's enhanced CPS estimates.

Estimates of the uninsurance rates for the total Virginia population, as well as the income and ages groups targeted by this demonstration, are shown in Table 1 and Figure 1. The uninsurance rate for the total Virginia population remained fairly stable during calendar years 2005 to 2012. The uninsurance rate for children through 18 years of age was consistently lower than that of the population as a whole. Uninsurance rates for the Virginia population with income less than 200% FPL were approximately twice the rates of the population as a whole. The three-year uninsurance rate for children in this low-income group dropped during the period of this demonstration, from 17.4% in 2005-2007 to 13.8% in 2009-2011 and to 12.7% in 2010-2012.

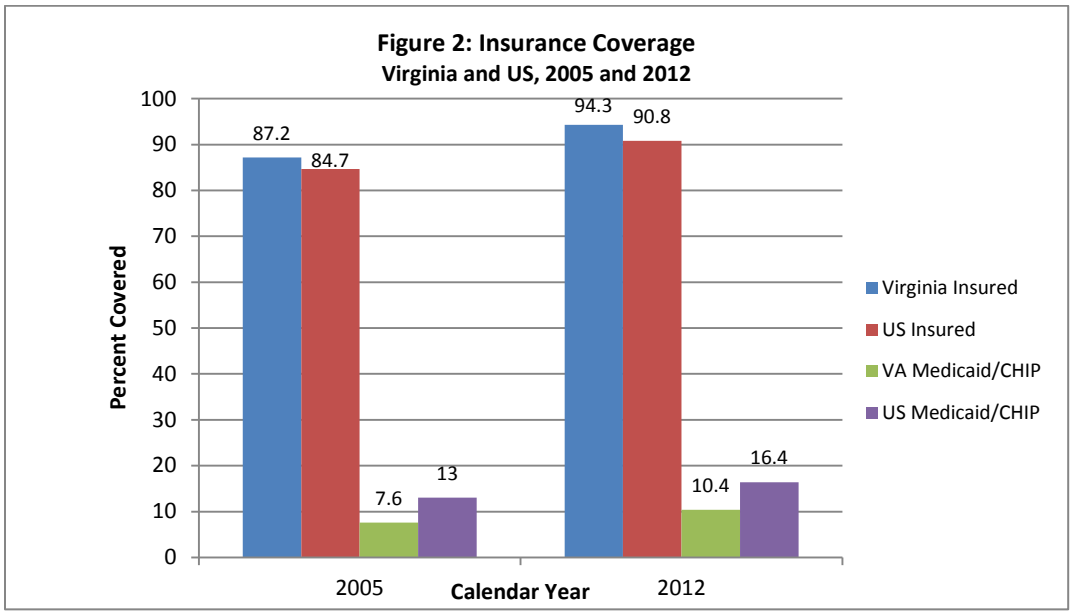
Table 1: Uninsured Population Estimates by Age and Poverty Level Groups
Virginia: Calendar Years 2005-2012

Calendar Year	All ages All income levels	Age 0-18 Yrs All income levels	All ages <200% FPL	Age 0-18 Yrs < 200% FPL
	Percent	Percent	Percent	Percent
2005	12.8	8.7	25.4	16.9
2006	13.3	10.6	28.1	20.3
2007	14.8	10.8	26.9	17.2
2008	12.4	7.7	24.4	13.1
2009	13.0	7.3	25.7	12.9
2010	14.1	8.7	29.2	16.7
2011	13.4	6.5	26.3	12.1
2012	12.5	5.7	24.0	8.7



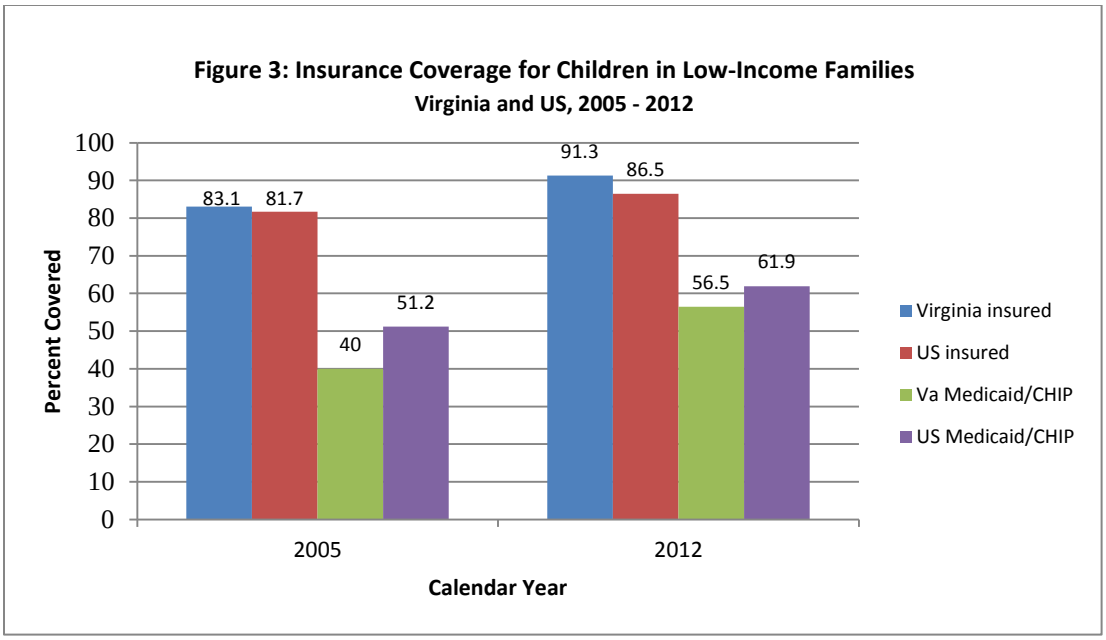
Source: SHADAC Data Center Web page, from CPS data, accessed March 2015

Figure 2 compares health insurance coverage (of any type) and Medicaid/CHIP coverage for Virginians to that of the United States (US) population in 2005, the beginning of the demonstration, and 2012, the most recent data available. In 2005 an estimated 87% of Virginians were insured, compared to almost 91% in 2012. In both 2005 and 2012, a higher percentage of Virginians were insured than the US population overall. A lower percentage of the Virginia population was covered by Medicaid and CHIP than the US population. In 2005, an estimated 8% of Virginians were covered by Medicaid or CHIP compared to 13% of the US population. In 2012, an estimated 10% of Virginians were covered by Medicaid or CHIP compared to 16% of the US population. Virginia, like the US, experienced an increase from 2005 to 2012 in the proportion of the population covered by Medicaid or CHIP.



Source: SHADAC Data Center Web page, from CPS data, accessed March 2015

The comparison between Virginia and the US is similar for coverage of children through 18 years of age in families with income below 200% FPL, the population targeted by Medicaid and FAMIS (Figure 3). Within low income families, the increase in health care coverage was greater for children than for other ages. In 2005, an estimated 83% of children in low-income families in Virginia were insured compared to 82% in the US population. In 2012, an estimated 91% of children in low-income families in Virginia were insured, compared to 87% in the US population. In 2005, an estimated 40% of children in low-income families in Virginia were covered by Medicaid or CHIP compared to 51% in this subpopulation of the US. In 2012, an estimated 57% of children in low-income families in Virginia were covered by Medicaid or CHIP compared to 62% in the US.



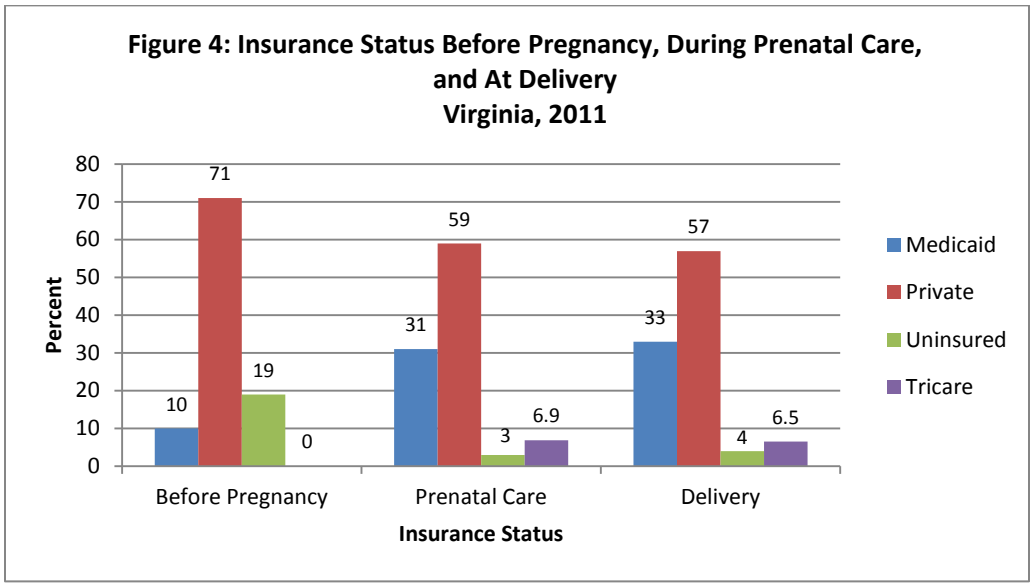
Source: SHADAC Data Center Web page, from CPS data, accessed March 2015

According to data from the CPS, the highest rate of uninsurance in Virginia in 2012 was in the 26 to 34 year age group (24.8%), followed by the 19 to 25 year age group (21.0%). Individuals with income below 200% FPL were found to have significantly higher rates of uninsurance than those with higher income. According to the Virginia Department of Health's 2015 Draft Virginia Title V Needs Assessment, Virginia Behavioral Risk Factor Surveillance System (BRFSS) data indicate that 82.1% of women ages 18-44 had insurance coverage in 2012, but coverage was 88.6% among women 45 and older. A VDH study of women's health indicators using BRFSS data from 2008-2012 showed that by age, women 18-24 were the least likely to have health insurance, with 22% reporting no insurance coverage. This was consistent with data from a similar study of the 2002-2006 period. FAMIS MOMS provides health care coverage for pregnant women in these population groups with traditionally high rates of uninsurance.

The Virginia Pregnancy Risk Assessment and Monitoring System (PRAMS) provides information about insurance coverage among pregnant women. PRAMS is a survey associated with live births and does not capture information about pregnancies that terminated in a natural fetal death or induced abortion. PRAMS data are currently available for births that occurred during calendar years 2007 through 2011.

The PRAMS survey asks women about Medicaid and CHIP coverage at three points in time: prior to pregnancy, for prenatal care, and for delivery. The PRAMS survey of 2011 births, the most recent available, estimates that only ten percent of infants were born to mothers who were covered by Medicaid before they became pregnant. Outreach for FAMIS MOMS targets women who become eligible for full Medicaid or CHIP coverage only when they are pregnant. Medicaid, FAMIS, or FAMIS MOMS paid for prenatal care for mothers of about 31 percent of newborns (Figure 4). Unlike the CPS, in the PRAMS data, women who have both private or

Tricare (military) coverage and Medicaid/CHIP coverage are counted in the private or Tricare category only.



Source: Virginia PRAMS, Virginia Department of Health

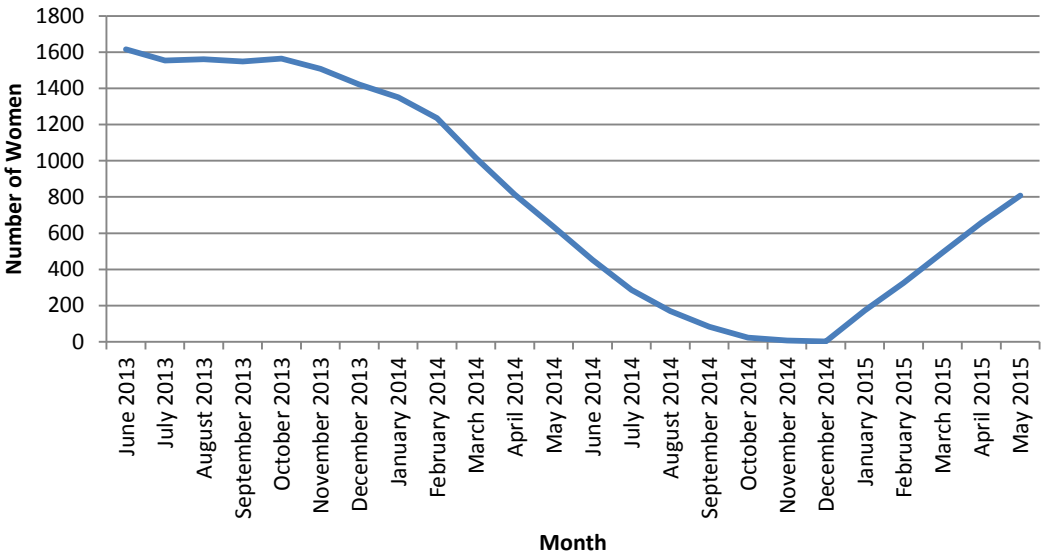
Conclusions

Virginia compares favorably with the United States population as a whole on rates of insurance coverage while covering a smaller proportion of the population through Medicaid and CHIP. There remains, however, a substantial population that is uninsured. The uninsurance rate for the Virginia population with income less than 200% FPL is approximately twice that of the population as a whole. Adults in the child-bearing age group are more likely than others to be uninsured. Virginia's HIFA Demonstration continues to target pregnant women and families with children in population groups with high rates of uninsurance.

Participation in FAMIS MOMS

Enrollment in FAMIS MOMS began in August 2005. The number of pregnant women enrolled increased to 1,203 on October 1, 2008, and then remained relatively level during the final two years of the initial demonstration period (Years 1 - 5). Enrollment increased during the demonstration extension period (Years 6 – 8) to a high of 1,670 in December 2012. In June 2013, 1,616 women were enrolled. Figure 5 shows the enrollment trend to date for the current renewal period. This clearly demonstrates the impact of stopping new enrollment in January 2014, and reinstating enrollment in December of that year.

Figure 1: FAMIS MOMS Enrollment*



*Number enrolled the first day of the month
Source: DMAS Recipient file

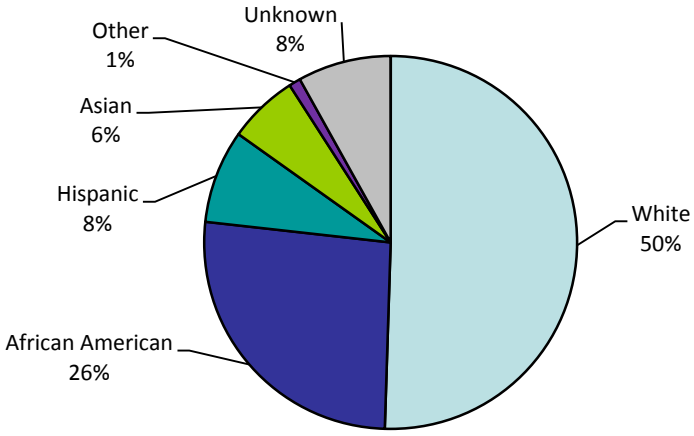
Between July 2013 and March 2015, over 54% of women enrolled in FAMIS MOMS were 20 to 29 years of age. Just over 18% of enrollees were 20 to 24 years old; 35% of enrollees were 25 to 29 years and one-fourth 30 to 34 years of age. As expected, FAMIS MOMS participation continued to be concentrated in the population centers of Northern Virginia, Greater Richmond, and Hampton Roads.

The previous demonstration evaluation noted the impact in Virginia of the number and percentage of Hispanic residents. A Hispanic Outreach Liaison actively promoted the FAMIS MOMS program to the Hispanic community statewide through July 2011. She participated in events and festivals aimed specifically at the Hispanic community and leveraged no cost advertising on Spanish radio and newspapers. Due to staffing reductions, since July 2011 outreach has been limited to regular distribution of printed materials in Spanish and through the Cover Virginia website's Spanish version.

The Hispanic population in Virginia has continued to increase. Between the 2000 and 2010 US Census, the locality with the highest rate of growth was Roanoke, increasing from one to six percent of the population. Other areas of substantial growth included the Northern, Central, and Tidewater cities and counties that have traditionally seen the highest proportion of Hispanic residents. From April 2010 to July 1, 2013, the Hispanic population in Virginia grew 12.8% statewide.

The proportion of women enrolled in FAMIS MOMS who identified their race as Hispanic decreased from 12% in June 2013 to 8% over the current renewal period. As illustrated by Figure 6, 50% of women enrolled in FAMIS MOMS identified their race as non-Hispanic white, 26% identified as non-Hispanic black/African American, and 6% identified as Asian. One percent of enrolled women specified another race or dual races. Race was unknown for the remaining 8% of enrollees.

Figure 6: FAMIS MOMS Enrollees by Race/Ethnicity
July 2013 - March 2015



Source: DMAS recipient file

Conclusions

Participation in FAMIS MOMS was stable up to the point when enrollment was stopped in January 2014. Since enrollment was reinstated, the number of women participating has increased at a rate of about 40 per week. This demonstrates a clear need for the program, and underscores the value perceived by providers and community partners, who refer to the program. The shift in population mix is likely due to two factors: (1) the loss of targeted outreach to the Hispanic community, and (2) the cessation of new enrollment during most of 2014.

Quality Measures on Access and Outcomes for FAMIS MOMS

At the time of the last evaluation, DMAS was taking steps to phase out FAMIS MOMS in response to actions of the General Assembly. This involved, as previously noted, stopping new enrollment in the program for most of calendar year 2014. Nevertheless, significant work has taken place with a goal of improving access to prenatal care and birth outcomes for all pregnant women, with a particular focus on high risk women. Evaluation data suggest that birth outcomes are improving for FAMIS MOMS, as well as for all Virginia resident births.

During this demonstration period the State Health Commissioner's Infant Mortality Work Group evolved to produce the Thriving Infants Strategic Plan, refocusing efforts around key evidence-based strategies that will likely produce better birth outcomes. DMAS staff continued to participate in this effort. In 2012, the infant mortality rate in Virginia dropped to 6.4 per 1,000 live births, and dropped again in 2013 to 6.2 per 1,000 live births.

At the same time, the Virginia Hospital and Healthcare Association (VHHA), the Virginia Chapter of the March of Dimes, and the Virginia Department of Health initiated efforts to reduce the rate of infants born prior to 39 weeks gestation without a medical reason, also known as early elective deliveries (EED). These organizations have worked with birth hospitals to establish policies and procedures affecting EED. All 53 Virginia hospitals that provide obstetrical services submitted their EED data to VHHA and are continuing efforts to reduce rates of EED across the state. Half of these hospitals have been recognized for maintaining rates of EED at less than five percent. The most recent VHHA data, from January 2013 to August 2014, shows that the state average rate of EED is 1.47%.

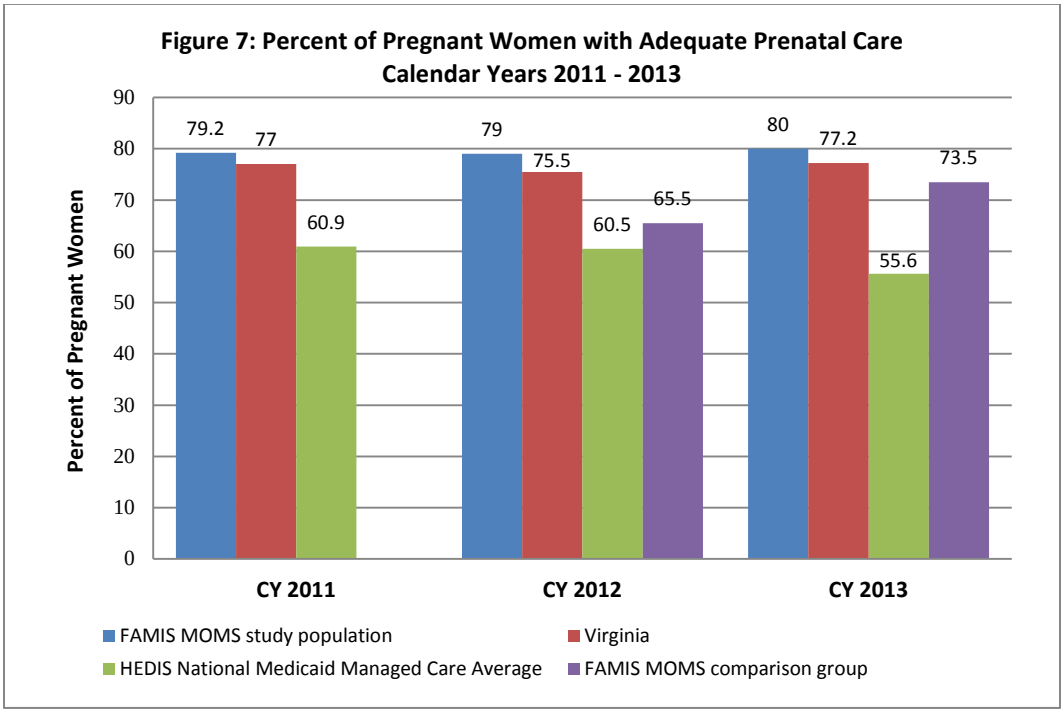
Each year of this demonstration period DMAS contracted with the Delmarva Foundation for Medical Care as the external quality review organization to evaluate access and outcomes for the FAMIS MOMS and Medicaid programs for pregnant women. Coverage and delivery systems are the same for both programs. The most recent findings are published in the *Calendar Year 2013 Improving Birth Outcomes through Adequate Prenatal Care Study*.

The Delmarva study population was limited to pregnant women who were eligible for coverage under the FAMIS MOMS or the Medicaid for pregnant women eligibility category and who were enrolled in a managed care organization (MCO) or the fee-for-service delivery system for at least 43 days prior to delivery and on the day of delivery, consistent with the HEDIS measure for managed care plans. Enrollment data for the study population were linked to data from birth certificate records to obtain the month prenatal care began, number of prenatal care visits, birth weight, and gestational age at delivery. The Delmarva study population definition excluded women who enrolled in FAMIS MOMS or an MCO close to the date of delivery, because late enrollment affords the delivery system limited opportunity to provide prenatal care and impact pregnancy outcome. A comparison population was identified of women who were enrolled on the day of delivery, but were not consistently enrolled for 43 days prior.

A brief summary of the Delmarva study findings specific to FAMIS MOMS and related to the demonstration hypotheses follows, supplemented by data from other sources.

Hypothesis 1 FAMIS MOMS will result in improved prenatal care for pregnant women between 143-200 percent of the FPL.

The Delmarva *Calendar Year 2013 Improving Birth Outcomes through Adequate Prenatal Care Study* evaluated the adequacy of prenatal care for women in the FAMIS MOMS program for the study population (n=1,505 for 2011; 1,649 for 2012; 1,665 for 2013) and comparison group (n=237 for 2013) using birth record data and the Kotelchuck Adequacy of Prenatal Care Utilization Index. Prenatal care was defined as adequate if care began in the first trimester of pregnancy *and* the number of prenatal care visits was at least 80% of expected visits, controlling for when care began and gestational age at delivery. Findings were compared with the national Medicaid managed care average for the HEDIS measure, "Frequency of Ongoing Prenatal Care". The Delmarva study concluded that 79.2% of FAMIS MOMS participants in the study population giving birth in 2011 received adequate prenatal care, 79.0% received adequate prenatal care in 2012, and 80.0% received adequate prenatal care in 2013, compared with HEDIS national Medicaid managed care averages of 60.9% in 2011, 60.5% in 2012, and 55.6% in 2013. Among the comparison group, 73.5% received adequate prenatal care in 2013, an increase of more than 7% over 2012's comparison group (See Figure 7).



Sources: *CY 2013 Improving Birth Outcomes through Adequate Prenatal Care Study* and VDH *2015 Maternal and Child Health Services Title V Block Grant State Narrative for Virginia*

Data analysis for the Delmarva study was based on all prenatal care visits reported on the birth record, including visits prior to enrollment in FAMIS MOMS or an MCO. DMAS program staff and community health care providers have observed that many women initiate prenatal care at a local health department or other safety net provider or under the DMAS fee-for-service delivery system prior to enrolling in an MCO. The Delmarva study findings support this observation; a larger proportion of the study population began prenatal care in the first trimester than enrolled in their final delivery system during the first trimester. It is of note that in CY 2013, 73.0% of FAMIS MOMS participants in the study group began prenatal care in their first trimester compared to only 5.1% in the comparison group.

It must be recognized that, while similar in concept, the Delmarva study and HEDIS measures use different definitions and data sources. The Delmarva study definition of adequate prenatal care, unlike HEDIS, includes the criterion that prenatal care be initiated in the first trimester of pregnancy. The Delmarva study counted all recorded prenatal care visits, while the HEDIS measure is limited to visits provided under a particular health plan. The Delmarva study is based on the number of prenatal care visits reported on the birth certificate; the HEDIS measure counts visits based on insurance claims data and medical record review. Finally, the HEDIS measure references the national Medicaid population, which includes pregnant women with lower family income than FAMIS MOMS.

The Title V Maternal and Child Health program monitors adequacy of prenatal care as a health systems capacity indicator. This measure applies the Kotelchuck Index to birth record data. The *Maternal and Child Health Services Title V Block Grant State Narrative for Virginia, September 22, 2014*, reported that the percent of all Virginia women age 15 to 44 years giving birth who received adequate care was 77.0% in 2011 and 75.5% in 2010 (Figure 7). Based on provisional data, VDH staff estimated that 77.2% of women of all ages giving birth in 2013 received adequate prenatal care.

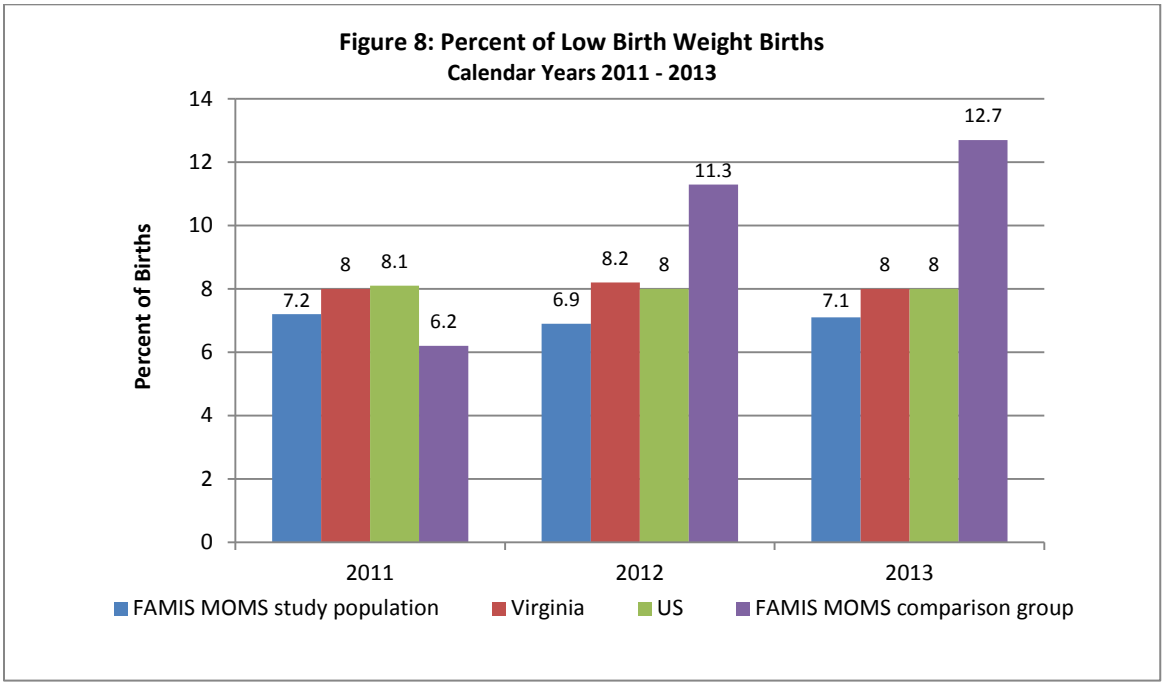
Neither of these comparison statistics on adequacy of prenatal care is strictly comparable to the Delmarva FAMIS MOMS study population. However, taken together these data suggest that the adequacy of prenatal care for women enrolled in FAMIS MOMS is as good as, or better than, that of the total population in Virginia.

Hypothesis 2 FAMIS MOMS will improve birth outcomes thereby decreasing the medical costs incurred for infants born to women in this income range.

A 2014 study sponsored by the March of Dimes found that the average medical cost for a healthy, full-term baby, through the first year of life, was $5,085. For premature and/or low birth weight babies (born at less than 37 weeks gestation and/or at less than 2500 grams) the average cost was $55,393 through the first year of life. Premature and low birth weight infants spent an average of 15 days in the hospital, compared to just over two days for the healthy full-term infant. Premature babies averaged about 20 outpatient medical visits compared to just 14 for full-term infants. To the extent that FAMIS MOMS participants deliver fewer preterm or low birth weight infants, the program is contributing to reduced medical costs for women in this income range.

The Delmarva *Calendar Year 2013 Improving Birth Outcomes through Adequate Prenatal Care Study* evaluated the birth outcomes for women in the FAMIS MOMS study population based on birth weight and gestational age from the birth record data. Findings were compared with national birth weight and gestational age data. The percent of births that were low weight was consistently lower for FAMIS MOMS than for the state or nation as a whole. The Delmarva study found that low birth weight (<2,500 grams) among the FAMIS MOMS study population remained stable across the three year study period: 7.2% in 2011, 6.9% in 2012, and 7.1% in 2013. These results were slightly better than National Center for Health Statistics data on low birth weight rates. However, the latter is based on the entire US population, not restricted to low income women, and is therefore limited in true comparability. In the FAMIS MOMS comparison group the rates were 6.2% in 2011, 11.3% in 2012, and 12.7% in 2013. While the small numbers of women associated with the comparison group do not lend themselves to drawing conclusions about differences with the study group, the trend over the past three study years shows an increase in the rates of low birth weight in the comparison group while that of the FAMIS MOMS study population has been stable and comparatively lower.

Figure 8 compares the Delmarva study population with birth weight data for the total Virginia and United States populations of the same year. The Virginia Division of Health Statistics reported that 8.0% of Virginia resident live births were low weight in 2011, increasing slightly to 8.2% of births 2012 and dropping back to 8.0% of births in 2013. Nationally, low birth weight remained similarly stable from 8.1% in 2011, to 8% in both 2012, and 2013.

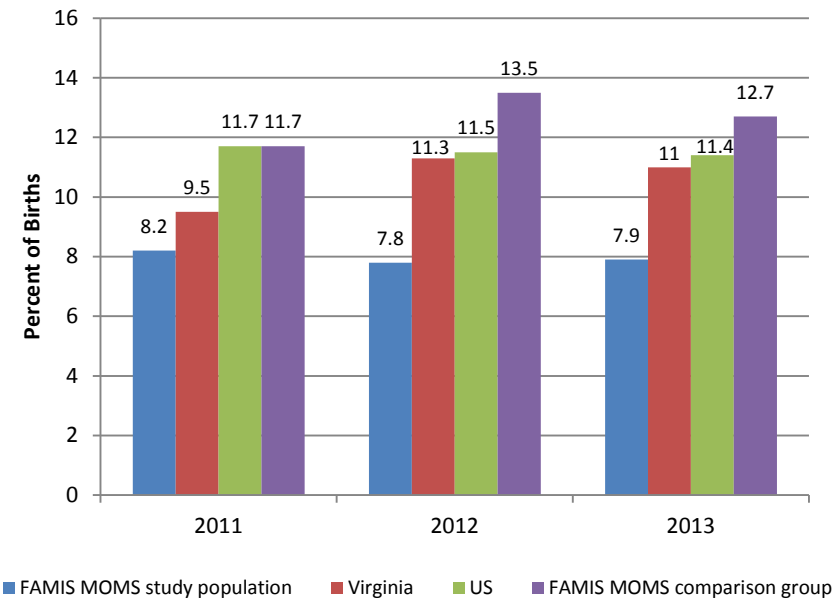


Sources: *CY 2013 Improving Birth Outcomes through Adequate Prenatal Care Study,* VDH Division of Health Statistics, and National Center for Health Statistics

The Delmarva study found that very low birth weight (< 1,500 grams) among the FAMIS MOMS study population remained relatively stable (1.6% and 1.5%) through the period 2011 – 2013. The Virginia Division of Health Statistics reported that 1.6% of all Virginia resident births were very low weight during these years. At the same time, very low birth weight rates nationally remained stable 1.4% of births. While slightly higher than the national rate, very low birth weight among FAMIS MOMS is comparable to that of the Virginia population as a whole.

Prematurity is the primary risk factor for low birth weight and infant mortality. A preterm birth is defined as a birth delivered at less than 37 completed weeks gestation. Figure 9 compares the percent of preterm births in the Delmarva study population with that of all Virginia and United States births of the same year. Preterm births among the Delmarva study population remained relatively stable at 8.2% in 2011, 7.8% in 2012, and 7.9% in 2013. Among the FAMIS MOMS comparison group 11.7% of births were premature in 2011, followed by 13.5% in 2012, and 12.7% in 2013.

Figure 9: Percent of Births Delivered Preterm
Calendar Years 2011 - 2013



Sources: *CY 2013 Improving Birth Outcomes through Adequate Prenatal Care Study,* VDH Division of Health Statistics, and National Center for Health Statistics

Women who enter prenatal care late or who deliver prematurely are at higher risk for delivering an infant with low birth weight. The data suggest that birth outcomes for those pregnant women who were enrolled in a FAMIS MOMS health care delivery system before the last six weeks of their pregnancy were better than birth outcomes for all Virginia residents, for women nationally, and for those in the comparison group.

Hypothesis 3 FAMIS MOMS will decrease the number of months income eligible babies will go without insurance.

Since July 1, 2010, children who are born to individuals eligible for FAMIS MOMS on the date of the child's birth are deemed to have applied and been determined eligible for Medicaid or FAMIS, as appropriate, on the date of birth and remain eligible until their first birthday. At the end of January 2013, DMAS initiated a pilot program with selected hospitals to implement an on-line process for hospitals to report births of deemed newborns to the FAMIS Central Processing Unit (now Cover Virginia). The success of this pilot led to expanding the process statewide in 2014.

Through much of the current demonstration renewal period, enrollment in FAMIS MOMS was suspended, and infants born to active participants were not identified separately from all deemed newborns. Between July 1, 2013 and March 1, 2015, 58,137 newborns were deemed eligible for Medicaid and FAMIS. During calendar year 2014, 12,647 newborns were deemed through electronic hospital reporting to Cover Virginia.

The DMAS Office of Data Analytics prepared an analysis of enrollment in FAMIS and Medicaid over the years 2011 – 2014. Children under age six experienced a downward trend, with a particularly sharp drop for children under age one; only 1,594 infants under one year of age were enrolled in FAMIS in December 2014, an all-time, four-year low. While this aligns somewhat with a decrease in enrollment of children aged one to six years, it may directly reflect the lack of FAMIS MOMS enrollment during most of 2014. By comparison, December enrollment counts for infants under age one for 2011 – 2013 were in the range of 2,500 each year.

Conclusions and Recommendations for FAMIS MOMS

The previous evaluation of the demonstration period noted that under the provisions of the Affordable Care Act, beginning January 1, 2014, most women in the FAMIS MOMS income range would qualify for health insurance coverage that includes maternity care with a federally subsidized premium through the Health Insurance Marketplace. An amendment to the state's biennium budget directed DMAS to eliminate the FAMIS MOMS program when this subsidized coverage became available. Accordingly, DMAS took the necessary steps to phase out FAMIS MOMS beginning January 1, 2014. No new applications for FAMIS MOMS coverage were accepted after December 31, 2013, while women with FAMIS MOMS eligibility beginning on or prior to December 31, 2013 retained eligibility for the duration of their pregnancy and post-partum period. During the subsequent legislative session, funding was included in the state budget to support reinstating enrollment in FAMIS MOMS, recognizing that the Health Insurance Marketplace was not adequately meeting the needs of this population in Virginia. Enrollment in FAMIS MOMS was reinstated in December 2014.

During the initial portion of the current demonstration extension period -- July 2013, through May 2015 -- the FAMIS MOMS program continued to accomplish its goal of providing quality prenatal care to those enrolled women living within the Title XXI income range and likely to give birth to FAMIS eligible children. The FAMIS MOMS program continued to provide eligible pregnant women the same comprehensive coverage that pregnant women receive from the Virginia Medicaid program. The quality indicators associated with birth outcomes demonstrated that pregnant women served by the FAMIS MOMS program had better results than that of the total population in Virginia. This held true for adequacy of prenatal care, rates of low birth weight, and rates of premature births. These results have remained quite stable over the past five years of the demonstration. Of interest, since the evaluation has included a comparison group of women who were not enrolled in FAMIS MOMS for at least 43 days prior to delivery, the differences in outcomes for the latter underscores the need to reach more women earlier in their pregnancies.

While the quality of the care received by women in FAMIS MOMS has been substantiated, it is perhaps more significant that suspending enrollment clearly demonstrated a need for the program. The number of newborns enrolled in FAMIS and Medicaid during the hiatus of FAMIS MOMS enrollment reached an all-time, four-year low. The proportion of FAMIS MOMS participants of Hispanic origin also decreased during this period, while the Hispanic population in Virginia continued to increase. Most telling is that, since being reinstated in late 2014, enrollment in the program has grown at a rate of approximately 40 pregnant women per week. This reinforces the perceived need for and value of the program among the public, providers, and community partners.

During this time period, there has also been an increased, statewide interest in improving birth outcomes and maternal health, including preconception and inter-conception wellbeing. This is evident by a number of developments including, but not limited to, implementation of the Virginia Thriving Infant Strategic Plan, engagement of the COIIN Initiative, growth of the Strong Start grant, and strengthening of the Home Visiting Consortium activities. DMAS has been an active partner in all of these efforts. It is recommended that these partnerships continue.

In the latter half of 2014, Governor McAuliffe released *A Healthy Virginia*, his plan for increasing access to health care for citizens of the Commonwealth. This plan included steps to make FAMIS available to state employees, and add dental services coverage for pregnant women in Medicaid and FAMIS MOMS, all of which have been implemented. *A Healthy Virginia* also targeted increasing enrollment in FAMIS and Medicaid by 35,000 children. To this end, significant resources have been added to marketing and outreach activities. This includes adding regional outreach coordinators around the state. Key regions of focus are the Roanoke and northern Virginia areas, which have seen the greatest proportion of growth in the Hispanic population. These additional outreach efforts are likely to have an impact on FAMIS MOMS enrollment going forward. It is recommended that these efforts include targeted initiatives to reach the Hispanic community.

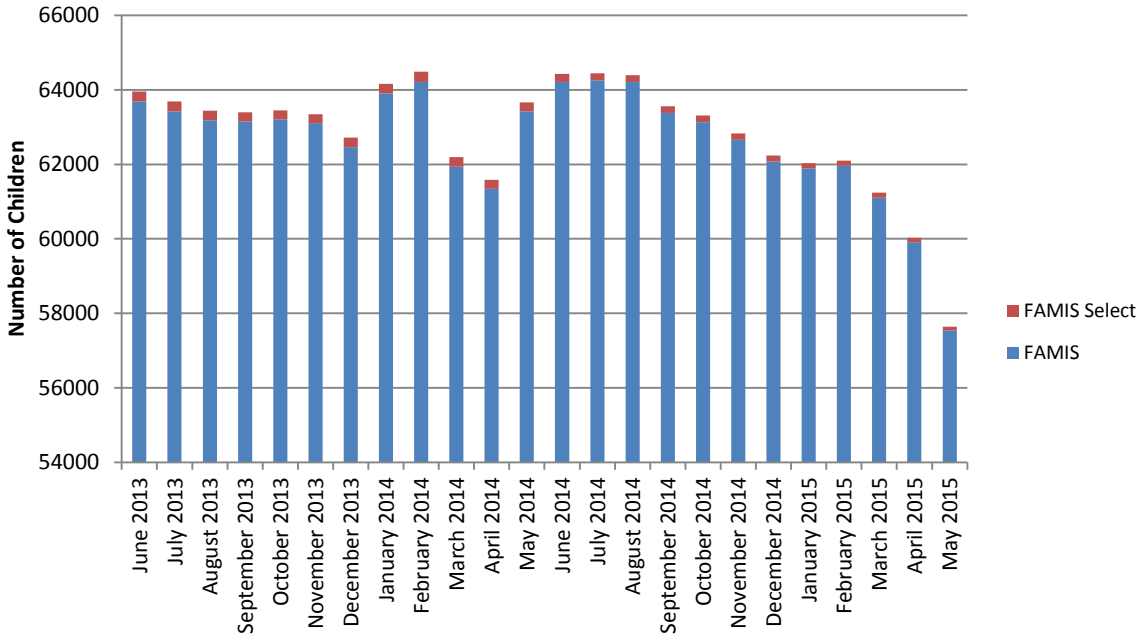
Additionally, in 2014 DMAS initiated the Maternal and Infant Improvement Project (MIIP). This internal, cross-divisional, multidisciplinary project has been convened to improve efficiency and effectiveness of strategies, policies, and procedures to positively impact maternity and postpartum care for DMAS beneficiaries in Medicaid and FAMIS MOMS. The next evaluation of FAMIS MOMS may see further improvements in adequacy of prenatal care measures as a result of operational improvements.

All of the above referenced projects are aimed at improving access to appropriate care and services for more pregnant women, with the goals of improving early prenatal care, enhancing high quality postpartum care, and producing better inter-conception health. It is recommended that these opportunities continue to be engaged to have the greatest impact on services to and outcomes for pregnant women in the Commonwealth. It is further recommended that the FAMIS MOMS program be continued while the utility of the Federally Facilitated Marketplace is monitored for its capacity to meet the needs of this high risk population.

Participation in Premium Assistance in CHIP: FAMIS *Select*

A total of 98 children were enrolled in FAMIS *Select* in August 2005, the first month of the program. Enrollment reached a high of 480 children in March 2009. Both FAMIS and FAMIS *Select* experienced a decline in enrollment during the final year of the initial demonstration period. Figure 10 shows the trend in FAMIS and FAMIS *Select* enrollment over the course of the current demonstration extension period. Although FAMIS enrollment has fluctuated during this time, enrollment in FAMIS *Select* continued to decline. As of April 2015 only 120 children, less than one percent of FAMIS recipients, were enrolled in FAMIS *Select* statewide. A total of 810 children in 352 families, an average of 2.3 children per family, received coverage through the FAMIS *Select* premium assistance program during the period, July 1, 2013 through December 31, 2014. Ninety-three percent of the children in FAMIS *Select* were covered under an employer-sponsored plan; 7% were covered under a private plan.

Figure 10: FAMIS and FAMIS Select Enrollment*

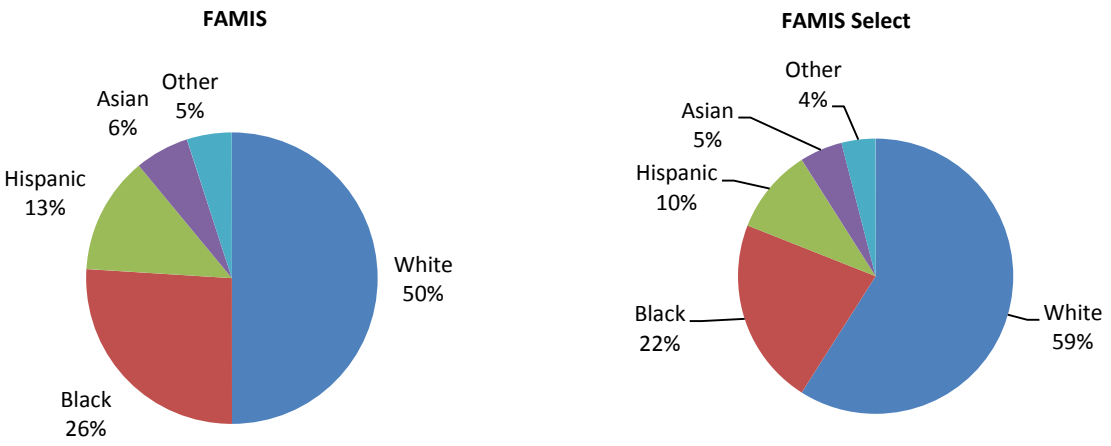


* Number enrolled as of the first day of the month.
Source: DMAS Recipient file

The Affordable Care Act provides protection for children who become ineligible for Medicaid as a result of the elimination of income disregards. At their first renewal, children who exceed the MAGI income limit for Medicaid and become ineligible due to the elimination of income disregards are enrolled in FAMIS. These children then have the option to enroll in FAMIS *Select*. In January 2015, Virginia eliminated the exclusion of state employee dependents from FAMIS eligibility. The latter are now able to enroll in FAMIS if otherwise eligible; this will also allow the option of using FAMIS *Select* to remain in the state sponsored health insurance plan, if families so choose.

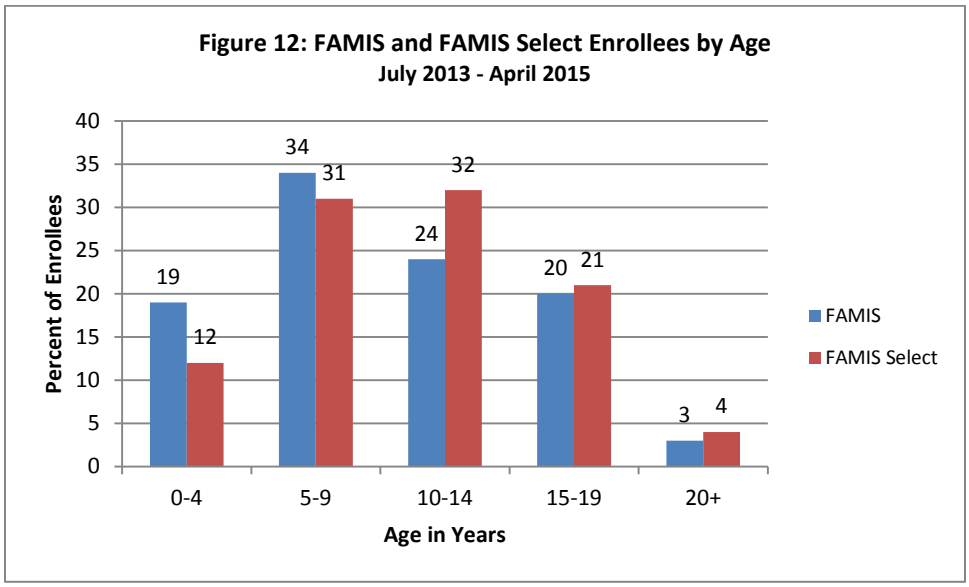
As illustrated in Figure 11, the racial distribution of FAMIS *Select* participants is largely similar to that of all children enrolled in FAMIS. During this initial portion of the extension period, 59% of children in FAMIS *Select* were non-Hispanic white compared to 50% of all FAMIS enrollees. At the last evaluation, only 34% of FAMIS enrollees were non-Hispanic white compared to 52% of FAMIS *Select* enrollees. Similarly, at the last evaluation, 23% of FAMIS enrollees were Hispanic compared to 12% of FAMIS *Select* enrollees; these proportions are currently 13% and 10%, respectively. The increasingly small number of FAMIS *Select* participants in relation to the total FAMIS population does not lend itself to drawing conclusions about differences between the groups. Even so, the racial/ethnic disparity between FAMIS *Select* and FAMIS enrollees appears to have increased from June 2013 to April 2015. As noted for the FAMIS MOMS population, outreach efforts targeted toward the Hispanic community have been limited since 2011.

Figure 11: FAMIS and FAMIS *Select* Enrollees by Race and Ethnicity
July 2013 – April 2015



Source: DMAS Recipient file

Figure 12 compares the ages of children in FAMIS and FAMIS *Select* from July 2013 through April 2015. As found in past analyses, FAMIS *Select* enrollees were distributed more toward the center of the age spectrum compared to all FAMIS enrollees. Fifty-three percent of children in FAMIS *Select* were 10 through 19 years of age compared to 44% of all children in FAMIS. Only 12% of enrollees in FAMIS *Select* were under the age of four, while 19% of FAMIS enrollees were in this age group. This is consistent with the previous finding that FAMIS *Select* is more attractive to families with multiple children enrolled in FAMIS; families with more than one eligible child are more likely to have at least one child in the older age group.



Source: DMAS Recipient file

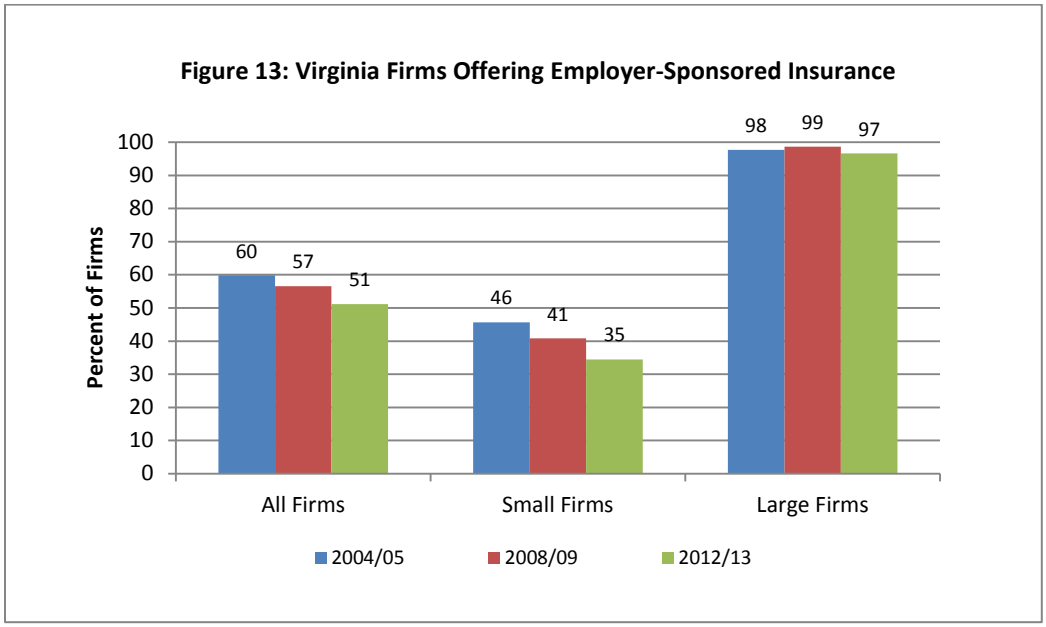
Coverage of Adults and Other Children

FAMIS *Select* provides premium assistance only for children eligible for the FAMIS program and does not cover adults. However, because families receive $100 per month per eligible child, the premium assistance payment may make coverage affordable for the entire family. Based on the information provided on enrollment applications, between July 1, 2013 and December 31, 2014, 265 additional family members (79 adults and 186 other children) were also covered by the health insurance policies supported by FAMIS *Select*.

Analysis of Employer Sponsored Health Insurance

The decline in use of FAMIS *Select* is felt to be largely due to changes in employer based health insurance options. According to a SHADAC analysis of data from the Medical Expenditures Panel Survey – Insurance Component, the proportion of US employers that offered employer-sponsored insurance (ESI) dropped from almost 60% in 2000/01 to 50% in 2012/13. Nationally, this affected small employers (those with fewer than 50 employees) more than large employers (with 50 or more employees); the former declined by 11.6 percentage points while the latter by only 1.1 percentage points over this time period.

Figure 13 demonstrates a similar trend in Virginia based on data from three time periods: 2004/05, 2008/09, and 2012/13. Overall, employers offering ESI decreased from almost 60% in 2004/05, to just over 51% in 2012/13, a statistically significant decrease. Among small employers, the proportion went from 45.7% to 34.5%, also statistically significant, while the decrease among large employers was only slightly more than one percentage point.

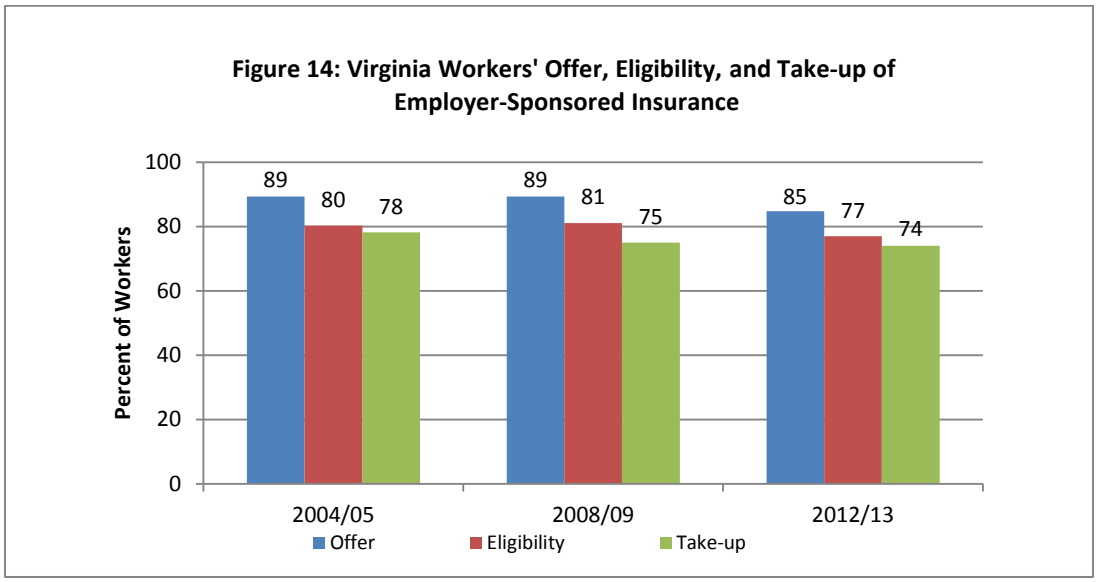


Source: Medical Expenditure Panel Survey- Insurance Component as analyzed by SHADAC; State Level Trends in Employer-Sponsored Health Insurance; SHADAC 2015

The analysis by SHADAC articulates three components to determining the scope of ESI coverage: (1) the employee must work in a firm that offers ESI; (2) the worker must be eligible for ESI coverage based on the employer's criteria; and (3) the worker must "take up" the option. The 2008/09 period saw a significant decrease in the proportion of workers employed in firms offering ESI in 24 states – including Virginia. In four states during this time, including Virginia, there was also a significant decrease in the proportion of workers who were eligible for ESI. Nationally, between 2004/05 and 2012/13, the percentage of workers "taking up" ESI declined significantly from 79.7% to 75.3%.

The trend among Virginia workers for these three components is shown in Figure 14. Workers in firms that offered ESI decreased from 89.3% in 2004/05 to 84.8% in 2012/23, a statistically significant reduction. In 2012/13, 77.0% of workers in Virginia were eligible for the ESI offered them, down from 81.1% in 2008/09, another statistically significant decrease. Finally, the proportion of workers who opted to take ESI dropped from 78.2% in 2004/05 to 74.0% in 2012/13.

The cost of ESI is clearly a main contributor to employers' decisions to offer it, and workers' decisions to take it up. During the period of the referenced SHADAC study, insurance premiums for family coverage increased over 22% from an average of $10,367 (2004/05) to $12,663 (2008/09), and again almost 29% to $16,302 (2012/13). While employers cover a large share of these premium costs, the share paid by employees has also been increasing. Between 2004/05, employee contributions for family coverage increased from 24.3% to 27.2%; this appears to have remained stable for the 2012/13 period.



Source: Medical Expenditure Panel Survey- Insurance Component as analyzed by SHADAC; State Level Trends in Employer-Sponsored Health Insurance; SHADAC 2015

In Virginia in 2012/13, the average annual family plan premium for a worker getting ESI was $15,647, compared to $5,359 for individual coverage. Of these costs, on average 31.4% of the family plan premium was the employee's responsibility, while 23.4% of the individual plan cost was passed to the employee. Based on these figures, the following scenario exemplifies what an average family in the FAMIS-eligible income bracket might face:

- **The average employee contribution toward an employer-sponsored family premium was $4,913/year, or $409/month**
- **For a family of three (one parent and two children), a monthly gross income of $3,433 would qualify them for FAMIS (200% FPL)**
- **The employee contribution to the employer-sponsored premium for family coverage would be approximately 12% of the monthly gross income**
- **Under FAMIS Select, the employee would be reimbursed $200/month to cover two children, leaving the employee's net out-of-pocket expense at $209/month**
- **By comparison, the employee could purchase individual coverage from the employer for $1,254/year, or $105/month (approximately 3% of income), and enroll the children on FAMIS**
- **Cost sharing on FAMIS is limited to no more than $180 or $350 maximum per family per year, while cost sharing on the employer-sponsored plan is likely to be much higher.**

Given the financial realities associated with ESI for low-income workers, it is not surprising that participation in FAMIS *Select* is waning.

Analysis of Cost Effectiveness

Despite declining participation, FAMIS *Select* continues to be a cost effective alternative. Table 2 presents the state fiscal year 2014 analysis of FAMIS *Select* expenses and offsetting savings based on FAMIS expenses. The average per enrollee per month cost under FAMIS was $204.80. The maximum FAMIS *Select* premium subsidy was $100.00 per enrollee, while the average subsidy per enrollee was $91.41. Factoring in administrative expenses, the average monthly cost associated with a FAMIS *Select* enrollee was $123.51. This resulted in a savings per FAMIS *Select* enrollee of $81.29, which translates to an annual estimated savings of $254,208.

Table 2:

Cost Analysis of the FAMIS *Select* program (State Fiscal Year 2014)	
Program Expense Categories	**Costs**
Premium Subsidies	$285,849
Administration	$100,352
Total	**$386,201**
Cost Effectiveness Comparison	
Average Per Enrollee Per Month Cost for FAMIS	$204.80
Maximum FAMIS Select Premium Assistance Subsidy Per Enrollee	$100.00
Actual Average Monthly Premium Subsidy Per FAMIS Select Enrollee	$91.41
Actual Average Monthly Cost for FAMIS Select Enrollee with administrative and other costs	$123.51
Savings Per FAMIS Select Enrollee	**$81.29**
Estimated Average Annual Savings	***$254,208***

Quality Measures on Access and Outcomes for FAMIS *Select*

Access to Services

Children enrolled in the FAMIS *Select* program have access to the services covered by their private or employer-sponsored insurance plan from the network of providers offered by that plan. Parents are encouraged to carefully compare services covered under the private or employer plan with covered services available through the standard FAMIS package. Coverage provided under their plan for children participating in FAMIS *Select* during the three-year demonstration period as reported on the FAMIS *Select* enrollment application is shown in Table 3. Based on parental report, almost all children are covered for doctor visits, hospital and emergency care, prescription drugs, lab and x-rays, well-child check-ups, and immunizations. Coverage for dental care, vision care, and mental health care are each available to between 72% and 81% of the children.

Table 3:

Coverage Provided by FAMIS *Select* Plans
July 2013 – December 2014

Coverage	Number of children	Percent of children
Doctor visits	804	99%
Hospital and emergency care	792	98%
Prescription drugs	787	97%
Well-child checkups	783	97%
Lab and x-rays	786	97%
Immunizations	773	95%
Dental care	660	81%
Mental health care	595	73%
Vision care	583	72%

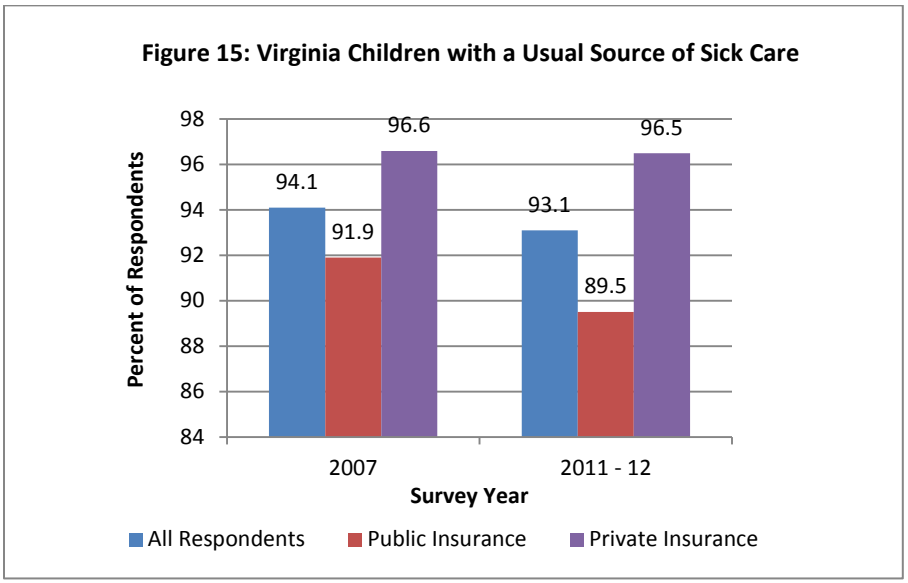
Source: FAMIS Select Applications

Hypothesis 1 The number of providers serving as usual sources of care (medical homes) for children in the State's Title XXI program will increase.

Due to the complexity associated with physician participation in multiple managed care provider networks, the number of providers serving as medical homes is not readily available. Data from the National Survey of Children's Health (NSCH) reveal that in 2007, 58.8% of Virginia respondents met the survey definition of having a medical home. In the 2011-12 survey, this dropped to 56.7%.

One component of assessing the presence of a medical home is whether or not the family (or child) has a usual source of care available for treatment or advice when ill. Figure 15 shows Virginia data on this point from the NSCH for the survey years 2007 and 2011-12. Although

having a usual source for sick care went down one percentage point for all respondents, it dropped 2.4 percentage points for those with public health insurance, while staying stable for those with private or employer-sponsored health insurance. However, the proportionally very small number of children enrolled in FAMIS *Select* is not likely to make a measureable difference in the reported rates of medical homes in Virginia; these children would be reflected in the responses for "private insurance".



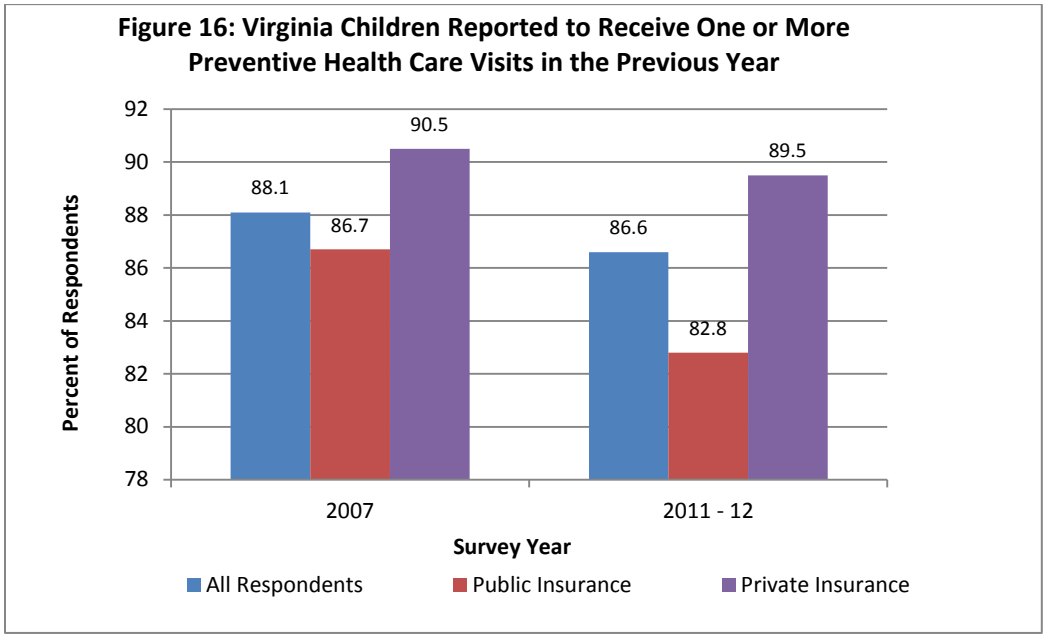
Source: National Survey of Children's Health: Data query from the Child and Adolescent Health Measurement Initiative; retrieved April 2015

Hypothesis 2 ***There will be no difference in the percentage of children who are up-to-date on immunizations among FAMIS and FAMIS Select children and that both programs result in an increase in the percent of children who are up-to-date on immunizations.***

According to the Virginia Immunization Survey for 2013, conducted by VDH, statewide immunization compliance with kindergarten entry requirements was 81.5%. Data are not available based on payer source or insurance status. However, with some exceptions, State law mandates that medical care insurers cover routine immunizations for children from birth through six years of age. Health Departments serve as safety net providers to offer immunizations across the state. Ninety-five percent of children enrolled in FAMIS *Select* during the initial portion of the demonstration extension period were reported to have immunization coverage through their private or employer-sponsored plan. All children are provided coverage on a fee-for-service basis for routine immunizations not covered by the plan.

Hypothesis 3 There will be no difference in the percentage of FAMIS and FAMIS Select children who receive appropriate well-child care and that both programs result in an increase in the number of children receiving appropriate well child care.

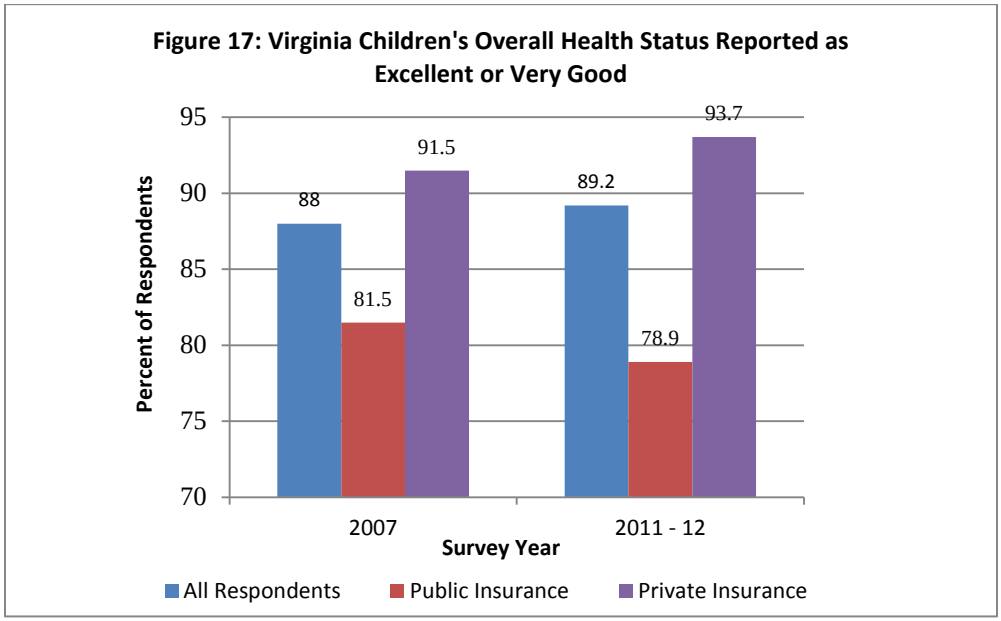
With some exceptions State law mandates that most health care plans cover child health supervision services at intervals from birth through six years of age. Ninety-seven percent of children enrolled in FAMIS *Select* during this interim evaluation period were reported to have coverage for well-child care through their private or employer-sponsored plan. Because data on utilization of services for FAMIS *Select* enrollees is not available, it is not possible to directly measure results related to this hypothesis. However, data from the NSCH were reviewed to obtain a sense of utilization of preventive health care services in Virginia. Figure 16 shows survey results from 2007 compared to those from 2011-12. The percent of all respondents who reported their child had received one or more preventive health visits in the previous year decreased from 88.1% in 2007 to 86.6% in 2011-12. While those with private health insurance (including FAMIS *Select* participants) dropped from 90.5% to 89.5% during this time period, those with public insurance such as Medicaid or CHIP experienced a larger decrease from 86.7% to 82.8%.



Source: National Survey of Children's Health: Data query from the Child and Adolescent Health Measurement Initiative; retrieved April 2015

Contracted managed care organizations all participate in HEDIS data reporting, and results are combined for Virginia's Medicaid and CHIP programs. In HEDIS reporting year 2014, 65% of children who turned 15 months old during the measurement year had six or more well-child visits; another 17% had five visits, and 10% had four visits. While these figures do not reflect the FAMIS *Select* population, they are another indicator of child health care access in Virginia.

The ultimate goal of promoting access to health care services is to improve the health status of the target population. According to Virginia results from the NSCH for 2007 and 2011-12, children whose parents reported their health status as "excellent or very good" increased slightly from 88% to 89.2% (see Figure 17). In this instance, children with access to private health insurance, including FAMIS *Select* participants, had excellent or very good health at higher rates in 2011-12 than in 2007 (91.5% to 93.7%), while those with public health insurance declined (81.5% to 78.9%).



Source: National Survey of Children's Health, 2007 and 2011/12

These results from the NSCH reflect *all* public sources of health insurance, and do not distinguish between Medicaid and CHIP. Children in Virginia with private insurance reportedly have better access to health care and overall health status than children with public insurance. This supports the value of offering FAMIS *Select* as an option for families to allow their children access to private insurance. However, it is of concern that insurance source continues to appear to be contributing to health disparities in children.

Conclusions and Recommendations for FAMIS *Select*

Most children have coverage for basic health care services, including immunizations and well child care, through their insurance plan. However, coverage for dental care, vision care, and mental health care is reported for only about three-fourths of children enrolled in FAMIS *Select*. It is nevertheless of concern that statewide metrics associated with access to and utilization of health care services continue to demonstrate disparities based on source of insurance.

The FAMIS *Select* program continues to accomplish its goal of providing a streamlined and cost-effective alternative to the standard FAMIS program. However, enrollment continued to decline during this demonstration period. The program remains small, as expected given the increasing costs of participation in employer-sponsored plans, and the availability of the alternative FAMIS plan with a comprehensive benefits package and very low cost sharing. The FAMIS *Select* plan is generally advantageous only for those families with more than one child and a generous employer-sponsored plan.

During the demonstration extension period, Virginia eliminated the uninsured waiting period for FAMIS enrollment, and opened eligibility for FAMIS to dependents of state employees. These policy changes could have an impact on FAMIS *Select* participation. At this juncture, it would be very beneficial to better understand families' decisions with regard to participating in FAMIS or FAMIS *Select*, if they have access to ESI. It is recommended that a survey be conducted of FAMIS and FAMIS *Select* users to assess the key influences on their choice of program, as well as their satisfaction with the program selected.

As with FAMIS MOMS, participation in FAMIS Select has shifted to reflect an increasingly White, non-Hispanic group, despite growth in the Hispanic population in Virginia. It is recommended that outreach and marketing efforts aimed at increasing enrollment in Medicaid and FAMIS include targeted initiatives to reach the Hispanic community for participation in the demonstration programs.

Appendix

List of Tables and Figures