

Virginia CARTS FY2021 Report

Basic State Information

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

1. State or territory name:

Virginia

2.

Program type:

- Both Medicaid Expansion CHIP and Separate CHIP
- Medicaid Expansion CHIP only
- Separate CHIP only

3. CHIP program name(s):

Family Access to Medical Insurance Security (FAMIS)

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

4. Contact name:

Hope Richardson

5. Job title:

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7. Full mailing address:

Include city, state, and zip code.

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8. Phone number:

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PRA Disclosure Statement.

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

Program Fees and Policy Changes

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

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

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

Yes

No

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

N/A

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

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

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

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

1.

Does your program charge an enrollment fee?

Yes

No

2.

Does your program charge premiums?

Yes

No

3.

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

Yes

No

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

N/A

5.

Which delivery system(s) do you use?

Select all that apply.

Managed Care

Primary Care Case Management

Fee for Service

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

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

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

- Yes
- No
- N/A

2.

Have you made any changes to the eligibility redetermination process?

- Yes
- No
- N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A

6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to the substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

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

Yes

No

N/A

11.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

Yes

No

N/A

12.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

13.

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

- Yes
- No
- N/A

14.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

- Yes
- No
- N/A

15.

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

- Yes
- No
- N/A

16.

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

Yes

No

N/A

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

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

18.

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

- Yes
- No
- N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that

do require a SPA.

1.

Have you made any changes to the eligibility determination process?

Yes

No

N/A

2.

Have you made any changes to the eligibility redetermination process?

Yes

No

N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

Yes

No

N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

Yes

No

N/A

5.

Have you made any changes to the single streamlined application?

Yes

No

N/A

6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

Yes

No

N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

Yes

No

N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

Yes

No

N/A

9.

Have you made any changes to substitution of coverage policies?

For example: removing a waiting period.

Yes

No

N/A

10.

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

Yes

No

N/A

11.

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

Yes

No

N/A

12.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

Yes

No

N/A

13.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

Yes

No

N/A

14.

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

Yes

No

N/A

15.

Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

16.

Have you made any changes to your Pregnant Women State Plan expansion?

For example: expanding eligibility or changing this population's benefit package.

Yes

No

N/A

17.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

Yes

No

N/A

18.

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

Yes

No

N/A

19.

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

Yes

No

N/A

20.

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

Yes

No

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

Through a 2020 CHIP Disaster SPA and other federal and state authorities, DMAS has enabled emergency flexibilities during the COVID-19 public health emergency, including accommodations for extended application and renewal processing timelines. No closures or adverse actions will be taken on enrollees through the end of the emergency unless a death is reported, an enrollee moves from Virginia permanently, or an enrollee requests closure of coverage.* Appeals flexibilities include an extension for the timeframe to file client appeals; an extension of provider appeal timeframes; automatic continuation of coverage during client appeals when the action involves a denial, reduction, or termination of existing eligibility or service; hearings conducted by telephone and client appeal reschedule requests automatically granted when the appellant misses a scheduled hearing. DMAS has also issued guidance around allowances for 90-day fills on prescriptions and streamlined service authorization processes. Virginia Medicaid and CHIP are providing full coverage of COVID-19 testing and treatment in compliance with federal mandate. Outreach is being conducted largely through electronic/remote modalities. Regarding item 15 above, Virginia's "unborn child" CHIP SPA, extending coverage to our new FAMIS Prenatal members, became effective July 1, 2021. * NOTE: Federal continuity of coverage requirements do not apply to lawfully residing non-citizen pregnant women and children under age 19. Additionally, the continuity of coverage requirements do not apply to FAMIS MOMS pregnant women whose sixty (60) day postpartum period has ended (as of FFY2021), or FAMIS children turning 19. CHIPRA-214 individuals described above, individuals turning 19, or FAMIS MOMS reaching the end of their 60 days postpartum (as of FFY2021) are re-determined and enrolled in other coverage or, if no longer eligible, referred to Marketplace coverage.

Enrollment and Uninsured Data

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2020	Number of children enrolled in FFY 2021	Percent change
Medicaid Expansion CHIP	63,796	117,272	83.823%
Separate CHIP	36,495	103,959	184.858%

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

On a monthly basis (average monthly enrollment over the course of the year) our enrollment numbers have grown year-over-year for both our separate CHIP program and our Medicaid Expansion CHIP program. Enrollment in Medicaid Expansion CHIP in particular has grown during the COVID-19 pandemic. We will check the SEDS data; it is possible that there is an error or that updates are needed.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection

of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2016	54,000	6,000	2.8%	0.3%
2017	51,000	6,000	2.6%	0.3%
2018	48,000	5,000	2.5%	0.3%
2019	40,000	5,000	2.1%	0.3%
2020	Not Answered	Not Answered	Not Answered	Not Answered

Percent change between 2019 and 2020
Not Available

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

2.

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

Yes

No

3.

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

Yes

No

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

5.

Optional: Attach any additional documents here.

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

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

Browse...

Eligibility, Enrollment, and Operations

Program Outreach

1.

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

Yes

No

2.

Are you targeting specific populations in your outreach efforts?

For example: minorities, immigrants, or children living in rural areas.

Yes

No

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

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

For 20 years, the most effective outreach strategy employed by DMAS in reaching children has always been the annual FAMIS Back-To-School (BTS) campaign. This year, we continued to adapt our outreach strategies in response to the COVID-19 public health emergency. Working in close partnership with the Virginia Department of Education, we made our outreach more flexible and virtual than in previous years. We shipped 1.3 million flyers to every public school in the state (1,800-plus, including elementary, middle and high schools) with a request that flyers be distributed through the end of the calendar year instead of just included as a single distribution in first-day-of-school packets. Again this year, we were also able to include a banner placed across the BTS flyers announcing that parents might also be eligible for adult coverage. Several campaigns were launched in 2021 to include the 40 Quarters campaign and mailing, FAMIS Prenatal Coverage, and New Adult Dental Coverage. The targeted mailings have been the most effective in reaching these populations.

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

Outreach efforts have grown significantly over the past year. Outreach to immigrant populations has been a continued topic of conversation, but has taken off with better messaging, print materials available in more languages, a mirror-image Spanish Cover Virginia website, and ads also running in Spanish on social media. Targeting outreach to various populations tends to provide more information than if it were added to a rollout of other outreach topics, drive more interest, and allows for a specific period of time to be spent focused on that population. The Community Outreach and Member Engagement Team (COMET) has added a new Outreach and Community Engagement Manager and an Outreach and Community Engagement Specialist to modernize, streamline, and develop innovative approaches to outreach across the Commonwealth. The Manager is in the process of hiring community outreach coordinators for the central and southwest regions as well as an additional graphic designer to support the outreach team's efforts anticipating the wind-down of the federal public health emergency. Filling these roles will help the division to increase outreach efforts and reach more current and potential Medicaid and FAMIS members.

5.

Optional: Attach any additional documents here.

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

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

Eligibility, Enrollment, and Operations

Substitution of Coverage

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

1.

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

- Yes
- No
- N/A

2.

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

- Yes
- No
- N/A

%

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

Data are not available for #3 above.

6.

Optional: Attach any additional documents here.

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

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

Eligibility, Enrollment, and Operations

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1.

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

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

- Yes
- No
- N/A

2.

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

Yes

No

3.

Do you send renewal reminder notices to families?

Yes

No

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

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

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

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

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

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

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

Part 2: CHIP Eligibility Denials (Not Redetermination)

1.

How many applicants were denied CHIP coverage in FFY 2021?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

2.

How many applicants were denied CHIP coverage for procedural reasons?

For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

3.

How many applicants were denied CHIP coverage for eligibility reasons?

For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

3a.

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

4.

How many applicants were denied CHIP coverage for other reasons?

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

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

Table: CHIP Eligibility Denials (Not Redetermination)

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

Type	Number	Percent
Total denials	Not Answered	Not Answered
Denied for procedural reasons	Not Answered	Not Answered
Denied for eligibility reasons	Not Answered	Not Answered
Denials for other reasons	Not Answered	Not Answered

Part 3: Redetermination in CHIP

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

1.

How many children were eligible for redetermination in CHIP in FFY 2021?

2.

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

3.

How many children were retained in CHIP after redetermination?

4.

How many children were disenrolled in CHIP after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

Computed:

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b.

How many children were disenrolled for eligibility reasons?

This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c.

How many children were disenrolled for other reasons?

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

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

Table: Redetermination in CHIP

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	Not Answered	Not Answered
Children retained after redetermination	Not Answered	Not Answered
Children disenrolled after redetermination	Not Answered	Not Answered

Table: Disenrollment in CHIP after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	Not Answered	Not Answered
Children disenrolled for procedural reasons	Not Answered	Not Answered
Children disenrolled for eligibility reasons	Not Answered	Not Answered
Children disenrolled for other reasons	Not Answered	Not Answered

Part 4: Redetermination in Medicaid

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

1.

How many children were eligible for redetermination in Medicaid in FFY 2021?

2.

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

3.

How many children were retained in Medicaid after redetermination?

4.

How many children were disenrolled in Medicaid after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

Computed:

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b.

How many children were disenrolled for eligibility reasons?

This could be due to an income that was too high and/or eligibility in CHIP instead.

4c.

How many children were disenrolled for other reasons?

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

Due to limitations in the data captured through our renewal processes, we are unable to report on #1-4 at this time.

Table: Redetermination in Medicaid

These tables are auto-populated with the data you entered above.

Type	Number	Percent
Children screened for redetermination	Not Answered	Not Answered
Children retained after redetermination	Not Answered	Not Answered
Children disenrolled after redetermination	Not Answered	Not Answered

Table: Disenrollment in Medicaid after Redetermination

Type	Number	Percent
Children disenrolled after redetermination	Not Answered	Not Answered
Children disenrolled for procedural reasons	Not Answered	Not Answered
Children disenrolled for eligibility reasons	Not Answered	Not Answered
Children disenrolled for other reasons	Not Answered	Not Answered

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

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

Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort): included in 2020 report.

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

719

967

1127

581

July - September 2020 (6 months later): included in 2020 report.

4.

How many children were continuously enrolled in CHIP six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

581

731

889

463

5.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

5

7

6

3

6.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

4

6

6

2

7.

How many children were no longer enrolled in CHIP six months later?

Possible reasons for no longer being enrolled:
b" Transferred to another health insurance program other than CHIP
b" Didn't meet eligibility criteria anymore
b" Didn't complete documentation
b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

133

229

232

115

8.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

119

208

212

102

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

January - March 2021 (12 months later): to be completed this year.

This year, please report data about your cohort for this section

10.

How many children were continuously enrolled in CHIP 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

531

628

765

405

11.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

12

20

17

9

12.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

11

17

16

7

13.

How many children were no longer enrolled in CHIP 12 months later?

Possible reasons for not being enrolled:
b" Transferred to another health insurance program other than CHIP
b" Didn't meet eligibility criteria anymore
b" Didn't complete documentation
b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

179

330

356

171

14.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

152

298

324

156

July - September of 2021 (18 months later): to be completed this year

This year, please report data about your cohort for this section.

15.

How many children were continuously enrolled in CHIP 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

427

563

715

368

16.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

22

31

28

15

17.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

21

27

26

12

18.

How many children were no longer enrolled in CHIP 18 months later?

Possible reasons for not being enrolled:
b" Transferred to another health insurance program other than CHIP
b" Didn't meet eligibility criteria anymore
b" Didn't complete documentation
b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

278

389

398

203

19.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

236

350

363

184

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

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2021. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 must be born after March 2004.

1.

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

Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

Yes

No

January - March 2020 (start of the cohort): included in 2020 report

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

10411

5782

6541

3229

July - September 2020 (6 months later): included in 2020 report

You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

4.

How many children were continuously enrolled in Medicaid six months later?

Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

10120

5516

6248

3062

5.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

26

45

52

32

6.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

13

17

25

17

7.

How many children were no longer enrolled in Medicaid six months later?

Possible reasons for no longer being enrolled:
b" Transferred to another health insurance program other than Medicaid
b" Didn't meet eligibility criteria anymore
b" Didn't complete documentation
b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

265

222

245

139

8.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

128

116

132

76

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

January - March 2021 (12 months later): to be completed this year

This year, please report data about your cohort for this section.

10.

How many children were continuously enrolled in Medicaid 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

9989

5361

6097

2981

11.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

64

107

100

57

12.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

34

67

63

40

13.

How many children were no longer enrolled in Medicaid 12 months later?

Possible reasons for not being enrolled:
b" Transferred to another health insurance program other than Medicaid
b" Didn't meet eligibility criteria anymore
b" Didn't complete documentation
b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

482

374

410

224

14.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

201

198

215

122

July - September of 2021 (18 months later): to be completed next year

This year, please report data about your cohort for this section.

15.

How many children were continuously enrolled in Medicaid 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

9727

5215

5961

2912

16.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

124

150

157

73

17.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

91

106

110

54

18.

How many children were no longer enrolled in Medicaid 18 months later?

Possible reasons for not being enrolled:
b" Transferred to another health insurance program other than Medicaid
b" Didn't meet eligibility criteria anymore
b" Didn't complete documentation
b" Didn't pay a premium or enrollment fee

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

684

477

489

277

19.

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

Ages 0-1

Ages 1-5

Ages 6-12

Ages 13-16

300

224

231

141

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

Eligibility, Enrollment, and Operations

Cost Sharing (Out-of-Pocket Costs)

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

1.

Does your state require cost sharing?

Yes

No

2.

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

- Families ("the shoebox method")
- Health plans
- States
- Third party administrator
- Other

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

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

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

0

5.

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

Yes

No

6.

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

Yes

No

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

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

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

N/A

9.

Optional: Attach any additional documents here.

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

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

Eligibility, Enrollment, and Operations

Employer Sponsored Insurance and Premium Assistance

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

1.

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

Yes

No

1.

Under which authority and statutes does your state offer premium assistance?

Check all that apply.

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

2.

Does your premium assistance program include coverage for adults?

- Yes
- No

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

This only applies to states operating an 1115 demo.

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

4.

Does your premium assistance program provide wrap-around coverage for gaps in coverage?

This only applies to states operating an 1115 demo.

Yes

No

N/A

5.

Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?

This only applies to states operating an 1115 demo.

Yes

No

N/A

6.

Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?

This only applies to states operating an 1115 demo.

Yes

No

N/A

7.

How many children were enrolled in the premium assistance program on average each month in FFY 2021?

43

8.

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

\$ 100

9.

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

\$

10.

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

\$

Table: Coverage breakdown

Child

State	Employer	Employee
100	Not Answered	Not Answered

11.

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

Average Monthly Contribution

Starts at

\$ 0



Ends at

\$ 100

12.

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

Average Monthly Contribution

Starts at

\$ 0



Ends at

\$ 0

13.

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

Federal Poverty Levels

Starts at



Ends at

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

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

15. What challenges did you experience with your premium assistance program in FFY 2021?

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

16. What accomplishments did you experience with your premium assistance program in FFY 2021?

Virginia's revised Section 1115 demonstration evaluation plan for FAMIS Select was approved November 3, 2021, and DMAS is now working to complete annual evaluation tasks for the upcoming reporting period.

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

Data are not available for items 9 and 10 above.

18.

Optional: Attach any additional documents here.

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

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

Eligibility, Enrollment, and Operations

Program Integrity

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

1.

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

Yes

No

2.

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

Yes

No

3.

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

Yes

No

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

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

5.

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

Yes

No

N/A

6.

How many eligibility denials have been appealed in a fair hearing in FFY 2021?

32

7.

How many cases have been found in favor of the beneficiary in FFY 2021?

17

8.

How many cases related to provider credentialing were investigated in FFY 2021?

9.

How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

10.

How many cases related to provider billing were investigated in FFY 2021?

11.

How many cases were referred to appropriate law enforcement officials in FFY 2021?

12.

How many cases related to beneficiary eligibility were investigated in FFY 2021?

1186

13.

How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

11

14.

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

- CHIP only
- Medicaid and CHIP combined

15.

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

- Yes
- No

16.

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

Yes

No

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

Data are not available for #8 and 9 above.

18.

Optional: Attach any additional documents here.

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

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

Eligibility, Enrollment, and Operations

Dental Benefits

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

Note on age groups

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

1.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-18 years) instead.

Yes

No

2.

How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2021?

Ages 0-1

Ages 1-2

Ages 3-5

Ages 6-9

Ages
10-14

Ages
15-18

1809

7987

15411

20676

25857

18820

3.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	329	4756	9399	12333	8154

Dental care service codes and definitions

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

4.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	306	4543	8977	11466	7181

Dental care service codes and definitions

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

5.

How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2021?

This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	76	1516	4720	6923	5107

Dental treatment service codes and definitions

The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim. All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6.

How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2021?

1665

Sealant codes and definitions

The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32. All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7.

Do you provide supplemental dental coverage?

Yes

No

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

9.

Optional: Attach any additional documents here.

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

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

Eligibility, Enrollment, and Operations

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to ARHQ.

1.

Did you collect the CAHPS survey?

Yes

No

Part 2: You collected the CAHPS survey

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

1.

Upload a summary report of your CAHPS survey results.

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

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

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

2.

Which CHIP population did you survey?

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

3.

Which version of the CAHPS survey did you use?

- CAHPS 5.0
- CAHPS 5.0H
- Other

4.

Which supplemental item sets did you include in your survey?

Select all that apply.

- None
- Children with Chronic Conditions
- Other

5.

Which administrative protocol did you use to administer the survey?

Select all that apply.

- NCQA HEDIS CAHPS 5.0H
- HRQ CAHPS
- Other

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

Part 3: You didn't collect the CAHPS survey

Eligibility, Enrollment, and Operations

Health Services Initiative (HSI) Programs

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

1.

Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?

Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

Yes

No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

FAMIS Prenatal Coverage

2.

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

Yes

No

3. Which populations does the HSI program serve?

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

4.

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

802

5.

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

802

Computed: 100%

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

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

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

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

In FFY2021, an estimated 802 individuals were served in the program (cumulative for the program as of September 30, 2021). Costs of the HSI from July 1, 2021 through September 30, 2021 were \$42,848.

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

This HSI launched July 1, 2021, so the reporting period for this year is a single quarter (Q4 of FFY 2021). Claims lag may affect the completeness of the data on program costs.

9.

Optional: Attach any additional documents.

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

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

1. What is the name of your HSI program?

Virginia Poison Control Centers

2.

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

Yes

No

3. Which populations does the HSI program serve?

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

4.

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

30906

5.

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

9736

Computed: 31.5%

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

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

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

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

In 2020, Virginia's poison control centers responded to 67,720 calls for assistance, 58,623 of which were human poisoning exposures. Of these calls, 52.72% of cases (30,906) involved children. 79% of all pediatric cases were safely managed at the site of exposure, as opposed to a health care facility. Virginia estimates that in 2020 at least 12,000 pediatric ED visits were averted. Assuming an average cost of \$1,000 (facility plus physician fee), prevention of 12,000 ED visits results in a conservative estimate of \$12 million in annual savings to the Commonwealth.

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

9.

Optional: Attach any additional documents.

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

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

Browse...

Do you have another in this list?

Optional

State Plan Goals and Objectives

Part 1: Tell us about your goals and objectives

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

1. Briefly describe your goal for this objective.

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

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

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4.

Numerator (total number)

93

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

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

6.

Denominator (total number)

100

Computed: 93%

7.

What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8.

Which data source did you use?

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

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

Virginia first identified the children's participation rate as a goal in last year's CHIP Annual Report. Last year we reported 2018 data, and the children's participation rate for that year was 92.2%. The Commonwealth's participation rate for 2019 (the most recent year available) increased to 93.0%.

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

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

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

Please note that we are reporting Virginia's Medicaid and CHIP children's participation rate as a percentage derived from a secondary source that calculates this rate using ACS/IPUMS data. This is not DMAS' original calculation. Source: Haley, J., et al., "Uninsurance Rose among Children and Parents in 2019" (District of Columbia: The Urban Institute, July 2021). The latest update for the children's participation rate that we are able to report at this time is from 2019, prior to the current reporting period for this CHIP Annual Report (FFY2021). This was the year of Virginia's adult Medicaid Expansion, effective in January 2019. In Table A-3 of the same Urban Institute report (see attachment), the authors note that between 2016 and 2019, Virginia's children's participation rate increased by 2.3 percentage points, which is statistically significant at the 0.05 level.

12.

Do you have any supporting documentation?

Optional

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

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

Do you have another in this list?

Optional

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

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

Increase Access to Care

1. Briefly describe your goal for this objective.

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

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

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

Surveyed family members of enrolled FAMIS children. Numerator is the 2021 FAMIS Program "Getting Needed Care" CAHPS composite measure (General Child)

4.

Numerator (total number)

83

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

Survey sample

6.

Denominator (total number)

100

Computed: 83%

7.

What is the date range of your data?

Start

mm/yyyy

07

/

2020

End

mm/yyyy

06

/

2021

8.

Which data source did you use?

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

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

Virginia first identified this as a goal in last year's CHIP Annual Report. Last year we reported SFY2020 data, and the metric was 89.6%. The SFY2021 metric declined to 83.0%. It is likely that the COVID-19 pandemic contributed to the decline in this percentage from SFY2020 to SFY2021.

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

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

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

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

12.

Do you have any supporting documentation?

Optional

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

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

Do you have another in this list?

Optional

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

You can edit the suggested objective to match what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

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

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

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

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

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

4.

Numerator (total number)

65

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

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

Sample size

6.

Denominator (total number)

100

Computed: 65%

7.

What is the date range of your data?

Start

mm/yyyy

01

/

2019

End

mm/yyyy

12

/

2019

8.

Which data source did you use?

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

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

Virginia's average this year was 64.28%, compared to the national benchmark (HEDIS 50th percentile) of 71.05%. Last year, Virginia's average was 66.08%, compared to the national benchmark of 70.68%. DMAS has tracked and reported on this HEDIS measure for some time; however, in 2018, Virginia incorporated this measure into the CHIP Annual Report. That year, the magnitude of changes to Virginia's Medicaid and FAMIS managed care programs necessitated a break in trending with some children's HEDIS measures from previous years. A number of major changes and innovations occurred in the Virginia Medicaid and CHIP programs in 2018, including the phased rollout of the Medallion 4.0 managed care program. Children's data from the Medallion and Commonwealth Coordinated Care Plus (CCC+) programs were also combined for the first time. These changes are continuing to impact the composite scores.

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

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

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

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

12.

Do you have any supporting documentation?

Optional

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

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

Do you have another in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

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

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

domain, administrative measures, included the following measures: b" Assessments of Foster Care Population b" MCO Claims Processing b" Monthly Reporting Timeliness and Accuracy. The second domain, HEDIS measures, included the following measures: b" Childhood Immunization Status - Combination 3 b" Controlling High Blood Pressure b" Prenatal and Postpartum Care - Timeliness of Prenatal Care. Finally, the Children's Health Insurance Program Advisory Committee (CHIPAC) monitors FAMIS program data related to enrollment, access, utilization, and retention, and continues to be actively interested in improving utilization of preventive services for children.

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

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

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

The birth outcomes study referenced above is a focused study that includes women served by the FAMIS MOMS program and their infants (who at birth are deemed eligible for FAMIS or Medicaid, as applicable). Previous years' analyses have demonstrated that women who participate in the FAMIS MOMS program have birth outcomes (e.g., rates of preterm and low birthweight births) that compare favorably to those of similar populations. The 2019-20 Birth Outcomes Focused Study is attached.

4.

Optional: Attach any additional documents here.

For example: studies, analyses, or any other documents that address your performance goals.

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

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

Program Financing

Tell us how much you spent on your CHIP program in FFY 2021, and how much you anticipate spending in FFY 2022 and 2023.

Part 1: Benefit Costs

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

1.

How much did you spend on Managed Care in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 356,535,291

\$ 363,420,481

\$ 387,962,467

2.

How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 68,934,885

\$ 75,484,543

\$ 77,605,035

3.

How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

4.

How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

Table 1: Benefits Costs

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

Type	FFY 2021	FFY 2022	FFY 2023
Managed Care	356535291	363420481	387962467
Fee for Service	68934885	75484543	77605035
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	0	0	0
Total benefit costs	425470176	438905024	465567502

Part 2: Administrative Costs

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

1.

How much did you spend on personnel in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

This includes wages, salaries, and other employee costs.

2021

2022

2023

\$ 4,459,231

\$ 3,599,966

\$ 3,911,306

2.

How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 143,119

\$ 115,541

\$ 125,533

3.

How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 20,389,758

\$ 16,460,785

\$ 17,884,379

4.

How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 3,380,386

\$ 2,729,007

\$ 2,965,023

5.

How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 555,620

\$ 448,555

\$ 487,348

6.

How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 203,700

\$ 5,950,173

\$ 3,876,747

7.

How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$

\$

\$

Table 2: Administrative Costs

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

Type	FFY 2021	FFY 2022	FFY 2023
Personnel	4459231	3599966	3911306
General administration	143119	115541	125533
Contractors and brokers	20389758	16460785	17884379
Claims processing	3380386	2729007	2965023
Outreach and marketing	555620	448555	487348
Health Services Initiatives (HSI)	203700	5950173	3876747
Other administrative costs	Not Answered	Not Answered	Not Answered
Total administrative costs	29131814	29304027	29250336
10% administrative cap	47274464	48767224.89	51729722.44

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding. This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

FMAP Table	FFY 2021	FFY 2022	FFY 2023
Total program costs	454601990	468209051	Not Available
eFMAP	65	65	Not Available
Federal share	295491293.5	304335883.15	Not Available
State share	159110696.5	163873167.85	Not Available

8.

What were your state funding sources in FFY 2021?

Select all that apply.

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

9.

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

- Yes
- No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1.

How many children were eligible for Managed Care in FFY 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

2022

2023

154875

155423

156422

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

Round to the nearest whole number.

2021

2022

2023

\$ 192

\$ 195

\$ 207

Type	FFY 2021	FFY 2022	FFY 2023
Eligible children	154875	155423	156422
PMPM cost	192	195	207

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1.

How many children were eligible for Fee for Service in FFY 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

2022

2023

162902

163479

164595

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

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

2021

2022

2023

\$ 228

\$ 224

\$ 236

Type	FFY 2021	FFY 2022	FFY 2023
Eligible children	162902	163479	164595
PMPM cost	228	224	236

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

2.

Optional: Attach any additional documents here.

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

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

Challenges and Accomplishments

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

Over the last two years, uncertainty caused by the COVID-19 public health emergency and its economic impacts has at times made project planning more challenging and caused delays in implementation. DMAS continues to uphold our central mission of providing high quality healthcare to our members, and we have ensured that the necessary adaptations and flexibilities are in place for us to continue to provide critical coverage to low-income children and families without disruption, which is more important than ever during this unprecedented public health crisis.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

Most of DMAS' workforce has continued to work remotely through 2021. During the ongoing public health emergency, DMAS is working with our managed care plans to ensure that children are receiving essential health care including well visits and scheduled immunizations. We are also focusing attention on meeting the needs of children and youth with behavioral health conditions. DMAS continues to track new federal legislation and guidance and ensure rapid deployment of policy directives related to pandemic response and recovery. We are currently planning for the post-PHE unwinding.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

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

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

As mentioned above, Virginia established new coverage for previously ineligible pregnant individuals through our unborn child option CHIP SPA, as well as two new Health Services Initiatives. These changes were made in response to state legislative directives. In addition, in November 2021, Virginia's Section 1115 waiver amendment was approved to extend 12 months postpartum coverage for CHIP pregnant women in our FAMIS MOMS program. This coverage expansion aims to reduce maternal mortality and severe morbidity and address racial disparities in maternal health. We look forward to reporting on the implementation of the new extended postpartum coverage in FFY 2022.

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

N/A

6.

Optional: Attach any additional documents here.

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

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