



MEETING MINUTES

**Meeting Minutes
June 9, 2022
1:00-3:00 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 WebEx option was also available to allow Committee members and the public to attend virtually.

The following CHIPAC members were present in person:

- Irma Blackwell Virginia Department of Social Services
- Dr. Susan Brown American Academy of Pediatrics – Virginia Chapter
- Sara Cariano Virginia Poverty Law Center
- Heidi Dix Virginia Association of Health Plans
- 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
- Michael Muse Virginia League of Social Services Executives
- Emily Roller Virginia Health Care Foundation
- Hanna Schweitzer Dept. of Behavioral Health & Developmental Services

The following CHIPAC members attended virtually:

- Michael Cook Board of Medical Assistance Services
- Tracy Douglas-Wheeler Virginia Community Healthcare Association
- Dr. Nathan Webb Medical Society of Virginia

The following CHIPAC members sent a substitute:

- Jennifer Macdonald Virginia Department of Health
(Dr. Vanessa Walker Harris, attending virtually)
- Freddy Mejia The Commonwealth Institute for Fiscal Analysis
(Laura Goren, attending virtually)

The following CHIPAC members were not present:

- Dr. Tegwyn Brickhouse VCU Health

Welcome – Sara Cariano, CHIPAC Chair, called the meeting to order at 1:01 p.m. Cariano welcomed committee members and members of the public and explained that the meeting would have a hybrid format: A quorum was present in person, enabling the committee to hold votes and discuss substantive matters. In addition, a link was posted on the Virginia Regulatory Town Hall website to enable committee members and members of the public to attend virtually. A brief overview of the hybrid meeting format and procedures was provided to the attendees, then attendance was taken by roll call.

I. CHIPAC Business

A. Review and Approval of Minutes – Committee members reviewed draft minutes from the March 3 meeting. Heidi Dix made a motion to approve the minutes, Shelby Gonzales seconded, and the Committee voted unanimously to approve.

B. Membership Update – Cariano provided an update on committee membership. She informed the Committee that the following members have renewed their terms: Emily Griffey, Tracy Douglas-Wheeler, Shelby Gonzales, Michael Muse, Dr. Nathan Webb, Dr. Tegwyn Brickhouse, Michael Cook, Freddy Mejia, and Sara Cariano. She informed the committee that the Department of Education had not yet nominated a new representative; however, Joseph Wharff, Associate Director of Student Services, was attending in the interim. Cariano announced that Lanette Walker, formerly CHIPAC representative from the Virginia Hospital and Healthcare Association (VHHA), had stepped down from her position as CHIPAC Vice Chair and accepted the position of CFO of the Health and Human Resources Secretariat. She explained that the Executive Subcommittee had recommended Kelly Cannon as the new Committee representative from VHHA. Cariano directed members to Cannon’s member questionnaire in the meeting materials. Shelby Gonzales made a motion to approve Cannon’s membership. Jeff Lunardi seconded, and the committee voted unanimously to approve Cannon as VHHA’s representative. Cariano reminded members that with Walker’s departure from the committee, the Vice Chair position is currently vacant. She invited nominations for the position.

II. Emergency Medicaid Changes (DMAS)

DMAS staff provided the Committee with updates on several Medicaid-related changes scheduled to take effect July 1 and beyond. First, Yolanda Chandler, DMAS Assistant Director of Eligibility and Enrollment Services, and Pat Arevalo, Program Manager in the Program Operations Division, gave an update on changes related to the Emergency Medicaid program.

Chandler explained that under federal law, states provide temporary, limited-scope Medicaid coverage for specific emergency services to individuals who otherwise meet eligibility requirements but do not meet immigration status requirements for full-benefit Medicaid. In order to be reimbursed under Emergency Medicaid, claims must be related to care for medical problems that could seriously harm the patient’s body part, general health, or ability to function. These services are generally provided in an emergency room setting or an acute care hospital admission.

Chandler described the new system of “evaluate and enroll.” In this new process, all individuals applying for Emergency Services will no longer need to wait until after the services are rendered to be approved for Emergency Medicaid. An application received by the local department of social services (LDSS) will be evaluated without the need for additional upfront medical documentation. The individual will be enrolled in one of the two new aid categories for Emergency Services and will remain in that aid category until a claim is received and deemed an emergency. Although these cases will still require an annual redetermination by LDSS, the new process considerably streamlines the workload.

Chandler explained that there are benefits for everyone involved, from the applicant to LDSS and DMAS. Applicants and LDSS will no longer need to gather and sort medical records; LDSS will not have to submit records to DMAS for approval, and DMAS will no longer be required review the medical records and communicate decisions back to LDSS.

Chandler stated that two new aid categories (ACs) will be created for Emergency Services: individuals who meet criteria for Medicaid Expansion will be in AC 112 while AC 113 will consist of children under 19, caretaker relatives, and aged, blind and disabled (ABD) populations. Members enrolled in AC 112 and AC 113 will not receive Medicaid ID cards. However, members should keep all documents and make note of the Medicaid ID number listed on the Notice of Action that is mailed at approval.

Arevalo explained that the Emergency Services claims process is going paperless starting July 1. Claims must pass edits for adjudication, and claims that do not pass will be pended for a nurse to review against the regulatory guidelines to determine an emergency diagnosis. Arevalo stated that now that claims will be automated, providers can check their claims status online or through the Medicaid system, and they can call the toll-free Provider Helpline for complex claims issues. She explained that additional information for providers is forthcoming in the form of a Medicaid Memo.

Shelby Gonzales, Center on Budget and Policy Priorities, expressed support for the changes. She asked whether individuals going through the general application process for Medicaid will have a determination made and be “pre-certified” for Emergency Medicaid if they don’t meet eligibility criteria for Medicaid full-benefit coverage. She also asked if members who are eligible for Marketplace coverage but not eligible for full-benefit Medicaid will still be referred to the Marketplace even if they are enrolled in Emergency Medicaid.

Chandler confirmed that the application is the same application and initial process that someone applying for full-benefit Medicaid coverage would go through. When individuals do not meet immigration status criteria, they will be determined eligible for only Emergency Services coverage and will be enrolled upfront rather than waiting until they have an emergency and an associated medical claim. However, their coverage will be limited to claims that meet Emergency Services criteria.

Chandler stated that DMAS will work with the marketing and outreach teams to communicate these changes so the agency can help ensure that Emergency Medicaid members understand their benefits and the process for accessing Emergency Services. Chandler and Irma Blackwell, VDSS, stated that they would follow up regarding the issue of referrals to the Marketplace.

Michael Muse, Virginia League of Social Services Executives, stated that he was supportive of the changes and thought they would streamline the process for local departments of social services (LDSS). He asked whether there is a plan for training LDSS on the new policy and process. Blackwell stated that DMAS and the Central Office of VDSS would be meeting the following week to create a training plan that will include Emergency Services training as well as training on other upcoming changes.

III. School-Based Services: Overview of Expanded Options for Medicaid Reimbursement (DMAS and VDOE)

Amy Edwards, Medicaid Specialist, Virginia Department of Education, and Rebecca Anderson, Senior Policy Advisor, DMAS Program Operations Division, gave a presentation explaining the expanded options for Medicaid reimbursement of school-based services. Edwards provided background on the current system of reimbursement for Medicaid school-based services. She explained that local education agencies (LEAs, or school divisions) receive federal Medicaid reimbursement for expenditures related to providing certain health services to students enrolled in Medicaid and FAMIS. Expenditures that are reimbursed include a portion of salaries and benefits of professionals who render or administratively support school health and support services. Other costs that are reimbursed include specialized transportation when needed for a student to access services and materials and supplies used in providing services to students.

Edwards explained that LEAs are reimbursed for a portion of the dollars they spend providing student health and support services, based on a formula that takes into account the percentage of staff time spent directly with students providing services and the proportion of students enrolled in Medicaid or FAMIS.

Anderson described the changes planned for school-based services reimbursement. She stated that DMAS has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to expand the options for Virginia schools to seek federal Medicaid and CHIP cost-based reimbursement. DMAS is currently working with CMS to secure federal approval of the SPA and aiming to implement the changes for the next school year. Although currently reimbursement is generally limited to services provided to students under an Individualized Education Program (IEP), if approved, Virginia will allow Medicaid reimbursement for the cost of providing additional covered services beyond the IEP/special education, and for students who do not have an IEP (general education students). Licensed school counselors, substance use treatment practitioners, licensed behavior analysts, and assistant behavior analysts will be added to the list of professionals whose time spent providing services may be eligible for reimbursement. Schools would also be allowed to include costs associated with adaptive behavior therapy and substance use treatment

services in cost settlement. The existing services already allowed for students with an IEP will be allowed for all general education students (Speech, Occupational Therapy, Physical Therapy, Audiology, Behavioral Health, Nursing, Personal Care, Physician/PA/NP services). There will also be pathways for schools to seek reimbursement for a portion of administrative costs associated with public health emergency activities.

Heidi Dix, Virginia Association of Health Plans, asked for clarification regarding who receives the reimbursement. Anderson explained that the LEA is reimbursed for their costs for staff and contractors who provide services to students. LEAs are reimbursed for fee-for-service claims through a cost-based reimbursement process outside of managed care, regardless of whether the individual student is enrolled in a Medicaid managed care plan.

Jeff Lunardi, Joint Commission on Health Care, asked for clarification regarding the cost-based reimbursement formula. Anderson explained that schools are paid based on the formula and their annual cost report. There is an interim claiming process that functions primarily as a program integrity measure. LEAs submit individual claims for services provided to students, which establishes an audit trail and documents that the services were actually provided. The schools receive an interim payment, but there is an end of the year “true-up” when the balance of the payment established through the reimbursement formula and cost report is made to LEAs. Lunardi asked whether the proportion of time spent providing reimbursable services to Medicaid students might sometimes be disproportionately high relative to the percentage of Medicaid students in the LEA student body overall, such that the cost of serving Medicaid students is not adequately reflected in the existing formula, resulting in schools getting less Medicaid reimbursement than appropriate. He noted that students on Medicaid waivers might need more intensive supports and might account for a large proportion of students receiving school services. Edwards stated that currently time spent providing reimbursable services is calculated using a statewide random moment time study (RMTS), and the types of providers included in the time study work primarily with special education students. Gonzales stated that time studies are imperfect and school systems nationwide have struggled with this. Anderson explained that the review and approval of the cost-based reimbursement methodology, and the RMTS, is part of the SPA process and must be approved by CMS and follow parameters that they will accept. Anderson and Edwards stated that additional questions on this topic could be directed to them after the meeting.

Dr. Susan Brown, American Academy of Pediatrics, Virginia Chapter, asked whether students in the 3-5 year old age group who have aged out of Part B Early Intervention services but are not yet old enough to be enrolled in elementary school can access school services, or if there might be an opportunity presented by the expansion for public schools to leverage Medicaid funding to provide services to those children. Anderson clarified that Medicaid reimbursement for school-based services is to the Local Education Agency that provides the services to the student. Ali Faruk, Families Forward Virginia, asked whether, if a student was enrolled in Virginia Preschool Initiative (VPI) or a preschool program provided by the public school, these services would be Medicaid reimbursable to the LEA. Anderson and Edwards stated that they

could review the issue of current or potential future opportunities for Medicaid reimbursement to LEAs for school-based services provided by LEAs through VPI and other early education programs.

Emily Griffey, Voices for Virginia’s Children, stated that she hoped this would be an opportunity to leverage integrated health services in schools and think creatively about how to improve behavioral health care for students. Griffey asked if there were nuances related to documentation or medical necessity that identify certain services as being eligible for Medicaid reimbursement. Anderson stated that in the current program, the IEP provides guardrails and acts as a sort of service authorization and statement of medical necessity. For the additional school services that are being added to the scope of the cost-based reimbursement program that are not within an IEP, a signed plan of care will be required to document medical necessity. The plan of care must be developed by a licensed professional working within the scope of their license.

Griffey asked whether there is a moment in time when the numbers used in the formula for Medicaid-enrolled student population are pulled, when that occurs, and whether it is by school or by division. She highlighted current high enrollment due to the ongoing federal public health emergency and potential concern that the percentage of Medicaid-enrolled students used in the formula could decline during the PHE unwinding. Edwards explained that the Medicaid participation percentage is calculated at division level and it is done as a quarterly point-in-time match to the Medicaid eligibility list.

Dix asked if the General Assembly required the change and if it aligns with what other states are doing, and why the Commonwealth decided to make this change. Anderson stated that the change was pursuant to state legislation in response to an opportunity created by federal guidance allowing increased flexibility in the school services that can be reimbursable by Medicaid. Factors that motivated the change included concerns about staff shortages in schools and concerning trends in student behavioral health. Anderson stated that approximately 15-18 states have submitted SPAs to expand school services. A smaller number of states have received approval of their SPAs and implemented expanded programs, but the number is expected to steadily grow.

IV. Maternal Health Updates - Community Doula Benefit and 12 Months Postpartum Coverage (DMAS)

Natasha Turner, Doula Program Analyst, DMAS Health Care Services Division, shared an update about the new Medicaid community doula benefit. She explained that community doulas are trained, community-based, non-medical professionals who provide continuous physical, emotional, and informational support to pregnant women prenatally, throughout pregnancy, during labor and delivery, and in the postpartum period. Community doulas also provide referrals and connections to critical community resources and partner with the birthing parents and their medical care team to help members feel empowered to navigate their medical care and make choices that align with their birthing plan.

Turner stated that the Virginia Medicaid Benefit for Community Doula Services work group study published in December 2020 cited evidence that pregnant individuals who receive doula care are more likely to have a healthy birth outcome and a positive birth experience.

Turner gave an overview of the structure of the new benefit. She explained that in one full episode of care, a member is eligible to receive nine touchpoints, including one initial prenatal visit and up to three additional prenatal visits, four postpartum visits, and attendance at delivery. She stated that to improve continuity of care for mothers and their newborns during the postpartum period, doulas are eligible to receive two linkage to care incentives. One incentive payment can be received by the doula if the member attends one postpartum visit with an obstetric clinician, and the second incentive payment can be received if the newborn attends one visit with a pediatric provider after the birth.

Turner explained that Virginia is the fourth state in the nation to implement doula services for Medicaid members. She stated that in April, Virginia approved the first state-certified community doula, and in May that doula was enrolled as a Medicaid provider. Turner reported that at the time of the meeting there were 31 state-certified doulas and five doulas pending Medicaid enrollment.

Turner provided information about the community doula state certification process. Effective in January 2022, VDH established the minimum requirements to be considered a certified doula in Virginia based on the core competencies for doula certification used by national organizations and community-based organizations in Virginia. The Virginia Certification Board (VCB) serves as the certifying body and maintains a public registry of state-certified doulas.

Turner explained the steps to becoming a state-certified Medicaid community doula. First the individual must complete at least 60 hours of doula training provided by one or more state-certified training entities approved by the VCB, and submit a state-certified doula application to receive state certification. In addition to state certification, the doula must also obtain a National Provider Identifier (NPI) and proof of liability insurance at the \$1 million per claim / \$3 million per year policy levels to complete the process of enrolling as a Medicaid provider. Finally, the doula must contract with one or more managed care organizations in order to provide services to members enrolled in managed care. Turner explained that currently DMAS is working to build a network of state-certified, Medicaid-approved doulas. The agency is working to engage the community and current doula providers to increase awareness of the program and share information about the opportunity with doulas who might be interested in enrolling.

Ali Faruk asked whether it was possible for an agency to enroll as opposed to individual doulas enrolling as Medicaid providers. Turner stated that yes, doulas can enroll as an individual, as an individual within a group, or a group can enroll. Faruk asked whether there was a model contract with the MCOs, or if the doula might have to have different contracts with each of the MCOs. Turner responded that no, there is not a common application; rather, each individual health care plan has its individual

contract. However, DMAS is working with each MCO as the doulas begin to come into the network to assist with the process since the doulas are new to Medicaid, the contracting process, and managed care billing. DMAS is also providing technical assistance to the doulas and working with the MCOs to create guides and instructional materials that explain the process.

Dr. Brown asked whether there is an observation period as part of certification/recertification and, since the doulas are non-medical professionals who provide care to the member in their home, if there would be any oversight to ensure that the information provided to families is appropriate. Turner explained that the core competencies established in the state certification process are intended to ensure that the doulas have the training needed. In addition, prior to initiating services, doulas must have a recommendation from a medical care provider.

Kelly Cannon, VHHA, asked whether the training and certification applies at an individual level while the enrollment and MCO contracting can be done as a group. Turner stated that if a group is going to be approved as a training entity they have to meet certain requirements. If a group will only be doing billing or processing, they will go through a separate credentialing for those processes. These are separate from the requirements for individuals. The group has to go through Medicaid background checks, fingerprinting, etc.

Cannon asked whether a referral or prior authorization is needed for a doula to be reimbursed. Turner stated that the doula needs to receive a recommendation from a medical provider, but it is not the same as a referral or prior authorization. The medical provider does not have to be a Medicaid-enrolled provider. The recommendation will be in a standardized form available on the DMAS website and the provider portal.

Faruk commented that the community doula benefit is the result of great effort from DMAS and stakeholders and stated that the community-embedded aspect of the doula benefit will be valuable in addressing members' experiences of racism and racial disparities in access to care by helping them navigate a complex and fragmented health care system.

Hope Richardson, Senior Policy Analyst, DMAS Division of Policy, Regulation and Member Engagement, gave an update on implementation of 12 months postpartum continuous coverage. Richardson stated that Virginia was the third state to receive federal approval to extend Medicaid and CHIP coverage to a full year postpartum, and systems changes to fully implement the postpartum coverage expansion across all eligible coverage groups will take effect July 1, 2022.

Richardson explained that during the federal public health emergency, full-benefit Medicaid populations have generally received continuous coverage under a maintenance of effort provision of federal COVID response legislation. She stated that the new systems changes taking effect July 1 will mean that (1) populations who previously did not receive continuing coverage under the MOE, including FAMIS MOMS and lawfully residing pregnant women, will now receive guaranteed continuous

coverage through 12 months postpartum, and (2) going forward, into the “unwinding” period after the PHE ends, and beyond, the systems changes will be in place to ensure a smooth transition into 12 months protected postpartum coverage for all eligible populations.

Richardson explained that the 12 months postpartum continuous coverage applies to all pregnant full-benefit Medicaid and FAMIS MOMS members. It is not limited to pregnancy coverage groups. Individuals will remain enrolled in coverage during pregnancy and through 12 months postpartum, regardless of income changes. Richardson stated that members in FAMIS Prenatal Coverage are an exception and their coverage will continue to end at 60 days postpartum as DMAS currently does not have state or federal authority to further extend postpartum coverage for this population.

Emily Roller, Virginia Health Care Foundation, asked about individuals who have already delivered and lost coverage but who may still be within 12 months postpartum, and whether any outreach is currently being done for those members. Richardson stated that DMAS is working to put together a mailing to be sent to individuals who were recently disenrolled informing them about the new coverage and explaining how to find out if they are eligible. In some circumstances, individuals will be eligible to have their coverage reinstated, and in other cases the individual would need to reapply for coverage.

V. Committee Discussion of Legislative & Policy Priorities

Cariano presented the results of an informal poll conducted by the Executive Subcommittee to gauge CHIPAC members’ priorities for the coming legislative session. She explained that some members representing state agencies and entities were not able to participate in the poll or take a position on the Committee’s priorities for legislative session.

Cariano stated that members prioritized the following items for inclusion in the DMAS budget package (in descending order): 12 months continuous eligibility for children in Medicaid and FAMIS; increasing the income limit for FAMIS children and FAMIS MOMS; creating a state-funded program for children regardless of immigration status; merging the FAMIS program with children’s Medicaid while retaining the higher CHIP federal match; increasing behavioral health provider reimbursement rates; and allowing Medicaid/FAMIS-enrolled children in residential treatment facilities (RTFs) to maintain managed care enrollment.

Cariano stated that she was open to members’ suggestions of how to present the recommendations, and options included drafting a Committee letter to the DMAS Director and Secretary of Health and Human Resources sharing these recommendations. Griffey suggested the idea of including funding in the state budget request for technical assistance services and support for new implementations like doula provider enrollment or training on the school services expansion. She also suggested exploring the idea of how crisis stepdown services can be provided as part of future rounds of the Project BRAVO Medicaid-funded behavioral health services

reshaping. Gonzales stated that another federal policy option Virginia could consider adopting would be presumptive eligibility.

The Committee discussed next steps, and Cariano stated that she would circulate a draft letter summarizing the priority recommendations to state Medicaid/HHR leadership.

VI. Agenda for September 1 CHIPAC Meeting

The committee discussed potential subjects to include in the meeting agenda for the September 1 meeting. Richardson stated that the Executive Subcommittee was proposing a behavioral health focus for the meeting. Additional member suggestions included an update on the COVID vaccination status of Medicaid-enrolled children, an update on Medicaid children's immunizations more broadly, and an update on Medicaid provisions in the final enacted budget.

VII. Public Comment

Public comment was invited, but there was no verbal public comment. LeVar Bowers submitted the following written comment in the chat:

If approved by CMS, how will school-based Medicaid services be classified in the behavioral health system for our state, now that they will extend outside of IEPs? Will it be considered a lower level of care, duplication of services, etc., with similar services? Will students who receive school-based services still be eligible to receive similarly classified services at a CSB/BHA/private provider? For example if a student is receiving some level of substance use or ABA services in school, would they still be eligible for an outside SA/intensive outpatient or ABA clinic or in-home-based service through Medicaid at an outside provider?

DMAS staff followed up directly with Bowers after the meeting with the response that the LEA-provided school-based services discussed during the meeting are carved out of the Medicaid managed care contracts. They will not be considered a lower level of care, duplication of services, or make the student ineligible to receive other services outside of school. Under DMAS' contracts with the managed care organizations (MCOs), MCOs may not deny medically necessary covered services rendered in a non-school setting based on the fact that the child is receiving the same covered services as part of a LEA school-based services program.

Closing

The meeting was adjourned at 2:46 p.m.