

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



November 18, 2021

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

Dear Ms. Kimsey:

The Centers for Medicare & Medicaid Services (CMS) is approving Virginia's request to amend its section 1115 demonstration project entitled, "Virginia Family Access to Medical Insurance Security (FAMIS) MOMS and FAMIS *Select*" (Project Nos. 21-W-00058/3 and 11-W-00381/3), in accordance with section 1115(a) of the Social Security Act. Approval of this demonstration amendment will enable the Commonwealth to test the effects of providing state plan benefits to postpartum individuals in Medicaid and the Children's Health Insurance Program (CHIP), with income up to and including 200 percent of the federal poverty level (FPL), for a total of 12 months. The Commonwealth will also provide continuous eligibility for these individuals during the entire postpartum period, ensuring continuity of coverage.

We have determined that this amendment will promote the objectives of Medicaid and CHIP by increasing and strengthening overall coverage and improving the health of mothers in Virginia, as well as reducing the rate of maternal mortality in the Commonwealth by addressing continuity of care for individuals postpartum. This approval is effective November 18, 2021 through June 30, 2029, except where otherwise noted in the expenditure authorities; and upon such date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

Consistent with CMS's requirements for all section 1115 demonstrations, and as outlined in the Special Terms and Conditions (STCs), Virginia will be required to undertake systematic monitoring and a thorough evaluation of the demonstration. Throughout the life-cycle of the demonstration approval period, monitoring will support tracking the Commonwealth's progress towards its demonstration goals, and we expect that such monitoring will accommodate new policy areas such as those approved with this amendment. Similarly, the Commonwealth will update the evaluation design to address this amendment component, to ensure a careful assessment of whether the demonstration initiatives, including those in the amendment, are effective in producing the desired outcomes for enrollees as well as for the CHIP and Medicaid programs overall.

CMS’s approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authorities, STCs, and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The Commonwealth may deviate from Medicaid and CHIP state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable under the demonstration.

Consideration of Public Comments

The Commonwealth provided public notice for this amendment in accordance with the processes described in the September 27, 1994 Federal Register notice (59 FR 49249) as generally acceptable methods of state public notice for demonstration amendments. CMS generally considers a state to have provided acceptable public notice if the state provides for a formal notice and comment process on the section 1115 proposal in accordance with the state’s administrative procedure act; provided that such notice is given at least 30 days prior to submission to CMS. Accordingly, Virginia conducted a 31-day public comment period and held one virtual meeting for the public to provide input. The Commonwealth received 24 comments from individual members of the public as well as representatives of 20 organizations and all were in support of the amendment.

Virginia also conducted tribal consultation with its seven federally recognized tribes by providing written notice on January 29, 2021 and a 60-day tribal comment period on the proposed amendment. The Commonwealth did not receive any comments from the tribes.

Consistent with the CMS April 27, 2012 State Medicaid Director/State Health Official Letter on the “Revised Review and Approval Process for Section 1115 Demonstrations” (SHO# 12-001), a federal public comment period was opened from April 7, 2021 to May 7, 2021. CMS received 14 comments that represented 50 enrollee and provider advocacy organizations. All commenters strongly advocated support of the state’s proposal to extend the postpartum eligibility period; providing national and Virginia specific maternal health statistics to promote this amendment as a critical step to reducing maternal mortality and morbidity for lower income individuals as well as racial disparities in maternal and infant health outcomes.

The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Ms. Ticia Jones. Ms. Jones is available to answer any questions concerning implementation of the Commonwealth’s section 1115(a) demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Ticia.Jones@cms.hhs.gov

We appreciate your commitment to improving the health of people in Virginia, and we look forward to our continued partnership on the Virginia FAMIS MOMS and FAMIS *Select* section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



Daniel Tsai
Deputy Administrator and Director

Enclosures

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 21-W-00058/3 and 11-W-00381/3

TITLE: Virginia FAMIS MOMS and FAMIS *Select* Section 1115
Demonstration

AWARDEE: Virginia Department of Medical Assistance Services

Expenditure Authority

All requirements of Medicaid and the Children’s Health Insurance Program (CHIP) shall apply to the demonstration populations and expenditures listed below, except those identified below as “not applicable.” All Medicaid and CHIP rules not expressly waived or identified as not applicable in this document shall apply to the demonstration. These expenditure and “non-applicable” authorities, as well as the associated Special Terms and Conditions (STCs), are in effect as of November 18, 2021, the date on the accompanying CMS approval letter, through June 30, 2029, except where otherwise noted in these expenditure authorities.

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the Commonwealth of Virginia for the items identified below (which are not otherwise included as expenditures under section 1903 or section 2107(e)(2)(A)) shall, for the period of this demonstration in accordance with the STCs, be regarded as matchable expenditures under Virginia’s title XXI and title XIX state plan:

Title XXI Expenditure Authority:

1. Expenditures for extending health insurance coverage through CHIP to uninsured pregnant individuals with income up to and including 200 percent of the federal poverty level (FPL), who are not otherwise Medicaid eligible. This includes those pregnant individuals who are lawfully residing in the United States and those with access to state employees’ health benefit coverage. These expenditures are authorized for the “FAMIS MOMS” component of the demonstration.

Should the Commonwealth freeze enrollment or otherwise discontinue coverage of the CHIP pregnant woman population, the title XXI expenditure authority will terminate and will not be subject to extension.

2. Expenditures for extending health insurance coverage to children in families with income up to and including 200 percent of the FPL, who are eligible for Virginia’s separate title XXI CHIP coverage but choose to elect a monthly premium assistance subsidy for private or employer-sponsored insurance coverage. These expenditures are authorized for the “FAMIS *Select*” component of the demonstration.

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

5. Federal Matching Payment and Family Coverage Limits Section 2105

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

Title XIX Expenditure Authority:

1. Expenditures for extending the postpartum eligibility period for pregnant and postpartum individuals enrolled in any Medicaid state plan eligibility group from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy. These expenditures are authorized for the “postpartum extension” component of the demonstration.

This expenditure authority is limited to a five-year period starting on April 1, 2022 through March 31, 2027 for Medicaid “lawfully residing” pregnant individuals as described in STC 17.

2. Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 17.

This expenditure authority is limited to a five-year period starting on April 1, 2022 through March 31, 2027 for Medicaid “lawfully residing” pregnant individuals as described in STC 17.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)**

DEMONSTRATION NUMBERS: 21-W-00058/3 and 11-W-00381/3

TITLE: FAMIS MOMS and FAMIS *Select*

AWARDEE: Virginia Department of Medical Assistance Services

I. PREFACE

The following are Special Terms and Conditions (STCs) for the Virginia FAMIS MOMS and FAMIS *Select* section 1115 demonstration program. The parties to this agreement are the Virginia Department of Medical Services (Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the Commonwealth's obligations to CMS during the approved demonstration period specified in these STCs. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. These STCs are effective November 18, 2021, the date of the CMS approval letter that accompanied these STCs, through June 30, 2029.

The STCs have been arranged into the following subject areas:

- II. Program Description and Historical Context
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Benefits
- VI. Cost Sharing
- VII. Delivery System
- VIII. General Reporting Requirements
- IX. Monitoring
- X. Evaluation of the Demonstration
- XI. General Financial Requirements
- XII. Monitoring Allotment Neutrality
- XIII. Monitoring Budget Neutrality

Attachment A: Developing the Evaluation Design

Attachment B: Preparing the Interim and Summative Evaluation Reports

Attachment C: CMS Approved Demonstration Evaluation Plan

Attachment D: Proxy Methodology for the Title XIX New Adult Group (*reserved for CMS approval*)

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

Demonstration Description

Virginia's FAMIS MOMS and FAMIS *Select* demonstration has three components.

The first component of the demonstration entitled, “FAMIS MOMS” provides coverage to uninsured pregnant individuals, including lawfully residing pregnant individuals, in families with income up to and including 200 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid. “FAMIS MOMS” also provides coverage to pregnant individuals with access to state employees’ health benefit coverage (in accordance with the hardship exception as provided in section 2110(b)(6)(C) of the Social Security Act (the Act)); thereby aligning the Commonwealth’s coverage of pregnant individuals with the expansion of CHIP coverage to children of state employees. FAMIS MOMS coverage is the same as that provided to pregnant individuals 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, consistent with 42 CFR 435.117 and 457.360. These infants are deemed eligible on the date of birth and remain eligible until attaining the age of 1.

The second component of the demonstration entitled, the “FAMIS *Select*” program, provides premium assistance for private or employer-sponsored insurance to uninsured children, ages 0 through 18, in families with income up to and including 200 percent of the FPL, who are eligible for direct CHIP state plan coverage. These individuals are provided the option to receive premium assistance for private 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 at any time.

The third component of the demonstration, effective as of the date of these amended STCs, extends the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy, for the “FAMIS MOMS” population and pregnant individuals in any Medicaid state plan eligibility group. As described in STC 17, individuals who are within 12 months postpartum but whom are outside of the state plan 60-day postpartum coverage period (including those who were not enrolled in Virginia Medicaid or CHIP while pregnant), have household income up to and including 200 percent of the FPL, and meet all other Medicaid or CHIP eligibility criteria may receive extended postpartum coverage.

Demonstration History

The Virginia FAMIS MOMS and FAMIS *Select* demonstration was initially approved on June 30, 2005 and implemented August 1, 2005.

FAMIS MOMS

Virginia implemented the FAMIS MOMS program incrementally beginning August 1, 2005. The intent of this demonstration program component is to provide prenatal care to uninsured

individuals within the title XXI income range and likely to give birth to FAMIS-eligible (i.e., CHIP state plan) children. The first stage expanded eligibility to pregnant individuals with family income above the Medicaid limit of 133 percent of the FPL but less than or equal to 150 percent of the FPL. The second stage, implemented September 1, 2006, covered pregnant individuals with incomes through 166 percent of the FPL. Subsequent stages covered pregnant individuals through 185 percent of the FPL (July 1, 2007) and through 200 percent of the FPL (July 1, 2009). Effective July 1, 2010, CMS approved an amendment to eligibility requirements to allow enrollment of pregnant individuals with income below 133 percent of the FPL who do not meet eligibility requirements for full Medicaid coverage but do meet the FAMIS MOMS requirements.

During the period January 1, 2014 through November 30, 2014, this demonstration component was phased-out because the Virginia General Assembly adopted an amendment to the Commonwealth's biennial budget directing the Commonwealth to phase-out and eliminate the FAMIS MOMS program when health insurance coverage under the Federally Facilitated Marketplace (FFM) became available on January 1, 2014. New applications for FAMIS MOMS coverage were not accepted after December 31, 2013. However, individuals enrolled in FAMIS MOMS on or prior to December 31, 2013 retained eligibility for the duration of their coverage period. Any application received for pregnancy coverage beginning January 1, 2014 through November 30, 2014, was screened for Medicaid under pregnant individuals eligibility and for CHIP. If the applicant was ineligible for Medicaid or CHIP, the application was transferred to the FFM. Beginning on December 1, 2014, enrollment was reopened and new applications accepted for uninsured pregnant individuals with income up to and including 200 percent of the FPL. This income eligibility threshold aligns with children's coverage levels under the CHIP state plan.

On April 3, 2015, CMS approved a demonstration amendment to add coverage for dental services to the FAMIS MOMS program component, consistent with the addition of these benefits for pregnant individuals under Medicaid. This demonstration amendment also allowed eligibility to be expanded to include pregnant individuals with access to subsidized health insurance through state employee benefits.

The title XXI goals and objectives of the FAMIS MOMS program are as follows:

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

FAMIS Select

Virginia implemented the FAMIS Select program beginning August 1, 2005. FAMIS Select replaced Virginia's former employer-sponsored health insurance program and provides an alternative for families with children enrolled in FAMIS (i.e., the CHIP state plan) and who have access to private or employer-sponsored coverage. The Commonwealth provides a set monthly premium assistance subsidy for health insurance coverage for children with family income up to 200 percent of the FPL who are eligible for direct coverage in FAMIS. All children are first enrolled in FAMIS. Parents may then choose the premium assistance subsidy in lieu of direct FAMIS coverage for their child(ren). Premium assistance payments are paid directly to the

family based on verified payroll withholding amounts; with the maximum subsidy not to exceed a family's total share of the total monthly premium.

Parents that choose FAMIS Select are responsible for all cost-sharing associated with the private or employer-sponsored plan. Virginia does not wrap benefits with the exception of immunizations if the family's chosen plan does not provide such coverage.

The title XXI goals and objectives of the FAMIS Select program is as follows:

- 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; and,
- Assure the aggregate cost-effectiveness of the FAMIS Select program.

Postpartum Extension for FAMIS MOMS and Medicaid State Plan Pregnant Individuals

On November 18, 2020, Virginia Governor Ralph Northam signed into law the 2020 Special Session I Virginia Acts of Assembly, Chapter 56, directing the Department of Medical Assistance Services (DMAS) to seek federal approval to cover pregnant individuals for up to 12-months postpartum. Accordingly, Virginia submitted this section 1115 amendment request on March 31, 2021, and following the effective date of these STCs and an operational ramp-up period, will begin to implement the extension of postpartum coverage to provide a full 12-month period following the end of pregnancy. The 12-month postpartum period will be implemented statewide and made available to pregnant and postpartum individuals as detailed in STC 17.

This program component will support the demonstration's goal of facilitating access to prenatal, obstetric, and postpartum care, particularly for those in the Commonwealth facing the highest rates of maternal and infant mortality and morbidity. This amendment is expected to improve continuity of coverage and access to care for Medicaid and CHIP enrolled individuals during the postpartum period and will be evaluated on whether 12-months postpartum coverage reduces maternal and infant mortality and morbidity, improves health outcomes for both the mother and the infant, and advances health equity.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The Commonwealth must comply with applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557).
- 2. Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of Medicaid and CHIP expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The Commonwealth must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the Commonwealth must adopt, subject to CMS approval, a modified budget and/or allotment neutrality agreement for the demonstration as necessary to comply with such change. The modified budget and/or allotment neutrality agreement will be effective upon the implementation of the change. Further, the Commonwealth reserves the right to seek an amendment to the demonstration (as per STC 7) as a result of the change in FFP.
- b. If mandated changes in the federal law requires legislation by the Commonwealth, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such legislation enacted by the Commonwealth becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. State Plan Amendments. The Commonwealth will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans governs.

6. Changes Subject to the Amendment Process. Changes related to demonstration features, such as eligibility, enrollment, enrollee rights, benefits, beneficiary rights, delivery systems, cost-sharing, sources of non-federal share of funding, allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The Commonwealth must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, companion amendments to the Medicaid or CHIP state plan may be required as well. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based

expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the Commonwealth to submit required elements of a viable amendment request as specified in this STC and submission of required deliverables specified in these STCs in accordance with the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
- a. *Demonstration Amendment Summary and Objectives.* The Commonwealth must provide a detailed description of the amendment, including what Virginia intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary;
 - b. *Allotment Neutrality Worksheet* (for changes impacting title XXI funding). The Commonwealth must provide an up-to-date CHIP allotment neutrality worksheet that identifies the impact of the proposed amendment on the Commonwealth's available title XXI allotment;
 - c. *Budget Neutrality Worksheet* (for changes impacting title XIX funding). The Commonwealth must provide an up-to-date data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment.
 - d. *Waiver and Expenditure Authorities.* The Commonwealth must provide a list of waivers and expenditure authorities that are being requested or terminated, along with the programmatic description of why these waivers and expenditure authorities are being requested for the amendment;
 - e. *Evaluation.* The Commonwealth must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring, and measurement of the provisions; and,

- f. *Public Notice.* An explanation of the public process used by Virginia, consistent with the requirements of STC 13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the Commonwealth in the final amendment request submitted to CMS.
- 8. Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a phase-out plan consistent with the requirements of STC 9.
- 9. Demonstration Phase-Out.** The Commonwealth may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
 - a. *Notification of Suspension or Termination.* The Commonwealth must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The Commonwealth must submit its notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the Commonwealth must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the Commonwealth must conduct tribal consultation in accordance with STC 13. Once the 30-day public comment period has ended, the Commonwealth must provide a summary of each public comment received, the Commonwealth's response to the comment, and how the Commonwealth considered the comments received when developing the revised transition and phase-out plan.
 - b. *Transition and Phase-out Plan Requirements.* The Commonwealth must minimally include in its phase-out plan the process by which it will notify affected beneficiaries; the content of said beneficiary notices (including information on the beneficiary's appeal rights); the process by which the Commonwealth will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries; the process by which the Commonwealth will ensure ongoing coverage for eligible beneficiaries; and undertake any community outreach activities to notify affected beneficiaries (including any community resources that are available).
 - c. *Transition and Phase-out Plan Approval:* The Commonwealth must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

- d. *Transition and Phase-out Procedures.* The Commonwealth must comply with applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, and 431.213. In addition, the state must assure all applicable and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the Commonwealth must maintain benefits as required in 431.230. In addition, the Commonwealth must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in the October 1, 2010 State Health Official letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the Commonwealth must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e. *Exemption from Public Notice Procedures per 42 CFR Section 431.416(g).* CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. *Enrollment Limitation during Demonstration Phase-Out.* If the Commonwealth elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the Commonwealth's obligation to determine Medicaid or CHIP eligibility in accordance with the approved Medicaid or CHIP state plans.
- g. *Federal financial participation (FFP).* If the demonstration project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with the termination or expiration of the demonstration, including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Close-out Report. Within 120 calendar days after the end of the demonstration (i.e., upon expiration or early termination), the Commonwealth must submit a draft Close-out Report to CMS for comments.

- a. The draft report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-out report.
- c. The state must take into consideration CMS' comments for incorporation into the final Close-out Report.

- d. The final Close-out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the Close-out Report may subject the state to penalties described in STC 26.

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of titles XIX and/or XXI. CMS will promptly notify the Commonwealth in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the Commonwealth an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

12. Adequacy of Infrastructure. The Commonwealth must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach and enrollment; maintaining eligibility systems; compliance with cost-sharing requirements; and reporting on financial and other demonstration components.

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The Commonwealth must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the Commonwealth must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The Commonwealth must also comply with the public notice procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The Commonwealth must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid or CHIP state plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state

14. Federal financial participation (FFP). No federal matching for expenditures for this demonstration, including administrative and medical assistance expenditures, will be available until the effective date identified in the CMS demonstration approval letter that accompanied these STCs.

15. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations

(MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

16. Common Rule Exemption. The Commonwealth must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs or procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

17. Eligibility Groups Affected by the Demonstration. The following populations are eligible under this demonstration as described therein:

- a. **FAMIS MOMS.** Coverage is provided to uninsured pregnant individuals in families with income up to and including 200 percent of the FPL who are not eligible for Medicaid, including lawfully present (CHIPRA 214) individuals. FAMIS MOMS coverage is also provided to pregnant individuals with access to state employee’s health benefit coverage (in accordance with the hardship exception as provided in section 2110(b)(6)(C) of the Act), thereby aligning the Commonwealth’s coverage of pregnant individuals with the expansion of CHIP coverage to children of state employees. FAMIS MOMS coverage is the same as that provided to pregnant individuals 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, consistent with 42 CFR 435.117 and 457.360. These infants are deemed eligible on the date of birth and remain eligible until attaining the age of 1.

- b. **FAMIS *Select* Premium Assistance.** Children eligible for and enrolled in Virginia’s separate CHIP program, may elect to enroll in FAMIS *Select* and receive CHIP premium assistance payments to purchase private or employer sponsored health insurance coverage. Such enrollment is voluntary and based on informed choice regarding all implications of choosing premium assistance in lieu of direct CHIP state plan coverage, including the possibility of reduced benefits and increased cost-sharing, and that the CHIP cost-sharing limit of five percent on annual, aggregate cost sharing will not apply.

The Commonwealth will ensure that enrollees are annually notified that they may choose direct CHIP state plan coverage at any time. The Commonwealth will inform families that all age-appropriate immunizations in accordance with the

recommendations of the Advisory Committee on Immunization Practices (ACIP) are covered by CHIP if their private or employer sponsored health insurance coverage does not provide for such immunizations. Families will continue to be told that this coverage is a factor to consider in choosing premium assistance in lieu of direct CHIP state plan coverage. The Commonwealth shall provide information as to where children may receive immunizations, well-baby, and well-child services in the event these services are not covered in the private or employer-sponsored health plan in which they are enrolled. In the case where title XXI eligibles are enrolled in private or employer-sponsored health insurance that does not include immunizations, the Commonwealth has an established mechanism in effect to reimburse providers for the cost of immunizations.

- c. **Postpartum Extension.** The Commonwealth will extend continuous postpartum coverage for Medicaid and CHIP pregnant individuals from the end of the state plan 60-day postpartum benefit period to the end of the 12th month following the end of the pregnancy (including individuals enrolled while pregnant during a period of retroactive eligibility and/or for individuals who did not have enrollment in Medicaid or CHIP while pregnant). Eligible populations will be provided 12-month continuous extended postpartum coverage as follows:
- i. Individuals enrolled in the “FAMIS MOMS” population as described in subparagraph a, with exception for individuals whose program eligibility is derived by section 1903(v)(4) or 2107(e)(1)(O) of the Act as described in subpart c.iv below.
 - ii. Pregnant and postpartum individuals in any Medicaid state plan eligibility group, with exception for individuals whose program eligibility is derived by section 1903(v)(4) or 2107(e)(1)(O) of the Act as described in subpart c.iv below.
 - iii. Individuals who are within 12 months postpartum but beyond the state plan 60-day postpartum coverage period (including those who were not enrolled in Medicaid or CHIP while pregnant), have household income up to and including 200 percent of the FPL, and meet all other Medicaid or CHIP eligibility criteria, with exception for individuals whose program eligibility is derived by section 1903(v)(4) or 2107(e)(1)(O) of the Act as described in subpart c.iv below.
 - iv. Lawfully present (CHIPRA 214) Individuals – Individuals determined to be “lawfully residing” in the United States for the purpose of establishing Medicaid or CHIP eligibility in accordance with section 1903(v)(4) or 2107(e)(1)(O) of the Act are only eligible for continuous 12-month postpartum coverage in accordance with sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2), for a five-year period starting April 1, 2022 through March 31, 2027. During this time-limited 5-year coverage period, lawfully present pregnant individuals are

eligible to receive full Medicaid or CHIP state plan benefits for the duration of the pregnancy and the 12-month continuous postpartum period.

- d. **Enrollment upon the Effective Date of the Postpartum Extension Period:** Upon the effective date of this approval, individuals who are within 12 months postpartum, but whom are outside of the state plan 60-day postpartum coverage period, may be enrolled or reenrolled in Medicaid or CHIP for the purpose of receiving extended postpartum coverage for the period of time that equates to the end of the 12th month following the end of the pregnancy. These individuals enrolled in the extended postpartum coverage period, not immediately following pregnancy but at a later point in time within the 12-month coverage period, are only eligible for the period of time that remains prior to the end of the 12th month following the end of the pregnancy. For example, an eligible individual who is enrolled in the fourth month following pregnancy, will only be eligible to receive eight additional months of continuous postpartum coverage.
- e. **Redetermination of Eligibility after the Postpartum Extension Period:** The Commonwealth will conduct any required redetermination or renewal of eligibility at the end of the extended postpartum period consistent with 42 CFR 435.916 and 42 CFR 457.343. This includes determining Medicaid eligibility on all bases consistent with 42 CFR 435.916(f)(1) prior to determining an individual ineligible. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CFR 435.917 and 42 CFR Part 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(f)(2). Separate CHIP enrollees no longer eligible for CHIP must be screened for eligibility in other insurance affordability programs in accordance with 42 CFR 457.350(b), and receive timely written notice of termination in accordance with 42 CFR 457.340(e).

18. Screening for Medicaid. Applicants for the demonstration will continue to be screened for Medicaid eligibility. Demonstration applicants eligible for Medicaid will be enrolled in Medicaid and receive the full Medicaid benefit package.

19. Enrollment Limits. There is no enrollment cap for any component of this demonstration. Enrollment in an individual or employer-sponsored plan under FAMIS *Select* is voluntary and the child may continue to elect to switch to direct CHIP state plan coverage at any time.

20. Applicability of title XXI Maintenance of Effort to Demonstration Populations. The maintenance of effort provision at section 2105(d)(3)(A) of the Act applies to title XXI eligible children enrolled in FAMIS *Select*. This provision requires that, with certain exceptions, as a condition of receiving federal financial participation for Medicaid, states must maintain CHIP “eligibility standards, methodologies, and procedures” for children that are no more restrictive than those in effect on March 23, 2010. See STCs 49 and 50 related

to title XXI funding limits and shortfalls.

Section 2105(d)(3) of the Act is not applicable to pregnant individuals enrolled under the FAMIS MOMS component of the demonstration.

V. BENEFITS

21. Demonstration Benefits. There are three distinct benefit packages offered under this demonstration:

- a. **FAMIS MOMS** – Individuals enrolled in FAMIS MOMS as described in STC 17.a receive the same package of benefits as provided to pregnant individuals covered by Virginia’s Medicaid program. The benefit package includes comprehensive health and dental benefits, including orthodontics (orthodontics benefit is limited to individuals under the age of 21). All dental services must be received through the Commonwealth's contracted *Smiles for Children* service provider.

If changes are made in the benefit package that would cause FAMIS MOMS to no longer receive the same benefits provided to pregnant individuals under the Medicaid state plan, the Commonwealth must submit the proposed change to CMS for review and approval, as outlined in STC 7, before modifications can be implemented by the Commonwealth.

- b. **FAMIS *Select* Premium Assistance.** For families with CHIP eligible children who choose to receive premium assistance for private or employer-sponsored health insurance coverage, benefits are limited to premium assistance subsidies and immunizations as described in STC 17.b.

Consistent with 2105(c)(3) of the Social Security Act, cost-effectiveness for the purchase of employer-sponsored insurance shall be determined relative to the amount of expenditures (determined on an individual or aggregate basis) under the state child health plan, including administrative expenditures, that the state would have made to provide comparable coverage to the targeted low-income child or family involved (as applicable).

- c. **Postpartum Extension** – Individuals who are eligible for the 12-month extended postpartum coverage period as described in STC 17.c will receive full state plan benefits during the pregnancy and postpartum period.

22. Minimum Essential Coverage (MEC). In accordance with CMS’ February 12, 2016 correspondence to the Virginia Department of Medicaid Assistance Services' Director, Cynthia Jones, the Commonwealth's benefit package provided to uninsured pregnant individuals and newborn children under the FAMIS MOMS component of the demonstration is equivalent to CHIP state plan coverage. Accordingly, CMS has determined coverage provided to these individuals and children under this demonstration is recognized as MEC.

CMS also concluded that the Commonwealth's coverage provided under the FAMIS Select component of the demonstration does not meet the comprehensive criteria for MEC. The FAMIS Select program does not provide premium assistance enrollees with wrap-around services or cost-sharing assistance that is comparable to CHIP state plan out-of-pocket limits, thus, this is a lesser benefit than coverage afforded to children who are eligible for CHIP state plan coverage. Accordingly, CMS has determined that the coverage provided to these children under the FAMIS Select demonstration component is not recognized as MEC.

For the 12-month postpartum extension, effective as of the date of these amended STCs, CMS also concluded that the Commonwealth's benefit package provided to postpartum individuals is equivalent to Medicaid and CHIP state plan coverage. Accordingly, CMS has determined the postpartum coverage provided to these individuals under this demonstration is recognized as MEC.

VI. COST SHARING

23. Cost Sharing. The cost-sharing requirements for this demonstration are outlined below:

- a. **FAMIS MOMS** - The cost-sharing requirements for the FAMIS MOMS component of the demonstration are consistent with those described in the Medicaid state plan. There are no monthly premiums or enrollment fees associated with participation in the demonstration.

Co-payments for services received by FAMIS MOMS are identical to co-payments required of pregnant individuals covered by Medicaid. By policy, there are no co-payments required for pregnancy related services or for medical conditions that may complicate the pregnancy, including dental services. Also, it is a contractual requirement that Managed Care Organization (MCO) not charge pregnant individuals co-payments for any services. Therefore, the only co-payments that may be charged to a pregnant individual receiving services through Medicaid or FAMIS MOMS would be for non-pregnancy related services delivered through fee-for-service.

- b. **Postpartum Extension** – There is no cost-sharing requirement associated with services received during the 12-month extended postpartum coverage period.
- c. **FAMIS *Select* Premium Assistance.** For families with CHIP eligible children who choose to receive premium assistance for private or employer-sponsored insurance and supplemental immunization benefits in lieu of receiving coverage under the CHIP state plan, cost-sharing requirements will continue to be set by their private or employer-sponsored insurance plan.

VII. DELIVERY SYSTEM

24. Demonstration Delivery System. The demonstration delivery system varies by population as described below:

- a. **FAMIS MOMS and Postpartum Extension** - Health care services are delivered primarily through one of the Managed Care Organizations (MCOs) contracted by DMAS to provide Medicaid and FAMIS (CHIP) benefits. Initially, benefits are provided on a fee-for-service basis until the pregnant individual is enrolled in an MCO. Dental services are provided by the contracted *Smiles for Children* service provider.
- b. **FAMIS Select Premium Assistance.** For families who select premium assistance, health care services are delivered through the private or employer-sponsored plan of choice.

VIII. GENERAL REPORTING REQUIREMENTS

25. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in an amount up to \$1,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The Commonwealth does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the Commonwealth in writing that the deliverable was not accepted for being insufficient, or inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
- b. For each deliverable, the Commonwealth may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the Commonwealth’s anticipated date of submission. Should CMS agree to the Commonwealth’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the Commonwealth as an interim step before applying the deferral, if the Commonwealth proposes a corrective action plan in the state’s written extension request.

- c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the Commonwealth fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the Commonwealth.
- d. If the CMS deferral process has been initiated for the Commonwealth's non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, the Commonwealth's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

26. Submission of Post-Approval Deliverables. The Commonwealth must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

27. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the Commonwealth; and,
- c. Submit deliverables to the appropriate system as directed by CMS.

IX. MONITORING

28. Monitoring Reports. The Commonwealth must submit one Semi-Annual Monitoring Report and one Annual Monitoring Report each demonstration year. The Semi-Annual Reports are due no later than 90 calendar days following the end of the six-month period from July through December (semi-annual report will be due by March 31 each year). The compiled Annual Report is due no later than 90 calendar days following the end of the demonstration year (i.e., the July–June compiled annual report will be due by September 28 each year). The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a reference/bibliography section. The Monitoring Reports must follow the

framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums conducted in accordance with required by 42 CFR 431.420(c) regarding the progress of the demonstration.
- b. Performance Metrics. The performance metrics will provide data to demonstrate how the Commonwealth is progressing towards meeting the demonstration's goals, and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and any grievances and appeals. The requiring monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- c. Budget and Allotment Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The Commonwealth must provide an updated budget and allotment neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring allotment neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget and allotment neutrality data upon request. In addition, the Commonwealth must report quarterly expenditures associated with the populations affected by this demonstration on the appropriate Form CMS 64.9 or CMS-21. No later than six months after the end of each demonstration year, or as soon thereafter as data are available, the Commonwealth will calculate and report to CMS annual demonstration expenditures for the completed year. Administrative costs should be reported separately.
- d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the Commonwealth shall include a summary of the progress of evaluation activities, including rapid cycle evaluation assessments, key milestones accomplished, and any challenges encountered and how they were addressed.

- 29. Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid or CHIP, CMS reserves the right to require the Commonwealth to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waiver or expenditure authorities as outlined in STC 11. CMS will withdraw an authority, as described in STC 11, when metrics indicate substantial and sustained directional change inconsistent with the Commonwealth's demonstration goals, and the Commonwealth has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 30. Monitoring Calls.** CMS and the Commonwealth will hold monitoring calls no later than 60 calendar days after submission of the Monitoring Reports described in STC 28 to discuss the program update provided in the reports and any issues associated with the continued operation of the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, allotment neutrality, and progress on evaluation activities. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration. The Commonwealth and CMS will jointly develop the agenda for the calls.
- 31. Post Award Forum.** As required by 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the Commonwealth must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The Commonwealth must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the Commonwealth must include a summary of the comments in the Monitoring Report associated with the demonstration period in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

- 32. Evaluation Design Approval and Subsequent Updates.** The Commonwealth's CMS-approved evaluation design is incorporated into these STCs as Attachment C. A revised draft evaluation design addressing the postpartum extension component of the demonstration shall be submitted for CMS approval by no later than 180 calendar days after the approval of the demonstration. The revised draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs as well as any additional evaluation guidance provided by CMS specific to any program component being tested under this demonstration. Any CMS feedback on modifications needed to the revised draft Evaluation Design must be addressed within 60 calendar days after receipt of CMS'

comments. Upon CMS approval of the revised Evaluation Design, the document will be included as an updated Attachment C to these STCs.

Per 42 CFR 431.424(c), the Commonwealth will publish the approved revised Evaluation Design on the Commonwealth's website within 30 calendar days of CMS approval. The Commonwealth must implement the Evaluation Design and submit a description of its evaluation implementation process in each of the Monitoring Reports, including any required rapid cycle assessments specified in these STCs. If the Commonwealth wishes to make additional changes to the CMS-approved evaluation design, it must submit a revised evaluation design with the proposed changes to CMS for approval.

Failure to comply with this STC may result in a deferral being issued as outlined in STC 25.

- 33. Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the Commonwealth must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The Commonwealth must include in its contracts with entities who collect, produce, or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The Commonwealth may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 25.
- 34. Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations, such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.
- 35. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the Commonwealth intends to test. Each demonstration component should have at least one evaluation question and hypotheses. The evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. The Commonwealth must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation and Medicaid/CHIP health service expenditures.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS' Core Set of Health Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by the National Quality Forum (NQF). The findings from each evaluation component must be integrated to help inform whether the Commonwealth met the overall demonstration goals, with recommendations for future efforts regarding all components.

36. Interim Evaluation Report. The Commonwealth must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Evaluation Report should be posted to the Commonwealth's website with the application for public comment.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For any demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. The Commonwealth must provide a draft Interim Evaluation Report for the corresponding years, no longer than one year after completion of the measurement period, as follows. The Commonwealth must submit a final Interim Evaluation Report for each measurement period 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the documents to the Commonwealth's website.
 - i. An Interim Evaluation Report for the period of July 2019 through June 2022 will be due by no later than June 30, 2023.
 - ii. An Interim Evaluation Report for the period of July 2019 – June 2024 will be due by no later than June 30, 2025.
 - iii. An Interim Evaluation Report for the period of July 2019 – June 2027 will be due by no later than June 30, 2028.
- d. If the Commonwealth is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the Commonwealth made changes to the demonstration in its application for extension, the research questions and hypotheses, and how the design was adapted should be included. If the Commonwealth is not requesting a demonstration extension, an Interim Evaluation report is due one year prior to the end of the demonstration. For demonstration phase-out prior to the expiration of this demonstration approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

- e. The Commonwealth must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report. The Commonwealth must post the final Interim Evaluation Report to the Commonwealth's website within 30 calendar days of approval by CMS.
- f. The Interim Evaluation Report must comply with attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

37. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the Commonwealth to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the Commonwealth's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

38. Evaluation Outcomes. CMS may exercise its rights as described in STC 11 to not reauthorize any demonstration program authority for which there are no evaluation findings to support the conclusion that the state is making progress in achieving the goals of the demonstration program component in accordance with the CMS approved evaluation design for the demonstration. If CMS makes such determination, the Commonwealth must submit a phase-out plan for that demonstration component in accordance with STC 9.

39. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The Commonwealth must submit a draft Summative Evaluation Report for the demonstration approval period specified in these STCs within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the Commonwealth shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the Commonwealth's website within 30 calendar days of approval by CMS.

- 40. State Presentations for CMS.** CMS reserves the right to request that the Commonwealth present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.
- 41. Public Access.** The Commonwealth shall post the final documents (e.g., Monitoring Reports, Close-out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on its website within 30 calendar days of approval by CMS.
- 42. Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the Commonwealth, contractor, or any other third party directly connected to the demonstration over which the Commonwealth has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XXI and title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

- 43. Extent of Federal Financial Participation (FFP) for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP only for the medical assistance services and premium assistance payments as described in STC 21 and associated administrative expenditures. CMS will provide FFP at the applicable federal matching rate for the demonstration as outlined below, subject to the Commonwealth's title XXI allotment limit and the title XIX total computable expenditure limit set forth in STC 55:
- a. Medicaid or CHIP program administrative costs, including those associated with the administration of the demonstration.
 - b. Net expenditures and prior period adjustments of the Medicaid or CHIP program that are paid in accordance with the approved state plans.
 - c. Medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.
- 44. Sources of Non-Federal Share.** The Commonwealth must certify that the matching non-federal share of funds for the demonstration are state/local monies. The Commonwealth further certifies that such funds shall not be used as the match for any other federal grant or

contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The Commonwealth assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid or CHIP state plan.
- d. Certification of Funding Conditions. The Commonwealth must certify that the following conditions for non-federal share of demonstration expenditures are met:
 - i. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
 - ii. To the extent the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XXI or title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XXI or title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
 - iii. To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the Commonwealth the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the Commonwealth's claim for federal match.
- e. The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XXI or title XIX payments.

- f. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the Commonwealth as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of Medicaid or CHIP payments. This confirmation of Medicaid/CHIP payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes - including health care provider-related taxes - fees, and business relationships with governments that are unrelated to Medicaid or CHIP, and in which there is no connection to Medicaid or CHIP payments) are not considered returning and/or redirecting a Medicaid or CHIP payment.

45. Program Integrity. The state must have a process in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XII. MONITORING ALLOTMENT NEUTRALITY

46. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

- a. Tracking Expenditures: In order to track expenditures under this demonstration, the Commonwealth must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual.
- b. Use of Waiver Forms: Title XXI demonstration expenditures will continue to be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The Commonwealth must submit separate forms CMS-21 Waiver and/or CMS-21P Waiver for each demonstration population (i.e., FAMIS MOMS, FAMIS Select, and Postpartum Extension).
- c. Premiums: Premium contributions under the demonstration shall be reported to CMS on Form CMS-21 Waiver, line 29, in order to assure that the demonstration is properly credited with premium collections.
- d. Claiming Period: All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the Commonwealth must continue to identify separately, on the Form CMS-21 Waiver, net

expenditures related to dates of service during the operation of the demonstration.

- 47. Standard CHIP Funding Process.** The standard CHIP funding process will continue to be used during the demonstration. Virginia will continue to estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the Commonwealth shall provide updated estimates of expenditures for the demonstration populations. CMS will make federal funds available based upon the Commonwealth's estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the Commonwealth, and include the reconciling adjustment in the finalization of the grant award to the Commonwealth.
- 48. Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM".
- 49. Limit on Title XXI Funding.** Virginia will be subject to a limit on the amount of federal title XXI funding that the Commonwealth may receive on current eligible CHIP state plan populations and the demonstration populations described in STC 17 during the demonstration period. Federal title XXI funds for the Commonwealth's CHIP program (i.e., the approved title XXI state plan and this demonstration) are restricted to the Commonwealth's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.
- 50. Exhaustion of Title XXI Funds.** If the Commonwealth exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the Commonwealth must continue to provide coverage to the approved title XXI state plan separate child health program population and the demonstration populations described in STC 17 with Commonwealth funds.

XIII. MONITORING BUDGET NEUTRALITY

- 51. Expenditures Subject to the Budget Neutrality Agreement.** For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include all medical assistance expenditures made on behalf of Medicaid pregnant and postpartum individuals enrolled in the 12-month postpartum extension component of the demonstration.
- 52. Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name "ADM".
- 53. Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of

calculating the overall budget neutrality limit for the demonstration, a separate annual budget limit will be calculated for each demonstration year on a total computable basis, by multiplying the predetermined “per member, per month” (PMPM) cost for the (title XIX) “Postpartum Extension” eligibility group by the corresponding actual member months total, and summing the results of that calculation. The federal share of this limit will represent the maximum amount of FFP that the Commonwealth may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 57 below. The demonstration expenditures subject to the budget neutrality limit are those reported using the assigned waiver name - “Postpartum Extension.”

54. Reporting Member Months. The following describes the reporting of member months for the demonstration:

- a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the Annual Monitoring Report required per STC 28, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the Annual Monitoring Report certifying the accuracy of this information.
- b. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are each eligible for two months, each contribute two eligible member months, for a total of four eligible member months.

55. Budget Neutrality Annual Expenditure Limits. For each demonstration year (reflected as “DY” in the below table), an annual budget limit will be calculated for the demonstration. For the purposes of this demonstration, the state’s demonstration cycle is based on the state fiscal year which starts July 1 through June 30 of each year. Virginia will report expenditures in accordance with the annual demonstration cycles outlined as follows:

Demonstration Year 17 – July 1, 2021 – June 30, 2022
Demonstration Year 18 – July 1, 2022 – June 30, 2023
Demonstration Year 19 – July 1, 2023 – June 30, 2024
Demonstration Year 20 – July 1, 2024 – June 30, 2025
Demonstration Year 21 – July 1, 2025 – June 30, 2026
Demonstration Year 22 – July 1, 2026 – June 30, 2027
Demonstration Year 23 – July 1, 2027 – June 30, 2028
Demonstration Year 24 – July 1, 2028 – June 30, 2029

PMPM Cost. The following table provides the PMPM (total computable) cost ceiling for each demonstration year represented in this demonstration approval period. The PMPM cost ceilings were constructed based on the state’s historical expenditures from July 1, 2015 through June 30, 2020 and increased by a 5.2 percent rate of

growth; which is the trend rate included in the President’s Medicaid Budget for federal fiscal year 2022 for the same period of time that represents demonstration year 17 through demonstration year 24. The PMPM cost ceiling for each demonstration year represents the medical assistance payments for up to 12 months of continuous postpartum coverage for eligible individuals.

The budget limit for each demonstration year will be calculated using the below PMPM cost multiplied by the actual number of member months (as calculated in accordance with STC 54) and the Composite Federal Share.

Demonstration Year (DY)	Per Member Per Month (PMPM) Limit	Demonstration Year (DY)	Per Member Per Month (PMPM) Limit
DY17	\$648.88	DY21	\$794.50
DY18	\$682.41	DY22	\$835.81
DY19	\$717.90	DY23	\$879.27
DY20	\$755.23	DY24	\$924.99

56. Hypothetical Budget Neutrality Test. The title XIX (postpartum extension) component of the demonstration is structured as a “pass-through” or “hypothetical” expenditure test. Therefore, the Commonwealth may not accumulate or access budget neutrality “savings.” A prospective per capita cap on federal financial risk is established based on the costs that eligible individuals are expected to incur under the demonstration.

If total FFP for hypothetical expenditures should exceed the federal share of the Hypothetical Cap, the difference must be reported as a cost against the budget neutrality limit described in STC 55.

57. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on the Schedule C report, with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms.

58. Reporting Expenditures Subject to the Title XIX Budget Neutrality Agreement.

- a. Tracking Expenditures. In order to track expenditures under this demonstration, the Commonwealth must report demonstration expenditures through the Medicaid and Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported

each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00381/3) assigned by CMS, including the project number extension (i.e., 17, 18, 19, etc.) which indicates the demonstration year in which services were rendered.

- b. Use of Waiver Forms. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name “Postpartum Extension.”
- c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- d. Pharmacy Rebates. When claiming these expenditures the Commonwealth may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf>). The Commonwealth must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

59. Postpartum Coverage for the New Adult Group. The Commonwealth must submit to CMS a proxy methodology for state expenditures to qualify for the newly eligible FMAP under section 1905(y) of the Act, consistent with requirements provided in 42 CFR 433.206(d). This methodology must be approved by CMS and incorporated as Attachment D to these STCs, prior to the Commonwealth claiming enhanced newly eligible FMAP. The proxy methodology must identify the proportion of claimed expenditures for beneficiaries receiving post-partum benefits who are reasonably estimated to meet the definition of newly eligible under section 1905(y)(2)(A) of the Act for whom enhanced newly eligible FMAP may be claimed, and the proportion claimed for beneficiaries who do not meet this definition for whom the regular FMAP must be claimed.

60. Budget Neutrality Monitoring Tool. The Commonwealth and CMS will jointly develop a budget neutrality monitoring tool (using a mutually agreeable spreadsheet program) for the Commonwealth to use for quarterly budget neutrality status updates. The tool will

incorporate the “Schedule C Report” for monitoring actual expenditures subject to budget neutrality.

- 61. Risk.** The Commonwealth will be at risk for the per capita cost (as determined by the method described below) for state plan and demonstration populations enrolled in the demonstration for the 12-month postpartum extension, but not at risk for the number of participants enrolled in the demonstration. By providing FFP without regard to enrollment for all demonstration populations, CMS will not place the Commonwealth at risk for changing economic conditions. However, by placing the Commonwealth at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
- 62. Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- 63. Enforcement of Budget Neutrality.** If the Commonwealth exceeds the calculated cumulative target limit by the percentage identified below for any of the demonstration years (DYs), the Commonwealth must submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
DY17	DY 17 budget limit amount	+1.75 percent
DY18	DY 17 through DY 18 combined budget limit amount	+1.50 percent
DY19	DY 17 through DY 19 combined budget limit amount	+1.25 percent
DY20	DY 17 through DY 20 combined budget limit amount	+1.00 percent
DY21	DY 17 through DY 21 combined budget limit amount	+0.75 percent
DY22	DY 17 through DY 22 combined budget limit amount	+0.50 percent
DY23	DY 17 through DY 23 combined budget limit amount	+0.25 percent
DY24	DY 17 through DY 24 combined budget limit amount	+0.00 percent

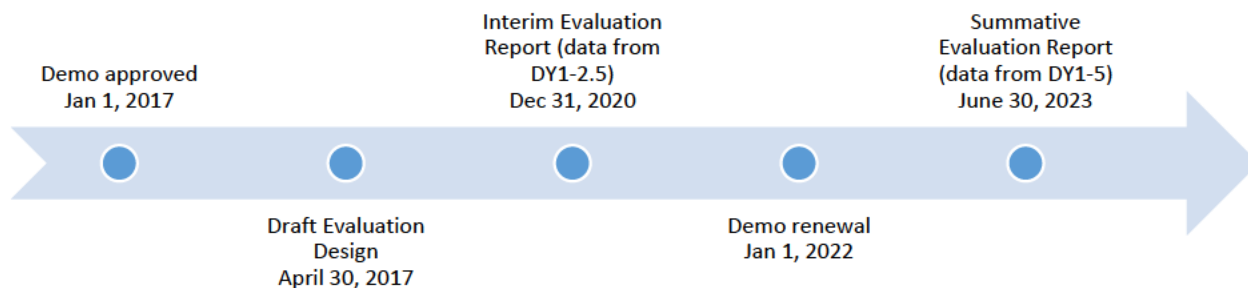
Attachment A Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations.

The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve

health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible

Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
 - a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
 - b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
 - c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
 - d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
 - a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
 - b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes;
 - b. No or minimal appeals and grievances;

- c. No state issues with CMS-64 reporting or budget neutrality; and
- d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a “No Conflict of Interest” statement signed by the independent evaluator.
2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

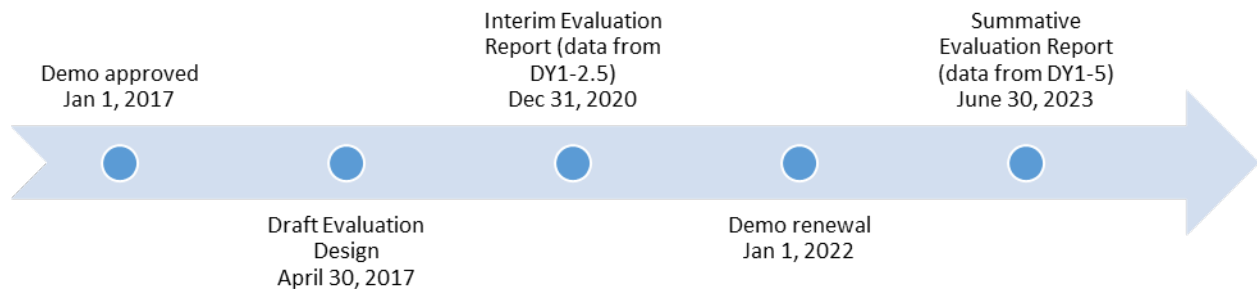
Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and,
- J. Attachment(s).

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
 3. A description of the population groups impacted by the demonstration.
 4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
 5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).
- C. Evaluation Questions and Hypotheses** – In this section, the state should:
1. Identify the state’s hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
 2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
 3. Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
 4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- D. Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C
CMS APPROVED DEMONSTRATION EVALUATION PLAN

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

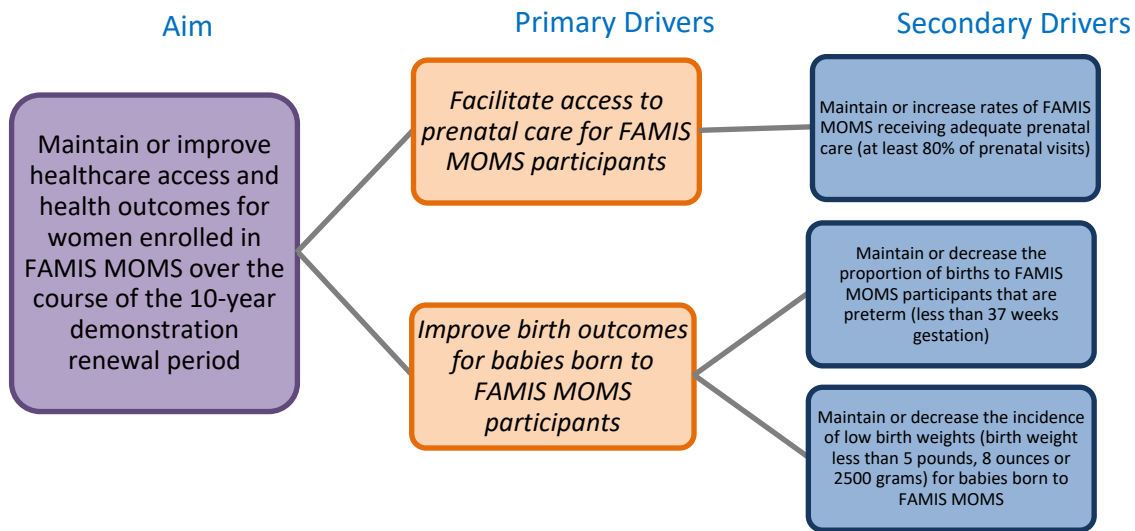
The FAMIS Select program was implemented in Virginia on August 1, 2005, replacing the former employer-sponsored health insurance (ESHI) program. FAMIS Select provides an alternative for families with children enrolled in FAMIS who have access to private or employer-sponsored coverage. All children are 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

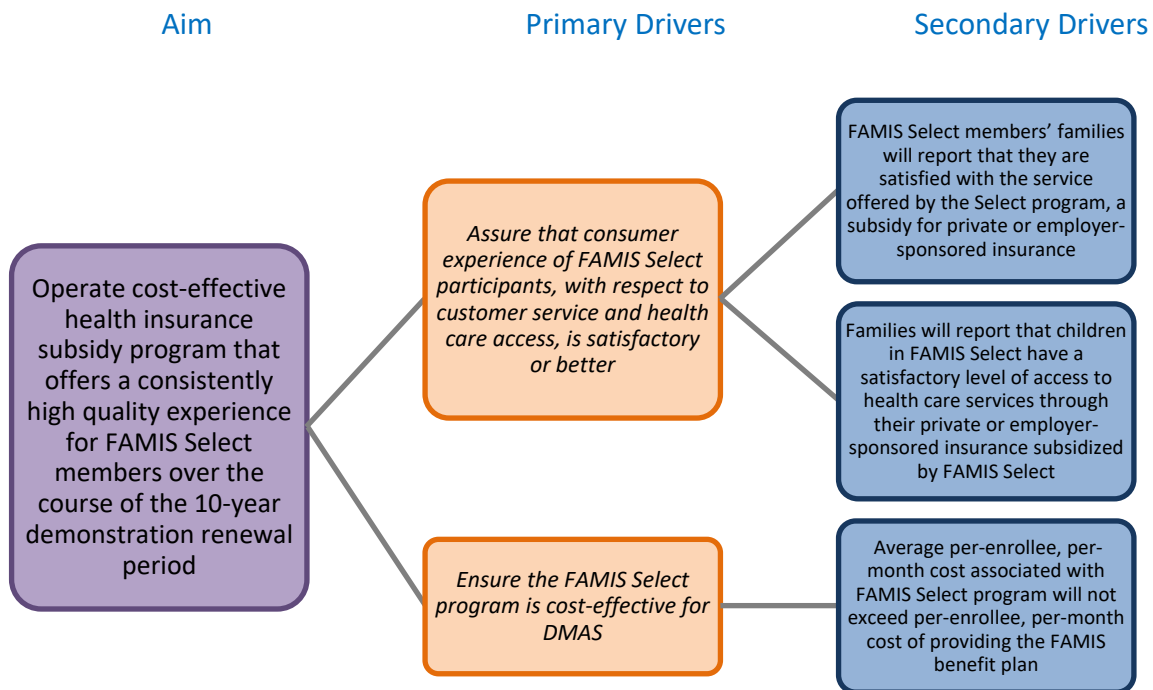
FAMIS MOMS: The demonstration will maintain or improve healthcare access and health outcomes for women enrolled in FAMIS MOMS over the course of the 10-year demonstration renewal period by:

- 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(b)(6)(C) 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 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 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 1 percentage point improvement for each year.⁶ DMAS will compare study indicator findings

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.

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

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.

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.

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)
Numerator	Number of infants born to FAMIS MOMS with a birth weight less than 5 pounds, 8 ounces (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.

Denominator	Total number of live, singleton births to FAMIS MOMS
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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.

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

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.medicicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

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.

Consistent with these STCs and 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

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.

ATTACHMENT D – Proxy Methodology for the New Adult Group

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