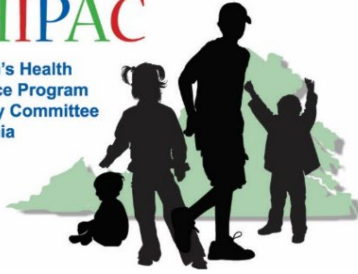

AGENDA

December 8, 2022, 1:00-3:30 PM
This will be an all-virtual meeting.

Join Meeting Remotely via WebEx: Click here to enter event
Meeting # (Access Code): 2429 880 1499 **Meeting password:** Y6bxrPCBc22
Dial in (Phone): 1-517-466-2023 US Toll 1-866-692-4530 US Toll Free
Click here for Remote Conference Captioning

I. Welcome *1:00 pm*

II. CHIPAC Business *1:05-1:25 pm*
   A. Review/approval of minutes from September 1 meeting
   B. Membership items
   C. CHIPAC bylaws
   D. CHIPAC meeting schedule for 2023

III. Managed Care Procurement Discussion *1:25-1:55 pm*

IV. Data & Quality Updates: Children's Vaccinations & Preventive Health *1:55-2:35 pm*
   - DMAS Health Economics and Economic Policy (HEEP); Office of Quality and Population Health
   - Anthem HealthKeepers: Strategies to Improve Well Visits and Vaccination Rates

V. Maternal Health Updates *2:35-3:15 pm*
   - DMAS Health Care Services Maternal-Child Health Unit
   - Virginia Premier: Maternal and Child Health Programs

VI. Agenda for March 2, 2023 CHIPAC Meeting *3:15-3:25 pm*

VII. Public Comment *3:25-3:30 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.

MEETING MINUTES

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Meeting Minutes
September 1, 2022
1:00-3:30 pm

A quorum of the full Committee attended the meeting at the Department of Medical Assistance Services (DMAS) offices at 600 East Broad Street, Richmond. A Zoom option was also available for members of the public to attend virtually.

The following CHIPAC members were present in person:

Member	Organization
Sara Cariano	Virginia Poverty Law Center
Ali Faruk	Families Forward Virginia
Shelby Gonzales	Center on Budget and Policy Priorities
Emily Griffey	Voices for Virginia's Children
Jeff Lunardi	Joint Commission on Health Care
Jennifer Macdonald	Virginia Department of Health
Freddy Mejia	The Commonwealth Institute for Fiscal Analysis
Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
Heidi Dix	Virginia Association of Health Plans
Alexandra Javna	Virginia Department of Education
Michael Muse	Virginia League of Social Services Executives
Emily Roller	Virginia Health Care Foundation
Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services

The following CHIPAC members sent a substitute to attend in person:

Member	Organization
Irma Blackwell (Jessie Watkins)	Virginia Department of Social Services

The following CHIPAC members were not present in person:

Member	Organization
Dr. Tegwyn Brickhouse	VCU Health
Kelly Cannon	Virginia Hospital and Healthcare Association
Michael Cook	Board of Medical Assistance Services
Tracy Douglas-Wheeler	Virginia Community Healthcare Association
Dr. Nathan Webb	Medical Society of Virginia

I. Welcome

Sara Cariano, CHIPAC Chair, called the meeting to order at 1:02 pm. Cheryl Roberts, Acting Director of DMAS, welcomed the committee and expressed support for CHIPAC's mission and appreciation for their work. Attendance was taken by roll call. Cariano explained that, due to new legislation that took effect the day of the meeting (September 1), only members attending in person could be recorded as present for this meeting. Members could attend online as a member of the public but their votes could not be counted.

II. CHIPAC Business

a. **Review and Approval of Minutes** – Committee members reviewed draft minutes from the June 9 meeting. Heidi Dix, Virginia Association of Health Plans, made a motion to approve the minutes. Emily Griffey, Voices for Virginia's Children, seconded, and the Committee voted unanimously to approve.

b. **Membership Update** – Cariano welcomed the newly appointed CHIPAC representative from the Virginia Department of Education, Alexandra Javna. No confirmation vote was required as VDOE is a statutory member of the Committee.

   Cariano nominated Freddy Mejia, The Commonwealth Institute, to serve as CHIPAC Vice Chair. Ali Faruk, Families Forward Virginia, made a motion to approve Mejia as Vice Chair, Jeff Lunardi, Joint Commission on Health Care, seconded, and the Committee voted unanimously to approve.

c. **Committee Discussion and Vote on Virtual Meetings and Remote Participation Policy** – Hope Richardson, DMAS Division of Policy, Regulation and Member Engagement, gave an overview of new state legislation and FOIA Council guidance requiring public bodies to approve a policy on virtual meetings and remote participation. Richardson directed members to a draft amendment to the CHIPAC bylaws in the meeting packet that set out a proposed policy for the Committee. She explained that under the new legislation that took effect that day (September 1, 2022), public bodies, including CHIPAC, are required to have an approved policy in place before allowing all-virtual meetings or remote participation by members. Richardson stated that the Committee could vote on the draft amendment/policy at the meeting in order to have a policy in place, which would not preclude future adjustments to the policy. Alternatively, the Committee could opt not to approve the proposed policy and to delay holding all-virtual meetings or allowing remote member participation until a vote was held at a future meeting to approve a final policy. Richardson also recommended putting a more in-depth discussion of the policy on the agenda for the next Executive Subcommittee meeting and invited interested members to attend for that discussion.

   Richardson explained that under the proposed policy, the Committee could hold two nonconsecutive "all-virtual" meetings per year. These meetings would be announced as virtual in advance. Public access would be provided by electronic communication

means, no physical quorum would be required, and all members could vote and participate just as they would for an in-person meeting.

Richardson explained that for the two remaining meetings per year that were not all-virtual, individual members could be approved to participate remotely if they met one of three exceptions: a temporary or permanent disability or other medical condition of the member, a family member's medical condition requiring the member to provide care for the family member, or a principal residence more than 60 miles from the meeting location.

Lunardi asked for clarification regarding "personal exceptions" allowable under the state legislation and whether the draft policy included this type of exception. Richardson clarified that the new legislation does allow for personal exceptions but that a public body is not required to include this type of exception in their remote participation policy. She stated that the draft policy before the Committee did not include personal exceptions.

Lunardi asked if members not attending in person and not approved to attend virtually would be allowed to watch the meeting online. Richardson confirmed that for in-person meetings, members without an approved exception could watch virtually as a member of the public but could not vote or be counted as officially present.

Jennifer Macdonald, Virginia Department of Health, asked about voting during virtual meetings. Richardson explained that voting during all-virtual meetings would be the same as in person, and a physical quorum would not be required. For in-person meetings, a physical quorum is required for any votes to be held, but if an individual member meets the criteria and is approved to attend remotely, that member can vote and participate in the same way that they would if attending in person.

Members suggested that the Committee might consider changing the draft policy's use of the term "medical condition" to "health condition" as a broader and more inclusive term. Richardson stated that the policy mirrors the language of the state legislation, and pointed out that the nature of the medical/health condition would not be disclosed. Dix further explained the legal reasoning behind the "medical condition" language of the policy using the same terminology as the Code of Virginia. Cariano stated that members would not need to provide detail of a medical or health condition to the committee.

Ali Faruk asked if it was the committee goal to approve the policy today. Cariano confirmed that was the goal, since the committee could allow virtual options only with an approved policy in place. She reminded the committee that the policy could be altered at any time after being approved.

Members inquired about public emergency meeting guidance. Richardson clarified that the proposed policy applied to virtual meetings held outside of a declared public emergency and that separate legislation and rules applied to virtual meetings during a public emergency.

After further discussion, the committee decided to vote on the draft policy without changes and tasked the executive subcommittee to review the policy in their next meeting, including personal exemption language that might be added, discuss adjustments needed to the policy, and bring any proposed amendments to the next full committee meeting for follow-up discussion and vote. Mejia made a motion to approve, Gonzales seconded the motion, and the committee voted unanimously to adopt the policy and task the executive subcommittee with reviewing for potential future revisions.

Members asked if in-person meetings would continue to be held at the DMAS building. Richardson answered that the Committee currently plans to hold the meetings at DMAS offices at least through 2023 but invited members to contact DMAS staff or the executive subcommittee with any concerns or to propose other meeting locations.

d. **CHIPAC Meeting Schedule for 2023** – Proposed meeting dates for 2023 were reviewed. Emily Griffey, Voices for Virginia's Children, made a motion to approve the schedule. Faruk seconded, and the Committee voted unanimously to approve.

   i. **Approved 2023 Meeting Schedule**

      1. CHIPAC Full Committee Meetings for 2023
         a. Thursday, March 2 (1:00 – 3:30 pm)
         b. Thursday, June 1 (1:00 – 3:30 pm)
         c. Thursday, September 7 (1:00 – 3:30 pm)
         d. Thursday, December 7 (1:00 – 3:30 pm)

      2. CHIPAC Executive Subcommittee Meetings for 2023
         a. Friday, January 20 (1:00 pm – 3:00 pm)
         b. Friday, April 14 (10:00 am – 12:00 pm)
         c. Thursday, July 13 (10:00 am – 12:00 pm)
         d. Friday, October 13 (10:00 am – 12:00 pm)

III. Project BRAVO / ARTS Updates (DMAS)

The DMAS Behavioral Health Division, joined by Dr. Alexis Aplasca of the Department of Behavioral Health and Developmental Services (DBHDS), provided a Medicaid behavioral health policy update, including updates on the progress of the Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes) and ARTS (Addiction and Recovery Treatment Services) projects/programs.

Laura Reed, DMAS Behavioral Health Senior Program Advisor, shared behavioral health statistics in Virginia compared to national averages, including prevalence of diagnosis of a major depressive episode in youths, adults reporting any mental illness, adult substance use disorder, youth substance use disorder, and adults reporting symptoms of depression and anxiety during COVID-19. Reed explained that Virginia's ranking for many of these statistics is near the national average.

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Dr. Alexis Aplasca, Deputy Commissioner for Clinical and Quality Management at DBHDS, provided an update on Project BRAVO and enhancement of Virginia's Medicaid-funded behavioral health service array. She described the six services rolled out through Phase 1 of Project BRAVO on July 1 and December 1 of 2021. The goal of the initial phase of services was to build out the highest levels of care in the system in order to serve patients in crisis. The services are assertive community treatment (a "hospital without walls" approach), intensive outpatient, partial hospitalization, comprehensive crisis services (including mobile crisis response, community stabilization, 23-hour crisis stabilization, and residential crisis stabilization units), multisystemic therapy (MST), and functional family therapy (FFT). MST and FFT, which rolled out December 1 of 2021, are youth-focused, highly evidence-based therapies.

Dr. Aplasca gave an overview of BRAVO's accomplishments and challenges over its first year of activity. She then explained BRAVO's future steps including service learning collaboratives, continuing to build out the crisis system, metrics and evaluation, and opportunities for expansion. Systems-focused future directions include addressing widespread concern of the impact of COVID-19 on youth isolated and without regular community, and integration of behavioral health care into existing primary and long-term care. Dr. Aplasca explained the Crisis Now model of crisis services and its implementation in Arizona. She presented objectives of developing and aligning with the Crisis Now model and how it would fit into the BRAVO continuum. The objective in implementing the Crisis Now model is the development of a community-based, trauma-informed, recovery-oriented crisis system that responds to crises in the community and prevents out-of-home placements. Dr. Aplasca described the new nationwide 988 hotline and how it fits into a community-based crisis response.

Ashley Harrell, DMAS Behavioral Health Senior Program Advisor, presented on plans to better integrate healthcare services for co-occurring mental health and substance use disorders (SUD). Harrell stated that there is a high rate of co-occurrence of mental health and SUD conditions; Medicaid plays a significant role as it is the largest payer for substance use disorder nationally, and approximately 40% of individuals with an opioid use disorder are enrolled in Medicaid. For this reason, changes in the Medicaid system can drive improvements in the broader healthcare system, including for patients who are commercially insured. Harrell detailed effective behavioral therapies for treating co-occurring disorders including assertive community treatment (a high-intensity, team-based treatment delivered in the community for individuals with serious mental illness), MST and FFT, and comprehensive crisis services. Providers and crisis teams trained in integrated care strategies will be prepared to help individuals in crisis who are using substances.

Dr. Aplasca clarified that the crisis services model would not restrict providers' ability to provide services. The needs of the person experiencing the crisis would drive determinations around the services and level of care. Dr. Alyssa Ward, DMAS Behavioral Health Clinical Director, commented on the success of crisis treatment in other states, especially in youth populations, and the vision of similar results in Virginia.

Ali Faruk, Families Forward Virginia, asked whether state resources were being allocated for effective workforce development and training of providers. Dr. Ward responded that DMAS acknowledges the need for resources but cannot speak to the direction of the commonwealth's leadership. Faruk commented that advocating for those resources could be a task for CHIPAC. Dr. Aplasca stated that COVID-19 has had a major impact on the behavioral health workforce. Griffey commented about the need for training in implementing the new types of services and making providers across systems aware of the continuum of services now available. Dr. Ward agreed with Griffey's comments and stated that DMAS is interested in forging community partnerships to enable additional systems training and orientation. Dr. Susan Brown, American Academy of Pediatrics, Virginia Chapter, commented on increasing public knowledge of the new crisis services and the 988 hotline.

Harrell highlighted recent work enabled through the SUPPORT Act grant, an approximately $5 million grant from the federal Centers for Medicare and Medicaid Services (CMS) to increase SUD provider capacity in Virginia. A focus of the grant was services for pregnant and parenting individuals with SUD. One goal for the agency summarized in a recent document available here is to improve access to peer recovery supports for individuals with mental health conditions and SUD. This includes increasing the number of peer recovery support specialists who are mothers in recovery with shared life experience as pregnant and parenting women. Harrell stated that DMAS has partnered with Virginia Commonwealth University (VCU) as independent evaluator for the ARTS benefit and shared highlights from VCU's evaluation report on diagnosis and treatment of substance use disorders in pregnant women covered by Medicaid. She noted that, among the findings, treatment rates for Medicaid-enrolled pregnant women with opioid use disorder increased considerably from 2017 to 2018, from 58% to 76%. In addition, the report found that disparities persist in treatment: Black women with SUD diagnoses while pregnant were less than half as likely to receive any treatment prior to delivery (20%) compared to white women (44%).

IV. Behavioral Health Utilization Dashboard

Reed presented on DMAS' Behavioral Health Service Utilization and Expenditures dashboard, available on the DMAS website. Reed explained that the dashboard is intended to improve Medicaid data transparency, but is also a powerful tool for DMAS to review data internally and identify trends and areas for improvement.

Metrics investigated include utilization of specific behavioral health services pre-COVID compared to now, how utilization trends could reduce burden on state psychiatric hospitals and emergency departments, measuring the expansion of access to BRAVO services, improving coordination of care for youth in foster care and reducing the need for residential treatment. Reed gave a virtual tour of the dashboard and highlighted notable trends.

Griffey commented on the decline in spending and utilization of behavioral health services delivered in schools during the pandemic, particularly therapeutic day treatment (TDT). She stated that, going forward, it is important to investigate ways to

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meet children's behavioral health needs in the school setting post-pandemic, across systems, including investments in the educational system as well as investment in Medicaid school services/resources. Reed followed up by using the dashboard to show utilization and expenditures on two other services—intensive in-home and behavior therapy. Reed explained that these two services remained stable or increased instead of experiencing the large drop that TDT did over the same time period; it is possible that many of the children previously receiving TDT accessed these services during the pandemic. In addition, outpatient psychotherapy experienced a large amount of growth during the pandemic, perhaps partly due to the availability of access to these services through telehealth modalities.

Mejia commented on the decline in the average expenditures per member receiving TDT over the course of the pandemic. Dr. Ward explained that DMAS is working together with stakeholders to explore potential adjustments to the structure of the benefit to ensure children receive the appropriate level of behavioral health supports in school while also remaining integrated in the classroom instructional setting as much as possible. She stated that the system-wide priority should be to make the most robust and appropriately distributed investment in behavioral health services possible, across all payers, including but not limited to Medicaid.

Dr. Brown asked for further details on services for the 0-3 age group population and impacts of the pandemic on early intervention services during the pandemic. Dr. Ward responded recommending use of the dashboard for further investigation and highlighted the importance of enabling reimbursement that supports dyadic services to caregivers and children in this age group.

V. Behavioral Health HEDIS Dashboard

Dr. Laura Boutwell, Director of the DMAS Office of Quality and Population Health (QPH), presented on the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used set of performance measures in the healthcare industry, and the reporting dashboard developed by DMAS. HEDIS measures are developed and owned by the National Committee for Quality Assurance (NCQA). Virginia Medicaid managed care organizations are accredited by NCQA and are required to report HEDIS measures annually. The Behavioral Health HEDIS dashboard on the DMAS website was developed to demonstrate the quality of care of Virginia Medicaid, to provide transparency to members, stakeholders, and regulators, and to demonstrate accountability of Virginia Medicaid. The current dashboard utilizes the HEDIS 2020, also known as measurement year (MY) 2019, rates as a baseline year of reporting, and DMAS will update the dashboard annually.

Dr. Boutwell gave a static tour of the dashboard, which can be found on the DMAS website, with a focus on behavioral health care for children and adolescents. She explained that in alignment with DMAS' Quality Strategy, the performance benchmark for the MCOs is the national 50th percentile, meaning that the MCOs must perform in the top 50% for quality measures. Dr. Boutwell also provided an overview of DMAS' External Quality Review (EQR) activities with its EQR partner, Health Services

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Advisory Group (HSAG) related to behavioral health and children's/maternal health services.

Mejia asked about the timeline for inclusion of race and ethnicity data in publicly available DMAS data and reports. Dr. Boutwell responded that for the current year's data collection, the MCOs will report race and ethnicity data for several measures, and DMAS plans to expand the number of measures including this information in future years. Gonzales asked whether the data on race and ethnicity comes from providers, applications, or other sources. Dr. Boutwell answered that the dashboard's race and ethnicity data comes from information reported in Medicaid applications, but that MCOs collect their own information and are often able to update this information more readily after a member is enrolled. She explained that DMAS is in ongoing conversations with NCQA regarding requirements for sourcing of race/ethnicity data and will continue to ensure compliance with NCQA requirements while working to improve the accuracy of demographic information.

VI. Agenda for December 8 CHIPAC Meeting

The committee discussed the agenda for the next meeting December 8. Cariano listed topics members have expressed an interest in, including an update on children's vaccinations, a report on DMAS efforts to improve rates of well child visits for young children, an update on Cardinal Care, a follow-up on recently implemented maternal health projects and programs, a timeline for unwinding from the public health emergency, coverage options for immigrant children, and follow-ups on other previous presentations of the past year.

Mejia stated that it would be helpful to have information at the meeting about children's health-related budget requests and priorities. Gonzales suggested inviting guest speakers to discuss potential children's coverage expansions. Faruk suggested a later follow-up discussion on reducing children's behavioral health hospitalizations and disproportionate impact on foster youth.

VII. Public Comment

Cariano invited public comment before the committee but there was no public comment.

VIII. Closing

The meeting adjourned at 3:23 p.m.

Martha Crosby, Virginia Community Healthcare Association

Martha Crosby is the Programs and Business Lead at the Virginia Community Healthcare Association (VCHA). VCHA is a non-profit membership organization that serves as the primary care association for Virginia's thirty community health centers and look-alike health centers.

Before working with VCHA, Martha was the Chief of Staff – Legislative Aide to Delegate Roxann L. Robinson, O.D., Chair of House Finance, and member of the House Health, Welfare and Institutions, and General Laws Committees. In 2018, Martha aided the Delegate in passing monumental healthcare legislation that allowed Nurse Practitioners to practice autonomously in the Commonwealth of Virginia.

Martha holds a bachelor's degree from Virginia Commonwealth University in Political Science. In her free time, she likes to take her two energetic dogs to the river and works on multiple craft projects.

CHIPAC Candidate Questionnaire

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

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

   I have a great deal of experience to bring to the CHIP Advisory Committee due to my extensive background working for healthcare entities and state government focusing on healthcare policies.

   For over 6 years, I worked for Delegate Robinson as her Chief of Staff – Legislative Aide. While working for the Delegate, her main legislative objective was to help all Virginians by improving healthcare quality and growing the healthcare workforce. I have assisted the Delegate in multiple healthcare workgroups, working with stakeholders and state departments, including DMAS, organized House committee and sub-committee meetings, and researched talking points for legislation. In 2018, I aided Delegate Robinson with passing legislation that allows Nurse Practitioners to practice autonomously, giving more care to the most medically deprived areas in Virginia.

   In my current role as the Programs and Business Lead at the Virginia Community Healthcare Association, I can receive first-hand information regarding the struggles of families trying to receive healthcare services in the Commonwealth of Virginia. I also can provide outreach for community and healthcare-based organizations. This information can guide the CHIP Advisory Committee to positive pathways.

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

   As a candidate for the CHIP Advisory Committee, I will aim to give children and their families quality healthcare by working with community organizations, businesses, state agencies, and legislators to accomplish such a task. My goal as a member would be to help improve the quality of care for maternal and pediatric mental health in Virginia.

BYLAWS

CHIPAC Bylaws

ARTICLE I – NAME

The name of the committee is the Children's Health Insurance Program Advisory Committee, hereinafter known as the Committee.

ARTICLE II – MISSION OF THE COMMITTEE

The mission of the Committee is to advise the Director of the Department of Medical Assistance Services (DMAS) and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS programs to address the health needs of children.

ARTICLE III – LEGAL BASE AND POWERS AND DUTIES OF THE COMMITTEE

Legal Base: Code of Virginia, § 32.1-351.2:

> *The Department of Medical Assistance Services shall maintain a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee shall consist of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge of and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.*

ARTICLE IV – MEMBERSHIP OF THE COMMITTEE OF THE DEPARTMENT

Section 1. Composition (as stipulated in the Code of Virginia):

The Committee shall consist of no more than 20 members and shall include a member from each of the following appropriate entities:

- The Joint Commission on Health Care,
- The Department of Social Services,
- The Department of Health,
- The Department of Education,
- The Department of Behavioral Health and Developmental Services, and
- The Virginia Health Care Foundation.

Other members may come from various provider associations and children's advocacy groups or may be individuals with significant knowledge of and interest in children's health insurance issues.

Section 2. Terms:

A. Appointments

1. Organizational Members Mandated in the Code of Virginia
   Membership from six organizations is mandated in the Code of Virginia. A representative of a mandated member organization shall serve a term of three years. After three years, that representative may be reappointed at the discretion of the organization, or the organization may appoint another representative to serve on the Committee. If the representative leaves his/her position or can no longer serve on the Committee, the mandated member organization shall appoint another representative to complete his/her term.

2. All Other Committee Members
   The Committee will make recommendations to the Director of DMAS to fill the other fourteen membership positions. The Director of DMAS maintains final authority to invite individuals or groups to serve on the Committee.

   Committee members other than representatives of the mandated member organizations shall serve for a term of two years. Members may serve no more than four consecutive two-year terms. A person appointed to fill a vacancy during a term may serve three additional consecutive terms. If a person cannot complete his/her term, the Committee will recommend appointment of a replacement to the Director of DMAS.

B. Absences

1. Organizational Members Mandated in the Code of Virginia
   If a mandated member organization's representative misses two consecutive meetings of the Committee (without providing a substitute), inquiry shall be made of the organization to ascertain whether they desire to appoint another representative.

2. All Other Committee Members

For all other Committee members who miss two consecutive meetings (without providing a substitute), the Committee may ask the member to resign and recommend a replacement to serve the remainder of the member's term. If a person misses three or more meetings without providing a substitute during his/her term, he/she may be asked to resign and the Committee would then recommend a replacement to serve the remainder of the member's term.

C. Substitutes

1. If a person is unable to attend a meeting, they may send an appropriate substitute in their place. The member is responsible for letting the Chairperson or appropriate DMAS staff know of such substitution, if possible, in a reasonable time frame.

2. The substitute will be understood to have the authority to vote on behalf of the person/organization they are representing on matters before the Committee on the day of the meeting.

Section 3. Authority of Individual Members:

No member of the Committee shall at any time act or purport to act on behalf of or in the name of the Department or the Committee without prior authority from the Committee and the Department.

ARTICLE V – ORGANIZATION

Section 1. Officers of the Committee:

The officers of the Committee shall be a Chairperson and a Vice-Chairperson.

Section 2. Selection of Officers:

A. The Chairperson shall be elected by the Committee from among its membership in odd-numbered years. The Chairperson shall serve for a term of two years. The incumbent shall be eligible to serve an additional consecutive term of two years.

B. The Vice-Chairperson shall be elected by the Committee from among its membership in even-numbered years. She/he shall serve for a two-year term. The Vice-Chairperson shall also be eligible to serve an additional consecutive term of two years.

C. Elections for Chairperson and Vice-Chairperson shall be held in the month of December, with the term of office beginning at the start of the new calendar year. In the case of the Chair being vacant, the Vice-Chairperson shall serve as the temporary Chairperson until the next Committee meeting, at which time a new election shall be held to fulfill the remainder of the original term.

Section 3. Duties of Officers:

A. The Chairperson shall preside at all meetings of the Committee, shall be a member ex officio of all standing subcommittees, and shall perform such other duties as may be imposed by action of the Committee or as set forth in other sections of these policies and procedures.

B. The Vice-Chairperson shall serve in the absence of the Chairperson of the Committee and shall perform such other duties as may be imposed by action of the Committee or as set forth in other sections of these regulations.

Section 3. Executive Subcommittee:

A. The Executive Subcommittee shall consist of the Chairperson, the Vice-Chairperson, Chairpersons of any existing subcommittees, and one or more at-large CHIPAC members appointed at the discretion of the CHIPAC Chair.

B. The Executive Subcommittee shall carry out functions as assigned by the Committee in keeping with the purposes of the Committee. The Executive Subcommittee may assist Department staff in problem solving and decisions.

C. The Executive Subcommittee may be called to meet as needed and at the request of the Chairperson.

Section 4. All other subcommittees:

A. Subcommittees shall be appointed by the Chairperson whenever they are deemed necessary by the Committee. A subcommittee shall be restricted to its assigned task, shall report its recommendations to the Committee, and shall be dissolved when its report is complete and accepted by the Committee unless otherwise provided by the Committee.

B. Subcommittees may invite others with topic expertise who are not serving on the full Committee to participate as advisors or consultants in subcommittees. Only full Committee members or their substitutes will be counted in the quorum and can vote.

C. The chair of any subcommittee must be a member of the full Committee.

ARTICLE VI – MEETINGS OF THE COMMITTEE

Section 1. Regular Committee Meetings:

A. A gathering, whether physical or by electronic means, of three or more Committee members discussing or transacting Committee business is considered a meeting.

B. The Committee shall meet at the call of the Chairperson, but no less than four times a year.

C. Meetings will be held quarterly in December, March, June, and September.

~~**D.** The time and place of any scheduled meeting may be changed if notification is given to Committee members at least 10 working days prior to the meeting.~~

Section 2. Special Meetings:

A. Special meetings may be called by the Chairperson, upon the written request of any three members of the Committee, or by the Director of the Department of Medical Assistance Services.

B. Notice to all Committee members stating the time, place and purpose of the special meeting shall be e-mailed as early as possible, but in no case less than five working days prior to the meeting.

Section 3. Agendas:

A. The agenda for each meeting of the Committee shall be prepared by the Department in consultation with the Chairperson. Copies of the tentative agenda shall be provided in hard copy or electronically to each member at least three working days prior to each regular meeting.

B. Copies of the agenda and materials provided to the Committee members shall be available to the public at the same time they are made available to the Committee members.

Section 4. Meetings to be Public:

A. All regular and special meetings of the Committee shall be open to the public, provided that the Committee may meet in Closed Meeting to consider matters as permitted by the Freedom of Information Act (Va. Code §2.2-3711). Such Closed Meetings shall be held when feasible after all items of business on the agenda have been conducted.

B. Notice of a regular Committee meeting shall be posted publicly at least three working days prior to the meeting.

Section 5. Citizen Participation:

A. Individuals or representatives of groups may speak on agenda topics at a publicly announced time on the agenda during each meeting, provided ~~they have notified the Chairperson of their desire to do so~~ the Chairperson has approved this request prior to the meeting being called to order. Such individuals or group representatives will be allotted up to ten minutes to present their information to the Committee. ~~The Committee may, by majority vote, extend such time limit as it deems appropriate.~~ At the discretion of the Chairperson or by majority vote of the Committee, such time limit may be extended as appropriate.

B. After the Committee has dispensed with items on the agenda, members of the public will be permitted ~~ten minutes~~ to speak ~~on non-agenda matters~~ during a designated public comment period. ~~The Committee may, by majority vote, extend or further limit time on such appearance if it seems appropriate~~. Each individual/group shall be allotted up to two minutes to make their comment. At the discretion of the Chairperson or by majority vote of the Committee, such time limit may be extended as appropriate.

C. Except in emergencies, the Committee shall not attempt to decide upon any question before examining and evaluating the information any person requests the Committee to consider. The appropriate subcommittee of the Committee shall be given an opportunity to examine and to evaluate all such information and to recommend action before the Committee makes a decision.

Section 6. Quorum:

A majority of the filled Committee member positions shall constitute a quorum for the transaction of business at a full Committee meeting. For a subcommittee meeting, a quorum shall consist of at least half of the subcommittee membership.

Section 7. Voting:

If a quorum exists, an affirmative vote of a majority of the Committee members present is required for the Committee to act. All votes must be recorded and take place in an open meeting.

Section 8. Closed Meetings:

A. A closed meeting may be held within an open meeting under certain conditions. There must be an affirmative vote during an open meeting to hold a closed meeting. The motion to approve the closed meeting must include the following: (1) the subject of the closed meeting, (2) the purpose of the closed meeting, and (3) the reference to the applicable exemption from the open meeting requirements.

B. Following the closed meeting, the Committee must reconvene an open meeting and take a vote to affirm that they restricted their discussion during the closed meeting to only those items specifically mentioned in the closed meeting motion. A decision made during a closed meeting only becomes official once the Committee reconvenes an open meeting and votes on the decision.

Section 9. Remote Participation and All-Virtual Meetings:

A. Remote Participation of Individual Members

Consistent with § 2.2-3708.3 of the Code of Virginia, effective September 1, 2022, an individual member of the Committee may participate remotely instead of attending a meeting in person if, in advance of the public meeting, the member notifies the CHIPAC Chair and DMAS staff of the following:

1. The member has a temporary or permanent disability or other medical condition that prevents the member's physical attendance;
2. A family member's medical condition requires the member to provide care for such family member, thereby preventing the member's physical attendance; or
3. The member's principal residence is more than 60 miles from the meeting location identified in the required notice for the meeting.

The member and the Committee must follow the Procedure for Remote Participation Approval outlined below. When an individual member participates remotely under this process, the Code of Virginia requires that a quorum of the Committee be physically assembled at the primary or central meeting location. Members participating remotely may participate in discussions, make motions, vote, join in closed meetings, and otherwise participate fully as if they were physically present. A separate set of requirements apply to all-virtual meetings, described below under All-Virtual Meetings Policy.

B. Procedure for Remote Participation Approval

1. Request: The member requesting to participate remotely must notify the Chair and DMAS staff on or before the day of the meeting. The member must include the reason for the request for remote participation, citing one of the specific reasons listed above.

2. Approval: Approval shall be granted unless a member's participation would violate this policy or the provisions of § 2.2-3708.3. If a member's participation from a remote location is challenged, then the Committee shall vote whether to allow such participation.

3. Documentation: The following information must be included in the meeting minutes:

   a. The fact that the member participated through electronic communication means and the reason as listed in A.1, 2, or 3 above.

   b. Notwithstanding the disclosure requirement, the specific medical condition(s) or related clinical information affecting the member requesting remote participation shall not be publicly disclosed.

   c. If a member's participation from a remote location is disapproved because such participation would violate this policy, such disapproval shall be recorded in the minutes with specificity.

4. Limitation: There is no limit on the number of times per calendar year an individual member may participate remotely.

5. Consistent Application of Policy: In accordance with § 2.2-3708.3 of the Code of Virginia, this policy shall be applied strictly and uniformly, without exception, to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

The policy for remote participation and procedures for approval shall also apply to meetings of any subcommittee designated by the Committee to perform delegated functions or to advise the Committee.

C. All-Virtual Meetings Policy

Consistent with § 2.2-3708.3 of the Code of Virginia, effective September 1, 2022, the following policy defines the circumstances under which an all-virtual public meeting of the CHIPAC will be allowed. All-virtual meetings may be held at the option of the Chair or by vote of the full Committee. No more than two (2) all-virtual meetings shall be held per calendar year, such meetings must be non-consecutive, and the following requirements must be met.

1. An indication of whether the meeting will be in-person or all-virtual shall be included in the required meeting notice along with a statement notifying the public that the method by which the Committee chooses to meet shall not be changed unless the Committee provides a new meeting notice in accordance with the provisions of § 2.2-3707.

2. Public access to the all-virtual public meeting shall be provided via electronic communication means.

3. The electronic communication means used shall allow the public to hear all members of the Committee participating in the all-virtual meeting and, when audio-visual technology is available, to see the members as well.

4. A phone number or other live contact information shall be provided to alert the Committee if the audio or video transmission of the meeting provided fails. Committee staff shall monitor such designated means of communication during the meeting, and the Committee shall take a recess until public access is restored if the transmission fails for the public.

5. A copy of the proposed agenda and all agenda packets and, unless exempt, all materials furnished to members shall be made available to the public in electronic format at the same time that such materials are provided to members.

6. The public shall be afforded the opportunity to comment through electronic means, including by way of written comments, when public comment is customarily received.

7. No more than two members of the Committee shall be together in any one remote location unless that remote location is open to the public to physically access it.

8. If a closed session is held during an all-virtual public meeting, transmission of the meeting to the public shall resume before the Committee votes to certify the closed meeting as required by subsection D of § 2.2-3712.

9. Minutes shall be taken as required by § 2.2-3707 and shall include the fact that the meeting was held by electronic communication means and the type of electronic communication means by which the meeting was held.

Section 10. Recordings of the Meeting:

A. Typed minutes of each meeting shall be maintained as a public record in the custody of the Department of Medical Assistance Services. These minutes shall be sent to each Committee member and approved at the next full Committee meeting.

B. Draft minutes will be posted on the ~~Commonwealth of Virginia~~ Department of Medical Assistance Services web site ~~(www.virginia.gov)~~ and on a central electronic calendar maintained by the Commonwealth within ten days of the meeting. Approved minutes will be posted ~~on the Commonwealth of Virginia web site~~ within three days of the meeting at which they were approved.

Section 11. Adjourned Meetings:

Meetings may be adjourned as the business of the Committee requires. At the time of adjournment, the time, date and place of the continuation of the meeting or next meeting shall be determined and announced.

Section 12. Parliamentary Procedure:

Robert's Rules of Order shall prevail except as otherwise provided herein.

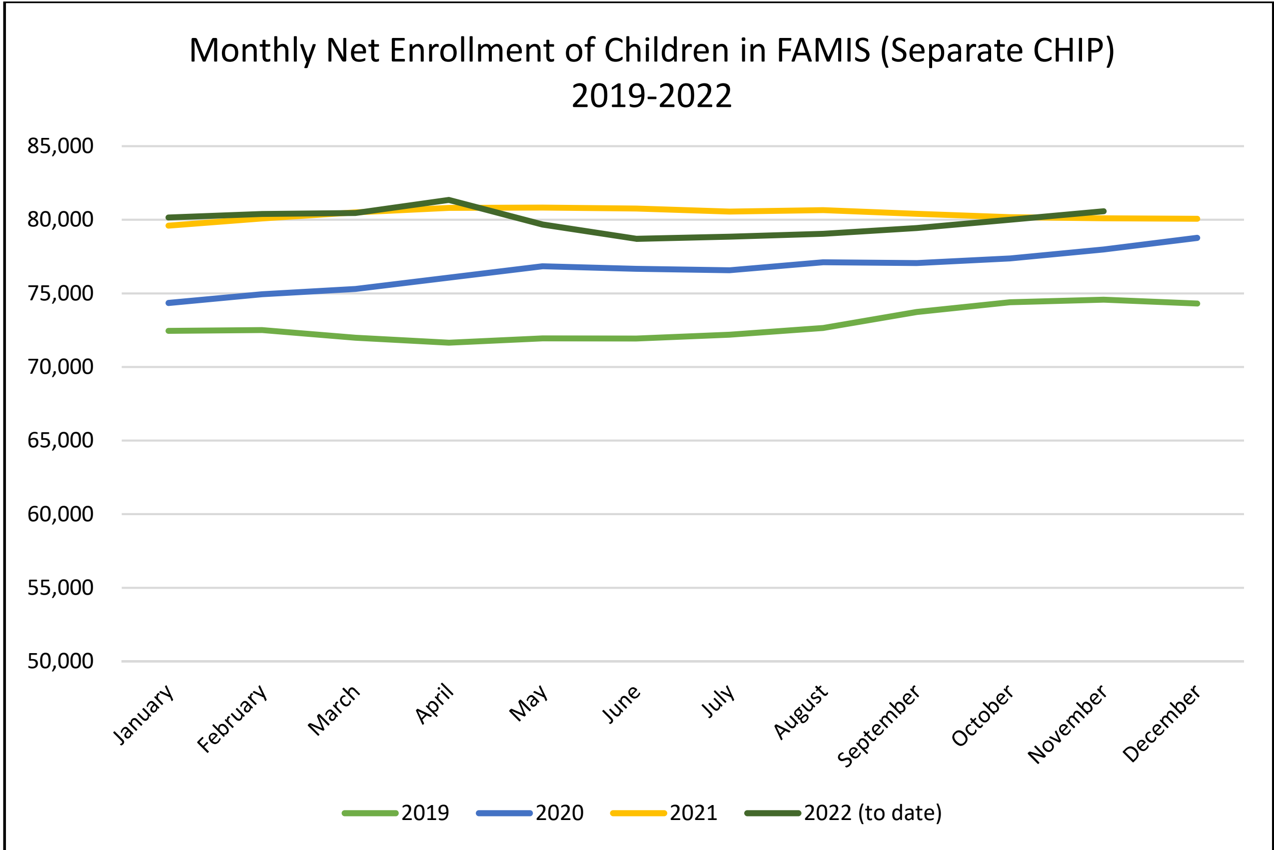
ARTICLE VII – REPORTING

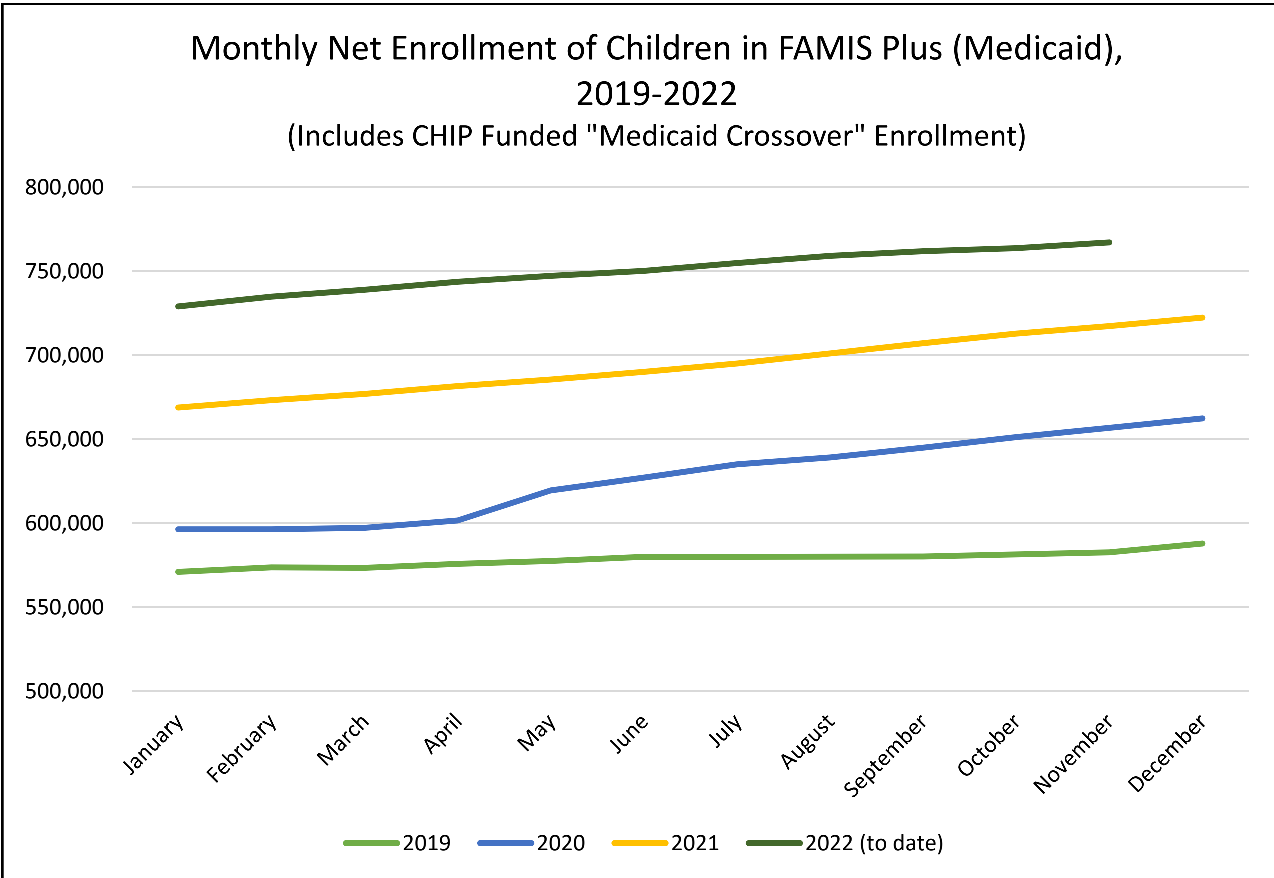
The Committee shall, at its discretion, report on the current status of the FAMIS programs and submit recommendations to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

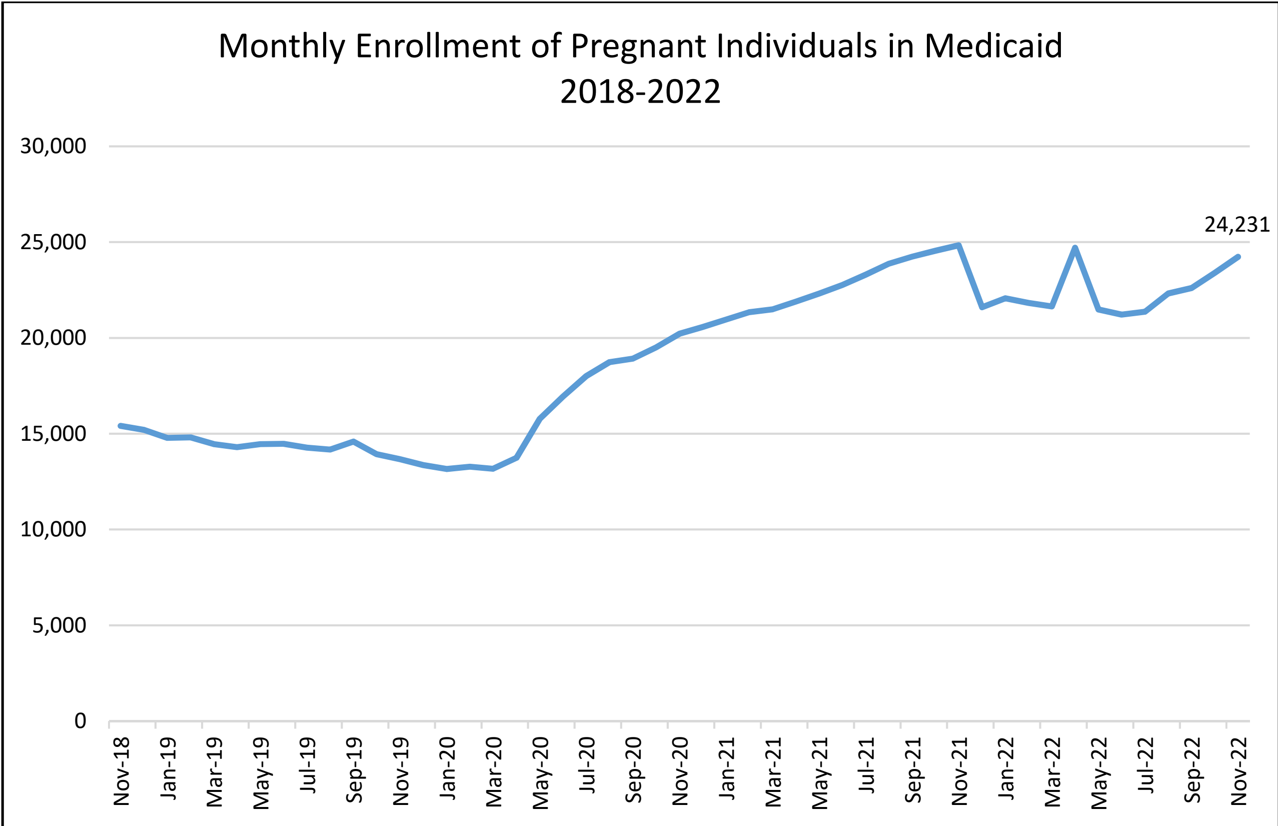
ARTICLE VIII – AMENDMENTS

These ~~regulations~~ bylaws, except those quoted from the enabling statute, may be amended at any meeting of the Committee by a simple majority.

ADOPTED by the Committee September 1, 2022.


Monthly Net Enrollment of Children in FAMIS (Separate CHIP)
2019-2022
85,000
80,000
75,000
70,000
65,000
60,000
55,000
50,000
January
February
March
April
May
June
July
August
September
October
November
December
2019
2020
2021
2022 (to date)


Monthly Net Enrollment of Children in FAMIS Plus (Medicaid),
2019-2022
(Includes CHIP Funded "Medicaid Crossover" Enrollment)
800,000
750,000
700,000
650,000
600,000
550,000
500,000
January
February
March
April
May
June
July
August
September
October
November
December
2019
2020
2021
2022 (to date)


Monthly Enrollment of Pregnant Individuals in Medicaid
2018-2022
30,000
25,000
20,000
15,000
10,000
5,000
0
24,231
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
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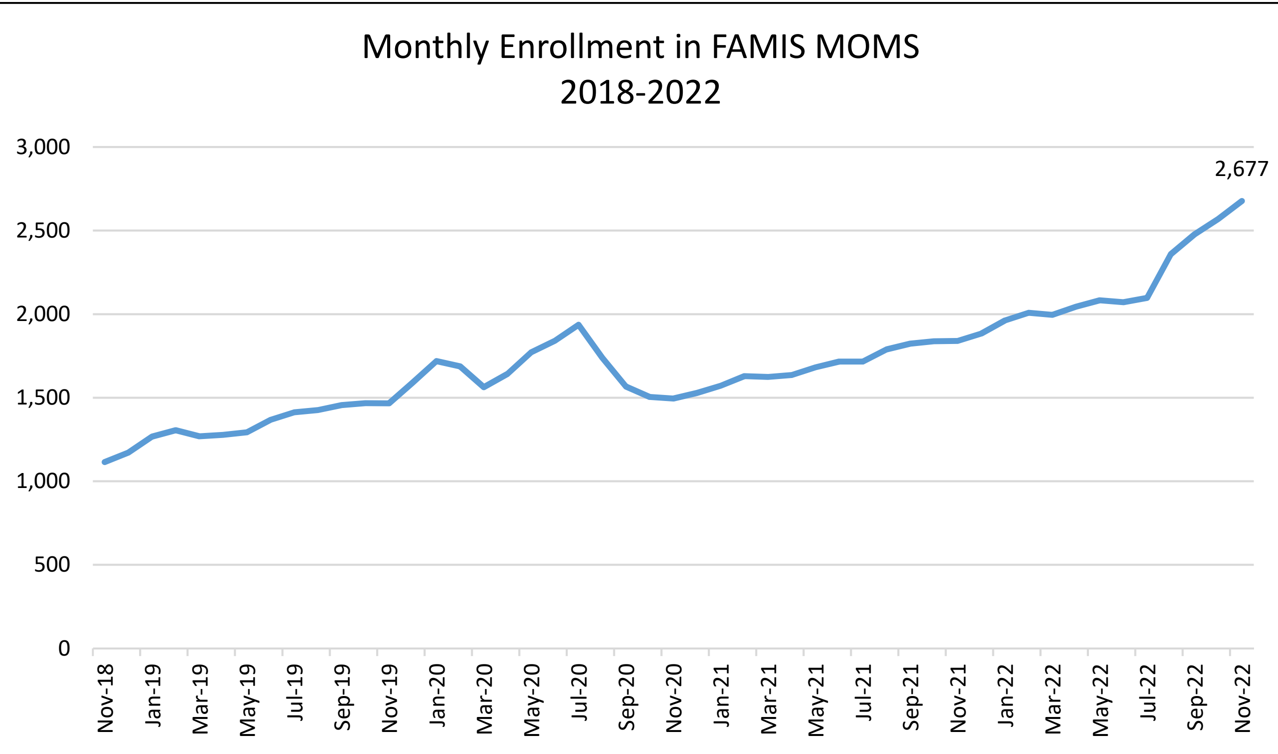
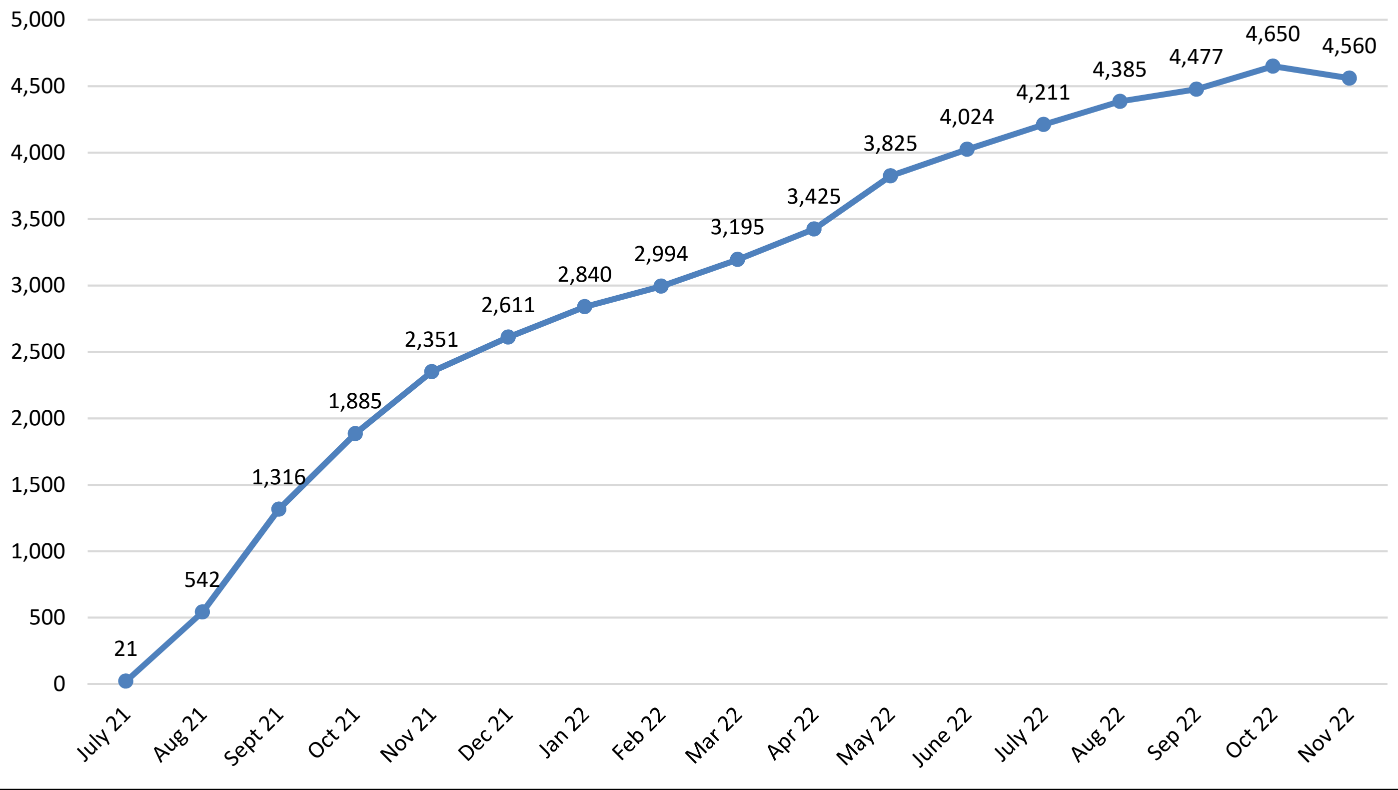
Jan-22
Mar-22
May-22
Jul-22
Sep-22
Nov-22


Monthly Enrollment in FAMIS MOMS
2018-2022
3,000
2,500
2,000
1,500
1,000
500
0
2,677
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
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


Monthly Net Enrollment in FAMIS Prenatal Coverage
July 2021-November 2022
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
21
542
1,316
1,885
2,351
2,611
2,840
2,994
3,195
3,425
3,825
4,024
4,211
4,385
4,477
4,650
4,560
July 21
Aug 21
Sept 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
June 22
July 22
Aug 22
Sep 22
Oct 22
Nov 22

COVID-19 PHE: UNWINDING UPDATES

Medicaid Continuous Coverage Requirements Under the Families First Coronavirus Response Act (FFCRA)

To support states and promote stability of coverage during the COVID-19 pandemic, FFCRA provided a 6.2 percentage point increase in the regular Medicaid matching rate, tied to certain conditions that states must meet in order to access the enhanced funding.

- As one of several conditions of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase under FFCRA, **states are required to maintain enrollment of individuals in Medicaid** until the end of the month in which the public health emergency (PHE) ends **(the "continuous coverage" requirement)**.
- The continuous coverage requirement **applies to individuals enrolled in Medicaid as of March 18, 2020 or who were determined eligible on or after that date**, and has allowed people to retain Medicaid coverage and get needed care during the pandemic.
- When continuous coverage is eventually discontinued **state will be required to redetermine eligibility for nearly all Medicaid enrollees**.

★ *The current federal Medicaid continuous coverage requirement ends on January 31, 2023.*

Source: FFCRA §6008(b)(3); SHVS, Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates.

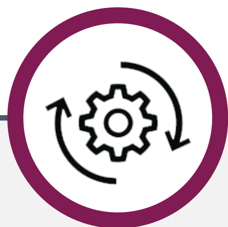
Updates on CMS Guidance

DMAS and DSS are working together to implement CMS' state based approach to keep eligible individuals enrolled, reduce churn, maximize successful transition to other coverage where appropriate, and achieving a sustainable renewal schedule.

- While states are still required to initiate all renewals within 12 months, CMS granted an additional two months for states to complete clean up actions to come into compliance with Federal requirements for a total of 14 months.
- HHS has committed to providing a 60-day PHE final end date notice to CMS/states
  - Current PHE expiration date is January 11, 2023, a 60-day notice would have been due on November 12, 2022 for January expiration.
  - Another extension of the PHE is expected prior to the January expiration date – it is anticipated this extension will last for a full 90 days.
    - If this extension is the final PHE, the 60-day notice would be given on February 10, 2023 with a new assumed end date of April 11, 2023.
    - First month coverage termination could begin May 1, 2023.
    - 6.2% FMAP would end June 30, 2023.

Medicaid Enrollment in the Commonwealth During the PHE

The end of the continuous coverage requirement in the Commonwealth will present the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA).



Historically, the Commonwealth has experienced **churn, which is enrollees who reapply and re-gain coverage shortly after being terminated**.

From March 2020 through November 1, 2022, the Commonwealth experienced an **increase of 560,375 enrollees (a 27% increase in enrollment growth).**

Enrollment growth has been the **fastest among non-elderly, non-disabled adults**, and slower among children and aged, blind, and disabled (ABD) eligibility groups.

Post continuous coverage, **roughly 14% of the state's total Medicaid enrollees may lose coverage, and up to 4% of members may lose and regain coverage within 1-6 months of closure. The national average for loss is around 20%.**

Preparations to Resume Normal Operations

In mid-2020, shortly after the PHE declaration, preparations for resuming normal operations began. Much of this work will require teams to pivot to finalize the changes and undo temporary policies and procedures to revert to normal operations.

System Updates (VaCMS & MES)
20 Changes Implemented
3 Changes in Progress

Clean Up & Pre-Unwinding Processes
5 New or Updated Processes Implemented

Stakeholder Outreach
4 Toolkits
18 Outreach Templates
65 Provider Memos Issued
2 PHE Website Pages

Member Outreach
1 million + Letters Mailed
1 Social Media Campaign
Radio Campaign in 5 Regions
3 PHE Website Page
1 Television Campaign

Training
7 Trainings Developed

Policy Flexibilities
9 Flexibilities Made Permanent

Unwinding Waivers
7 Waivers Submitted & Approved

Temporary Flexibilities
116 Total Implemented
(74: Ended, 42: in Progress)

CHIPAC Member List 2022

	Organization	Representative	Contact info
1.	Joint Commission on Health Care*	Jeff Lunardi Executive Director 3-year term: Dec. 2020 – Dec. 2023	Joint Commission on Health Care P.O. Box 1322 Richmond, VA 23218 804-786-5445 JLunardi@jchc.virginia.gov
2.	Department of Health*	Jennifer O. Macdonald Director, Division of Child and Family Health 3-year term: March 2021 – March 2024	Virginia Department of Health 109 Governor Street Richmond, VA 23219 (804) 864-7729 Jennifer.Macdonald@vdh.virginia.gov
3.	Department of Education*	Alexandra Javna Student Services Specialist, Office of Student Services 3-year term: Sept. 2022 – Sept. 2025	Virginia Department of Education Office of Student Services P.O. Box 2120 Richmond, VA 23218 (804) 786-0720 alexandra.javna@doe.virginia.gov
4.	Virginia Department of Behavioral Health and Developmental Services*	Hanna Schweitzer VMAP Program Administrator Office of Child and Family Services 3-year term: Dec. 2021 – Dec. 2024	Virginia Department of Behavioral Health and Developmental Services P.O. Box 1797 Richmond, VA 23218 hanna.schweitzer@dbhds.virginia.gov
5.	Virginia Health Care Foundation*	Emily Roller Health Insurance Program Manager 3-year term: Dec. 2021 – Dec. 2024	Virginia Health Care Foundation 707 East Main Street, Suite 1350 Richmond, VA 23219 emily@vhcf.org

** Member organizations required per Code of Virginia*

6.	Virginia Department of Social Services*	Irma Blackwell Medical Assistance Program Manager 3-year term: March 2021 – March 2024	Division of Benefit Programs Virginia Department of Social Services 801 East Main Street, Richmond, VA 23219 i.blackwell@dss.virginia.gov
7.	Virginia Poverty Law Center	Sara Cariano Policy Specialist and Lead Navigator *Vice Chair* 2-year term: March 2022 – March 2024	Virginia Poverty Law Center 919 East Main Street, Suite 610 Richmond, VA 23219 (804) 332-1432 Sara@vplc.org
8.	DMAS Board Member	Michael H. Cook Chair, Board of Medical Assistance Services Partner and Co-chair, Health Care Group, Liles Parker PLLC 2-year term: June 2022 – June 2024	Liles Parker, PLLC 2121 Wisconsin Avenue, NW Suite 200 Washington, DC 20007 (202) 298-8750 MCook@lilesparker.com
9.	Medical Society of Virginia	Dr. Nathan Webb, MD, MS, FACOG Assistant Professor, Department of Obstetrics & Gynecology 2 year term: Dec. 2021 – Dec. 2023	VCU Health P.O. Box 980034 Richmond, VA 23298 (804) 828-1809 Charles.webb@vcuhealth.org
10.	Center on Budget and Policy Priorities	Shelby Gonzales Director, Enrollment and Outreach 2-year term: March 2022 – March 2024	Center on Budget and Policy Priorities 1125 1st Street NE Washington, DC 20002 (202) 408-1080 gonzales@cbpp.org

11.	VCU Health	Dr. Tegwyn H. Brickhouse, DDS, PhD Chair, Dept. of Dental Public Health and Policy VCU School of Dentistry 2 year term: Dec. 2021 – Dec. 2023	Dept. of Dental Public Health and Policy 1101 E. Leigh Street Richmond, VA 23298 (804) 827-2699 thbrickhouse@vcu.edu
12.	Virginia League of Social Services Executives	Michael J. Muse Director 2-year term: March 2022 – March 2024	Stafford County Social Services P.O. Box 7 Stafford, VA 22555 (540) 658-8744 Michael.muse@dss.virginia.gov
13.	Families Forward Virginia	Ali Faruk Policy Director 2-year term: December 2021 – December 2023	Families Forward Virginia 8100 Three Chopt Road, Suite 212 Richmond, VA 23229 afaruk@familiesforwardva.org
14.	The Commonwealth Institute for Fiscal Analysis	Freddy Mejia Deputy Director of Policy 2-year term: June 2022 – June 2024	The Commonwealth Institute for Fiscal Analysis 1329 E. Cary St. #200 Richmond, VA 23219 (804) 396-2051 x106 freddy@thecommonwealthinstitute.org
15.	Voices for Virginia's Children	Emily Griffey Chief Policy Officer 2-year term: March 2022 – March 2024	Voices for Virginia's Children 1606 Santa Rosa Road, Suite 109 Henrico, VA 23229 (804) 649-0184 Emily@vakids.org

16.	Virginia Association of Health Plans	Heidi Dix Senior Vice President of Policy 2-year term: March 2022 – March 2024	Virginia Association of Health Plans 1111 E. Main Street, Suite 910 Richmond, VA 23219 heidi@vahp.org
17.	Virginia Chapter of the American Academy of Pediatrics	Dr. Susan Brown 2-year term: March 2022 – March 2024	(804) 363-7732 Gollobrown@gmail.com
18.	Virginia Hospital and Healthcare Association	Kelly Cannon Senior Director, VHHA Foundation 2-year term: June 2022 – June 2024	(804) 212-8721 kcannon@vhha.com