



Children's Health
Insurance Program
Advisory Committee
of Virginia



MEETING MINUTES

Meeting Minutes
March 4, 2021
1:00-3:30 pm

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

The following CHIPAC members were present:

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| • Denise Daly Konrad | Virginia Health Care Foundation |
| • Michael Cook | Board of Medical Assistance Services |
| • Sara Cariano | Virginia Poverty Law Center |
| • Freddy Mejia | The Commonwealth Institute for Fiscal Analysis |
| • Shelby Gonzales | Center on Budget and Policy Priorities |
| • Quyen Duong | Virginia Department of Education |
| • Michael Muse | Virginia League of Social Services Executives |
| • Dr. Nathan Webb | Medical Society of Virginia |
| • Lanette Walker | Virginia Hospital and Healthcare Association |
| • Dr. Tegwyn Brickhouse | VCU Health |
| • Bern’Nadette Knight | Department of Behavioral Health and
Developmental Services |
| • Jeff Lunardi | Joint Commission on Health Care |
| • Ali Faruk | Families Forward Virginia |
| • Christine McCormick | Virginia Association of Health Plans |
| • Irma Blackwell | Virginia Department of Social Services |
| • Jennifer Macdonald | Virginia Department of Health |

The following CHIPAC members sent substitutes:

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| • Victor James sent Dr. Suzanne Brixey | Virginia Chapter of the American Academy of
Pediatrics |
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The following new CHIPAC members were confirmed at the meeting:

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| • Tracy Douglas-Wheeler | Virginia Community Healthcare Association |
| • Emily Griffey | Voices for Virginia’s Children |

Meeting Minutes

Welcome

Denise Daly Konrad, CHIPAC Chair, called the meeting to order at 1:02 pm. Konrad welcomed Committee members and members of the public, gave a brief overview of the electronic meeting format and procedures, and informed the attendees that the meeting was being held virtually due to the ongoing COVID-19 public health emergency. Attendance was taken by roll call.

I. CHIPAC Business

- A. Review and Approval of Minutes** – Minutes from the December 3, 2020 quarterly meeting were reviewed. Dr. Nathan Webb, Medical Society of Virginia, made a motion to approve the minutes, Sara Cariano, Virginia Poverty Law Center, seconded, and the Committee voted unanimously to approve.
- B. Approval of New December Meeting Date** – Konrad directed members to the revised 2021 meeting schedule with the December meeting date changed to December 9, 2021, from 1:00-4:30 p.m. Sara Cariano moved to approve the date change, Dr. Webb seconded, and the Committee voted unanimously to approve the new date.
- C. Membership Update** – Konrad gave an update on committee membership. She informed the Committee that several new members were joining or nominated to join the Committee due to staff transitions within member organizations. Konrad announced that two statutory member organizations have appointed new members: Jennifer Macdonald will represent the Virginia Department of Health and Irma Blackwell will represent the Virginia Department of Social Services. In addition, two candidates for membership were presented to the Committee: Tracy Douglas-Wheeler of Virginia Community Healthcare Association and Emily Griffey of Voices for Virginia’s Children. A vote was held on the Executive Subcommittee’s recommendation to approve the two candidates for membership. Sara Cariano moved to approve, and Dr. Webb seconded. Both new members were approved unanimously by the Committee.
- D. CHIPAC Orientation** – A brief orientation was provided for new CHIPAC members outlining the Committee’s history, charge, member organizations, meeting content, and member responsibilities.

Hope Richardson, Department of Medical Assistance Services, gave an overview of CHIPAC’s history and charge. She explained that two similar entities – Virginia Coalition for Children’s Health and the Outreach Oversight Committee – preceded CHIPAC and performed similar roles dating back to the beginning of the Children’s Health Insurance Program in 1997. After the passage of federal legislation establishing CHIP, a coalition was formed called the Virginia Coalition for Children’s Health. This organization worked to help establish Virginia’s S-CHIP program, originally called CMSIP (Children’s Medical Security Insurance Plan). Consistent with the federal legislation establishing CHIP, CMSIP provided coverage for uninsured Virginia children in low-income working families whose incomes were too high for their children to qualify for Medicaid but too low to afford commercial health insurance. The Coalition also launched the *SignUpNow* statewide outreach initiative to help encourage families to enroll their children after passage of the state legislation.

Richardson explained that in 2000, CMSIP became FAMIS, Family Access to Medical Insurance Security, as it is known today, and in the state legislation establishing FAMIS, the General Assembly provided that DMAS was to maintain an Outreach Oversight Committee.

The Outreach Oversight Committee was composed of representatives from community organizations doing outreach, as well as social services eligibility workers, providers, health plans, and consumers. Later, in the 2004 General Assembly session, new legislation established the CHIPAC to replace the Outreach Oversight Committee. At that time, the scope of the Committee was broadened. The Outreach Oversight Committee was primarily tasked with recommending strategies to improve outreach activities and streamline the application process, but CHIPAC's charge also extends to an advisory role on policies and operations, and with oversight of children's Medicaid (FAMIS Plus) as well as FAMIS.

Richardson stated that CHIPAC's charge in the *Code of Virginia* is to assess the policies, operations, and outreach efforts of FAMIS and FAMIS Plus, as well as to evaluate enrollment, utilization of services, and health outcomes of children eligible for the programs. She explained that the Committee makes recommendations on these topics to the DMAS Director and the Secretary of Health and Human Resources.

Konrad provided an overview of the composition of the Committee and what to expect as a CHIPAC member. She stated that in Code, required member entities are the Joint Commission on Health Care, Department of Social Services (VDSS), Virginia Department of Health (VDH), Department of Education (VDOE), Department of Behavioral Health and Developmental Services (DBHDS), and the Virginia Health Care Foundation. Other members, up to a maximum of 20, shall include "various provider associations and children's advocacy groups, and other individuals with significant knowledge and interest in children's health insurance."

Konrad explained that CHIPAC's mission is to advise the DMAS Director and Secretary on ways to optimize the efficiency and effectiveness of DMAS' children's programs. She stated that the Committee strives to make timely, actionable recommendations, and works with DMAS to ensure meeting content is geared towards providing the Committee the opportunity to help shape the agency's decision-making.

Konrad informed the Committee that attendance at quarterly CHIPAC meetings is required for members. If unable to attend, members should designate a substitute and notify DMAS staff with that person's contact information.

Richardson provided a brief overview of the entities involved in applications processing, eligibility and enrollment functions, a frequent subject of discussion at CHIPAC meetings. She explained that DMAS, as the "single state agency" under federal law, is designated to administer Virginia's Medicaid and CHIP programs. DMAS oversees implementation of Medicaid and CHIP policy at the state level. The agency submits state plan amendments and coordinates with the federal Centers for Medicare and Medicaid Services. DMAS also has the role of conducting fair hearings and appeals of denials of eligibility.

Richardson stated that DMAS delegates authority to the Virginia Department of Social Services to supervise 120 local social services agencies in performing eligibility determinations. In that role, DSS and local agencies are responsible for initial determinations of eligibility, as well as ongoing case maintenance and annual redeterminations of eligibility. DSS is responsible for notifying DMAS and the applicant or member of the initial eligibility decision and any changes in eligibility status. DSS also administers all other public benefit programs directly.

Finally, Richardson stated that DMAS oversees the Cover Virginia website, Call Center, Eligibility Central Processing Unit (CPU) and Incarcerated Unit, which are operated by a contractor. Cover Virginia processes Medicaid and FAMIS eligibility determinations through its CPU and inputs telephonic applications, renewals, and status inquiries through the Call Center. The Cover Virginia CPU also receives all CommonHelp (online) applications for the state and applications referred from the Federally Facilitated Marketplace.

II. CHIPAC-DMAS Collaboration: 12-Months Postpartum Coverage Waiver Amendment and Public Comment

Konrad explained that the Committee would be hosting a presentation and public comment on Virginia's proposed amendment to the FAMIS MOMS CHIP 1115 waiver to extend pregnancy coverage from 60 days to 12 months postpartum. She stated that the presentation and opportunity for discussion by the committee and the public are part of the Committee's efforts to work with DMAS to develop timely and actionable meeting content for the quarterly CHIPAC meetings.

Richardson presented on the proposed Demonstration amendment. She provided background on the legislative and executive actions that led to the policy mandate, stating that the Governor's Introduced Budget for the 2020 Session initially directed DMAS to seek federal authority to extend coverage to twelve months postpartum for certain pregnant women who currently do not qualify to transition to other Medicaid coverage after their 60 day postpartum period ends. Richardson explained that funding for this coverage extension was included in the 2020 Appropriation Act but was later "un-allotted" in April 2020 due to uncertainty with the onset of the COVID-19 emergency. Funds then were "re-allotted" by the General Assembly during the 2020 Special Session, and this revised budget was signed by the Governor November 18, 2020, with a new effective date of April 1, 2021, or upon federal approval.

Richardson explained that the next step is to secure federal approval for Virginia to implement this change. She stated that DMAS had developed a draft application to amend Virginia's FAMIS MOMS/CHIP Section 1115 waiver, and the application was available to the public on the DMAS website at the following web address: <https://www.dmas.virginia.gov/#/hifawaiver>. Richardson stated that the public comment period for the waiver amendment began February 19 and would continue through March 22, and provided information on how to submit comments. She stated that the public comment forum after the presentation would also be an opportunity for individuals to provide comments. She stated that at the conclusion of the public comment period, DMAS would review, summarize, and respond to comments in an addendum to the waiver application, incorporate any changes based on public input, and then submit the final application to the federal Centers for Medicare and Medicaid Services. She explained that once CMS receives Virginia's application, they will also hold a federal public comment period.

Richardson provided an overview of the waiver amendment provisions. She stated that under the Demonstration, the individual will remain continuously enrolled until 12 months after the delivery date. Under the existing waiver, FAMIS MOMS benefits are aligned with those provided to pregnant women under the Medicaid state plan, with no cost sharing, and that will continue to be the case. Richardson explained that DMAS believes the additional postpartum coverage will improve continuity and access to care during the critical postpartum period, which will help Virginia meet the three main goals identified for the Demonstration. Those goals are: to reduce maternal and infant mortality and morbidity, improve health outcomes for postpartum Medicaid and CHIP enrollees and their infants, and advance health equity by reducing racial and ethnic disparities in maternal mortality and morbidity and in children's health outcomes.

Richardson explained that in 2019, Governor Northam announced a goal to eliminate racial disparities in the state's maternal mortality rate by 2025 and codified the Maternal Mortality Review Team through state legislation. She stated that those initiatives were motivated by an increasing recognition of alarmingly high rates of maternal mortality and severe morbidity, particularly for Black women.

Richardson stated that Virginia's data on racial disparities in maternal mortality and morbidity reflects the nationwide trend, with Black women more than twice as likely to have a pregnancy-related death than white women. She explained that Virginia's Maternal Mortality Review Team has found that there are significant differences by race in the manner of death, with Black women more often dying of natural causes. Additionally, data from the Review Team suggest that the majority of pregnancy-associated deaths in the Commonwealth occur more than 43 days after pregnancy ends, with over 62 percent of these deaths occurring between 43 and 365 days after the pregnancy ended. Richardson explained that the Review Team also found that lack of care coordination and incomplete health care coverage before and after pregnancy contributed to maternal mortality in Virginia. The Review Team found that 45 percent of women who died with a chronic condition during the 2009-2013 time period analyzed (prior to Virginia's Medicaid Expansion) had public insurance that only provided coverage during pregnancy and the six weeks postpartum.

Richardson stated that now that Virginia has implemented Medicaid expansion, more enrollees than ever have coverage before becoming pregnant, postpartum, and between pregnancies. The proposed waiver amendment is aimed at closing a remaining coverage gap that exists for those who are not eligible to transition into the new adult coverage at the end of their 60 days postpartum. Richardson summarized some of the benefits of continuous postpartum coverage. By remaining enrolled in their health plan for a full year postpartum, an enrollee is able to continue to see a trusted provider that they may have seen during their pregnancy. There is an increased opportunity for care coordination and follow-up care to treat any health conditions that may have been identified during pregnancy and birth. Extended postpartum care also enables better screening and identification of high-risk conditions and appropriate referrals and ongoing care to treat those conditions.

Richardson explained that program participants will have greater extended access to new proposed and planned benefits such as home visiting and access to the full continuum of care under the ARTS program for FAMIS MOMS with substance use disorders. She stated that DMAS believes this increased access will also benefit newborns and infants because there will be opportunities for dyadic care, such as extended lactation support. Research indicates that children's access and utilization of care improves when a parent has coverage, so DMAS hopes to improve infants' access to preventive care, vaccinations, developmental screenings, and other needed care. Richardson stated that DMAS is also continuing to build on the coverage already available by coordinating other important initiatives such as expediting enrollment of pregnant women into managed care, improving newborn enrollment processes, ensuring continued coverage for eligible individuals, and making the transition to the Medicaid expansion group or other coverage group as seamless as possible postpartum.

Richardson explained that the current waiver's outcome measures include adequacy of prenatal care as well as birth outcomes such as low birthweight and preterm births. With the waiver amendment, Virginia proposes to expand the evaluation to include new research questions. The three central research questions proposed are whether 12-months postpartum coverage will (1) reduce maternal and infant mortality and morbidity, (2) improve health outcomes for mother and infant, and (3) advance health equity.

Freddy Mejia, The Commonwealth Institute, asked whether the waiver's postpartum coverage would include women newly eligible for prenatal care under the recently passed state budget provision to offer prenatal coverage to women otherwise ineligible due to citizenship/immigration status. Richardson responded that the waiver application would not include this population at this time due to the timing of the change; the federal application will be submitted before the Governor signs the budget to provide state authority to create this new coverage group.

Sara Cariano, Virginia Poverty Law Center, stated that in the Budget Reconciliation package currently being considered at the federal level, there is a proposed provision that would give states the option to extend coverage to 12 months postpartum via a state plan amendment. She asked how this provision, if passed, would affect the state's waiver amendment application and if it might disrupt the process of applying for this authority through an 1115 waiver. Richardson explained that DMAS will be working closely with CMS throughout the process and at this time the agency believes that continuing with the waiver amendment application submission will give Virginia options moving forward, toward the goal of enabling extended postpartum coverage for as many women as possible through the appropriate federal and state authorities.

Konrad asked whether it might be possible to later include in the waiver the women newly eligible for prenatal care that Mejia had referenced in his question, and what that process might look like. Richardson explained that to date, the federal government has strictly limited federal funding to extend coverage beyond the birth for this population. In most cases, postpartum coverage has been limited to obstetrical services only, as included in a bundled payment. Some states have provided postpartum care using state funds and, in two instances, states have set up a CHIP Health Services Initiative to enable federal match for postpartum care to align the benefit with that offered to Medicaid and CHIP pregnant women through 60 days postpartum. However, there is no precedent for federal match beyond 60 days postpartum for this coverage group, and available guidance and signals from CMS currently indicate additional flexibility would be unlikely at this time.

Tracy Douglas-Wheeler asked whether the 12 months postpartum coverage would be only on the OB-Gyn side or if it would include safety net providers. Karen Kimsey, DMAS Director, responded that the coverage is a full benefit, not limited to obstetrical coverage. Richardson stated that while currently, women between 148 and 205% FPL are eligible for a limited family planning benefit through the Plan First program, with the waiver amendment, coverage would be comprehensive and would be the same coverage as provided to Medicaid pregnant women and FAMIS MOMS during their pregnancies.

Jeff Lunardi, Joint Commission on Health Care, stated that the General Assembly members on the Commission have been very focused on the disparities in maternal-child health, and that the waiver amendment also touches upon issues of affordability for members above eligibility for Medicaid but still low-income. He asked if DMAS has information about where these individuals are currently falling, and whether they are typically uninsured, or if they are on the Marketplace, but due to out of pocket expenses forgoing care and not able to access needed services. Richardson stated that DMAS currently only has information on the individuals who are enrolled in the family planning benefit, and that until very recently, before Virginia's Medicaid expansion, most women did not qualify for continuing coverage after 60 days postpartum, except for very low-income parents who qualified for the Low-Income Families with Children benefit. Richardson explained that individuals in the Plan First family planning program do qualify for other coverage since it is a limited benefit, but that the agency does not have data on other coverage they may be enrolled in. She explained that FAMIS MOMS is a

relatively small program, likely because many women in that income range do have access to other coverage options, including subsidies on the Exchange. Cariano provided context based on experience coordinating Navigation programs. She stated that currently when postpartum individuals have a qualifying event due to their FAMIS MOMS coverage ending and become eligible for Marketplace coverage, that the file transfer is sent to the Marketplace, but that it is a fairly complex process, especially because these women are two months postpartum. She stated that the process is especially confusing when it comes to family coverage and for individuals who are eligible for pregnancy coverage due to being in “lawfully residing” immigrant status but are not eligible to transition to Medicaid expansion postpartum because they do not meet the stricter immigration requirements that exist outside of pregnancy. She stated that those individuals can now go to the Marketplace but there are additional barriers such as sometimes a need for language assistance. Cariano stated that for these reasons, she supported the inclusion of the lawfully residing immigrant group in the waiver amendment application. Cariano stated that this is also an area where it will be helpful as Virginia moves to a state-based exchange, because with a more integrated system we will be able to get more granular data.

Konrad read a question in the Chat asking how many members would be affected by the extension of coverage (how many estimated women in FAMIS MOMS would be eligible)? Richardson stated that several thousand women would be impacted, and that additional detail on enrollment numbers is in the waiver amendment application. Konrad stated that in the children and pregnant women’s programs, many more individuals between 0-138% FPL are enrolled than between 138 and 200% FPL. She stated that even more individuals are enrolled between 0 and 100% FPL than between 100 and 138% FPL; the medical assistance programs’ enrollment is concentrated in the very low income category.

Konrad asked about the evaluation hypotheses slide. She stated that there seemed to be hypotheses to track health outcomes for children but not specifically to track mothers’ health outcomes. She asked whether this is because mothers’ outcomes are implied in the disparities measure or in the morbidity measure. Richardson stated that in row 1 of the table, the hypothesis “Extending postpartum coverage to 12 months in Medicaid and CHIP will reduce disparities and advance health equity for postpartum women and their infants,” would involve an examination of maternal health outcomes data.

Public Comment

Stephanie Spencer, Director of Urban Baby Beginnings, asked about the estimated proportion of enrollees who are people of color who would be eligible for the postpartum extension, in order to understand the impact from a race and ethnicity perspective. Richardson cited that based upon data from the annual Birth Outcomes Study, approximately 31% of the FAMIS MOMS population were Black, 43% white, and approximately 15% Hispanic in the most recent year. She stated that the race/ethnicity percentages vary from year to year and stated that DMAS can follow up with additional detail. Spencer stated that she appreciated the work that is being done to expand postpartum coverage. She stated that the organization often sees in the community that they are trying to get people connected with services with practitioners and often individuals have to go to free clinics because they don’t qualify for Medicaid or FAMIS MOMS, so having this additional coverage will be very beneficial for this population. Karen Kimsey, DMAS Director, stated that many states are also looking into ways to extend this coverage and there is excitement nationwide about possibilities for providing more robust postpartum coverage.

Konrad read the following comment posted in the Chat from Emily Eckert, policy manager at the American College of Obstetricians and Gynecologists (ACOG) and resident of Alexandria, VA: “ACOG fully supports state efforts to extend postpartum coverage. The Virginia Section of the American College of Obstetricians and Gynecologists will be submitting detailed written comments in support of this waiver proposal. Thank you for your work!”

Emily Griffey, Voices for Virginia’s Children, asked if more information could be provided to help people understand when the benefits would be coming online. She asked, now that there are two changes, dealing with prenatal coverage and extension of postpartum coverage, whether it would be possible to go through a timeline of when the coverage might become available. Richardson responded that, for the postpartum coverage extension, as soon as approval and funding were formally granted in November, DMAS began working on a compressed timeline to write the amendment application and initiate the required public comment and tribal notice periods mandated under federal transparency requirements. DMAS has worked as quickly as possible to expedite the state piece of the process because once the waiver amendment application is submitted, the timeline is largely dependent on the federal government and the approval process and negotiations with Virginia regarding the waiver terms and conditions. She stated that under the terms of the waiver, there is a minimum period of approximately four months from submission of the amendment application before the state can implement the new waiver provisions, barring any emergency authority. For this reason it is not possible to predict with certainty when the state will be able to implement the postpartum coverage extension, but DMAS is making preparations to implement as soon as federal authority is granted. Richardson responded that, regarding the new prenatal coverage, first DMAS must await formal state authority with the Governor’s approval of the state budget. DMAS has begun working internally to prepare and be ready to act quickly upon state approval. She stated that this change is federally authorized through a CHIP State Plan Amendment, which is a faster and more predictable process than an 1115 waiver amendment application, and DMAS will submit the amendment application as soon as possible after state approval is granted, while incorporating the necessary public comment and other state-mandated processes for state plan changes. Richardson stated that the effective date in the Conference Budget for the prenatal coverage is July 1.

Michael Cook, Board of Medical Assistance Services, asked whether, if the waiver process is held up, DMAS could pursue authority through the state plan process, as the effective date for a state plan amendment is the beginning of the calendar quarter of submission. Richardson stated that DMAS is closely following the federal negotiations that may make a state plan option for 12 months postpartum coverage available. At this time, it is not known what the effective date of the federal legislation will be, but that DMAS will continue to track closely and explore all available options with CMS.

III. DMAS Update

Karen Kimsey, DMAS Director, provided the DMAS update. She thanked the Committee members for their dedication and service on the Advisory Committee. Kimsey began with an update on Medicaid enrollment, explaining that one in five Virginians are covered by Medicaid. She stated that since the public health emergency (PHE) was declared, DMAS has gained 257,343 new members, with a total of almost 1.8 million members enrolled as of February 17. Kimsey explained that during the PHE, not only has adult enrollment grown, but children’s enrollment as well. She stated that during the emergency, DMAS is gaining approximately 4,700 new members per week. Kimsey explained that more than 528,000 members are now enrolled in the Medicaid expansion group. These members are using their benefits to treat chronic conditions such as high blood pressure, diabetes, asthma, chronic obstructive

pulmonary disease (COPD), and other conditions that may increase health risk when infected with COVID. Kimsey highlighted data on utilization of the Addiction and Recovery Treatment Services (ARTS) benefit. To date, nearly 44,000 Medicaid expansion members have received an ARTS service. Kimsey noted that this benefit has been of particular importance given concerns about increased overdoses and deaths during the COVID-19 public health emergency. Kimsey described flexibilities that the agency has employed during the PHE, such as expanded access to telehealth services, provision of 90-day prescriptions, and the removal of copayments for the duration of the emergency period. She explained that DMAS also implemented initiatives for providers, including a 29 percent rate increase through directed payments to primary care providers; increased resources to nursing facilities to support COVID-19 response; CARES Act funds used to stabilize at-risk providers, including hospitals, long-term care providers, residential providers, and Developmental Disability (DD) waiver providers; and opening reimbursement for new COVID-19 tests, treatment, and vaccinations.

Kimsey explained that DMAS is working with state, community, and local partners to ensure that Medicaid members are connected with opportunities to receive COVID-19 vaccinations. The agency considers this a top priority. She stated that DMAS' commitment to facilitating vaccination for members includes opportunities for those who unable to leave their homes. Kimsey explained that working with trusted community partners who serve populations at particularly high risk from the virus is a priority.

Kimsey provided information about state budget provisions affecting Medicaid and CHIP. She explained that Virginia experienced a less severe impact to state revenues than some other states have had due to COVID-19's economic impacts. Kimsey stated that Virginia is working on setting up a state-based Exchange, and that DMAS is part of that work. She explained that the Governor's budget includes reallocation of funding to enable FAMIS MOMS to access Substance Use Disorder (SUD) treatment in an Institution for Mental Diseases (IMD) setting, providing the same access to the full continuum of SUD services available to other enrollees. She explained that the Governor's budget also funds doula services for pregnant women, and that DMAS has been working to develop the design of this benefit. Virginia will be among the first states to offer doula benefits in its Medicaid program. Kimsey stated that DMAS has been working very closely with the doula provider community on developing the benefit, and that there will be a certification program through the Department of Health Professions. The benefit will offer reimbursement for up to eight visits, attendance at the birth, and up to two linkage-to-care payments.

Kimsey explained that the Introduced Budget included authority to expand Medicaid addiction treatment services beyond opioid use disorder, affirmed Medicaid coverage of medically necessary gender dysphoria-related services (both medications and surgeries), funded a federal mandate related to durable medical equipment (DME) outside of the home, and authorized telehealth services to continue after the public health emergency ends. Kimsey described other provisions of the Introduced Budget related to Medicaid, including a live-in caretaker exemption to electronic visit verification (EVV) that authorizes provision of 12 months of prescription contraceptives for Medicaid and FAMIS members. The budget also funds COVID-19 vaccine coverage for non-expansion Medicaid adults, including the cost of administering the vaccine, and allows pharmacy immunizations for covered services, including COVID-19 immunizations and other vaccinations.

Kimsey described several key bills that the agency was tracking during the General Assembly session. Senate Bill (SB) 1307 directs DMAS to expand Medicaid coverage of school health services in public schools beyond the special education services provided under a student's Individualized Education Program (IEP). House Bill (HB) 1987 and SB 1338 mandate Medicaid

coverage of remote patient monitoring through telehealth. SB 1102 requires DMAS to establish an annual training and orientation program for all personal care aides who provide Medicaid self-directed services.

Kimsey explained several key Medicaid and CHIP/FAMIS amendments in the General Assembly's budget, including prenatal coverage for otherwise-eligible women regardless of immigration or citizenship status; retainer payments for DD waiver day support providers; continuation of telehealth services; school-based mobile vision clinics for children; and funding for the development of a new home visiting benefit.

Kimsey then provided an overview of the new plan to fulfill a state legislative mandate to merge the two Medicaid managed care programs in Virginia into a single program, called Project Cardinal. She explained that most states have transitioned their Medicaid populations to managed care, and that Virginia was among the first states to do this. Kimsey stated that over the course of the last 25 years, DMAS has worked to incrementally expand managed care to new geographical areas and new populations, with over 90% of Medicaid members currently served through managed care. She explained that the 2020 Appropriations Act directed DMAS to write two reports – one laying out a plan to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs, and another analyzing the costs and benefits of combining the medical loss ratios and underwriting gain provisions. Kimsey stated that the ultimate goal of Project Cardinal is to effectuate a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to members and adds value for providers and the Commonwealth.

Kimsey explained that, in response to the DMAS report, the General Assembly directed DMAS in the 2021 Special Session Budget to seek federal authority to merge the programs, effective July 1, 2022. The Budget language also directs DMAS to deliver a legislative report on the impact of merging the children's programs, FAMIS and children's Medicaid, by November 1, 2021, and to conduct an analysis of current contracts and staffing and determine operational savings from merging the managed care programs, and report on administrative savings and merger-related costs by October 1, 2021.

Dr. Tegwyn Brickhouse, VCU Health, stated that she wished to highlight the new adult dental benefit becoming available to Medicaid members July 1. She stated that, from a provider perspective, implementation is going very well, and that getting the word out about the new benefit is very important. Dr. Brickhouse explained that the new benefit will be a comprehensive dental benefit, which Virginia had not previously offered across all adult populations in its Medicaid program. She noted the relationship between a parent's oral health and the child's oral health, and stated that if a parent has access to care then this improves the child's access as well. Kimsey thanked Dr. Brickhouse for highlighting this change and stated that DMAS is very pleased to be launching the new adult dental benefit.

Sara Cariano, Virginia Poverty Law Center, asked whether the change to remove the 40 quarters work requirement for lawful permanent residents was still on schedule for implementation April 1. Kimsey responded that the change was on schedule. Kimsey then introduced Sarah Hatton, DMAS Deputy Director of Administration, to present on the Cover Virginia/Maximus implementation project.

Hatton explained that Maximus will be the new vendor for Cover Virginia and that the transition will take place March 29. She stated that DMAS is committed to ensuring a smooth transition of responsibility for Cover Virginia systems and operations to Maximus, Inc., while continuing

to provide excellent service, without disruption. The agency's goal is to provide an even higher level of customer service with the transition. Hatton stated that Cover Virginia is much more than a call center, and that there are four main operational units that make up Cover Virginia: the Medicaid/FAMIS Statewide Call Center, the Eligibility Central Processing Unit (CPU), the Cover Virginia Incarcerated Unit (CVIU), and the Cover Virginia website. The Call Center receives and inputs telephonic applications, renewals, and changes, and provides general information to callers. The Eligibility CPU initiates modified adjusted gross income (MAGI) Medicaid/FAMIS eligibility determinations in the VaCMS system as well as Hospital Presumptive Eligibility (HPE) and hospital newborn enrollments. The Cover Virginia Incarcerated Unit performs eligibility determinations and enrollments for incarcerated individuals and also at release from correctional facilities, and houses a separate dedicated call center. Another operational unit hosts and maintains the CoverVA website as well as the Spanish-language website, CubreVirginia.

Hatton explained that each month, Cover Virginia receives an average of 70,000 calls and approximately 10,000 applications. Cover Virginia enrolls approximately 2,000 newborns each month. The Cover Virginia Incarcerated Unit enrolls an average of 1,750 inmates per month. She explained that the new vendor will be gearing up for the special enrollment period when application volume will increase. At go-live, Cover Virginia will offer an automated customer service survey. Maximus will continue the enhancements in application processing for pregnant women's applications, which require that these applications be processed within five days. There will be an improved portal and enhanced web forms to process Hospital Presumptive Eligibility applications and newborn enrollments that are submitted from hospitals. New electronic communication features will include capability for live chats; communication through dedicated e-mail boxes to receive documentation; and ability for individuals to receive text messages that will provide general information about the Medicaid program. Other features that will roll out prior to this year's Open Enrollment include a single statewide toll-free telephone number for all social benefits (DSS-operated Enterprise Call Center and/or Cover Virginia). Prior to Open Enrollment, a new and improved interactive voice response (IVR) system will be launched that will allow people to self-serve or to be connected to a live agent. In addition, a mobile app will allow members to submit requested documentation and to receive notifications and reminders.

Hatton explained that translation services have been moved earlier in the call menu selection so that individuals who need these services will be connected to a translator earlier in the process. The new vendor will have improved service levels, including a decreased application processing timeline from eight business days to five business days. This will align all applications with the pregnant women's application standard.

Hatton explained that the Cover Virginia Incarcerated Unit is a collaboration with the Department of Corrections, local and regional jails, and the Department of Juvenile Justice. She stated that beginning in March, entry and release dates from local and regional jails will be included on the updated data exchange. This information will allow for faster enrollment in coverage soon after an individual's release. Other CVIU improvements include an updated interactive voice response system for callers and new web forms for improved workflow management.

Hatton stated that both the Cover Virginia and Cubre Virginia websites will roll out with a fresh design and changes that will help visitors find resources more easily.

Stephanie Spencer, Urban Baby Beginnings, stated that she appreciates the efforts being made to recognize the needs of vulnerable populations. She asked what processes will be put

in place to ensure that community-based organizations are able to help their clients and communities navigate the new system with the new benefits rolling out for pregnant women. She explained that her organization works with uninsured and Medicaid-covered individuals and that they spend a lot of time assisting with applications and helping members navigate the system. She stated that she wanted to make sure her organization is prepared to help Spanish speakers or speakers of other languages to enroll in the new coverage they may qualify for. She asked whether DMAS has a task force they are working with that is community-based to prepare for the changes. Hatton responded that DMAS is very interested in hearing from community partners about their experiences and that the agency values this feedback. Kimsey asked whether it might make sense to establish a CHIPAC subcommittee to look at this issue.

Janice Holmes, Operations Manager, DMAS Eligibility and Enrollment Services, provided an update on Cover Virginia, the call center and application processing. Cover Virginia is continuing operations while preparing for a new contractor to take over effective in March. Holmes explained that preparations for the transition are proceeding smoothly. She stated that currently, excessive wait times are continuing at the call center, and having 90 percent of staff teleworking presents challenges. She stated that the current contractor has increased staffing and engaged other corporate resources to handle additional demand and that DMAS continues to monitor and address issues as they arise. Holmes explained that at the Cover Virginia Central Processing Unit, applications volumes increased tremendously with Open Enrollment and were much higher than projected forecasts. Part of the reason for the increased volume was duplicate applications coming from the federally facilitated marketplace (FFM). Holmes stated that overtime and additional resources were engaged to handle the increased volume and that state staff have also been engaged from local agencies and DMAS to assist with processing after working hours.

Hope Richardson, DMAS Policy Planning and Innovation Division, reviewed updated sections of the CHIPAC Dashboard and invited questions. Richardson stated that updated Dashboard sections included the enrollment charts and the “Dental Benefits for Pregnant Women, Activity and Outcomes” table. Emily Griffey, Voices for Virginia’s Children, asked about the Dashboard children’s mental health utilization data, how often it was updated and whether it could be updated soon, particularly due to concerns about children’s access to behavioral health services during the COVID-19 public health emergency. Konrad responded that the Committee could work with DMAS to get updated information on this measure. Lanette Walker, Virginia Hospital and Healthcare Association, made several suggestions regarding Dashboard improvements. She recommended using a percentage rather than raw numbers in the pregnant women’s dental benefit utilization table. Walker stated that the monthly net enrollment for children graph would be easier to read as a continuous line rather than a stacked line graph. Konrad thanked Walker for her input. Richardson suggested that the Executive Subcommittee could discuss the Dashboard at their upcoming meeting and identify potential updates and improvements. She stated that the CHIPAC Dashboard is an evolving product that presents information requested by the Committee and that DMAS aims to ensure that the Dashboard can be readily adapted to include information that is useful and relevant to the Committee’s needs and will best inform CHIPAC decision-making.

IV. VDSS Update

Irma Blackwell, Medical Assistance Program Manager, Division of Benefit Programs, Virginia Department of Social Services, provided an update from VDSS. Blackwell stated that VDSS’ home office has hired additional wage or “P-14” staff to assist local agencies in processing Medicaid applications. The workers receive assigned spreadsheets with FFM and CPU

metrics and are required to report on actions that have been taken, in order to enable close monitoring.

Blackwell stated that VDSS, in conjunction with DMAS, has begun exploring options for a process that could be used for hospital-based workers to obtain telephonic signatures in order to address COVID-related patient access limitations. The process would need to properly address security parameters, recording capabilities, privacy, FOIA-related issues, and would need to provide for how recordings would be saved and stored, and any applicable contractual adjustments that would need to be made.

Blackwell explained that VDSS recognizes the importance of building awareness and trust of COVID-19 vaccination efforts, and the Department is involved with outreach efforts in conjunction with DMAS and other agency partners to get information out to the community. Mail inserts, flyers, and website banners are being planned to get the word out. Blackwell stated that advance planning is also taking place for the end of the public health emergency. Once the public health emergency ends, there will need to be a satisfactory mitigation plan in place to ensure that workers are not overwhelmed with overdue applications. The mitigation plan is being developed and processes are being put in place to enable automation to the extent possible.

Blackwell explained that training for new hires about the medical assistance programs has been moved to a virtual platform.

Michael Muse, Virginia League of Social Services Executives, asked when information will be provided to local social services agencies about the mitigation plan for overdue renewals. Blackwell responded that VDSS recognizes that the mitigation plan and planning for the transition is an ongoing concern of local agencies. She stated that a plan will be developed and shared in advance to ensure that the caseloads will not become overwhelming for local agency workers. Sarah Hatton stated that she is aware that VDSS is awaiting guidance from DMAS, and DMAS in turn is awaiting guidance from the new leadership at the federal Centers for Medicare and Medicaid Services (CMS) under the new administration. Hatton explained that paper renewals have been turned off, and with indications that the public health emergency is likely to extend to the end of the year, DMAS believes this will help minimize confusion. Jessica Anecchini, DMAS, explained that automated processes and reevaluation tools have been developed to lessen the load on workers, and deploying these new tools when the time comes will be key to improving efficiency of processes and making the transition proceed smoothly.

V. Agenda for the June 3, 2021 CHIPAC meeting

In order to allow sufficient time for public comment, Konrad invited members to send ideas regarding agenda items for the June 3 meeting to her or to DMAS staff.

VI. Public Comment

LeVar Bowers, Civitas Healthcare Services, commended the Committee on its hard work. He stated that from his perspective as an advocate it can be difficult to connect the strategic process of Committees such as CHIPAC to the implementation happening on the ground. He stated that many people in local communities, including some providers, do not see or understand the impact of initiatives that are in progress such as Project Cardinal, STEP-VA, and Behavioral Health Enhancement. He stressed the importance of provider training and development to ensure access and a high level of quality care for program participants. He

expressed support for the 12 months postpartum coverage extension and other steps to close racial equity gaps.

Closing

The meeting was adjourned at 3:40 pm.