CardinalCare
Virginia's Medicaid Program

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

VIRGINIA'S MEDICAID PROGRAM
DMAS

Thursday, December 12, 2024
1:00 PM to 3:30 PM

This meeting will be held virtually.

To Join Meeting:
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZTVkODQ4MDktY2ZhZi00NmIyLWE3MDMtZGQ2ZmZmNTRmZmE1%40thread.v2/0?context=%7b%22Tid%22%3a%22620ae5a9-4ec1-4fa0-8641-5d9f386c7309%22%2c%22Oid%22%3a%229093fb46-2494-4ee8-a8f9-eab4f689bc31%22%7d

Remote Conference Captioning Link:
https://www.streamtext.net/player?event=HamiltonRelayRCC-1212-VA4122

AGENDA

#	Item	
I.	Welcome and Announcements	1:00 PM – 1:05 PM
II.	CHIPAC Business A. Review/approval of minutes from September 5, 2024 meeting B. Committee membership updates	1:05 PM – 1:15 PM
III.	Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit *Kimberli Myrick, Child Health Program Operations Analyst, Health Care Services Division, DMAS*	1:15 PM – 2:00 PM
IV.	Twelve Months Postpartum Extension Evaluation *Emily Roller, Senior Management Analyst, Policy Division, DMAS*	2:00 PM – 2:45 PM
V.	CHIPAC 2025 Priorities Discussion	2:45 PM – 3:10 PM
VI.	Agenda for March 6, 2025 CHIPAC Meeting	3:10 PM – 3:20 PM
VII.	Public Comment	3:20 PM – 3:30 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
September 5, 2024

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

The following CHIPAC members were present in person:

• **Freddy Mejia (*Chair*)**	The Commonwealth Institute for Fiscal Analysis
• **Sarah Stanton**	Joint Commission on Health Care
• **Jennifer Macdonald**	Virginia Department of Health
• **Alexandra Javna**	Virginia Department of Education (DOE)
• **Kari Savage** (substitute)	Virginia Department of Behavioral Health and Developmental Services (DBHDS)
• **Joanna Fowler**	Virginia Health Care Foundation
• **Irma Blackwell**	Virginia Department of Social Services (VDSS)
• **Kelly Cannon**	Virginia Hospital and Healthcare Association
• **Laura Harker**	Center on Budget and Policy Priorities
• **Tiffany Gordon**	Virginia League of Social Services Executives
• **Emily Moore (*Vice Chair*)**	Voices for Virginia's Children
• **Heidi Dix**	Virginia Association of Health Plans
• **Dr. Susan Brown**	American Academy of Pediatrics (VA Chapter)
• **Martha Crosby**	Virginia Community Healthcare Association
• **Kenda Sutton-EL**	Birth in Color
• **Ben Barber** (substitute)	Virginia Health Catalyst
• **Victoria Richardson**	Virginia Poverty Law Center

I. **Welcome and Announcements.** Freddy Mejia, CHIPAC Chair, called the meeting to order at 1:04pm. Mejia welcomed Committee members and members of the public and explained that the in-person meeting would be recorded. Attendance was taken by roll call.

Mejia introduced DMAS Director Cheryl Roberts, who shared that CHIPAC was created in 2004 and celebrates its 20-year anniversary this year. As of September 1, DMAS covers 789,542 children; the largest number of children enrolled at any point in agency history. Included are a growing number of children in crisis (including those

experiencing mental health issues, and those being released to the custody of teenagers). Director Roberts encouraged the Committee to listen to the DMAS Board meeting on Tuesday, September 17; visit the newly updated DMAS website, and view the DMAS Strategic Plan; download the Cardinal Care App; and follow DMAS Instagram and Facebook pages.

II. CHIPAC Business

A. Review and approval of June 20, 2024, meeting minutes. Committee members reviewed draft minutes from the June 20 meeting. Emily Moore introduced a motion to approve the minutes. Jennifer MacDonald seconded, and the Committee voted unanimously to approve the minutes.

B. Membership Updates. The Committee welcomed Victoria Richardson, Virginia Poverty Law Center, who began a two-year term in June 2024, and Joanna Fowler, Virginia Health Care Foundation, who begins a three-year term this month. The Committee also welcomed two new members to the Executive Subcommittee: Dr. Susan Brown, Virginia Chapter of the American Academy of Pediatrics, and Kelly Cannon, Virginia Hospital and Healthcare Association.

CHIPAC Chair Freddy Mejia also renewed his membership for an additional two-year term.

C. Review and approval of 2025 Full Committee and Executive Subcommittee Meeting Dates:

2025 CHIPAC Full Committee Meetings
- Thursday, March 6, 2025 (1:00–3:30 pm)
- Thursday, June 5, 2025 (1:00–3:30 pm) *Virtual Meeting*
- Thursday, September 4, 2025 (1:00–3:30 pm)
- Thursday, December 11, 2025 (1:00–3:30 pm) *Virtual Meeting*

2025 CHIPAC Executive Subcommittee Meetings
- Friday, January 17, 2025 (10:00 am–12:00 pm) *Virtual Meeting*
- Friday, April 18, 2025 (10:00 am–12:00 pm)
- Friday, July 18, 2025 (10:00 am–12:00 pm) *Virtual Meeting*
- Friday, October 17, 2025 (10:00 am–12:00 pm)

Emily Moore made motion to approve, Kelly Cannon seconded, and the Committee unanimously agreed to approve.

III. School-Based Services Updates

. Amy Edwards, Alexandra Javna, and Kristinne Stone with the Virginia Department of Education (DOE), and Dr. Bern'Nadette Knight, Jessica Caggiano, and Kari Savage with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) introduced themselves and thanked the Committee for its interest in school-based mental health.

Mental Health Trends, Statistics, and Support Services. DOE began the presentation with findings from the 2021 Virginia Youth Survey: 42.6% of middle school students did not feel good about themselves, and the percentage of high school students who engaged in self-harm increased from 15.5% in 2019 to 21.2% in 2021.

School systems are well positioned to identify and respond to the behavioral health needs of students. Mental health services are most effective when integrated into academic instruction (Sanchez et. al., 2018). Youth are six times more likely to complete mental health treatment in schools than in community settings (Jaycox et al., 2010). Schools offer a multi-tiered system of supports (MTSS) which allows them to provide evidence-based practices and interventions. The 2023 Behavioral Health Commission report found that 77% of Virginia public school students receive Tier 1 (preventative) supports in school; 55% of students in need of Tier 2 mental health supports (including small group interventions for those who are at risk of mental health concerns) can access them at school; and 54% of students in need of Tier 3 mental health supports (targeted, higher-intensity interventions, including individual psychotherapy) can receive these supports at school.

Mental health support services are provided by a variety of school-based professionals. School counselors (1:325 students) hold a master's degree in counseling and provide direct counseling services to students 80% of the school day. School psychologists develop school-wide practices for prevention/ safety/wellness, train school staff, and design and implement interventions for students when needed. School Social Workers direct services to students, families, school personnel, and the school division. Not every school has a school social worker or school psychologist.

DOE supports school-based mental health professionals with learning communities, leadership conferences, a robust Career and Learning Center, and Social Emotional Learning frameworks, resources, and curricula.

Interagency Collaboration. Kristinne Stone, DOE School Mental Health Grant Project Manager, highlighted Virginia's success receiving competitive federal grants to support school-based mental health professionals. Virginia is the only state in the nation to receive three consecutive grants (FY19, FY20, and FY22), totaling more than $20 million, to help recruit and retain school-based mental health professionals. Funds enabled DOE to hire an additional 145 school based-mental health professionals. DBHDS also provided a School Mental Health Integration Grant to DOE in FY23.

Additional information and school mental health funding data can be found at vastudentservices-clc.org/data/. Dr. Susan Brown, Virginia Chapter of the American Academy of Pediatrics, asked whether data exists on whether professionals are serving high school, middle or elementary students. Stone responded there is public-facing data that captures position vacancies. School psychologists are the number one vacancy across school divisions.

Emily Moore asked whether the Career and Learning Center is open to **any** educator in a school division, or just to school-based mental health professionals. Stone

responded that the DOE Learning Center is open to any leader, teacher, or other school division staff member, and to the community.

School Based Mental Health Integration Project. Kari Savage, DBHDS Office of Child and Family Services Director, shared that the General Assembly appropriated $7.5 million in FY24 to continue the School-Based Mental Health (SBMH) Pilot Program which began the prior year. The program included technical assistance to school divisions seeking to integrate mental health services; grants to school divisions to contract with community-based mental health service providers; and a requirement to report on the success of the program. The program has grown from six school divisions in the pilot to 23 divisions in Year 2 (216% increase).

SBMH Participating Districts. Jessica Caggiano, DBHDS Child and Adolescent Program Specialist, shared a map displaying districts participating in the SBMH program, and noted that the program now has a waiting list of interested districts. In the last 4.5 months of FY24, more than 3,200 students were served, 416 personnel received some form of mental health education. Most students served were in middle (37%) or high school (26%). Services provided were heavily in Tier 2 and Tier 3. Trainings in Q2 FY24 focused most heavily on Tier 1 to help mitigate the need for Tier 2 and 3 services going forward.

Mejia asked whether it is possible to disaggregate data by ethnicity in addition to race. Caggiano answered that future data collection will include both race and ethnicity, but that this breakdown was not available for the current year.

DBHDS also invited participation in a Youth Mental Health First Aid (YMHFA) Training and Train-the-Trainer Program. Forty-eight individuals in 18 school districts indicated interest, but 25 needed the required initial YMHFA certification before they could become trainers. All received it, and a total of 37 have now completed the Train-the-Trainer program.

Mejia asked whether staff that indicated interest were teachers, community members, or other school-based professionals. Caggiano responded that participants were only asked if they were full- or part-time staff and were not asked their role, but indicated participants' roles will be collected in future recruitment questionnaires. Ben Barber, Virginia Health Catalyst, asked what YMHFA certification entails. Caggiano responded that it is a one-day (8-hour) course.

Overall, 352 personnel received some form of SBMH training. One district, Arlington, offered the course in Spanish. Savage noted that YMHFA Trainers must conduct three trainings per year to maintain the Trainer credential.

MacDonald asked about the Mental Health First Aid Training's contents. Savage responded that the curriculum is high-level (not diagnostic), and includes typical hallmarks and behaviors associated with anxiety and depression, and what brief interventions and supports exist to help mitigate them.

School Based Services Moving Forward. Bern'Nadette Knight, PhD, DBHDS Child and Adolescent Program Specialist, shared that the 2024 Virginia General Assembly (GA) appropriated $15M each for FY25 and FY26 ($30M total) to DBHDS to contract with Federally Qualified Health Centers (FQHC) or other healthcare organizations in partnership with DOE, to establish school-based health clinics to serve students, their families, and school personnel. This new focus incorporates an expanded scope (primary medical care, dental, vision) in addition to mental health and substance use services, and a requirement that contracted organizations have the capacity to bill for services. DBHDS will report on this effort to the House Appropriations and Senate Finance Committees annually beginning December 1, 2024.

Dr. Knight shared a table comparing the SBMH Integration Pilots and the new School-Based Health Clinic model and noted that DBHDS has worked with 23 school divisions over the last few months to shift to the new model. DBHDS has sought other funding to sustain services and continuation of the YMHFA Train-the-Trainer program. It collaborated to map the location of FQHCs to best support expansion, and is working with DOE on clinic implementation and with DMAS on billing capabilities for the healthcare centers.

Medicaid and Schools. Amy Edwards, DOE Medicaid Specialist, gave an overview of the Medicaid and Schools program, through which 108 Virginia school divisions receive Medicaid reimbursement for eligible health services provided by Medicaid-qualified providers to Medicaid-enrolled students, and partial reimbursement for health-related administrative activities. Statewide, school divisions received a total of $6,525,324 for administrative activities and $49,540,943 for direct services, in FY23.

Medicaid reimbursable direct services include physical and occupational therapy; speech language pathology; mental/behavioral health; nursing services; medical evaluations; personal care services; applied behavioral therapy; EPSDT physicals; and specialized transportation, among others. Reimbursable health-related administrative services include outreach & application assistance; scheduling/arranging of specialized transportation; translation services related to health care service delivery; referral, coordination and monitoring of health services.

Effective July 1, 2022, Virginia finalized a Medicaid State Plan Amendment removing the requirement that billable services relate to an IEP. This expanded services to include those outside of special education, such as behavioral health services by a licensed psychologist or school counselor; some crisis care and screening; applied behavioral therapy (as a direct service); and public health (as an administrative activity). The SPA also expanded the definition of a vehicle for reimbursable services. Edwards referred the group to the DMAS School Services and DOE Medicaid and Schools webpages for additional information.

Mejia, a social worker by trade, thanked DBHDS and DOE on their joint presentation and opened the floor for questions. Questions from the Committee:

- Referring to the DBHDS services map: **Southwest Virginia and in particular Northern Virginia (a dense population center,) do not appear to have services available. Why is this?** (Kelly Cannon)

Savage/Stone: The application for districts to participate was available statewide. Data was not collected about reasons a school district did not apply. Services may be accessed in other ways and may not be needed through the school system. DOE will creatively use FQHC model to help pull in areas that were not represented. DOE will also reach out to see why those regions did not apply, as part of assessing future sustainability and needs.

- Referring to DBHDS services map linked in presentation: **FQHCs are represented by a variety of shapes. Is there an indicator available about what the shapes mean?** (Martha Crosby)

  Knight: DBHDS used one shape for the FQHC's main health center and one shape for the administrative. May need to zoom in on slides to see labels. DBHDS will also share the legend for the maps.

- **What, if any, initiatives does DBHDS/DOE have in place during the summer to help students with mental health issues?** (Martha Crosby)

  Knight: DBHDS is evaluating what services and supports exist for students during the summer. School-Based Mental Health pilots are doing a lot of work during the summer and DBHDS is working with DOE partners to determine what summer supports/services can be supported with the funding.

  Stone: Part of the first part of the initiative was learning about how services integrate with school, community and home. Community of Practice sessions involved the community to help bridge the gap.

- **Given resource limitations, where does progress stand on adding third-party payers to billing (since not all students receiving services are Medicaid-eligible)? Are you able to include that as these programs are being built to help address capacity and funding challenges that will result if every student in the schools needs to access mental health services?** (Dr. Susan Brown)

  Savage: New budget languages include accountability for DBHDS to build out billing capacity outside of Medicaid, to enable children to receive services through schools regardless of insurance status.

  Stone: DOE Office of Behavioral Health and Wellness is tasked with creating a school mental health system that includes flexible funding to sustain some of these initiatives.

- **Could you explain the budget history for the Pilots vs. the School-Based Health Centers? Has the additional money been, in part, due to the addition of services with the move to the School-Based Health Center model?** (Ben Barber)

Savage: Initially, the School-Based Health Integration Pilots were funded in the first 2 years with $7.5M. In the new budget language that includes integration with FQHCs, there is $15M each in FY25 and FY26 ($30M total over 2 years). Yes, this is due in part to the expansion of services offered, and funds obtained through the Mental Health Block Grant will help sustain the Pilots.

IV. Federal Regulatory Updates

Sara Cariano, Director, Eligibility Policy and Outreach Division
Jessica Annecchini, Senior Advisor for Administration, Director's Office
Virginia Department of Medical Assistance Services

The Centers for Medicare and Medicaid Services (CMS) finalized a proposed Eligibility Rule in 2 parts: one impacting members enrolled in the Medicare Savings Programs, and the other impacting a broader group including children enrolled in Medicaid and CHIP. All are available online in the Federal Register.

Changes will require policy and system modifications, and compliance deadlines range from immediately upon finalization through June 2027. Rules include a requirement to allow medically needy individuals to deduct prospective medical expenses, and several measures to improve transitions between Medicaid and CHIP (FAMIS) with which Virginia already complies.

CMS also codified removal of any state limits on the number of Reasonable Opportunity Periods allowed and clarified the primacy of burden on states to verify income and resources. Mejia asked whether states, including Virginia, can/do use other data sources (e.g., SNAP data) to confirm eligibility for children and adults. Annecchini stated that these "agency knowledge" data sources can and should be tapped by states to help determine eligibility.

Rules' provisions around returned mail and address updates (dual-modality outreach, utilization of outside data sources) go into effect in 2025. The 2024 GA already directed DMAS to establish a statewide mailroom to help minimize procedural terminations due to returned mail.

V. Return to Normal Enrollment Updates

Jessica Annecchini

As of the meeting date, Virginia had redetermined eligibility for all but 2.38% members within its "unwinding cohort" (members whose redeterminations needed to be completed as part of the return to normal operations). Annecchini praised local Departments of Social Services for their work completing these redeterminations. Out of the 2.2 million redeterminations needing to be completed at the beginning of the unwinding period (March 2023), just over 51,000 remain.

The largest number of closures have occurred among nonelderly, non-disabled adults. The gap between the number of these members and the number of children being closed has grown throughout the "unwinding" period due to Virginia's revising its automated *ex parte* review process in August 2023.

Virginia initiated its last month of unwinding-related renewals in February 2024. CMS released guidance in early September giving states until December 2025 to complete their unwinding-related work. Virginia's redetermination dashboard will be replaced by a more evergreen model.

Emily Moore asked what is encompassed in "Other" reasons for closure (noted in the chart on slide 84). Annecchini responded that this catchall includes system-related closures and others that do not fall into the other reasons captured (e.g., an individual enrolled via spenddown's spenddown budget period concluding).

VI. Agenda for December 12, 2024, CHIPAC Meeting

Jen Macdonald and Kelly Cannon requested an update on maternal health utilization and recommendations (either for December 2024 or a future meeting). Macdonald offered that the VDH Title V Needs Assessment is underway and could provide additional context by the June 2025 meeting.

VII. Public Comment.

LeVar Bowers, a longtime advocate with interest in children's mental health, thanked the Committee, DMAS, DBHDS and DOE for their work on school-based mental health, and commented on how critical these services are for families. Bowers expressed gratitude for DBHDS and DOE data collection efforts, and noted the importance of HeadStart, Virginia Preschool Initiative (VPI), parent training, and alternative school settings as opportunities to build on existing initiatives. Alexandra Javna, DOE, offered her contact information in follow-up.

VIII. The meeting adjourned at 3:21pm.

CHIPAC

Children's Health Insurance Program Advisory Committee of Virginia

Quarterly Meeting

December 12, 2024

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Virginia's Medicaid Program

Real-time Remote Captioning

Remote conference captioning is being provided for this event.

- The link to view live captions for this event will be pasted in the chat.
- You can click on the link to open up a separate window with the live captioning.

Meeting Notice – Public Access

This meeting is being held virtually.

- There will be a public comment period at the close of the meeting.
- This meeting is being recorded.

Roll Call

Organization	Name
Joint Commission on Health Care*	Sarah Stanton
Virginia Department of Health*	Jennifer Macdonald
Virginia Department of Education*	Alexandra Javna
Virginia Department of Behavioral Health and Developmental Services*	Hanna Schweitzer
Virginia Health Care Foundation*	Joanna Fowler
Virginia Department of Social Services*	Irma Blackwell
Virginia Hospital and Healthcare Association	Mary Brandenburg (substitute)
Center on Budget and Policy Priorities	Laura Harker

** Member organizations required per Code of Virginia*

Roll Call

Organization	Name
Virginia League of Social Services Executives	Tiffany Gordon
The Commonwealth Institute for Fiscal Analysis	Freddy Mejia, *Chair*
Voices for Virginia's Children	Emily Moore, *Vice Chair*
Virginia Association of Health Plans	Heidi Dix
Virginia Chapter of the American Academy of Pediatrics	Dr. Susan Brown
Virginia Community Healthcare Association	Martha Crosby
Birth in Color	Kenda Sutton-EL
Virginia Health Catalyst	Sarah Bedard Holland
Virginia Poverty Law Center	Victoria Richardson

CHIPAC

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EPSDT: Medicaid's Early & Periodic Screening, Diagnostic & Treatment Services

Kimberli Myrick
Child Health Program Operations Analyst
Division of Health Care Services

DMAS

Medicaid Population

Medicaid serves our members through five accredited health plans.

773,894
Children

92,766
FAMIS

Population by Delivery System	
Aetna	92,032
Anthem	254,274
Molina	42,333
Sentara	288,723
United Health	86,328
Fee-for-Service	10,204

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Source: Nov 15, 2024: DMAS Enrollment Dashboard - Medicaid / FAMIS Enrollment (virginia.gov)

Overview

- EPSDT is a benefit. Not a program or service.
- Children enrolled in Medicaid are entitled to EPSDT as a benefit.
- This includes children under age 21 who are enrolled in one of DMAS' Home and Community Waiver programs.
- Children enrolled in Virginia's CHIP program (called the Family Access to Medical Insurance Security or FAMIS) are not entitled to the full EPSDT benefit. They have access to the well child visit portion of the benefit, but no the treatment portion.
- There is no additional application process for children with Medicaid to access the EPSDT benefit.
- Services covered under this benefit are NOT limited to services listed in the Virginia state plan, however, the medically necessary treatment services, when required by the member, must be allowed under federal Medicaid law at Sec 1905(a) of the Social Security Act.

EPSDT BASICS

EPSDT stands for:

Early: Assessing and identifying problems early

Periodic: Checking children's health at periodic, age-appropriate intervals

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic: Performing diagnostic tests to follow up when a risk is identified

Treatment: Correct or ameliorate to reduce health problems found

EPSDT BASICS

Goals of EPSDT

The benefit is designed to ensure children and youth under 21 receive early detection and medically necessary care to diagnose and treat health problems at no cost to the enrollee. Qualified providers:

- Identify health concerns,
- Assure that treatment is provided before problems become complex,
- Provide medical justification for services.

EARLY & PERIODIC SCREENING

✓ States must provide or arrange for EPSDT screening services both at established times (periodic) and on an as-needed (inter-periodic) basis to identify health and developmental issues as early as possible

Covered Screening Services

Comprehensive health and developmental history	Comprehensive, unclothed physical exam, including nutritional, height and weight, and Body Mass Index assessment	Appropriate vision and hearing screening
Developmental screening for physical and mental health development using standardized screening tool	Appropriate immunizations (based on age and history)	Appropriate laboratory tests, including blood lead test
Dental screenings and referrals to a dentist (starting at age 3)	Health education and anticipatory guidance for child and caregiver	Psychosocial/behavioral assessment, including depression screening and tobacco, alcohol or drug use assessment

EARLY & PERIODIC SCREENING

- EPSDT screenings need not be conducted by a Medicaid-enrolled provider in order to trigger EPSDT coverage for follow-up diagnostic and treatment services.
- Screenings may be provided in a variety of settings such as at provider offices, local health departments, schools, or community health centers
- To receive *payment* for the screening, however, the provider must be enrolled with Medicaid.

Families do not need to make a special request or secure a referral for EPSDT screenings
EPSDT is a benefit, not a program or waiver that requires an application

EARLY & PERIODIC SCREENING (UNDER VIRGINIA MEDICAID)

Age:	Days		Months										Years																	
	New born	3-5	1	2	4	6	9	12	15	18	24	30	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
History, Measurement, Physical Exam, Lab Tests, and Anticipatory Guidance, etc.	*Follow the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care*																													
Mandatory Blood Lead Test								★			★		*Lead test if no prior history*																	
Immunizations	*Follow American Committee on Immunization Practices (ACIP) for immunizations*																													
Vision Screen													★	★	★	★		★		★		★			★			★		
Hearing Screen	★													★	★	★		★		★										
Psychosocial/Behavioral Assessment	*Follow the AAP Recommendations for Preventive Pediatric Health Care*																													
Developmental Testing							★			★	★	★																		
Refer to Dental Home/ Assess Oral Risks								★			★	★	*Refer to dental services at 3 and 6 years Provide dental exams every 6 months*																	

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EARLY & PERIODIC SCREENING – Dental

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this best practice for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [3,7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [3,8]	•	•	•	•	•
Counseling for nonnutritive habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech/language development [11]	•	•	•		
Assessment developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal-risk ssessment [3,14]			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/ vaccine				•	•
Counseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

DIAGNOSTIC AND TREATMENT SERVICES

EPSDT covers all medically necessary services that are included within any of the category's services allowed under federal Medical law (42 CFR Subpart B)

- ✓ Physician services
- ✓ Pediatric and family nurse practitioner services
- ✓ Inpatient and outpatient hospital services
- ✓ Laboratory and X-rays
- ✓ Medical supplies and durable medical equipment
- ✓ Family planning services and supplies
- • Federally Qualified Health Clinics and Rural Health Clinics
- ✓ Non-emergency medical transportation
- ✓ Pregnancy-related services
- ✓ Freestanding birth center services (when licensed or otherwise recognized by the state)
- ✓ Home health services
- ✓ Medication-assisted treatment (MAT)
- ✓ Nurse-midwife services
- ✓ Tobacco cessation counseling and pharmacotherapy for pregnant women
- • Mental Health and SUD
- ✓ Case management
- ✓ Community supported living arrangements
- ✓ Chiropractic services
- ✓ Clinic services
- ✓ Critical access hospital services
- ✓ Dental services
- ✓ Dentures
- ✓ Emergency hospital services (in a hospital not meeting certain federal requirement)
- ✓ Eyeglasses
- ✓ Health homes for enrollees with chronic conditions
- ✓ Hospice services
- ✓ Inpatient psychiatric services for individuals under age 21
- ✓ Intermediate care facility services for individuals with intellectual disabilities
- ✓ Occupational therapy
- ✓ Optometry services
- ✓ Other diagnostic, screening, preventive and rehabilitative services
- ✓ Other licensed practitioners' services
- ✓ Personal care services
- ✓ Physical therapy
- ✓ Podiatry services
- ✓ Prescribed drugs
- ✓ Primary care case management services
- ✓ Private duty nursing services
- ✓ Prosthetic devices
- ✓ Respiratory care services for ventilator dependent individuals
- ✓ Services furnished in a religious non-medical health care institution
- ✓ Speech, hearing and language disorder services
- ✓ State Plan Home and Community Based Services
- ✓ Targeted case management services
- ✓ Tuberculosis-related services

DEFINING MEDICAL NECESSITY UNDER EPSDT

Centers for Medicaid and Medicare Services emphasize that a service need not cure a condition in order to be covered under EPSDT.

- Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition.
- Ameliorate is a key term used in federal law in defining the EPSDT benefit.
- Ameliorate is commonly translated as "make more tolerable".

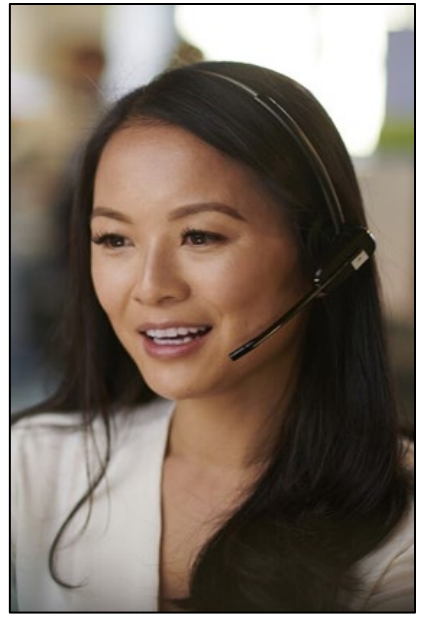
In this way, the EPSDT benefit not only ensure services that can cure, correct or improve a health condition, but it ensures that children have access to services that can "make more tolerable" their health condition or its effects.

OUTREACH AND INFORMING

Federal EPSDT law requires that all persons under age 21 that are eligible for Medicaid be informed of the availability of EPSDT services and the need for age-appropriate immunizations against vaccine-preventable diseases.

The law requires ***outreach*** accomplished through activities involving direct contact, whether it is face-to-face, telephone, social media, community events, etc.

Outreach is the responsibility of multiple state agencies, in addition to DMAS, as well as participating MCOs, primary care physicians (PCPs) and others that complete EPSDT screening services.



Early & Periodic Screening, Diagnostic, & Treatment (EPSDT)

Bipartisan Safer Communities Act

- Section 11004 of the Bipartisan Safer Communities Act charged CMS with issuing State Health Official (SHO) guidance to provide states policy guidance and provide effective strategies and best practices to support/address gaps in deficiencies with EPSDT. The SHO focused on key topics in the following areas:
  - Key Topic #1 – Promoting EPSDT Awareness and Accessibility
  - Key Topic #2 – Expanding and Using Children-Focused Workforce
  - Key Topic #3 – Improving Care for Children with Specialized Needs

GUIDANCE

- Centers of Medicare and Medicaid Services. *Early and Periodic Screening, Diagnostic, and Treatment at* https://www.Medicaid.gov
- Centers of Medicare and Medicaid Services. (June 2014). *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. https://www.Medicaid.gov
- Link to Virginia State Regulations - https://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section130/
- DMAS Provider Manual: EPSDT Supplements. https://vamedicaid.dmas.virginia.gov/
- DMAS EPSDT mailbox

  EPSDT@dmas.virginia.gov

Thank you!

EPSDT Questions

EPSDT@DMAS.virginia.gov

CHIPAC

Children's Health Insurance Program Advisory Committee of Virginia

CardinalCare
Virginia's Medicaid Program

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Virginia's 12-Months Postpartum Extension 1115 Demonstration

Emily Roller

Senior Management Analyst, Policy Division

DMAS

Medicaid/CHIP Postpartum Extension: Background

- *Two possible extension authority pathways:*
  - *State Plan Amendment*
  - *1115 Demonstration Waiver**

- *1115 pathway includes additional **reporting** and **public transparency** requirements, and an **external evaluator** (VCU Department of Health Behavior and Policy).*

**Virginia extended using 1115 waiver pathway, effective July 1, 2022.*

Postpartum Extension Goals

Promote continuous coverage and **continuity of care** for members in the postpartum period

Increase **access to medical and behavioral health services** and treatments for postpartum members

Improve **health and financial outcomes** for **postpartum** Medicaid and CHIP members

Improve **health care access and health outcomes for infants** of postpartum Medicaid and CHIP members

Advance **health equity** by reducing racial/ethnic and other disparities in maternal coverage, access, and health outcomes and infant health outcomes

Postpartum Extension Hypotheses

Does the demonstration promote continuous coverage and **continuity of care** for members in the postpartum period?

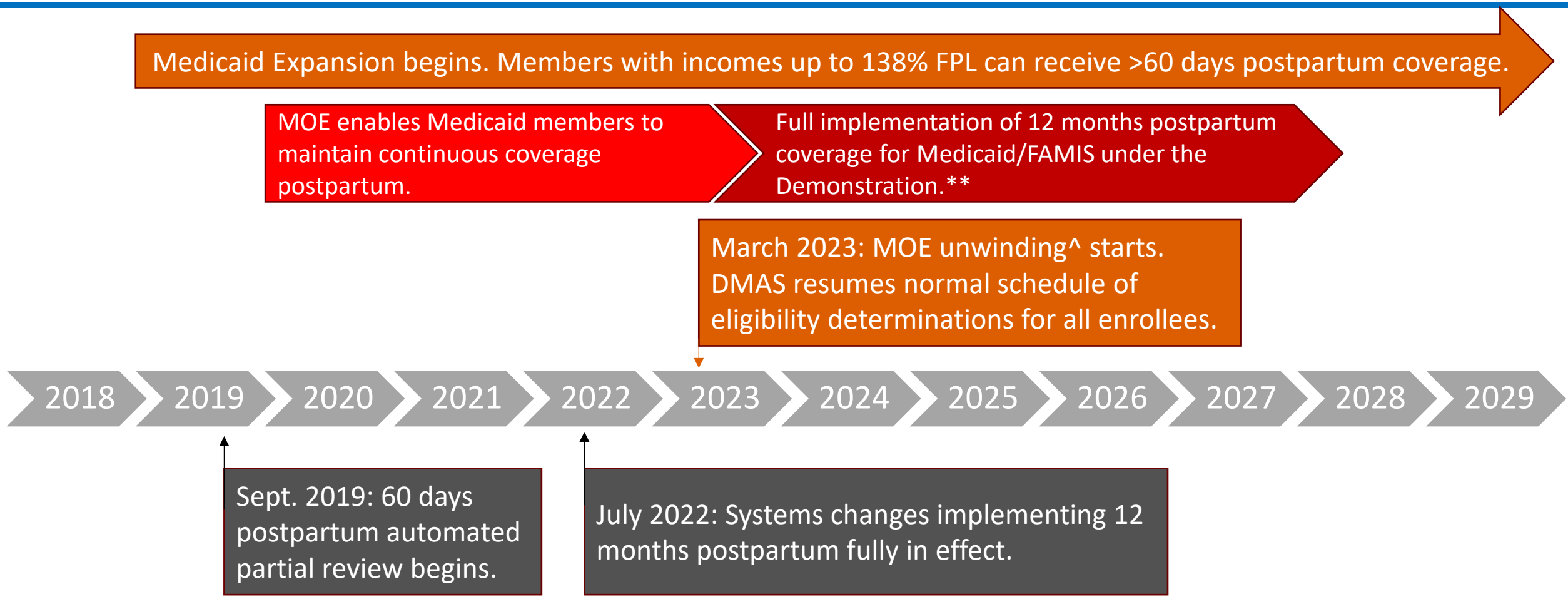
Does the demonstration increase **access to medical and behavioral health services** for women in the postpartum period?

Does the demonstration improve **health outcomes, and outcomes related to health-related social needs,** for **postpartum** Medicaid/CHIP members?

Does the demonstration increase access to **health care services, and improve outcomes, for infants** of postpartum Medicaid/CHIP members?

Does the demonstration advance **health equity** by reducing racial/ethnic and other disparities for postpartum women and their infants?

Postpartum Extension Timeline



*** With the exception of FAMIS Prenatal Coverage.*

^ The 2023 Consolidated Appropriations Act de-linked the PHE from the maintenance of effort/continuous coverage. Virginia initiated "unwinding" from the MOE on March 1, 2023, with the first terminations occurring in May 2023.

1115 Postpartum Extension Evaluation

- *Required to submit and receive federal approval on formal **Evaluation Plan** (approved September 2023).*

- *Data collection tools include:*
  - *External data sources (VDH Vital Statistics, CDC PRAMS, APCD)*
  - *Internal data (enrollment and claims), **linked** with above*
  - *Member survey*
  - *Provider/stakeholder qualitative analysis (interviews)*

DMAS Enrollment/Claims Data and MCO Reports

Pre- and Demonstration period data about:

- Continuous days of postpartum enrollment
- Care coordination (MCO) utilization postpartum
- Use of community doula services during labor and postpartum
- Intimate partner violence
- Well-child visits in the first 30 months of life

VDH Vital Statistics Data Linked with DMAS Claims Data

Pre- and Demonstration period data about:

- Preterm births
- Low birthweight infants
- Maternal mortality (pregnancy-associated deaths)
- Infant mortality

All-Payer Claims Database (APCD)

Pre-Demonstration period data about:

- Postpartum outpatient visits
- Lactation consultation utilization
- Blood pressure control
- Depression screening
- Emergency Department utilization postpartum
  - Mental health and/or substance use follow-up for those with mental health or substance use diagnosis.
  - ED visits for individuals with a diagnosis of mental illness and who received a follow-up visit for mental illness within 30 days of the ED visit (31 total days) & within 7 days of the ED visit (8 total days).
- Dental visit during 12 months postpartum
- Birth control use postpartum and pregnancy spacing

Member Survey

Under development. Will ask postpartum members about:

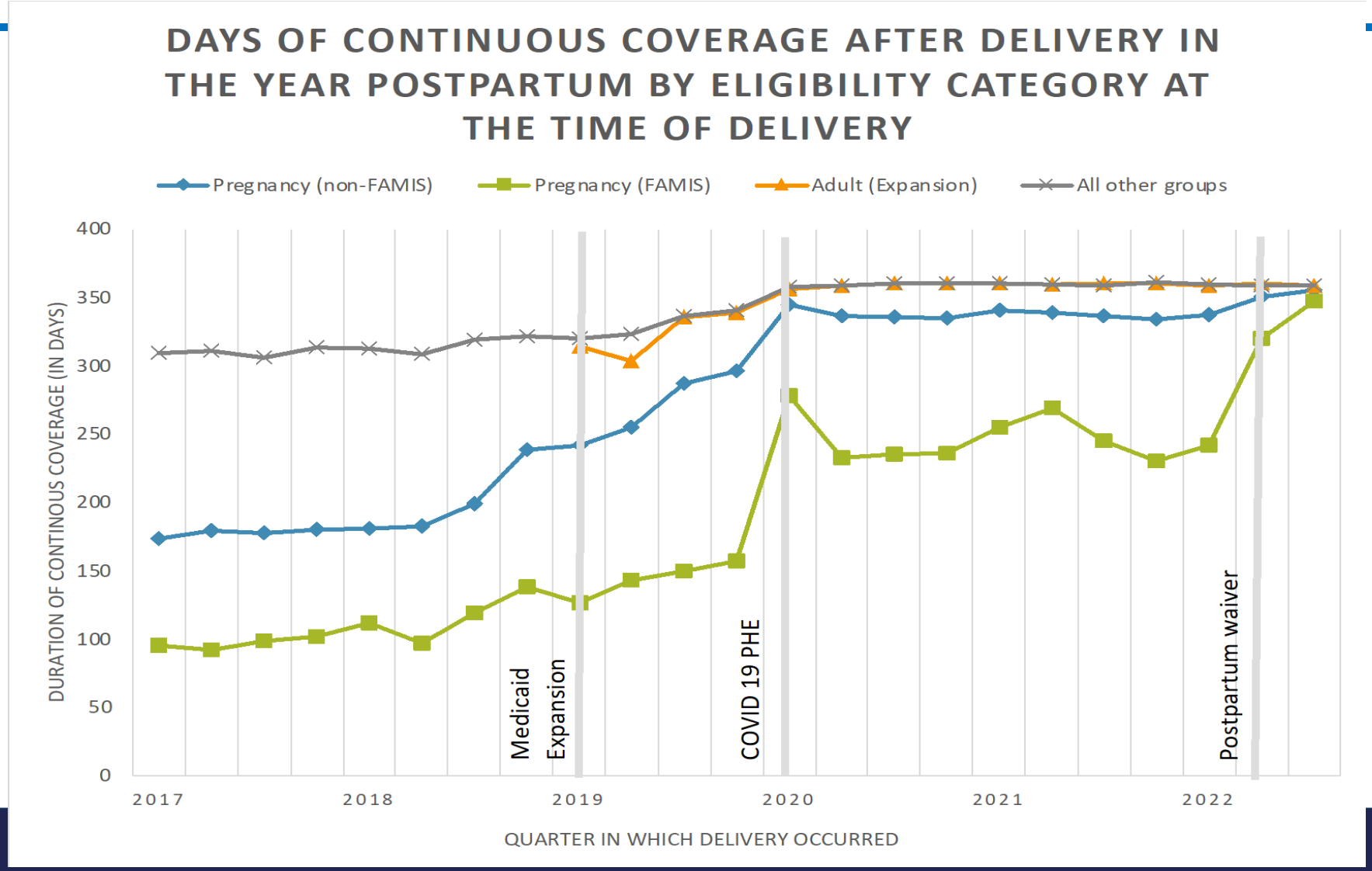
- Experiences accessing care in the prenatal and postpartum period
- Receipt of respectful care
- Self-rating of health (both postpartum member and infant)
- Use of doula services and/or MCO care coordination
- Postpartum mental health screenings
- Social determinants of health (emphasizing housing and food security)

Provider/Stakeholder Qualitative Analysis

Under development. Aims to assess, via brief dialogical interviews:

- Providers' and stakeholders' knowledge about the extension
- Providers' observations about extension's impact on patients' well-being
- Successes and challenges of early phases of demonstration's implementation, education, and outreach efforts

12-Month Postpartum Extension: Preliminary Data



Evaluation Logic Model

Moderating factors: sociocultural characteristics (race/ethnicity, health status, justice involvement), built environment characteristics (rurality, social deprivation, segregation, health care supply)

Policy

- **Provide extended continuous coverage**, regardless of changes in income, for a full year postpartum
- Medicaid **and FAMIS**-enrolled members

Intermediate Outcomes

- **Decrease disparities in use of:**
  - Maternal postpartum services (e.g., community doulas)
  - Recommended maternal health care utilization
  - Recommended infant health care utilization
  - Care coordination services and connections to other social programs

Long-term Outcome

- **Advance health equity through improved health outcomes for mothers and infants:**
  - Reduced maternal mortality and morbidity
  - Reduced infant mortality and morbidity

CHIPAC

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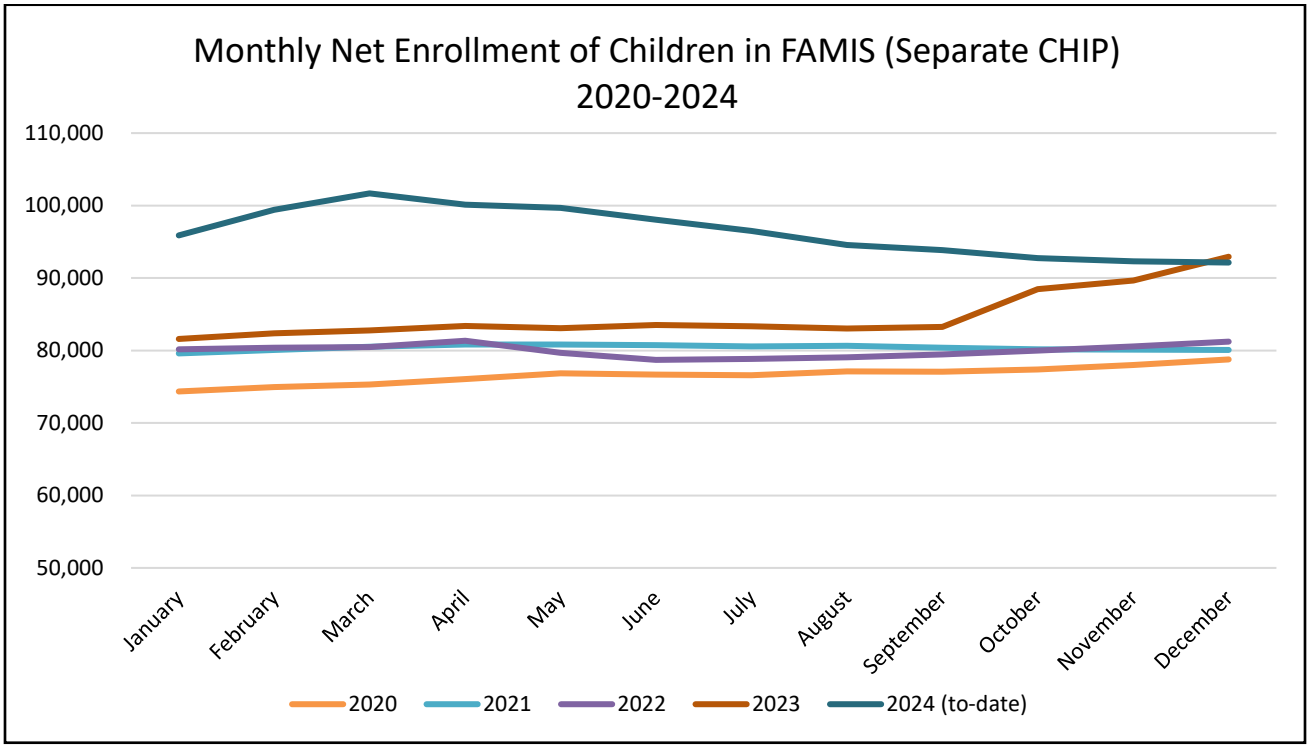
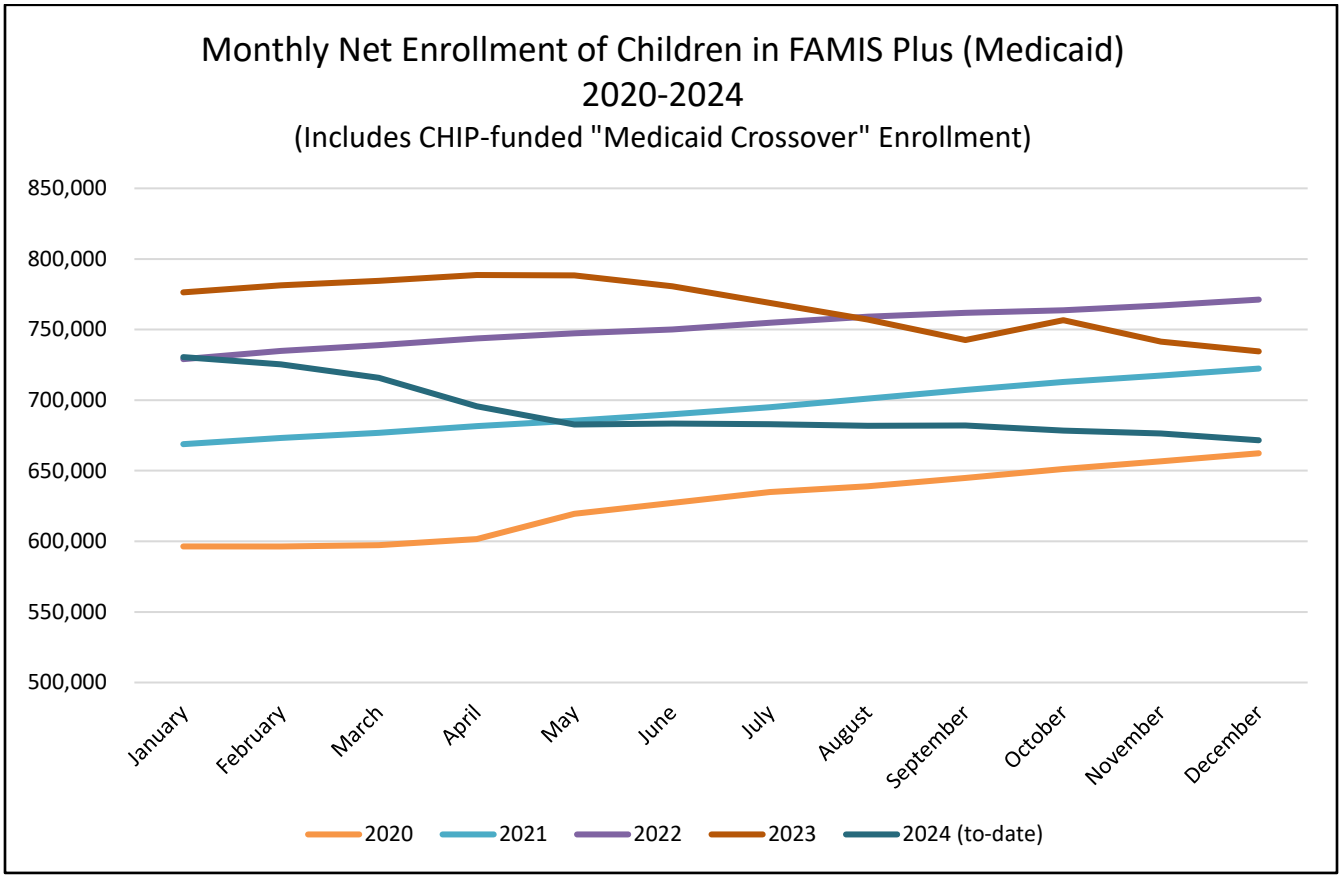
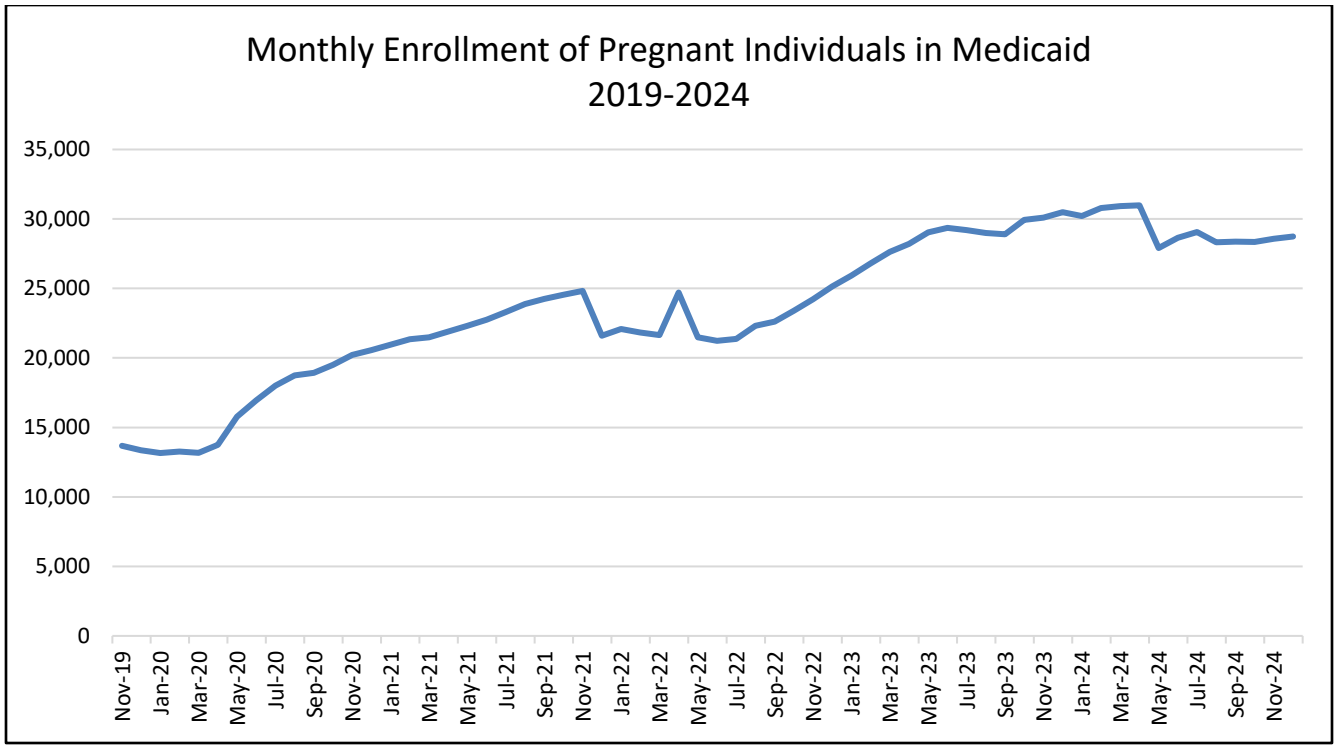
CHIPAC Quarterly Enrollment Dashboards

December 12, 2024






Monthly Enrollment of Pregnant Individuals in Medicaid
2019-2024
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22
May-22
Jul-22
Sep-22
Nov-22
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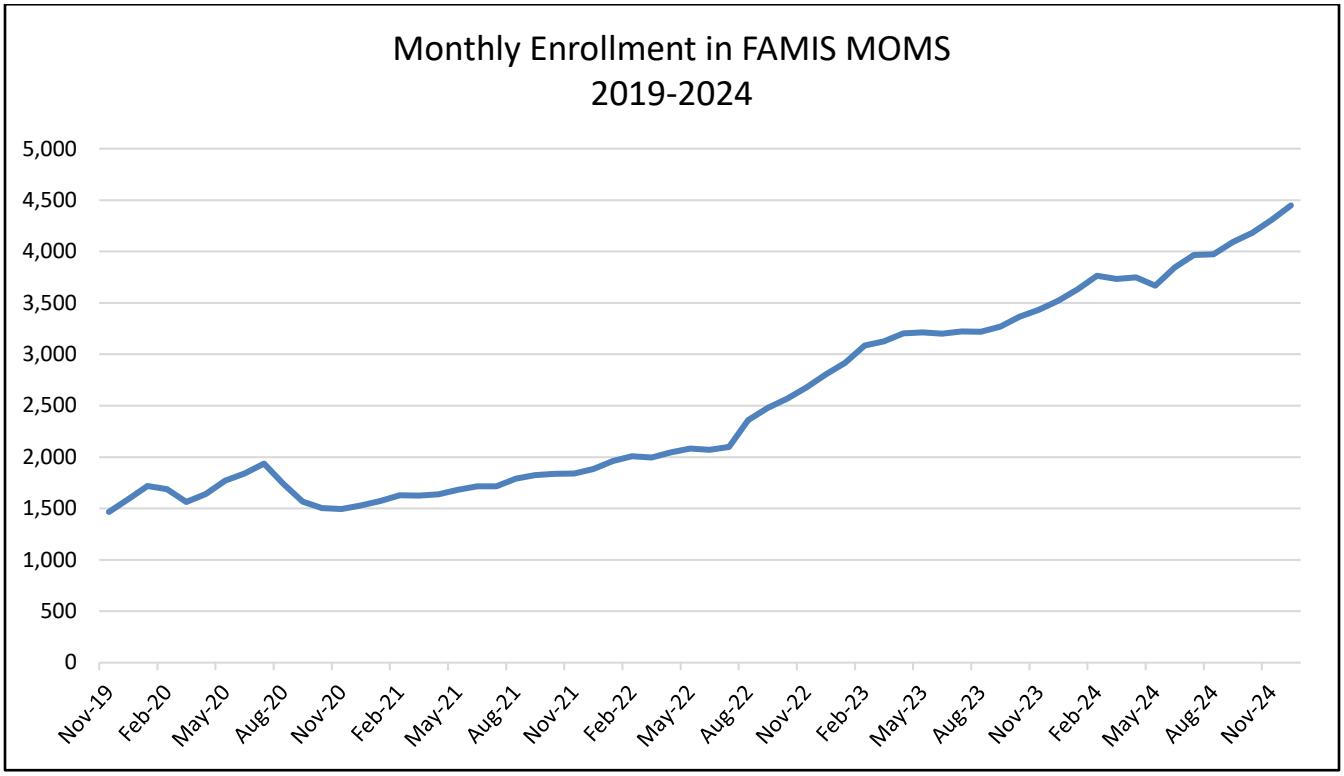
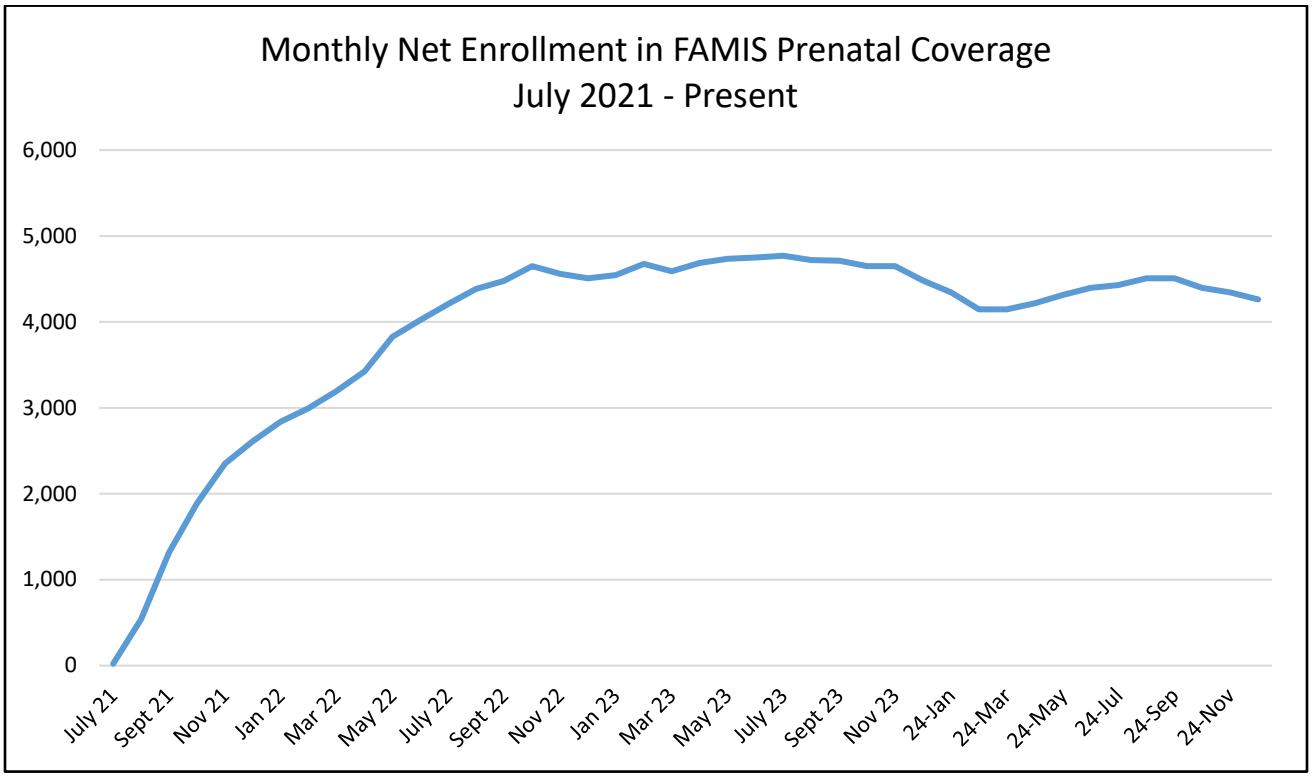
Jan-24
Mar-24
May-24
Jul-24
Sep-24
Nov-24


Monthly Enrollment in FAMIS MOMS
2019-2024
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Nov-19
Feb-20
May-20
Aug-20
Nov-20
Feb-21
May-21
Aug-21
Nov-21
Feb-22
May-22
Aug-22
Nov-22
Feb-23
May-23
Aug-23
Nov-23
Feb-24
May-24
Aug-24
Nov-24


Monthly Net Enrollment in FAMIS Prenatal Coverage
July 2021 - Present
6,000
5,000
4,000
3,000
2,000
1,000
0
July 21
Sept 21
Nov 21
Jan 22
Mar 22
May 22
July 22
Sept 22
Nov 22
Jan 23
Mar 23
May 23
July 23
Sept 23
Nov 23
24-Jan
24-Mar
24-May
24-Jul
24-Sep
24-Nov