MEETING MINUTES

Meeting Minutes – 3/7/19

Virginia Community Healthcare Association
3831 Westerre Parkway
Henrico, VA 23233
1:00 – 4:30 p.m.

The following CHIPAC members were present:

• Michele Chesser	Joint Commission on Health Care
• Amy Edwards	Virginia Department of Education
• Rachel Lynch	Partnership for Healthier Kids
• Shelby Gonzales	Center on Budget and Policy Priorities
• Lisa Dove	Virginia Community Healthcare Association
• Michael Muse	Virginia League of Social Services Executives
• Dr. Cornelia Deagle	Virginia Department of Health
• Christine McCormick	Virginia Association of Health Plans
• Ashley Everette	Voices for Virginia's Children
• Dr. Tegwyn Brickhouse	VCU Health
• Jennifer Wicker	Virginia Hospital and Healthcare Association
• Katharine Hunter	Department of Behavioral Health and Developmental Services
• Dr. Sandy Chung	Virginia Chapter of the American Academy of Pediatrics

The following CHIPAC members sent substitutes:

• Jay Speer sent Jill Hanken	Virginia Poverty Law Center
• Sherry Sinkler-Crawley sent Chartoya Newton	Virginia Department of Social Services
• Dr. Karen Rheuban sent Rebecca Gwilt	DMAS Board Member
• Denise Daly Konrad sent Emily Roller	Virginia Health Care Foundation

The following CHIPAC members were not present:

• Rodney Willett	Impact Makers
• Dr. Nathan Webb	Medical Society of Virginia

The following DMAS staff members were in attendance:

- Brian McCormick, Director, Policy Planning and Innovation Division
- Rita DeVaughn, Senior Contract Monitor and Eligibility Supervisor, Eligibility and Enrollment Services Division
- Dr. Kathy Sardegna, Pediatric Medical Director
- Dr. Alyssa Ward, Behavioral Health Clinical Director
- Shelagh Greenwood, Outreach and Consumer Communications Manager
- Emily Creveling, Maternal and Child Health Supervisor, Health Care Services Division
- Rebecca Anderson, Policy Planning and Innovation Division
- Hope Richardson, Policy Planning and Innovation Division

Meeting Minutes

Welcome

Michele Chesser, Vice-Chair of CHIPAC, called the meeting to order at 1:10 pm. Chesser welcomed everyone and outlined the agenda for the meeting.

I. CHIPAC Business

A. Approval of Minutes – Minutes from the December 6, 2018 quarterly meeting were reviewed and approved.

B. Membership Subcommittee Update – Amy Edwards, CHIPAC Membership Chair, gave an update on committee membership. Edwards announced that Jill Christiansen, longtime member of CHIPAC and Program Director of Inova Partnership for Healthier Kids, had moved out of state. Edwards noted Christiansen's many contributions to CHIPAC and that she will be missed on the Committee. Rachel Lynch, Program Outreach Administrator, will continue to represent Inova at CHIPAC meetings. Edwards stated that two members whose terms are ending have agreed to renew their membership for another term: Lisa Dove of Virginia Community Healthcare Association and Ashley Everette of Voices for Virginia's Children. Finally, Edwards announced that Dr. Sandy Chung of the Virginia Chapter of the American Academy of Pediatrics has decided to step down to pursue other projects at the end of her term and that this would be her final CHIPAC meeting. The Executive Subcommittee/ Membership Committee will present nominees for new members to the full Committee for consideration at a future meeting.

II. Behavioral Health Redesign Presentation and Discussion

Chesser introduced Dr. Alyssa Ward, Behavioral Health Clinical Director at DMAS, and Nina Marino, Director of the Office of Child and Family Services at DBHDS, who gave a presentation on the status and goals of Virginia's Behavioral Health Redesign. Dr. Ward stated that she and Marino were there representing the interagency team and stakeholders that have been working for six months on the Behavioral Health Redesign project. She explained that Medicaid is the largest payer of behavioral health services in Virginia, and about a third of Medicaid members have a behavioral health diagnosis. Thus behavioral health is very relevant and important to Virginia Medicaid members. Virginia's rankings on behavioral health access are low. Although the Commonwealth has seen some recent improvement in these rankings, Virginia remains 40th in the country on overall access to mental health care, and 41st on mental

health workforce supply (rankings from Mental Health America). The bulk of Medicaid behavioral health spending currently goes to a small number of high-need services, including mental health skill-building, therapeutic day treatment, and intensive in-home treatment. Total behavioral health Medicaid expenditures for FY2017 were over $862 million. Dr. Ward stated that the goal with the behavioral health redesign is to move toward prevention and early intervention, which is expected to reduce costs and improve outcomes.

Nina Marino described the state psychiatric bed crisis. Virginia has seen tremendous increases at all hospitals and is operating at 95-100 percent capacity, which is not safe and may put staff in difficult situations. Children's hospitals have this issue as well. At the same time, it can be challenging to safely discharge children back into community settings after an inpatient psychiatric stay because the intensive community-based services they need are not widely available. Thus the system currently offers low-level services and highly intensive inpatient services, but what is needed instead is a broader Medicaid service array that includes a range of services between lowest and highest intensity. Marino described the STEP-VA project and other statewide behavioral health reform efforts and explained that they see Redesign as the "hub" in the center supporting numerous efforts taking place statewide. A number of agencies and initiatives are coming together, including Juvenile Justice EBP implementation, VDOE's Tiered System of Supports in the schools, Addiction and Recovery Treatment Services (ARTS) available through Medicaid, the Family First Prevention Act implementation, STEP-VA, the Governor's Children's Cabinet on Trauma-Informed Care, and the Virginia Mental health Access Project (VMAP).

Dr. Ward explained that the vision for the behavioral health redesign is to develop an evidence-based, trauma-informed, cost-effective continuum of care. The services currently known as Community Mental Health Rehabilitation Services (CMHRS) will become Intensive Community-Based Supports that are tiered based on the intensity of an individual's needs and include evidence-based best practices. This will optimize taxpayer dollars, while meeting people's needs in environments where they already seek support, such as schools and primary care settings. With assistance from the Farley Health Policy Center at the University of Colorado, the behavioral health redesign workgroup has completed a service gap analysis, evidence review, stakeholder survey, and continuum document. The stakeholder workgroup has been meeting regularly.

Dr. Ward described goals regarding trauma-informed care. She stated that the very act of moving away from acute crisis-oriented situations is a trauma-informed practice that avoids experiences that can be re-traumatizing. In addition, it is important to use a trauma-informed lens when considering the workforce, keeping in mind such issues as protecting the behavioral health workforce against secondary traumatic stress.

Dr. Ward stated that greater emphasis on managed care will help control spending and prevent waste, fraud and abuse. An open discussion followed the presentation. Jill Hanken, VPLC, commented that she wanted to emphasize the importance of DMAS/state oversight and management of the managed care organizations (MCOs) in their requirements and standards, to prevent unnecessary or inappropriate limiting of services and ensure that Medicaid members are well served.

Dr. Ward stated that it is important to think creatively about workforce development, in terms of developing a future workforce and keeping mental health professionals in the state after they are trained. The hope is that with improvements and innovations in the behavioral health delivery system, it will be an exciting time to be part of the workforce in Virginia. Dr. Cornelia Deagle, Virginia Department of Health, stated that we want to make sure that people are

offering the same evidence-based practice throughout the system and that certifications carry across systems, that people are developing transferable skills. This will ensure that individuals are receiving same quality care throughout the system. Rebecca Gwilt, Board of Medical Assistance Services (BMAS), stated that she hopes barriers between state agencies can be dismantled so that individual entities are not protective of their training resources and all agencies can benefit mutually from workforce training that is shared across the workforce.

Dr. Ward described an 1115 waiver opportunity posted in November that would allow states to draw down federal Medicaid matching funds for certain mental health services. The state must have the services set up before it is able to be competitive for the opportunity. Jennifer Wicker, Virginia Hospital and Healthcare Association, asked how much of the system would have to be in place before applying for the waiver. Dr. Ward stated that the language is not specific, and her impression is that applicants must demonstrate that they have a functioning system with services available. She stated that Virginia has the potential to achieve this in the near term and is gearing its phased implementation of the Behavioral Health Redesign to "front load" it to be competitive for this opportunity.

III. Virginia Mental Health Access Program (VMAP) Presentation and Discussion

Dr. Sandy Chung, Virginia Chapter of the American Academy of Pediatrics, presented on the Virginia Mental Health Access Program (VMAP). She explained that children's mental health is a common concern for pediatricians. One in five children has a diagnosable mental disorder, so mental health is very much a children's health issue. If we can intervene early, this can help protect from complications that develop later in life, or even potentially help prevent substance abuse, criminality, and other negative outcomes. Dr. Chung explained that many pediatricians' training years ago did not focus adequately on mental health and that there are many practicing pediatricians who do not feel well-equipped to deal with children's mental health issues in their offices. Over 65 percent of pediatricians reported they lacked mental and behavioral health knowledge and skills. However, patients with mental health-related symptoms will see their primary care physician before they have been diagnosed with a mental health condition, so the development of this skillset in PCPs is important. In addition, pediatricians are finding it difficult to refer children to receive critical psychiatric services elsewhere in a timely fashion due to the extreme workforce shortage of psychiatrists and other mental health professionals throughout the state. Dr. Chung reported that according to one analysis, only two counties in Virginia have enough child psychiatrists to handle all the children who need them.

Dr. Chung described the key objectives of VMAP. The program (1) provides education for PCPs on screening, diagnosis, management, and treatment of mental and behavioral health conditions; (2) connects PCPs with telephonic/video consults provided by regional VMAP teams comprised of a child and adolescent psychiatrist, psychologist, and/or social worker; (3) offers telehealth visits with psychiatrists or psychologists; and (4) offers care navigation to help identify regional mental health resources. The education and training models used include the REACH Institute model – a "mini-fellowship" training in treatment of depression, anxiety, and ADHD; Project ECHO, a hub-and-spoke model of learners who connect remotely with a central expert; and practice quality improvement projects to implement screening tools, implement integrated mental health, and improve outcomes. VMAP offers PCP consults to regional VMAP teams in five regions of Virginia, each centered around academic hospitals: northern, central, eastern, western, and southwestern. Regional VMAP teams consist of child and adolescent psychiatrists, psychologists and/or social workers, and a care coordinator. PCPs use a central phone number to reach the on-call regional VMAP psychiatrist for support with patient management. Patients with complex or second-opinion assessment needs may be

seen by an on-call psychiatrist in person or by video, then patient care will be returned to the PCP or community psychiatrist. Telehealth offers a solution to the problem of transportation and access challenges that exist for rural and underserved regions of the state. The majority of existing telehealth programs do not offer pediatric mental health services, and VMAP hopes to fill this gap by providing telehealth solutions for regions that do not already have a platform available.

Dr. Chung noted that while VMAP is working to show proof of concept here in Virginia, there is evidence of its success in 30 other states. Massachusetts has the longest-running program, MCPAP, which has been in place for over 10 years and has documented success. Under MCPAP, the percent of PCPs who agreed that they were able to meet the needs of children with psychiatric problems increased from 8 percent to 63 percent after participation in the program. The percent of PCPs who were able to obtain a child psychiatry consultation in a timely manner increased from 8 percent to 80 percent after participation in the program. Dr. Chung reported that VMAP has been awarded a HRSA grant of $445,000 per year for five years, in-kind support of $189,818, and received funding through the state budget of $1.23 million for the 2019-2020 biennium. The anticipated overall budget need for the statewide VMAP program is $4 million per year.

A discussion followed the presentation. Dr. Kathy Sardegna, DMAS, inquired about feedback to PCPs after a referral is made. Dr. Chung indicated that in most cases, when a PCP makes a referral to a specialist, they get a note back about what happened, but that is rare in the mental health world. With VMAP, they do get a note back; it is built into the VMAP model and is considered essential that the PCP receive that follow-up.

IV. BREAK

V. General Assembly Session Update

Jill Hanken, Virginia Poverty Law Center, provided an update on the General Assembly Session that recently concluded. Hanken stated that there were many positive developments in the area of child mental health during this legislative session. These included increases in Medicaid provider reimbursement rates, STEP-VA, and the formation of a school-based health centers joint task force that will conduct a broader examination of what kinds of health services are and should be available in schools. Hanken also cited legislation related to the foster care system and the Family First Prevention Services Act, and an increase in TANF benefit amounts, as positive developments for children and families during the recent session. Hanken stated that the General Assembly also passed bills regarding the availability of telehealth through Medicaid and increasing the age for coverage of autism-related services in private insurance.

Ashley Everette, Voices for Virginia's Children, stated that she was excited about legislation related to provider reimbursement and the credentialing process for licensed mental health professionals.

Hanken stated that, thanks to efforts that culminated in the previous General Assembly sessions in 2018, Medicaid expansion coverage began January 1 and, to date, enrollment efforts have led to more than 200,000 individuals newly accessing Medicaid. Michael Muse, Virginia League of Social Services Executives, stated that VDSS is fortunate that there was funding available to handle the additional work that expansion efforts required, and while there are pockets of local agencies that have had a more challenging time than others, it has not been as overwhelming as some anticipated.

VI. CHIPAC Dashboard Review

A. An overview of the data in the CHIPAC Dashboard was provided, followed by a period of questions and discussion. Chesser reminded the group that red asterisks in the dashboard indicate items that have been updated in this quarter's dashboard. Chesser asked members to consider Medicaid expansion as they review the Dashboard and invited suggestions of ways that Medicaid expansion data of interest to CHIPAC can be incorporated into the Dashboard.

i) **CHIPAC Recommendations section:** Chesser updated the group on the status of the CHIPAC letter to Virginia Secretary of Health and Human Resources Dr. Daniel Carey and DMAS Director Dr. Jennifer Lee regarding the Department of Homeland Security's proposed federal rule on public charge in immigration policy. The letter urged the Secretary and DMAS Director to submit public comment during the federal public comment period. The letter was sent on Dec. 6, 2018. Chesser reported that Secretary Carey responded on Dec. 7 with the information that the Governor shares CHIPAC's concerns and has submitted comment.

ii) **HEDIS Measures and other health outcome measures:** Chesser stated that the HEDIS data in the Preventive Health and Prenatal Care section of the Dashboard was updated with new data in December. The Prenatal Care Indicators are derived from the Birth Outcomes Focused Study, and this data was updated in 2018 to reflect the most recent Birth Outcomes Study completed. The Adolescent Health and Oral Health sections also reflect the most recent updates from December and June, respectively. Chesser stated that the "Dental Benefits for Pregnant Women, Activity & Outcomes" section is updated quarterly and had been updated for this meeting. Richardson informed the Committee that in response to questions at the December 6 meeting about this section presenting cumulative data since the beginning of the benefit in 2015, DMAS is exploring whether there is a better and more readily understandable way to present the data. She stated that as a starting point, in this quarter's dashboard, there are numbers in parentheses showing the change in each statistic since the previous quarter's dashboard.

iii) **Enrollment and Operations measures:** The committee discussed Plan First / family planning enrollment numbers from the February 2019 enrollment report (Dashboard p. 4). Chartoya Newton, VDSS, reminded the group that Plan First enrollees were one of the populations identified to be auto-enrolled into the Medicaid expansion population to expedite the application process for those individuals. The Plan First program will not end with Medicaid expansion, as eligibility for this coverage group extends up to 205% of the federal poverty limit (FPL). However, we will continue to see a decline in these numbers, because many in this population – up to 138% FPL – are eligible for increased benefits under Medicaid expansion and will transition to the full benefit package. Dr. Deagle commented that we should start to see a decrease in family planning visits because there will be increased access to LARCs (long-acting reversible contraceptives).

Also in the enrollment table, members were asked whether they would like to see enrollment information tracking the number and percentage of newly enrolled caregiver adults within the expansion population enrollment numbers. This statistic is relevant to CHIPAC because of efforts to extend enrollment to the newly eligible parents of Medicaid and FAMIS-enrolled children, and because of research indicating that increased parental coverage may result in more stable coverage and access to health care services for children in the household. Members indicated that they would favor the addition of the caregiver adults enrollment numbers in this part of the Dashboard.

iv) **Applications processing measures:** A question was raised about the number of denials, and whether there is a way to tell apart administrative denials versus action denials in the reported data. Newton stated that DSS will check on this. Chesser clarified that for the January 2019 data reported in this table, the high number of denials is because of the timing of this report, coinciding with the much higher number of applications being processed during that period, after Open Enrollment and at the start of the Medicaid expansion rollout. Dr. Sardegna stated that it might be useful to track how long it takes applicants to respond to requests for documentation and additional information – in order to distinguish situations where DMAS/DSS are awaiting data from the applicant from situations where an application decision is being delayed by agency eligibility/enrollment processing times.

VII. DMAS Update

Brian McCormick, Director of the Policy Planning and Innovation Division, began the DMAS update with a summary of legislation monitored by the agency during the recent General Assembly session. He described HB 2035, a bill related to criminal background checks. McCormick stated that DMAS worked with legislators to draft this legislation in response to the problem of an increasing number of provider appeals in which providers felt they were not allowed to release any information to DMAS related to a criminal background check. The legislation clarifies that DMAS is not asking for the content of the background check from state police, but simply verification that the background check was performed and that the individual is eligible to work (i.e., has not been convicted of a barrier crime). The legislation clarifies that DMAS is not asking providers to release specific information related to criminal charges. This is a key issue for transportation providers and providers in the Home and Community-Based waiver.

McCormick also discussed legislation related to telehealth. DMAS is already providing telemedicine services to Medicaid members; HB 1970 and SB 1221 clarify that DMAS covers services provided via telemedicine that it would cover if provided "face-to-face." McCormick also provided an overview of other legislation related to Medicaid fraud prevention and payment for services to hospice patients. McCormick stated that there were many bills during this session involving DMAS.

McCormick explained to the Committee that DMAS is conducting a top-to-bottom review of forecasting and rate-setting processes in response to an increase in the Medicaid forecast the agency reported to the General Assembly. He stated that DMAS wants to make it clear that the revision in the forecast is <u>not</u> related to Medicaid expansion. Rather, the revision stems from the fact that projected short-term savings for the CCC Plus managed care program were overestimated. In November, the agency discovered that the estimates were incorrect and reported this to the GA, then took immediate steps to put together an action plan to deal with the problem. Internally, the agency's new Chief Financial Officer, Chris Gordon, is leading efforts to assemble a workgroup with DMAS staff and staff from other agencies. This will be DMAS' internal watchdog and will closely monitor the agency's forecasting and rate-setting processes. DMAS will provide notice in advance of decision-making to the GA and other stakeholders. There will be publicly accessible dashboards in which DMAS will provide updates on financial benchmarks in addition to quality measures and other metrics. Milliman, Inc., the independent, objective reviewer DMAS will be working with on the forecasting and rate-setting review, has done this work in approximately 20 other states.

McCormick provided an enrollment update. He noted that FAMIS monthly child enrollment as of March 1 was 71,984. FAMIS Plus (Medicaid child) enrollment was 573,432, and FAMIS MOMS enrollment was 1,269. McCormick stated that March 1 total monthly enrollment for all populations was 1,333,731, and Medicaid expansion enrollment was 237,165, of which an estimated 37 percent were caretaker adults. McCormick described DMAS' new Expansion Dashboard, which can be accessed through the website at www.dmas.virginia.gov, by clicking on "Medicaid Expansion Dashboard" under "New Initiatives." With the Dashboard, visitors to the website can view the latest updates on overall expansion enrollment, with breakdowns of parent enrollment, age and gender of new enrollees, and enrollment by region. Hanken commented that the Dashboard is informative and well-executed.

McCormick provided an update on DMAS' establishment of a Medicaid Member Advisory Committee (MAC). The MAC is a member engagement forum that invites the insight and recommendations of Virginia's Medicaid enrollees with the goal of helping DMAS improve enrollment and health care delivery. Committee members will all be Medicaid enrollees or an authorized representative of a Medicaid enrollee. The MAC will allow DMAS to have a formal method of hearing directly from those it serves. DMAS recruitment efforts for committee members considered a variety of diversity factors, such as Medicaid program type, region of the state represented, race, gender, and age. Meetings will be held quarterly, with the first meeting scheduled for April 1 at DMAS offices. Meetings will be open to the public.

Rita DeVaughn, Senior Contract Administrator, continued the DMAS update with information regarding Cover Virginia, applications processing, and enrollment efforts. DeVaughn stated that approximately 19,568 fast-track applications for Medicaid expansion were received from SNAP participants and parents of enrolled children. Eligible GAP and Plan First enrollees were auto-enrolled into the new adult coverage. DeVaughn stated that currently there is an application backlog, and they are working diligently to process those applications. DeVaughn also said that there has been an increase in call volume due to the backlog. DeVaughn updated the group on the special Cover VA unit being established for coordination and ongoing case maintenance of Department of Corrections applications.

Shelagh Greenwood, Outreach and Consumer Communications Manager, DMAS, provided an update on outreach and communications efforts. She announced that DMAS launched a responsive, redesigned Cover Virginia website on March 1. The redesign allows for viewing on a computer, tablet, or phone without any loss of readability. Lisa Dove, Virginia Community Healthcare Association, commented that the mobile-responsive design is very helpful. Greenwood stated that during the last week of February, CoverVA.org hit the milestone of 2 million views since its 2013 launch. In addition, between June 7, 2018 and March 3, 2019, more than 193,800 people visited the Medicaid Expansion page and more than 97,800 accessed the screening tool. Greenwood stated that MAGI applications, as well as brochures, flyers and posters for adult coverage and FAMIS have all been updated with the new income guidelines. They are available for online order in English and Spanish through the Materials page (under Partners) on CoverVA.org. An Adult Coverage flyer is also available in 17 languages for on-demand printing. Finally, Greenwood gave an update on the New Adult Health Coverage outreach campaign, stating that DMAS contracted with Washington, DC, agency Reingold, Inc. to place "Who's Covering You?" ads, including radio (Spanish and English), digital, newspaper, and out-of-home (gas toppers, bus kings, and billboards).

VIII. VDSS Update

Chartoya Newton gave the VDSS update. She stated that the benefit programs division is still focused on training for local departments of social services. They offered a weekly update during

the height of Medicaid expansion enrollment efforts, maintaining close contact with the local agencies that are the front line. VDSS gauged local application volume and solicited updates on training and staffing needs and other local impacts. Newton stated that training efforts will continue, and staff will be kept up to date with policy changes. VDSS is also focusing on automated processing, such as self-correct applications that do not have to wait for a worker to process them. Newton stressed the importance of getting automated processes in place to evaluate groups that will be eligible for continued coverage as part of the expansion group in the future, such as pregnant women, children turning 19, and foster care children "aging out" of the foster care system at 26. She stated that DSS is working on system changes for automated processes to ensure continued coverage for those eligible, versus a need for more intensive worker intervention to evaluate these individuals for continued eligibility.

IX. Public Comment

Public comment was invited but there were no comments.

X. June 6, 2019 CHIPAC Meeting

Chesser reminded members that the next CHIPAC meeting will take place on June 6 from 1:00 to 4:30 pm.

Closing

The meeting adjourned at 4:25 p.m.