CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

DRAFT
Meeting Minutes
3/7/24

A quorum of the full Committee attended the meeting in person.
The Webex link was also made available for members of the public to attend virtually.

The following CHIPAC members were present:

• Freddy Mejia (Vice Chair)	The Commonwealth Institute for Fiscal Analysis
• Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
• Michael Muse	Virginia League of Social Services Executives
• Emily Roller	Virginia Health Care Foundation
• Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services
• Kelly Cannon	Virginia Hospital and Healthcare Association
• Heidi Dix	Virginia Association of Health Plans
• Martha Crosby	Virginia Community Healthcare Association
• Sarah Bedard Holland	Virginia Health Catalyst
• Kenda Sutton-El	Birth in Color
• Sarah Stanton	Joint Commission on Health Care
• Irma Blackwell	Virginia Department of Social Services

The following CHIPAC members sent a substitute:

• Jennifer Macdonald (Marcus Allen)	Virginia Department of Health

The following CHIPAC members were present virtually:

• Shelby Gonzales	Center on Budget and Policy Priorities
• Emily Moore	Voices for Virginia's Children (remote participation due to illness)

I. **Welcome** – Freddy Mejia, CHIPAC Chair, called the meeting to order at 1:02 pm. Meija welcomed committee members and members of the public.

Meija introduced DMAS Director Cheryl Roberts for special remarks and Medicaid updates. The word of the year for DMAS is SOAR (Service, Operations, Accountability, Results). Updates included initial budget rate increases for EPSDT. Governor is making maternity a priority along with behavioral health. He held a Maternal Health Roundtable last week to discuss the issue with statewide agencies, community organizations, providers, and other stakeholders. Rural health will also be a focus. For the first time, both VDH and DMAS Directors are Maternal and Child Health advocates and have great synergy. DMAS has posted the Managed Care Re-Procurement Notice of Intent to Award (NOIA) and DMAS is currently in the protest period.

Meija welcomed DMAS Chief Deputy Jeff Lunardi and DMAS Chief Medical Officer Dr. Lisa Stevens.

II. **CHIPAC Business**

A. **Review and approval of minutes from Dec 7 meeting** – Committee members reviewed draft minutes from the December 7 meeting. Kenda Sutton-El made a motion to approve the minutes; Kelly Cannon seconded, and the minutes were approved by majority vote.

B. **Membership items** – The memberships of Michael Muse and Shelby Gonzales are expiring.

A motion to approve Laura Harker to the CHIPAC committee was made by Kelly Canon and Emily Roller seconded. The Committee voted to approve the membership of Laura Harker.

A motion to approve Tiffany Gordon to the CHIPAC committee was made Sarah Beddard Holland and Martha Crosby seconded. The Committee voted to approve the membership of Tiffany Gordon.

Irma Blackwell, Jennifer MacDonald, Heidi Dix, and Dr. Susan Brown have renewed their memberships.

Dr. Susan Brown was re-hired by Elevance to help build a NICU program.

III. **2024 General Assembly Session Update**

Will Frank, Senior Advisor for Legislative Affairs at DMAS gave a General Assembly update, noting that it is technically not done. GA is set to adjourn on Saturday 3/9. He noted that just under 3,000 bills were introduced and DMAS was assigned about 40 lead bills.

This session DMAS had four main categories of bills: new Medicaid benefits, changes to rules for paid family caregivers (Legally Responsible Individuals), eligibility changes for waiver recipients, and pharmacy changes.

The presentation provided a list of new benefit proposals that were introduced this session. Additionally, there was an overview of Legally Responsible Individuals (LRI) including legislation that has been introduced around the provisions of allowing reimbursement for LRI who provide care to their children or spouses. The legislation would allow 40 hours per member if there are two Medicaid members in the household, and the LRI would provide Proof of Services if another provider wasn't found.

Pharmacy legislation included proposed changes to drug costs and purchasing. There was legislation related to a statewide centralized pharmacy, Prescription Drug Affordability Board, and changing payment structures for long-acting injectables.

Waiver and screening bills include seeking CMS approval to disregard SSDI when determining financial eligibility for DD waivers, increasing time a DD waiver slot can be retained from 150 days to up to 365 days, and greater flexibility for nursing facilities and PACE programs to conduct LTSS screenings in certain circumstances.

Other legislation includes a bill to require timeliness of lien settlements when DMAS has a claim for reimbursement against the settlement of a member, and also creating a new provider type (BH technicians and BH technician assistants).

IV. 2024 Budget Update

Truman Horowitz, DMAS Budget Division Director shared information about the 2024 budget in a presentation for the Committee. The presentation covered look-back expenditure data from the last 5 years, and compared this year against both the forecast and expenditures. The presentation included data through January for each of the years posted, showing the year-over-year change from this point last year to today. There is about an 11% increase in FAMIS expenditures year after year between 2023 and 2024. This is because enrollment is up on average by 10% from this time last year in FAMIS. As redeterminations are occurring by individuals, there are many cases and members being moved to Medicaid Expansion, or out of Medicaid, but some children are moving to CHIP/FAMIS. There was also a 30% increase in dental rates in 2023 impacting FAMIS and MCHIP expenditures over the last two years.

The MCHIP MCO category has a decrease in enrollment by 11%, and pharmacy rebates were $1.26m higher in FY23 than 24, but FY24 is more in line with history. Looking at fund type we see decreasing FMAP associated with PHE unwinding, which requires the general fund to pick up more of the burden. That is why the general fund expenditures are higher than they were last year.

The presentation reviewed forecasted to actual expenditures for FY2024, noting the variance is primarily attributable to higher enrollment in FAMIS. There is a large variance in FAMIS FFS because of redeterminations made at household level earlier in the fiscal year. When members enter Medicaid the first time they enter Fee-For-

Service first, which is why there is a one-time spike in FFS that we are seeing. MCHIP is also seeing a slightly higher enrollment than anticipated, driving a very small variance. Overall, spending is trending higher than forecasted, which DMAS is monitoring, and DMAS expects that unwinding-related disenrollments will bring spending down to forecasted levels by end of fiscal year.

Mejia asked about the funding put aside by the Senate and House in case more funding was needed than forecasted in November for contingency; are we seeing similar trends for adults? Lunardi answered that generally yes, it's across all eligibility categories, but looking at breakdown in enrollment children are trending higher.

Mejia asked if unwinding is behind the schedule that was anticipated when the expenditures were forecasted in November. Lunardi responded that it's a combination of multiple factors, including new enrollments vs. disenrollments through unwinding. DMAS Senior Advisor Jessica Annecchini also pointed out that enrollment churn is a factor.

V. Return to Normal Enrollment Update

Jessica Annecchini, DMAS Senior Policy Advisor for Administration, provided an update on the process of unwinding from the federal public health emergency and redetermining Medicaid members' eligibility.

The public-facing DMAS dashboard was refreshed yesterday. Out of those redetermined, 83% remain enrolled and 17% have closed. The 17% figure includes 14% closure and 4% churn. The total amount redetermined is 84.56%. The highest jump in closures occurs between the last week of reporting and the first week of the next month.

Annecchini reviewed closures by eligibility groups. Renewals are completed on an individual basis. One of the trends we have noticed is that the numbers between non-ABD adult group and children were similar; non-ABD adult is the largest group losing coverage.

Annecchini then reviewed procedural vs. non-procedural closures by eligibility grouping through 2/21/24. Non-procedural outweighs procedural, which is good because it means we know why their coverage is ending. With procedural closures, we don't know why they chose not to retain coverage. Some states have started doing disenrollment surveys, which DMAS is learning about during weekly meetings with other states and CMS, and is considering.

Annecchini shared some answers DMAS can provide regarding recently asked questions.

Questions about data-

- Does DMAS have an exact or approximate number of children who transitioned from FAMIS to FAMIS Plus during renewal? There is some data, but not a comprehensive review.
- Is county data showing reason for determination? Some you can see on dashboard.

- Is parental coverage loss is more likely to result in coverage loss for kids? The gap is growing, and Horowitz shared this data in his presentation. DMAS does not have all the data available for every covered group.
- Does DMAS have an estimate on number of renewals that have been submitted but not processed, and separated out by method (online, in person)? Yes, there is data collected about all of this but not necessarily a report pulled together with it from all sources. The best option currently is to submit a FOIA request to see if that is even possible, since some would be DMAS data and some would be DSS data on the eligibility end. There are items on dashboard where there is an asterisk instead of data. If a locality's population is under a certain number, DMAS cannot report the data because of HIPAA regulations. HIPAA trumps FOIA for this data. There may be a different way to aggregate it to go around those limitations.
- How does the unwinding churn rate for children compare to churn rate for children pre-pandemic? DMAS is looking into this with the data team so that we can provide this information at the next meeting. The number of children who transitioned from Medicaid to the marketplace – this would be more of a request for Virginia Insurance Marketplace because they are going to have more recent and thorough data than what DMAS may receive.

Questions about closures-

- *What steps has the state taken to minimize closures for children?* DMAS has waivers allowing flexibilities through the end of this year. DMAS may try to extend some indefinitely as we see which has biggest impact, so that we can make state plan amendments to adopt those. Some we would love to see would be ones around getting updated information without needing outreach if we have an accurate and verifiable source.
- *Does DMAS have data about number of renewal packets that were returned as undeliverable?* VDSS has a team tracking things that come to the home office. A number of returned mail also goes to local offices, so it's hard to track each one. We are trying to share guidance around returned mail and make it more clear in the eligibility manual. There is also a budget item about having a centralized mail room.
- *Children's coverage loss estimates compared to predictions?* We predicted 14% loss and 4% churn. We are on track and will have a churn review out at the next meeting.
- *Will we be doing surveys?* Partly already addressed that we are looking into it, but unfortunately do not have a timeline. If there are any questions that you would like to see on a survey, I can't guarantee the questions will be added, but we would be happy to take those as we are putting that together. Our executive leadership team will review and approve all the questions on the survey. So we are willing to entertain questions related to anything that you might want to know about former members, that will help us to make sure we are giving you not only the responses, but the information you really want to know.

Question from Emily Roller during meeting:

- *In terms of surveys conducted in other states, were there any common top-lines?* Some common answers included ones such as, “I have other coverage.” One thing that states have noted is that they don’t necessarily know if they get employer-sponsored coverage, or where their coverage comes from. Another reason coming up is that they knew they had been ineligible for some time so they were hesitant to respond to unwinding efforts, without realizing they could be transferred to the marketplace. We get uploads of some third-party data within our enrollment system, but not all. It depends on where the coverage comes from and the technology of that company. That is something that other states have noted, that I am hoping we might be able to get a little information on.

Mejia expressed hope that DMAS will be able to do a survey around unwinding and indicated that this could be a critical way to see where families go after their time with Medicaid, and to understand that sooner than the time lag when the census information comes out.

Question from Mejia:

- *For the Churn Report you mentioned there are several different definitions; is the definition for this dashboard 6-months, or is it still TBD?* DMAS wants to expand the timeframe so that individuals could look at three months, six months, or as long as they want to. There is also the difference between just coming back, and “where were you before?” and, “when did you come back?” That is what the dashboard doesn't say right now. For example, you may have redetermined people, but who stayed in full coverage? Who moved to limited? Who aged out that was still able to retain? We have a lot of people in the Children under 19 groups that have aged out, but because of the income limits a majority of them could move to expansion. Knowing they aged-out, they may have their own income now accountable. It is not only a straight number, but, also, what does it mean to churn back in, and where are they going?

Annecchini wrapped up the presentation by indicating that DMAS is looking forward to what we are going to change after unwinding is complete. We are looking at what we want to keep. We know the dashboard has been helpful, so we are looking at making parts of dashboard permanent, as well as other temporary measures taken than were helpful and can be made permanent.

VI. Discussion of agenda items for June 6, 2024, CHIPAC Meeting

Mejia indicated that there may be additional funding in the House and Senate budget, coming out today at 4:00pm, for training for DSS. Additionally, there is funding for improvements to CommonHelp, and the centralized mail location for Medicaid in the House budget.

Mejia announced the June 6, 2024, meeting at DMAS offices. The goal is to have a full conversation about things that people care about, and are interested in learning about when it comes to Children's Health Insurance. By June it will be a different landscape

in terms of unwinding, finalizing the General Assembly and the budget. Mejia asked members if they had suggested agenda items for the June meeting.

Sarah Bedard Holland suggested that there are some opportunities to talk about the integration between some of the pieces of the dental benefit and children's health; one of the new benefits that went into place this year was increasing the age that providers are able to apply fluoride varnish, which positively impacts rate of cavities. This is an inexpensive, easy thing to do for kids that can virtually eradicate cavities. Utilization is 5% so we have massive opportunities to improve.

Kenda Sutton-El wants to discuss exploring the car seat technician program. There is currently no funding for that, hospitals don't do it, and fire departments only have specific days they do it. Some birth centers and doulas are currently doing it as a volunteer service, but are being bombarded with requests and driving all over the state to assist. Mejia indicated that in the past CHIPAC has provided recommendations about things that are important to our CHIPAC members, and things that we would like for the stakeholders to look at and support, if possible. CHIPAC could discuss writing a letter of recommendation around exploring possible avenues for funding this program.

Mejia invited members to submit any additional ideas or requests for the June meeting agenda to the Executive Subcommittee for consideration at their April subcommittee meeting.

VII. Public Comment

Dan Sullivan, member of the public. Sullivan noted that he happens to be a Healthcare Navigator with Enroll Virginia: Senator Deeds summed up the challenge of the Virginia policy operation: "When you have seen one CSB, you have seen one CSB." There are 120 local DSS offices. There may not be one best way to run a local DSS, but there are not 120. That is what we run into all the time. It seems like there is a right way and the Virginia way. The Virginia way is to attempt to delegate responsibility and maintain authority. There are local offices where caseworkers almost never come into the office, or have an office, or work with someone in-person. Richmond City provides paltry support. Virginia likes to say there is no wrong door when submitting Medicaid applications. But if people apply online, the CommonHelp app may sit dormant for weeks and get passed to locals just in time for 45-day deadline for processing. Locals hear they have 45 days for processing, so the bar is low. The 10-day standard for processing Medicaid applications for pregnant members is not able to happen because of lack of staff and untrained staff. There have been challenges to the Medicaid system. Each has offered opportunities for improvement that have been squandered. Responsibility has been delegated. That will never change unless there is leadership from DMAS, and as a starting point, I suggest statewide standardized caseworker and training and testing and job aides. The Medicaid manual is far from a user-friendly. I recommend a requirement for Annual Continuing Education, and development of meaningful key performance indicators for both caseworkers and Departments of Social Services. Thanks. I heard some of this being talked about already here. I would say key is the training. It is just not adequate training, except from the Healthcare Foundation.

Kimberly Dyke-Harsley provided public comment online via chat wish for a Medicaid SPA soon.

VIII. Closing

The meeting was adjourned at 2:21pm