CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

Meeting Minutes – 9/5/19

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

The following CHIPAC members were present:

• Denise Daly Konrad	Virginia Health Care Foundation
• Michele Chesser	Joint Commission on Health Care
• Rachel Lynch	Partnership for Healthier Kids
• Shelby Gonzales	Center on Budget and Policy Priorities
• Lisa Dove	Virginia Community Healthcare Association
• Carla Hegwood	Virginia Department of Health
• Christine McCormick	Virginia Association of Health Plans
• Ashley Everette	Voices for Virginia's Children
• Dr. Nathan Webb	Medical Society of Virginia
• Michael Muse	Virginia League of Social Services Executives
• Katharine Hunter	Department of Behavioral Health and Developmental Services

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
• Ashley Everette sent Allison Gilbreath	Voices for Virginia's Children
• Amy Edwards sent Martha Montgomery	Virginia Department of Education

The following CHIPAC members were not present:

• Dr. Karen Rheuban	DMAS Board Member
• Dr. Tegwyn Brickhouse	VCU Health
• Rodney Willett	Impact Makers
• Jennifer Wicker	Virginia Hospital and Healthcare Association

The following DMAS staff members were in attendance:

- Alyssa Ward, Behavioral Health Clinical Director
- Kelly Pauley, Eligibility and Enrollment Manager, Eligibility & Enrollment Services
- Janice Holmes, Operations Manager, Eligibility & Enrollment Services
- Shelagh Greenwood, Outreach and Consumer Communications Manager
- Lauryn Walker, Health Economics and Economic Policy Division
- Jennifer Palazzolo, Health Economics and Economic Policy Division
- Myra Shook, Dental Program Manager
- Laura Reed, Behavioral Health Manager
- Rebecca Anderson, Manager, Policy Research and Analysis, Policy Planning & Innovation Division
- Hope Richardson, Senior Policy Analyst, Policy Planning & Innovation Division

Meeting Minutes

Welcome

Denise Daly Konrad, CHIPAC Chair, called the meeting to order at 1:10 pm.

I. CHIPAC Business

A. Review and Approval of Minutes – Minutes from the June 6, 2019 quarterly meeting were reviewed. Jill Hanken, Virginia Poverty Law Center, noted that the minutes did not document that the Committee voted to request data from DMAS to inform CHIPAC's planning and recommendations regarding the upcoming General Assembly session. Hanken moved that the June 6 minutes be updated to add detail and reflect that a motion to request the data was approved (in section V). The motion was seconded by Michele Chesser and unanimously approved by the Committee. (Revised June 6, 2019 minutes can be accessed via the Virginia Regulatory Town Hall website.)

B. Review and Approval of 2020 Meeting Dates – Konrad informed the Committee that a copy of the 2020 meeting dates had been circulated. The Committee reviewed the proposed dates and voted unanimously to approve the dates.

The approved 2020 CHIPAC meeting dates are March 19, June 4, September 10, and December 3. All meetings will take place from 1-4:30 pm at Virginia Community Healthcare Foundation, Westerre Conference Center, 3831 Westerre Parkway, Henrico, VA.

C. Membership Subcommittee Update – Konrad gave an update on committee membership. She reported that the Executive Subcommittee had approved two nominees for the Committee's consideration to join CHIPAC: Lisa Specter-Dunaway of Families Forward and Victor James of the Virginia Chapter of the American Academy of Pediatrics. Konrad noted that due to members departing over the past few months, the Committee currently had 18 seats filled, out of a statutory maximum of 20. Konrad informed the Committee that biographies and completed member questionnaires had been circulated for both nominees. The Committee reviewed the materials and voted unanimously to approve Lisa Specter-Dunaway and Victor James's membership.

Konrad stated that the Executive Subcommittee will develop a list of suggested potential member organizations to fill new vacancies that may open up in the future. Ideas for the types of member organizations that have been proposed so far include organizations with connectivity to the Hispanic community and organizations that focus on pregnancy and maternal-child health. Konrad noted that the Executive Subcommittee has also recommended that CHIPAC would benefit from including more clinicians as members, particularly in light of the recent departures of members with clinical backgrounds. Konrad asked members of the full committee to direct suggestions of types of new member organizations that would be a good fit for CHIPAC to Committee leadership.

D. CHIPAC Dashboard Review – The Committee reviewed the September quarterly dashboard. Hope Richardson, DMAS, called members' attention to several changes to the way data is presented in the Dashboard. Richardson noted that these changes were made in response to member comments and questions and with the goal of streamlining the information presented and making it more understandable at a glance. Richardson stressed that DMAS is open to member feedback and changes can be reversed in future dashboards if the Committee does not find this format helpful.

Richardson pointed out that the CHIPAC Recommendations section at the top of p. 1 of the dashboard has been removed to focus the dashboard more on data and outcomes and because most of the recommendations had been included in the dashboard for a long time. She stated that records are kept of past recommendations of CHIPAC, and DMAS is working on compiling them in other formats such as a handout and potentially for inclusion on a CHIPAC page on the DMAS website. Richardson stated that the format of the children's oral health (EPSDT) data, also on p. 1 of the dashboard, had been updated in response to member input. Members had requested that the data be broken down by age groups, and that the table include percentages as well as numbers for children receiving dental and preventive dental services. Richardson stated that the headings of the dashboard have been changed to be more intuitive and the "table of contents/priorities" was removed since it was unclear for members who were not on the Committee when the dashboard data requests were last reevaluated.

Konrad reminded the Committee that DMAS has also revised the way the pregnant women's dental data is presented (now at top of p. 2). The new format of the table organizes the information by state fiscal year rather than aggregating all information for the history of the program to date. This will enable the Committee to better track the program's progress and changes in utilization and expenditures over time.

Chartoya Newton, Medical Assistance Consultant at the home office of VDSS, reviewed the Enrollment and Applications Processing sections of the dashboard. She stated that the information that currently appears on pages 6 and 7 of the dashboard will be changing. DSS will be adding information on pending applications specifically for children. They will change some of the organization of information to reflect CMS reporting format. Newton stated that DSS hopes to provide this updated information at the December meeting.

Shelby Gonzales, Center on Budget and Policy Priorities, stated that she is interested in applications processing data tracking whole families. Konrad said that she hoped there would be an opportunity to discuss this at the December meeting when the DSS data is presented in the new format. Hanken stated that she would support CHIPAC seeking timeliness information on a broader range of applications. Hanken said that historically, the reason CHIPAC requested data about pregnant women and renewals was because those were problematic

areas. Applications processing is supposed to be expedited to 10 days for pregnant women. Renewals have been the cause of several backlogs in the past few years.

Based on input during the dashboard discussion, Konrad asked whether CHIPAC members had recommendations they would like to propose to DMAS leadership regarding enrollment processes. The Committee discussed topics for a proposed CHIPAC letter. Gonzales moved that a letter be sent to the DMAS Director and the Secretary of Human Resources outlining recommendations to improve processes, ensure that individuals are evaluated at key transition points, and automate transitions as much as possible for (1) people reaching the end of the postpartum period. This recommendation focuses on individuals who may not qualify for expansion under the income reported when they were initially determined eligible for pregnancy coverage, but whose income may have declined during pregnancy and postpartum; (2) children aging out of children's Medicaid at 19; and (3) former foster youth aging out who remain eligible for Medicaid regardless of income until age 26. Hanken seconded the motion and the committee voted in favor of submitting the letter.

II. DMAS Update

Richardson provided an update on DMAS milestones and new initiatives. Richardson announced that the 50th anniversary of the founding of Virginia's Medicaid program was July 1, 2019. In addition, Virginia surpassed 300,000 newly eligible adults enrolled as a part of Medicaid expansion as of July 25, 2019. More than 229,000 Medicaid expansion members have received a Medicaid service to date. Richardson stated that recent enrollment data shows 60 percent of newly eligible adults are women and 45 percent are between the ages of 19 and 34.

Richardson emphasized DMAS' commitment to member-focused initiatives, including the newly formed Member Advisory Committee (MAC) that meets quarterly, and DMAS' project of updating member communications to be more user friendly, language accessible, and accessible for individuals who are visually impaired, deaf or hard of hearing. Richardson then introduced DMAS' Healthy Birthday Initiative. She explained that on June 5, Governor Northam announced a goal to eliminate racial disparities in maternal mortality by 2025. In support of this goal, DMAS has launched an initiative called Healthy Birthday Virginia, in collaboration with other state agencies and stakeholders, to support the Governor's goal and improve outcomes for mothers and infants. Richardson explained that Healthy Birthday Virginia builds on the Governor's goal and aims to ensure that all of our mothers and babies celebrate the child's first birthday together, healthy and thriving, by the year 2025. DMAS plans to work toward this goal with improvements in enrollment, policy and legislation, and by seeking opportunities to offer additional benefits and care coordination. Richardson stated that one of the Healthy Birthday Virginia priorities is to streamline enrollment of pregnant women and enroll them in care sooner. Under previous eligibility rules, most women had access to Medicaid coverage for only a narrow window of time during their pregnancy and for 60 days postpartum. Medicaid expansion now enables more women to receive coverage before, during, and after their pregnancy. As of September 1, systems changes ensure that eligible women who are ending their 60 days postpartum Medicaid coverage will roll into the Medicaid expansion group. This reform will ensure that pregnant/postpartum women retain their coverage without interruption or any delays in service.

Richardson gave an update on enrollment numbers for children and pregnant women and stated that FAMIS/CHIP children's and pregnant women's annual average monthly enrollment numbers are increasing.

Janice Holmes, Operations Manager in Eligibility & Enrollment, provided an update on Cover Virginia and application processing. She stated that Cover Virginia is currently in the middle of the Back to School campaign, and is experiencing high call volume and long wait times. Holmes reported that a callback process has been implemented as a menu option whereby callers are told what the wait time is and can choose to get a callback within 24 hours of the time they left the message. She stated that Cover Virginia is currently reviewing applications within 7 or 8 days. Cover Virginia and DMAS are reviewing forecasts to identify efficiencies in processing and ensure that any issues are addressed prior to Open Enrollment. Holmes reported that statewide trainings (regional and local trainings with the jails) are currently being conducted working with the incarcerated unit.

Shelagh Greenwood, DMAS Outreach and Consumer Communications Manager, gave an update from the Outreach and Consumer Communications unit. Greenwood reported that the Cover Virginia website had 9,350 unique weekly visitors in June, July, and August, significantly up from the same period in 2018. Greenwood explained that additions have been made to the website to improve accessibility, in response to recommendations from the Medicaid Member Advisory Committee. A page focusing on how to access services for children with a disability will be added. Changes to improve the website's navigability and readability have raised the site's ADA accessibility score from 75 to 88 percent. Greenwood explained that a project is underway to build a Spanish-language website that will mirror Cover Virginia. Shelby Gonzales, Center on Budget and Policy Priorities, asked about the process for review of the Spanish language website, and whether Spanish-speaking individuals have been involved in the review. Greenwood stated that closer to implementation, DMAS plans to share the website with Spanish-speaking stakeholders to provide feedback.

Greenwood announced that a new FAMIS MOMS flyer is being produced in support of the Healthy Birthday Virginia initiative. She provided an update on the 2019 Back to School Campaign, in which 1.5 million flyers were mailed out during the first week of July. Greenwood reiterated that when these flyers are sent home in children's backpacks, there is an uptick in calls at the call center.

Lauryn Walker of DMAS' Health Economics and Economic Policy Division (HEEP) provided an update on DMAS' work analyzing data about children receiving behavioral health services. Walker explained that the HEEP division is a new division at DMAS that has been focusing recently on examining member outcomes and analyzing data to understand member experiences in order to develop policies that benefit members. As part of this work, Walker stated that HEEP has been looking at behavioral health services data in conjunction with the behavioral health redesign project. Walker explained that community mental health and rehabilitation services (CMHRS), which were traditionally fee for service, were "carved into" managed care recently. DMAS has been examining data on this set of intensive behavioral health treatment services. In this process, rather than focusing on individuals' diagnoses, HEEP focused on the data from a services perspective and examined utilization patterns. They wanted to capture the baseline picture of how members are utilizing services currently, for comparison with the desired future behavioral health services landscape in which a broader array of services are available and there is greater opportunity to match intensity of service to members' level of need.

Walker presented several charts analyzing historical data. She explained that a greater number of members under age 19 received a CMHRS service as compared to members in the 19-64 age range. More than 45,000 children (6.4% of total children enrolled) received a CMHRS service in SFY2018. A large share of Medicaid mental health services spending goes

toward these intensive services. The most common CMHRS services provided to children are therapeutic day treatment (TDT), case management, and intensive in-home services. Skill building and crisis intervention services are more commonly provided to the adult population. An estimated 19,088 members under the age of 19 received TDT in SFY2018. Walker explained that TDT services are school-based or after-school intensive services that are largely delivered by qualified mental health professionals (QMHP) who must be registered and have a certain level of education and experience but are not required to have a particular license. Within TDT there is also required to be a therapeutic component such as therapy and supervision by individuals who are licensed or registered mental health professionals. Services tend to be provided for numerous hours per day. In contrast to TDT, intensive in-home services are primarily provided in the home. However, this service is also predominantly delivered by a non-licensed workforce. The CMHRS services have medical necessity criteria that require that children receiving these services are likely to be placed out of home. Walker stated that there are racial disparities in the utilization of these intensive services, with black children disproportionately referred to them.

Dr. Alyssa Ward, Behavioral Health Clinical Director at DMAS, stated that the intention of the behavioral health redesign data analysis is to understand how children currently are being served in the system, what their needs are, and what is driving their placement in the services they are receiving. Phase 1 of the behavioral health redesign aims to introduce new, evidence-based intensive services including multi-systemic therapy (MST) and family focused therapy (FFT) for the relatively small number of children in need of services at that level of intensity. With a good baseline to understand what the current system looks like, DMAS can examine the changes in how children utilize services, what populations and diagnoses are connected to services differently, and how the system shifts to adapt to the new services introduced. Dr. Ward introduced Laura Reed, a licensed clinical social worker and the new Behavioral Health Manager at DMAS. Dr. Ward stated that Reed will attend future CHIPAC meetings on behalf of DMAS' behavioral health division.

III. Dental Programs Update

Kristen Gilliam, Executive Director of DentaQuest, provided an update on Smiles for Children, DMAS' dental program for children and pregnant women. Gilliam reported that 56 percent of Medicaid children ages 0-20, and 62 percent of children ages 3-20, utilized dental services in SFY2019. Gilliam stated that when looking at pediatric dental utilization over the last five years, a small percentage decrease is evident in SFY2019. Gilliam explained that this is not a decrease in utilization of services, because a greater number of children are being treated. Rather, there was a significant increase in children *eligible* for these services between 2018 and 2019, especially in the 19-20 age group that has lower utilization. Percentages dipped due to this larger denominator. Gilliam reported that there has been an increase in the use of silver diamine fluoride (SDF) to arrest decay – up 186 percent from 2018 to 2019. As for application of fluoride varnish by non-dental providers, there was a 14 percent increase in children receiving a varnish.

Gilliam then reported on a similar metric that is calculated differently and measures additional children, the percentage of Medicaid and CHIP enrollees ages 2-21 who received a dental visit in 2018, a nationally reported HEDIS measure. Gilliam explained that Virginia is performing very well on this measure and is approaching the 90th percentile of high-performing states. Utilization is at 66.9%, which is well above the national average of 54.1%.

Gilliam reported that DMAS and DentaQuest have seen a steady increase in the number of pregnant women receiving dental services, with the SFY2019 numbers indicating that 6,900

pregnant women received services that year and paid claims totaled $5.5 million. (There is claims lag on the 2019 data, so it is expected that the numbers will increase.) Gilliam stated that the majority of services are posterior resin restorations, x-rays, prophylaxis and periodontal scaling.

Gilliam described the robust dental outreach program set up for members. She reported that DentaQuest recently coordinated a very effective robocall campaign to 61,000 members ages 1-18 identified as not having received a dental service in the previous 12 months. After the robocalls, 46 percent of those contacted visited a dentist. Gilliam also described the DentaQuest pregnant women outreach campaign, which provided Smiles for Children pregnant women's oral health kits to MCOs, dental clinics, and partner organizations for distribution. Smiles for Children has effectively collaborated with VDH, nurse midwives, Head Start, Capital Area Health Network, and MCOs at various conferences and meetings, which has resulted in direct engagement with over 100,000 individuals and 100+ community partners.

Gilliam highlighted the importance of provider participation to ensure that children have a place to go to utilize services. She stated that since she came to the program in 2005, there has been great improvement in the network. As of June 30, 2019, 1,925 dentists are participating in the Smiles for Children program, which represents approximately 25% of Virginia's licensed dentists and 34% of the state's practicing dentists. In addition, 95 percent of providers in the network are actively accepting patients and 88 percent are submitting claims, compared to less than half prior to Smiles for Children. Gilliam attributed some of this success to a high-touch approach to provider engagement.

Gilliam reported results of the member and provider satisfaction surveys. 71 percent of adults surveyed reported that they have seen an improvement in their or their child's oral health in the past year. 88 percent of providers reported that they were satisfied with the Smiles for Children program, and 97 percent of providers plan to continue participating in the Smiles for Children network next year.

IV. VDSS Update

Chartoya Newton gave the VDSS update. Newton stated that DSS is working with DMAS and the division of enterprise systems on several projects. They are working to ensure automated reevaluation of foster care children turning 18. Newton explained that a systems change became effective September 1 to allow for Medicaid pregnant women, when coming to the end of pregnancy eligibility, to be auto-enrolled into continued coverage. Newton stated that they have fewer than 1,000 overdue applications, and part-time processors are helping local agencies to process applications. They have approved almost 10,000 applications since they started in March. Newton explained that with Open Enrollment coming, and the anticipated influx of applications, these part-time processors will likely remain onboard to assist local agencies through that period and prevent applications pending for an extended period of time. Newton stated that DSS is working with DMAS to review processes that can be improved, such as revising all notices. This includes the verification checklist that customers receive when additional information is needed to process their case, as well as the renewal forms that customers receive. Shelby Gonzales, Center on Budget and Policy Priorities, asked whether this process is incorporating consumer review. Newton responded that, yes, the process includes the Medicaid Member Advisory Committee reviewing the notices and giving feedback. Newton stated that the twice-yearly Medicaid training for eligibility staff occurs in October.

V. Family First Prevention Services Act Discussion

Allison Gilbreath of Voices for Virginia's Children provided an update on the Family First Prevention Services Act and its impact on Virginia. Gilbreath explained that the Act was passed by Congress in February 2018 in the omnibus spending bill. The Act was primarily motivated by increased pressure on the foster care system as a result of the opioid epidemic; an understanding of the limitations of previous "reactionary" federal funding structures; and an over-reliance on congregate care for children in foster care. The Family First Act makes changes to Title IV-E and IV-B of the Social Security Act to allow federal funds to be used for foster care prevention services and limits payments to congregate care institutions. Historically, IV-E funds have been used primarily for maintenance payments for children in foster care. With Family First, IV-E is changing and a new focus is being placed on preventing entry into foster care. The federal matching rate for Title IV-E funds is 50/50.

Gilbreath explained that Title IV-E funds will be available beginning October 1 for up to 12 months for services to families of children who are considered "candidates for foster care." These are children who are at "imminent risk," but federal guidance further defining this term is not available. The Virginia workgroup that is aiming to implement Family First in January 2020 has defined what "candidate for foster care" will mean for Virginia and how these children will be identified. It is clear that the funds will not be used for primary prevention, but for tertiary prevention at best. Typically the population of children that Virginia will be serving through the new opportunities identified under Family First will be identified in a prevention plan, and the children receiving services would have ongoing CPS cases.

Under Family First, federal funding will be provided for prevention services and programs subject to an evidence-based standard similar to that developed by the California Evidence-Based Clearinghouse for Child Welfare. Services and programs must be classified as "promising," "supported," or "well supported" (50 percent must be well-supported). Services and programs must also be "trauma-informed." Gilbreath explained that we have a very low number of services that meet these criteria. The main programs being considered are in-home parent skill-based programs that include in-home parent training, home visiting, and individual/family therapy. Gilbreath described the Three Branch Model being used by VDSS to collaborate on decision-making around Family First. Three Branch is a model designed to bring the three branches of government together to develop an action plan to address the most pressing child welfare issues for the state. The purpose is to share best practices, identify priority issues, and deal collectively with matters of public policy and governance at the state and national levels.

Gilbreath explained that Virginia has seen a significant increase in children coming into care because of parents' substance use disorders. Communities across Virginia are experiencing an increase in substance exposed infants, with 1,543 reports of substance exposed infants in FY2017. Family First has the potential to provide a way to bill for IV-E services for mothers and their babies to receive treatment together. Gilbreath stated that it will be critical to track these outcomes. In addition, it will be challenging to find the beds for the moms and babies, and it is important to connect them with the right services and providers. Gilbreath reviewed some of the other challenges for Virginia, such as determining which services Medicaid funds will pay for versus Title IV-E, and when Medicaid pays for the service (Title IV-E is payer of last resort), whether those services can count toward the 50% minimum "well-supported" practices. There is also work to be done figuring out what as a state Virginia can do to get more services into the clearinghouse, and reaching agreement on what services and age groups to prioritize.

Gilbreath explained that the layering of Family First implementation as it relates to the behavioral health redesign will be very important. Gilbreath explained that Virginia is unique in that we have a different state department that manages the foster care funds. The state match will come from that budget because those are dollars already being spent on prevention services, such as multisystemic therapy (MST), family functional therapy (FFT), methadone maintenance therapy, home-based parenting programs, healthy families, and nurse family partnership. We have four services that are "well supported," with the others in the "supported" or "promising" categories. Gilbreath stated that additional funds to hire DSS workers to do this work are not budgeted. DSS workers' role has historically been reactive, in keeping with past federal funding impetus, and it will be important to provide training for staff to learn how to do preventive services work with families. While Family First is creating new preventive services funding for Virginia, it's only paying for the services, and not funding staffing or administrative dollars to build the infrastructure to make these services available. Laura Reed, DMAS, echoed that it is a challenge that local departments of social services are under-resourced and understaffed and have difficult with recruitment and retention. 40 percent of new workers quit in their first year, and training programs are four months, so many people are not even fully completing training. With current salaries at $27,000, many caseworkers are having to apply for the same services that they are connecting families with. Gilbreath stated that the recent JLARC report should be helpful in driving legislative changes, such as increasing LDSS salaries.

VI. Agenda for the next CHIPAC meeting

The Committee discussed agenda items for the December 5 CHIPAC meeting. Konrad stated that an update on the CHIPAC letter to the DMAS Director and Secretary of Health and Human Resources would be an agenda item. She requested additional input on agenda items. Members discussed topics including the public charge rule, updates on efforts of DMAS and other agencies related to maternal mortality, and the Healthy Birthday initiative. Hanken recommended that the agenda for the December meeting include a comparison of how Virginia's FAMIS programs compare to CHIP programs in other states. She cited examples of income eligibility criteria, scope of services for the CHIP population, as well as how Virginia spends its CHIP allotment.

VII. Public Comment

Public comment was invited, but there were no comments.

VIII. Next CHIPAC Meeting

Konrad reminded members that the next CHIPAC meeting will take place on December 5, 2019, from 1:00 to 4:30 pm.

Closing

The meeting adjourned at 4:00 p.m.