

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

May 20, 2026

Steven Ford
Director
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

Dear Director Ford:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Family Access to Medical Insurance Security (FAMIS) MOMS and FAMIS Select Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #36 “Interim Evaluation Report” of the section 1115 demonstration, “Virginia FAMIS MOMS and FAMIS Select” (Project Nos: 21-W-00058/3 and 11-W-00381/3), effective through June 30, 2029. This Interim Evaluation Report covers the period from July 1, 2019 through June 30, 2022. CMS determined that the Evaluation Report, submitted on April 15, 2024 and revised on June 27, 2025, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state’s FAMIS MOMS and FAMIS Select Interim Evaluation Report.

The Interim Evaluation Report uses both quantitative and qualitative methods to assess outcomes. Quantitative analyses include descriptive statistics to examine year-over-year changes and comparisons to national benchmarks (e.g., Healthy People 2030 goals, CMS Child Core Set, and the National Vital Statistics System [NVSS]) for FAMIS MOMS outcomes. Qualitative data come from one-on-one interviews used to evaluate FAMIS Select outcomes. Overall, findings were generally favorable. From calendar year (CY) 2019 to CY 2022, rates for births with early and adequate prenatal care, preterm births (<37 weeks gestation), and newborns with low birth weight (<2,500 grams) remained generally stable, with CY 2022 rates 77.4%, 8.3%, and 7.5%, respectively. These findings also compared favorably to national benchmarks. Interviews with families of FAMIS Select members indicated satisfaction with the service offered by the program, as well as their child’s access to health care services. In addition, the state conducted a cost-effectiveness analysis comparing FAMIS Select to the standard state child health plan (FAMIS). Results showed FAMIS Select cost the state substantially less per enrollee per month than standard FAMIS, generating an estimated \$80,768.64 in annual state savings. Limitations included data matching constraints—particularly for individuals without Social Security numbers—and the relatively small FAMIS MOMS population size, which limited subgroup analyses and the ability to detect meaningful differences. The state noted that future evaluation

reports will contain additional data stratifications and recommendations, particularly with the addition of the 12-months postpartum extension group.

In accordance with STC #41, the approved Interim Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Report on Medicaid.gov.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We look forward to our continued partnership on the Virginia FAMIS MOMS and FAMIS Select section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Margaret Kosherzenko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

FINAL INTERIM EVALUATION REPORT

Virginia's Maternal & Child Health Section 1115 Demonstration: FAMIS MOMS, FAMIS Select, and 12 Months Postpartum Coverage

Project Nos. 21-W-00058/3 and 11-W-00381/3

Demonstration Period: October 25, 2019 through June 30, 2029
Evaluation Reporting Period: July 1, 2019 through June 30, 2022

Table of Contents

| | |
|---|----|
| Executive Summary | 2 |
| Background | 5 |
| Demonstration Goals..... | 8 |
| FAMIS MOMS Evaluation – Methodology..... | 14 |
| FAMIS MOMS Evaluation – Limitations..... | 14 |
| FAMIS MOMS Evaluation – Questions and Hypotheses..... | 15 |
| FAMIS MOMS Evaluation – Results | 19 |
| FAMIS MOMS Evaluation – Conclusions and Recommendations | 28 |
| FAMIS Select Evaluation – Methodology | 29 |
| FAMIS Select Evaluation – Limitations | 30 |
| FAMIS Select Evaluation – Questions and Hypotheses | 31 |
| FAMIS Select Evaluation – Results..... | 33 |
| FAMIS Select Evaluation – Conclusions and Recommendations..... | 41 |
| APPENDIX I: List of Tables and Figures..... | 44 |
| APPENDIX II: Approved Evaluation Design for FAMIS MOMS and FAMIS Select | 45 |
| State Demonstrations Group..... | 46 |

Virginia’s Maternal & Child Health Section 1115 Demonstration: FAMIS MOMS, FAMIS Select, and 12 Months Postpartum Coverage

Project Nos. 21-W-00058/3 and 11-W-00381/3

Demonstration Period: October 25, 2019 through June 30, 2029

Evaluation Reporting Period: July 1, 2019 through June 30, 2022

Executive Summary

Virginia’s Maternal and Child Health Section 1115 Demonstration has three components. Two of the demonstration programs provide coverage of Title XXI populations, FAMIS MOMS and FAMIS Select. These programs have been in place since the beginning of the demonstration in 2005. The third component is the more recently approved 1115 waiver authority enabling Virginia to provide continuous, full-benefit health coverage through 12 months postpartum for beneficiaries in both Medicaid and CHIP.

The demonstration was most recently approved for a ten-year extension for the period October 25, 2019, through June 30, 2029. Subsequently, on November 18, 2021, CMS approved Virginia’s request to amend the demonstration to test the effects of providing continuous coverage to postpartum individuals in Medicaid and CHIP with income up to and including 200 percent of the federal poverty level (FPL), for a total of 12 months after the end of the pregnancy. The Department of Health Behavior (HBP) and Policy at Virginia Commonwealth University School of Medicine serves as the external evaluator for the postpartum component of the Demonstration.

This evaluation report provides a summary of findings for the FAMIS MOMS and FAMIS Select evaluations, covering the three-year period from July 1, 2019 through June 30, 2022. The 12 Months Postpartum Coverage demonstration component was implemented effective July 1, 2022, after the period covered by this evaluation report; therefore, evaluation findings for that component of the demonstration are not included in the report. This is the first evaluation report based on the revised evaluation design for FAMIS MOMS and FAMIS Select approved by CMS November 2, 2021. Virginia’s previous evaluation report covered the 2016-19 demonstration period and was based on the previous evaluation plan. Measures and benchmarks have changed substantially from the previous plan, limiting Virginia’s ability to make comparisons between the previous demonstration period and the period covered by this evaluation report.

The demonstration period covered by this evaluation report was a time of significant change and uncertainty at the federal and state levels. Notable changes and events included implementation of Virginia’s Medicaid expansion to newly eligible adults on January 1, 2019, with enrollment ramping up throughout that year; the onset of the COVID-19 public health emergency (PHE) in early 2020, and the COVID pandemic’s impact on maternal and birth outcomes, health care access and utilization; implementation of the maintenance of eligibility and other PHE flexibilities; and the subsequent unwinding of COVID eligibility policies beginning in 2022. These changes likely influenced demonstration outcomes, but the impact is difficult to disentangle from the direct effects of the demonstration features and program design.

Virginia’s FAMIS MOMS demonstration is intended to facilitate access to prenatal care

and to improve selected birth outcomes for participating enrollees and their newborns. DMAS' evaluation of FAMIS MOMS tracks the demonstration's progress toward the goals of maintaining or improving healthcare access and health outcomes for women enrolled in FAMIS MOMS over the course of the 10-year demonstration renewal period. Specifically, the measures included in the evaluation design are (1) to maintain or increase rates of FAMIS MOMS receiving adequate prenatal care (at least 80 percent of prenatal visits), (2) to maintain or decrease the proportion of births to FAMIS MOMS participants that are preterm (less than 37 weeks gestation), and (3) to maintain or decrease the incidence of low birthweight births (birth weight less than 5 pounds, 8 ounces or 2,500 grams) for infants born to FAMIS MOMS participants.

During the Demonstration period, the FAMIS MOMS program continued to provide quality prenatal care to participating uninsured women living within the Title XXI income range and likely to give birth to a FAMIS-eligible child. For the FAMIS MOMS population, rates of adequate prenatal care, preterm births, and low birthweight births were generally maintained across the demonstration period, and outcomes held steady without significant improvement or decline. Although small changes were observed from year to year, no trends were observed. None of the year-to-year changes were statistically significant for any of the measures in any year. Although CY2022 results for the FAMIS MOMS population slightly underperformed in comparison to CY2019 results, differences in performance for each measure from the beginning to the end of the evaluation period amounted to less than one percentage point.

Compared to the identified benchmarks, the FAMIS MOMS population's prenatal and birth outcomes were generally favorable for all three measures. For early and adequate prenatal care, FAMIS MOMS' rates exceeded the National Vital Statistics System (NVSS) national average in all years of the evaluation period. FAMIS MOMS rates of early and adequate prenatal care surpassed the Healthy People 2030 goal in CY2019 but fell short in following years. However, the Healthy People 2030 goal set an ambitious path of 1 percentage point improvement per year, and national rates of early and adequate prenatal care have also fallen short of this goal. On rates of preterm birth, the FAMIS MOMS population compared favorably to the Healthy People 2030 target as well as the NVSS national average in all years of the evaluation period. The FAMIS MOMS population's rates of low birthweight births were lower than the Medicaid and CHIP Child Core Set benchmarks (state median and mean) across all years of the evaluation period. For the preterm birth and low birthweight outcome measures, a lower number indicates better performance.

FAMIS Select continues to meet Virginia's goal of operating a cost-effective health insurance subsidy program that offers a consistently high-quality experience for enrollees. For the FAMIS Select evaluation, DMAS analyzed qualitative data gathered through interviews with parents and guardians of FAMIS Select enrollees. DMAS found that the reported consumer experience of FAMIS Select participants, with respect to customer service and health care access, was satisfactory or better. In addition, the FAMIS Select program continued to provide a streamlined and cost-effective alternative to FAMIS coverage. In state fiscal year 2022, the average per enrollee, per month cost for FAMIS was \$248.66, while that for FAMIS Select was \$102.34; the difference of \$146.32 represents overall annual estimated savings of \$80,768.64.

Through interviews conducted with FAMIS Select participating families, DMAS found that the application process is well designed for the customer's ease of use, program rules and processes are satisfactory to participants, and there was no indication that operational changes are needed to improve the consumer experience. DMAS found that there is potential for enhanced marketing and outreach efforts to improve awareness of the program. Accordingly, DMAS has identified outreach strategies for FAMIS Select for implementation during the Demonstration period with the goal of increasing participation. In addition, DMAS is evaluating options for program design improvements to FAMIS Select. In recent discussions with CMS, DMAS has identified changes that could potentially be made to the FAMIS Select eligibility and enrollment policies to allow for a more streamlined process of enrollment into the program.

In recent years, the FAMIS Select program has seen declining participation. To some extent, this decline is likely attributable to changes in employer-sponsored health insurance offerings. In Virginia and nationwide, employer-sponsored health insurance is not widely available, especially for workers in low-wage professions, and can be prohibitively expensive, with high employee cost-sharing, making family coverage a less affordable option for lower-income workers. Trends in private and employer-sponsored insurance markets should continue to be monitored for impact on FAMIS Select. Increasing enrollment of eligible children in FAMIS Select remains a goal, and through increased outreach and promotion the program has the potential to grow to reach a larger population.

Background

This evaluation report provides a summary of findings for the FAMIS MOMS and FAMIS Select evaluations, covering the three-year period from July 1, 2019 through June 30, 2022. This is the first evaluation report for the current demonstration renewal period of October 25, 2019 through June 30, 2029.

The 12 Months Postpartum Coverage demonstration component was implemented effective July 1, 2022—after the period covered by this evaluation report. Therefore, evaluation findings for that component of the demonstration are not included in this report. Virginia’s next interim evaluation report, for submission to CMS by July 1, 2025 and covering the period from July 1, 2019 through June 30, 2024, will include evaluation findings for the first two years of the 12 Months Postpartum Coverage demonstration.

Virginia’s Maternal and Child Health Section 1115 Demonstration has three components. The first two components, FAMIS MOMS and FAMIS Select, have been in place since 2005 and are part of Virginia’s Title XXI Children’s Health Insurance Program (CHIP), known as Family Access to Medical Insurance Security (FAMIS).

- The **FAMIS MOMS** program covers uninsured pregnant individuals with family income up to 200% of the federal poverty level (FPL) who are not eligible for Medicaid.
- The **FAMIS Select** program provides premium assistance for FAMIS-eligible children whose parents or guardians enroll them in private or employer-sponsored health insurance.

The third component of the demonstration is the more recently approved 1115 waiver authority enabling Virginia to provide continuous, full-benefit health care coverage through **12 months postpartum** for beneficiaries in both Medicaid and CHIP.

The Department of Medical Assistance Services (DMAS) administers Virginia’s Maternal and Child Health Section 1115 Demonstration. The Centers for Medicare and Medicaid Services (CMS) approved the original waiver on June 30, 2005, and DMAS began a phased implementation of the FAMIS MOMS and FAMIS Select programs on August 1, 2005. The demonstration was most recently approved for a ten-year extension for the period October 25, 2019, through June 30, 2029. Subsequently, on November 18, 2021, CMS approved Virginia’s request to amend the demonstration to test the effects of providing continuous coverage to postpartum individuals in Medicaid and CHIP with income up to and including 200 percent of the federal poverty level (FPL), for a total of 12 months after the end of the pregnancy. Through the amendment, DMAS aims to strengthen overall coverage and support the health of new mothers and infants in Virginia, including reducing rates of maternal mortality and severe morbidity.

CMS approved Virginia’s revised evaluation plan for FAMIS MOMS and FAMIS Select on November 3, 2021. This is the first evaluation report based on the revised evaluation design. Virginia’s previous evaluation report for the FAMIS MOMS and FAMIS Select programs covered the 2016-19 demonstration period and was based on the previous evaluation plan. The

revised evaluation plan for FAMIS MOMS and FAMIS Select has changed significantly from the previous plan, limiting Virginia's ability to make comparisons between the previous demonstration period and the period covered by this evaluation report (July 1, 2019 through June 30, 2022).

FAMIS MOMS Background

The intent of the FAMIS MOMS demonstration is to provide health care to uninsured pregnant women living within the Title XXI income range and likely to give birth to FAMIS-eligible children. 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. FAMIS MOMS uses the same health care services delivery systems (fee-for-service 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.

Virginia implemented the FAMIS MOMS program incrementally beginning August 1, 2005. Stage one expanded eligibility to pregnant women with family income above the Medicaid limit of 133% FPL but less than or equal to 150% FPL, and the second stage, implemented September 1, 2006, covered pregnant women with incomes through 166% FPL. Subsequent stages covered pregnant women at 185% FPL (July 1, 2007) and finally 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. Coverage was expanded to include otherwise eligible lawfully residing pregnant women July 1, 2012. 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 one, 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. Following approval by CMS of an amendment to the demonstration, 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 then restored funding to support enrollment in FAMIS MOMS, recognizing that many low-income individuals were 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 state fiscal year 2015 was passed and signed in late June 2014. An amendment to the demonstration, reinstating enrollment at an upper income level of 200% FPL (plus a 5% income 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 did not accept new applications for FAMIS MOMS between December 31, 2013 and November 30, 2014; for women already enrolled, FAMIS MOMS coverage continued

throughout their pregnancy and postpartum periods. FAMIS MOMS enrollment dropped from close to 1,600 on July 1, 2013, to 1,363 on January 1, 2014, and to single digits at its lowest point in late 2014. After the December 1, 2014 reinstatement of FAMIS MOMS, enrollment began to climb again, eventually returning to previous levels.

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.

Several amendments to the state budget affecting the FAMIS MOMS program were adopted by the General Assembly during the demonstration period covered in this report. The first of these amendments, included in the 2020 Appropriations Act, directed DMAS to seek federal authority to extend coverage for pregnant women from 60 days to one year postpartum. The same year, the General Assembly directed DMAS to offer medically necessary treatment for substance use disorder (SUD) in an institution for mental diseases (IMD) for FAMIS MOMS enrollees, mirroring the benefits offered to pregnant Medicaid members through Virginia's Addiction and Recovery Treatment Services (ARTS) program.

The state of emergency declared in Virginia in March 2020 due to the novel coronavirus (COVID-19) delayed the funding of these items, but state funding was later reinstated, enabling DMAS to seek federal authority for the changes. DMAS submitted its 1115 demonstration amendment application to extend coverage to 12 months postpartum in March 2021, and on November 11, 2021, CMS approved the amendment. On July 1, 2022, systems changes went into effect for full implementation of the 12 months postpartum continuous coverage. In consultation with CMS, DMAS determined that modifications to the STCs were not needed in order to authorize IMD coverage for FAMIS MOMS enrollees seeking medically necessary treatment for SUD, as this benefit is already offered to Medicaid pregnant women, and CHIP enrollees are not subject to the Medicaid IMD payment exclusion. FAMIS MOMS enrollees receive IMD coverage for SUD treatment effective July 1, 2021.

Virginia's 2021 Special Session I Appropriations Act directed DMAS to seek federal authority to provide Medicaid coverage of community doula services to pregnant and postpartum enrollees. In partnership with the Virginia Department of Health, the Commonwealth established training and certification processes as well as a state doula registry. DMAS and its managed care plans developed processes to enroll community doulas as Medicaid providers, and the community doula benefit is now available to members. Because FAMIS MOMS receive the same benefits as Medicaid pregnant women, FAMIS MOMS are eligible to receive community doula services.

FAMIS Select Background

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. The FAMIS Select program provides an alternative for families with children

enrolled in FAMIS who have access to private or employer-sponsored coverage. Children must first be found eligible and enroll in FAMIS before electing to receive coverage through FAMIS Select.

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 paystub or other proof of payment to the FAMIS Select program, and be reimbursed \$100 per month, per FAMIS-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 cost-sharing requirements 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 wraparound benefits other than immunizations. For some families, the FAMIS Select option may make health coverage affordable for the entire household. In other cases, it may allow a child to continue to see a doctor or dentist that does not accept FAMIS, or it may enable a family with special health care needs to access a broader choice of providers.

FAMIS Select initially enrolled more families and proved easier to administer than the former state plan ESHI program. Enrollment in FAMIS Select has been marked by periods of growth and decline. In August 2005, 66 children transferred from the ESHI to FAMIS Select. 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. As of June 2022, 58 children were enrolled in FAMIS Select statewide. (Enrollment reflects the number of FAMIS-eligible children directly enrolled in FAMIS Select. Totals do not include incidentally enrolled family members such as adults and non-FAMIS-eligible children in the family.)

Demonstration Goals

During the renewal period, the objectives of the demonstration to be evaluated are as follows:

FAMIS MOMS (Demonstration Population I):

- Facilitate access to prenatal care for FAMIS MOMS participants.
- Improve selected birth outcomes of FAMIS MOMS participants and their newborns.

FAMIS Select (Demonstration Population II):

- Facilitate access to affordable private and employer-sponsored health insurance for low-income families through premium assistance.
- Monitor and ensure member satisfaction with the FAMIS Select program.
- Assure the aggregate cost-effectiveness of the FAMIS Select program.

Table 1: FAMIS MOMS and FAMIS Select Demonstration Evaluation Design

| FAMIS MOMS | | | | | |
|--|--|---|---|--|--|
| <i>Hypothesis I: The proportion of pregnant women enrolled in FAMIS MOMS who are receiving adequate or better prenatal care will be maintained or will increase from SFY 2019 to SFY 2029.</i> | | | | | |
| Research Question: | Outcome Measures: | Population: | Data Sources and Analytic Methods: | Benchmarks: | Subgroups: |
| Is enrollment in FAMIS MOMS enabling pregnant women to obtain better access to adequate prenatal care? | Births with Early and Adequate Prenatal Care— Percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index score greater than or equal to 80 percent | Live, singleton births to FAMIS MOMS during a given calendar year | Deterministic and probabilistic data matching are used to create dataset of linked fee-for-service claims, managed care encounters, enrollment records, and birth registry records. Chi-square tests used to assess statistical significance of year-over-year changes. | Healthy People 2030 goal <i>Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08</i> | -Age -Race/ Ethnicity -Region |
| <i>Hypothesis II: The proportion of FAMIS MOMS enrolled in the FAMIS MOMS program with preterm births (less than 37 weeks gestation) will remain the same or will decrease from SFY 2019 to SFY 2029.</i> | | | | | |
| Research Question: | Outcome Measures: | Population: | Data Sources and Analytic Methods: | Benchmarks: | Subgroups: |
| Is enrollment in FAMIS MOMS improving birth outcomes of FAMIS MOMS participants? | Preterm Births (< 37 Weeks Gestation)— Percentage of births that occurred before 37 weeks of gestation | Live, singleton births to FAMIS MOMS during a given calendar year | Deterministic and probabilistic data matching are used to create dataset of linked fee-for-service claims, managed care encounters, enrollment records, and birth registry records. Chi-square tests used to assess statistical significance of year-over-year changes. | Healthy People 2030 goal <i>Reduce preterm births – MICH-07</i> | -Age -Race/ Ethnicity -Region |

Hypothesis III: The rate of low birth weight births (birth weight less than 5 pounds, 8 ounces [2,500 grams]) among FAMIS MOMS will decline or remain the same over the demonstration period.

| Research Question: | Outcome Measures: | Population: | Data Sources and Analytic Methods: | Benchmarks: | Subgroups: |
|--|--|---|---|---|---|
| Is enrollment in FAMIS MOMS improving birth outcomes of FAMIS MOMS participants? | Newborns with Low Birth Weight (<2,500 grams)—The percentage of newborns weighing less than 2,500 grams at birth. This includes birth weights in the very low birth weight category (birth weights less than 1,500 grams) and the low birth weight category (birth weights between 1,500 and 2,499 grams). | Live, singleton births to FAMIS MOMS during a given calendar year | Deterministic and probabilistic data matching are used to create dataset of linked fee-for-service claims, managed care encounters, enrollment records, and birth registry records. Chi-square tests used to assess statistical significance of year-over-year changes. | CMS Child Core Set measure <i>Newborns with Low Birth Weight (<2,500 grams)</i> . Median and mean for state Medicaid programs in the most recent federal fiscal year | -Age -Race/ -Ethnicity -Region |

FAMIS Select

Hypothesis IV: FAMIS Select members’ families will report that they are satisfied with the service offered by the FAMIS Select program, a subsidy for private/employer-sponsored insurance.

| Research Question: | Outcome Measures: | Population: | Data Sources: | Analytic Methods: |
|---|---|---|--|---|
| Is the self-reported consumer experience of participants in FAMIS Select satisfactory? What do participants report can be improved? | Analysis of responses to interview questions used to assess level of overall satisfaction | Parents/guardians of current FAMIS Select enrollees | Responses to interview questions about consumers’ experiences with DMAS-operated components of the program, such as customer service, responsiveness to customer inquiries, and timely processing of subsidy payments. | Qualitative analysis of interview responses |

Hypothesis V: FAMIS Select families will report that they are able to access preventive services, use specialty healthcare services, and schedule timely appointments with preferred providers.

| Research Question: | Outcome Measures: | Population: | Data Sources: | Analytic Methods: |
|--|---|---|---|---|
| Do families report that children in FAMIS Select have a satisfactory level of access to health care services through their private or employer-sponsored insurance subsidized by FAMIS Select? | Analysis of responses to interview questions used to assess level of access to health care services | Parents/guardians of current FAMIS Select enrollees | Responses to interview questions about consumers’ perception of their child’s level of access to health care services and providers under their private or employer-sponsored health insurance plan, including access to preventive services and specialty healthcare services, and ability to schedule timely appointments with preferred providers. | Qualitative analysis of interview responses |

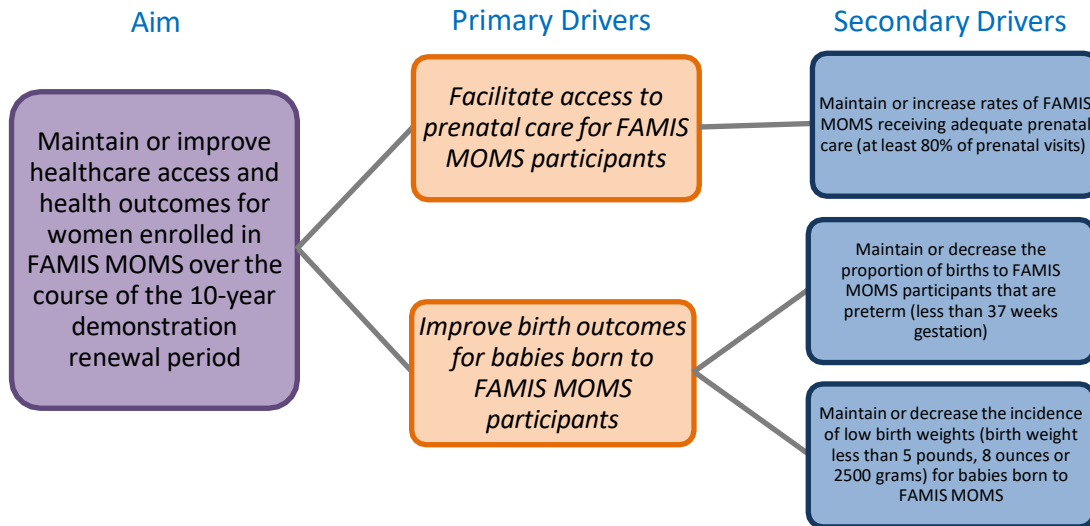
Hypothesis VI: The FAMIS Select program will be cost-effective as compared to the FAMIS program over the course of the demonstration year (state fiscal year)

| Research Question: | Outcome Measures: | Population: | Data Sources: | Analytic Methods: |
|---|---|---|---|---|
| Is the FAMIS Select program cost-effective? | Cost-effectiveness analysis (FAMIS Select-FAMIS comparison) | FAMIS Select enrollees during state fiscal year | Fee-for-service claims, managed care encounters and capitation payments, and enrollment records | Average per-enrollee, per-month cost and administrative expense associated with the FAMIS Select population, compared to the per-enrollee, per-month cost of providing the FAMIS benefit plan |

Figure 1: Driver Diagrams

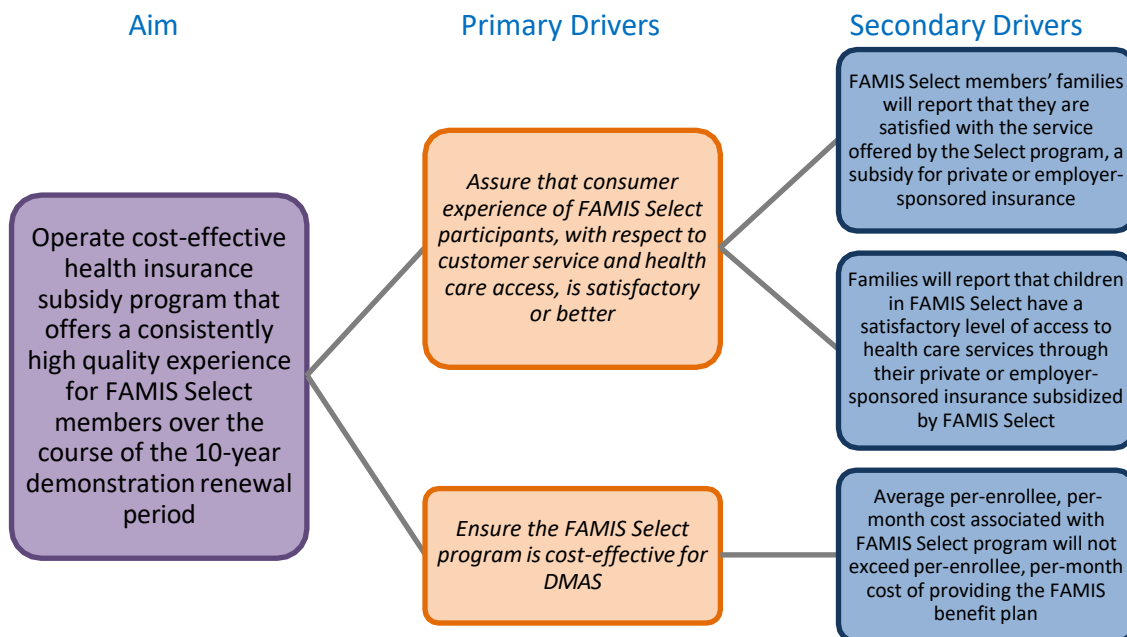
FAMIS MOMS: The demonstration will maintain or improve healthcare access and health outcomes for women enrolled in FAMIS MOMS over the course of the 10-year demonstration renewal period by:

- Facilitating access to prenatal care for FAMIS MOMS participants
- Improving selected birth outcomes of FAMIS MOMS participants and their newborns



FAMIS Select: The demonstration will operate a cost-effective health insurance subsidy program that offers a consistently high quality experience for FAMIS Select members over the course of the 10-year demonstration renewal period by:

- Assuring that consumer experience of FAMIS Select participants, with respect to customer service and health care access, is satisfactory or better
- Ensuring the FAMIS Select program is cost-effective for DMAS



FAMIS MOMS Evaluation – Methodology

For the FAMIS MOMS demonstration evaluation, DMAS uses the dataset from Virginia’s annual *Medicaid and CHIP Maternal and Child Health Focus Study* (formerly called the Birth Outcomes Study).¹ The dataset is created by DMAS’ contractor and DMAS subject matter experts using deterministic and probabilistic data linking to match FAMIS MOMS and Medicaid enrollees with birth registry records, thereby identifying births paid by Virginia Medicaid/CHIP during a given calendar year. Member claims and encounter data files are matched with birth registry data fields for members from each of the data linkage processes. All probabilistically or deterministically linked birth registry records are included in the eligible study population. The eligible population included in the demonstration evaluation dataset consists of FAMIS MOMS who gave birth during a given calendar year. A birth is included if the member was enrolled in FAMIS MOMS on the date of delivery, regardless of whether the birth occurred in Virginia. The birth registry contains records of live births; other pregnancy outcomes are excluded from the dataset used to calculate the evaluation measures. Since multiple gestation births are subject to different clinical guidelines, results are limited to singleton births, defined using the Plurality field in the birth registry data.

For each of the three FAMIS MOMS evaluation measures, DMAS reports year over year comparisons. Chi-square tests were used to determine whether statistically significant differences were observed between the prior year and subsequent year’s measures. For national benchmark comparisons of Measures I and II (Births with Early and Adequate Prenatal Care and Preterm Births), DMAS used baseline and target data from the Healthy People 2030 goals. (Baselines are drawn from nationwide vital statistics from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) National Vital Statistics System (NVSS)).² For the Newborns with Low Birth Weight measure, DMAS uses the CMS Core Set benchmark for the federal fiscal year that corresponds to the calendar year of the MCH Focus Study (e.g., FFY2019 Child Core Set benchmark for CY2019 MCH Focus Study measure).³

FAMIS MOMS Evaluation – Limitations

This analysis requires matching two data sources without a common unique identifier: 1) Medicaid enrollment data, and 2) birth records. Using this methodology enables DMAS to monitor outcomes not present in claims data such as gestational age, more comprehensive prenatal records, and birth weight. However, we may be underestimating the impact from mothers without Social Security numbers, the most common unique identifier in a deterministic match. DMAS has conducted analysis to determine likelihood of capturing a delivery through

¹ Currently the MCH Focus Study is conducted by DMAS’ External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG).

² Healthy People 2030, “Pregnancy and Childbirth.” U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth>

³ See, for example, “2022 Annual Core Set Reporting on the Quality of Care for Children in Medicaid and CHIP,” Child Health Care Quality Measures, Centers of Medicare & Medicaid Services. Available at <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

birth records and has confirmed that the match is sufficient for generalization.

Another limitation of our data is the limited sample size of the FAMIS MOMS population, which averaged in the range of 1,600 to 2,000 members during the demonstration years covered by this evaluation report. Small sample sizes create challenges when conducting more complex models or conducting analyses on subgroups. For purposes of this analysis, subpopulations should be grouped into the largest meaningful category and statistical tests limited to chi-squares. Future evaluation reports will contain additional data stratifications and recommendations that are broadly applicable to the FAMIS MOMS population, since a larger population will be addressed upon addition of the 12-months postpartum extension group.

FAMIS MOMS Evaluation – Questions and Hypotheses

Evaluation questions and hypotheses tied to each demonstration goal are summarized below, with measure specifications and benchmarks for each.

Demonstration Goal: Facilitate access to prenatal care for FAMIS MOMS participants.

Research Question: Is enrollment in FAMIS MOMS enabling pregnant women to obtain better access to adequate prenatal care?

Hypothesis I: The proportion of pregnant women enrolled in FAMIS MOMS who are receiving adequate or better prenatal care will be maintained or will increase from SFY 2019 to SFY 2029.

Measure I: Births with Early and Adequate Prenatal Care—The percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index score greater than or equal to 80 percent (i.e., births scoring in the “Adequate” or “Adequate Plus” categories)

| | |
|-------------|---|
| Measure 1 | Percentage of FAMIS MOMS Participants Receiving Adequate or Adequate Plus Prenatal Care as Defined by APNCU Index |
| Numerator | Number of Births to FAMIS MOMS Participants Receiving Adequate or Adequate Plus Prenatal Care |
| Denominator | Number of FAMIS MOMS Participants with Births During the Calendar Year* |

* Numerator and denominator are limited to live, singleton births during the calendar year.

Measure I Description, Specifications and Benchmarks: Data for Measure I is from fee-for-service claims, managed care encounters, enrollment records, and birth registry data to determine

eligibility group and prenatal visit utilization. As described above, the dataset includes live, singleton births to FAMIS MOMS during the given calendar year.

Adequate prenatal care was defined using the Adequacy of Prenatal Care Utilization (APNCU) Index, also known as the Kotelchuck Index. The adequacy of prenatal care received during pregnancy is associated with lower incidence of poor birth outcomes, such as preterm delivery and low birthweight births.⁴ The APNCU Index uses birth certificate information to assess prenatal care in relation to two separate and distinct components. First, it measures at what point in the pregnancy a mother initiated prenatal care. Second, the index considers the number of prenatal visits throughout the pregnancy. The two components are combined into a single prenatal care utilization composite score. Higher composite scores on the APNCU Index are assigned to women who initiate prenatal care early in pregnancy and complete at least 80 percent of the visits expected based on the time frame, adjusted for gestational age at prenatal care initiation and the infant’s gestational age at delivery.⁵

The table below shows the composite score categories and criteria defining each category.

APNCU Index Criteria for Adequacy of Prenatal Care

| APNCU Index Category | Index Criteria |
|----------------------|--|
| Adequate Plus | Prenatal care initiated by the fourth month of pregnancy and 110% or more of expected visits received |
| Adequate | Prenatal care initiated by the fourth month of pregnancy and 80% to 109% of expected visits received |
| Intermediate | Prenatal care initiated by the fourth month of pregnancy and 50 to 79% of expected visits received |
| Inadequate | Prenatal care initiated after the fourth month of pregnancy or less than 50% of expected visits received |

DMAS uses the target and most recent annual data identified for the Healthy People 2030 goal “Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08”—which uses data derived from the CDC, NCHS, NVSS, for the Births with Early and Adequate Prenatal Care measure—for each year corresponding to the calendar year of the Birth Outcomes Study. Healthy People 2030 published a national baseline of 76.4 percent, the percentage of women who received early and adequate prenatal care during 2018, with a target of 80.5 percent and a goal of 1 percentage point improvement for each year.⁶ DMAS compared

⁴ Krueger PM, Scholl TO. Adequacy of prenatal care and pregnancy outcome. *The Journal of the American Osteopathic Association*. 2000; 100(8):485–492.

⁵ Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. *American Journal of Public Health*. 1994; 84(9):1414–1420.

⁶ Healthy People 2030. “Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08.” U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse->

study indicator findings to the Healthy People 2030 target, goal, and NVSS average on an annual basis.

Virginia uses the APNCU to measure adequacy of prenatal care for pregnant women across the Medicaid programs. Using this index as one of the measures for the FAMIS MOMS evaluation enables DMAS to compare adequacy of prenatal care rates to other pregnant women’s aid categories and identify disparities that may exist across programs, or findings from the strengths of one program that can be implemented in other programs.

Demonstration Goal: *Improve selected birth outcomes of FAMIS MOMS participants and their newborns.*

Research Question: *Is enrollment in FAMIS MOMS improving birth outcomes of participants?*

Hypothesis II: The proportion of individuals enrolled in the FAMIS MOMS program with preterm births (less than 37 weeks gestation) will remain the same or will decrease from SFY 2019 to SFY 2029.

Measure II: Preterm Births (< 37 Weeks Gestation)—The percentage of births that occurred before 37 completed weeks of gestation

| | |
|-------------|---|
| Measure 2 | Rate of preterm birth for FAMIS MOMS |
| Numerator | Number of live, singleton births to FAMIS MOMS born prior to 37 completed weeks gestation |
| Denominator | Total number of live, singleton births to FAMIS MOMS |

Measure II Description, Specifications and Benchmarks: Data for Measure II is from eligibility and enrollment records along with birth registry records for live births. Eligibility and enrollment records of FAMIS MOMS are linked with birth registry records through probabilistic and deterministic matching in order to identify births to FAMIS MOMS members during the relevant evaluation year. Preterm births are defined as any live birth occurring before 37 weeks gestation.

In order to evaluate incidence of preterm births among the FAMIS MOMS population over time, DMAS is monitoring year-over-year percentage changes. DMAS will conduct further investigation as appropriate, such as geographic, provider, and co-morbidity analyses. Preterm

[objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08.](#)

birth (defined as birth prior to 37 weeks) is a common measure reported not only for other Virginia Medicaid populations, but also by other states' Medicaid programs and for other comparable populations. This commonality enables Virginia to compare rates seen among the FAMIS MOMS population to other internal and national benchmarks.

DMAS uses the Healthy People 2030 goal “Reduce preterm births—MICH-07” as a national benchmark for the preterm births measure. Healthy People 2030 published a national baseline of 10.0 percent—the percentage of live births that were preterm in 2018, with an initial goal of no more than 9.4 percent of live births being preterm.⁷ DMAS compared FAMIS MOMS performance on this measure to the Healthy People 2030 goal of 9.4 percent and will reassess the benchmark value on an annual basis.

Hypothesis III: The rate of low birthweight births (birth weight less than 5 pounds, 8 ounces (2,500 grams)) among FAMIS MOMS will decline or remain the same over the demonstration period.

Measure III: Newborns with Low Birthweight (<2,500 grams)—The percentage of newborns weighing less than 2,500 grams at birth. This includes birth weights in the very low birthweight category (birth weights less than 1,500 grams) and the low birthweight category (birth weights between 1,500 and 2,499 grams).

| | |
|-------------|---|
| Measure 3 | Infants born with low birthweight (weight < 2,500 grams) |
| Numerator | Number of infants born to FAMIS MOMS with a birth weight less than 5 pounds, 8 ounces (2,500 grams) |
| Denominator | Total number of live, singleton births to FAMIS MOMS |

Measure III Description, Specifications and Benchmarks: Data for Measure III comes from enrollment records along with birth registry records for live births. Eligibility and enrollment records of FAMIS MOMS were linked with birth registry records through probabilistic and deterministic matching in order to identify births to FAMIS MOMS members during the relevant evaluation year. Low birthweight is defined as birth weight less than 2,500 grams.

⁷ Healthy People 2030. “Reduce preterm births— MICH-07.” U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07>. Healthy People 2030 baseline is derived from NVSS reports. Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final Data for 2018. National Vital Statistics Reports. 2019; 68(13). Hyattsville, MD: National Center for Health Statistics. 2019. Available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.

In order to evaluate incidence of low birthweight infants born to FAMIS MOMS over time, DMAS monitors year-over-year percentage changes. The number of live births to FAMIS MOMS with a birthweight less than 2,500 grams is compared to the total number of live births to FAMIS MOMS in a given year.

Low birthweight is a common measure reported not only for other Virginia Medicaid populations, but also by other state Medicaid programs and for other comparable populations. This commonality enables Virginia to compare rates seen among the FAMIS MOMS population to other state populations and national benchmarks.

As a benchmark for the FAMIS MOMS evaluation’s newborns with low birthweight measure, DMAS uses the CMS Child Core Set measure Newborns with Low Birth Weight (<2,500 grams). An update is released annually and includes data for all states and Washington, D.C., for Medicaid/CHIP populations. DMAS compares evaluation data with the reported median and mean for state Medicaid programs in the most recent federal fiscal year for which data are available at the time of reporting.

FAMIS MOMS Evaluation – Results

Virginia’s FAMIS MOMS demonstration is intended to facilitate access to prenatal care and to improve selected birth outcomes for participating enrollees and their newborns. DMAS’ evaluation of FAMIS MOMS tracks the demonstration’s progress toward the goal of maintaining or improving healthcare access and health outcomes for women enrolled in FAMIS MOMS over the course of the 10-year demonstration renewal period. The measures included in the evaluation design are (1) to maintain or increase rates of FAMIS MOMS receiving adequate prenatal care (at least 80 percent of prenatal visits), (2) to maintain or decrease the proportion of births to FAMIS MOMS participants that are preterm (less than 37 weeks gestation), and (3) to maintain or decrease the incidence of low birthweight births (birth weight less than 5 pounds, 8 ounces or 2,500 grams) for infants born to FAMIS MOMS participants.

The report for this evaluation period (July 1, 2019 through June 30, 2022) includes data from four annual *Medicaid and CHIP Maternal and Child Health Focus Study* reports, covering the period CY2019 through CY2022. (The measurement year for the MCH Focus Study is the calendar year.) The MCH Focus Study is conducted by DMAS’ external quality review organization, Health Services Advisory Group (HSAG).⁸ The reporting period’s results for the three FAMIS MOMS demonstration outcome measures are summarized in the table below.

Table 2: FAMIS MOMS Overall Findings, CY 2019–2022

| Measure | CY 2019 | | CY 2020 | | CY 2021 | | CY 2022 | |
|--|---------|---------|---------|---------|---------|---------|---------|---------|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Births With Early and Adequate Prenatal Care | 1,626 | 78.3% | 1,564 | 76.8% | 1,382 | 78.1% | 1,391 | 77.4% |

⁸ This annual report was previously called the *Prenatal Care and Birth Outcomes Focus Study*.

| Measure | CY 2019 | | CY 2020 | | CY 2021 | | CY 2022 | |
|--|---------|---------|---------|---------|---------|---------|---------|---------|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Preterm Births (<37 Weeks Gestation)* | 168 | 7.7% | 163 | 7.8% | 161 | 9.0% | 150 | 8.3% |
| Newborns With Low Birth Weight (<2,500 grams)* | 158 | 7.2% | 150 | 7.2% | 145 | 8.1% | 137 | 7.5% |

* A lower rate indicates better performance for this indicator.
 No year-to-year changes between CY2018 and CY2022 were statistically significant.

DMAS tracked year over year performance for the FAMIS MOMS population for each of the three demonstration outcome measures. Chi-square tests were used to determine whether the differences were statistically significant between the prior year and subsequent year’s measures for each of the years 2019 through 2022. None of the year-to-year changes were statistically significant for any of the measures. Although small changes were observed from year to year, no trends were observed. Although CY2019 results surpassed CY2022 results, differences in performance for each measure from the beginning to the end of the evaluation period amounted to less than one percentage point. For the FAMIS MOMS population, rates of adequate prenatal care, preterm births, and low birthweight births were generally maintained across the demonstration period, and outcomes neither improved nor worsened substantially.

Below, we review performance of the FAMIS MOMS demonstration for each of the three evaluation measures and provide contextual information as well as comparisons with national benchmarks.

Demonstration Goal I: Facilitate access to prenatal care for FAMIS MOMS participants.

Research Question: Is enrollment in FAMIS MOMS enabling pregnant women to obtain better access to adequate prenatal care?

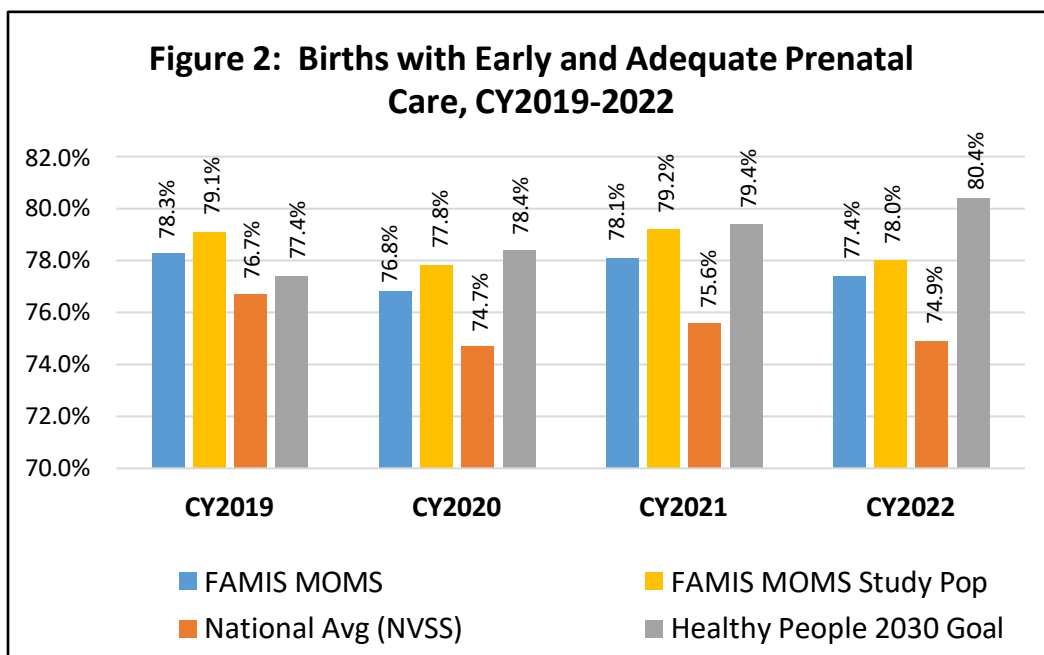
Hypothesis I: The proportion of pregnant women enrolled in FAMIS MOMS who are receiving adequate or better prenatal care will be maintained or will increase from SFY 2019 to SFY 2029.

Measure I: Births with Early and Adequate Prenatal Care—The percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index score greater than or equal to 80 percent (i.e., births scoring in the “Adequate” or “Adequate Plus” categories)

To gauge success in meeting Demonstration Goal I of facilitating access to prenatal care for FAMIS MOMS participants, and to answer the research question of whether enrollment in FAMIS MOMS enables pregnant women to obtain better access to prenatal care, DMAS used

the APNCU index, described above in the Methodology section, to measure the proportion of pregnant women enrolled in FAMIS MOMS who are receiving adequate or better prenatal care over the course of the evaluation period.

DMAS uses the target and most recent annual data identified for the Healthy People 2030 goal “Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08”—which uses data derived from the CCDC, NCHS, NVSS, for the Births with Early and Adequate Prenatal Care measure—for each year corresponding to the calendar year of the Birth Outcomes Study. Healthy People 2030 published a national baseline of 76.4%, the percentage of women who received early and adequate prenatal care during 2018, with a target of 80.5% and a goal of 1 percentage point improvement for each year. DMAS compared study indicator findings to the Healthy People 2030 target, goal, and NVSS average on an annual basis. Figure 2 below shows the FAMIS MOMS population’s rates of early and adequate prenatal care for the years CY2019 through CY2022 compared to benchmarks and comparison populations.



Sources: Health Services Advisory Group, *Medicaid and CHIP Maternal and Child Health Focus Study*; National Vital Statistics System Natality component (NVSS-N); Healthy People 2030 Goal.

FAMIS MOMS outcomes for Measure I during the evaluation period compared favorably to most of the identified benchmarks. Of all FAMIS MOMS participants giving birth in 2019, 78.3% received early and adequate prenatal care. This rate was higher than the NVSS national average of 76.7% and higher than the Healthy People 2030 baseline of 76.4%. It was also higher than the Healthy People annual goal for CY2019 of baseline plus one percentage point, or 77.4%.

The MCH Focus Study also identified a Study Population of FAMIS MOMS who were continuously enrolled in a managed care organization (MCO) or the fee-for-service delivery system for at least 90 days prior to, and including, the date of delivery. This subset excludes women who enrolled in FAMIS MOMS or an MCO less than 90 days before the date of delivery.

This study population typically has better outcomes than the broader FAMIS MOMS population because timely enrollment provides sufficient opportunity for the member to receive prenatal care and other covered benefits through the program, which increases the chance that the member's FAMIS MOMS health coverage will have a positive impact on birth outcomes. On Measure I for 2019, the FAMIS MOMS Study Population's rate of adequate prenatal care was 79.1%, higher than all identified benchmarks for that year.

For CY2020, FAMIS MOMS participants' rate of early and adequate prenatal care was 76.8%, which compared favorably to the NVSS national average of 74.7% but was lower than the new Healthy People 2030 goal for CY2020 of baseline plus two percentage points, or 78.4%. The FAMIS MOMS Study Population again outperformed the broader population with a rate of 77.9%. (In 2020 and subsequent years, the parameters for the Study Population changed to include only women continuously enrolled for 120 days prior to delivery.)

For CY2021, FAMIS MOMS participants' rate of early and adequate prenatal care was 78.1%, higher than the previous year and continuing to compare favorably to the NVSS national average of 75.6%. The FAMIS MOMS Study Population, with a rate of 79.2%, again outperformed the broader population but still fell slightly short of meeting the adjusted Healthy People 2030 goal for CY2021 of baseline plus three percentage points, or 79.4%.

Finally, for CY2022, the FAMIS MOMS population's rate of early and adequate prenatal care was 77.4%, lower than the previous year but still higher than the NVSS national average of 74.9%. The FAMIS MOMS Study Population's rate of 78.0% outperformed other benchmarks in that year, with the exception of the Healthy People 2030 goal for CY2022 of baseline plus four percentage points, or 80.4%.

Notably, year-over-year changes in the FAMIS MOMS population's rate of early and adequate prenatal care tracked the same pattern as nationwide NVSS rates, decreasing from 2019 to 2020, then increasing in 2021, and decreasing again in 2022. Because the Healthy People 2030 goal is to improve by one percentage point each year, it follows an upward trend. It is also worth noting that the period from 2019 to 2022 was marked by the onset of the COVID-19 pandemic, which initially affected access to routine preventive care, including prenatal care, and influenced health care utilization.

The following recommendation was offered in the *Medicaid and CHIP Maternal and Child Health Focus Study*: DMAS and the MCOs should investigate the factors contributing to women's ability to access timely prenatal care and implement targeted improvement efforts. These efforts should include ensuring that all women of childbearing age establish a primary care provider (PCP) or obstetrician/gynecologist (OB/GYN) prior to pregnancy.

Demonstration Goal II: *Improve selected birth outcomes of FAMIS MOMS participants and their newborns.*

Research Question: *Is enrollment in FAMIS MOMS improving birth outcomes of participants?*

Hypothesis II: *The proportion of individuals enrolled in the FAMIS MOMS program with preterm births (less than 37 weeks gestation) will remain the same or will decrease from SFY 2019 to SFY 2029.*

Measure II: *Preterm Births (< 37 Weeks Gestation)—The percentage of births that occurred before 37 completed weeks of gestation*

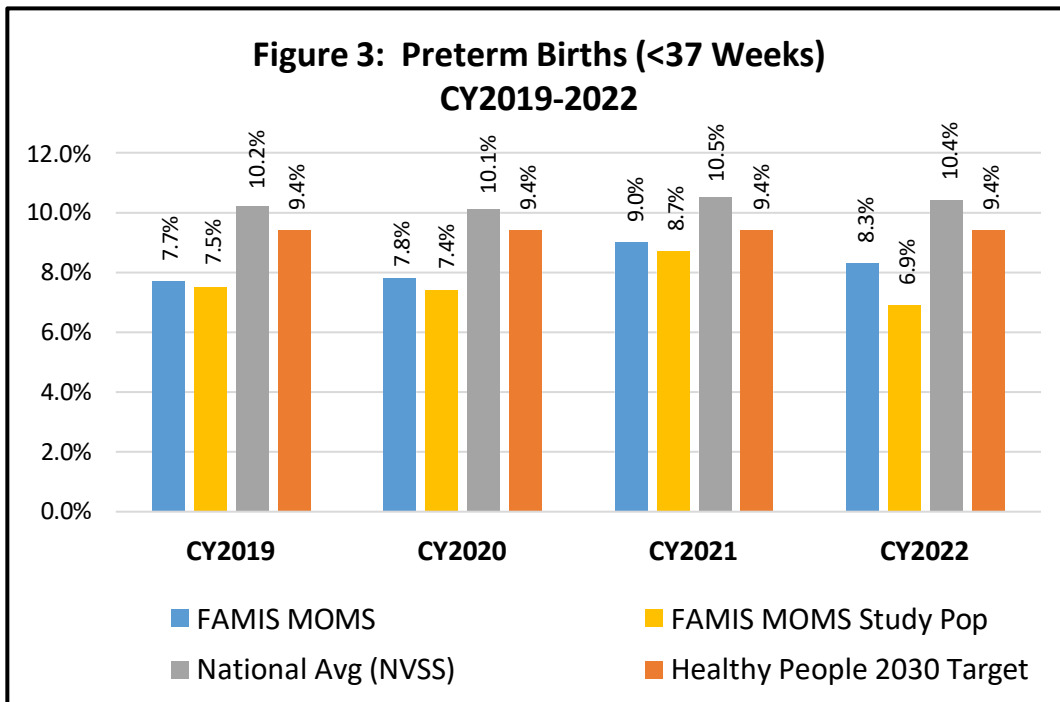
To track progress toward Demonstration Goal II of improving selected birth outcomes of FAMIS MOMS participants and their newborns, and to investigate the research question of whether enrollment in FAMIS MOMS improves birth outcomes of participants, DMAS monitored the percentage of preterm births for the FAMIS MOMS population over the course of the evaluation period. 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.

DMAS used the Healthy People 2030 goal “Reduce preterm births—MICH-07” as a national benchmark for the preterm births measure. Healthy People 2030 published a national baseline of 10.0%—the percentage of live births that were preterm in 2018, with an initial goal of no more than 9.4% of live births being preterm. DMAS compared FAMIS MOMS performance on this measure to the Healthy People 2030 target of 9.4% and NVSS average on an annual basis. FAMIS MOMS outcomes for Measure II during the evaluation period compared favorably to the identified benchmarks. Figure 3 below shows the FAMIS MOMS population’s rates of preterm births for the years CY2019 through CY2022 compared to benchmarks and comparison populations.

Of all births to FAMIS MOMS in 2019, 7.7% were preterm. This rate was lower than the NVSS national average of 10.2% and lower than the Healthy People 2030 target of 9.4%.⁹ The MCH Focus Study also identified a Study Population of FAMIS MOMS who were continuously enrolled in a managed care organization (MCO) or the fee-for-service delivery system for at least 90 days prior to, and including, the date of delivery. This subset excludes women who enrolled in FAMIS MOMS or an MCO less than 90 days before the date of delivery.

⁹ A lower rate indicates better performance for this indicator.

This study population typically has better outcomes than the broader FAMIS MOMS population because timely enrollment provides sufficient opportunity for the member to receive prenatal care and other covered benefits through the program, which increases the chance that the member’s FAMIS MOMS health coverage will have a positive impact on birth outcomes. On Measure II for 2019, the FAMIS MOMS Study Population’s rate of preterm births was 7.5%, outperforming all identified benchmarks for that year.



Sources: Health Services Advisory Group, Medicaid and CHIP Maternal and Child Health Focus Study; National Vital Statistics System Natality component (NVSS-N); Healthy People 2030 Goal

For CY2020, FAMIS MOMS participants’ rate of preterm birth was 7.8%, which compared favorably to the NVSS national average of 10.1% but was lower than the Healthy People 2030 target of 9.4%. The FAMIS MOMS Study Population again outperformed the broader population with a rate of 7.4%. (In 2020 and subsequent years, the parameters for the Study Population changed to include only women continuously enrolled for 120 days prior to delivery.)

For CY2021, FAMIS MOMS participants’ rate of preterm birth was 9.0%, higher than the previous year but continuing to compare favorably to the NVSS national average of 10.5% and the Healthy People 2030 target of 9.4%. The FAMIS MOMS Study Population, with a rate of 8.7%, again outperformed the broader population.

Finally, for CY2022, the FAMIS MOMS population's rate of preterm births was 8.3%, lower than the previous year and outperforming the NVSS national average of 10.4% as well as the Healthy People 2030 target of 9.4%. The FAMIS MOMS Study Population's rate of 6.9% outperformed other benchmarks in that year.

Year-over-year changes in the FAMIS MOMS population's rate of preterm births were not statistically significant. Year-over-year changes tracked the same pattern as nationwide NVSS rates, increasing from 2019 to 2020, then decreasing in 2021, and increasing again in 2022.¹⁰

The following recommendation was offered in the *Medicaid and CHIP Maternal and Child Health Focus Study*: DMAS and the MCOs should investigate the factors contributing to women's ability to access timely prenatal care and implement targeted improvement efforts. These efforts should include ensuring that all women of childbearing age establish a primary care provider (PCP) or obstetrician/gynecologist (OB/GYN) prior to pregnancy, and receive necessary preventive care (e.g., taking folic acid) and management of conditions (e.g., diabetes, high blood pressure, obesity) that were previously left untreated or unmanaged. Improving the health of a woman prior to conception will help to ensure better outcomes for both the mother and baby.

¹⁰ Healthy People 2030. "Reduce preterm births— MICH-07." U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07>.

Hypothesis III: *The rate of low birthweight births (birth weight less than 5 pounds, 8 ounces (2,500 grams)) among FAMIS MOMS will decline or remain the same over the demonstration period.*

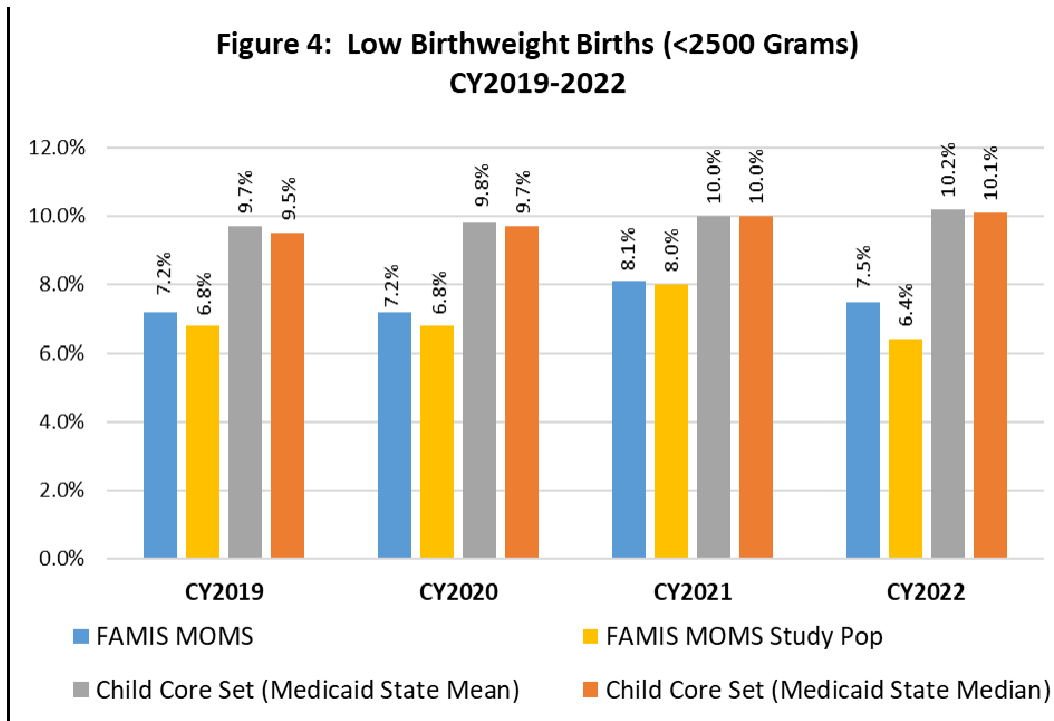
Measure III: *Newborns with Low Birth Weight (<2,500 grams)—The percentage of newborns weighing less than 2,500 grams at birth. This includes birth weights in the very low birth weight category (birth weights less than 1,500 grams) and the low birthweight category (birth weights between 1,500 and 2,499 grams).*

To assess whether Virginia is meeting Demonstration Goal II of improving selected birth outcomes of FAMIS MOMS participants and their newborns, and to answer the research question of whether enrollment in FAMIS MOMS improves birth outcomes of participants, DMAS monitored the rate of low birthweight births for the FAMIS MOMS population over the course of the evaluation period. Women who enter prenatal care late or who deliver prematurely are at higher risk for delivering an infant with low birth weight.

As a benchmark for the FAMIS MOMS evaluation’s newborns with low birthweight measure, DMAS uses the CMS Child Core Set measure Newborns with Low Birth Weight (<2,500 grams). An update is released annually and includes data for all states and Washington, D.C., for Medicaid/CHIP populations. DMAS compared evaluation data with the reported median and mean for state Medicaid programs by federal fiscal year. Figure 4 below shows the FAMIS MOMS population’s rates of low birthweight births (<2500 grams) for the years CY2019 through CY2022 compared to benchmarks and comparison populations.

FAMIS MOMS outcomes for Measure III during the evaluation period compared favorably to the identified benchmarks. Of all FAMIS MOMS participants giving birth in 2019, 7.2% were low birthweight births. This rate was lower than the Medicaid/CHIP Child Core Set mean of 9.7% and median of 9.5%.¹¹ The MCH Focus Study also identified a Study Population of FAMIS MOMS who were continuously enrolled in a managed care organization (MCO) or the fee-for-service delivery system for at least 90 days prior to, and including, the date of delivery. This subset excludes women who enrolled in FAMIS MOMS or an MCO less than 90 days before the date of delivery. This study population typically has better outcomes than the broader FAMIS MOMS population because timely enrollment provides sufficient opportunity for the member to receive prenatal care and other covered benefits through the program, which increases the chance that the member’s FAMIS MOMS health coverage will have a positive impact on birth outcomes. On Measure III for 2019, the FAMIS MOMS Study Population’s rate of low birthweight births was 6.8%, outperforming all identified benchmarks for that year.

¹¹ A lower rate indicates better performance for this indicator.



Sources: Health Services Advisory Group, *Medicaid and CHIP Maternal and Child Health Focus Study*; Centers for Medicare and Medicaid Services, Core Set of Children's Health Care Quality Measures

For CY2020, FAMIS MOMS participants' rate of low birthweight births was 7.2%, which compared favorably to the Child Core Set mean of 9.8% and median of 9.7%. The FAMIS MOMS Study Population again outperformed the broader population with a rate of 6.8%. (In 2020 and subsequent years, the parameters for the Study Population changed to include only women continuously enrolled for 120 days prior to delivery.)

For CY2021, FAMIS MOMS participants' rate of low birthweight births was 8.1%, higher than the previous year but continuing to compare favorably with the Child Core Set mean of 10.0% and median of 10.0%. The FAMIS MOMS Study Population, with a rate of 8.0%, again outperformed the broader population.

Finally, for CY2022, the FAMIS MOMS population's rate of low birthweight births was 7.5%, lower than the previous year and outperforming Child Core Set mean of 10.2% and median of 10.1%. The FAMIS MOMS Study Population's rate of 6.4% outperformed other benchmarks in that year.

Year-over-year changes in the FAMIS MOMS population's rate of low birthweight births were not statistically significant.

FAMIS MOMS Evaluation – Conclusions and Recommendations

The demonstration period covered by this evaluation report (July 1, 2019 through June 30, 2022) was a time of change and uncertainty affecting the Medicaid and CHIP programs in Virginia and nationwide. Many of these changes affected Virginia’s pregnant and postpartum populations. Virginia began its rollout of Medicaid expansion to newly eligible adults on January 1, 2019, a transition that led to expanded coverage of women prior to conception and between pregnancies. Immediately before Medicaid expansion, from August through December of 2018, Virginia implemented a phased rollout of the Medallion 4.0 managed care program. Medallion 4.0 is the program that serves FAMIS MOMS and FAMIS children as well as the new adult group.

In early 2020, the COVID-19 public health emergency and maintenance of eligibility policy began. Nationwide, the initial months and years of COVID-19 were marked by changes in utilization, with initial reductions in preventive care visits, including prenatal care. Research has established that COVID-19 infection during pregnancy can have adverse health effects for the mother and the developing fetus. Nationwide data indicates that maternal health outcomes, as well as mortality and morbidity, worsened during the years of the COVID-19 pandemic. Unwinding from the public health emergency began in spring 2022, near the close of the demonstration evaluation period covered in this report.

This is the first evaluation report based on the revised evaluation design approved by CMS November 2, 2021. Virginia’s previous evaluation report covered the 2016-19 demonstration period and was based on the previous evaluation plan. Measures and benchmarks have changed significantly from the previous plan, limiting Virginia’s ability to make comparisons between the previous demonstration period and the period covered by this evaluation report.

Compared to the identified benchmarks, the FAMIS MOMS population’s prenatal and birth outcomes were generally favorable for all three measures. For early and adequate prenatal care, FAMIS MOMS’ rates outperformed the NVSS national average in all years of the evaluation period. FAMIS MOMS rates of early and adequate prenatal care exceeded the Healthy People 2030 goal in CY2019 but fell short in following years. Note, however, that the Healthy People 2030 goal set an ambitious path for improvement of 1 percentage point per year and national rates of early and adequate prenatal care have also fallen short of meeting the goal. On rates of preterm birth, the FAMIS MOMS population compared favorably to the Healthy People 2030 Target as well as the NVSS national average in all years of the evaluation period. The FAMIS MOMS population’s rates of low birthweight births were lower than the Medicaid and CHIP Child Core Set benchmarks (state median and mean) across all years of the evaluation period.

DMAS’ recent transition to the new Cardinal Care Managed Care (CCMC) program for Medicaid and FAMIS provides an opportunity to reassess existing quality improvement strategies related to prenatal and postpartum care and resulting clinical outcomes among birthing people and newborns. Moving forward, the MCOs’ quality initiatives can be designed to ensure alignment with CCMC’s targeted topics regarding maternity services and services for infants.

The following additional recommendations were offered in the *Medicaid and CHIP Maternal and Child Health Focus Study*.

- Unplanned pregnancies are associated with higher rates of preterm births and newborns with low birthweight. LARCs are an effective contraceptive method that can help reduce unplanned and short-interval pregnancies. While Virginia’s rates for contraceptives received within three days of delivery are similar to national benchmarks, the MCOs should work to inform their providers and DMAS should continue to work with hospitals to institute protocols that allow physicians to leverage the Virginia Postpartum LARC toolkit.
- Given that Medicaid and FAMIS MOMS members can receive a 12-month supply of contraceptives, DMAS and the MCOs should assess how many members are using contraceptives prior to becoming pregnant. Given that the MCOs will be reporting the CMS Contraceptive Care—All Women measure for measurement year 2023 as part of the Non-Interactive Data Submission System (IDSS) data collection tool, DMAS can use this information to determine a baseline for contraceptive use. The MCOs can also work to ensure that women have an established gynecologist prior to pregnancy in order for women to discuss their contraceptive options with their provider.
- Given that doulas began providing services to Virginia Medicaid and FAMIS MOMS members in August 2022, DMAS should consider including an assessment of whether the use of doula services impacts birth and maternal health outcomes in a future MCH Focus Study.

FAMIS Select Evaluation – Methodology

For the FAMIS Select evaluation, DMAS conducted qualitative interviews with FAMIS Select enrollees’ adult family members to gain an understanding of how well participating families believe the program is working for their children and areas that could be improved. The original evaluation plan indicated that DMAS would gather this feedback through participant focus groups. However, when DMAS program staff reached out to the enrolled families about participation in a focus group, there was consistent feedback that families would prefer to discuss their experiences in individual phone interviews. Some family members stated that scheduling the time to participate in a focus group, whether in person or virtual, was challenging given variable and sometimes unpredictable work schedules. FAMIS Select subsidizes employer-sponsored health insurance, and the adult family members are typically employed in full-time jobs with limited time outside of work. Participating families also indicated that they would prefer to provide feedback privately rather than as part of a group discussion. In response to this

input from the families, DMAS decided not to organize focus groups and instead contacted participants by phone for one-on-one qualitative interviews.

Questions were concentrated in two key focus areas. One category of questions focused on consumers' experiences with DMAS-operated components of the program, such as customer service, responsiveness to customer inquiries, and timely processing of subsidy payments. Questions aimed to identify customer service issues and other shortcomings or strengths of the DMAS-operated aspects of the FAMIS Select program. The second category of questions focused on understanding consumers' perception of their level of access to health care services and providers under their private or employer-sponsored health insurance plan. For both categories, interview questions attempted to gauge consumer satisfaction and identify challenges encountered by FAMIS Select participants and ways the program could be improved.

The FAMIS Select evaluation is qualitative in nature due to the limited size of the program. An interview guide was developed by DMAS subject matter experts with expertise in qualitative evaluation methods. (See Figure 5.) The revised evaluation plan was approved by CMS in November of 2021; however, DMAS' timeline for conducting FAMIS Select interviews was delayed due to operational constraints during the COVID-19 public health emergency and the subsequent departure of key agency staff, including monitoring and evaluation subject matter experts.

The study population consisted of families with children enrolled in FAMIS Select for one or more months during the prior year. Program staff provided a list of FAMIS Select parents and guardians for whom the agency had verified up-to-date phone numbers on file. This list consisted of 13 adults, each of whom was the primary policyholder of an employer-sponsored health insurance (ESHI) plan with children enrolled in FAMIS Select. Between September 2023 and February of 2024, DMAS contacted each participating family by phone a minimum of two times, leaving voicemail messages at least once when possible. DMAS conducted phone interviews of approximately 10 minutes in length using the standardized interview guide. Transcripts of the interviews were produced and analyzed by theme to determine general satisfaction or dissatisfaction with the FAMIS Select program and to determine accessibility of healthcare services through the ESHI plan for members participating in the FAMIS Select program. DMAS staff reviewed the interviews to identify shortcomings or strengths of the DMAS-operated aspects of FAMIS Select and determine areas where program improvements could be made.

FAMIS Select Evaluation – Limitations

FAMIS Select is a small program and enrollment falls well short of the criteria for having at least 500 potential enrollees needed to include a comparison group in the evaluation, based on CMS' Modified Evaluation Design for the Section 1115 Demonstration expanding Title XXI coverage. Most recently, the program included 30 children across even fewer households, with enrollment sometimes dipping below the 30 necessary to draw valid statistical inferences. Therefore, DMAS focused our efforts on gathering high quality qualitative data to determine our members' satisfaction with the program and identify potential barriers or areas of improvement.

While focus groups are known for market research, with their potential to prompt open and candid discussion among a diverse group, the sensitivity of the topic (healthcare and finances), the potential for travel- and or connectivity-related challenges for the studied population, and the small size of the studied population, it is exceedingly unlikely to be able to draw statistically valid conclusions via focus groups. Potential limitations from the use of individual interviews (as opposed to taking a focus group approach) may include reduced efficiency in data collection, and a decrease in the quantity of potential insights. Given the small overall number of potential participants, and the importance of flexibility in scheduling offered by the interview approach, efficiency in collection was less of a concern.

In future years, should the FAMIS Select population grow in size, more complex sampling strategies could be explored.

FAMIS Select Evaluation – Questions and Hypotheses

Descriptions of each measure are provided in detail below.

Demonstration Goal: *Monitor and ensure member satisfaction with the FAMIS Select program.*

Research Questions:

Is the self-reported consumer experience of participants in FAMIS Select satisfactory? What do participants report can be improved?

Hypothesis IV: FAMIS Select members’ families will report that they are satisfied with the service offered by the FAMIS Select program, a subsidy for private/employer-sponsored insurance.

Measure IV: Analysis of responses gathered in interviews with families of current FAMIS Select enrollees

Measure IV Description: Data for Measure IV is gathered from interviews with FAMIS Select participants conducted by Virginia DMAS staff. Questions aim to understand consumers’ experiences with DMAS-operated components of the program, such as customer service, responsiveness to customer inquiries, and timely processing of subsidy payments. Questions aim to identify customer service issues or other shortcomings or strengths of the DMAS-operated aspects of FAMIS Select.

Responses were categorized into themes to determine general satisfaction or dissatisfaction with the FAMIS Select program, determining relevant attributes and synthesizing data to assign satisfaction levels as “not satisfied,” “somewhat satisfied,” “satisfied,” and “very satisfied.”

Demonstration Goal: Monitor and ensure member satisfaction with the FAMIS Select program.

Research Question: Do families report that children in FAMIS Select have a satisfactory level of access to health care services through their private or employer-sponsored insurance subsidized by FAMIS Select?

Hypothesis V: FAMIS Select families will report that they are able to access preventive services, use specialty healthcare services, and schedule timely appointments with preferred providers under their private or employer-sponsored insurance that is subsidized by FAMIS Select.

Measure V: Analysis of responses gathered in interviews with families of current FAMIS Select enrollees

Measure V Description: Data for Measure V is gathered from interviews with FAMIS Select participants conducted by Virginia DMAS staff. Interview questions aimed to understand consumers' perception of their child's level of access to health care services and providers under their private or employer-sponsored health insurance plan, including access to preventive services and specialty healthcare services, and ability to schedule timely appointments with preferred providers.

Responses were categorized into themes to determine accessibility of healthcare services for members participating in the FAMIS Select program, determining relevant attributes and synthesizing data to assign satisfaction levels as "not accessible," "somewhat accessible," "accessible," and "very accessible."

Demonstration Goal: Assure the aggregate cost-effectiveness of the FAMIS Select program

Research Question: Is the FAMIS Select program cost-effective?

Hypothesis VI: The FAMIS Select program will be cost-effective as compared to the FAMIS program over the course of the demonstration year (state fiscal year)

Measure VI: Cost-effectiveness analysis (FAMIS Select-FAMIS comparison)

Measure VI Description: Data for Measure VI will come from fee-for-service claims, managed care encounters and capitation payments, and enrollment records.

As required in STC #22 and consistent with 2105I(3) of the Social Security Act, DMAS monitors FAMIS Select program expenditures to ensure cost effectiveness. Specifically, DMAS compares the agency’s cost to subsidize the purchase of employer-sponsored insurance to the amount of expenditures, including administrative expenditures, that the state would have made to provide comparable coverage to the targeted low-income child or family involved under the state child health plan, FAMIS.

Cost-effectiveness is assessed by calculating the average per-enrollee, per-month cost and administrative expense associated with the FAMIS Select enrolled population, compared to the per-enrollee, per-month cost of providing the FAMIS benefit plan.

FAMIS Select Evaluation – Results

Qualitative Interviews with FAMIS Select Participating Families

The evaluation plan for FAMIS Select includes qualitative analysis of data gathered through interviews with participating families. These interviews enable Virginia to evaluate progress toward the following demonstration goals for the FAMIS Select program:

Demonstration Goal III: Facilitate access to affordable private and employer-sponsored health insurance for low-income families through premium assistance.

Demonstration Goal IV: Monitor and ensure member satisfaction with FAMIS Select program.

The study population consists of families with children enrolled in FAMIS Select for one or more months during the prior year. Program staff provided a list of FAMIS Select parents and guardians for whom the agency had verified up-to-date phone numbers on file. This list consisted of 13 adults, each of whom was the primary policyholder of an employer-sponsored health insurance (ESHI) plan with children enrolled in FAMIS Select. Between September 2023 and February of 2024, DMAS contacted each participating family by phone a minimum of two times, leaving voicemail messages at least once when possible.

Out of these attempted contacts, DMAS spoke with six FAMIS Select participating adults. One individual declined to participate in the phone interview. The remaining five participants were all the primary policyholder for the family's employer-sponsored health insurance plan. These five parents/guardians represented a total of 10 FAMIS Select-enrolled children. Of these five, one participant did not complete the full interview. This participant disclosed that they were no longer participating in the FAMIS Select program at the time of contact. Although the family had recently disenrolled from the program and still met criteria to participate in the evaluation, the participant chose not to complete the full interview. (All participants were informed that participation was voluntary and they could end the interview at any time.) DMAS conducted full interviews with four participants, using the standardized interview guide (Figure 5).

Questions focused on participants' experiences with the DMAS-administered components of FAMIS Select and the participants' self-reported satisfaction with the level of healthcare access through their ESHI plan. DMAS also included several questions to assess participants' awareness of the MOE unwinding and the importance of ensuring that contact information was up to date.

Figure 5: FAMIS Select Interview Guide

Interview Guide for FAMIS Select Evaluation

Hi, my name is [name]. I'm calling with Virginia DMAS about your child's FAMIS Select coverage and monthly reimbursement ("premium check"). We have a brief phone interview about your experiences with the program that we are asking families enrolled in the program to respond to. It should take about 10 minutes. Are you willing to participate?

If yes, read the following statement:

This survey is solely for the purpose of evaluating the FAMIS Select program and identifying ways to improve the program. Participation is not required. Your responses will not impact your participation in FAMIS Select in any way. The answers you give will be kept strictly confidential and your responses will not be linked with your name or other identifying information in any summaries or evaluation materials. We will not share your personal information with anyone outside of the evaluation team.

May I have your permission to record the interview?

Household Information:

1. How many children in your household are enrolled in FAMIS Select? What are their ages?
2. When did you first enroll your child/ren in FAMIS Select? Have you been enrolled for more than a year?
3. What is your relationship to the child/ren enrolled in FAMIS Select?
4. Is the insurance that you get the payment for through your employer or through another adult in the household?
5. How many family members (number of adults and number of children) are enrolled in the household's private/employer insurance plan?

Consumer Experience:

6. How did you first hear about FAMIS Select? (Prompt if needed: local department of social services, mailing from FAMIS/DMAS, friend or family member, FAMIS material on Cover VA or DMAS website)
7. Tell me about when you first got enrolled in the program and how that went. How easy or difficult was the process of first enrolling in FAMIS Select?
8. How easy or difficult is it to understand the rules and requirements of the program? Do you know what you need to do to stay enrolled and keep receiving monthly checks?
9. Now I have a few questions about the customer service you receive through DMAS each month.

- a. How easy or difficult is it to submit the required documentation/paperwork/paystubs to DMAS each month?
- b. Has there been a time when you've had to contact DMAS to answer additional questions or to correct a mistake? Was it easy to contact DMAS? Were you satisfied with how the issue was resolved?
- c. Are your payments usually processed when you expect them to be processed each month?
- d. How would you describe your overall level of satisfaction with the program? (Prompt if needed: very satisfied, satisfied, somewhat satisfied, not satisfied)
- e. What do you think could be improved about the program?

Healthcare Access through ESHI Plan:

- 10. Are there times when you use your child's FAMIS insurance card, like for vaccinations, or do you always present your employer health insurance card to the doctor or clinic?
- 11. We'd like to learn about your experience with health care services provided by your employer health insurance plan.
 - a. Do you have a regular family doctor, pediatrician, or clinic that your child goes to?
 - b. Thinking about the last year, were you able to schedule visits for your child for **preventive care** such as well visits or vaccinations?
 - c. Were you able to schedule appointments when your child needed them for preventive care?
 - d. If not, how long has your child had to wait for an appointment? Did this cause a problem?
- 12. Now I want to ask about sick visits. Thinking about the last year, were you able to schedule timely medical visits for your child **when they got sick, injured or needed medical attention quickly?**
- 13. **Specialists** are doctors and other medical professionals like allergy doctors, skin doctors, heart doctors and others who specialize in one area of health care.
 - a. Thinking about the last year, has your child needed to see one or more specialists?
 - b. Were you able to schedule a specialty care visit for your child with the chosen specialty provider you wanted to see?
 - c. Were you able to schedule a specialty care visit for your child within a reasonable time frame?
 - d. If not, how long did you have to wait for an appointment?
- 14. Overall, how would you describe the level of access to health care for your child(ren)? (Prompt if needed: very accessible, accessible, somewhat accessible, not accessible)

15. Would you like to share anything else about your experience with FAMIS Select and ideas for how we could improve the program?

Enrollment and Unwinding

Have you recently been through the process of renewing your child's FAMIS coverage after the COVID public health emergency?

Are you aware that you need to renew FAMIS coverage every 12 months to make sure your child stays enrolled in FAMIS Select and you continue to receive payments?

Participant Information

For the next few questions, you can choose the "prefer not to say" response if you don't want to share that particular information.

What region of the state do you live in?

Central
Charlottesville/Western
Northern and Winchester
Roanoke/Alleghany
Southwest
Tidewater
Prefer not to say

Is your employer that you get the insurance coverage through:

Large company
Small business
Nonprofit
Public agency (federal, state, or local)
Other
Prefer not to say

Is your child of Hispanic or Latino origin or descent?

Yes/no, or prefer not to say

What is your child's race? (One or more of the following)

- White/Caucasian
- Black or African-American
- Asian or Pacific Islander
- American Indian or Alaska Native
- Other
- Prefer not to say

Is your child or are your children male or female? (Or prefer not to say)

Findings

All four of the participants who completed a full interview had children who had been enrolled in FAMIS Select for more than one year, with length of enrollment ranging from two to eight years and an average length of enrollment of five years. Ages of participating children ranged from five to 18 years old with an average age of 13 and median age of 15. There were an average of four members per household (adults plus children) receiving coverage through the employer-sponsored plan. (This includes both FAMIS Select-enrolled children and enrollees receiving incidental coverage through the ESHI plan but not enrolled in FAMIS Select.)

FAMIS Select members' families were satisfied with the service offered by the program.

All FAMIS Select participants interviewed reported that the initial application and enrollment process for FAMIS Select was easy to understand and that they did not have any problems submitting their application. Participants described the process as “fairly simple” and “pretty easy.” Two participants reported that it was helpful that the FAMIS Select program application was available online, with one stating, “It was easy enough—I just filled out the application... I think I faxed it in with my paystub. It was easy.” Although most participants applied for the program years prior to the interview, the application process remains similar to what participants described in the interviews. Interview responses indicate that the application process is well designed for the customer’s ease of use.

Interview participants reported learning about the FAMIS Select program in a variety of ways. One participant learned of the program through the website. Another participant reported receiving information in the mail about FAMIS Select after initially enrolling their child in FAMIS. Another participant learned about the program through their own research, stating “It’s not like a widely known thing. Nobody I talk to knows what it is or has ever heard of it. I kind of just stumbled on it.” Although most participants enrolled many years prior to the interview, their responses indicate that there is potential for enhanced marketing and outreach efforts to improve awareness of the program.

None of the interview participants reported difficulty understanding the rules and requirements of the FAMIS Select program or completing the monthly process required to receive the subsidy payment. Participants described rules and processes as “pretty easy” and stated they “never had any issues” and “it’s not difficult at all.” One participant stated, “I know what I need to do. I just need to send in my pay stubs every month to show that I’m still paying my health insurance premium for my kids.” Another participant stated: “I’d say on a scale of one to five with five being not easy I’d put it at probably a three, just to make it neutral. I mean it really just depends on who you are and how tech savvy you are.” Based on the participant responses, program rules and processes are satisfactory to participants and there was no indication that changes are needed to improve the consumer experience.

Participants were asked about their experiences contacting DMAS for assistance when they encountered problems or had questions. Two participants described specific program staff who consistently handled their questions and were “always very nice,” and “always very prompt if you have a question.” One participant stated that “it’s easy if I ever have a question.” Two

participants reported having experienced a problem in the past that led to the delay of a subsidy payment. Both participants reported that the problem was resolved to their satisfaction. One participant described a problem they experienced that caused a payment delay and stated that program staff were “in constant communication with me explaining everything.” The other participant stated that their problem was “resolved pretty quickly.”

When asked their overall level of satisfaction with the program, three participants reported being “very satisfied” and one reported being “satisfied.” One participant stated, “It’s been a big help with my kids over the years.” When asked whether they thought anything could be improved about the program, participants did not identify any areas that needed improvement, with one stating, “I don’t think it can get much more simple.”

FAMIS Select members’ families reported that their children’s access to health care services through their subsidized private or employer-sponsored insurance was satisfactory.

All four participants who completed the interview reported that their children had a regular primary care provider and were able to schedule timely visits for their children for well visits and preventive care. One participant reported that their doctor’s office “always call[s] me if I don’t have an appointment already scheduled.” Another participant noted that the only reason they needed to wait to schedule a well visit for their child was because of their health plan’s policy that annual well child visits take place a minimum of 12 months apart, not because of any difficulty scheduling with their provider.

All participants reported that they were able to schedule timely medical visits for their children when they got sick, injured, or needed medical attention quickly. One participant indicated that they typically took their child to an urgent care facility for illnesses or injuries. Another participant reported that in the event of sudden illness or injury, they would seek care for their child either at an urgent care facility or an emergency department; however, they stated that this was not because they had experienced any difficulty scheduling sick visits with their regular pediatric provider.

Three of the four participants interviewed reported that one or more of their children had needed to see a specialist in the past year. Participants reported waits of 30 to 60 days for appointments for specialty care. One participant stated, “It was something that was so far out to the point that when [the child] finally did get in and get examined, [they were] actually better.” Another stated, “I think it was reasonable, based on the specialty.” All three of the participants who sought specialty care for their children expressed an expectation that specialty care is typically more difficult to access and requires a relatively long wait to schedule an appointment.

When asked to describe the overall level of access to care for their children through their employer sponsored health plan, participants responded that it was “somewhat accessible” and “accessible.” One participant stated, “I would say somewhere between *somewhat* and accessible.”

FAMIS Select Cost-Effectiveness Analysis

The final Demonstration goal identified in Virginia’s approved evaluation plan focuses on the cost-effectiveness of the FAMIS Select program.

Demonstration Goal V: Assure the aggregate cost-effectiveness of the FAMIS Select program

Research Question: Is the FAMIS Select program cost-effective?

Hypothesis VI: The FAMIS Select program will be cost-effective as compared to the FAMIS program over the course of the demonstration year (state fiscal year)

Measure VI: Cost-effectiveness analysis (FAMIS Select-FAMIS comparison)

Measure VI Description: Data for Measure VI will come from fee-for-service claims, managed care encounters and capitation payments, and enrollment records.

As required by the Demonstration terms and consistent with 2105(I)(3) of the Social Security Act, DMAS monitors FAMIS Select program expenditures to ensure cost effectiveness. Specifically, DMAS compares the agency’s cost to subsidize the purchase of employer-sponsored insurance to the amount of expenditures, including administrative expenditures, that the state would have made to provide comparable coverage to the targeted low-income child or family under the state child health plan, FAMIS.

The table below presents an analysis of FAMIS Select expenses and offsetting savings based on FAMIS expenses for SFY 2022. The average per enrollee, per month cost under FAMIS was \$248.66. The maximum monthly FAMIS Select premium subsidy was \$100 per enrollee, while the average subsidy per enrollee was \$98.64. Factoring in administrative expenses, the average monthly cost associated with a FAMIS Select enrollee was \$102.34. This resulted in a savings per FAMIS Select enrollee of \$146.32, which translates to an annual estimated savings of \$80,768.64.

The cost analysis was conducted in every year of the demonstration period and reported in biannual monitoring reports. The FAMIS Select program has remained consistently cost effective throughout the demonstration period to date.

Table 3:

| Cost Analysis of the FAMIS Select program (State Fiscal Year 2022) | |
|---|---------------------------|
| Program Expense Categories | Costs |
| Premium Subsidies | \$54,451 |
| Administration | \$2,044 |
| Total | \$56,495 |
| Cost Effectiveness Comparison | |
| Average per Enrollee per Month Cost for FAMIS | \$248.66 |
| Maximum FAMIS Select Premium Assistance Subsidy Per Enrollee | \$100.00 |
| Actual Average Monthly Premium Subsidy Per Enrollee | \$98.64 |
| Actual Average Monthly Cost for FAMIS Select Enrollee with administrative and other costs | \$102.34 |
| Savings Per FAMIS Select Enrollee | \$146.32 |
| <i>Estimated Average Annual Savings</i> | <i>\$80,768.64</i> |

FAMIS Select Evaluation – Conclusions and Recommendations

This interim evaluation report presents findings on three hypotheses concerning FAMIS Select:

- *FAMIS Select members’ families will report that they are satisfied with the service offered by the FAMIS Select program.*
- *FAMIS Select families will report that they are able to access preventive services, use specialty healthcare services, and schedule timely appointments with preferred providers.*
- *The FAMIS Select program will be cost-effective as compared to the FAMIS program over the course of the demonstration year (state fiscal year).*

Analysis of the data gathered in participant interviews indicates that through the FAMIS Select program, DMAS continues to meet the goal of operating a cost-effective health insurance subsidy program that offers a consistently high quality experience for FAMIS Select members. DMAS assures that the consumer experience of FAMIS Select participants, with respect to customer service and health care access, is satisfactory or better. Additionally, the FAMIS Select program continues to meet the goal of providing a streamlined and cost-effective alternative to the standard FAMIS program.

FAMIS Select enrollment continued to decline during this demonstration period. Factors likely contributing to the decline include the high 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 program is generally more advantageous for families with larger numbers of FAMIS-eligible children and/or with employer-sponsored plans that have a lower employee share of premiums and out-of-pocket cost sharing.

FAMIS Select has a small but loyal group of longer-term enrollees whose decision to continue participating underscores the program's value and potential. A past analysis of FAMIS Select cases indicated that the majority of households participating in the program in SFY2018 had been enrolled in FAMIS Select for longer than a year. Among households enrolled for longer than one year, mean length of time on FAMIS Select was 4.6 years and median length of time was 2.7 years. The longest a household had been enrolled was 12.8 years, possibly since the start of the program.

Increasing enrollment of eligible children in FAMIS Select remains a goal, and through increased outreach and promotion the program has the potential to grow to reach a larger population. DMAS has identified the following outreach strategies for FAMIS Select for implementation during the Demonstration period:

- **Refresh communication materials.** Widen distribution of the recently updated FAMIS Select brochure, which has been refreshed with new graphics and is more colorful and succinct than the previous product.
- **Share the updated flyer** in new FAMIS member welcome packets. The updated flyer was also recently posted to the website.
- **Research strategies for a targeted member mailing** to FAMIS member families that may benefit from the program.
- **Send blast e-mails to the Department of Social Services.** Utilizing communication channels used by Department of Social Service to provide updates to local DSS workers across the Commonwealth would increase understanding and awareness of the program. An email might include eligibility information and promotional materials about FAMIS Select.
- **Explore opportunities through state government human resources.** DMAS and the state's Department of Human Resources Management should explore partnerships for educating HR professionals about FAMIS Select and how to share information about the program with potentially eligible state employees.

In addition to these enhancements to the current outreach strategy, DMAS is evaluating options for operational and program design improvements to FAMIS Select. DMAS continues to consider options for adjusting the subsidy amount or restructuring the subsidy system for FAMIS Select. The \$100 per child, per month subsidy has not been updated since program inception and has not kept pace with the rising cost to employees of employer-sponsored health insurance. Restructuring or increasing the subsidy necessitates careful review and legislative approval of any change with a state budget impact. However, the FAMIS Select cost effectiveness analysis indicates that there is likely room for adjustments that would increase the program's appeal to

families while ensuring the program remains cost-effective for the Commonwealth and the federal government.

In recent discussions with CMS, DMAS has identified changes that could potentially be made to the FAMIS Select eligibility and enrollment policies to allow for a more streamlined process of enrollment in FAMIS Select. For example, DMAS is exploring whether it is federally permissible for a family to enroll their child directly into FAMIS Select if their child otherwise meets FAMIS eligibility criteria and is enrolled under their employer's health plan at the time of FAMIS application or renewal. This would offer a less burdensome process compared to needing to drop employer coverage and reapply for FAMIS, then apply separately for FAMIS Select as a subsequent step.

FAMIS Select has recently seen steep enrollment losses post-pandemic and during the unwinding period. This may be attributable to families' eligibility being reassessed after a lengthy enrollment in FAMIS under the MOE and a finding that they are eligible for Medicaid or, conversely, that their income is above the FAMIS eligibility limit. Since FAMIS Select families have at least one working parent with employer-sponsored coverage, it is possible that recent increases in Virginia's minimum wage have led to income gains for participating families that led some to "income off" the program.

APPENDIX I: List of Tables and Figures

| # | Title | Page |
|-----------------|--|-----------|
| Table 1 | FAMIS MOMS and FAMIS Select Demonstration Evaluation Design | 9 |
| Figure 1 | FAMIS MOMS and FAMIS Select Driver Diagrams | 13 |
| Table 2 | FAMIS MOMS Overall Findings, CY 2019–2022 | 19 |
| Figure 2 | Births with Early and Adequate Prenatal Care, CY 2019–2022 | 21 |
| Figure 3 | Preterm Births (<37 Weeks), CY 2019–2022 | 24 |
| Figure 4 | Low Birthweight Births (<2500 grams), CY 2019–2022 | 26 |
| Figure 5 | FAMIS Select Interview Guide | 33 |
| Table 3 | Cost Analysis of the FAMIS Select Program (State Fiscal Year 2022) | 39 |

APPENDIX II: Approved Evaluation Design for FAMIS MOMS and FAMIS Select

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

November 3, 2021

Karen Kimsey
Director
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Kimsey:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Virginia's Evaluation Design, which is required by the Special Terms and Conditions (STCs) of the Commonwealth section 1115 demonstration "FAMIS MOMS and FAMIS Select" (Project No: 21-W-00058/3), effective through June 30, 2029. CMS has determined that the Evaluation Design, which was first submitted on June 18, 2020 and subsequently revised with a final version submitted on October 4, 2021, meets the requirements set forth in the STCs, and therefore, approves the Commonwealth's FAMIS MOMS and FAMIS Select Evaluation Design.

In accordance with 42 C.F.R. §431.424, the approved Evaluation Design may now be posted to the Commonwealth's website within thirty days. CMS will also post the approved Evaluation Design on Medicaid.gov.

CMS appreciates the Commonwealth's commitment to a robust evaluation of the FAMIS MOMS and FAMIS Select section 1115 demonstration. Please note that three interim evaluation reports, in alignment with the approved Evaluation Design, are due to CMS per the expectations and timeline outlined in this approved Evaluation Design. Additionally, if the Commonwealth is seeking to extend the demonstration, the draft of the third Interim Evaluation Report (for the demonstration period covering June 2019-June 2027) is due at the time of the extension application. Likewise, a Summative Evaluation Report, consistent with this approved Evaluation Design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 C.F.R. §431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Virginia on the FAMIS MOMS and FAMIS *Select* section **1115** demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation
State Demonstration Group

Danie11e
Daly- S
Digitally signed by
Danielle Daly -S
Date: 2021.11.03
09:49:24 -04'00'

cc: Margaret Kosherzenko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

DEMONSTRATION EVALUATION PLAN
Virginia DMAS FAMIS MOMS and FAMIS Select CHIP Section 1115 Demonstration
Demonstration Period: July 1, 2019 - June 30, 2029

General Background

Consisting of two components, Virginia's Title XXI Section 1115 Demonstration expands Title XXI coverage to uninsured pregnant women with family income up to 200% FPL who are not eligible for Medicaid, through a program known as FAMIS MOMS, and 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 to receive coverage through FAMIS Select.

FAMIS MOMS Background

The intent of the FAMIS MOMS 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; stage one expanded eligibility to pregnant women with family income above the Medicaid limit of 133% FPL but less than or equal to 150% FPL, while the second stage, implemented September 1, 2006, covered pregnant women with incomes through 166% FPL. Subsequent stages covered pregnant women at 185% FPL (July 1, 2007) and currently 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 one, 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. Following approval by the Centers for Medicare and Medicaid Services (CMS) of an amendment to the Demonstration, administrative efforts were taken to implement this phase-out by ceasing 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. The amended state budget for state fiscal year 2015 was passed and signed in late June 2014. An amendment to the Demonstration, reinstating enrollment at an upper income level of 200% FPL (plus a 5% income 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 did not accept new applications for FAMIS MOMS between December 31, 2013 and November 30, 2014; for women already enrolled, FAMIS MOMS coverage continued throughout their pregnancy and postpartum periods. FAMIS MOMS enrollment dropped from close to 1,600 on July 1, 2013, to 1,363 on January 1, 2014, and to single digits at its lowest point in late 2014. After the December 1, 2014 reinstatement of FAMIS MOMS, enrollment began to climb again, reached 1,156 by August 2015, and currently remains stable. Monthly enrollment as of April 2020 was 1,642.

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.

FAMIS Select Background

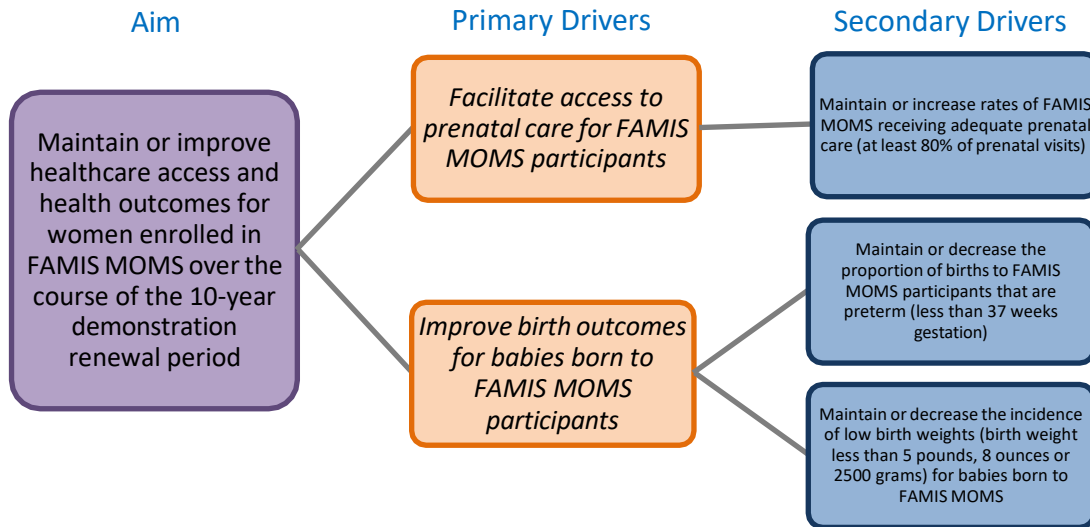
The FAMIS Select program was implemented in Virginia on August 1, 2005, replacing the former employer-sponsored health insurance (ESHI) program. FAMIS Select provides an alternative for families with children enrolled in FAMIS who have access to private or employer-sponsored coverage. All children are first enrolled in FAMIS. In some cases, 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 been marked by periods of 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. Average monthly enrollment for SFY2018 was 102. (Enrollment reflects the number of FAMIS-eligible children directly enrolled in FAMIS Select. Totals do not include incidentally enrolled family members such as adults and non-FAMIS-eligible children in the family.) The decline in participation is likely attributable to changes in employer-sponsored health insurance offerings; in Virginia and nationwide, employer-sponsored health insurance is becoming less widely available and more expensive, with higher employee cost-sharing, making family coverage a less affordable option for lower-income workers.

Driver Diagrams

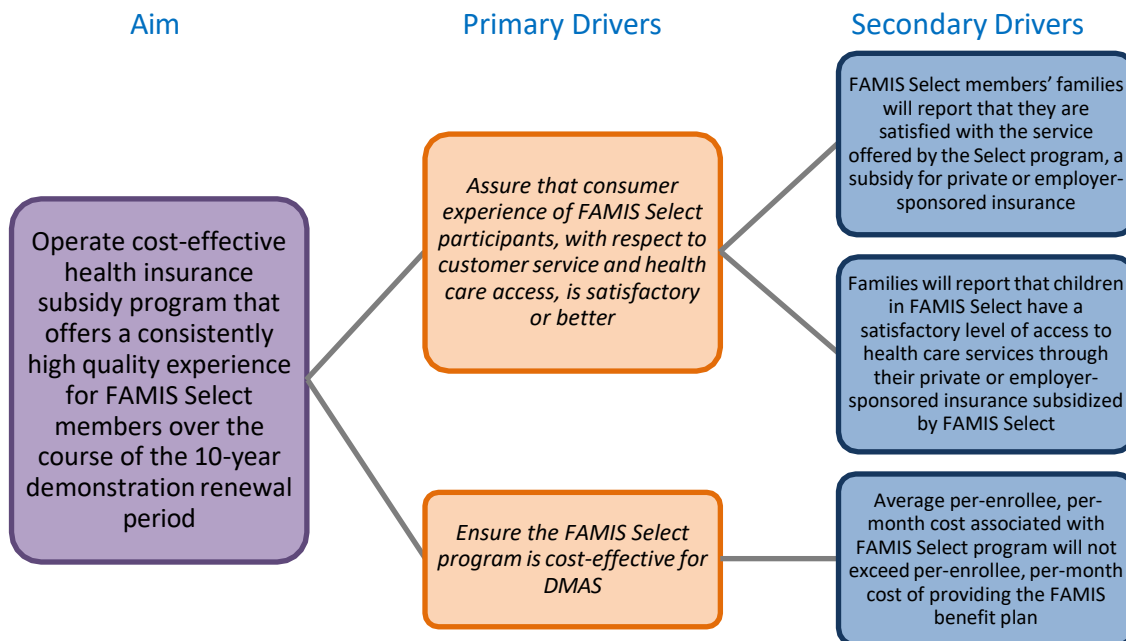
FAMIS MOMS: The demonstration will maintain or improve healthcare access and health outcomes for women enrolled in FAMIS MOMS over the course of the 10-year demonstration renewal period by:

- Facilitating access to prenatal care for FAMIS MOMS participants
- Improving selected birth outcomes of FAMIS MOMS participants and their newborns



FAMIS Select: The demonstration will operate a cost-effective health insurance subsidy program that offers a consistently high quality experience for FAMIS Select members over the course of the 10-year demonstration renewal period by:

- Assuring that consumer experience of FAMIS Select participants, with respect to customer service and health care access, is satisfactory or better
- Ensuring the FAMIS Select program is cost-effective for DMAS



Demonstration Populations

The FAMIS MOMS and FAMIS Select demonstration populations include:

A. Demonstration Population I – FAMIS MOMS

FAMIS MOMS provides coverage to uninsured pregnant women in families with income up to and including 200 percent (plus a five percent income disregard) of the federal poverty level (FPL) who are not otherwise eligible for Medicaid. FAMIS MOMS also provides coverage to lawfully residing pregnant women and pregnant women with access to state employee health benefit coverage (in accordance with the hardship exception as provided in section 2110(bX6XC) of the Social Security Act (the Act)), thereby aligning the Commonwealth's coverage of pregnant women with the expansion of CHIP coverage to children of state employees. FAMIS MOMS coverage is the same as that provided to pregnant women under the Medicaid state plan. Under the demonstration, Virginia is also authorized to deem infants born to FAMIS MOMS to be eligible for Medicaid or CHIP coverage, as appropriate. FAMIS MOMS beneficiaries receive health care services primarily through one of the managed care organizations (MCOs) contracted by the Commonwealth to provide Medicaid and FAMIS (CHIP state plan) benefits.

B. Demonstration Population II – FAMIS Select

FAMIS Select provides premium assistance for private or employer-sponsored insurance to uninsured children, from birth through age 18, in families with income up to and including 200 percent (plus a five percent income disregard) of the FPL, who are eligible for direct CHIP coverage. These individuals are provided the option to receive premium assistance for private or employer-sponsored insurance and supplemental immunization benefits in lieu of receiving coverage under the CHIP state plan. However, these individuals still retain the right to elect to receive direct CHIP coverage instead at any time. FAMIS Select beneficiaries receive health care services through the private or employer-sponsored plan of choice.

Demonstration Objectives to be Evaluated

During the renewal period, the objectives of the demonstration to be evaluated are as follows:

FAMIS MOMS (Demonstration Population I):

- Facilitate access to prenatal care for FAMIS MOMS participants.
- Improve selected birth outcomes of FAMIS MOMS participants and their newborns.

FAMIS Select (Demonstration Population II):

- Facilitate access to affordable private and employer-sponsored health insurance for low-income families through premium assistance.
- Monitor and ensure member satisfaction with FAMIS Select program.
- Assure the aggregate cost-effectiveness of the FAMIS Select program.

Table 1. FAMIS MOMS and FAMIS Select Demonstration Evaluation Design

| <i>FAMIS MOMS</i> | | | | | |
|--|--|---|---|---|---|
| <i>Hypothesis I: The proportion of pregnant women enrolled in FAMIS MOMS who are receiving adequate or better prenatal care will be maintained or will increase from SFY 2019 to SFY 2029.</i> | | | | | |
| Research Question: | Outcome Measures: | Population: | Data Sources and Analytic Methods: | Benchmarks: | Subgroups: |
| Is enrollment in FAMIS MOMS enabling pregnant women to obtain better access to adequate prenatal care? | Births with Early and Adequate Prenatal Care— Percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index score greater than or equal to 80 percent | Live, singleton births to FAMIS MOMS during a given calendar year | Deterministic and probabilistic data matching are used to create dataset of linked fee-for-service claims, managed care encounters, enrollment records, and birth registry records. Chi-square tests used to assess statistical significance of year-over-year changes. | Healthy People 2030 goal <i>Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08</i> | -Age -Race/ -Ethnicity -Region |
| <i>Hypothesis II: The proportion of FAMIS MOMS enrolled in the FAMIS MOMS program with preterm births (less than 37 weeks gestation) will remain the same or will decrease from SFY 2019 to SFY 2029.</i> | | | | | |
| Research Question: | Outcome Measures: | Population: | Data Sources and Analytic Methods: | Benchmarks: | Subgroups: |
| Is enrollment in FAMIS MOMS improving birth outcomes of FAMIS MOMS participants? | Preterm Births (< 37 Weeks Gestation)— Percentage of births that occurred before 37 completed weeks of gestation | Live, singleton births to FAMIS MOMS during a given calendar year | Deterministic and probabilistic data matching are used to create dataset of linked fee-for-service claims, managed care encounters, enrollment records, and birth registry records. Chi-square tests used to assess statistical significance of year-over-year changes. | Healthy People 2030 goal <i>Reduce preterm births – MICH-07</i> | -Age -Race/ -Ethnicity -Region |

Hypothesis III: The rate of low birth weight births (birth weight less than 5 pounds, 8 ounces [2,500 grams]) among FAMIS MOMS will decline or remain the same over the demonstration period.

| Research Question: | Outcome Measures: | Population: | Data Sources and Analytic Methods: | Benchmarks: | Subgroups: |
|--|--|---|---|---|---|
| Is enrollment in FAMIS MOMS improving birth outcomes of FAMIS MOMS participants? | Newborns with Low Birth Weight (<2,500 grams)—The percentage of newborns weighing less than 2,500 grams at birth. This includes birth weights in the very low birth weight category (birth weights less than 1,500 grams) and the low birth weight category (birth weights between 1,500 and 2,499 grams). | Live, singleton births to FAMIS MOMS during a given calendar year | Deterministic and probabilistic data matching are used to create dataset of linked fee-for-service claims, managed care encounters, enrollment records, and birth registry records. Chi-square tests used to assess statistical significance of year-over-year changes. | CMS Child Core Set measure <i>Newborns with Low Birth Weight (<2,500 grams)</i> . Median and mean for state Medicaid programs in the most recent federal fiscal year | -Age -Race/ -Ethnicity -Region |

FAMIS Select

Hypothesis IV: FAMIS Select members’ families will report that they are satisfied with the service offered by the FAMIS Select program, a subsidy for private/employer-sponsored insurance.

| Research Question: | Outcome Measures: | Population: | Data Sources: | Analytic Methods: |
|---|---|---|--|--|
| Is the self-reported consumer experience of participants in FAMIS Select satisfactory? What do participants report can be improved? | Analysis of responses to focus group questions used to assess level of overall satisfaction | Parents/guardians of current FAMIS Select enrollees | Responses to focus group questions about consumers’ experiences with DMAS-operated components of the program, such as customer service, responsiveness to customer inquiries, and timely processing of subsidy payments. | Qualitative analysis of focus group material |

Hypothesis V: FAMIS Select families will report that they are able to access preventive services, use specialty healthcare services, and schedule timely appointments with preferred providers.

| Research Question: | Outcome Measures: | Population: | Data Sources: | Analytic Methods: |
|--|---|---|---|--|
| Do families report that children in FAMIS Select have a satisfactory level of access to health care services through their private or employer-sponsored insurance subsidized by FAMIS Select? | Analysis of responses to focus group questions used to assess level of access to health care services | Parents/guardians of current FAMIS Select enrollees | Responses to focus group questions about consumers’ perception of their child’s level of access to health care services and providers under their private or employer-sponsored health insurance plan, including access to preventive services and specialty healthcare services, and ability to schedule timely appointments with preferred providers. | Qualitative analysis of focus group material |

Hypothesis VI: The FAMIS Select program will be cost-effective as compared to the FAMIS program over the course of the demonstration year (state fiscal year)

| Research Question: | Outcome Measures: | Population: | Data Sources: | Analytic Methods: |
|---|---|---|---|---|
| Is the FAMIS Select program cost-effective? | Cost-effectiveness analysis (FAMIS Select-FAMIS comparison) | FAMIS Select enrollees during state fiscal year | Fee-for-service claims, managed care encounters and capitation payments, and enrollment records | Average per-enrollee, per-month cost and administrative expense associated with the FAMIS Select population, compared to the per-enrollee, per-month cost of providing the FAMIS benefit plan |

Demonstration Evaluation Design

FAMIS MOMS (Demonstration Population I)

Methodology

For the FAMIS MOMS demonstration evaluation, Virginia will employ the dataset from the annual Birth Outcomes Study conducted by DMAS' contractor.¹ The dataset is created by the contractor and DMAS subject matter experts using deterministic and probabilistic data linking to match FAMIS MOMS members with birth registry records, thereby identifying births paid by Virginia Medicaid/CHIP during a given calendar year. Member claims and encounter data files are matched with birth registry data fields for members from each of the data linkage processes. All probabilistically or deterministically linked birth registry records are included in the eligible study population. The eligible population included in the demonstration evaluation dataset will consist of FAMIS MOMS who gave birth during a given calendar year. A birth will be included if the member was enrolled in FAMIS MOMS on the date of delivery, regardless of whether the birth occurred in Virginia. The birth registry contains records of live births; other pregnancy outcomes will be excluded from the dataset used to calculate the evaluation measures. Since multiple gestation births are subject to different clinical guidelines, results will be limited to singleton births, defined using the Plurality field in the birth registry data.

For each of the three FAMIS MOMS evaluation measures, DMAS will report year over year comparisons. Chi-square tests will be used to determine whether statistically significant differences are observed between the prior year and current year's measures. For national benchmark comparisons of measures I and II (Births with Early and Adequate Prenatal Care and Preterm Births), DMAS proposes to use baseline and target data from the Healthy People 2030 goals. (Baselines are drawn from nationwide vital statistics from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) National Vital Statistics System (NVSS)).² For the Newborns with Low Birth Weight measure, DMAS proposes to use the CMS Core Set benchmark for the federal fiscal year that corresponds to the calendar year of the Birth Outcomes Study (e.g., FFY2019 Child Core Set benchmark for CY2019 Birth Outcomes Study measure).³ In annual and semiannual monitoring reports, DMAS will present additional supplemental analysis as appropriate to provide context for the reported outcomes, such as data on key maternal demographic characteristics (race/ethnicity, geographic region) and other relevant information (managed care vs. fee-for-service enrollment, timing and duration of enrollment).

¹ Currently the Birth Outcomes Study is conducted by DMAS' External Quality Review Organization (EQRO).

² Healthy People 2030, "Pregnancy and Childbirth." U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth>. Accessed January 4, 2021.

³ See, for example, "Performance on the Child Core Set Measures, FFY 2019." Child Health Care Quality Measures, Centers of Medicare & Medicaid Services, Oct. 2020. Available at <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

Limitations

Analysis requires matching two data sources without a common unique identifier: 1) Medicaid enrollment data, and 2) birth records. Using this methodology enables DMAS to monitor outcomes not present in claims data such as gestational age, more comprehensive prenatal records, and birth weight. However, we may be underestimating the impact from mothers without Social Security numbers, the most common unique identifier in a deterministic match. DMAS has conducted analysis to determine likelihood of capturing a delivery through birth records and has confirmed that the match is sufficient for generalization.

Another limitation of our data is the limited sample size of the FAMIS MOMS population, which is typically no more than 1,650 members. Small sample sizes create challenges when conducting more complex models, or conducting analyses on subgroups, such as comparing women across race/ethnicities. Therefore, DMAS has concluded that all subpopulations should be grouped into the largest meaningful category and statistical tests limited to chi-squares.

Measure specifications and benchmarks for each measure are described in detail below.

Demonstration Goal: *Facilitate access to prenatal care for FAMIS MOMS participants.*

Research Question: *Is enrollment in FAMIS MOMS enabling pregnant women to obtain better access to adequate prenatal care?*

Hypothesis I: The proportion of pregnant women enrolled in FAMIS MOMS who are receiving adequate or better prenatal care will be maintained or will increase from SFY 2019 to SFY 2029.

Measure I: Births with Early and Adequate Prenatal Care—The percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index score greater than or equal to 80 percent (i.e., births scoring in the “Adequate” or “Adequate Plus” categories)

| | |
|-------------|---|
| Measure 1 | Percentage of FAMIS MOMS Participants Receiving Adequate or Adequate Plus Prenatal Care as Defined by APNCU Index |
| Numerator | Number of Births to FAMIS MOMS Participants Who Received Adequate or Adequate Plus Prenatal Care |
| Denominator | Number of FAMIS MOMS Participants with Births During the Calendar Year* |

* Numerator and denominator are limited to live, singleton births during the calendar year.

Measure I Description, Specifications and Benchmarks: Data for Measure I will come from fee-for-service claims, managed care encounters, enrollment records, and birth registry data to determine eligibility group and prenatal visit utilization. As described above, the dataset will include live, singleton births to FAMIS MOMS during a given calendar year.

Adequate prenatal care will be defined using the Adequacy of Prenatal Care Utilization (APNCU) Index, also known as the Kotelchuck Index. The adequacy of prenatal care received during pregnancy has been associated with lower incidence of poor birth outcomes, such as preterm delivery and low-birth-weight births.⁴ The APNCU Index uses birth certificate information to assess prenatal care in relation to two separate and distinct components. First, it measures at what point in the pregnancy a mother initiated prenatal care. Second, the index considers the number of prenatal visits throughout the pregnancy. The two components are combined into a single prenatal care utilization composite score. Higher composite scores on the APNCU Index are assigned to women who initiate prenatal care early in pregnancy and complete at least 80 percent of the visits expected based on the time frame, adjusted for gestational age at prenatal care initiation and the infant’s gestational age at delivery.⁵

The table below shows the composite score categories and criteria defining each category.

APNCU Index Criteria for Adequacy of Prenatal Care

| APNCU Index Category | Index Criteria |
|----------------------|--|
| Adequate Plus | Prenatal care initiated by the fourth month of pregnancy and 110% or more of expected visits received |
| Adequate | Prenatal care initiated by the fourth month of pregnancy and 80% to 109% of expected visits received |
| Intermediate | Prenatal care initiated by the fourth month of pregnancy and 50 to 79% of expected visits received |
| Inadequate | Prenatal care initiated after the fourth month of pregnancy or less than 50% of expected visits received |

DMAS will use the annual baseline identified in the Healthy People 2030 goal “Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08”—which uses data derived from the CDC, NCHS, NVSS, for the Births with Early and Adequate Prenatal Care measure—for each year corresponding to the calendar year of the Birth Outcomes Study. Healthy People 2030 published a national baseline in which 76.4 percent of women received early and adequate prenatal care during 2018, with an initial goal of 80.5 percent and a

⁴ Krueger PM, Scholl TO. Adequacy of prenatal care and pregnancy outcome. *The Journal of the American Osteopathic Association*. 2000; 100(8):485–492.

⁵ Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. *American Journal of Public Health*. 1994; 84(9):1414–1420.

1 percentage point improvement for each year.⁶ DMAS will compare study indicator findings for 2018 to the Healthy People 2030 baseline goal of 76.4 percent and will adjust the target goal on an annual basis.

Virginia has been using the APNCU to measure adequacy of prenatal care for pregnant women across the Medicaid programs. Using this index as one of the measures for the FAMIS MOMS evaluation will enable DMAS to compare adequacy of prenatal care rates to other pregnant women’s aid categories and identify disparities that may exist across programs, or findings from the strengths of one program that can be implemented in other programs.

DMAS will conduct additional analysis as appropriate, such as stratification of outcomes by geography, race and ethnicity, managed care enrollment, etc., to better understand and address trends that may disproportionately affect subgroups, and/or collection of additional input from current enrollees, case managers, providers, and managed care organization staff and to identify opportunities for improvement.

Demonstration Goal: *Improve selected birth outcomes of FAMIS MOMS participants and their newborns.*

Research Question: *Is enrollment in FAMIS MOMS improving birth outcomes of participants?*

Hypothesis II: The proportion of individuals enrolled in the FAMIS MOMS program with preterm births (less than 37 weeks gestation) will remain the same or will decrease from SFY 2019 to SFY 2029.

Measure II: Preterm Births (< 37 Weeks Gestation)—The percentage of births that occurred before 37 completed weeks of gestation

| | |
|-------------|---|
| Measure 2 | Rate of preterm birth for FAMIS MOMS |
| Numerator | Number of live, singleton births to FAMIS MOMS born prior to 37 completed weeks gestation |
| Denominator | Total number of live, singleton births to FAMIS MOMS |

⁶ Healthy People 2030. “Increase the proportion of pregnant women who receive early and adequate prenatal care – MICH-08.” U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08>. Accessed on January 5, 2021.

Measure II Description, Specifications and Benchmarks: Data for Measure II will come from eligibility and enrollment records along with birth registry records for live births. Eligibility and enrollment records of FAMIS MOMS will be linked with birth registry records through probabilistic and deterministic matching in order to identify births to FAMIS MOMS members during the relevant evaluation year. Preterm births will be defined as any live birth occurring before 37 weeks gestation.

In order to evaluate incidence of preterm births among the FAMIS MOMS population over time, DMAS will monitor year-over-year percentage changes. DMAS will conduct further investigation as appropriate, such as geographic, provider, and co-morbidity analyses. Preterm birth (defined as birth prior to 37 weeks) is a common measure reported not only for other Virginia Medicaid populations, but also by other states’ Medicaid programs and for other comparable populations. This commonality enables Virginia to compare rates seen among the FAMIS MOMS population to other internal and national benchmarks.

DMAS will use the Healthy People 2030 goal “Reduce preterm births—MICH-07” as a national benchmark for the preterm births measure. Healthy People 2030 published a national baseline in which 10.0 percent of live births were preterm in 2018, with an initial goal of no more than 9.4 percent of live births being preterm.⁷ DMAS will compare FAMIS MOMS performance on this measure to the Healthy People 2030 goal of 9.4 percent and will reassess the benchmark value on an annual basis.

Hypothesis III: The rate of low birth weight births (birth weight less than 5 pounds, 8 ounces (2,500 grams)) among FAMIS MOMS will decline or remain the same over the demonstration period.

Measure III: Newborns with Low Birth Weight (<2,500 grams)—The percentage of newborns weighing less than 2,500 grams at birth. This includes birth weights in the very low birth weight category (birth weights less than 1,500 grams) and the low birth weight category (birth weights between 1,500 and 2,499 grams).

| | |
|-----------|---|
| Measure 3 | Infants born with low birth weight (weight < 2,500 grams) |
|-----------|---|

⁷ Healthy People 2030. “Reduce preterm births— MICH-07.” U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07>. Healthy People 2030 baseline is derived from NVSS reports. Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final Data for 2018. National Vital Statistics Reports. 2019; 68(13). Hyattsville, MD: National Center for Health Statistics. 2019. Available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.

| | |
|-------------|---|
| Numerator | Number of infants born to FAMIS MOMS with a birth weight less than 5 pounds, 8 ounces (2,500 grams) |
| Denominator | Total number of live, singleton births to FAMIS MOMS |

Measure III Description, Specifications and Benchmarks: Data for Measure III will come from enrollment records along with birth registry records for live births. Eligibility and enrollment records of FAMIS MOMS will be linked with birth registry records through probabilistic and deterministic matching in order to identify births to FAMIS MOMS members during the relevant evaluation year. Low birth weight will be defined as birth weight less than 2,500 grams.

In order to evaluate incidence of low birth weight infants born to FAMIS MOMS over time, DMAS will monitor year-over-year percentage changes. The number of live births to FAMIS MOMS with a gestational weight less than 2,500g will be compared to the total number of live births to FAMIS MOMS in a given year.

Low birth weight is a common measure reported not only for other Virginia Medicaid populations, but also by other state Medicaid programs and for other comparable populations. This commonality enables Virginia to compare rates seen among the FAMIS MOMS population to other internal and national benchmarks. Virginia will analyze the change in rates of low birth weight births and will conduct further investigation, such as geographic, provider, and co-morbidity analyses as appropriate.

As a benchmark for the FAMIS MOMS evaluation’s newborns with low birth weight measure, DMAS will use the CMS Child Core Set measure Newborns with Low Birth Weight (<2,500 grams). An update is released annually and includes data for all states and Washington, D.C., for Medicaid/CHIP populations.⁸ DMAS will compare evaluation data with the reported median and mean for state Medicaid programs in the most recent federal fiscal year for which data are available at the time of reporting.

FAMIS Select (Demonstration Population II)

Methodology

For the FAMIS Select evaluation, DMAS will conduct focus groups with FAMIS Select participants’ adult family members to gain an understanding of how the members’ families believe the program is working for their child. Due to concerns regarding the current public health emergency and social distancing requirements, DMAS believes virtual focus groups will be the most effective and efficient method of gathering input from FAMIS Select members’ family members. Additionally, resources are significantly limited at this time.

⁸ “Performance on the Child Core Set Measures, FFY 2019.” Child Health and Quality Measures, Centers of Medicare & Medicaid Services, Oct. 2020. Available at <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

Questions will be grouped into two categories. One category of questions will aim to understand consumers' experiences with DMAS-operated components of the program, such as customer service, responsiveness to customer inquiries, and timely processing of subsidy payments. Questions will aim to identify customer service issues or other shortcomings or strengths of the DMAS-operated aspects of the FAMIS Select program. The second category of questions will aim to understand consumers' perception of their level of access to health care services and providers under their private or employer-sponsored health insurance plan. For both categories, focus groups will gauge consumer satisfaction and identify challenges encountered by FAMIS Select participants and ways the program could be improved. Focus group structure will also allow members to discuss additional items as introduced by other group members from discussion.

The FAMIS Select evaluation is qualitative in nature due to the limited size of the program. In future years, should the FAMIS Select population grow in size, more complex sampling strategies may be explored. The study population will consist of children enrolled in FAMIS Select for one or more months. DMAS will contact parents/guardians of FAMIS Select participants as part of this evaluation (current enrollment is approximately 50 children) and seek to include the family members in focus groups. Based on past experience with outreach to participants in this program, DMAS anticipates that we will be able to complete two focus groups, representing approximately 20 percent of participating families.

The focus group prompts will be refined in consultation with DMAS subject matter experts. The focus groups will be administered and data compiled and analyzed by DMAS staff following the proposed timeline attached. DMAS staff with training and background in focus group design, evaluation, and analysis will be consulted regarding content and analysis of responses.

Limitations

In SFY2018, there were an estimated 102 enrollees covered under the FAMIS Select demonstration. This falls well short of the criteria for having at least 500 potential enrollees needed to include a comparison group in the evaluation, based on CMS' Modified Evaluation Design for the Section 1115 Demonstration expanding Title XXI coverage. Most recently, the program included 50 children, with enrollment often dipping below even the 30 necessary to draw minimal statistical inferences. Therefore, DMAS will focus our efforts on gathering high quality qualitative data to determine our members' satisfaction with the program and identify potential barriers or areas of improvement.

Descriptions of each measure are provided in detail below.

Demonstration Goal: Monitor and ensure member satisfaction with the FAMIS Select program.

Research Questions:

Is the self-reported consumer experience of participants in FAMIS Select satisfactory? What do participants report can be improved?

Hypothesis IV: FAMIS Select members' families will report that they are satisfied with the service offered by the FAMIS Select program, a subsidy for private/employer-sponsored insurance.

Measure IV: Analysis of responses gathered in focus groups with families of current FAMIS Select enrollees

Measure IV Description: Data for Measure IV will come from focus groups with FAMIS Select participants conducted by Virginia DMAS staff. Group questions will aim to understand consumers' experiences with DMAS-operated components of the program, such as customer service, responsiveness to customer inquiries, and timely processing of subsidy payments. Questions will aim to identify customer service issues or other shortcomings or strengths of the DMAS-operated aspects of FAMIS Select.

Focus group responses will be systematically categorized into themes using dynamic methods to determine general satisfaction or dissatisfaction with the FAMIS Select program. Independent coders will determine relevant attributes and synthesize data to assign satisfaction levels as "not satisfied," "somewhat satisfied," "satisfied," and "very satisfied."

Demonstration Goal: Monitor and ensure member satisfaction with the FAMIS Select program.

Research Question: Do families report that children in FAMIS Select have a satisfactory level of access to health care services through their private or employer-sponsored insurance subsidized by FAMIS Select?

Hypothesis V: FAMIS Select families will report that they are able to access preventive services, use specialty healthcare services, and schedule timely appointments with preferred providers under their private or employer-sponsored insurance that is subsidized by FAMIS Select.

Measure V: Analysis of responses gathered in focus groups with families of current FAMIS Select enrollees

Measure V Description: Data for Measure V will come from focus groups with FAMIS Select participants conducted by Virginia DMAS staff. Focus group questions will aim to understand consumers' perception of their child's level of access to health care services and providers under their private or employer-sponsored health insurance plan, including access to preventive services and specialty healthcare services, and ability to schedule timely appointments with preferred providers.

Group responses will be systematically categorized into themes using dynamic methods to determine accessibility of healthcare services for members participating in the FAMIS Select program. Independent coders will determine relevant attributes and synthesize data to assign healthcare service accessibility levels as “not accessible,” “somewhat accessible,” “accessible,” and “very accessible.”

Demonstration Goal: Assure the aggregate cost-effectiveness of the FAMIS Select program

Research Question: Is the FAMIS Select program cost-effective?

Hypothesis VI: The FAMIS Select program will be cost-effective as compared to the FAMIS program over the course of the demonstration year (state fiscal year)

Measure VI: Cost-effectiveness analysis (FAMIS Select-FAMIS comparison)

Measure VI Description: Data for Measure VI will come from fee-for-service claims, managed care encounters and capitation payments, and enrollment records.

As required in STC #22 and consistent with 2105(c)(3) of the Social Security Act, DMAS monitors FAMIS Select program expenditures to ensure cost effectiveness. Specifically, DMAS compares the agency's cost to subsidize the purchase of employer-sponsored insurance to the amount of expenditures, including administrative expenditures, that the state would have made to provide comparable coverage to the targeted low-income child or family involved under the state child health plan, FAMIS.

Cost-effectiveness will be assessed by calculating the average per-enrollee, per-month cost and administrative expense associated with the FAMIS Select enrolled population, compared to the per-enrollee, per-month cost of providing the FAMIS benefit plan.

EVALUATION TIMELINE

FAMIS MOMS Annual Evaluation Timeline for the Demonstration Year

| Task | Date |
|--|-------------------------------------|
| DMAS and subject matter experts, including EQRO, develop requirements for quantitative analyses of prior calendar year data | April-July |
| DMAS submits member, eligibility, enrollment, and claims/encounter data through June vendor files to EQRO | July |
| EQRO processes, loads, and validates data through June vendor files received from DMAS | July |
| DMAS obtains linked Birth Registry data from prior calendar year and submits files to EQRO | June-August |
| EQRO and DMAS SMEs conduct file review and resolve any questions or concerns | August |
| EQRO calculates and validates Birth Outcomes Study indicators and stratification categories | August-September |
| EQRO generates and validates Birth Outcomes Study analytic tables and figures | October |
| EQRO generates and validates analytic dataset and corresponding data dictionary | October-December |
| EQRO submits draft report to DMAS | October-November |
| DMAS provides feedback and EQRO incorporates into report | November-December |
| EQRO submits final Birth Outcomes Study report and analytic dataset to DMAS | December-January |
| DMAS conducts supplemental analysis of the FAMIS MOMS data, such as subgroup analyses, as appropriate | January-April |
| DMAS delivers semi-annual report to CMS, to include reporting of the FAMIS MOMS evaluation metrics described in this document (drawn from Birth Outcomes Study analysis). (Example: Semiannual report for April 29, 2021 will incorporate FAMIS MOMS birth outcomes data from Calendar Year 2019) | No later than April 29 of each year |

FAMIS Select Annual Evaluation Timeline for the Demonstration Year

DMAS proposes that this focus groups be conducted annually with FAMIS Select participating families.

| Task | Date |
|--|----------------------------|
| Finalize focus group questions in consultation with CMS and DMAS subject matter experts | January-February |
| DMAS staff contact parent/caretaker of each child member to request and conduct focus groups (based on member experience over the past year of enrollment) | February-March |
| Second round of calls to parents/caretakers for second focus group | March-May |
| DMAS compiles and analyzes results | June-July |
| DMAS composes update on FAMIS Select Evaluation incorporating results | July-September |
| DMAS delivers annual report to CMS, to include reporting of the FAMIS Select evaluation metrics described in this document for the prior calendar year | No later than September 28 |

* As of end of April 2021, DMAS did not have an approved evaluation design. Therefore, focus group data may not be included and analyzed for September 2021 report due to time constraints.

FAMIS MOMS and FAMIS Select Demonstration Milestones (per STC 38)

| Task | Date |
|--|---|
| DMAS delivers Draft Interim Evaluation Report for the period July 2019-June 2022. | No later than June 30, 2023 |
| DMAS delivers Final Interim Evaluation Report for the period July 2019-June 2022; DMAS posts final document and any supporting documents on DMAS website. | No later than 60 days after receiving CMS comments on the Draft Interim Evaluation Report |
| DMAS delivers Draft Interim Evaluation Report for the period July 2019-June 2024. | No later than June 30, 2025 |
| DMAS delivers Final Interim Evaluation Report for the period July 2019-June 2024; DMAS posts final document and any supporting documents on DMAS website. | No later than 60 days after receiving CMS comments on the Draft Interim Evaluation Report |
| DMAS delivers Draft Interim Evaluation Report for the period July 2019-June 2027. (Draft Interim Evaluation Report will accompany Application for Demonstration Extension, if applicable, and will be posted to the Commonwealth’s public website, along with the application, for public comment.) | No later than June 30, 2028 |
| DMAS delivers Final Interim Evaluation Report for the period July 2019-June 2027; DMAS posts final document and any supporting documents on DMAS website. | No later than 60 days after receiving CMS comments on the Draft Interim Evaluation Report |
| DMAS delivers Draft Summative Evaluation Report for the demonstration period (July 2019-June 2029) | No later than December 30, 2030 |
| DMAS delivers Final Summative Evaluation Report for the demonstration period (July 2019-June 2029) | No later than 60 days after receiving CMS comments on the Draft Summative Evaluation Report |
| DMAS posts Final Summative Evaluation Report to the Commonwealth’s website | Within 30 calendar days of approval by CMS. |

EVALUATION BUDGET

The data for Measures I through III are collected as part of the process for the annual Birth Outcomes Study conducted by DMAS' External Quality Review Organization (EQRO). Additional analysis as well as monitoring and reporting tasks will be conducted in-house by DMAS staff and are not expected to incur additional costs.

Given the uncertainty posed by the COVID-19 public health emergency, for Measures IV and V DMAS has intentionally limited data collection methods in the draft evaluation plan to virtual focus groups conducted by DMAS staff. In the future, DMAS could potentially revisit this decision and consider hosting in-person interviews and/or focus groups onsite at the DMAS offices, conducted by DMAS staff. We do not expect any additional staffing or contract costs attributable to the evaluation. DMAS will continue to provide updated information regarding program enrollment and will work with CMS to revise the evaluation plan and budget for FAMIS Select if necessary.

Data for Measure VI are gathered and analyzed internally by DMAS Budget and Data Analytics staff.

