BOARD OF MEDICAL ASSISTANCE SERVICES

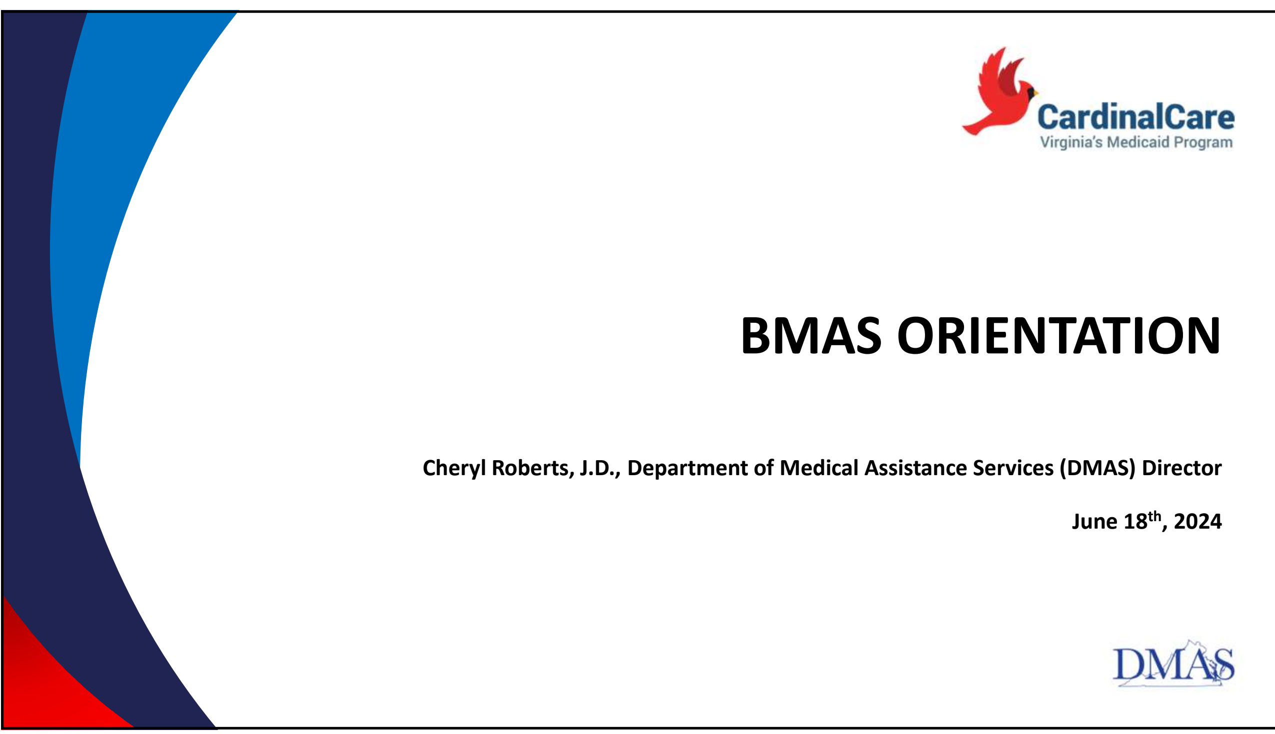
Tuesday, June 18, 2024
12:00 PM to 2:00 PM
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
1st floor Conference Rooms A&B

To Join Meeting Remotely:
https://covaconf.webex.com/covaconf/j.php?MTID=m73e207a7e632bfabb17941e79be0da29
Remote Conference Captioning Link:
https://www.streamtext.net/player?event=HamiltonRelayRCC-0618-VA4194

BMAS ORIENTATION AGENDA

	MEDICAID OVERVIEW	PRESENTER
1	DMAS Mission and Values	Cheryl Roberts
2	Functions of Agency/Departments • DMAS Org Chart • Individual Divisions and descriptions	Jeff Lunardi
3	Medicaid Authority- Agency and board	Emily McClellan
4	What is Medicaid and who qualifies (income guidelines) and how to apply	Sara Cariano
5	Who We Serve ▪ children ▪ pregnant women ▪ the aged, blind, and individuals with disabilities ▪ adults - Medicaid Expansion 2020 maag + updated enrollment #'s ▪ 12-month Continuous Eligibility for children ▪ Continuous Coverage Unwinding Updates	Yolanda Chandler
6	Programs and Benefits ▪ Services ▪ FFS vs. Managed Care ▪ Transition to Managed Care Cardinal Care ▪ Long Term Services and Supports (LTSS) ▪ High level review of services (waivers, etc) ▪ High level review of benefit programs (ARTS, PACE, etc)	Adrienne Fegans Tammy Whitlock
7	Finance • Medicaid Funding and Authority • Finance Overview • Historical Enrollment	Chris Gordon Rich Rosendahl

	• MCO Claims and Utilization Data	
8	DMAS Major Initiatives of the Agency ▪ MES ▪ Pharmacy Services ▪ Behavioral Health ▪ General Assembly and State Based Exchange ▪ Maternal and Child Health	John Kissel Dr. Lisa Stevens Tammy Whitlock Jeff Lunardi Adrienne Fegans
9	Resources: Dashboards, digital communications, MAAG, BMAS report, Med 101 handout, Board date calendar, links to studies and reports.	Rich Rosendahl and Cheryl Roberts



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Agenda

- Medicaid Overview
- Programs and Benefits
- Finance
- DMAS Major Initiatives
- Resources

CardinalCare
Virginia's Medicaid Program

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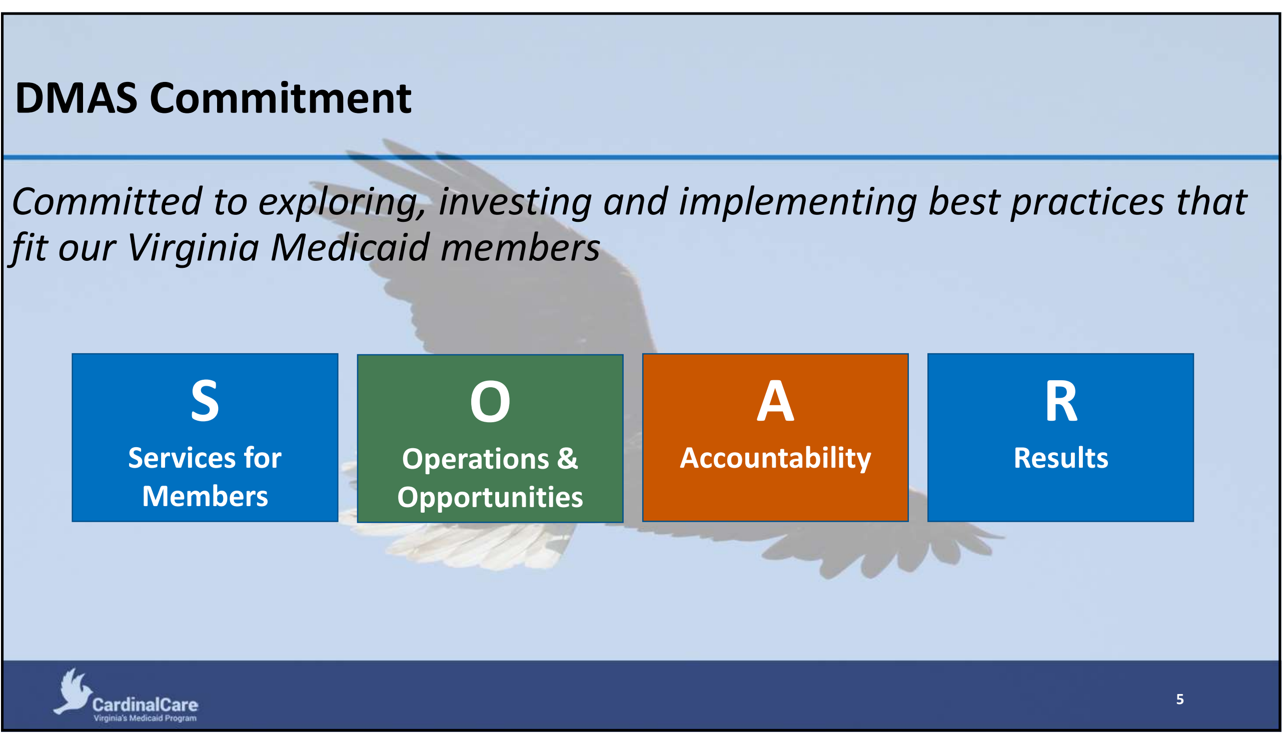
CardinalCare Virginia's Medicaid Program

DMAS is Member Focused

<u>DMAS Provides:</u>

- Coverage
- Education and Information
- Services – Accessible and Available
  - Provider Networks
  - Support Services
- Member's ability to chose plans, services and providers
- DMAS listens, learns, evaluates and improves the program



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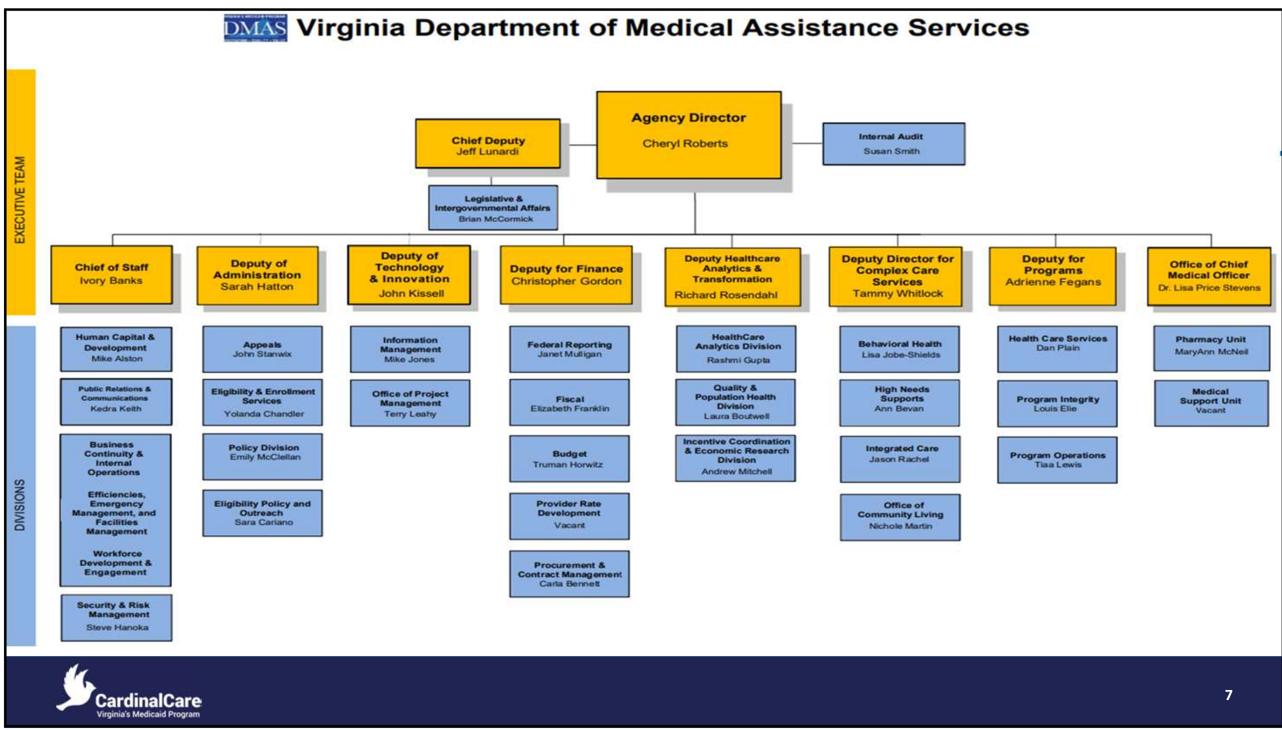

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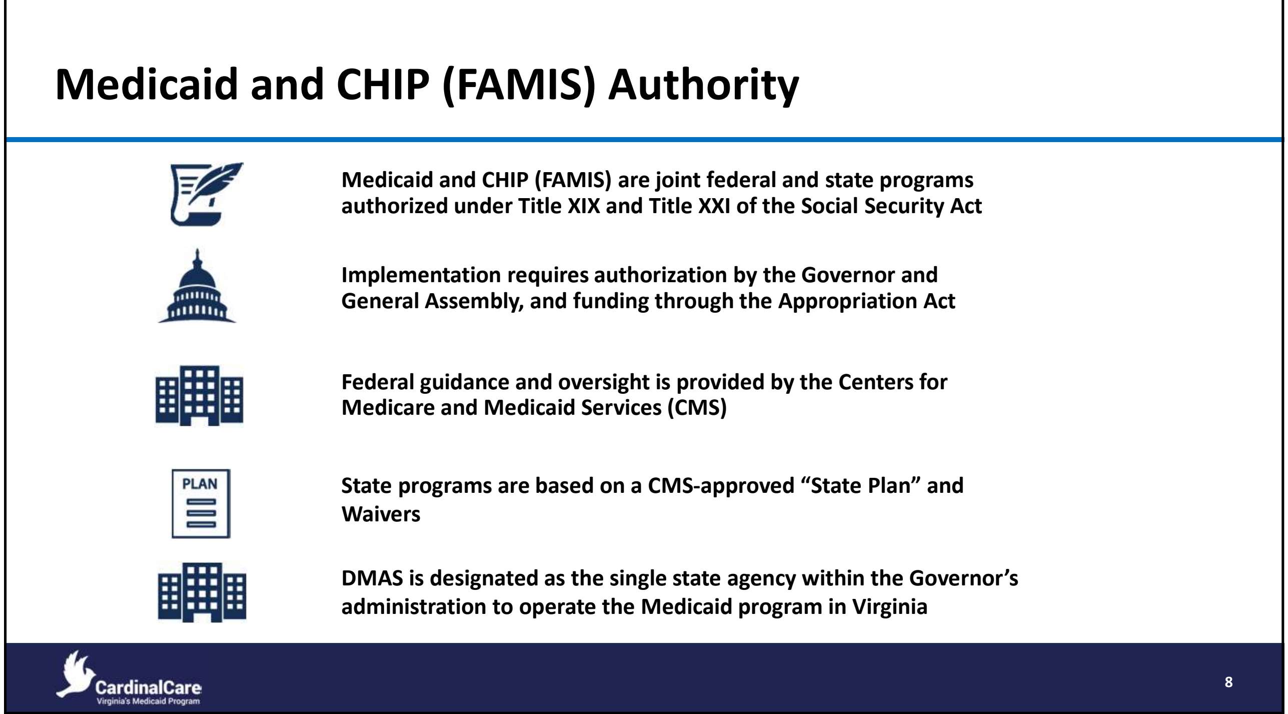

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Waivers

Waivers give the State authority to waive select federal Medicaid rules

Waivers require state and federal approval.
- A waiver is a state request that the U.S. Secretary of Health and Human Services (HHS) waive select provisions of the Social Security Act (SSA) to authorize Medicaid program changes that are not otherwise allowed under the federal rules.

Waivers allow exceptions to normal Medicaid rules.
- E.g., to require enrollment in managed care programs, or to provide services not otherwise covered to a targeted population.

Waivers are time-limited.
- Generally approved for three to five years and can be renewed.

Waivers are distinct from State Plan Amendments (SPAs)
- SPAs are used for changes to the Medicaid State Plan that may address program administration (e.g., eligibility, benefits, services, provider payments). Proposed changes must be approved by the state and comply with federal rules.
- If the program change deviates from federal rules, then the State may seek General Assembly approval to apply for a waiver.

Waiver Types

Medicaid Waivers

§1915(b): Provide services through contracted Managed Care Organizations (e.g., Cardinal Care managed care)

§1915(c): Provide long-term services and supports in the community in lieu of an institution (e.g., CCC Plus Waiver, Developmental Disability Waivers)

§1115: Demonstrate and test new models of care delivery or financing (e.g., residential Addiction and Recovery Treatment Services and coverage for certain former foster care individuals)

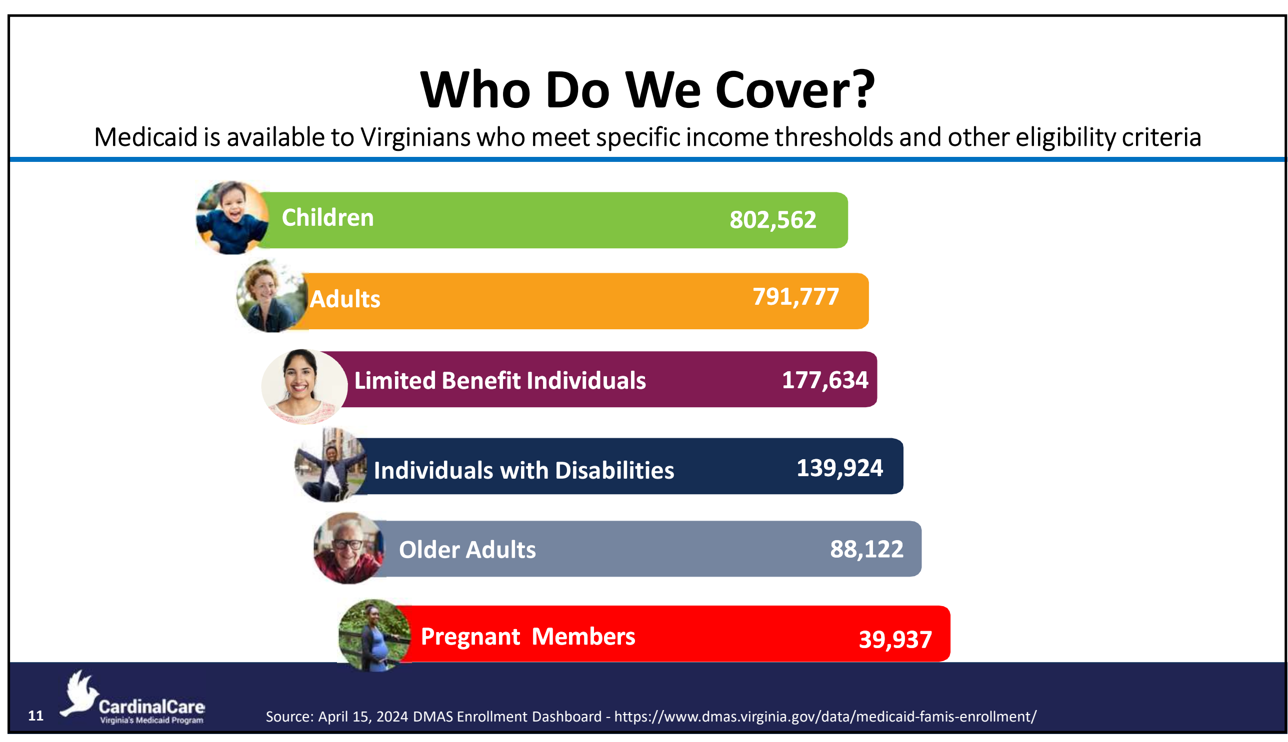
Other Waivers

§1332 Waivers are also known as a State Innovation Waiver

Under a **§1332** waiver, states may request permission from the federal government to change elements of the Affordable Care Act that apply to private health insurance coverage

- **§1332** Waivers can be combined with an **§1115** Waiver but will be evaluated separately by the federal government

§1135 Waiver for the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act



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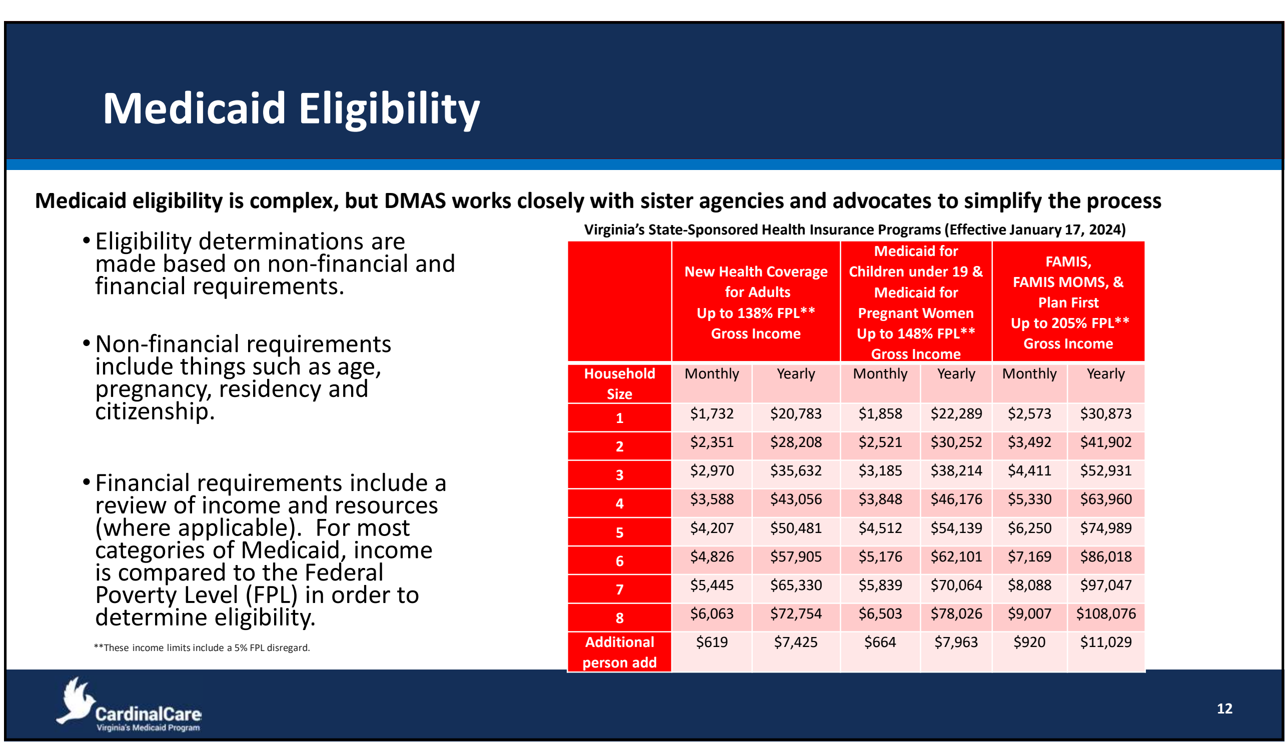

Medicaid Eligibility

Medicaid eligibility is complex, but DMAS works closely with sister agencies and advocates to simplify the process

- Eligibility determinations are made based on non-financial and financial requirements.
- Non-financial requirements include things such as age, pregnancy, residency and citizenship.
- Financial requirements include a review of income and resources (where applicable). For most categories of Medicaid, income is compared to the Federal Poverty Level (FPL) in order to determine eligibility.

**These income limits include a 5% FPL disregard.

Virginia's State-Sponsored Health Insurance Programs (Effective January 17, 2024)

	New Health Coverage for Adults Up to 138% FPL** Gross Income		Medicaid for Children under 19 & Medicaid for Pregnant Women Up to 148% FPL** Gross Income		FAMIS, FAMIS MOMS, & Plan First Up to 205% FPL** Gross Income	
Household Size	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$1,732	$20,783	$1,858	$22,289	$2,573	$30,873
2	$2,351	$28,208	$2,521	$30,252	$3,492	$41,902
3	$2,970	$35,632	$3,185	$38,214	$4,411	$52,931
4	$3,588	$43,056	$3,848	$46,176	$5,330	$63,960
5	$4,207	$50,481	$4,512	$54,139	$6,250	$74,989
6	$4,826	$57,905	$5,176	$62,101	$7,169	$86,018
7	$5,445	$65,330	$5,839	$70,064	$8,088	$97,047
8	$6,063	$72,754	$6,503	$78,026	$9,007	$108,076
Additional person add	$619	$7,425	$664	$7,963	$920	$11,029

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Applying for Medicaid

Virginia offers many ways to apply for Medicaid:

Apply via Virginia Cardinal Care app

Apply online at **www.commonhelp.virginia.gov**

Apply online at the Virginia's Insurance Marketplace at **www.marketplace.virginia.gov**

Apply by calling Cover Virginia at 833-5CALLVA
(TDD: 1-888-221-1590)

CardinalCare Virginia's Medicaid Program

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12-Month Continuous Eligibility (CE) for Children

Medicaid and FAMIS enrolled children receive 12-months of protected coverage, regardless of changes in circumstance.

- CE periods begin at initial enrollment and each renewal
- Coverage cannot be closed or reduced during this period
  - Limited exceptions such as turning 19, moving out of state, or family requesting the coverage end apply.
- Annual renewals are still required
- Continuity of care and uninterrupted access to the essential health coverage.

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Continuous Coverage Unwinding Updates

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Medicaid Continuous Coverage Requirements: Background

The end of the continuous coverage requirement, or "unwinding" has represented the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA).

- The Families First Coronavirus Relief Act required states to maintain enrollment of Medicaid members (enrolled as of March 18, 2020) to receive the additional 6.2 % increase until the end of the month in which the federal Public Health Emergency (PHE) ended.
- In December 2022, the Consolidated Appropriations Act (CAA) 2023 was signed into effect decoupling the PHE from the continuous coverage requirement effective March 31, 2023. Additionally, the CAA:
  - Allowed states 12 months to initiate all renewals, with an additional two months to complete redeterminations. Virginia initiated unwinding renewals in March 2023; February 2024 will be the 12th month of initiations.
  - Stepped down the enhanced federal match rate beginning April 1 and completely phasing out the enhanced match effective December 31, 2023.
  - Virginia received a total of $3.067 billion in enhanced funding beginning in March 2020 through the end of calendar year 2023.
  - Virginia was one of 44 states required to submit a mitigation plan prior to unwinding, which was approved by the Centers for Medicare and Medicaid Services on March 29, 2023.

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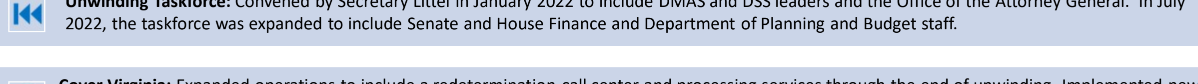
Medicaid Continuous Coverage Requirements: Preparation

Health Human Resources (HHR) agencies acted early in the PHE to implement flexibilities and protect needed coverage during the PHE to allow access to services. In a parallel effort, the DMAS and DSS began planning in mid-2020 for the eventual unwinding of those flexibilities. Virginia has been named a leader in the country for innovative and thorough outreach, education, and communication to all stakeholders.



- **Unwinding Taskforce:** Convened by Secretary Littel in January 2022 to include DMAS and DSS leaders and the Office of the Attorney General. In July 2022, the taskforce was expanded to include Senate and House Finance and Department of Planning and Budget staff.
- **Cover Virginia:** Expanded operations to include a redetermination call center and processing services through the end of unwinding. Implemented new permanent units dedicated to pregnant women and application assisters/advocates.
- **Outreach and Education:** Launched outreach campaigns through radio, television, social media, and 3 websites. Development of 4 stakeholder toolkits, 18 outreach templates, 60 provider memos. Engagement through speaking events to include 8 public townhalls to nearly 1000 different stakeholder groups.
- **25 System Updates**: Increased the number of successful "no touch" actions at application, change, and renewal to promote consistency, reduce local worker burden, and allow a stronger focus on high-risk populations which require manual processing.
- **Training and Information Sessions**: eLearning and webinars held for over 3,000 local agency staff. Expanded learning opportunities through existing Virginia Health Care Foundation partnership to increase assistance resources, added trainings for aged and disabled populations.
- **Managed Care Organization Collaboration**: Executed agreement with the six health plans to solidify plans for four round of targeted member outreach across all modalities. Implemented new data sharing processes to include addresses, closures, and closure reason.

CardinalCare
Virginia's Medicaid Program

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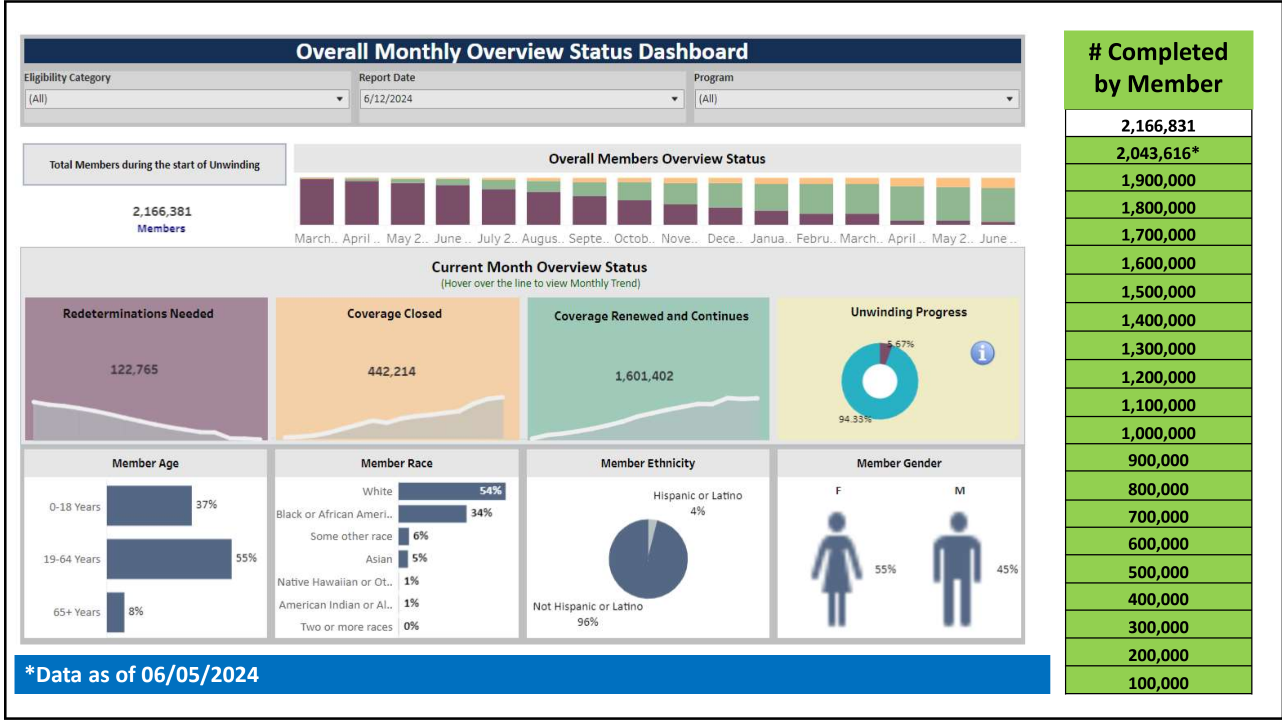

Completed by Member
2,166,831
2,043,616*
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
1,300,000
1,200,000
1,100,000
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000

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Virginia Medicaid Services

Primary Care

Acute Care

Behavioral Health & ARTS

Maternal Health

Pharmacy

Long Term Services & Supports

DD Waiver Medical

Infant/Well Child Services

Transportation

"Carved-out" services include dental, school health, and DD Waiver services

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Virginia's Medicaid Program

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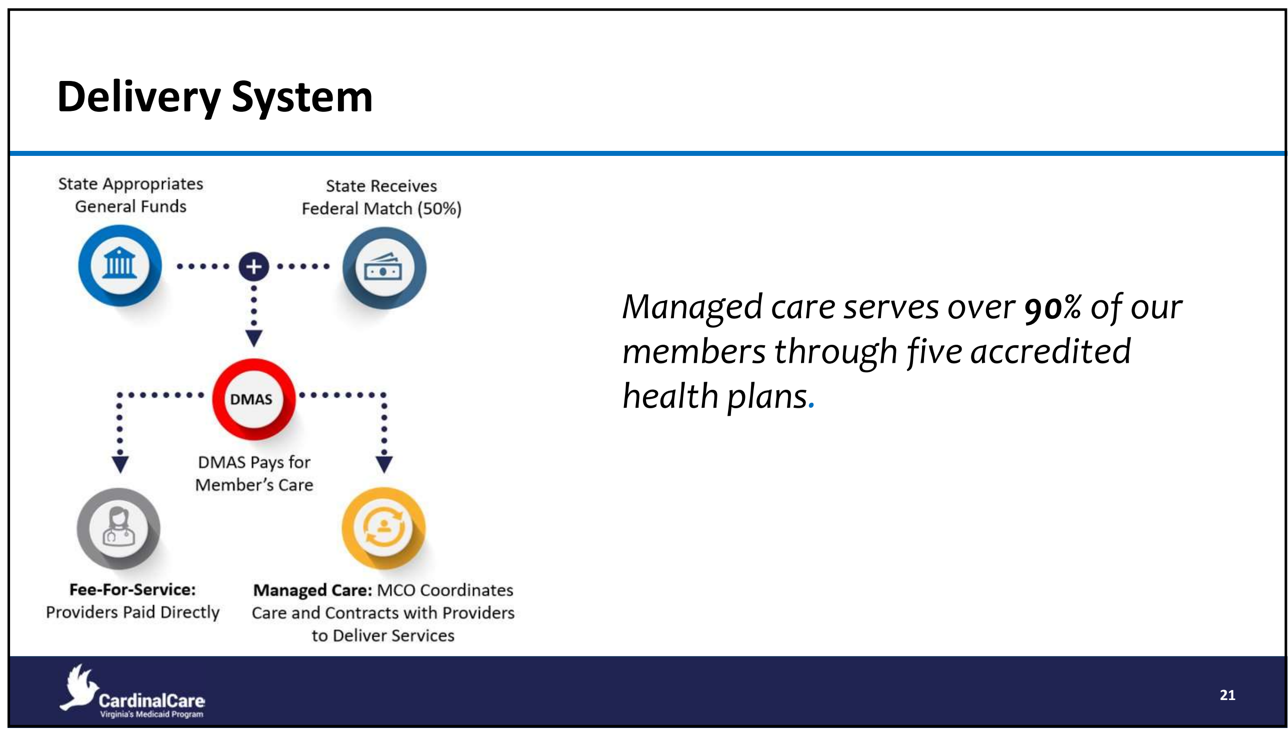

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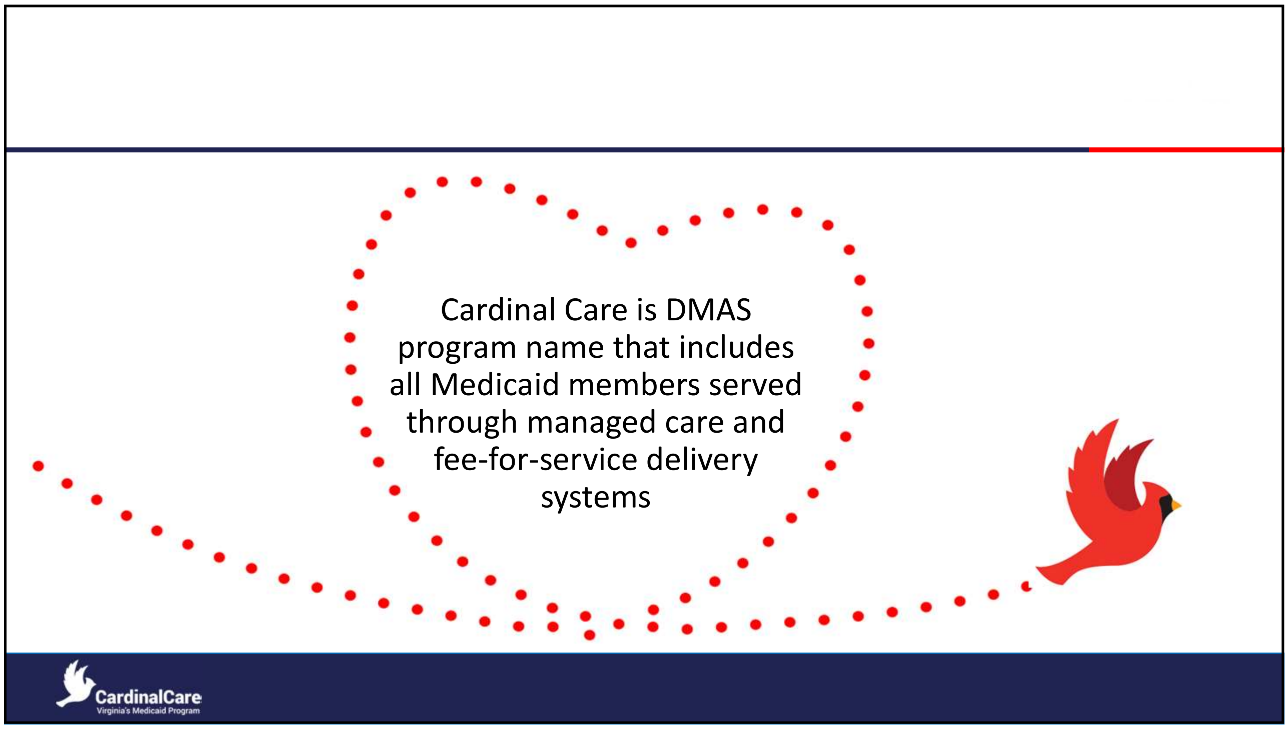

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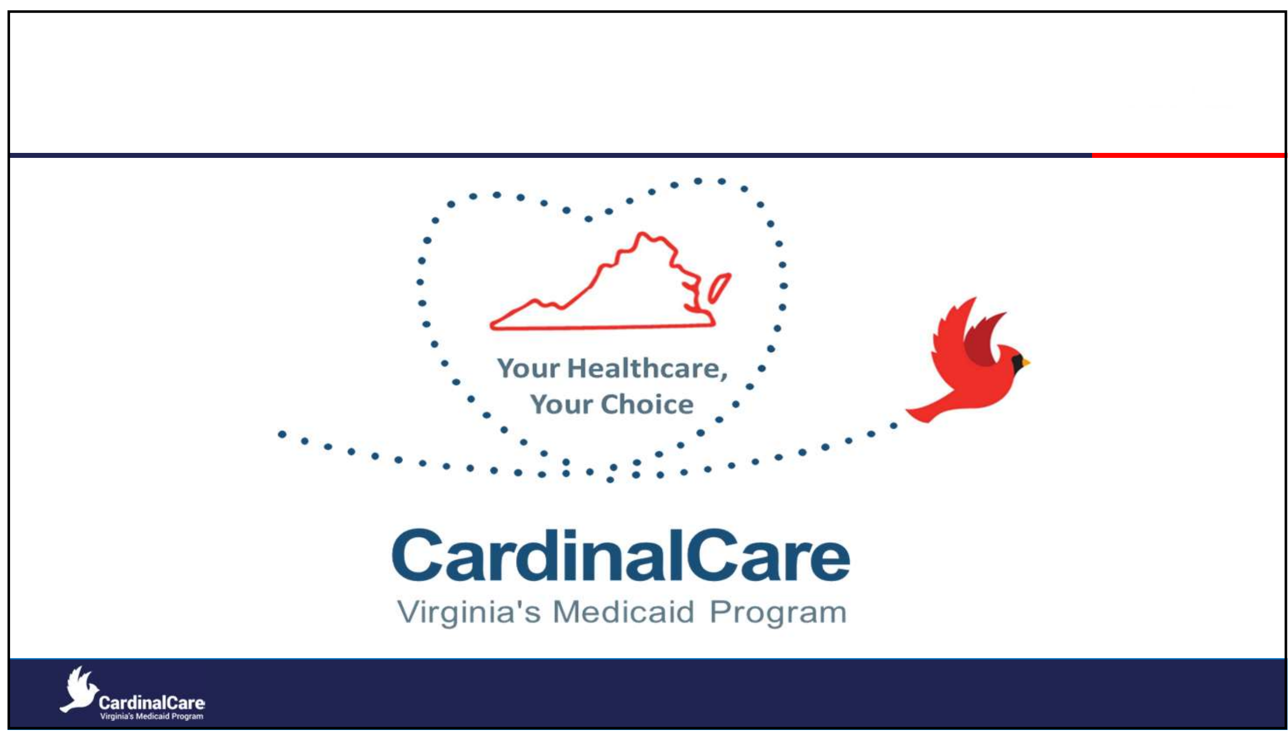

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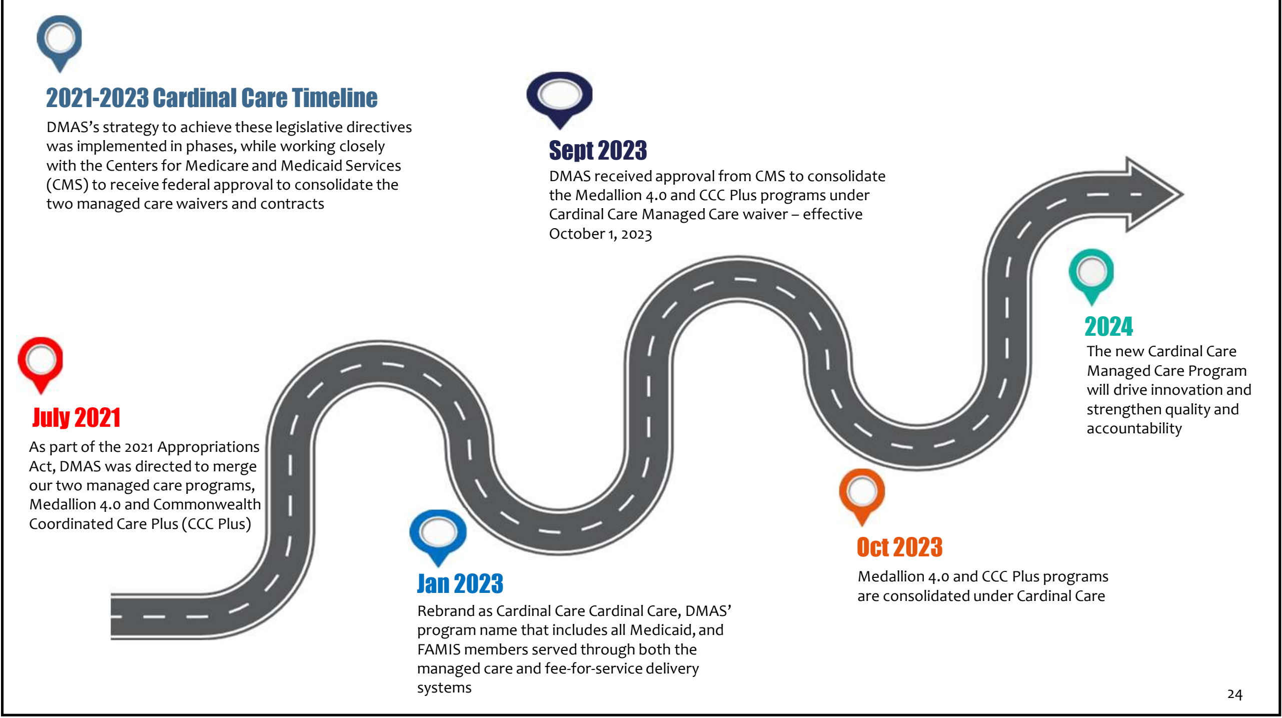

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Cardinal Care Managed Care

- The Cardinal Care Managed Care (CCMC) program provides comprehensive health care services for 1.8 million Virginians receiving Medicaid and CHIP through five contracted health plans
- DMAS is taking a bold approach to improve the program with three steps:
  - Creation of Cardinal Care Managed Care – A consolidation of the two programs formerly known as Commonwealth Coordinated Care Plus and Medallion 4.0
  - Defining the transformation goals for the program
  - Reprocurement of the Cardinal Care Managed Care delivery system

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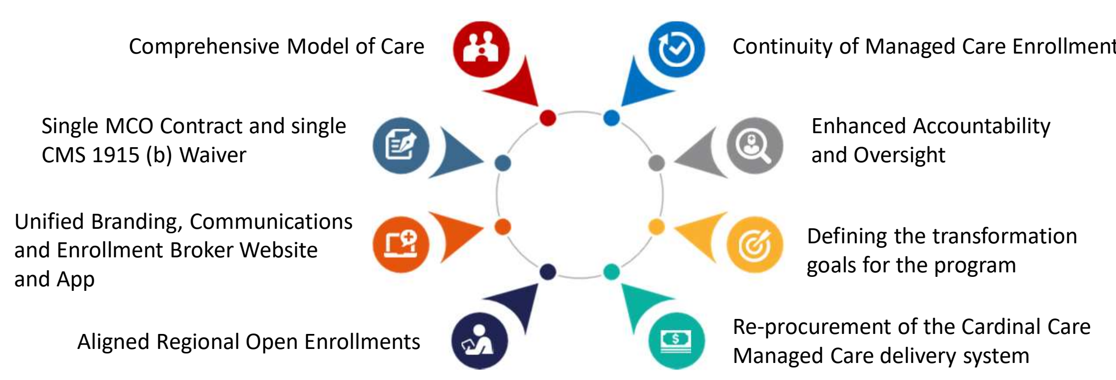
Cardinal Care Managed Care

DMAS is improving the Cardinal Care Managed Care (CCMC) program with these steps:



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What Stays the Same

- Benefits and Services (no reductions or changes)
- Services included in Managed Care (Services carved-out of managed care are not changing)
- Populations eligible for managed care (excluded populations are not changing)
- Members have choice of health plans and providers

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What Changed

- Benefits alignment
- Open enrollment alignment
- No need to switch plans if health care needs change
- Care coordination available to all

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Virginia's Medicaid Program

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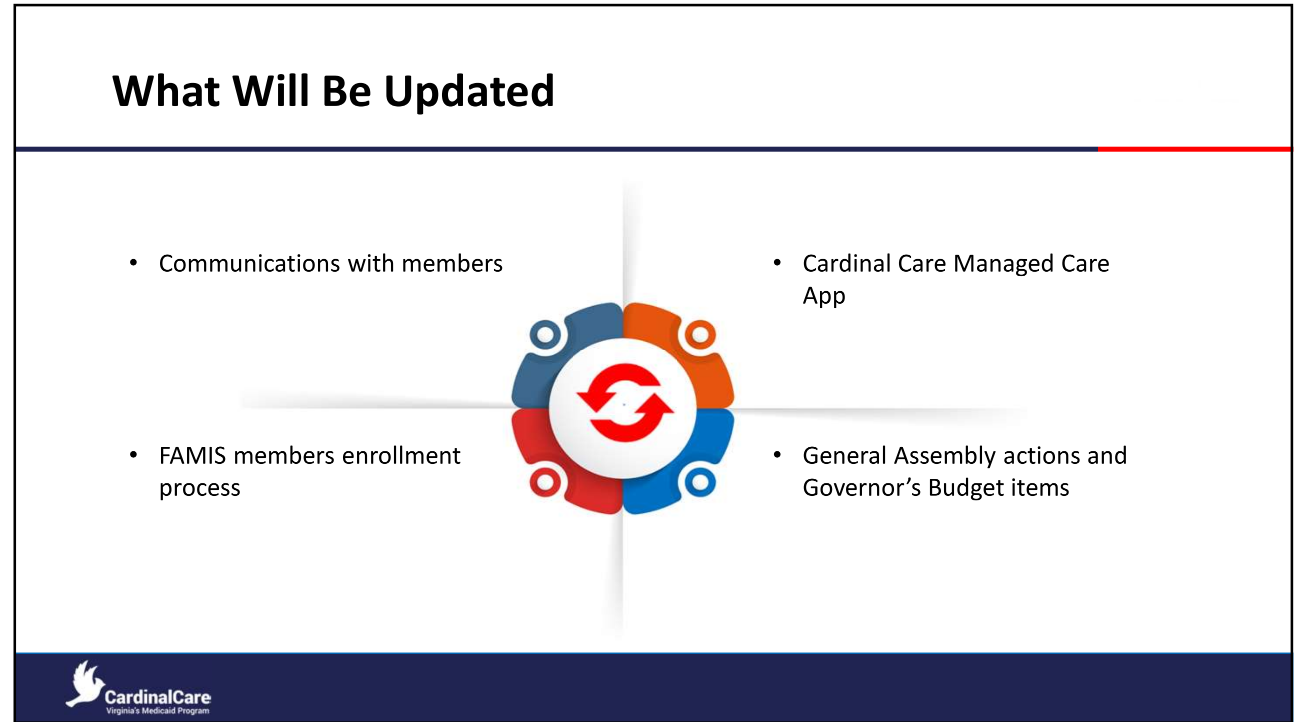

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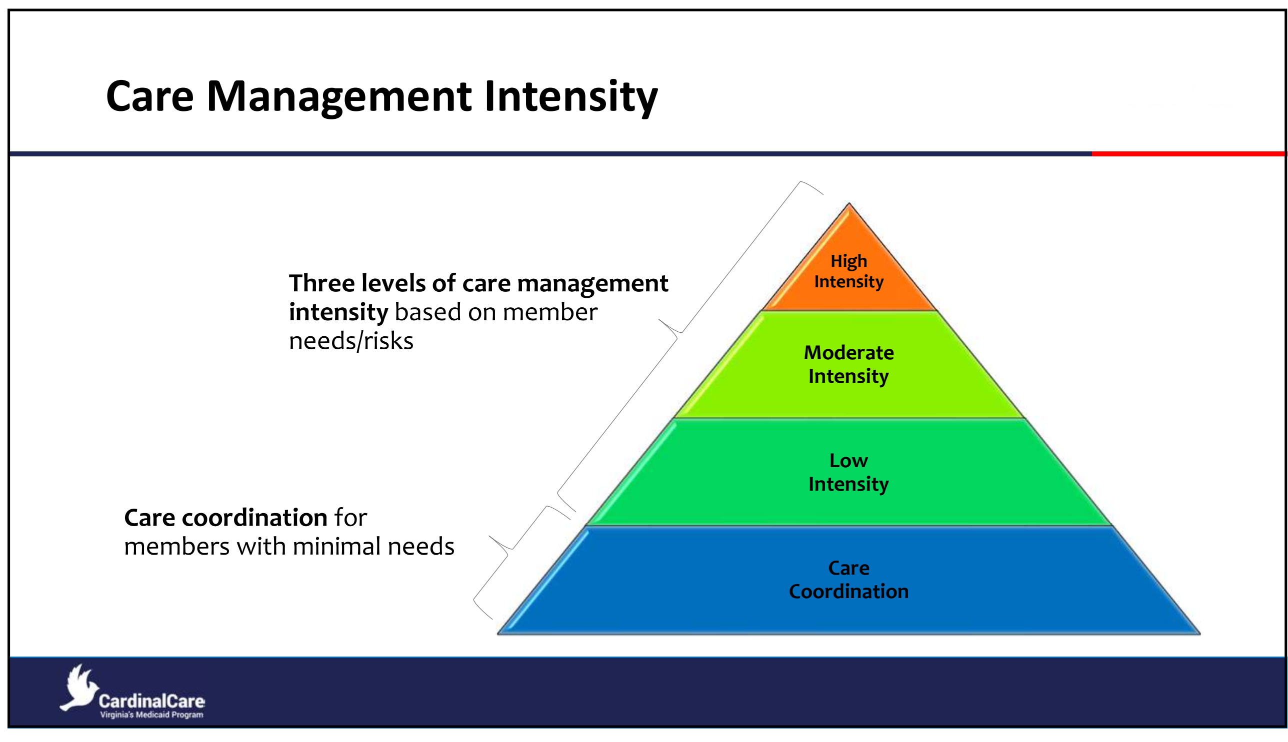

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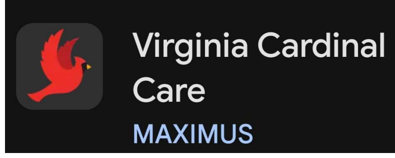
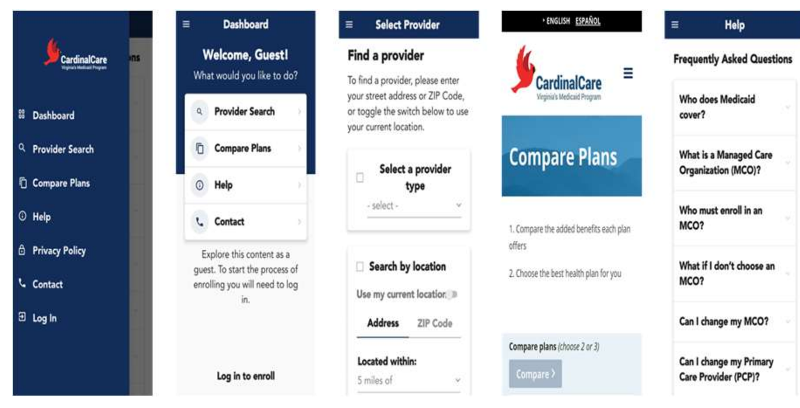
Download the Member App

The Virginia Cardinal Care mobile app is designed to make it simple to find and enroll in a health care plan.

Download for Android or iPhone





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Questions?

- **Enrollment Broker Website:** https://virginiamanagedcare.com/
- **Enrollment Broker Phone Number:**
  - **Toll-free number:**
    - 1-800-643-2273
    - **TTY:** 1-800-817-6608
  - **Hours of operation**:

    Monday – Friday

    8:30 a.m. – 6:00 p.m.

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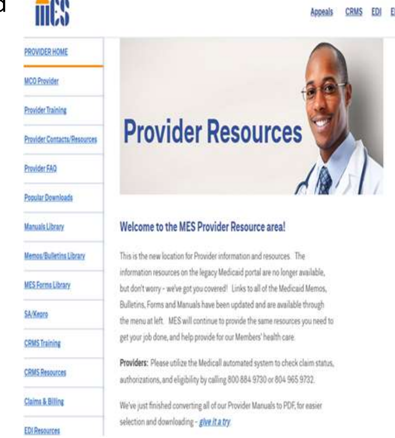
Medicaid Provider Enrollment

- The 21st Century Cures Act (Act) is a federal mandate requiring all Medicaid Managed Care network providers to enroll and periodically revalidate with the state's Medicaid program in PRSS
- Providers can enroll as FFS, FFS+MCO, or MCO only
- PRSS handles federally required background checks, fees, and site visits based on the provider's risk level
- Providers must be enrolled in PRSS prior to contracting with an MCO
- Enrollment information is available at https://vamedicaid.dmas.virginia.gov/training/providers



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Provider Revalidation

- Medicaid fee-for-service and Managed Care Organization (MCO) network providers need to enroll in PRSS and revalidate enrollment at least every five years
- Providers must submit the revalidation electronically through our Provider Services Solution (PRSS) portal
- Provider notices are sent via email or USPS at least 90 prior to the end of their enrollment period
- Reminder notices are also sent at 60 and 30 days prior to the revalidation deadline
- In accordance with federal requirements, providers who do not revalidate by the revalidation due date will have their Virginia Medicaid participation status terminated from fee-for-service and MCO networks until the provider successfully enrolls/revalidates in PRSS
- MCO network providers who have had their network participation terminated due to failure to revalidate may need to recredential with the MCOs once they have successfully re-enrolled in PRSS. Federal rules prohibit the MCOs from contracting with providers who are not enrolled or have had their enrollment terminated in PRSS.
- Visit the Medicaid Enterprise System (MES) at https://www.dmas.virginia.gov/for-providers/medicaid-enterprise-system/ for more info

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Long Term Services and Supports (LTSS)

Institution Based Care

Nursing Facilities, Specialized Care Nursing Facilities, Long-Stay Hospitals, Out of State Placement, and Intermediate Care Facilities for Individuals with Intellectual Disabilities

Home & Community-Based Services (HCBS)

Provides supports for individuals in a community-based setting. These services are available for both children and adults. The services will differ based on the individual needs and program criteria met.

Developmental Disability (DD) Waivers

- For individuals with developmental disabilities through three waivers. Services may include residential, day, and employment supports.

Commonwealth Coordinated Care Plus Waiver

- For seniors or individuals with physical disabilities, services include personal care, respite, and adult day healthcare.

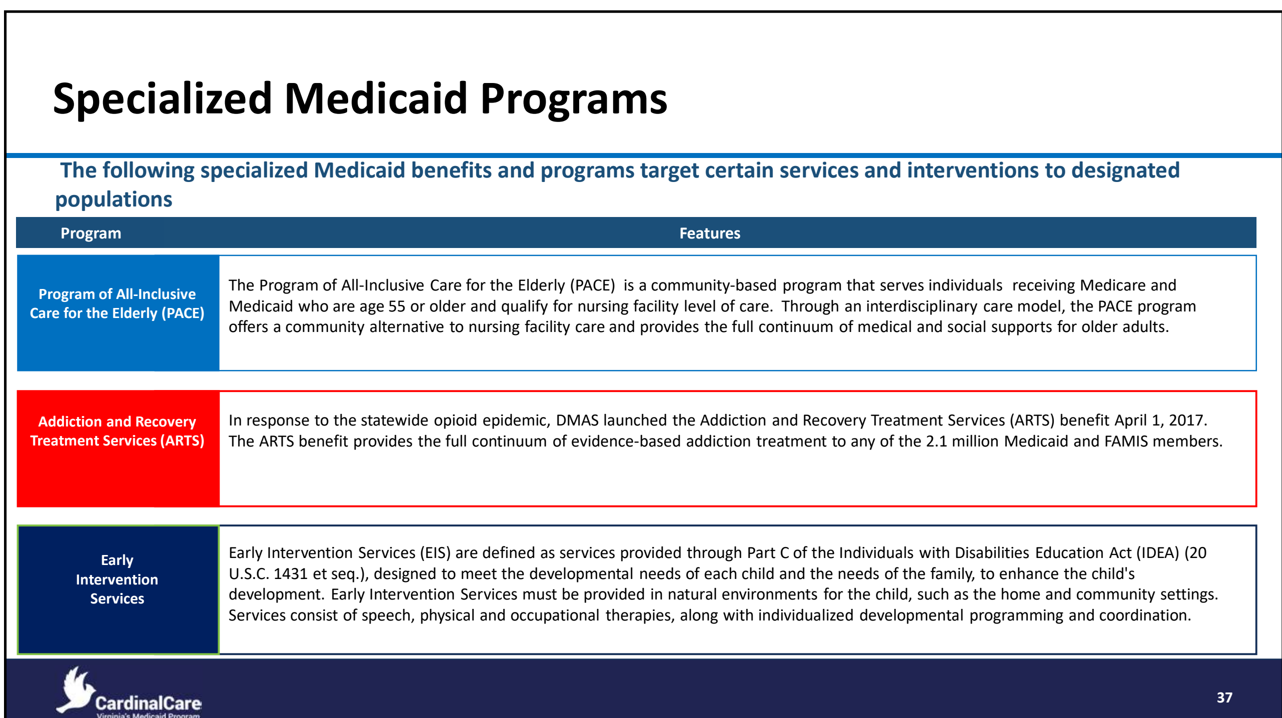
Program for All-Inclusive Care Services for the Elderly (PACE)

- For adults ages 55+ who are living with chronic health care needs and/or disabilities and receive community-based health care services and supports from an approved PACE program.

Home and Community Based Waivers

The Medicaid home and community-based waivers (§1915(c)) offer individuals who require assistance with activities of daily living and/or supportive services the opportunity to receive care in the community rather than in a facility setting

Waiver	Features
Community Living Waiver	Provides 24/7 services and supports for adults and some children with exceptional medical and/or behavioral support needs. This includes residential supports and a full array of medical, behavioral and non-medical supports.
Family and Individual Supports Waiver	Provides supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.
Building Independence Waiver	Provides supports for adults able to live independently in the community with housing subsidies and/or other types of support. The supports available in this waiver will be periodic or provided on a regular basis as needed.
Commonwealth Coordinated Care Plus Waiver	Provides supports for elderly and disabled individuals, including adult day health care; medication monitoring; personal care services; respite care; and personal emergency response systems. Also provides supports for children and adults who are chronically ill or severely impaired and require both a medical device and substantial and ongoing skilled nursing care to avert further disability or to sustain their lives



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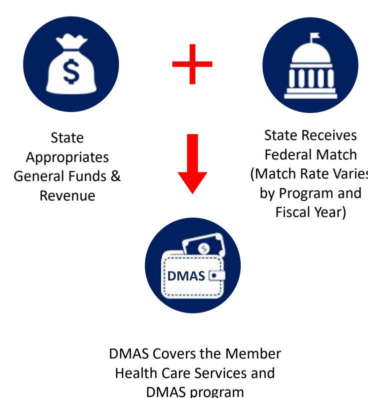
Medicaid Funding and Authority

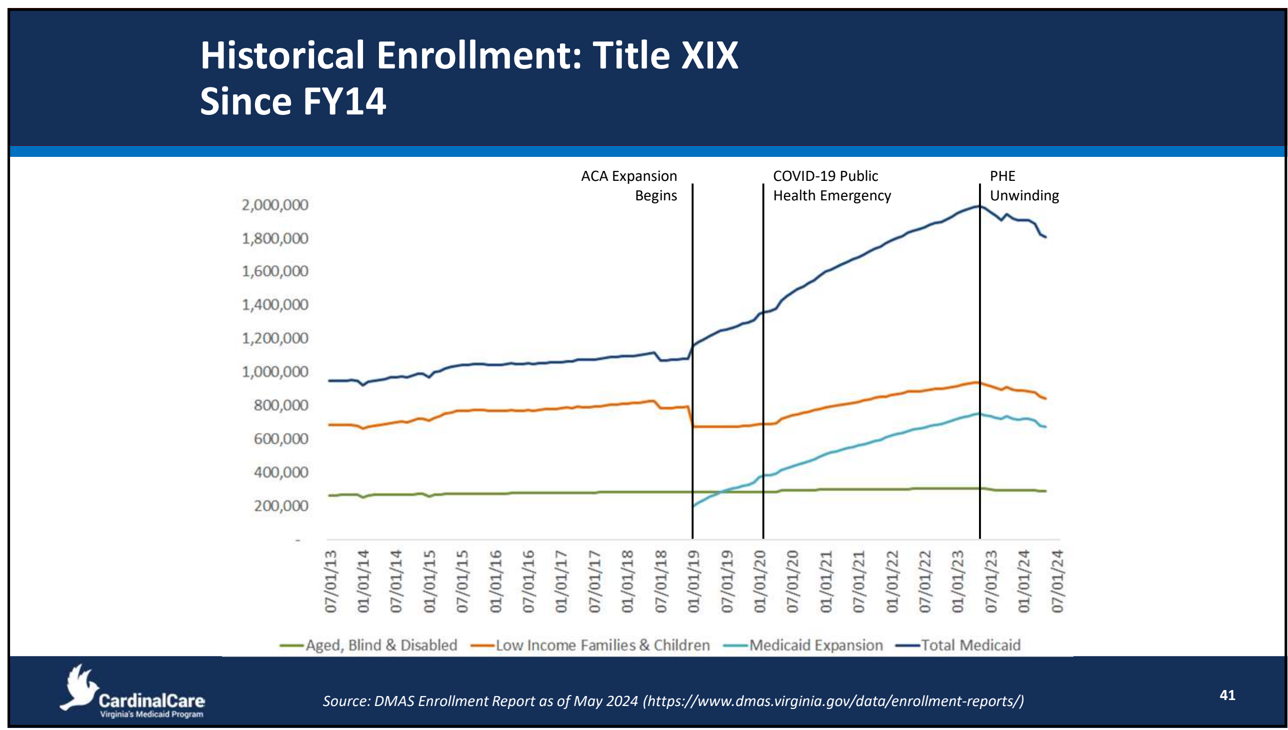
- Current Appropriations is $22.7 billion
- $0.22 out of every state tax dollar collected annually goes to fund the state share of Medicaid



Finance Overview
FY24 Appropriation (Chapter 1, 2024 Special Session I)

	FY24 Appropriation (In Millions)
Title XIX Base Medicaid & Medicaid Expansion	$ 21,730.9
Title XXI Children's Health Insurance Program	590.1
Administration	340.2
Temporary Detention Orders	11.8
Insurance Premiums for HIV-Positive Individuals	0.6
Uninsured Medical Catastrophe	0.3
Total	**$ 22,673.9**

Source: PB Reports, as of May 20, 2024 https://pbreporting.virginia.gov/rdPage.aspx



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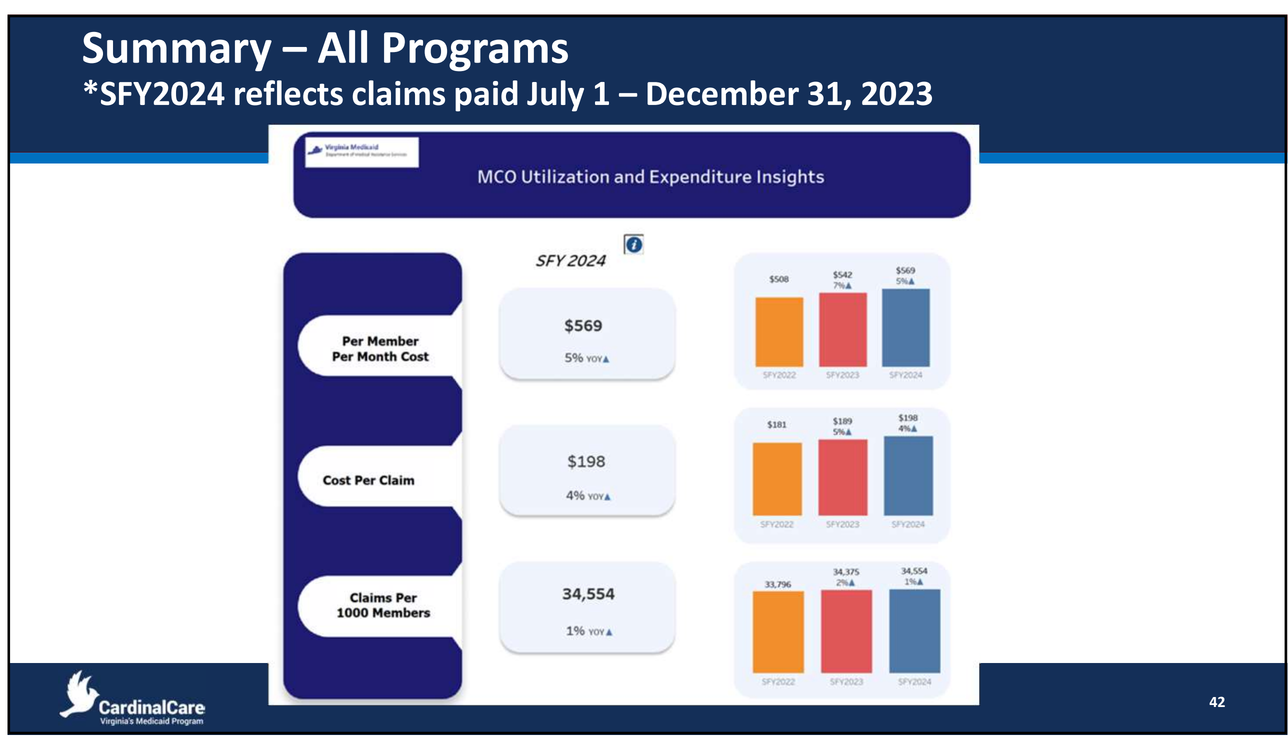

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Cardinal Care Acute Overview (Managed Care)

Big 3 By Cost Category

Program: MEDALLION4 (Acute) | Healthplan*: (All) | Eligibility Category: (All)

		SFY2022	SFY2023	SFY2024	% Difference SFY23 - 24
Grand Total	PMPM	$290	$309	$318	2.7%▲
	Cost Per Claim	$165	$171	$182	6.2%▲
	Claims Per 12K Members	21,063	21,699	20,978	-3.3%▼
ER	PMPM	$16	$19	$21	11.8%▲
	Cost Per Claim	$123	$146	$165	13.2%▲
	Claims Per 12K Members	1,514	1,571	1,551	-1.3%▼
In-Patient	PMPM	$58	$55	$55	0.3%▲
	Cost Per Claim	$8,750	$7,987	$8,121	1.7%▲
	Claims Per 12K Members	80	83	82	-1.3%▼
Nursing Facility	PMPM	$0	$0	$0	98.1%▲
	Cost Per Claim	$2,472	$3,804	$4,333	13.9%▲
	Claims Per 12K Members	0	0	0	73.9%▲
Other Facility	PMPM	$4	$5	$5	-8.5%▼
	Cost Per Claim	$1,071	$1,229	$1,239	0.9%▲
	Claims Per 12K Members	48	52	47	-9.2%▼
Out-Patient	PMPM	$33	$40	$44	9.9%▲
	Cost Per Claim	$390	$502	$540	7.5%▲
	Claims Per 12K Members	1,014	958	980	2.2%▲
Pharmacy	PMPM	$73	$80	$82	2.4%▲
	Cost Per Claim	$107	$111	$117	5.6%▲
	Claims Per 12K Members	8,234	8,672	8,405	-3.1%▼
Physician Services	PMPM	$106	$110	$110	0.4%▲
	Cost Per Claim	$125	$127	$134	5.0%▲
	Claims Per 12K Members	10,173	10,363	9,913	-4.3%▼

*Beginning SFY2024, Virginia Premier has become part of Sentara.

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Virginia's Medicaid Program

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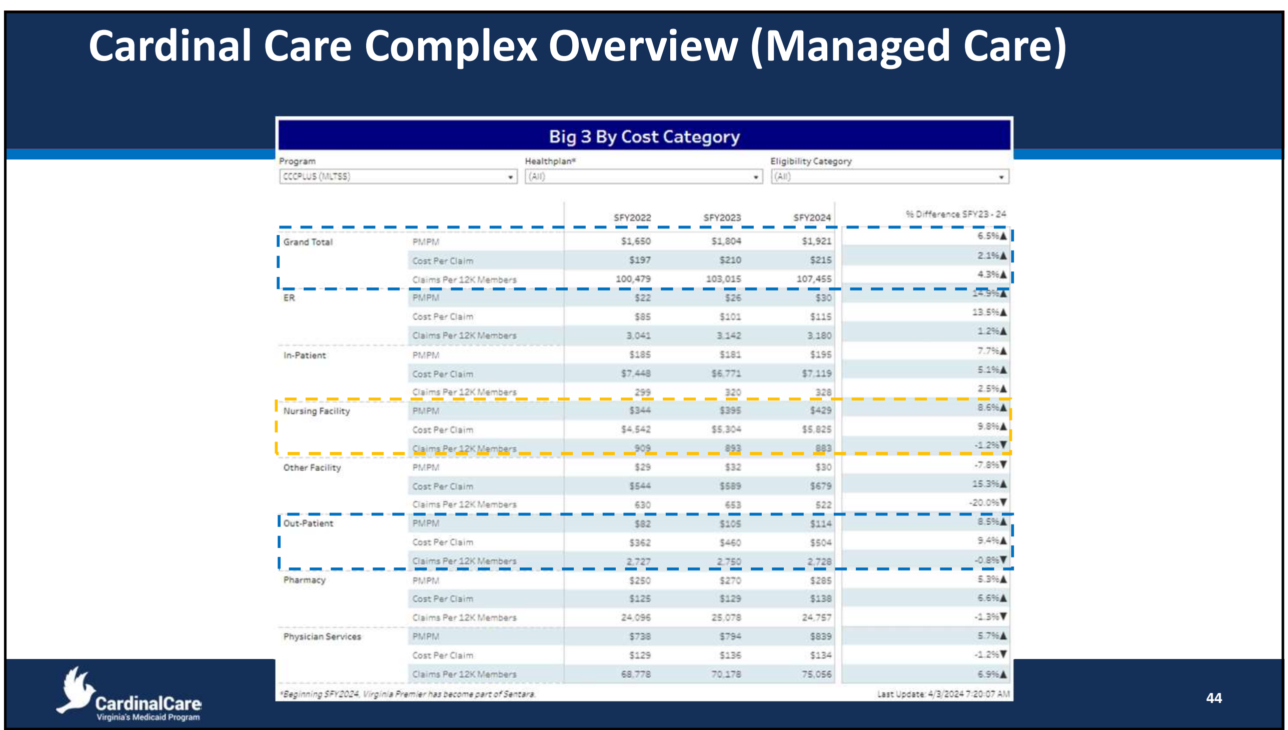

Cardinal Care Complex Overview (Managed Care)

Big 3 By Cost Category

Program: CCCPLUS (MLTSS) | Healthplan*: (All) | Eligibility Category: (All)

		SFY2022	SFY2023	SFY2024	% Difference SFY23 - 24
Grand Total	PMPM	$1,650	$1,804	$1,921	6.5%▲
	Cost Per Claim	$197	$210	$215	2.1%▲
	Claims Per 12K Members	100,479	103,015	107,455	4.3%▲
ER	PMPM	$22	$26	$30	14.9%▲
	Cost Per Claim	$85	$101	$115	13.5%▲
	Claims Per 12K Members	3,041	3,142	3,180	1.2%▲
In-Patient	PMPM	$185	$181	$195	7.7%▲
	Cost Per Claim	$7,448	$6,771	$7,119	5.1%▲
	Claims Per 12K Members	299	320	328	2.5%▲
Nursing Facility	PMPM	$344	$395	$429	8.6%▲
	Cost Per Claim	$4,542	$5,304	$5,825	9.8%▲
	Claims Per 12K Members	909	893	883	-1.2%▼
Other Facility	PMPM	$29	$32	$30	-7.8%▼
	Cost Per Claim	$544	$589	$679	15.3%▲
	Claims Per 12K Members	630	653	522	-20.0%▼
Out-Patient	PMPM	$82	$105	$114	8.5%▲
	Cost Per Claim	$362	$460	$504	9.4%▲
	Claims Per 12K Members	2,727	2,750	2,728	-0.8%▼
Pharmacy	PMPM	$250	$270	$285	5.3%▲
	Cost Per Claim	$125	$129	$138	6.6%▲
	Claims Per 12K Members	24,096	25,078	24,757	-1.3%▼
Physician Services	PMPM	$738	$794	$839	5.7%▲
	Cost Per Claim	$129	$136	$134	-1.2%▼
	Claims Per 12K Members	68,778	70,178	75,056	6.9%▲

*Beginning SFY2024, Virginia Premier has become part of Sentara.

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Virginia's Medicaid Program

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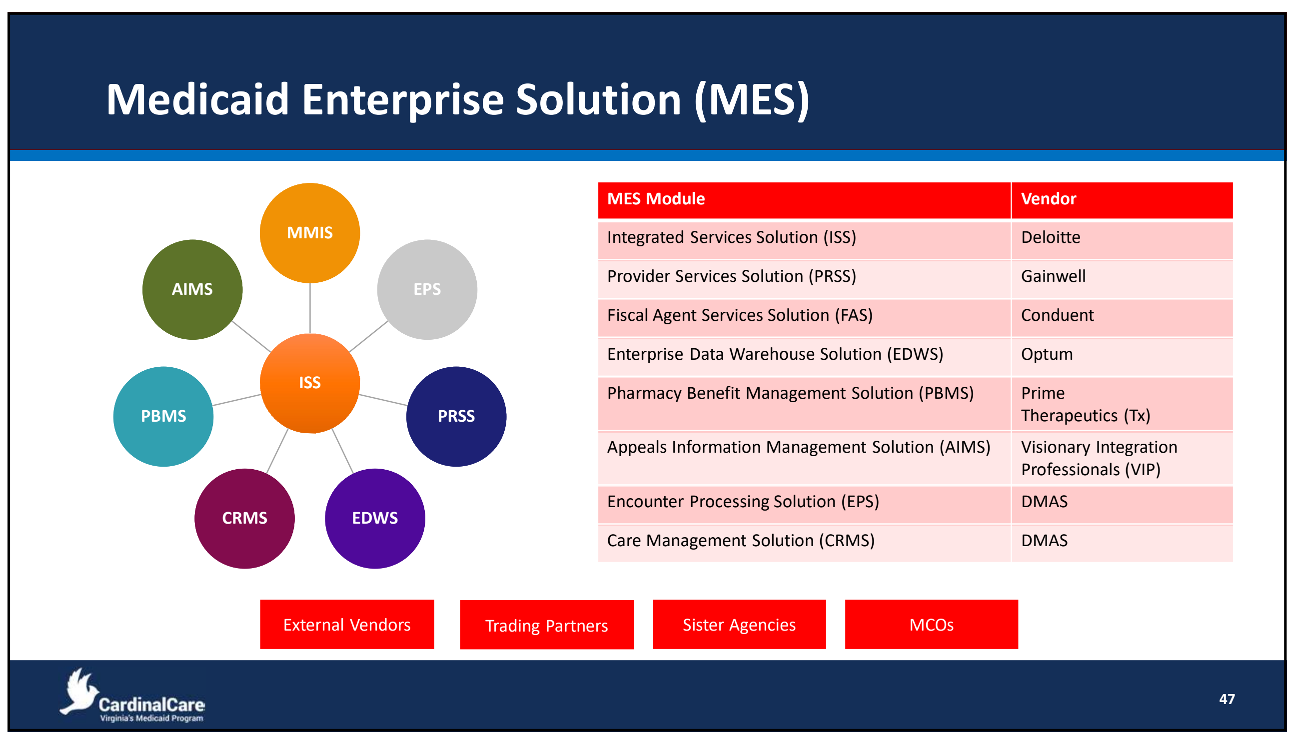

MES Module	Vendor
Integrated Services Solution (ISS)	Deloitte
Provider Services Solution (PRSS)	Gainwell
Fiscal Agent Services Solution (FAS)	Conduent
Enterprise Data Warehouse Solution (EDWS)	Optum
Pharmacy Benefit Management Solution (PBMS)	Prime Therapeutics (Tx)
Appeals Information Management Solution (AIMS)	Visionary Integration Professionals (VIP)
Encounter Processing Solution (EPS)	DMAS
Care Management Solution (CRMS)	DMAS

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Module Contract End w/Options and Description

- **ISS (9/30/2027)**
  - The central coordinator for all the information flowing through MES. Data flows from module to module in the cloud, with ISS directing the traffic to the right place. ISS includes the MES Portal, where users can connect to any module they are approved for, right from their web browser.
- **PRSS (11/30/2027)**
  - Provides overall management for provider related activities including enrollment services for fee-for-service and managed care network providers.
- **FAS (6/30/2027)**
  - Core of Medicaid Management including Member enrollment, claims adjudication, financials, and payment processing.
- **EDWS (9/30/2027)**
  - Main storage repository for data within MES and receives and supplies data on demand to MES modules through ISS and the source for data analytics and dashboards.
- **PBMS (9/30/2025)**
  - Manages pharmacy benefits across the Provider and Member communities.
- **AIMS (9/30/2027)**
  - Automates member and provider appeals processes.
- **EPS (N/A)**
  - Rules engine for receipt and validation of encounter claims submitted by MCOs and other Trading Partners.
- **CRMS (N/A)**
  - CRMS streamlines and standardizes the information exchange among MCOs and DMAS business areas through Member Transition Records and offers a comprehensive set of health records for Behavioral Health and Long-Term Care using eMLS, LOCERI and PACE web applications.

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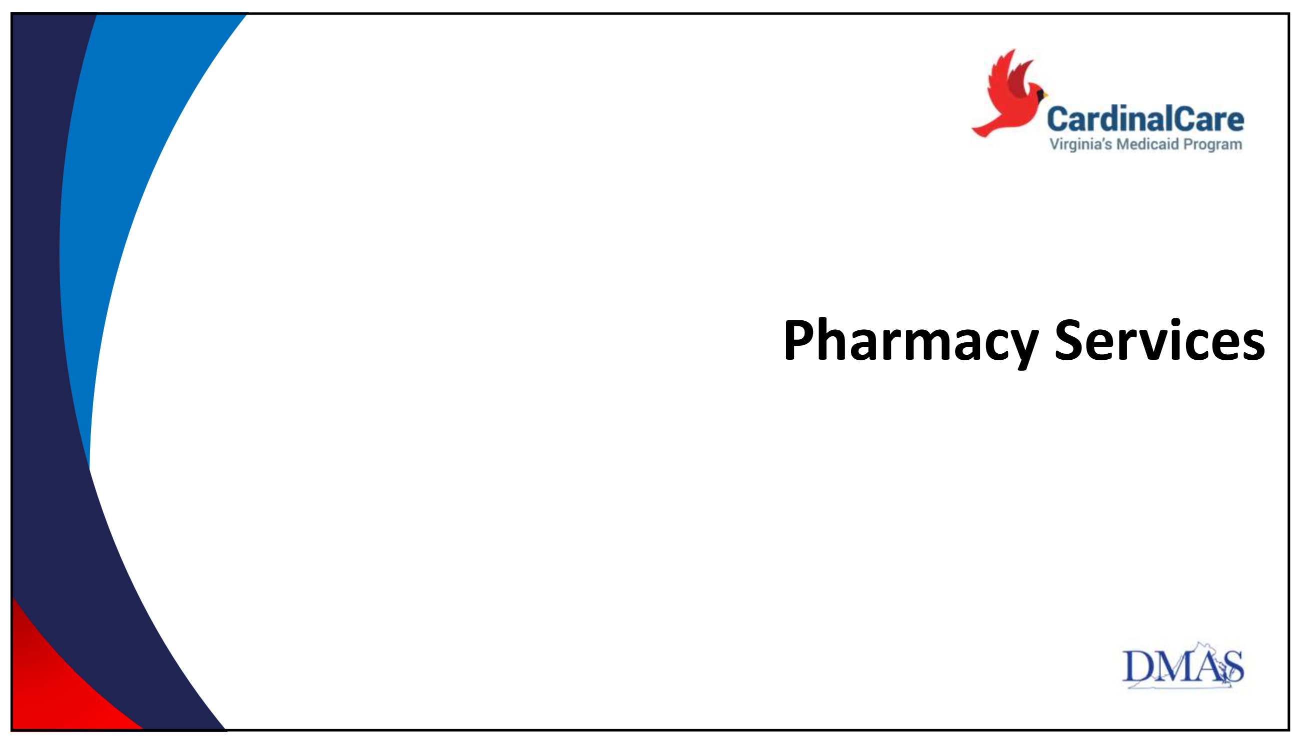

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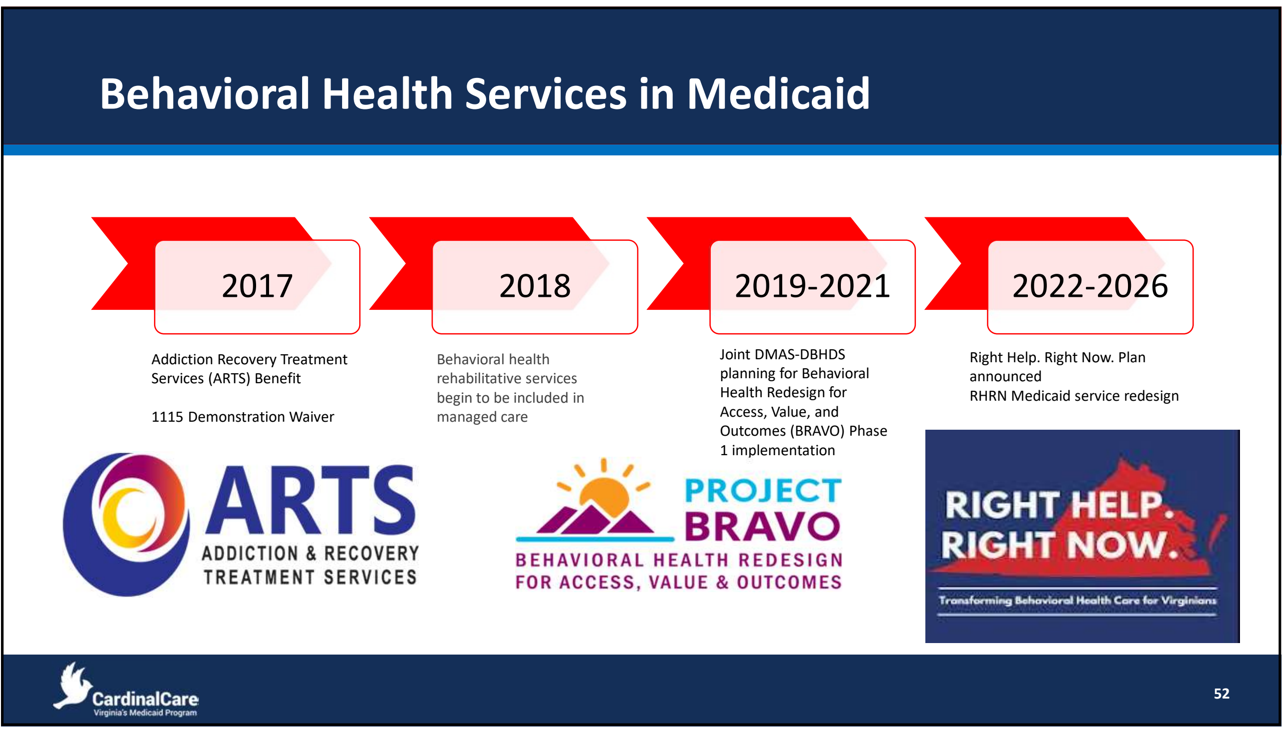

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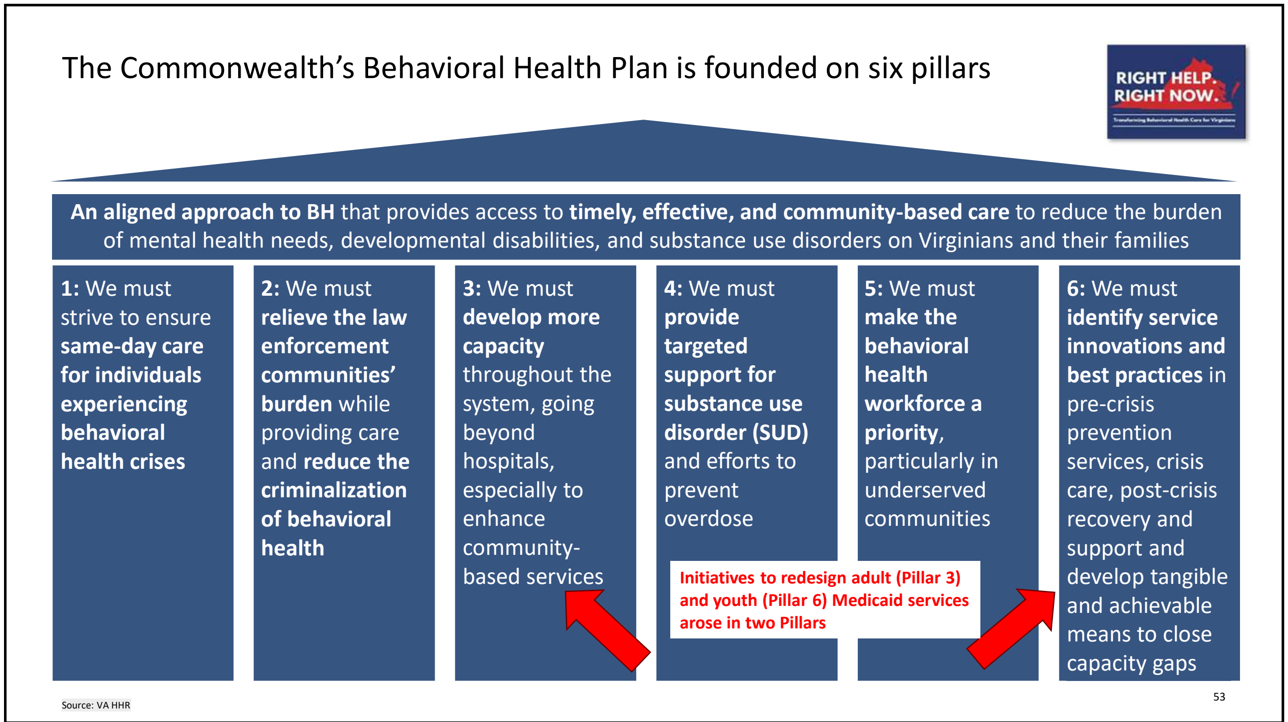

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Medicaid Behavioral Health Services Redesign Priorities

Strengthen the evidence-based, trauma-informed service continuum for youth and adults

Promote earlier intervention and increase access through tiered service design

Design services to complement Virginia's complex behavioral health delivery system

Integrate workforce priorities and workforce supports into service design and implementation

Implement the program in both FFS and the managed care organizations

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Project Overview

DMAS, in coordination with DBHDS and DHP, is employing an integrated and comprehensive approach to address rate, service, and workforce/provider roles for Medicaid over the next two years.

The project seeks to redesign DMAS' youth and adult legacy services: intensive in home, therapeutic day treatment, mental health skill building, psychosocial rehabilitation, and targeted case management.

The budget language authorizes DMAS to move forward with budget neutral changes to replace the legacy services with evidence based, trauma informed services.

The project will include stakeholder engagement, and policy and rate development for youth and adult services redesign as well as QMHP/BH Technician planning and integration.

This project will work with Managed Care Organizations and providers on all aspects of the program and implementation.

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Serving Medicaid Members in Behavioral Health Crisis

- In December 2021, Virginia Medicaid implemented four crisis specific services to support the implementation of a statewide Crisis Now Model for all Virginians.

Mobile Crisis Response	23 Hour Crisis Stabilization	Residential Crisis Stabilization	Community Stabilization (transition service)

- July 2022: All Medicaid providers must be under Memorandum of Understanding with the regional crisis hubs and use statewide Crisis CONNECT data platform
- December 2023: Medicaid Mobile Crisis Response service dispatched via regional mobile crisis hubs and regional 9-8-8 call centers, in line with the Crisis Now Model. *20,000 Medicaid members have received a mobile crisis response during State Fiscal Year 2024 so far.*

988 SUICIDE & CRISIS LIFELINE

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General Assembly and State Based Exchange

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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

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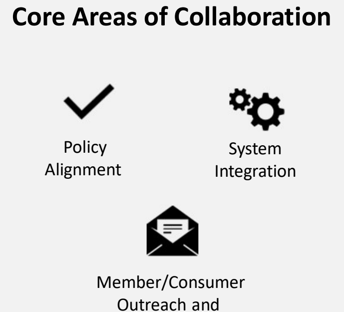
2024 General Assembly Session – Major Topics

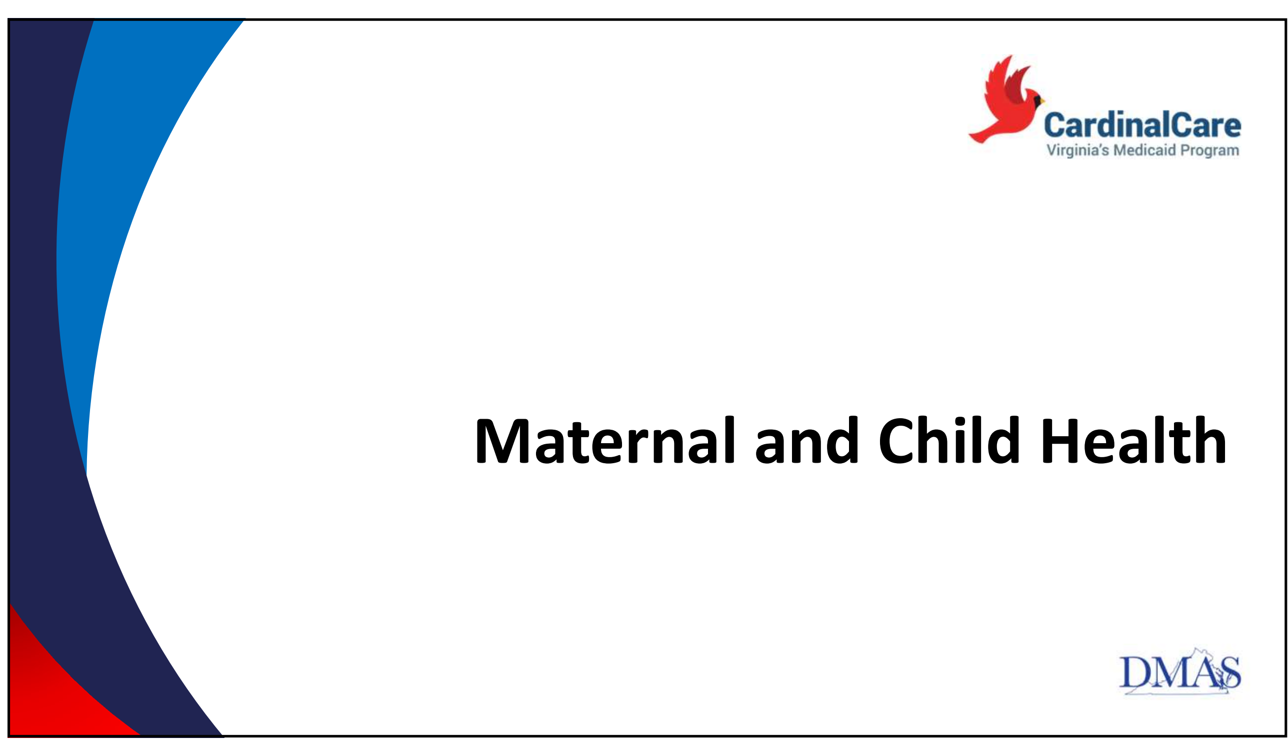
- Proposed new Medicaid benefits
- Changes to rules for paid family caregivers (legally responsible adults)
- Eligibility changes for waiver recipients
- Proposed pharmacy benefit changes
- Provider rate increases

DMAS and Virginia's State Based Exchange

- Department of Medical Assistance Services
- **2 million** members
- Funded jointly by federal and state governments



- Health Benefit Exchange, State Corporation Commission
- **400,000** consumers
- Individual premiums and cost sharing; federally funded premium tax credits and cost-sharing reductions



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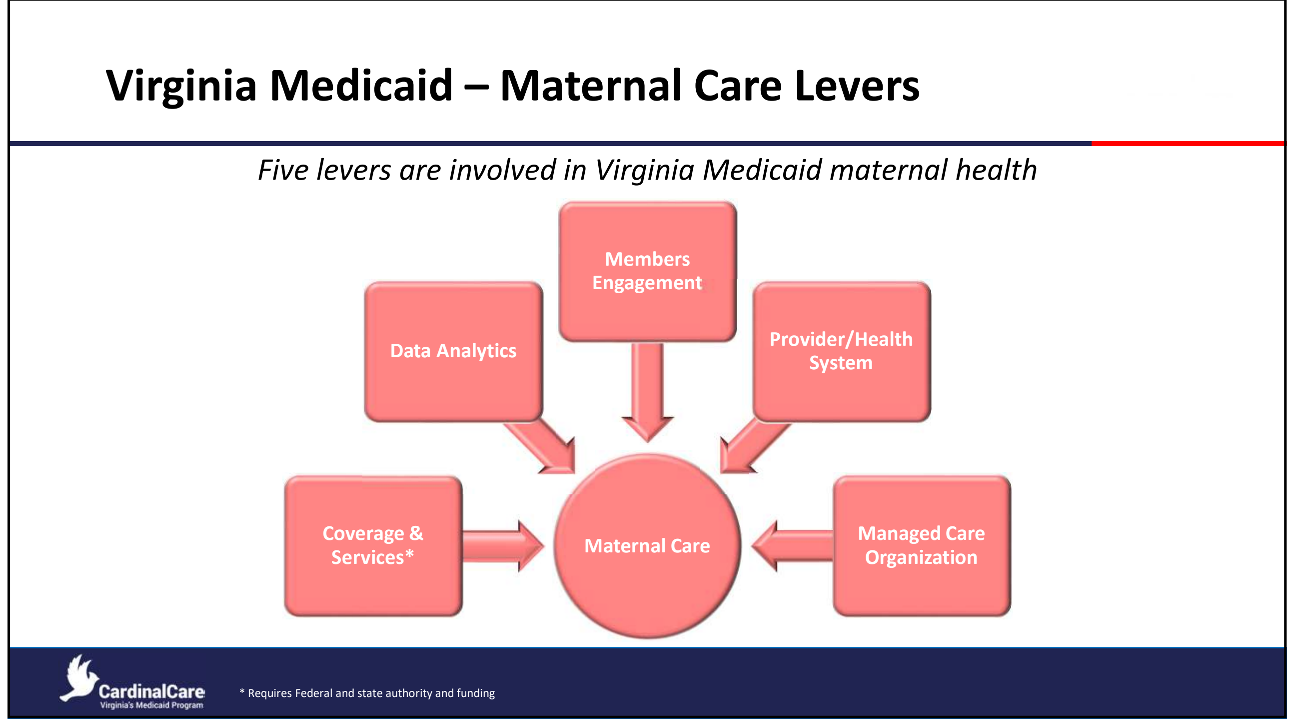

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DMAS Covers 1/3 of the Births in the Commonwealth

Four basic coverage categories receive full Medicaid benefits to include maternal and comprehensive health services, dental, transportation, behavioral health, and no cost sharing

- ❖Medicaid for Pregnant Women
- ❖Medicaid Base
- ❖Medicaid Expansion
- ❖FAMIS Moms

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DMAS Enrollment Dashboard

Virginia Medicaid and FAMIS Enrollment | Monthly Enrollment by Eligibility Category | Monthly Enrollment by Health Plan | Monthly Enrollment by Region | Footnotes

Virginia Medicaid and FAMIS Enrollment

Reporting Period: May 15, 2024 | Member Eligibility: Pregnant Members | Health Plan: (All) | Program: (All)

Eligibility Categories

Category	Count
Grand Total	36,616
Pregnant Members	36,616

Virginia Localities

© 2024 Mapbox © OpenStreetMap

* indicates suppressed data

Ethnicity: Non-Hispanic 93%; Hispanic 7%

Race: White 61%; Black or African American 27%; Asian 6%; Other 4%; Native Hawaiian or Other Pacific Islander 2%; American Indian or Alaskan Native 1%

Gender: 100% F

Age Groups: 0-19 Years 3%; 20-34 Years 79%; 35-64 Years 18%

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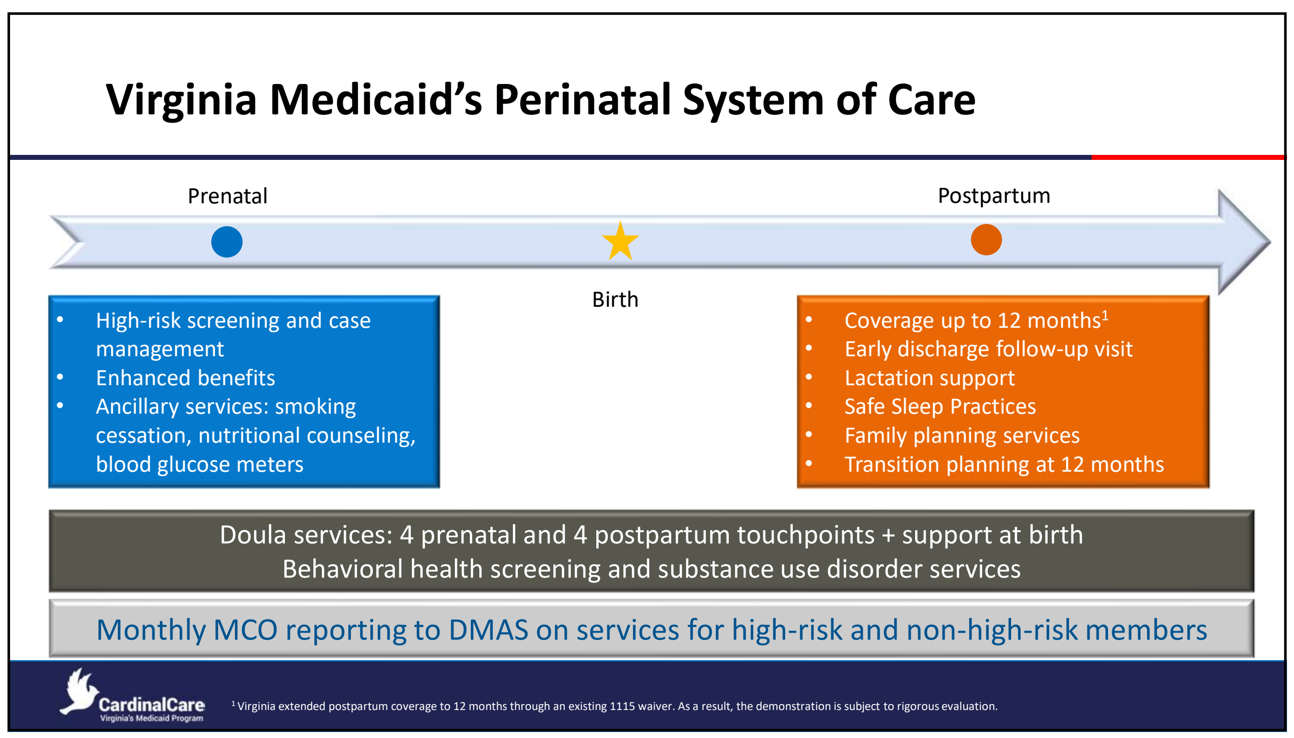

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Programs To Support Parents In The Postpartum Period

- Postpartum coverage extension
- Community doula program
- Managed care partnerships and contracting
- Baby Steps VA
- Community partnerships
- Evaluation

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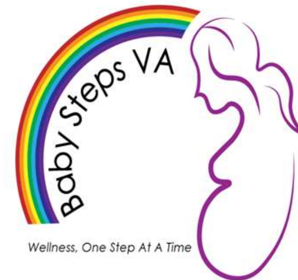
Baby Steps VA

- Eligibility and Enrollment
- Outreach and Information
- Connections
- New and Improved Services and Policies
- Program Oversight



Our next meeting is **Friday July 12th from 10-11:30am**

BabyStepsVA@dmas.virginia.gov

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Managed Care Organizations

- Managed Care Organizations (MCO) develop comprehensive maternity care programs that align with DMAS goals
- MCOs have specialized clinical programs as well as provide transportation, support services, and client connection teams such as doulas, community health workers, and home visitors
- Additional added benefits provided by MCOs may include:
  - Free diapers, highchairs, and car seats
  - Baby showers
  - Grocery gift cards
  - Meals sent after delivery
  - Health related social needs such as food and housing

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Care Management for High-Risk Pregnant Individuals

- Care management services must be provided to pregnant individuals deemed high-risk by the health plan
- Within three (3) business days of a member being identified as high-risk, the health plan makes efforts to contact the member and/or their physicians to identify and assess their specialized needs (medical, psychosocial, nutritional, etc.)
- The health plan monitors the risk status of pregnant members not originally considered "high-risk maternity" for potential enrollment in their high-risk maternity programs

What We Measure

Healthcare Effectiveness Data and Information Set (HEDIS) measures

- The percentage of deliveries of live births that received a **prenatal visit** in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization
- The percentage of deliveries of live births that had a **postpartum visit** on or between 7 and 84 days after delivery

Utilization data from claims

Program data from evaluation and monitoring reports from EQRO

More info available at https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/

DMAS Actions to Connect the Dots

- Reviewing data to inform policies and programs
- Reviewing national trends and state searches for best practices
- Working with the provider community on extended hours
- Adding the postpartum visit to the hospital discharge checklist
- Special mailings to members who have not had a prenatal or postpartum visit
- Participating in National Governor's Association learning opportunity with VDH
- Participating with the Governor and Secretary of Health and Human Resources on the Maternal Health Roundtable

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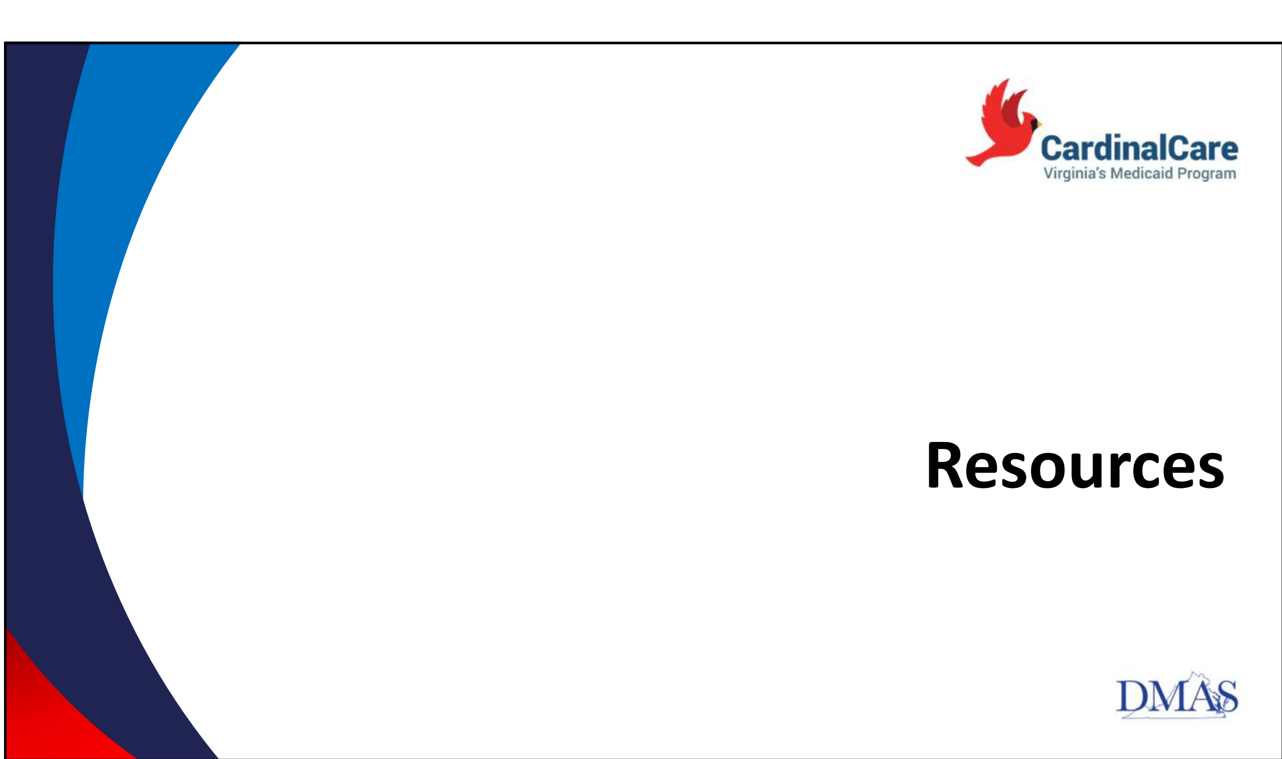

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Resources: Medicaid/FAMIS Enrollment Dashboard

Updated twice/month

Historical enrollment totals are shown for each month

Part of DMAS's efforts to provide transparency in our data for stakeholder engagement

Storyboard #1 provides an overview of enrollment and demographic data

Additional storyboards display monthly enrolment data by Eligibility Category, Health Plan and Region

[Medicaid/FAMIS Enrollment Dashboard]

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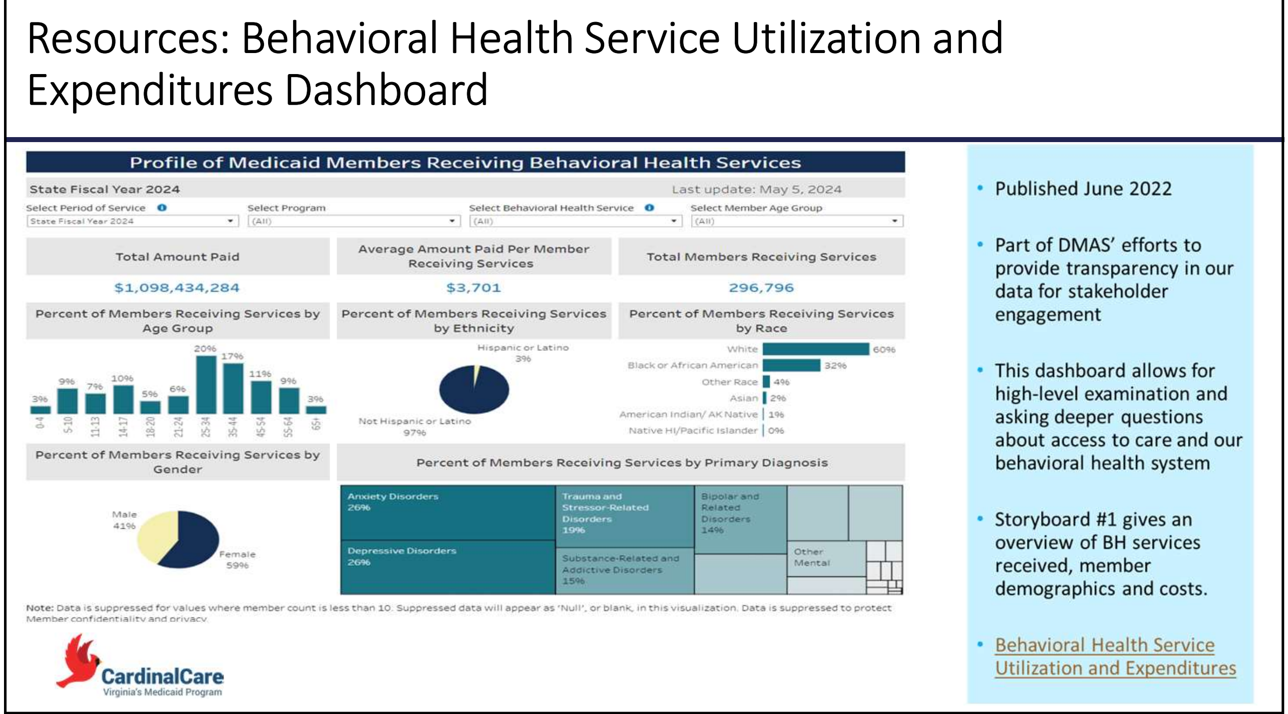
Resources: Behavioral Health Service Utilization and Expenditures Dashboard



- Published June 2022
- Part of DMAS' efforts to provide transparency in our data for stakeholder engagement
- This dashboard allows for high-level examination and asking deeper questions about access to care and our behavioral health system
- Storyboard #1 gives an overview of BH services received, member demographics and costs.
- [Behavioral Health Service Utilization and Expenditures]

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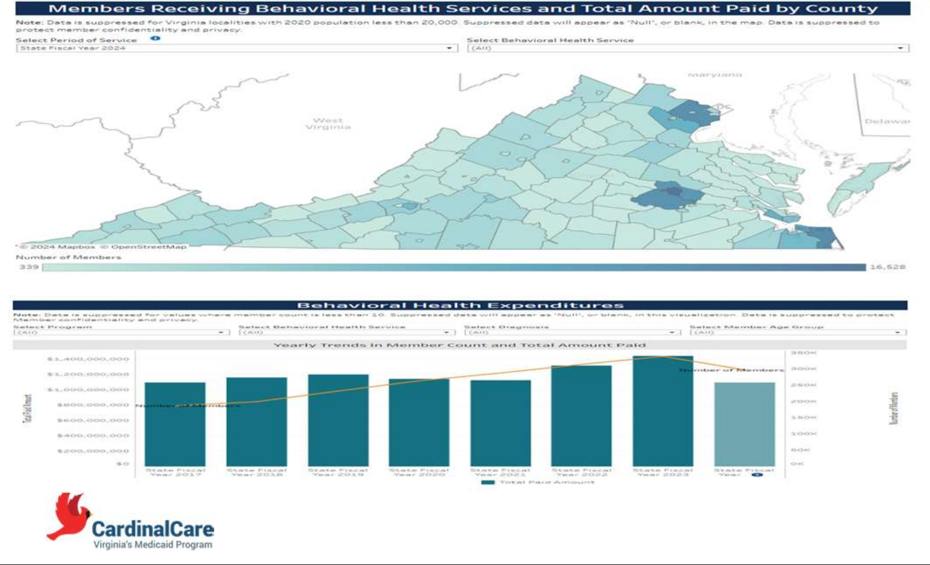
Resources: Behavioral Health Service Utilization and Expenditures Dashboard



- Storyboard #2 shows the number of members using BH services and the total cost of BH claims in each county. The map can be filtered by State Fiscal Year and BH service.
- Storyboard #3 shows the annual cost of BH claims by State Fiscal Year and a count of unique members using BH services. The bar chart can be filtered by Program, BH Service, Diagnosis, and Age Group

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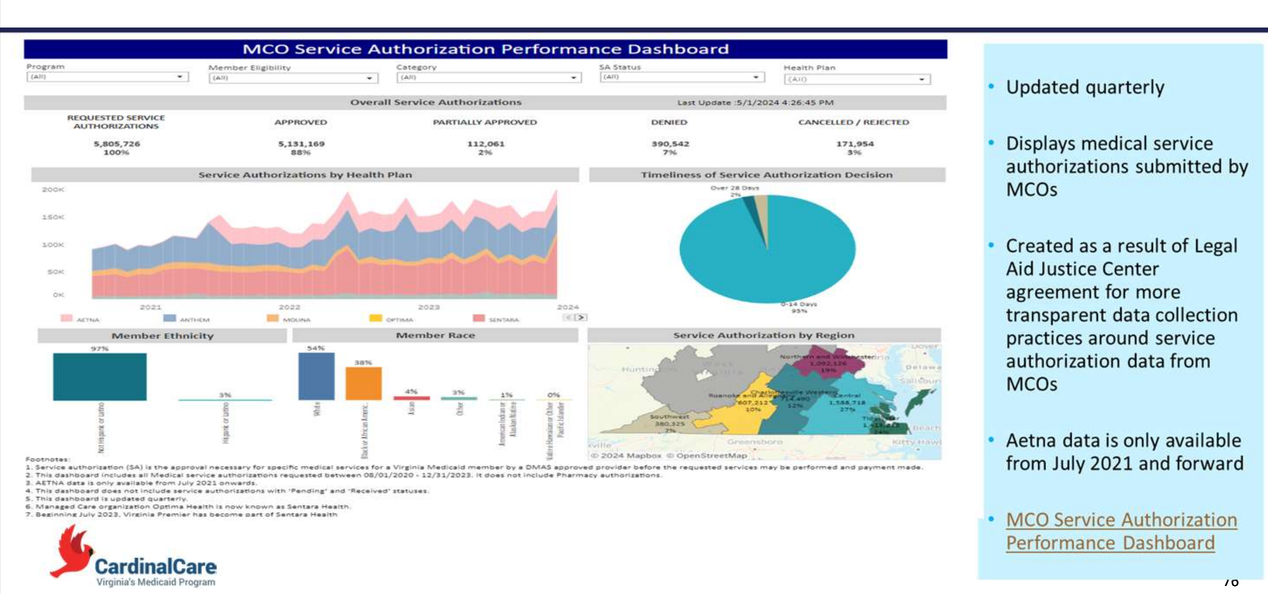
Resources: MCO Service Authorization Performance Dashboard



- Updated quarterly
- Displays medical service authorizations submitted by MCOs
- Created as a result of Legal Aid Justice Center agreement for more transparent data collection practices around service authorization data from MCOs
- Aetna data is only available from July 2021 and forward
- MCO Service Authorization Performance Dashboard

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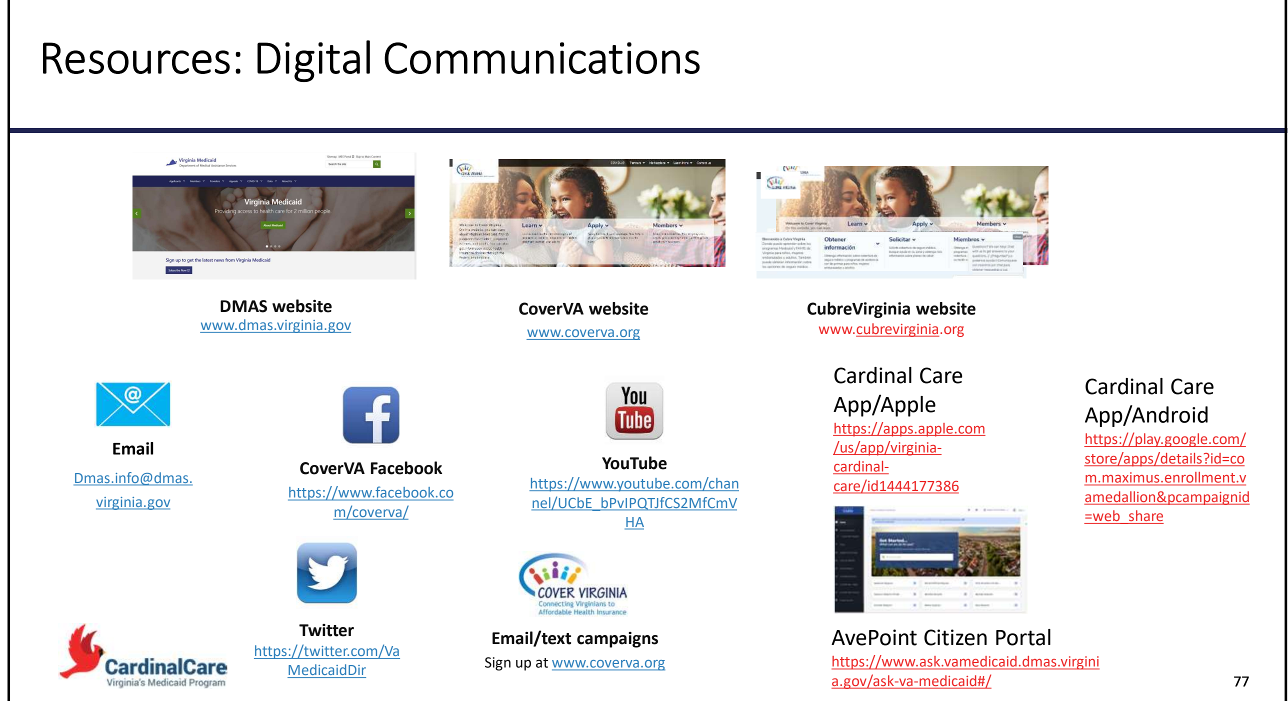

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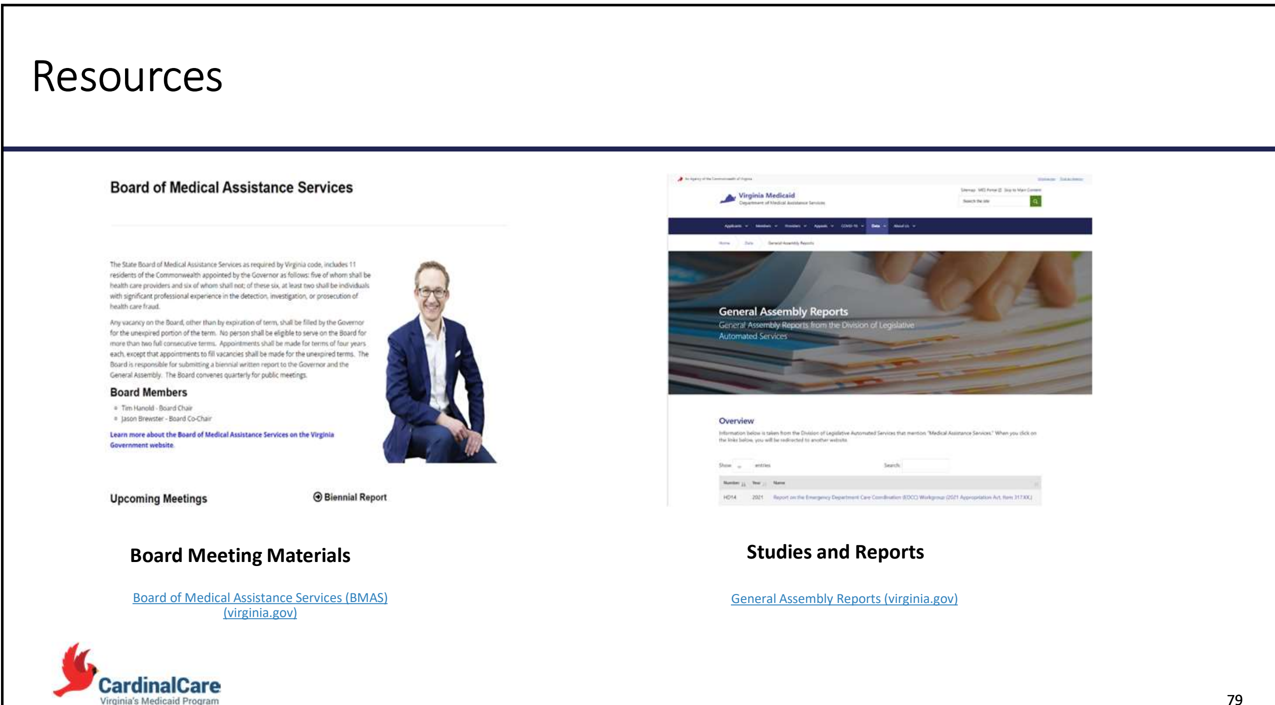
Resources



Board Meeting Materials

[Board of Medical Assistance Services (BMAS) (virginia.gov)]

Studies and Reports

[General Assembly Reports (virginia.gov)]

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