BOARD OF MEDICAL ASSISTANCE SERVICES

FINAL BMAS MINUTES
Tuesday June 14, 2022
10:00 AM

Present: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Michael H Cook Esq., Elizabeth Noriega, Tim Hanold

Absent: Ashley Gray
Virtual Attendees: Patricia Cook, Paul Hogan, Ashish Kachru

1. **Call to Order**

2. **Introduction of New Board Members**

   Paul Hogan, Ashish Kachru, Tim Hanold

3. **Approval of 03/08/2022 BMAS Draft Minutes**

   Moved by Greg Peters Dr; seconded by Kannan Srinivasan to Approve
   Motion Passed: 7 - 0
   Voting For: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Michael H Cook Esq., Elizabeth Noriega, Tim Hanold
   Voting Against: None

4. **Vote on Bylaw Amendment:**
   2.7 Electronic Participation in Meetings

   Voted by roll call with all members present voting "aye"
   Motion: 7 - 0
   Voting For: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Michael H Cook Esq., Elizabeth Noriega, Tim Hanold
   Voting Against: None

5. **Director's Report – Cheryl Roberts, Acting Director**

   Acting Director Roberts agenda for the meeting included current enrollment, agency priorities and DMAS returns to 600 East Broad Street.

   Current Enrollment:
   - Virginia's Medicaid Program plays a critical role in the lives of nearly 1.76 million Virginians.
   - Virginia Medicaid serves: Children, pregnant women, older adults, individuals with disabilities, and low-income adults.
   - Medicaid generally covers the full continuum of health care services similar to other commercial insurance.

- We also cover additional services for certain populations not covered by commercial insurance, like long-term services and supports that is, nursing home or community-based care.

Agency Priorities:

- July 1, 2023, General Assembly Initiatives
    - New initiatives, rate increases and studies
    - Win: we were able to quickly resolve concerns
    - Modifying forecast, trends, utilization, and contracts
    - There will be program, contracts, and rate delays
- Unwinding/Redetermination for 2.2 million
- Provider Enrollment Module – Hard launch in April 2022
    - Focus to Improving productivity
    - Need to enroll 30,000 MCO providers into MES portals
- Earned Credit Release for 4,000 inmates June-July 2022
    - Working with DOC and DSS on transition and long-term solutions
- Maternal and Child Health
    - Continued work on 12-month post-partum (#3 in country)
    - and Community Doula benefit (#4 in country)
- Long Term Services and Supports
    - Working to provide $1,000 COVID support payments for home care aides who delivered agency-directed or consumer-directed personal care, respite care, or companion care services to Medicaid members during the first quarter of the State Fiscal Year (SFY) 2022
- COVID-19
    - Vaccinations- need to increase Medicaid vaccination rate beyond 54%
    - VDH/DMAS/MCO collaborative
    - Focus on increasing preventive and acute care
- Procurements
- Compliance and Oversight
    - Program and financial oversight including dashboards

Provider Enrollment (PRSS)

- We are working with Gainwell, the vendor for Provider Services Solution (PRSS), to address a high volume of provider requests for assistance with the transition to this new module. Many of these requests are for providers whose primary account holder information was not up to date in the former Medicaid Management Information System (MMIS). We also have a number of providers requesting assistance as we transition to the use of taxonomy codes for identification of provider types and areas of specialization.

- Taxonomy codes are a national best practice that will ensure consistency for our providers who serve Medicaid members in multiple states. Taxonomy codes will also improve our agency's ability to fulfill federal reporting requirements.

- Gainwell has added additional staff to assist with our response to provider questions and processing of primary account holder and enrollment submissions. We have made progress in addressing the number of pending requests related to both primary account holder and taxonomy questions. We also are working individually with providers to ensure that they are able to make this transition, including advanced payments to certain providers as needed.

Behavioral Health

Medicaid is the dominate Behavioral Health payer in country

- Crisis: The need for behavioral health and supportive services increased
- Need to increase access to behavioral health services
- BRAVO services
- ARTS
- Governor‘s Safe and Sound Task Force

DMAS Returns to 600 East Broad Street

- In May, Governor Youngkin announced changes to the state employee telework policy bringing staff back into the office 5 days a week.
    - Agency head can approve 1 day of telework
    - OSHHR can approve 2 days on a case-by-case basis
    - All other requests are reviewed by the Governor’s Chief of Staff
    - Are some ADA and childcare exceptions (especially through the summer)
- DMAS leadership turned around new telework agreements for ~500 employees
- Preparing office spaces, training management, developing new routines

6. Medicaid Public Health Emergency (PHE) Unwinding Update – Sarah Hatton

Deputy Hatton spoke on the Public Health Emergency unwinding.

To support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Response Act provided a 6.2% enhanced Federal Medical Assistance Percentage (FMAP) matching rate tied to certain conditions that states must meet, primarily the requirement to maintain enrollment of individuals in Medicaid through the end of the federally declared Public Health Emergency.

- As a result of the continuous coverage requirement, enrollment has grown 30% during the public health emergency, to more than 2 million individuals. All of these individuals will require a redetermination when continuous coverage requirements end.
    - DMAS estimates between 14% and 20% of members will lose coverage during the unwinding period.
    - An additional 4% will lose and regain coverage within one to six months after closure of the unwinding period.
    - The current federal COVID-19 PHE expires on July 15, 2022. Federal officials continue to indicate to states that they will provide a 60-day notice prior to the end of the PHE.
    - States did not receive the 60-day notice in time for the July expiration date; this means another PHE extension will likely be announced prior to July 15th.
    - The Maintenance of Effort (MOE) to keep individuals enrolled continues through month in which the PHE ends (currently July 31, 2022). The 6.2% enhanced FMAP continues through the end of the quarter in which the PHE ends (currently September 30, 2022).

- Closures from redeterminations may not occur prior to the month after the PHE ends. Redeterminations must be managed over a 12-month period to ensure an even distribution of overdue redeterminations combined with currently due renewals, and a sustainable workload for local agencies in future years. Assuming a PHE end date of July 15, 2022, normal Medicaid operations would resume in September 2023. As states did not receive 60-day notice for a July 15, 2022 end date, this timeline will shift based on the extension.
    - CMS has defined month one of the unwinding period to occur when a state has initiated the ex-parte process.
    - A full redetermination is required for all members.
    - Previously submitted verifications may not be used in redetermination.
    - States should not initiate redeterminations for more than 1/9 of the total population per month.
- Local DSS agencies face a significant increase in Medicaid workloads when the PHE ends. Increased enrollment and the redetermination of over 2 million individuals is expected to have major impacts to call centers, member appeals, and other operational areas within both agencies.
    - To address the redetermination effort, DMAS and DSS are working closely to ensure readiness in three major areas:
        - **Outreach & Communication**
            - Health plans are collaborating closely with DMAS to align all communication and outreach and to follow the three-prong approach:
            - Strategy 1: Encourage Members to Update Contact Information
            - Strategy 2: Sharing Renewal Files with Plans to Conduct Outreach and Provide Support to Individuals Enrolled in Medicaid during their Renewal Period
            - Strategy 3: Enabling Plans to Conduct Outreach to Individuals Who Have Recently Lost Coverage for Procedural Reasons
            - Strategy 4: States encourage Medicaid managed care plans that also offer a Qualified Health Plan (QHP) to share information with enrollees who are determined ineligible for Medicaid.
            - Health plans are communicating with members through multiple modalities: Mail, email, texts, phone, social media, and other digital marketing.
            - Outside of using the Health Plan Toolkit, DMAS reviews all language for any other outreach material.
        - **System Improvements**
            - System improvements to increase automation and no touch processing will be critical to ensure timely and accurate redeterminations while balancing staffing shortages, attrition rates, and training needs. DMAS has allocated American Rescue Plan Act (ARPA) funding, totaling $1.6 million, for seven system enhancements. Improvements are expected in June 2022, with final changes in September 2022.
            - The planned system enhancements include seven updates to the DSS-owned eligibility determination system and one change to the DMAS-owned Medicaid enrollment system. Of those changes:
                - Five enhancements are permanent, or ongoing, solutions which will increase accuracy and decrease worker intervention.

- Six enhancements *may* result in cost savings for the Commonwealth, either through complete automation of a process or decreasing the need for manual work.
- Five enhancements will result in more timely processing at application, annual redetermination, or when a change occurs, which will result in improved customer service for Virginians.
- One enhancement provides federally required reporting during the unwinding period.

- **Staffing**
  - Strategy 1: Creation of Agile Taskforce
    - Temporary contracted staff to augment existing workforce.
    - Structure has been built with some positions already filled.
    - Taskforce currently working to assist local agencies in clearing backlogs and making needed manual corrections in preparation for unwinding.
  - Strategy 2: Overtime for local agencies:
    - DSS is exploring the use of overtime for local agencies for the 14-month unwinding period.
  - Additional strategies being researched include:
    - Strategy 3: Creation of a state-wide determination pool.
      - Status: LDSS staffing shortages and attrition rates may impact the feasibility of this strategy. DMAS/VDSS analyzing workload distribution and availability at 120 local agencies.

7. Finance and Technology Update

Chris Gordon, CFO presented on Key Metrics, FY22 Appropriation, Medical Spend, MCO Performance and Appropriation Act

Key metrics discussed included:

- Prompt pay – VA code requires all providers be paid within 30 days of billing; at 96%, DMAS is exceeding its 95% target
- SWaM – While the target is 55%, DMAS chose to exceed that rate, currently 63%
- Admin Spending – Slightly under target at $59.5m but on track to end year with $1m in the general fund
- Medical spending – Currently at $15.47b and we are on track to leave $22m in the general fund

Of the 20.6 billion, 19.7 billion reflects Title 19, which is both Medicaid base and expansion. Our admin budget is 1.6% of our total budget. This not only includes funds to run the agency, but also administrative services and organization contracts. Chip is 1.5%. Under the American Rescue Plan Act (ARPA) we were given $41 million from the administration prior.

In summary, agency key Finance &Technology metrics continue to exceed targets. Ongoing extensions of PHE continue to create enrollment and expenditure forecasting challenges. Five MCOs did not meet MLR targets, all six made more than 3% profit in FY21.

8. Medicaid Managed Care Organization & Social Determinants of Health

Ms. Tameeka Smith – Chief Executive Director – United Health Care – Ms. Smith spoke addressing Social Determinants of Health and UnitedHealthcare's Housing + Health Program

Housing + Health Program
Intentionally goes beyond traditional care to remove barriers to care — social and clinical.

- Evidence-based solution to stabilize members with complex socio-clinical needs and improve outcomes
- Addresses the underlying issues that resulted in homelessness
- Provides transitional apartment or congregate housing
- Integrated physical and behavioral health care, and end-to-end care management
- Provides 1:1 support from an expert interdisciplinary team
- Incorporates wrap-around services that empower and enable: health coaching, goal planning, employment navigation, non-emergent transportation, addiction recovery support, ongoing guidance after graduation

Mr. Randy Ricker – Plan President – Optima Health – Mr. Ricker spoke on addressing Social Determinants of Health.

The U.S. Department of Health and Human Services defines social determinants of health (SDOH) as the conditions in the environments where people are born, live, learn, work, play, and worship that affects a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health have a major impact on people's health, well-being, and quality of life. These conditions can affect anyone, regardless of age, race, or ethnicity.

Housing Instability: Current State

- In the U.S. each year, 1.5 million individuals experience homelessness[1]
- Housing instability may negatively impact health outcomes and increase the risk of premature death.[2]
- Homelessness has higher incidents of diabetes, hypertension, asthma, major depression, and a substance use disorder. [2]

1: Source: http://www.rootcausecoalition.org/wp-content/uploads/2016/11/White-Paper-Housing-and-Health.pdf
2: Source: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability

Equity in Action

Access:
- Tools and resources
- Needs of individual communities
- Reduce gaps and disparities

Opportunity:
- Meet the demands of the communities
- Building a pipeline and network of community and faith-based organizations and outreach programs to address SDOH

Engagement:
- Ingrain in the community

- Trust and buy-in of our members

Power of Partnership

Partnerships aimed at building capacity help connect our most vulnerable members to healthcare, shelter, and support services.

Goal 1: To create programs that provide social, physical, and economic platforms to support a member in attaining his/her full potential for health and well-being.

Goal 2: To create a social support system through the convergence of the Health Plan, the community, technology, and innovation to achieve health equity.

Boosting care and referral options

Optima Health has partnered with Virginia Supportive Housing to launch a two-year pilot program to support members with housing instability and an acute mental health condition. Through this partnership, Optima Health will help identify permanent stable housing situations, obtain appropriate care for chronic and behavioral health conditions, and work to reduce non-emergency department visits and non-emergency psychiatric acute inpatient visits.

9. SUD/ SUPPORT Act Grant Update – Ashley Harrell, ARTS Senior Program Advisor

Ashley Harrell provided an overview of the Substance Use Disorder Prevention that Promotes Opioid Recover and Treatment for Patients and Communities (SUPPORT) Act: Section 1003. The program's purpose is to increase the number of SUD treatment and recovery providers through ongoing assessment of the state's needs; recruitment, training, and technical assistance for SUD providers; and improved reimbursement. SUPPORT Act goals include appreciating successes while learning from challenges, reduce workforce entrance barriers, focus on members who have legal/carceral experiences and/or who may be pregnant or parenting (60% of these members were identified as having SUD) and maintaining our person-centered, recovery-oriented core values.

Virginia Medicaid's SUPPORT Act Grant Goals:

- Learn from Addiction and Recovery Treatment Services (ARTS) benefit program
    - Appreciate successes
    - Learn from challenges
- Decrease barriers to enter workforce
- Focus on specific subpopulations
    - Members who have legal/carceral experience
    - Members who are pregnant and parenting
- Maintain our core values
    - Person-centered, strengths-based, recovery-oriented

Support Act Gran Achievements

- Strengthened relationships with state Departments of Corrections, Health, and Social Services
- Provided policy-specific recommendations to leadership on opportunities to address gaps, barriers, and challenges for substance use disorder treatment
- Identified opportunities to improve continua of care for pregnant/parenting members and members with legal/carceral involvement
- Provided more than 225 training and technical assistance sessions (virtual and in person) to more than 11,000 professionals
- Identified and addressed challenges and opportunities for implementation and expansion of peer recovery services

- Provided trainings on race-based trauma and culturally sensitive treatment practices that were attended by more than 1,200 individuals
- Addressed challenges for Medicaid members who have substance use disorders as well as infectious diseases such as HIV and hepatitis C

Support Act Grant Overview

Highlights of Completed Contracts

•VCU Department of Health Behavior and Policy (DBHP)
- Medicaid member survey, including semi-structured in-depth follow-up to better understand member experiences
    - This produced Virginia's first ever look at Medicaid member experiences with ARTS
    - Survey found overall positive experiences with ARTS, and improved outcomes as a result of engaging in ARTS services
- Review of Department of Corrections data to examine impact of substance use disorders (SUD)
- Analysis of Peer Recovery Supports to examine utilization and capacity
- Multi-faceted review of buprenorphine-waivered professionals and providers, including:
    - Surveys of buprenorphine-waivered physicians and office-based addiction treatment providers to understand successes and challenges in buprenorphine treatment
    - Analysis of Drug Enforcement Administration data to determine frequency of prescribing done by waivered professionals, and how that compares to other states

- Manatt Health – SUD-specific Policy Landscape Review
    - Assessed SUPPORT Act and other federal and state SUD-related policy requirements and opportunities
    - Performed 44 stakeholder interviews
    - Identified key strengths and opportunities for DMAS, which were presented to agency leadership;
        - Strengths include covering full spectrum of American Society of Addiction Medicine levels of care, utilizing data to improve service provision and efficiency, and offering ongoing technical assistance
        - Opportunities include strengthening and evolving current care coordination system, increasing utilization of peer recovery services, and strengthening enrollment and linkages for members with legal/carceral experience
- Health Management Associates (HMA) – Legal/carceral system, SUD, and Medicaid
    - Completed an environmental scan of current system, including surveys of and focus groups with stakeholders
    - Conducted systems analyses with five pilot sites, including "current state" assessments and individualized site reports with "future state" goals
    - Convened two regional cross-sector stakeholder events to bring stakeholders together to identify and address opportunities for growth and collaboration
    - Presented findings to DMAS Justice-Involved Workgroup
- Carilion Clinic: Emergency Department Bridge Clinic
        - Expanded and enhanced existing Bridge Clinic services
        - Expanded Bridge Clinic staff, including licensed social worker and peer recovery specialist
        - Developed a curriculum for bridge clinic implementation based on quality improvement work done in partnership with Virginia Department of Health
        - Established Virginia Emergency Department Bridge Replication program, with an initial cohort of five non-Carilion hospitals and three Carilion expansion sites that are hoping to implement their own bridge clinic programs

- Subaward program
  - Awarded seven grants to providers throughout the Commonwealth – Lynchburg, Norfolk, Northern Virginia, Richmond, and Roanoke
  - Accomplishments include:
    - Expansion of telehealth services
    - Expanded peer recovery services
    - Expanded Harm reduction services
    - Creation of Patient navigation for pregnant and parenting members

Projects Update – Contracts ending September 2022

- VCU Wright Center and Institute for Drug and Alcohol Studies
  - Provider webinar survey
  - Brightspot Assessment
- Emergency Department Virtual Bridge Clinic Model
  - VCU Emergency Department Virtual Bridge Clinic (VBC)
    - Implementing a VBC at VCU ED to VCU MOTIVATE Clinic
- Virginia Department of Health – Harm Reduction Organizations
  - "One stop shop" approach to provide potential members opportunity for enrollment
  - Telemedicine: connecting to MOUD, hepatitis C and HIV treatment, and behavioral health treatment

10. New Business/Old Business

Topics of interest for next meeting:

- Conversation/questions regarding pay to home health providers/personal care.
- Compliance and oversight.
- Behavioral health crisis.

12. Adjournment

Moved by Michael Cook; seconded by Maureen Hollowell, Elizabeth Noriega and Greg Peters. Motion: 7 - 0
Voting For: All members present voted 'aye'
Voting Against: None