VIRGINIA MEDICAID MEMBER ADVISORY COMMITTEE

2022 ANNUAL REPORT

VIRGINIA'S MEDICAID PROGRAM

DMAS

Introduction

The Virginia Department of Medical Assistance Services (DMAS) provides services and programs for approximately 2.2 million people in the Commonwealth of Virginia. DMAS is the single state entity responsible for Virginia's Medicaid program, children's health insurance program, and Medicaid waivers.

Approximately four percent of the Medicaid population is in fee-for-service (a method in which doctors and other health care providers are paid directly by DMAS for each service performed), with the remaining majority receiving care through Cardinal Care. Managed care is the delivery of health care services emphasizing the relationship between a primary care provider (PCP) and the Medicaid member. The goal of managed care is to have a central point through which all medical care is coordinated. DMAS' mission is to improve the health and well-being of Virginians through access to high-quality healthcare coverage.

In 2019, DMAS established the Medicaid Member Advisory Committee (MAC), comprised entirely of Medicaid members or their authorized representatives, to provide Medicaid members with the opportunity to share their experiences, observations, and recommendations with agency leadership and staff. Since its inauguration, the MAC has been made up of Medicaid members and representatives who desired to be a part of a team effort to review and offer recommendations to improve the delivery of quality healthcare services and programs.

As a part of its outreach and continuing effort to improve and enhance the delivery of Medicaid services and programs, Cheryl Roberts, Acting-Director of DMAS, has stated that the Agency is committed to providing a public platform for Medicaid members to share their perspective and observations about Virginia's Medicaid program. The robust participation of DMAS leadership and staff illustrates DMAS' investment in and commitment to the MAC.

DMAS Outreach and Community Engagement Manager, Natalie Pennywell, serves as the committee's facilitator and provides management of the MAC initiative. Deputy for Administration Sarah Hatton, serves as the committee's *ex officio* member, provides executive leadership oversight of the MAC initiative. MAC meetings generally take place on a quarterly basis.

DMAS posts the date, time, location and or means of access, and agenda for each meeting on Virginia Townhall (http://townhall.virginia.gov/). Each meeting reserves a period for public comment. To promote even greater public access and participation, DMAS ensured that closed captioning services were provided at the meetings.

As it concerns the Virginia Medicaid Program, translation and interpretation services are available in all languages through Cover Virginia at 1-855-242-8282.

The following report examines and documents the work of the 2022 MAC. To see reports for 2019, 2020, and 2021 please visit the Medicaid Member Advisory Committee webpage:

https://www.dmas.virginia.gov/for-members/member-advisory-committee/

2022 Committee Background

In 2022, the MAC comprised ten (10) individuals representing a diversity of Medicaid members or authorized representatives from across the Commonwealth of Virginia. An eleventh-seated MAC member was unable to participate. The participating MAC members were:

- Ghadah Aljamali
- Karin Anderson
- Olatunji Fakunmoju
- Michelle Meadows

- Elvira Prince
- Sabrina Redd (new member as of June 2022)
- Summer Sage
- Geoffrey Short
- Craig Thomson (new member as of June 2022)
- L. J. Tisdale (new member as of June 2022)

The 2022 MAC

Building upon the work of the preceding MACs, the 2022 MAC members sought to explore deeper Medicaid issues, providing member perspectives and observations designed to improve Virginia's Medicaid Program. The members represented themselves, children, autistic individuals, parents, individuals with serious medical conditions, and spoke to areas of concern and interest to the broad Medicaid population. Some of the reasons that these members wanted to be a part of the MAC are as follows:

- To offer a broad range of Medicaid members' viewpoints, considerations, and ideas;
- To help make Medicaid increasingly accessible and understandable to Virginians; and
- To discuss issues ranging from programs, services, processes, etc., and recommend options for consideration for improving, enhancing the Medicaid program.

The 2022 MAC meetings were conducted virtually using Web-Ex or Zoom in April and June, and as hybrid meetings (virtual and in-person) in August and December. DMAS periodically asked MAC members to recommend topics for consideration for agenda meetings. In addition, to help facilitate meaningful, respectful interaction within the meetings, MAC Policies and Procedures were shared with and agreed upon by the committee members. *See Attachment A.*

April 12, 2022 MAC MEETING

Director Kimsey and Deputy Director Hatton welcomed and encouraged MAC members to share their considerations for improving Virginia's Medicaid program. During the course of their introductions, MAC members expressed excitement and their interest in providing feedback to DMAS. These members noted the importance of

- having access to affordable quality health care;
- Medicaid members understanding the policies and the services that are available to them in order to ensure effective and timely utilization; and
- that an interactive and robust forum is provided where members can communicate the successes and challenges of the program to DMAS agency and staff.

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April 2022 Agenda

Presentation - The Role of Managed Care Organizations in Virginia Medicaid

Estelle Kendall, Member & Provider Solutions Manager – Healthcare Services
Bryan Talbert, Contract Administrator – Healthcare Services
Lynne Vest, Member and Provider Relations Specialist – Integrated Care

Bryan Talbert, *Contract Administrator – Healthcare Services,* explained that Managed Care is a delivery system used to manage cost, benefit utilization, and quality of care in Medicaid. DMAS contracts with six Managed Care Organizations (MCOs), each of which receives a monthly rate per member for providing care, called a capitation fee.

As shared by Mr. Talbert, managed care ensures a high-quality provider network, enhanced benefits, and comprehensive healthcare coverage focused on

prevention. Approximately 96% of DMAS members receive care through MCOs. Medallion 4.0 covers 1.5M members like infants, children, pregnant members, caretaker adults, and newly eligible adults. Commonwealth Coordinated Care (CCC+) covers older adults, disabled children, disabled adults, and medically complex newly eligible adults.

The six MCOs are:

- Aetna
- Anthem
- Optima Health
- United Healthcare
- Molina Healthcare (acquired Magellan in 2021)
- Virginia Premier

Members can change their assigned health plans at designated times or with good cause. DMAS assigns members to an MCO according to a determination system. Once assigned, members have 90 days to request an MCO change. Members can choose a health plan via phone, website, or mobile app.

Lynn Vest, Member and Provider Relations Specialist, noted that each member is assigned a Care Coordinator to help members. Care Coordinators help answer questions and resolve network barrier issues, including transportation and provider coordination, even when providers are out of network. DMAS monitors the contracts with each organization to ensure compliance with the agreements, including issues like appeals and compliance actions. Ms. Vest asked MAC members who work with CCC+ if they had received outreach from Care Coordinators, and, if so, whether they received the assistance needed. In response, Ms. Sage shared that she had had a great relationship with her CCC+ Care Coordinator. Still, Ms. Sage observed that, while respectful, the Care Coordinators sometimes struggled to have information, resources, and new services for recipients. Ms. Sage also stated that Care Coordinators set up Integrated Care calls with the Care Coordinator, members, and people like educators, Primary Care Physicians (PCPs), groups like Moms in Motion, and similar groups. However, she noted, rarely does anyone participate in these important calls. Ms. Sage pointed out that doctors do not always participate in the calls because they cannot bill Medicaid for those calls. She asked if DMAS was gathering data about the impact of the calls and the effect of not being able to organize all parties in the calls. She further inquired whether DMAS is gathering any kind of data on the impact of these calls and the lack of an ability to get everybody in the room simultaneously and the impact on care coordination.

Ms. Vest answered that she has experience participating in the interdisciplinary care team (ICT) meetings. She stated that sometimes Care Coordinators could organize information from PCPs or organizations who cannot participate in the calls and relay the information back to the call. Ms. Vest was able to confirm that DMAS does not collect any data on Interdisciplinary Care Team Meetings but assured the MAC she was willing to follow up to assist and facilitate anything needed for ICT meetings with the MCO and providers."

In response to inquiries regarding mode of communication to care coordinators, Ms. Vest answered that email is also acceptable, but that mode of communication best suited for the member is the communication that should be followed. Still, parties must communicate health information via secure email to comply with HIPAA regulations.

Presentation – Public Health Emergency Updates

Sarah Hatton – Deputy of Administration
Natalie Pennywell – Outreach and Community Engagement Manager, PRME, Administration
Miriam Siddiqui – Senior Advisor, Administration

Deputy Hatton informed the MAC that while federal funding increased due to the Federal Public Health Emergency (PHE), states had to maintain enrollment of individuals in Medicaid until the PHE ends to receive an additional 6.2% match federal fund. Exceptions to that maintained enrollment included if

someone passed away, moved from the state, or asked DMAS to close their coverage.

One in four Virginians has Medicaid, which is 500,000 more people than were enrolled before the PHE. The PHE renews every 90 days, and as of the April 2022 MAC meeting, scheduled to end April 16, 2022. Nevertheless, DMAS expected the federal government to renew the PHE one more time. DMAS expected to begin renewals in July 2022, when the federal government indicates, the PHE should end based on projections.

DMAS is preparing for the end of PHE and working with DSS and local agencies. DMAS has not completed paper renewals since PHE began, but has completed automatic renewals, which have confirmed coverage for individuals who would otherwise retain coverage. At the end of the PHE, DMAS and the Department of Social Services (DSS) will need to re-determine eligibility for all 2 million Medicaid members in Virginia. When the PHE ends, DMAS expects to review eligibility for most Medicaid recipients for 12-months. DMAS expects about 20% of individuals will lose coverage.

Before the emergency, 25% of the Virginia Medicaid population would lose coverage for administrative reasons, like failure to complete renewals, and they would reapply soon after losing coverage. DMAS is working with MCOs to reach all members to ensure DMAS has appropriate contact information to complete renewals. Some individuals will be ineligible due to excess income from new employment and DMAS will refer those individuals to the Health Insurance Marketplace to seek coverage. DMAS and DSS expect to renew more than 100,000 members per month after PHE. DMAS and DSS, working together, want to complete renewals efficiently and accurately, so they intend to spread the renewal analysis over 12-months as allowed by the federal government. Local agencies will also be reaching out for contact information and verification of necessary eligibility standards from members. DMAS and DSS have created systems updates that will improve automation such as access to information electronically to reduce verification requests to members. DMAS and DSS will also augment staff to local agencies, as needed, through the "Adjunct Task Force," where backlogs exist. If a person's coverage ends due to failure to complete a renewal, that member has 90 days after the termination to complete a renewal, and, if approved, receive Medicaid coverage with no gap once re-approved.

Questions raised by Committee Members included:

Ms. Prince asked about the income limits for Medicaid. Deputy Hatton responded that income limits depend on the covered group, family size, and others. Ms. Meadows asked if there were guidelines for a single individual with no children. Deputy Hatton indicated that there were screening tools on the Cover Virginia Website to help individuals. Jessica Annecchini reflected in the chat feature of WebEx: See: https://coverva.org/en/our-programs for general income limits!" Ms. Redd asked if members should proactively complete a renewal form or wait until they receive a paper renewal. Deputy Hatton shared that DMAS encourages members to communicate contact information to DMAS, local agencies, and MCOs now, but instructed members not to complete a renewal yet because it would not be valid as a post-PHE renewal. The federal government will not allow DMAS to use old data, so members would be required to submit a second renewal packet during the appropriate month of unwinding.
Natalie Pennywell discussed outreach information that DMAS has sent and will be sending to members. DMAS sent a member letter asking members to update contact information and how to update that information, which is available in seven languages. MCOs and non-MCO members have toolkits, and both toolkits are available on the Cover Virginia website. The toolkits include stakeholder documents, member documents, messaging templates, and customizable templates for outreach and that this is an ongoing effort of engagement. Ms. Pennywell noted that DMAS is looking for feedback from Medicaid members as they continue

to develop the current and future toolkits and resources.

Presentation – Understanding the Role & Process of Appeals

John Stanwix, Director, Appeals
Michael Puglisi, Eligibility Cases Manager, Appeals
Mavora Donoghue, Medical and Provider Cases Manager, Appeals
Aneida Winston, Quality Assurance Manager, Appeals

Michael Puglisi summarized that the purpose of appeals is to provide due process to the applicants, members, and providers. Due process includes written notice of an adverse action, the opportunity to review documents, present testimony, and have an attorney or representative at review, as determined in a United States Supreme Court case *Goldberg v. Kelly*.

Conducting the appeal hearings are Hearing Officers who are impartial and separate from the eligibility workers who made the initial decisions. The Hearing Officer issues a written decision based on the facts and appropriate law. Client appeals involve eligibility issues like denials, termination, reduction of services, and medical issues regarding certain medical services. Eligibility issues include failure to evaluate an application, failure to provide verifications, failure to review, income and resource issues, ands Recipient Audit Unit recovery. Medical issues include appeals related to the provision of medical services, like preadmission screening, personal care hours, and nursing home appeals.

DMAS conducts hearings under a process called *de novo (new)*. The purpose is to provide Medicaid members the opportunity to challenge eligibility and medical services determinations that are not in their favor. DMAS strives to ensure that members' due process rights are protected and that they have a fair opportunity to be heard.

In a *de novo* review, a Hearing Officer must issue a new eligibility decision back to the application or agency's denial or termination. Appellants may submit additional documentation at any time during the appeals process. The DSS workers must review any new documentation and evaluate it to determine if the new documentation would change the outcome. If it would, the DSS worker must reevaluate the case and issue a new Notice of Action. The Hearing Officer must review the information that the Agency did not have at the time of its determination, if any exists. The Hearing Officer will evaluate if that new decision from the DSS resolves the case, and if it does not, the DSS worker must provide an appeal summary with all appropriate documentation and proceed to the hearing. The Hearing Officer will issue a decision encompassing the entirety of the appeal process.

Ms. Donoghue outlined the appeal process. Generally, a timely appeal must be filed within 30 days of receipt of notification. The Virginia Administrative Code assumes that notification is received within five days of mailing. There are four exceptions to that rule:

- the appellant was unable to appeal due to a medical issue;
- the appellant did not receive the notice;
- the appellant sent the appeal to the wrong agency, like the Department of Social Services; and
- unusual or unavoidable circumstances.

Appeals are deemed received on the postmark date of the letter or actual receipt if delivered other than by mail. DMAS has 90 days to issue a decision on the appeal request.

MCO appeals are those regarding specific medical coverage denied by the MCO, and include a two-step filing process. Members must appeal first through the MCO appeal process, and then appeal to DMAS if dissatisfied with the outcome through the MCO.

MCO Appeals: The Appeals Division has 90 days minus the time MCO took to decide the internal appeal (exception for the appellant delay)

Expedited Appeals: When a doctor certifies that operating under the standard time frame (90 days) could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function

- 7 days for eligibility related matters
- 3 days for benefit or services related matters

All Hearing Officers are lawyers, are familiar with the due process requirements, and must maintain order within the hearing. Each party must be allowed to present facts they find relevant to the case and the Hearing Officer must focus on the issue(s) at appeal. The Hearing Officer gathers evidence to use based on evaluating the documents and policy before the hearing.

Medicaid hearings are informal. The Hearing Officer will introduce the participants, explain the process, and define the issue on appeal as needed. The Hearing Officer then asks the Agency questions about the action taken, reason and authority for the Agency's action, and asks the Agency to discuss any new information provided by the Appellant under the de novo process. The Appellant may then present testimony and evidence they believe will prove their case. The parties at the end of the hearing may make closing remarks.

After all questioning, the Hearing Officer will issue a closing statement outlining the process after the hearing, including when to expect the written decision.

After the hearing, the Hearing Officer will issue a final decision, which the appellant may appeal to Circuit Court. The local Agency does not have appeal rights from the Hearing Officer's decision. The outcomes are sustained where the Hearing Officer agrees with the Agency; reverse, where the Hearing Officer disagrees with the Agency; or remand, where the Hearing Officer sends the case to the Agency for further review. A remand will be accompanied by specific instructions for the Agency and a timeframe to complete the instructions. The decision may be a combination of sustain, reverse, and/or remand.

Ms. Winston outlined the Appeals Information Management System (AIMS), a portal that streamlines the appeals process and communication with parties. Members, providers, and agency workers can all access each associated case through the AIMS portal, upload documents, and review case status through AIMS. The AIMS Portal Training Website https://vamedicaid.dmas.virginia.gov/training/appeals includes training documents, videos, practice simulations, and frequently asked questions for the portal.

The DMAS Appeals Webpage outlines an overview of client and provider Medicaid appeals, information for applicants and members for client appeals, appeals overview, and appeals forms in English and Spanish. The webpage includes a link to AIMS. Ms. Winston included contact information for the Appeals Division and commonly used acronyms in the presentation.

Ms. Winston asked three questions of the MAC members:

- What mode of communication works best for you?
- If you need to file an appeal, what resources would you use to learn more about the appeals process?
- How user-friendly are our online resources?

Questions and responses presented by Committee Members included:

Ms. Redd asked about notices of appeal rights, and stated that some notices included dmas-info@dmas.virginia.gov , which is an inactive email address. When she contacted the Appeals division, Ms. Redd shared that she was advised that the email

should not be on the Notice of Action (NOA), but that DMAS cannot force the author to remove that email address from the NOA. HIPP denials indicate, "Not approved due to medical necessity," but no more specific denial reason. Will *de novo* and due process requirements drive updates and additional, detailed information on HIPP notices? Will appellants receive the appeal summary? Mr. Stanwix stated that the referenced email address is being phased out and he asked Ms. Redd to provide copies of the referenced NOAs to him to ensure the upholding of appellants' fundamental rights.

In response to Ms. Winston's questions, Ms. Meadows answered that she preferred written communications, and that she would use the DMAS website or search engine to learn how to file an appeal and about the appeals process. "User friendliness for the appeals process has greatly improved over the last ten years. It is still tedious but is much easier to use than it used to be."

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June 13, 2022 MAC MEETING

Deputy Director Hatton welcomed and thanked the Committee for participating in the virtual MAC meeting. Ms. Hatton explained that the August 2022 meeting would be hybrid, that members are welcome to join in person, and that DMAS hopes to have future meetings fully in person.

Deputy Hatton introduced Interim Director Cheryl Roberts. Ms. Roberts explained how important DMAS members are to the Agency, including their access and needs. Ms. Roberts asked the members to comment, ask questions in the meeting, and evaluate whether the information provided was sufficient.

June 2022 Agenda

Presentation – Cardinal Care Transition

Jason Rachel – Division Director for Integrated Care

Daniel Plain – Division Director for Health Care Services

Mr. Rachel explained that DMAS would merge the CCC+ and Medallion 4.0 programs into Cardinal Care, which is one contract for healthcare. The purpose is to align the two programs and make its administration simpler and more effective. DMAS used the health plans, agency staff and national consultants to evaluate and pick the best of each contract and merge them into one to create Cardinal Care. The contract for the plan is important to make certain that all members have access to the best program possible.

Regarding enrolling members into Managed Care Organizations, historically, Medallion 4.0 has a regional, calendar-based, rolling open enrollment, where the 90-day open enrollment period is a specific period annually based on the member's address. CCC+ uses the Medicare open enrollment period from October through December for all members. The Cardinal Care program will use the regional, calendar-based, rolling open enrollment for all managed care members. This will add some simplicity to the process, especially where there are households that might have Medallion 4.0 and CCC+ members. This enrollment process will become effective in January 2023. Currently, when a member needs to change MCOs, a member is disenrolled from their current MCO to fee for service until the member can enter a new MCO at its next open enrollment period. This can be disruptive for the member and the provider. However, Cardinal Care Continuity of Managed Care enrollment would allow someone, for example, to move from traditional services into a nursing facility without disenrolling in their health plan or experiencing a disruption of services.

Under the Medallion 4.0 and CCC+ programs, there were over 400 reports coming in, six times per year, creating over 2400 reports to review. Cardinal Care will allow greater accountability and ease of oversight. Under Cardinal Care, DMAS has enhanced or improved accountability, and reduced

the reports to approximately 110 reports coming in six times per year, creating only 660 reports to review.

The branding opportunity changes from CCC+ and Medallion4 to Cardinal Care, including new Medicaid cards, to reduce the confusion in identifying a member's care. DMAS expects the health plan's interactions with members to be responsive. Instead of creating a care plan for a member based on pre-determined standards, the health plan will be required to respond to what is happening to a member as it happens. DMAS has identified two primary care levels, care coordination, and case management.

Care coordination includes an assessment and baseline care, and the opportunity to reach out to the health plan. This will be available to all members. Care management will be split into three levels

- low intensity
- moderate intensity
- high intensity, which includes an assessment, baseline care, the opportunity to reach out, and increasingly more complex care as the member requires.

This change will allow the care to shift with the member's needs, providing a holistic approach to care.

Mr. Plain stated that members had given feedback regarding changes they would like to see. Under Cardinal Care, high-quality healthcare access will continue, members and providers will not see any disruptions, DMAS will continue to contract with all MCOs, and the current CCC+ and Medallion 4.0 requirements will continue. Mr. Plain indicated that a soft rollout of Cardinal Care was scheduled to start July 1, 2022, but will begin September 1, 2022, for some members, based on a delay in the state budget. The program will fully launch on January 1, 2023, including new ID cards, re-branded documentation, and a shift to the new regional open-enrollment periods.

Medicaid and Brand Perception Survey

Rebecca Dooley – Senior Advisor, Strategic Communications Manager
Gabby Valle – Motivf

Ms. Dooley introduced the Medicaid and Brand Perception survey. Motivf created a digital communications assessment for members, providers, stakeholders, and partners to identify Medicaid branding and recognition. Ms. Dooley introduced Gabby Valle of Motivf.

Ms. Valle shared that this project is to inform DMAS as it works to improve information access and enrollment resources on Virginia Medicaid. She noted that DMAS and Cover Virginia websites were the most recognized in their survey responses and asked MAC members whether that was true for them. Some responses included:

- Craig Thomson indicated that the websites had changed significantly over the past year.
- Sabrina Redd pointed out that people use the website, but they are not easy to navigate.
- L.J. Tisdale noted that he has specific feedback regarding pain management treatment and the prior approval process.
- Michelle Meadows indicated that in her community, the Cover Virginia website would not be easily recognized.
- Craig Thomson specified that if the website is intended to replace the call center, that would be fine, but there should be a guidebook on how to use the often-changing website. It was noted that the website was not intended to replace the call center.

Ms. Valle informed the MAC that responses from the survey regarding challenges included that information from the Cover VA call center was insufficient; there was a digital equity gap, like when a member lacked computer access; the members did not know where to go; members needed assistance; and members could not find information on the websites. Ms. Valle asked members to complete the survey if they had not, and

informed members that there would be dialogues regarding the changes, as appropriate, prior to returning information to DMAS. Finally, Ms. Valle noted that Motivf would reach out to members to join the dialogues and asked that MAC members complete the survey and communicate their contact information to participate in the dialogues.

Questions raised by Committee Members included:

- Olatunji Fakunmoju asked, in response to the care and Cardinal Care model, do the groups have 100 key performance indicators monthly? Is there a score per member after a comprehensive assessment to categorize someone's needs when identifying who does and does not need more care? When the comprehensive assessment is performed, does anyone evaluate soft, non-clinical data like whether someone is receiving adequate care? Is data collected from one level to the other to see what is changing in the member's health status? In changing from predictive modeling to responsive modeling, how do you manage the differences in lack of care or continuity of care? Are there any targeted reports that would proactively enhance care?

Mr. Rachel answered that the 400 to 100 figure is about specific reports that DMAS will receive from the health plans, containing anywhere from one key performance indicator to several. Mr. Rachel stated that the reviews would evaluate formal caregivers and informal caregivers, which varies significantly across individual situations, along with risk and stability regarding to those care levels. The evaluation will include quantifiable data, like medical numbers, and softer data like the informal network of care being provided, creating a full health risk assessment to give the care manager and health plan clarity about the member's situation. The parties can then review these evaluations over time and identify changes as they occur. Certain groups of individuals will enter the care levels based on the assessments, and some groups will be mandatory based on specific health needs, like ventilator use. DMAS hopes to respond to data as available and predict potential changes that could result in higher care needs, allowing increased response and reducing or eliminating gaps in care.

Presentation – Virginia General Assembly Update

Will Frank – Senior Advisor for Legislative Affairs

Mr. Frank informed the MAC that this General Assembly session was interesting and technically not done yet. The General Assembly (GA) timeline started on December 16, 2021, when Governor Northam introduced his final budget. On January 12, 2022, the GA convened, and on January 15, 2022, Governor Youngkin was inaugurated. On February 16, 2022, the bills in the GA crossed over from House to Senate and vice versa, and March 12, 2022, was sine die, the last day of the regular session, which ended without a budget. On April 4, 2022, the GA convened a special session, but nobody had yet agreed on the budget, so the members met, ended the meeting, and left Richmond. On April 27, 2022, there was a veto session, but still, no budget, and on June 1, 2022, the GA came back with a budget, and held a special session to vote on the budget. The budget has since gone to the Governor, who can sign or amend the budget. DMAS is hearing that the Governor will add amendments to the budget, and GA members may return Friday, June 17, 2022, to respond to the budget amendments.

DMAS monitors introduced legislation, reviews the legislation and budget language for Secretary and Governor, and communicates position recommendations to them. DMAS also communicates the Governor's positions to the GA and provides expert testimony and technical assistance to legislators on legislation.
During the GA session, 2633 bills were introduced. DMAS had to evaluate 21 bills, 11 of which are still alive, and the Governor has signed 9 of the 11 (with

2 of the 11 having a fiscal impact and carried over to the special session and were passed). Nine bills failed, and DMAS commented on another 23 bills assigned to other agencies and tracked 82 other bills. Mr. Frank outlined several bills affecting Medicaid, including House Bill (HB) 241 – brought by Delegate Dawn Adams, which requires DMAS to cover durable medical equipment (DME), like chairs, passed and will require a work group. HB680 – provided for targeted case management for individuals with severe traumatic brain injury – passed last week. HB800 – individuals in the custody of correctional facilities must get limited coverage Medicaid. This policy is already in place, but now it is codified in the Virginia Code. HB987 – brought by Delegate Tran, states that program information regarding Medicaid sent to members must expand language access on the documentation. Senate Bill (SB) 426 – requires DMAS to pay for telehealth and remote patient monitoring. SB594 – provides for Medicaid participant payment for opioid treatment and has been passed and signed by the Governor. SB663 – another bill regarding telehealth originating site payment. HB925 and SB405 – regarding medically necessary prosthetic devices. Questions raised by Committee Members included:

Mr. Thomson noted behavioral health advocates are saying they have been told that reimbursed and covered follow-up psychiatric appointments must be in person or on a platform similar to Zoom. Is that correct? In response, Deputy Director Tammy Whitlock stated that it is incorrect as telehealth is very strong in the behavioral health field.

Mr. Fakunmoju asked if there were any outstanding issues that providers are raising that DMAS could compartmentalize and use within DMAS?
Ms. Whitlock answered that the behavioral health providers are not shy to report issues to DMAS. She noted that the workforce shortage is the biggest and most frequent complaint. The increased reimbursement rates, which will be approved in the new budget, should help with some of the issues. The rate increases are monumental and DMAS is grateful to the GA for them.

Presentation – Maternal Health Care Access: DMAS Program Overview and Updates

Hope Richardson – Senior Management Analyst, PRME

Ms. Richardson summarized pregnant and post-partum care changes through FAMIS and FAMIS Moms programs. Pregnant women can obtain Pregnant Woman Medicaid with income up to 143% of the federal poverty level (which is equivalent to $34,085 for a household of three). FAMIS Moms is available to uninsured women with income up to 200% of the federal poverty level (which is equivalent to $47,212 for a household of three). More information is available at https://coverva.org/en/our-programs. Coverage includes prenatal checkups, screening and testing, other general and specialty care, prescriptions, screening and treatment for behavioral health and substance use disorders, dental care, non-emergency transportation to appointments, and breastfeeding and post-partum family planning services. In the future, community doula care will be covered. Doula support services are evidence-based, reduce the use of epidurals and C-sections for delivery, and can increase the incidence of breastfeeding following birth. Pregnant women do not have cost sharing, like copays, for these services. A newborn born to a Medicaid-eligible woman will be Medicaid eligible for the first year of life. Ms. Richardson explained that the six MCOs provide pregnant women care and will continue to do so as Cardinal Care is rolled out. All programs have a risk assessment component to identify members who may have a higher risk for adverse health outcomes and care coordinators to help manage that care. The plans are required to regularly report on their activities and maternal health outcomes. Virginia is the third state to extend Medicaid and FAMIS coverage for a full year postpartum, effective July 1, 2022. During the Public Health Emergency (PHE), most Medicaid members have had continuous coverage since March 2020. Still, the system changes will ensure that

coverage includes FAMIS Moms and lawfully residing immigrant pregnant women. When the PHE ends, the system changes will be in place to ensure the 12-month postpartum continuing coverage is in place for eligible members. The 12-month postpartum coverage is in place even if the member's income or household changes and will be in place regardless of the covered group. Extending postpartum can reduce maternal mortality, which has been increasing nationwide. Disparities resulting in maternal mortality are often based on race and ethnicity. Black women are three times more likely to die than white women postpartum and one and a half times more likely to die during pregnancy than white women. The state will address high-risk and chronic health conditions through this program.
FAMIS Prenatal Coverage is available for individuals who did not have insurance prior to the Medicaid application and primarily for individuals who did not meet immigration status requirements. This program offers prenatal coverage through labor and delivery and 60 days postpartum. FAMIS Prenatal recipients will not receive 12 months of coverage postpartum, as neither the state nor federal government authorized the extra care. The coverage is not restricted to simply prenatal care, members will receive access to the same set of plans and provider networks as FAMIS Moms and Pregnant Women. There are no copays or cost sharing with FAMIS Prenatal.

Virginia will be studying and reporting the impact of the extended coverage to the federal government over the next seven years.

Questions raised by members included:

Ms. Anderson asked to confirm that behavioral healthcare is also available to pregnant women, and Ms. Richardson answered that pregnant women would receive behavioral healthcare.

Mr. Fakunmoju asked if DMAS could ask the MCOs what need they have to evaluate improvement and care disparity, specifically to identify what may have occurred to cause maternal mortality both pre-and post-partum. Ms. Richardson stated that the goal is to enroll members as soon into pregnancy as possible. Research shows that if the mom receives postpartum care, the baby also receives healthcare. DMAS will be looking at age, race, and location disparities to identify what DMAS can do to identify the programs and care for all.

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August 8, 2022 MAC MEETING

Deputy of Administration Hatton greeted the Committee and thanked the Committee for their participation in the virtual MAC meeting. She explained that Acting Director Cheryl Roberts was out, but that she would review the minutes after the meeting. Deputy Hatton thanked everyone for attending both in person and virtually, and indicated that the program would discuss Project Bravo, waivers, and behavioral health.

August 2022 Agenda

Presentation – Waiver 101

Nichole Martin, Director – Office of Community Living

Ms. Martin observed that Home and Community-Based Services (HCBS) waivers are for long-term services and support (LTSS), also known as 1915(c) waivers, and provided within the home and community rather than in an institutional setting. Home and Community-Based Services waivers allow the Medicaid program to waive specific requirements:

- State wideness (though not done in Virginia)
- Comparability of services – make services available to only certain groups of people at risk for institutionalization.
- Income and resources- provide Medicaid to people who would otherwise be eligible only

in an institutional setting, often due to the income and resources of a spouse or parent.

The state must:

- Demonstrate that the waiver will not cost more than providing care in an institution.
- Ensure the state will continue to protect the members' health and welfare.
- Provide adequate and reasonable provider standards to meet the needs of the population.
- Make sure that the services follow an individualized and person-centered standard of care.

To be eligible for a waiver, the individual must be Medicaid eligible, and meet the criteria for institutional level of care.

The Commonwealth Coordinated Care Plus (CCC+) Waiver serves all ages and does not have a waiting list; it is the most extensive waiver in Virginia and provides care in the home and community rather than in a nursing facility or other specialized medical care facility. Personal care, private nursing, respite, assistive technology and environmental modifications, and adult day care services are available through CCC+. The individual recipient must have a medical need for waiver services, and the medical need must meet the institutional level of care. CCC+ eligibility criteria: Individuals must need a nursing facility, specialized care, or long-stay hospital visit.

While evaluating medical needs, medical professionals use the Uniform assessment instrument (UAI) to assess the individual's functional capacity, like activities of daily living, medical or nursing needs, and imminent risk of placement.

Individuals can access waivers through their local Department of Social Services or Health Department when living in the community. While in the hospital, individuals can obtain screening through the hospital Social Worker or Discharge Planner. The screening team will screen the individual, discuss the type of care needed and available, and give a list of providers for the individual to contact and begin care.

Developmental Disabilities (DD) Waivers include three sub-category waivers, and there is currently a waitlist to obtain these waivers. DD Waivers provide employment and alternate day options, self-directed, residential, crisis support, medical and behavioral support, and additional options for recipients.

- The Building Independence Waiver currently serves 330 individuals and is available for adults aged 18 and older living independently in their homes or apartment. Often these individuals receive non-waiver-funded rent subsidies.
- The Family and Individual Support Waiver serves about 4400 individuals with medical needs who live with family or friends. There are no age limits for the Family and Individual Support Waiver.
- The Community Living Waiver serves about 11,700 individuals and includes residential support and medical, behavioral, and non-medical support. The Community Living Waiver is also available to individuals of any age.

To access DD waivers, all members must start through the Community Services Board (CSB), and meet eligibility criteria, including developmental disability diagnosis and the level of care evaluated by the Virginia Individual Developmental Disability Survey (VIDES). Individuals must accept services within 30 days of offering and be Medicaid eligible. If individuals meet these criteria, they go on a single waitlist that serves each of the three sub-categories.

As of June 24, 2022, the waitlist had 2,910 individuals in Priority I, who are projected to need services within a year. Priority II individuals should

need services within 1-5 years, and there are 6,004 people on that list. Priority III individuals will need services for more than five years, and 4,912 individuals are in this group. The DMAS website has web pages for waiver information, and CCCPlusWaiver@dmas.virginia.gov is available for specific questions.

Questions presented by members included:

Ms. Anderson asked if waivers included foster children, and Ms. Martin stated that it depends on the foster child's needs. She also sought to confirm which program did not have a waitlist, and Ms. Martin answered that only CCC+ does not have a waitlist. Ms. Anderson inquired if the severity of the diagnosis helps move someone up the waiting list, and Ms. Martin indicated that was correct.

Mr. Thomson noted that this presentation is helpful, in representing the unhoused population who had to receive therapy, including shock therapy, to understand the care they could receive upon discharge from the temporary therapy. He indicated that the wrap-around care options assisted individuals with care needs, including coexisting intellectual disability and substance use disorder diagnoses.

Mr. Fakunmoju requested information about the level of compliance for care and care coordination. How do you provide the community with the level of services needed within the community? Could the state help these individuals get placement in facilities while waiting for their position in the waiting list? Ms. Martin responded that the UAI scoring is a portion of the evaluation. When a slot becomes available, the CSB provides it to a person within their community according to highest need. Currently 16,000 slots are funded. DMAS must provide assurances to Centers for Medicare and Medicaid Services (CMS) regarding the care provided.

Ms. Redd indicated that families in crisis in hospital services do not know how to access waiver services. Ms. Redd noted that her experience, though several years old, indicated a lack of knowledge from stakeholders that waivers exist, or even how to become eligible for waiver services. Families do not understand what it means to have nursing home level care needs, and Ms. Redd encourages DMAS to get information into communities about actual eligibility criteria, as well as information about how to get onto the waitlist or receive services.

Presentation – Behavioral Health Update: Project Bravo

Dr. Alyssa Ward, Clinical Director – Behavioral Health

Dr. Ward stated that, at DMAS, behavioral health used to cover only mental health, until DMAS added addiction treatment. Mental health is now referred to as "Project Bravo," (Behavioral Health Redesign for Access Value & Outcomes). See https://www.dmas.virginia.gov/for-members/benefits-andservices/behavioral-health/. The Behavioral Health division hopes to bring the two parts together for whole-person care. Behavioral Health supports other decisions by interpreting and applying Medicaid policy, and by interacting with most divisions within DMAS as well as recipients and stakeholders. Magellan of Virginia helps the division to manage residential services, and the division oversees Magellan of Virginia for service authorizations and claims payments for fee-for-service recipients. The division writes policy, updates existing policy, manages state law and incorporates it into Medicaid policy.

DMAS is the largest payer of behavioral health services in Virginia and about one-third of members receive behavioral health services. The nature of DMAS federal funding means that we also must define and rationalize the services we pay for and how we pay for them in our state plan. Because of our sphere of influence as a payor, we work on

nearly any implementation involving Behavioral Health services that happens in the system. We are always advocating for the needs of our members within the larger system, as well as simplification and ease of access in our complex system of care. Licensed health professionals are the only mental healthcare providers who can receive payment for care under most private health insurance providers. DMAS will pay qualified health professionals for some care.

When COVID occurred, technological utilization and enhancements allowed DMAS to increase care for individuals in many ways, including rolling out telehealth, including audio-only care, and YouTube videos. Providers indicated that telehealth increased care, attendance, and engagement for recipients. The division wants to increase dedicated telehealth spaces, expand telehealth, and improve telehealth opportunities as people leave their homes post-COVID.

Project Bravo, which began in 2018, aims to provide holistic care outside of Community Services Boards and make sure it is financially sustainable. High Fidelity Wraparound is high-intensity care coordination serving a youth with highest needs. Virginia has been paying for High Fidelity Wraparound through a grant and CSAs, but there is no billing process through Medicaid. Bravo intends to create a Medicaid rate to increase providers and ensure payment is available for recipients. Bravo should allow individuals to receive the level of care, and shift between different levels of care, that was not available in previous Medicaid models.

Bravo has introduced assertive community treatment, which is a team-based, approve for high-level care in the community; intensive outpatient care; partial hospitalization; and comprehensive crisis services. Comprehensive crisis services includes four levels:

- Someone to talk to, like 988 (crisis lifeline), for which DMAS does not pay
- Someone to respond, like a mobile crisis response teams
- Community stabilization, also called a warm handoff, meaning the first provider shakes hands with the next provider for the individual recipient and
- Somewhere to stay, providing contained environments for 23 hours to give someone a place to re-center without entering or prior to entering residential treatment. Assertive community treatment also includes multi-systemic therapy and functional family therapy.

DMAS is experiencing the same workforce concerns that most industries have, where professionals are leaving positions. The future goals include service-learning collaborative projects to learn how things are working and to learn what members and providers need. It would also seek to build out the crisis system, which is the safety net to the safety net for needs; identify metrics and evaluation; and request budget increases to expand services for members. Ongoing programs include Project Bravo; Marcus Alert to remove police presence to crisis response whenever possible; the bed crisis, which has been ongoing for a decade, but increasing during COVID; 988, similar to 911, but for mental health, which is available with or without insurance; (System Transformation Excellence and Performance) Step-VA; and the Department Of Justice Settlement regarding DD services.

With a similar program, Arizona saw about 80% of crises were resolved via phone, and about 70% of mobile responses were resolved in the community. This led to few people resorting to hospitalization. Virginia has seen similar numbers. Objective: The development of a community-based, trauma-informed, recovery-oriented crisis system that responds to crises where they occur and prevent out-of-home placements. Dr. Ward hopes that Behavioral Health Urgent Care becomes a regular service option in the future.

Observations / Questions raised by Committee Members included:

Mr. Thomson, noting the impact upon members, shared that he is aware of medical providers who provide diagnostic testing to individuals, but then the providers do not provide written reports of the testing. He feels this is because there is no recourse for the medical provider not providing those reports. Response – individually, those professionals can be reported to the Department of Health Professions for failing to provide those written reports.

Mr. Fakunmoju indicated that some providers, especially psychologists, would only provide reports to other medical professionals. Dr. Ward agreed that some providers would write a raw data report that remains in the file, but also write a plain language report to provide to the families.

Mr. Thomson indicated that families would have to obtain the raw data and provide it to another provider to clarify the data for the initial provider. Dr. Ward indicated that the plain-English written reports are an expectation for payment and indicated that it is a concerning case and asked to speak to Mr. Thompson more about it after the MAC. Mr. Thompson stated that providers prefer Magellan because they feel they receive higher pay with fee for-service model rather than the Managed Care Organization model. Dr. Ward noted that MCO contracts pay fee-for-service rates as a minimum, and she would like to know more information about that preference.

Ghadah Aljamali stated that Project Bravo is a great program, but asked where holistic care providers and supplements fit into Project Bravo, because DMAS will not pay for that care. Dr. Ward indicated that Medicaid care continues to expand.

Ms. Anderson asked whether individuals receive continued care from DMAS during COVID, and then asked whether those individuals will receive assistance to obtain healthcare on their own. Response – not all of the closures will be bad, as some people will be able to afford healthcare. However, the unwinding will take about a year, and all individuals will have the opportunity to provide information to DMAS about their situation prior to any Medicaid closures.

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December 12, 2022 MAC MEETING

Director Roberts greeted the Committee members and thanked them for participating in the MAC meeting. She indicated that there are currently open enrollment periods for Medicare, the Federal Health Insurance Marketplace, and Managed Care Organizations (MCO). Members can decide to stay with the current MCO or leave the MCO for a new MCO.

Director Roberts urged members to view the comparison chart to determine if their doctors are in the network, and to evaluate whether there are additional care options that the member desires. Director Roberts hoped all members make an affirmative choice regarding their MCO.

December 2022 Agenda

Presentation – MAC Public Meeting Rules Update

Natalie Pennywell – Outreach and Community Engagement Manager, PRME, Administration

Ms. Pennywell explained that DMAS provided updated guidance for remote attendance for meetings. The guidance requires that the Agency indicate standards for fully remote meetings, when individuals may appear remotely, and asks that members follow procedures. If members intend to attend only virtually, they must indicate which

criteria in Va. Code §2.2-3708.3, D, 1-4, they are relying on to attend virtually.

The members unanimously voted to adopt the policy regarding virtual meetings.

Presentation – Public Health Emergency (PHE) Updates

Sarah Hatton – MHSA, Deputy of Administration, Director's Office
Jessica Annecchini – Senior Policy Advisor, Administration
Natalie Pennywell – Outreach and Community Engagement Manager, PRME, Administration

Deputy Hatton noted that nearly 2.2 million Virginians are enrolled in Medicaid. Due to the COVID-19 protections under the Public Health Emergency (PHE), more members have coverage than would typically be covered. DMAS expects the PHE to extend in January 2023, extending additional coverage until mid-April 2023. If the PHE ends in April 2023, DMAS will begin reevaluating all member eligibility in May 2023. Until the PHE ends, DMAS will receive a 6.2% match from the federal government to help cover the costs of additional member coverage. DMAS expects approximately 14%, or 300,000 members, to lose health coverage when the PHE ends. Deputy Hatton indicated she hoped many of individuals who lost their jobs at the start of COVID had gotten their jobs back since then, or others who will lose coverage because their income has increased over time. Approximately 4% of the population will lose coverage due to administrative issues, like DMAS being unable to identify their location, members not completing renewals timely, or members did not return verifications on time.

Deputy Hatton noted that DMAS has been preparing for COVID and the PHE to end since September 2020, and has been updating plans since then. She indicated that DMAS works with MCOs to improve member data and preparedness. Currently, DMAS is pushing members to update mailing addresses and communication preferences. MCOs will then help with outreach to encourage members to complete redeterminations when that becomes appropriate. Finally, MCOs will work with members to transition them to other coverage if they do not retain Medicaid eligibility.

In the first 60 days before the PHE ends, DMAS intends to post notifications about the coming end of the PHE. DMAS will host Medicaid Ambassador workgroups, a very large, virtual PHE Unwinding Summit, and participate in monthly calls preparing for the end of the PHE. DMAS intends to release a toolkit regarding these communications, as well. Deputy Hatton asked members to indicate interest in participating in the Medicaid Ambassador program.

Ms. Pennywell introduced the Unwinding Toolkits. If the 60-day notice regarding the PHE comes in January, DMAS will encourage updated addresses. Phase II will follow that notice, DMAS will encourage members to complete paperwork, and the campaign is expected to continue from February 2023 to January 2024. Phase III will encourage members who lose coverage for administrative reasons to complete the necessary paperwork and to assist those who lose coverage due to eligibility reasons to obtain other health coverage. DMAS is working with community programs and organizations to share this information.

The DMAS website will include flowcharts and additional toolkit information to assist members in renewing their Medicaid eligibility upon the end of the PHE. These documents will be specifically targeted for particular populations to ensure the processes described match the processes those members will follow. All documents will be available via paper or digital so members can access and share them.

Observations / Questions raised by Committee Members included:

Unhoused members who do not have fixed addresses struggle during the renewal period, as it is challenging to locate them, and because they or the local Department of Social Services (DSS) may lose all identifying information. There has been significant difficulty obtaining electronic communications for unhoused members, but non-profits are increasing computer access. Digital access could decrease administrative terminations.

The Anthem MCO document indicates an eye exam every 24 months on one page, and every 12 months on the other. The DMAS staff identified that the two coverage options are under different care types.

Deputy Hatton acknowledged the comments and indicated it could be helpful to have the Department of Social Services, and local agency representatives at future MAC meetings. She stated that there is a known training need for local workers, especially since some have never completed renewals, and none have completed renewals in the past three years.

Members indicated that it would be great to hear from a DSS representative and would be interested in learning how local DSS agencies could align their processes with DMAS, as there seems to be a disconnect and a need for consumer understanding.

Deputy Hatton noted that a large population of members prefers electronic communications, and that she intends to encourage DSS to increase its electronic communications when a member chooses to receive documents electronically. Ms. Pennywell thanked everyone for their comments and introduced Ms. Cariano.

Presentation – Federal Marketplace and Future State-Based Exchange

Sara Cariano – Senior Health Policy Analyst, Virginia Poverty Law Center (VPLC)

Ms. Cariano thanked members for participating in the MAC and identified her interest in the upcoming state-based exchange. In 2022, Virginia used the Federally Facilitated Marketplace (Marketplace) for healthcare plan purchases, created because of the Affordable Care Act (ACA). In 2023, Virginia will transition to a state-based exchange. Either marketplace intends to explain the types of coverage in plain language, to prevent denial for pre-existing conditions, and to allow people to shop for plans without obligation to purchase.

Individuals must reside in the state where they purchase coverage, be a US citizen or national, or lawfully present non-citizen. To get financial assistance, you may not have access to affordable and adequate insurance, like Medicaid, Medicare, and employer-based coverage. Individuals must have income above 100% of federal poverty guidelines. If someone has an income between 100% - 250% of the federal poverty level, they can qualify for additional financial assistance.

Financial assistance is based on Modified Adjusted Gross Income (MAGI) income evaluation. Affordable Care Act (ACA) plans to use tax filing household principles. The plan projects income for the year, and recipients must file taxes at the end to reconcile the household taxes to determine whether the individual received appropriate assistance

based on projected income. The Inflation Reduction Act enhanced subsidies through 2025. Open enrollment for the exchange is from November 1 through January 15, but individuals must apply by December 15 to have coverage by January 1. Special enrollment periods begin when individuals lose coverage, including Medicaid, move permanently to a new location, change immigration status, get married, have a child, and others.

In 2023, the plan eliminates the “family glitch,” which occurred if the plan was affordable for just the employee from their employer, the rest of the family could not qualify for marketplace coverage and subsidies. This arose in small companies where

the employer-subsidized the employee's healthcare costs, but not other family members.

The PHE is expected to end, shifting Medicaid members to Marketplace coverage upon renewal and termination due to eligibility. Even if a member knows they are ineligible for Medicaid, completing a renewal will help referrals to the Marketplace. Ms. Cariano introduced Enroll Virginia, the education and assistance program for which she works. The program can assist individuals in applying for coverage and enrollment. Enroll Virginia is willing to present to churches and social groups about healthcare enrollment.

Questions raised by Committee Members included:

How can DMAS and Enroll Virginia assist transitions for aged, blind, and disabled recipients, especially those receiving Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI), who could lose additional benefits being paid by the state? Individuals transitioning from supportive housing to housing vouchers could use the increased cost of Medicare premiums upon losing Medicaid coverage as an income deduction, allowing them to qualify for housing assistance.

Observations / Questions raised by Committee Members included:

Craig Thomson indicated the value of Medicaid expansion, which allows someone to transition from homelessness to supportive housing to a federal voucher program. He stated that the assistance eliminates permanent homelessness. The Marketplace requirements were burdensome to those transitioning and unhoused individuals, as they were required only to receive care from a traveling nurse practitioner. Medicaid expansion allows individuals to transition to more permanent housing while receiving significantly improved healthcare.

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To learn more about the 2022 MAC, including accessing presentations, reference documents, and other information, please visit:

https://www.dmas.virginia.gov/for-members/member-advisory-committee/2022-mac-meetings/

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DMAS thanks Governor Glenn Youngkin, Secretary John Little and the leadership and staff at HHR, Director Cheryl Roberts and the leadership and staff of DMAS, Commissioner Dr. Danny Avula, and the leadership and staff at the Virginia Department of Social Services, and our many state and local partners. Many thanks are given to the MAC staff liaisons, Walter Burton, Dorothy "Dot" Swann and Dalia Tejada Halter for their work with Natalie Pennywell, Outreach and Community Engagement Manager and Sarah Hatton, Deputy of Administration to ensure the Medicaid MAC has what it needs to thrive. Special thanks are given to the members of the MAC who have given their valuable time, work, and articulation of their life experiences in order to be a part of the effort to improve Virginia's Medicaid program.

VIRGINIA'S MEDICAID PROGRAM

DMAS

Improving the health and well-being of Virginians through access to high quality health care coverage