Thursday, March 7, 2024
1:00 PM to 3:00 PM
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
1st floor Conference Rooms A&B

This meeting will be held in person at the address below.
Members of the public may attend either in person or virtually.

To Join Meeting Remotely: ***Click here to Register***
Remote Conference Captioning Link: **https://www.streamtext.net/player?event=HamiltonRelayRCC-0307-VA4124**

DRAFT AGENDA

#	Item	
I.	Welcome and Announcements	1:00 PM – 1:05 PM
II.	CHIPAC Business A. Review/approval of minutes from December 7 meeting B. Committee membership and leadership updates and actions	1:05 PM – 1:30 PM
III.	2024 General Assembly Session Update *Will Frank, DMAS Senior Advisor for Legislative Affairs*	1:30 PM – 2:00 PM
IV.	2024 Budget Update *Truman Horowitz, Director, DMAS Budget Division*	2:00 PM – 2:30 PM
V.	Return to Normal Enrollment Update *Jessica Annecchini, Senior Policy Advisor, Administration*	2:30 PM – 2:50 PM
VI.	Agenda for June 6, 2024 CHIPAC Meeting	2:50 PM – 2:55 PM
VII.	Public Comment	2:55 PM – 3:00 PM

Reasonable accommodations will be provided upon request for persons with disabilities or limited English proficiency. Please notify the DMAS Civil Rights Coordinator at (804) 482-7269, or at civilrightscoordinator@dmas.virginia.gov, at least five (5) business days prior to the meeting to make arrangements.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

DRAFT
Meeting Minutes
12/7/23

A quorum of the full Committee attended the meeting virtually through Webex.
The Webex link was also made available for members of the public to attend virtually.

The following CHIPAC members were present virtually:

• Freddy Mejia (Vice Chair)	The Commonwealth Institute for Fiscal Analysis
• Shelby Gonzales	Center on Budget and Policy Priorities
• Emily Moore	Voices for Virginia's Children
• Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
• Michael Muse	Virginia League of Social Services Executives
• Emily Roller	Virginia Health Care Foundation
• Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services
• Kelly Cannon	Virginia Hospital and Healthcare Association
• Jennifer Macdonald	Virginia Department of Health
• Heidi Dix	Virginia Association of Health Plans
• Martha Crosby	Virginia Community Healthcare Association
• Estella Obi-Tabot (interim)	Joint Commission on Health Care

The following CHIPAC members sent a substitute:

• Alexandra Javna (Amy Edwards)	Virginia Department of Education

The following CHIPAC members were not present:

• Dr. Nathan Webb	Medical Society of Virginia
• Irma Blackwell	Virginia Department of Social Services

I. **Welcome** – Freddy Mejia, CHIPAC Vice Chair, called the meeting to order at 1:03 pm. Meija welcomed committee members and members of the public and explained that the meeting would be all-virtual.

Attendance was taken by roll call.

II. **CHIPAC Business**

A. **Review and approval of minutes from September 7 meeting** – Committee members reviewed draft minutes from the September 7 meeting. Kelly Cannon made a motion to approve the minutes; Jennifer Macdonald seconded, and the minutes were approved by majority vote (Yea: Brown, Cannon, Crosby, Gonzales, Macdonald, Mejia, Moore, Muse, Obi-Tabot, Roller; Nay: 0; No vote recorded: Dix, Edwards, Schweitzer).

B. **Membership items** – Hope Richardson, DMAS Policy Division, explained that after Sara Cariano's resignation as CHIPAC Chair, the Executive Subcommittee met in October to discuss committee leadership. The Executive Subcommittee voted to nominate Freddy Mejia, CHIPAC Vice Chair, to serve as CHIPAC Chair. Richardson explained that the full committee could vote on this nomination. Shelby Gonzales made a motion to confirm Mejia as chair, Estella Obi-Tabot seconded, and Mejia was confirmed as Chair by majority vote (Yea: Brown, Cannon, Dix, Gonzales, Macdonald, Moore, Muse, Obi-Tabot, Roller; Nay: 0; No vote recorded: Crosby, Edwards, Mejia, Schweitzer).

Mejia then explained that the Executive Subcommittee nominated Emily Roller, Virginia Health Care Foundation, to serve as the new committee Vice Chair, and that the full committee could vote on this nomination. Emily Moore made a motion to confirm, Heidi Dix seconded, and the Roller was confirmed as Vice Chair by majority vote. (Yea: Brown, Cannon, Crosby, Dix, Gonzales, Macdonald, Mejia, Moore, Muse, Obi-Tabot; Nay: 0; No vote recorded: Edwards, Roller, Schweitzer)

The committee then considered two nominations for new members, Kenda Sutton-EL of Birth in Color, and Sarah Bedard Holland of Virginia Health Catalyst. Emily Moore made a motion to approve Kenda Sutton-EL's membership, Heidi Dix seconded, and Sutton-EL was confirmed by majority vote (Yea: Brown, Cannon, Dix, Gonzales, Macdonald, Mejia, Moore, Muse, Roller, Schweitzer; Nay: 0; No vote recorded: Crosby, Edwards, Obi-Tabot).

Emily Moore then made a motion to approve Sarah Bedard Holland's membership; Emily Roller seconded, and Holland was confirmed by majority vote (Yea: Brown, Cannon, Dix, Gonzales, Macdonald, Mejia, Moore, Muse, Obi-Tabot, Roller, Schweitzer; Nay: 0; No vote recorded: Crosby, Edwards).

III. **Virginia Medicaid Unwinding Update**

Jessica Annecchini, DMAS Senior Policy Advisor for Administration, provided an

update on the process of unwinding from the federal public health emergency and redetermining Medicaid members' eligibility. The Unwinding of the Continuous Coverage Requirements has been in effect since March of 2023. While the coverage requirement ended March 31, 2023, states have been in planning mode since the PHE of March of 2020 to return to normal enrollment. The DMAS and Cover Virginia websites include information on Virginia's unwinding plan and any active flexibilities. Several provider flexibilities ended on November 11th, however, some flexibilities allowed through the 1902(e)14 waiver process remain in effect through the entirety of unwinding. The Medicaid.gov unwinding page goes into detail on the number of allowable flexibilities and a breakdown by state of the number and type of flexibilities adopted by each state/territory.

The redetermination dashboard, found under the Data tab on the DMAS website, has been enhanced over the summer to include additional demographic details, as well as more information on a regional and locality level basis. The closure tab gives additional information on closure reasons and the comparison of procedural vs. nonprocedural closures. DMAS is working with VDSS as well as stakeholders, advocates, and managed care health plans to ensure as many members turn in their renewal information as possible so that all members receive a full redetermination, whether that results in continued coverage or a transition referral for Marketplace coverage or cost sharing programs if eligible. In November of 2023, a procedural churn tab was added to the dashboard that shows the number of individuals closed for procedural reasons each month, and if they are reinstated coverage within their three-month reconsideration period.

As of 12/06/2023, 1,384,424 members have been redetermined of the 2,166,381 unwinding cohort as of 03/2023. (Note: this cohort is only individuals who were active and expected to receive a redetermination during unwinding. This does not include any new members added to the enrollment population since March of 2023.) Out of the members redetermined, 1,152,436 members retained coverage (83%) and 231,988 members were closed (17%). Overall, Virginia has completed 63.9% of all redeterminations needed for the unwinding cohort, which is due to the amazing work DMAS, VDSS, Cover Virginia has done, as well as the invaluable collaborations with stakeholders, advocates, and managed care health plans to ensure all eligible Virginians have access to high quality health care.

IV. DMAS Policy and Eligibility Updates

Sara Cariano, Director DMAS Division of Eligibility Policy and Outreach Division presented on eligibility updates.

Effective 1/1/24 children in Med and FAMIS will remain enrolled in 12 month protected coverage period regardless of changes in circumstances. Limited exceptions include turning age 19, moving out of state, member/representative requests termination of coverage, eligibility granted due to agency error or fraud/abuse, perjury, or death of

the enrolled child. Medicaid children remain in Medicaid and may not be moved to FAMIS during the (Continuous Eligibility) CE period. FAMIS children may be moved to Medicaid coverage if they qualify, but can't be disenrolled during the CE period. Obtaining other qualifying health coverage is not an exception to the CE requirement for FAMIS children.

V. Cardinal Care Update

Jeannette Abelson and Lynn Vest from DMAS Integrated Care Division provided update on Cardinal Care Model of Care overview and comparison with current program rules. Vest provided update about Cardinal Care and Model of Care. As a part of the 2021 Appropriations Act, DMAS was directed to merge the two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) in a manner that links seamlessly with the fee for service program. DMAS received approval from CMS to consolidate the Medallion 4.0 and CCC Plus program under Cardinal Care Managed Care (CCMC), effective October 1, 2023. This merge includes all existing managed care populations and services. CCMC members remain enrolled with their current managed care organizations (MCO) and can continue to see their doctors and providers. Full implementation of CCMC may require up to 60 days from October 1, 2023. The CCC Plus Home and Community -Based Services (HCBS) Waiver will continue to operate as the CCC Plus HCBS waiver. CCMC coverage for newborn enrollment, LTSS and Hospice Services, and members hospitalized at enrollment varied slightly, but will aligned coverage effective November 1, 2023. Providers will continue to contract with the same 5 MCOs and continue to use the same service authorization and billing processes for fee-for-service and MCOs, unless notified of a specific change. The names CCC Plus and Medallion 4.0 will be phased out starting January 1, 2024.

CCMC Model of Care ensures delivery of high-level care of Cardinal Care Members. It focuses on the member needs and where they are at any given time. The Model of Care uses data effectively to target appropriate and timely interventions to drive the right care at the right time. It provides access to care management services across populations, based on the member's evolving needs and health risks. Model of Care offers 3 levels of Care management based on the members needs/risks. There are those with high, moderate, and low intensity which would require Care Management. Some of the outcomes of Care Management focus on helping facilitate successful transitions between levels of care settings, establishes wrap-around community support, and collaborates with involved parties to ensure the member's health, safety, and welfare. Care coordination is more for members with minimal needs. Care Management partners with providers on behalf of member with significant health needs to support the members choice to reside in the least restrictive environment, successful transitions between levels of care, provide comprehensive health risk assessments, etc.

The process for Identifying Members for Care Management, MCOs use a risk stratification and scoring to identify Mandatory high priority populations, Mandatory Priority Populations, Priority Population and require Care Coordination services.

Susan Brown asked about the expectation for the MCOs percentage of members who qualify for care management that accept and enroll in care management. Vest mentioned that in Cardinal Care, everyone has access to care coordination, but everyone has the right to refuse. MCOs will track that and DMAS does a lot of care management trainings to help with best practices for our members and communication.

VI. DBHDS Update – School Mental Health Pilots

Katherine Hunter and Bern'Nadette Knight from DBHDS provided update for School Mental Health pilots. The General Assembly (GA) approved $2,500,000 towards School Based Mental Health services for technical assistance to school divisions seeking guidance on integrating MH services, grants to school divisions to contract for community based mental health services for students from public or private community-based providers, and the ability to report back to the GA on the success of the pilot and identify recommendations and resources to continue efforts by September 1, 2023.

This initiative is a part of the Governors larger Right Help, Right Now initiative behavioral health transformation. This encourages partnership with the school division and utilizing resources in the community. This Pilot Project used a multi-tiered system of implementation with schools to provide systems of support based on students need level. Tier 1 includes universal supports, Tier 2 increases access to academic support and school family communication, and Tier 3 engaged students, educators, and families in functional behavioral assessments and intervention planning.

DBHDS partnered with the Department of Education (DOE) in providing technical assistance in three phases: Universal (Virginia schools and providers), Pre-Implementation (New Implementers), and Implementation (For Grantees). The Universal technical assistance helped with the development of asynchronous modules for school leaders, community mental health providers, and specialized student support personnel. Pre-implementation facilitated exploration and installation activities such as needs assessment and resource mapping of division/community resources. Implementation provided peer-to-peer learning opportunities. Lunenburg County ($349.822.02), Hanover County ($374,850), Bristol ($213,119.55), Mecklenburg County (319,822.02), Hopewell City ($346,500), and Richmond Public Schools ($182,080) received funding totaling $1,786,193.59 between November 2022 through February 2023. Over 800 children were served for elementary, middle, and high school. Types of services provided include suicide prevention, and mental health awareness, motivational interviewing, Brief Intervention, and referral services, individual ang group therapy, group, and psychotherapy. Hanover implemented a calming center which had a great impact.

In order to receive feedback from stakeholders, they conducted a Focus Group conducted on Right Here Right Now regarding their feedback to expand school based mental health in the community, what is the biggest benefit, and biggest barrier to implement mental health-based services. Responses included consistent funding, continued technical assistance, increased collaboration, gaining buy in from key stakeholders, clear understanding of implementation of school based mental health services, and clear ways to measure success and outcomes.

Successes from Pilot include hiring of personnel with community partners, provision of services to students in need and TA support to schools. Some Challenges include full appropriation was not spent due to accelerated timeline, lack of available licensed behavioral health staff statewide challenged community partners, and uncertainty around sustainable funding impacted hiring a program implementation. Schools were unable to spend all funds due to lack of availability of licensed behavioral staff, accelerated timelines, and uncertainty around sustainable funding impacting hiring and program implementation.

Recommendations mentioned include a continued ability to build continuum of youth mental health care available, enhance support community-based partnership with schools, establish shared outcome measures using goals of schools and youth mental health outcomes, develop targeted efforts to expand the behavioral health workforce that serves youth. The overall aim continues to be the same with implementation with an increase of the budget to $7.5 million for this appropriation. There is an application process is underway for interested school division interested in funding. There will be continued collaboration with DOE on data/evaluation outcomes as well. The current timeline is November 2023 to January 2024.

A public comment asked how the calming rooms implemented impacted students regarding behaviors in the school and was there any data collected specifically on impact on behavior and mental health issues. There is no current specific data as of yet, but they will follow up on this and will get information on future schools utilizing this strategy.

VII. Discussion of agenda items for March 7, 2024, CHIPAC Meeting

Mejia announced that the March 7, 2024, meeting will be an in-person meeting held at DMAS offices. Mejia asked members if they had suggested agenda items for the March meeting. Mejia and Richardson invited members to submit any ideas or requests for the March meeting agenda to the Executive Subcommittee for consideration at their January subcommittee meeting.

VIII. Public Comment

Levar Bowers commented he wanted to thank everyone for all the hard work and dedication. This forum is always one of the most informative and well run, and the quality of work being done collectively is evident.

IX. Closing

The meeting was adjourned at 2:45pm

Laura Harker - Bio

Laura Harker is a Senior Policy Analyst on the Health Policy team. She is a health policy researcher and health equity advocate with exper se in Medicaid and other state health care programs. Most recently, she served as the Senior Health Policy Analyst at Georgia Budget and Policy Ins tute (GBPI), where she provided data for health advocacy partners and lawmakers and served as a key voice on health policy issues in the state. Previously, she served as a Fellow with the Congressional Hunger Center and led a community nutri on educa on program at the Children's Na onal Medical Center in Washington, D.C. Laura graduated from the University of North Carolina at Chapel Hill with a Bachelor of Science in Public Health and holds a Master's degree in Health Policy and Management from Emory University.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

Laura Harker

CHIPAC Candidate Questionnaire

The mission of Virginia's CHIP Advisory Committee (CHIPAC) is to advise the Director of DMAS and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS' programs that address the health needs of children (FAMIS/CHIP and FAMIS Plus/Medicaid).

1. Please describe the experience and qualifications you will bring to the CHIPAC, including those specifically related to children's health/health insurance. Please also include examples of your commitment to supporting and improving public medical assistance programs.

   I have over seven years of experience as a policy analyst and an advocate for protecting and expanding state health programs. For five of those years, I served as a key voice on state health policy issues in Georgia and built expertise on the state's Medicaid/CHIP program, as well as the state's behavioral health and public health services. Some of my work on Medicaid/CHIP included conducting analysis of the annual Medicaid budget, conducting dozens of interviews with the state and national media and being quoted on Medicaid and other state health issues, and providing legislative testimony to get bills passed that would ensure full funding for Medicaid, streamline eligiblity for the program or expand and extend Medicaid coverage to more people.

   Two years ago, I started in my current role where I continue to build and share Medicaid expertise with state advocates – but across multiple states through grant-funded projects that my organization oversees. Some of the topics I focus on include Medicaid expansion, maternal health initiatives such as Medicaid doula reimbursement and postpartum extension, expanding coverage to people regardless of immigration status, Medicaid (Section 1115) and marketplace (section 1332) waivers, continuous eligiblity for children and other groups, and supporting collaborations between grassroots and policy partners as they build power in their communities to advance health justice.

   Some examples of my commitment to supporting and improving public medical assistance programs include: serving on the leadership for the Medicaid expansion coalition in Georgia and traveling to locations across the state to share information about the opportunity to cover over 500,000 Georgians; leading efforts in my state to analyze and share the impact of proposed federal efforts in 2017 to block grant the Medicaid program (including an analysis of impact on hospital revenues) and information for education advocates on the impact of Medicaid cuts on K-12 schools; and prioritizing securing and maintain funding supports for our state advocacy grantees that are working directly with people served by public health insurance programs to share their stories and build their leadership as advocates and experts on the importance of these programs and how to make them work better for people.

2. What motivates you to participate in CHIPAC? What are your goals and priorities as a member of the Committee?

   I am motivated to participate in CHIPAC because most of my work has been on advocacy for new policy changes within Medicaid/CHIP and I am interested in learning more about the implementation side of seeing how the policies work for people as they roll out and evaluating their impact. I miss being more connected to state-level implementation work (since my work now is across multiple states and focused on legislative advocacy) and believe participating in CHIPAC would be a great opportunity for me to provide insights from my policy expertise at the federal level and my understanding of the landscape across several other states related to Medicaid/CHIP policy. I also am excited about the opportunity to meet more people in Virginia and get more connected to policy work in the state – as a new resident in the city of Richmond since moving from Atlanta with my husband and our dog at the end of 2022. We both work remotely but have family in the Richmond area and closer by in Eastern North Carolina.

   My initial goals and priorities as a member of the committee include developing relationships with other members of the committee and agency staff and determining how I can serve as a resource on the impact of federal policies that I am monitoring in my current role, including my team's work on following the unwinding process in states and the impacts of any proposed federal changes on DMAS programs and the children they serve.

Tiffany Gordon - Bio

Tiffany Gordon is a lifelong Virginia resident who graduated from Virginia Peninsula Community College and Christopher Newport University with a B.S. in Early Childhood Psychology. She has spent the last 22 years of her career in social services having worked for local departments and the Virginia Department of Social Services (VDSS). Ms. Gordon started her career at New Kent Department of Social Services (DSS) as a Children's Services Act Coordinator and as generic Family Services Specialist. From there she worked as an OASIS Trainer for the Virginia Department of Social Services. Ms. Gordon spent two years working for Virginia Tech as a case reviewer. After the contract with Virginia Tech ended, she landed at York-Poquoson DSS as a senior worker in the Child Protective Services Unit. While working her way up to a Family Services Supervisor she worked on her Master of Social Work from Norfolk State University. She completed her internship at Natasha House which serves homeless women and their children. After graduating she became the Assistant Director at York-Poquoson DSS. Ms. Gordon returned to VDSS where she audited adoption subsidy records and was the Child and Family Services Review Supervisor. Ms. Gordon has been the Director at Mathews DSS since March of 2016. Having little knowledge of Benefit Programs, Ms. Gordon joined the Benefit Program Committee as part of the Virginia League of Social Services Executives. For over five years, she has served as the Chair of the committee. Ms. Gordon is married with two adult daughters, one son in law and three grandsons. She and her youngest daughter are volunteer Puppy Raisers for Canine Companions, where they are raising their first future services dog Hans, who is 11 months old. She enjoys time with her family at her grandsons' baseball games, and camping. Ms. Gordon enjoys getting away and cruising any time she can. She is currently trying something new, adult ballet and adult tap.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

Tiffany Gordon

CHIPAC Candidate Questionnaire

The mission of Virginia's CHIP Advisory Committee (CHIPAC) is to advise the Director of DMAS and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS' programs that address the health needs of children (FAMIS/CHIP and FAMIS Plus/Medicaid).

1. Please describe the experience and qualifications you will bring to the CHIPAC, including those specifically related to children's health/health insurance. Please also include examples of your commitment to supporting and improving public medical assistance programs.

I have been in employed by either the Virginia Department of Social Services or a Local Department of Social Services since 2001. I have spent the majority of my career in Child Welfare, where I gained very minimal knowledge of FAMIS/CHIP and Medicaid. As an Assistant Director of York/Poquoson DSS, I gained more knowledge of Medicaid and FAMIS. We worked with the Lacky Free Clinic when clients did not qualify for Medicaid (prior to expansion). Currently, as the Director of Mathews Department of Social Services, I am the Chair for the Benefit Program Committee for the Virginia League of Social Services Executives and have been in that role for over five years. In both of those roles I have been an advocate for Medicaid so that for families and children can receive the necessary care for their medical, dental and mental health needs. Additionally, as the Chair of the committee I advocate with VDSS and DMAS.

2. What motivates you to participate in CHIPAC? What are your goals and priorities as a member of the Committee?

My motivation to participate is to continue ensuring that every child and family that qualifies for FAMIS or Medicaid applies and gets what they need. Health care is so expensive for families, and I believe many do not understand they could qualify. I want to continue collaborate with VDSS and DMAS to ensure the children and families of the Commonwealth get the coverage they need.

CardinalCare
Virginia's Medicaid Program

Virginia General Assembly Update

Will Frank
Senior Advisor for Legislative,
Department of Medical
Assistance Services

DMAS

DMAS Legislative Role

1. Monitor introduced legislation
2. Review legislation and budget language for Secretary and Governor
3. Make position recommendations to Secretary and Governor
4. Communicate Governor’s positions to General Assembly
5. Provide expert testimony and technical assistance to legislators on legislation

2024 GA Session Stats

- 2,852 bills introduced.
- DMAS was assigned 38 lead bills plus took an active role in key legislation led by other agencies
- These included bills with Amend, No Position, and Oppose positions.
- Major topics include:
  - New Medicaid benefits
  - Changes to rules for paid family caregivers (legally responsible adults)
  - Eligibility changes for waiver recipients
  - Pharmacy benefit changes

New Benefit Proposals

Comprehensive Children's Coverage	Human Donor Breast Milk
Community Health Workers	Adult Hearing Screenings
Violence Prevention Services	Fertility Preservation
Remote Fetal Monitoring	PANS/PANDAS Services
Brain Injury Services	Essential Hygiene Services

Legally Responsible Adults

- Legislation introduced in the House and the Senate to change specific provisions of DMAS's approved plans to continue paying Legally Responsible Individuals who provide personal care to their children
  - Allows 40 hours per member if there are two members in the household
  - LRI to provide services without proof of no other provider
  - Another parent can be employer of record
  - LRI is eligible for respite services
- Both House and Senate have rolled all potential changes into single bills and sent them to money committees.
- As of Feb. 21, Bills have been amended and House bill is different from Senate
  - HB909 removes respite but leaves in other flexibilities.
  - SB488 was turned into a study and report.

Pharmacy Legislation

- Legislation and Budget Amendments were introduced proposing changes to drug costs and purchasing
  - State-wide centralized pharmacy purchasing
  - Pharmacy carve-out from managed care
  - Prescription Drug Affordability Board
  - Changing payment structure for long-acting injectables (LAI)
- As of February 21st, Prescription Drug Affordability Board and changes to LAI payment structure were alive in at least one chamber

Waiver and Screening Bills

- Disregard Social Security Disability Insurance when determining financial eligibility for DD waivers
- Increase the time a DD waiver slot can be retained from 150 days to up to 365 days
- Greater flexibility for nursing facilities and PACE programs to conduct LTSS screenings in specific circumstances

Other Legislation

- Bill to require timeliness of lien settlements when DMAS has a claim for reimbursement against the settlement of a member (when they are injured and the settlement covers their medical costs)
- Bill creating a new provider type – behavioral health technicians and behavioral health technician assistants – would enable DMAS to potentially include these provider types in redesigned behavioral health services

Questions

Thank you

Will Frank- will.frank@dmas.virginia.gov

CardinalCare
Virginia's Medicaid Program

Finance Update

Truman Horwitz, Budget Division Director

DMAS

Overview

- Expenditure comparison

- Tracking to the forecast

Expenditure Comparison
In Millions

Five Year Look-back (Through January)

	Actuals through January - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	108.3	109.1	119.0	145.7	160.6	15	10.3%
FAMIS FFS	7.9	5.1	13.8	14.7	16.4	2	11.2%
FAMIS Dental	14.2	12.3	12.4	16.6	19.7	3	18.9%
FAMIS Total	**130.3**	**126.5**	**145.2**	**177.0**	**196.7**	**20**	**11.2%**

	Actuals through January - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	83.0	111.3	110.3	128.5	123.1	(5)	-4.2%
MCHIP FFS	4.6	4.7	4.3	2.5	4.3	2	70.9%
MCHIP Dental	14.4	13.7	14.0	20.4	22.8	2	11.5%
MCHIP Total	**102.0**	**129.7**	**128.6**	**151.4**	**150.1**	**(1)**	**-0.8%**

Fund Type - CHIP							
General	37.4	58.8	79.6	94.0	106.9	13	13.7%
FAMIS Trust Fund	6.8	7.0	3.3	7.0	7.0	-	0.0%
Federal	188.2	190.4	191.0	227.3	232.9	5.6	2.4%
Total	**232.4**	**256.2**	**273.8**	**328.3**	**346.8**	**18**	**5.6%**

Expenditure Comparison
In Millions

Five Year Look-back (Through January)

	Actuals through January - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	108.3	109.1	119.0	145.7	160.6	15	10.3%
FAMIS FFS	7.9	5.1	13.8	14.7	16.4	2	11.2%
FAMIS Dental	14.2	12.3	12.4	16.6	19.7	3	18.9%
FAMIS Total	**130.3**	**126.5**	**145.2**	**177.0**	**196.7**	**20**	**11.2%**

	Actuals through January - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	83.0	111.3	110.3	128.5	123.1	(5)	-4.2%
MCHIP Total	**102.0**	**129.7**	**128.6**	**151.4**	**150.1**	**(1)**	**-0.8%**
Fund Type - CHIP							
General	37.4	58.8	79.6	94.0	106.9	13	13.7%
FAMIS Trust Fund	6.8	7.0	3.3	7.0	7.0	-	0.0%
Federal	188.2	190.4	191.0	227.3	232.9	5.6	2.4%
Total	**232.4**	**256.2**	**273.8**	**328.3**	**346.8**	**18**	**5.6%**

Enrollment is **up** on average by **10%** from this time last year in **FAMIS**.

Expenditure Comparison
In Millions

Five Year Look-back (Through January)

	Actuals through January - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	108.3	109.1	119.0	145.7	160.6	15	10.3%
FAMIS FFS	7.9	5.1	13.8	14.7	16.4	2	11.2%
FAMIS Dental	14.2	12.3	12.4	16.6	19.7	3	18.9%
FAMIS Total	**130.3**	**126.5**	**145.2**	**177.0**	**196.7**	**20**	**11.2%**

Dental rates **increased** by 30% in FY23.

						FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	83.0	111.3	110.3	128.5	123.1	(5)	-4.2%
MCHIP FFS	4.6	4.7	4.3	2.5	4.3	2	70.9%
MCHIP Dental	14.4	13.7	14.0	20.4	22.8	2	11.5%
MCHIP Total	**102.0**	**129.7**	**128.6**	**151.4**	**150.1**	**(1)**	**-0.8%**
Fund Type - CHIP							
General	37.4	58.8	79.6	94.0	106.9	13	13.7%
FAMIS Trust Fund	6.8	7.0	3.3	7.0	7.0	-	0.0%
Federal	188.2	190.4	191.0	227.3	232.9	5.6	2.4%
Total	**232.4**	**256.2**	**273.8**	**328.3**	**346.8**	**18**	**5.6%**

Expenditure Comparison
In Millions

Five Year Look-back (Through January)

	Actuals through January - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
						5	10.3%
						2	11.2%
FAMIS Dental	14.2	12.3	12.4	16.6	19.7	3	18.9%
FAMIS Total	**130.3**	**126.5**	**145.2**	**177.0**	**196.7**	**20**	**11.2%**

Enrollment **decreased** by 11% in MCHIP Managed Care.

	Actuals through January - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	83.0	111.3	110.3	128.5	123.1	(5)	-4.2%
MCHIP FFS	4.6	4.7	4.3	2.5	4.3	2	70.9%
MCHIP Dental	14.4	13.7	14.0	20.4	22.8	2	11.5%
MCHIP Total	**102.0**	**129.7**	**128.6**	**151.4**	**150.1**	**(1)**	**-0.8%**
Fund Type - CHIP							
General	37.4	58.8	79.6	94.0	106.9	13	13.7%
FAMIS Trust Fund	6.8	7.0	3.3	7.0	7.0	-	0.0%
Federal	188.2	190.4	191.0	227.3	232.9	5.6	2.4%
Total	**232.4**	**256.2**	**273.8**	**328.3**	**346.8**	**18**	**5.6%**

Expenditure Comparison
In Millions

Five Year Look-back (Through January)

	Actuals through January - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
						5	10.3%
						2	11.2%
						3	18.9%
						0	**11.2%**

Pharmacy rebates were $1.26m **higher** in FY23 than FY24, but FY24 seems more in line with history.

	Actuals through January - MCHIP					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**Change**
MCHIP MCO	83.0	111.3	110.3	128.5	123.1	(5)	-4.2%
MCHIP FFS	4.6	4.7	4.3	2.5	4.3	2	70.9%
MCHIP Dental	14.4	13.7	14.0	20.4	22.8	2	11.5%
MCHIP Total	**102.0**	**129.7**	**128.6**	**151.4**	**150.1**	**(1)**	**-0.8%**
Fund Type - CHIP							
General	37.4	58.8	79.6	94.0	106.9	13	13.7%
FAMIS Trust Fund	6.8	7.0	3.3	7.0	7.0	-	0.0%
Federal	188.2	190.4	191.0	227.3	232.9	5.6	2.4%
Total	**232.4**	**256.2**	**273.8**	**328.3**	**346.8**	**18**	**5.6%**

Expenditure Comparison
In Millions

Five Year Look-back (Through January)

	Actuals through January - FAMIS					FY23 vs. FY24	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Change**	**% Change**
FAMIS MCO	108.3	109.1	119.0	145.7	160.6	15	10.3%
FAMIS FFS	7.9	5.1	13.8	14.7	16.4	2	11.2%
FAMIS Dental	14.2	12.3	12.4	16.6	19.7	3	18.9%
FAMIS Total	**130.3**	**126.5**	**145.2**	**177.0**	**196.7**	**20**	**11.2%**

	Actuals through January - MCHIP					FY23 vs. FY24	
Expenditure							
MCHIP MCO							
MCHIP FFS	4.6	4.7	4.3	2.5	4.3	2	70.9%
MCHIP Dental	14.4	13.7	14.0	20.4	22.8	2	11.5%
MCHIP Total	**102.0**	**129.7**	**128.6**	**151.4**	**150.1**	**(1)**	**-0.8%**
Fund Type - CHIP							
General	37.4	58.8	79.6	94.0	106.9	13	13.7%
FAMIS Trust Fund	6.8	7.0	3.3	7.0	7.0	-	0.0%
Federal	188.2	190.4	191.0	227.3	232.9	5.6	2.4%
Total	**232.4**	**256.2**	**273.8**	**328.3**	**346.8**	**18**	**5.6%**

Reflects the decreasing enhanced FMAP.

Expenditure Comparison – Another way to Look at the Data

In Millions

FY 2024 Compared Against the Forecast

Expenditures	YTD Nov Forecast	YTD FY 2024	Variance	Comments
FAMIS MCO	152,931,812	160,616,412	5.0%	FAMIS Average Enrollment above forecast
FAMIS FFS	14,473,423	16,383,895	13.2%	Fall disenrollment and re-enrollment
FAMIS Dental	21,080,582	19,716,462	-6.5%	Anticipated more utilization
FAMIS Total	**188,485,817**	**196,716,769**	**4.4%**	FAMIS Average Enrollment above forecast
MCHIP MCO	118,926,888	123,053,460	3.5%	MCHIP Average Enrollment above forecast
MCHIP FFS	4,695,124	4,269,640	-9.1%	Anticipated more utilization
MCHIP Dental	23,404,756	22,756,287	-2.8%	Anticipated more utilization
MCHIP Total	**147,026,768**	**150,079,387**	**2.1%**	MCHIP Average Enrollment above forecast
Title XXI Total	**335,512,585**	**346,796,157**	**3.4%**	

Key Point: The variance shown is primarily attributable to higher enrollment in FAMIS

Summary

- Expenditures through January are reflecting a slight trend above forecast.

- The team is monitoring but expects unwinding-related disenrollments to bring spending down to forecasted levels by the end of the fiscal year.

Overall Monthly Overview Status Dashboard

Eligibility Category: (All)

Report Date: 2/21/2024

Program: (All)

Total Members during the start of Unwinding

2,166,381
Members

Overall Members Overview Status

Current Month Overview Status

(Hover over the line to view Monthly Trend)

Redeterminations Needed

384,095

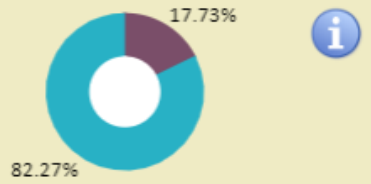
Coverage Closed

265,072

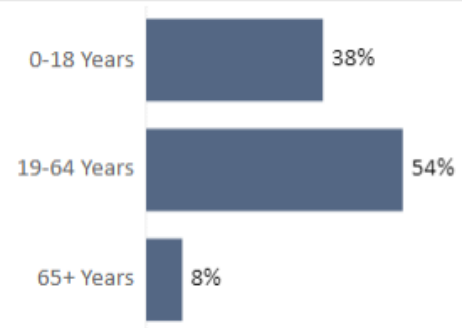
Coverage Renewed and Continues

1,517,214

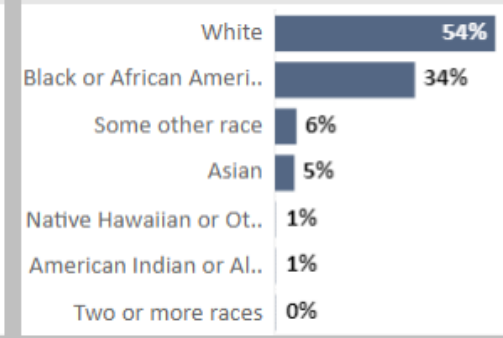
Unwinding Progress



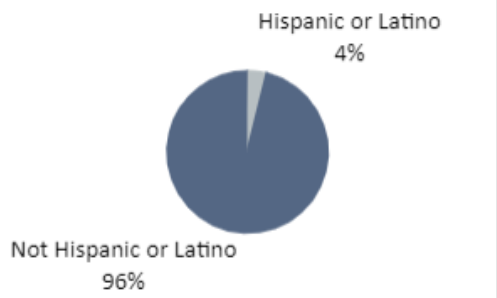
Member Age



Member Race



Member Ethnicity



Member Gender

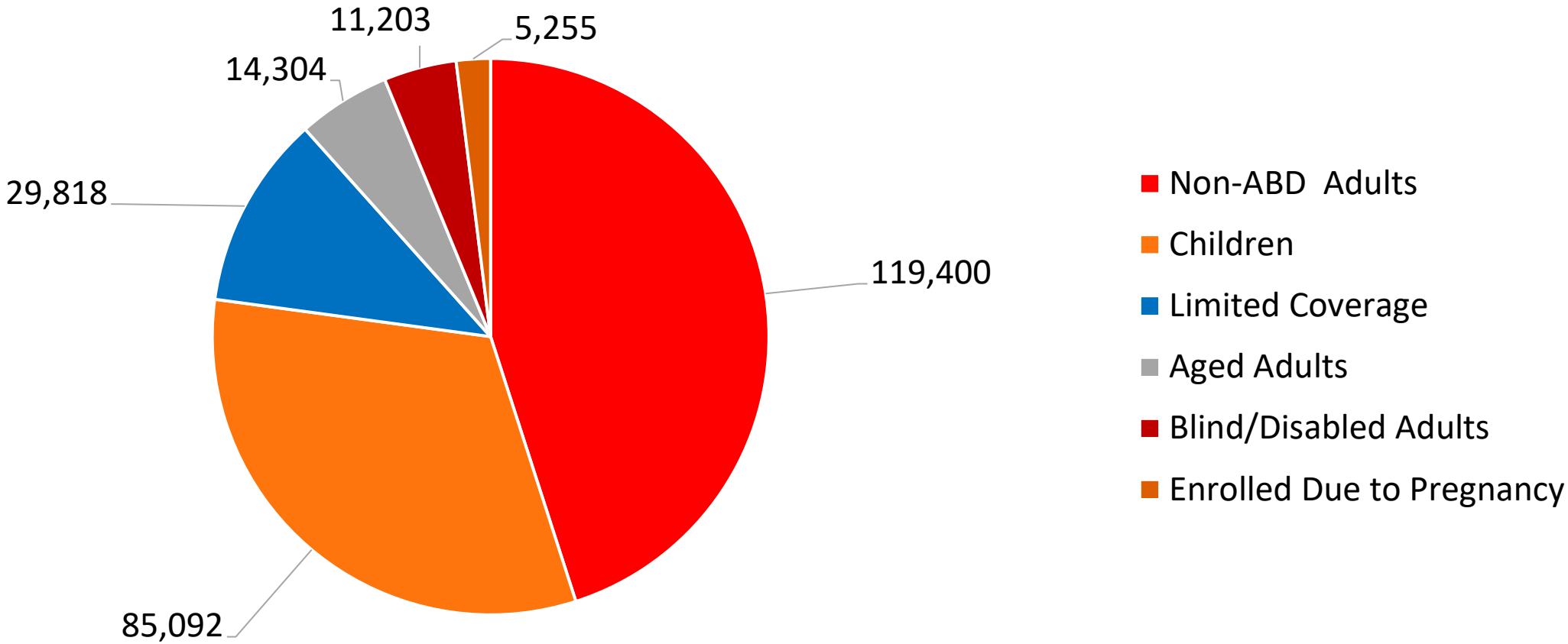
***Data as of 02/21/2024**

Completed by Member
2,166,831
2,000,000
1,900,000
1,800,000
1,782,286*
1,600,000
1,500,000
1,400,000
1,300,000
1,200,000
1,100,000
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000

Top Closures by Eligibility Grouping:

Closures through 02/21/2024

The highest closures have occurred among non-disabled adults between the ages of 19-64, followed by children, and then those enrolled in limited coverage such as Medicare Savings Plans, Plan First (family planning coverage), Incarcerated Coverage, and Emergency Medicaid.



Procedural vs. Non-Procedural Closures by Eligibility Grouping:

Closures through 02/21/2024

The highest closures have occurred among non-disabled adults between the ages of 19-64, followed by children, and then those enrolled in limited coverage such as Medicare Savings Plans, Plan First (family planning coverage), Incarcerated Coverage, and Emergency Medicaid.