



MEETING MINUTES

Meeting Minutes
June 3, 2021
1:00-3:00 pm

This meeting was held virtually due to the ongoing COVID-19 public health emergency.

The following CHIPAC members were present:

- Denise Daly Konrad
 - Irma Blackwell
 - Dr. Tegwyn Brickhouse
 - Sara Cariano
 - Michael Cook
 - Tracy Douglas-Wheeler
 - Quyen Duong
 - Ali Faruk
 - Shelby Gonzales
 - Emily Griffey
 - Victor James
 - Bern'Nadette Knight
 - Jeff Lunardi
 - Jennifer Macdonald
 - Freddy Mejia
 - Michael Muse
 - Lanette Walker
 - Dr. Nathan Webb
- Virginia Health Care Foundation
 - Virginia Department of Social Services
 - VCU Health
 - Virginia Poverty Law Center
 - Board of Medical Assistance Services
 - Virginia Community Healthcare Association
 - Virginia Department of Education
 - Families Forward Virginia
 - Center on Budget and Policy Priorities
 - Voices for Virginia's Children
 - American Academy of Pediatrics, Virginia Chapter
 - Dept. of Behavioral Health and Developmental Services
 - Joint Commission on Health Care
 - Virginia Department of Health
 - The Commonwealth Institute for Fiscal Analysis
 - Virginia League of Social Services Executives
 - Virginia Hospital and Healthcare Association
 - Medical Society of Virginia

The following CHIPAC members were not present:

- Christine McCormick
- Virginia Association of Health Plans

Meeting Minutes

Welcome

Denise Daly Konrad, CHIPAC Chair, called the meeting to order at 1:05 pm. Konrad welcomed Committee members and members of the public, gave a brief overview of the electronic meeting

format and procedures, and informed attendees that the meeting was being held virtually due to the ongoing COVID-19 public health emergency. Attendance was taken by roll call.

I. **CHIPAC Business**

- A. **Review and Approval of Minutes** – Minutes from the March quarterly meeting were reviewed. Jeff Lunardi, Joint Commission on Health Care, made a motion to approve the minutes. Sara Cariano, Virginia Poverty Law Center, seconded, and the Committee voted unanimously to approve.
- B. **Membership Update** – Konrad gave an update on committee membership. She informed the Committee that several members have terms coming up for renewal in September and December: Christine McCormick (Virginia Association of Health Plans), Dr. Nathan Webb (Medical Society of Virginia), Victor James (Virginia Chapter of the American Academy of Pediatrics), and Ali Faruk (Families Forward Virginia). She asked members whose terms are up for renewal to inform DMAS staff if they will not be renewing, and if they have a recommendation of potential nominees to replace them.

Konrad explained that the Executive Subcommittee currently has a vacancy for one additional member. She provided an overview of the Subcommittee's role. The Executive Subcommittee sets the agenda and priorities for the full committee. They meet the month before the full committee meetings, and most of the work associated with membership on the subcommittee takes place during the two-hour quarterly subcommittee meetings.

Konrad announced that her term as Chair is ending in December and that there is currently a vacancy for the Vice-Chair position. She asked members to consider their capacity and interest in each of those positions to sustain the work of the Committee. She requested that CHIPAC members who are interested in these roles, or who wish to nominate another committee member for the roles, inform Hope Richardson, DMAS, by August 2.

Konrad explained that the timeline for the Committee's return to in-person meetings has not yet been determined, and that depending on developments over the summer and the status of state emergency orders, DMAS staff or the Executive Subcommittee may poll members in the coming months to determine preferences for the format of the September meeting.

- C. **Dashboard Update** – Konrad directed members to the enrollment Dashboard in their meeting packets. She explained that going forward, in an effort to streamline the Dashboard, the document will focus on enrollment data since that can be readily updated on a quarterly basis. Konrad stated that some of the other items that are only updated annually, such as dental utilization and HEDIS measures, will be removed from the quarterly Dashboard and instead the Committee will receive timely updates at the following meeting when new annual data is released. She announced that a CHIPAC workgroup will convene over the summer and work with DMAS to identify behavioral health-related data that could be provided to CHIPAC to inform the Committee's work and recommendations in the area of children's behavioral health. Konrad asked that CHIPAC members interested in participating in this workgroup contact Richardson by June 15. Konrad explained that the Executive Subcommittee also plans to work with VDSS in the future to add application and enrollment data and information from DSS systems to the quarterly Dashboard.

Richardson provided an overview of the updated Dashboard. She explained that the Executive Subcommittee will monitor updates from DMAS and work to integrate annual data releases into quarterly meeting presentations and updates. These data may include HEDIS measures

previously updated in the Dashboard for the December meeting and EPSDT screening and oral health data typically updated for the June or September meetings. Richardson stated that the next Birth Outcomes Study is expected to be released in early 2022 reflecting data from calendar year 2020. Richardson explained that the data in the dashboard provides enrollment information as of May 1 for the Medicaid and FAMIS programs for children and pregnant persons.

II. DMAS Update

Karen Kimsey, DMAS Director, welcomed CHIPAC members and thanked them for their work on the Committee. Jessica Anecchini, Senior Advisor for Administration, provided an overview of enrollment, COVID-19 response, and recent DMAS milestones. Anecchini began with an update on Medicaid enrollment, explaining that since the start of the public health emergency (PHE), Virginia's Medicaid and CHIP programs have gained over 300,000 new members, with a total of approximately 1.84 million members enrolled as of late May. She stated that during the PHE, DMAS is gaining approximately 4,100 new members per week. Anecchini stated that federal PHE has officially been renewed through July 21 and is expected to continue being renewed in 90-day increments at least through end of the calendar year. She explained that CMS guidance is still forthcoming on "unwinding" after the emergency ends, but DMAS continues to track members that will need to be re-evaluated at that time. DMAS is working with VDSS to develop ways of automating some of the re-evaluation processes to ease the transition for local departments of social services.

Anecchini explained that the Pfizer vaccine for COVID-19 has been approved for ages 12 and older, and the managed care organizations (MCOs) have launched a messaging campaign to inform members of vaccination opportunities for 12-15 year olds. She stated that DMAS is working with the Virginia Department of Health (VDH) to identify areas of the state with low vaccination rates and conduct local Town Halls to encourage vaccination in those areas. Anecchini stated that DMAS has drafted and posted for public comment revisions to telehealth policy including policies related to maternal health screening and early intervention services. She announced that state legislation passed during the recent Special Session will enable Medicaid and FAMIS members to fill 12-month prescriptions for contraceptives, including self-administered products such as birth control pills.

Anecchini provided a summary of several recent policy changes, including the removal of the "40 quarters" work requirement. Starting April 1, green card holders (lawful permanent residents) with five or more years of U.S. residency may be eligible for Virginia Medicaid and will not have to meet this additional work requirement. Anecchini explained that the newly redesigned DMAS website has launched, including a searchable Medicaid State Plan and state plan amendments. In addition, DMAS launched a new appeals portal called the Appeals Information Management System (AIMS). The new portal will give applicants, Medicaid members, and providers a convenient way to file appeals, submit documents, and monitor the status of their cases online. DMAS Appeals Division staff worked with training experts to ensure that all AIMS users have videos, user guides and other resources to help them learn the new process.

Anecchini announced that the new adult dental benefit will be available to members on July 1. She stated that the benefit will be newly available to approximately 750,000 members. There is no dollar cap on the benefit; it includes three cleanings per year, restorations, dentures, partials, crowns, and oral surgery. Anecchini explained that the planning team is meeting regularly with the vendor, DentaQuest, in preparation for launch, and DMAS has

trained all call centers, Maximus, Conduent, and Cover VA. In addition, the free clinics and federally qualified health centers are engaged and ready to take patients.

Anneccchini explained that DMAS and the Department of Education (DOE) continue to prepare for expansion of cost-based reimbursement to services provided to Medicaid and FAMIS-enrolled children outside of special education. The timeline is to begin reimbursing local education agencies for non-IEP services in SFY2023 (starting July 1, 2022). This allows time to secure federal authority, revise policies and procedures for cost-settlement, and train schools. Expansion will emphasize mental health and school nursing services. Anneccchini stated that DMAS is working with the Secretary of Health and Human Resources, VDH, doula providers, licensed providers, and MCOs with the goal of operationalizing a new Medicaid doula benefit by November 2021. The benefit will provide reimbursements for up to eight visits, attendance at the birth, and up to two linkage-to-care payments. DMAS is supporting the Secretary's office and VDH in finalizing doula certification regulations. DMAS is also working with MCOs to enable doulas to enroll as Medicaid providers and engaging with licensed providers, health systems, etc., to facilitate linkages to doulas.

Hope Richardson, DMAS Policy, Regulation, and Member Engagement Division, provided an update on programs for pregnant individuals. She explained that starting July 1, DMAS will provide coverage to pregnant individuals who meet eligibility criteria for Medicaid Pregnant Women or FAMIS MOMS, regardless of their immigration or citizenship status. This new coverage, which is called FAMIS Prenatal, fulfills a GA mandate from the recent Special Session budget. Richardson explained that Virginia has provided coverage since 2012 for pregnant women who meet "lawfully residing" immigration status, and those individuals are exempt from the federal five-year U.S. residency requirement that applies to legal permanent residents (LPRs) as well as other federal eligibility restrictions that bar many lawfully residing adults from receiving coverage. However, undocumented immigrants, including pregnant women, are excluded from the federal provisions that allow for that coverage, and very limited coverage is available for undocumented individuals under federal law. Richardson stated that undocumented immigrants who meet Medicaid pregnant women's eligibility criteria may be eligible for Emergency Medicaid coverage of labor and delivery. However, until now, other medical assistance coverage has not been available to pregnant women who are undocumented. Richardson explained that when the coverage becomes effective July 1, these individuals will be able to enroll when they learn they are pregnant and receive full comprehensive coverage during the prenatal period, through labor and delivery and 60 days postpartum.

Richardson stated that DMAS has worked closely with the Centers for Medicare and Medicaid Services (CMS) to develop a benefit that will mirror the coverage received by other Medicaid and FAMIS pregnant populations, including 60 days postpartum coverage for the mother. She explained that the federal vehicle for this coverage is the CHIP "Unborn Child Option," which enables federal CHIP matching dollars to be used to allow the unborn child to be covered prenatally through the mother. Richardson stated that FAMIS Prenatal members will be enrolled in managed care in Medallion 4.0, which serves the majority of pregnant enrollees. FAMIS Prenatal members will receive the same benefit package as FAMIS MOMS, including dental benefits. Coverage will end the last day of the month in which the 60th day occurs.

Richardson provided an update on the status of Virginia's 1115 waiver amendment application for 12 months extended postpartum coverage. She stated that the Governor and General Assembly directed DMAS to seek federal authority to extend coverage to 12 months postpartum. This coverage extension fills a gap for women who are currently not eligible to transition to other coverage at the end of their 60-day postpartum coverage period – primarily

FAMIS MOMS and women who are over income for Medicaid expansion. Richardson stated that after the close of the state public comment period, DMAS formally submitted the waiver amendment application to CMS on March 31. A federal public comment period was held April 7 through May 7, with a very strong showing of support from both state and national organizations. Richardson stated that DMAS is now beginning the negotiation process with CMS over the waiver terms and conditions. The timeline for the coverage extension is uncertain because Virginia cannot begin implementation until DMAS has received formal approval from CMS, and there is no set timeline for securing federal approval.

Laura Reed, Behavioral Health Senior Program Advisor, DMAS, provided an update on Project BRAVO, the Behavioral Health Redesign for Access, Value, and Outcomes. She explained that the vision for the project is shifting the focus from a reactive, crisis-driven, high-cost system that is reliant on intensive services to one that is more proactive, preventative, and focused on cost-effective provision of services in the least-restrictive environment. There is a focus on addressing individuals' behavioral health needs in the settings where they already are, such as school settings and physical health providers' offices. Reed explained that there is also a focus on investing in prevention and early-intervention services that promote resiliency and buffer against the effects of adverse childhood experiences and trauma. Reed stated that currently, many of the available Medicaid-funded behavioral health services cluster together as less of a continuum and more as a group of acute care services more appropriate for individuals with high needs. There is a lack of evidence-based services, and service definitions and rate structure are outdated and do not support best practice. Reed explained that the long-term vision involves the development of a robust continuum of behavioral health services that meet individuals' level of need, from prevention to recovery.

Reed explained that the foundation for Project BRAVO is STEP-VA, and the implementation of services that improve access, increase quality, build consistency, and strengthen accountability across Virginia's public behavioral health system. She stated that in the current phase of the project, the priority is implementation of six high-quality, high-intensity, and evidence-based services that have demonstrated impact and value to patients. These services currently exist and are licensed in Virginia but are either not covered by Medicaid or not adequately funded through Medicaid at an appropriate rate or service definition. Reed explained that bringing these new services online will provide alternatives to state psychiatric admissions and offer step-down resources not currently available in the continuum of care, which will assist with the psychiatric bed crisis. The six services are Partial Hospitalization Program (PHP), Assertive Community Treatment (ACT), Intensive Outpatient Program (IOP), Comprehensive Crisis Services (Mobile Crisis, Intervention, Community-Based, Residential, 23-Hour Observation), Multi-Systemic Therapy (MST), and Functional Family Therapy (FFT).

Reed explained that under the current timeline, implementation of Phase 1 will occur for the first three services—ACT, PHP, and IOP—in July. In Phase 2 starting in December 2021, MST, FFT, and Crisis Services will go live. MCO readiness reviews are currently in process. Reed stated that an internal dashboard has been developed that will help track claims history and utilization as well as demographics of members receiving the services. DMAS plans to have a public-facing dashboard available on the website later this year. Reed stated that future enhancements are subject to availability of resources and priorities of the Commonwealth, and DMAS and DBHDS continue to plan for priorities if resources become available. DMAS is also aware that needs may shift due to the pandemic's impact on behavioral health and the mental health workforce.

Konrad asked whether recruitment of additional Medicaid providers is occurring now or if that will be a focus going forward. Reed responded that provider recruitment is a constant focus

due to the lack of behavioral health providers throughout the state, with Virginia ranked near the bottom of states in the availability of licensed mental health providers (LMHPs). She confirmed that there will be a rate increase for outpatient providers starting July 1 and, in hopes that that will increase the number of Medicaid LMHPs, MCOs are actively recruiting. Reed stated that recruitment of additional providers continues to be a challenge, given that the number of LMHPs becoming licensed in Virginia remains low.

Janice Holmes, Operations Manager, DMAS Eligibility and Enrollment Services, provided an update on Cover Virginia, the call center and application processing. Holmes explained that Cover Virginia transitioned to a new vendor, Maximus, at the end of March. She stated that DMAS is working with the vendor on a daily basis to improve processes and operations through the transition. Holmes stated that there has been significant improvement with the call center since the new vendor's launch, call wait times have decreased and the "abandonment rate" is down to 10 percent whereas it had previously been very high. Ninety percent of staff are still teleworking but will eventually transition to an office space. Continued quality assurance monitoring is taking place. Additional staff are being hired, trainings are occurring, and corporate resources are being engaged to address performance issues.

Lauryn Walker, Senior Advisor to DMAS' Chief Deputy and Chief Health Economist, gave a presentation on churn in Medicaid. Walker explained that DMAS made numerous changes in 2019 to reduce unnecessary churn in Medicaid and FAMIS. Medicaid expansion in January of 2019 was a significant step toward improving the number of members who remained enrolled. In addition, system improvements were made to automate income verification. Automatic re-evaluation of pregnant women in their postpartum period was implemented to ensure that women who are eligible for another coverage group can transition to that group. This has reduced administrative burden and significantly decreased churn. Finally, Walker highlighted that DMAS has a pending FAMIS Section 1115 waiver to extend postpartum coverage to 12 months, which will enable postpartum individuals to maintain health coverage for longer during a critical period when access to health care is very important.

Walker explained that with the COVID-19 public health emergency (PHE) beginning in 2020, member churn has temporarily been effectively eliminated due to federal maintenance of effort requirements that compel DMAS to keep members enrolled in most circumstances for the duration of the PHE. Walker described an analysis that DMAS conducted to evaluate the impact of churn during 2019, prior to the PHE. In this analysis, DMAS followed a cohort of members enrolled in February 2019 for 12 months (1,417,325 members). The agency identified members who (1) were continuously enrolled -- enrolled in Medicaid for a full 12 months -- 81% met this definition; (2) had a break in coverage -- lost coverage but returned prior to February 2020 -- 4% met this definition; or (3) lost coverage and did not return prior to February 2020 -- 15% met this definition.

Walker focused on the members who had a break in coverage or loss of coverage to better understand member churn. She explained that looking at coverage status by population, some trends are expected. Forty-eight percent of FAMIS MOMS lose coverage after two months, which is not surprising and hopefully will be addressed through the postpartum waiver once approved. Notably, the remainder of FAMIS MOMS either had a break in coverage or remained covered, so in many cases FAMIS MOMS are qualifying for other coverage at some point in the year after their FAMIS MOMS coverage ends. Among some groups, such as aged adults, a population that would be expected to have lower churn, the percentage of members who lost coverage was higher than expected. Walker explained that DMAS is examining the group of members who had a break in coverage but eventually were reenrolled in order to

understand if there are changes such as automated processes and policy changes that could improve member retention and increase continuous coverage.

Walker explained that the top five reasons for a break in coverage were failure to complete a renewal (30%), no longer meeting non-financial requirements (28%), children reaching age 19 (13%), pregnant women who have reached the end of 60-day coverage period (11%), and no longer meeting income or resource requirements (7%). The top five reasons for loss of coverage were failure to meet a renewal (33%), no longer meeting non-financial requirements (33%), no longer meeting income or resource requirements (9%), recipient requested cancellation (7%), and enrollee deceased (5%).

Walker stated that the vast majority of members are remaining continuously enrolled for 12 months. There is a marked improvement since Medicaid expansion; for example, prior to Medicaid expansion, pregnant women remained enrolled for an average of six months following delivery, but the average is a full year now that there is a new eligibility category that most Medicaid postpartum women are eligible to move into. Walker explained that one finding of the analysis was that when there is an administrative change such as needing to move to a new eligibility category, those changes were often associated with breaks in coverage. Walker explained that to ensure that members do not lose coverage unnecessarily, DMAS is considering expanding automated re-evaluation processes to include the following populations: individuals turning 1, individuals turning 19, individuals turning 65, and continuing to do so for postpartum women. To reduce the number of members who fail to renew, DMAS is also considering expanding automated processes to proactively send out renewal packets and to evaluate overdue renewals. Walker invited recommendations from the Committee regarding steps DMAS can take to reduce churn as the public health emergency unwinds.

III. VDSS Update

Irma Blackwell, Medical Assistance Program Manager, provided an update from the Virginia Department of Social Services. Blackwell explained that HB 2065 directed VDSS to study “Produce Rx” programs to improve health by addressing food insecurity. VDSS and partners from other agencies and stakeholders convened for their first workgroup session on May 24 and will meet again on June 9.

Blackwell described medical assistance training initiatives that are currently underway, stating that the Benefit Programs Division recently met with Workforce Development and Support to determine ways to better partner. VDSS currently has a statewide program likely to be launched in the fall that will encourage the locals to implement a more structured approach to onboarding. The sequencing and timing of training courses for new hires and seasoned workers will receive additional attention. In addition, there will be increased coaching and development post-training, and support for supervisors to aid in transfer of learning. Blackwell explained that there are two application processing teams in place at VDSS. The mission of the first Application Processing Team is to aid in any unusual backlogs that exist either regionally or within any specific LDSS; specifically applications that have moved beyond the 45-day processing time standard. The second team’s mission is to assist the Cover VA Application Processing Team with their overdue applications. Both of these teams are currently in place and actively working to support the locals and Cover VA.

Blackwell stated that VDSS expects to officially return to physical offices on October 1, but this date is subject to change based on COVID-19 case rates in Virginia and guidance from state policymakers.

Blackwell described HB1820, which establishes broad-based categorical eligibility. She explained that historically Virginia has been on the low end of federally allowable SNAP benefit eligibility. With broad-based categorical eligibility, the gross income eligibility standard will increase to 200% FPL, and there will be no asset/resource limit for eligibility. In addition, there will be increased opportunity to allow SNAP participants to satisfy applicable employment and training requirements through enrollment in an accredited public institution of higher education. With this change, more Medicaid and FAMIS members and their families will qualify for SNAP and be able to receive nutrition assistance in addition to medical assistance.

Blackwell provided statistics regarding automated ex parte batch runs. She stated that the percentage of cases that successfully completed ex parte renewal in February 2021 (for the April 2021 renewal month) was 79%.

IV. Public Comment

LeVar Bowers submitted the following written comment in the chat: *Has there been any discussion/strategic planning around provider deficits and the qualified clinician deficits in our workforce, and how those deficits impact minority, rural and or lower income communities ability to access quality services? Is that something we're tracking? If not, will there be any disparity/health equity initiatives to address these issues?*

Laura Reed responded: *LeVar, yes we have started a Racial Equity Workgroup with many stakeholders, to address health equity, knowing this is an issue across all of our services and all public serving entities. This is a very important and large issue to tackle and knowing we need to start somewhere, we are working on grassroots sub workgroups that will help work on access in local communities, we are in the planning stages and I can bring that information to the group next time.*

Closing

The meeting was adjourned at 3:05 pm.