



Children's Health
Insurance Program
Advisory Committee
of Virginia



MEETING MINUTES

Meeting Minutes
December 3, 2020
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:

- Denise Daly Konrad
 - Carla Hegwood
 - Freddy Mejia
 - Lisa Dove
 - Quyen Duong
 - Michael Muse
 - Dr. Nathan Webb
 - Lanette Walker
 - Dr. Tegwyn Brickhouse
 - Bern’Nadette Knight
 - Jeff Lunardi
 - Victor James
 - Ali Faruk
- Virginia Health Care Foundation
 - Virginia Department of Health
 - The Commonwealth Institute for Fiscal Analysis
 - Virginia Community Healthcare Association
 - Virginia Department of Education
 - Virginia League of Social Services Executives
 - Medical Society of Virginia
 - Virginia Hospital and Healthcare Association
 - VCU Health
 - Department of Behavioral Health and Developmental Services
 - Joint Commission on Health Care
 - Virginia Chapter of the American Academy of Pediatrics
 - Families Forward Virginia

The following CHIPAC members sent substitutes:

- Chris McCormick sent Nicole Pugar Lawter
 - Sherry Sinkler-Crawley sent Niani Vines
 - Sara Cariano sent Jill Hanken
 - Michael Cook sent Dr. Kannan Srinivasan
- Virginia Association of Health Plans
 - Virginia Department of Social Services
 - Virginia Poverty Law Center
 - Board of Medical Assistance Services

The following CHIPAC members were not present:

- Shelby Gonzales
- Center on Budget and Policy Priorities

Meeting Minutes

Welcome

Denise Daly Konrad, CHIPAC Chair, called the meeting to order at 1:10 pm. Konrad welcomed Committee members and members of the public, and DMAS staff gave a brief overview of the WebEx 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. Konrad stated that since some Committee members had not yet joined the call, the agenda would be shifted to move CHIPAC Business items later in the call.

Konrad reminded the Committee that the agenda included a continuation of the “State Agency Data and Racial Disparities” discussion that took place at the September 10 meeting. Konrad then introduced Dr. Melanie J. Rouse, Maternal Mortality Projects Manager, Office of the Chief Medical Examiner at the Virginia Department of Health.

I. State Agency Data and Racial Disparities Discussion, Part II (cont’d from Sept. 10 mtg.)

Dr. Rouse presented on Virginia’s Maternal Mortality Review Team data and risk factors for pregnancy-associated deaths that the team has identified. She explained that the Maternal Mortality Review team was developed through a partnership within VDH between the Office of Family Health Services and the Office of the Chief Medical Examiner. The team was first convened in 2002, but was codified through legislation in 2019. Funding is provided through Title V monies. The review team is a multidisciplinary team with members of diverse professional backgrounds, including forensic pathology, maternal-fetal medicine, nurse midwifery, obstetrics, pharmacy, nutrition, patient safety, psychiatry, health services research, and social work.

Dr. Rouse explained that the number of pregnancy-associated deaths varies from year to year with no clear pattern of increase or decrease. She presented an analysis of combined data from 2004-2013 plus preliminary data from 2015 and 2016. Over half of these 525 deaths were natural deaths (approximately 56%), 26% were accidental, 10% were homicides, 7% were suicides, and 1% were undetermined. Cardiac disorders were the leading cause of death (14.4%), followed by accidental overdoses (13.5%), motor vehicle accidents (10.5%), homicide (10.3%), and suicide (6.5%). Throughout the years, significant racial disparities have been identified in Virginia’s maternal mortality rates, causes of death, manners of death, and in the contributors to mortality. These disparities extend across all socioeconomic and educational backgrounds.

Dr. Rouse stated that disparities in maternal mortality rates between white and Black women over the five-year period from 2009 to 2013 ranged from just under twice as high, to up to three times as high, depending on the year. The overall rate of maternal mortality for Black women over this time period was 80.7 (rate per 100,000 live births) and the rate for white women was 35.3. There have also been significant differences by race in the manner of death, with Black women more often dying of natural causes (66.3% vs. 45.8%) and white women more often dying of accidental causes (34.6% vs. 14.6%). Among white women, accidental overdose was the most common cause of death, at 18.7%, followed by motor vehicle accidents (13.1%), cancer (10.3%), infection (10.3%), and suicide (10.3%). Among Black women, cardiac disorder was the leading cause of death (18.0%), followed by homicide (12.4%), exacerbation of a chronic disease (11.2%), pulmonary embolism (7.9%), and motor vehicle accident (6.7%). Dr. Rouse commented that several factors have been prevalent in these deaths. Among these is mental illness, including depression and anxiety. Over 25% of

maternal decedents in Virginia had been diagnosed with depression and about 20% had been diagnosed with anxiety at some point during their life. The review team found that approximately 25% of decedents had a chronic substance use issue. The team found that many chronic conditions, including substance use and mental illness, were inadequately addressed prior to pregnancy and after the traditional 42-day postpartum period. The lack of adequate care for chronic conditions was found to be a significant contributing factor in these deaths. In 2019, the review team released the report *Chronic Disease in Virginia Pregnancy-Associated Deaths, 1999-2012: Need for Coordination of Care*. Dr. Rouse explained that the report found there was a lack of coordination of care, with many women not receiving the appropriate screenings or referrals, or experiencing difficulty in following through on the referrals when navigating the health care system without adequate assistance.

Dr. Kannan Srinivasan, Board of Medical Assistance Services, asked for clarification that the most recent year of data in the report was 2012. Dr. Rouse confirmed this and explained that while the review team is working to finalize the 2015 and 2016 cases, with the codification of the review team's role, the team now has a three-year reporting requirement, so they needed to move ahead to be more current with what they are delivering to the General Assembly in the reports. Jill Hanken, Virginia Poverty Law Center, asked whether the team had made recommendations based on the data presented. Dr. Rouse stated that recommendations included screenings in emergency departments for pregnancy or recent pregnancy, and explained that they are working with the Virginia Neonatal-Perinatal Collaborative to create a survey to gather information about what emergency departments' current practices are regarding screenings. Recommendations also included improving the availability of nutrition services to provide access to these services early in pregnancy and throughout the course of the pregnancy. Other recommendations included requiring providers, other than just prenatal care providers and maternal-fetal medicine providers, to receive and maintain training in contemporary management of diseases among child-bearing women, in order to facilitate a coordinated system of care around these women. Daly Konrad asked whether the work is informing the work of DMAS' Healthy Birthdays initiative. Dr. Rouse stated that the team has provided information to DMAS but has not formally collaborated on the project.

Daly Konrad encouraged members to use the chat function to contribute comments on key takeaways for the Committee from Dr. Rouse's presentation.

II. **CHIPAC Business**

- A. Review and Approval of Minutes** – Minutes from the September 10, 2020 quarterly meeting were reviewed. Carla Hegwood, Virginia Department of Health, moved to approve the minutes, Dr. Nathan Webb, Medical Society of Virginia, seconded, and the Committee voted unanimously to approve.
- B. 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: Jeff Lunardi will represent the Joint Commission on Healthcare and Bern'Nadette Knight will represent the Department of Behavioral Health and Developmental Services. In addition, two candidates for membership were presented to the Committee, Ali Faruk of Families Forward Virginia and Lanette Walker of the Virginia Hospital and Healthcare Association. A vote was held on the Executive Subcommittee's recommendation to approve the two candidates for membership. Carla Hegwood moved to approve, and Jill Hanken seconded. Both new members were approved unanimously by the Committee.

Daly Konrad announced that Hegwood of VDH and Sara Cariano of VPLC had joined the Executive Subcommittee. Daly Konrad then stated that, with the departure of Michele Chesser from the Joint Commission on Health Care and thus from her Committee role, there is a vacancy for the Vice Chair position. Daly Konrad explained that the position has a two-year term and serves on the Executive Subcommittee as well as the full committee. The Executive Subcommittee meets once a quarter and helps to plan the full committee meetings. Konrad invited members interested in the position to contact her or Hope Richardson of DMAS.

III. Continuation of State Agency Data and Racial Disparities Discussion, Part II

Daly Konrad explained that the Committee would now resume the discussion of state agency data and racial disparities. She reminded the Committee of the question for consideration:

In reviewing the data and information presented today and at the last Committee meeting regarding racial health disparities, what do you see as the key takeaways for the CHIPAC's work?

Daly Konrad encouraged members to use the chat function to offer their comments in response to the question and presentation. She explained that members should select all/everyone for recipients of the chat comments and stated that chats would be saved so that the ideas shared could be referenced in future Committee discussions.

Mariam Siddiqui, Senior Programs Advisor for the DMAS Director's Office, presented on the work of the newly formed DMAS Health Equity Workgroup. She explained that this internal agency workgroup is working to identify, reduce, and ultimately eliminate health disparities. The workgroup's goal is to develop an agency-wide strategy to ensure that DMAS provides access to quality services for all Medicaid members and providers. Siddiqui stated that one way Medicaid agencies have been tackling health disparities is by addressing language barriers. She explained that DMAS has developed a language access plan and is collaborating with the Department of Social Services on developing automated translations for all public benefit-related notices. Siddiqui highlighted the fact that the COVID-19 pandemic has had a disproportionate health impact on vulnerable communities, especially BIPOC (Black, indigenous, and People of Color) individuals and populations, across the Commonwealth, with disproportionately high rates of infection and higher death rates in Black and Hispanic/Latinx communities in particular.

Siddiqui explained that the Health Equity Workgroup is currently focusing on identifying and cataloging projects in progress across the agency related to reducing health disparities, identifying key equity issues affecting Medicaid members, understanding what other state agencies are doing to address equity issues, and exploring opportunities to collaborate on these projects. Data, Quality and Measurement goals include developing an inventory of all available Social Determinants of Health (SDOH) data, evaluating system capabilities to update or add new data elements, reviewing and standardizing MCO annual health equity reports, and reviewing quality measures for health equity (such as the Healthcare Effectiveness Data and Information Set, or HEDIS, measures). Long-term goals for the workgroup include implementation of the language access plan, developing health equity performance measures for the Medicaid program and long-term, annual metrics to assess changes in health equity issues (e.g., access to care, quality of services, use of coverage, etc.), and developing a Medicaid enrollment dashboard with demographic information such as age, race, ethnicity, gender, sexual orientation, disability and other sociodemographic characteristics.

Siddiqui explained that the Workgroup has twice-a-month calls with the State Health Equity Workgroup, regular internal check-ins with subgroups and executive leadership, a monthly full-workgroup meeting, and the Workgroup is also planning to share quarterly stakeholder updates. She asked the Committee for recommendations regarding the stakeholder updates.

Daly Konrad asked about the State Health Equity Workgroup and how it was related to the DMAS internal Health Equity Workgroup. Siddiqui responded that VDH is the lead for the State Health Equity Workgroup that was created earlier this year as part of the state's COVID-19 response. DMAS has been attending meetings of the state workgroup and partnering with VDH in developing materials and providing information and updates regarding application processes and Cover Virginia when needed for community events.

Daly Konrad offered the Committee's assistance and input on DMAS health equity projects related to children and pregnant women. She stated that the Committee is interested in offering timely and actionable feedback on such projects and would like to work with DMAS executive leadership to communicate regarding opportunities to provide input.

Daly Konrad reminded the CHIPAC members that presenters from the December meeting were also on the call and invited any follow-up questions that members might have on the December presentations. Freddy Mejia, The Commonwealth Institute, asked about DMAS plans to look at the scope of uninsured children and barriers to coverage, with particular interest in immigrant populations. Lauryn Walker, Senior Advisor to the DMAS Chief Deputy and Acting Director of the Office of Data Analytics, explained that data on the uninsured can be challenging for DMAS to obtain since the data the agency has is based on the populations currently covered by Medicaid, applications and medical claims and encounters for those Medicaid members. To understand the uninsured population, DMAS must look to outside sources and extrapolate. She explained that to improve outreach campaigns, DMAS has been using publicly available sources such as Census American Community Survey (ACS) data to better understand the eligible-but-uninsured population. Walker explained that with Medicaid Expansion, as parents were enrolling, Medicaid experienced a boost in child enrollment as well. She explained that new ACS data was recently released and that VCU is looking at that data and working to better understand the remaining uninsured population as part of the Medicaid Expansion evaluation. Rachel Pryor, DMAS Deputy Director of Administration, explained that DMAS' strategic outreach planning is informed by ACS data and other data sources on the uninsured population and that it is a priority for DMAS to ensure that outreach is data-driven and targeted. She explained that DMAS has found that outreach has been most effective when advertising and communications campaigns are paired with on-the-ground enrollment events and outreach.

Mejia asked about the impact of in-person school moving to online instruction during the pandemic and whether Medicaid/FAMIS enrollment increases have been smaller during the usually-busy back-to-school period than in past years. Pryor responded that since the onset of the public health emergency, DMAS has prioritized transitioning outreach to online and socially distanced modes, and that a large-scale online/remote campaign was launched specifically for the annual Back-to-School enrollment drive. Walker stated that while DMAS has not specifically looked at this year's fall enrollment gains for children compared to last year's, the enrollment data that DMAS tracks on a weekly basis is showing very large, steady gains in children's enrollment. She stated that the data also show spikes in enrollment in response to outreach campaigns, and monitoring this helps DMAS confirm that outreach is having an observable impact.

Daly Konrad explained that the *Profile of Virginia's Uninsured* report that the Virginia Health Care Foundation released in March provides updated estimates of the percentage of the state's child population that is eligible for Medicaid or FAMIS but uninsured, and that the report also breaks the data out by age group. She stated that the report would be a valuable resource for understanding Virginia's uninsured population.

IV. DMAS Update

Hope Richardson, DMAS Policy Planning and Innovation Division, explained that the DMAS Dashboard is a collection of metrics selected by the Committee that is updated for each meeting for the members to review. Some sections of the Dashboard are updated quarterly and some are updated annually. Richardson provided an overview of the latest updates to the DMAS Dashboard. She explained that Children's Oral Health table that is updated annually had recently been updated, and that based upon Committee requests, the data in that table is now broken out by age. Richardson stated that the data in this table is based upon Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data on Medicaid-enrolled children's utilization of dental services. Richardson also reviewed quarterly updates to the dashboard, including Pregnant Women's Dental Benefit utilization data, application processing and enrollment data.

Rachel Pryor, DMAS Deputy Director of Administration, provided the Policy and Administration update. Pryor began by outlining key legislative developments during the recent General Assembly Special Session. She explained that funding was re-allotted to extend postpartum coverage from 60 days to one year for women up to 205 percent of the federal poverty level. Pryor stated that postpartum coverage is a key step in ensuring that DMAS' interventions to reduce maternal mortality and morbidity and eliminate racial disparities in maternal and infant outcomes are effective. Pryor explained that provisions in the budget for Medicaid Behavioral Health Enhancement will ensure that behavioral health services provided through Medicaid are evidence-based and provide access to a continuum of community rehabilitation services. She stated that provisions were also included in the budget to support ongoing distribution of CARES Act funding, including funding for long-term care facilities, personal protective equipment (PPE) for personal care attendants, hazard pay for personal care workers, hospital reimbursements for COVID-19 costs, and retainer payments for Developmental Disabilities (DD) waiver day support providers. Pryor stated that funding was also re-allotted to end the requirement that lawful permanent residents have 10 years of work history to qualify for Medicaid in Virginia. Additionally, a comprehensive adult dental benefit was approved effective July 2021, and rate increases were approved for certain providers, including anesthesiologists, mental health providers, skilled and private duty nursing services and DD waiver providers.

Pryor announced that DMAS recently delivered a report to the General Assembly on Medicaid-funded school health services. The report, which is now available on the Legislative Information System website, provides recommendations concerning the expansion of DMAS' cost-based reimbursement program for schools to include Medicaid-covered services outside of a student's Individualized Education Program (IEP). Currently, Virginia public schools may seek reimbursement using a cost-based methodology from federal Medicaid and CHIP for costs associated with providing covered special education-related services to member students with disabilities. CMS has released updated guidance enabling states to expand their Medicaid school-based services reimbursement programs to include services provided to Medicaid member students outside the IEP. Pryor explained that in order to implement DMAS' recommendations in the report, a state plan amendment and changes to Virginia's regulations would be required.

Trends in Enrollment and Service Utilization – Richardson explained that DMAS wished to respond to questions raised by CHIPAC members at the prior CHIPAC meeting regarding trends in children’s enrollment and service utilization and the impact of the COVID-19 public health emergency, particularly on well visits and preventive services such as immunization. Lauryn Walker then provided an overview of general enrollment trends, especially among pregnant women and children, and service utilization trends during COVID-19. Walker stated that since the state of emergency was declared on March 12, DMAS has gained 200,758 new members, for a total of 1,734,035 total members as of November 30. 99,874 of these new members are in Medicaid Expansion, and 65,706 are children. On average, Medicaid gains approximately 4,700 new members a week.

Walker explained that before COVID-19, enrollment would typically see a lot of “churn” with members moving in and out of coverage and between eligibility groups and programs. During the public health emergency (PHE), there has been significantly less churn, due to provisions in federal legislation that require continued coverage for most enrollees. For this reason, the 4,700 weekly statistic truly reflects new members, not simply members remaining enrolled in the program. Walker reviewed the Enrollment Dashboard and explained that the dashboard is available on the DMAS website, is updated every two weeks and that DMAS is developing an archive so that members of the public can access historical data. Walker presented pregnancy enrollment data, stating that currently about 22,000 pregnant women are enrolled. Prior to COVID, this number had been closer to 16,000 per month. Walker then presented children’s enrollment data. Walker stated that currently approximately 741,154 children are enrolled across programs. Before COVID, children’s enrollment numbers were closer to the 685,000 to 700,000 range. Walker pointed out that the dashboard also includes filters by ethnicity and race as well as by gender and age group.

Walker then presented data on service utilization during COVID-19. She stated that one of the main areas of concern was lower utilization of outpatient services. Elective outpatient surgery, for example, was put on hold for a time during the initial weeks and months of the pandemic. Walker explained that DMAS has been monitoring utilization of outpatient services to better understand how the pandemic is affecting enrollees’ ability to access care. Walker presented charts showing estimated service utilization. The charts showed paid claim amounts from MCOs and additional estimated amounts, based on historical data, to account for claims lag. The charts show a large drop in utilization across all outpatient services starting in February, bottoming out in April and beginning to return to normal in June, July, and August. The trend was the same across the two managed care programs; however the CCC Plus drop was less pronounced, likely due to the nature of the CCC Plus population with complex care needs and chronic conditions requiring treatment that is generally more difficult to avoid or defer. Walker explained that pregnant women and children’s populations look very similar to the trends for the managed care populations overall. Walker noted that the charts also accounted for enrollment growth during the pandemic; she pointed out a line in the chart that indicated adjusted totals in which utilization is seen to be close to, but not completely caught up with, pre-COVID utilization by late summer (the most recent data available due to claims lag). Walker stated that utilization as a whole has returned to around 90 percent of pre-COVID levels.

Ali Faruk, Families Forward Virginia, asked whether there was analysis on specific services, and if any areas have been identified where the drop was especially pronounced and has not recovered. Walker responded that the most pronounced drop has been observed in dental utilization, which is largely explained by widespread closures of dental offices. Walker explained that pharmacy actually saw an increase because many enrollees utilized 90-day prescription fills early in the public health emergency period.

Walker then presented data on vaccination claims during COVID-19 compared to vaccination claims in 2019. She explained that there is a clear decline in vaccinations not only for children but also for adult populations. Walker stated that vaccine utilization is seasonal, with September and October having the highest utilization. She added that when the data is available for the fall quarter, DMAS will have more information about the year-over-year impact. Fall school enrollment is closely tied to vaccination, and it is not yet known whether temporary school closures and transitions from in-person instruction to home-based instruction will impact fall vaccination rates.

Lanette Walker, Virginia Hospital and Healthcare Association, asked whether the count of pregnant women in the enrollment dashboard shows all pregnant women enrolled or if it is just the women in the aid categories specific to pregnant women. Lauryn Walker responded that the enrollment dashboard provides a count of just the women in the pregnancy aid categories (Medicaid pregnant women and FAMIS MOMS), who are enrolled because they are pregnant.

Richardson then shared information from a survey of the managed care organizations (MCOs) conducted by the DMAS Health Care Services Division. DMAS reached out to the MCOs to gather information about what they are doing currently and actions they plan to take to help get children back on track with immunizations, well-child visits, and other preventive services that they may have missed or delayed during 2020 due to the public health emergency. Richardson stated that one of the broader initiatives MCOs as a whole are undertaking is immunization drives involving large provider groups, schools, and community health fair type events. The plans are also looking at ways that they can encourage providers to expand office hours for appointments, since it can be difficult for working parents to take time off during typical business hours for preventive care that is less urgent or time-sensitive, especially if they are paid hourly or do not have access to paid time off. Availability of additional appointment hours provides more options for parents to choose from. Most plans responded that they are making children's immunization status available in regular reports and in reports that are shared with providers to encourage follow-up. Plans are also contacting members individually to remind them that it is time for a vaccination and/or well visit, through postcards and other mailings, but also through more active methods such as focused phone outreach through predictive modeling, calling members directly and walking them through scheduling office visits, and being a liaison with providers. Richardson explained that some of the MCOs have reported that they have had better response rates than usual with phone calls, perhaps due to more people being inclined to answer the phone during the pandemic. She stated that the MCOs reported they are working to identify and address barriers in access to care such as transportation challenges. She explained that MCOs are further integrating preventive care into existing member incentive programs and publicizing their incentive programs in hopes of improving immunization rates. The plans have also elevated their messaging about the importance of the flu vaccine this year in particular, for all ages. Richardson stated that prior to the pandemic, plans were already working on efforts to improve HEDIS scores, and those efforts continue. Plans have created training materials and developed trainings that can be accessed online due to the need for social distancing.

Richardson stated that if Committee members were interested in learning more about DMAS and the MCOs' work in this area, DMAS could follow up at a later meeting when the fall data is available and/or invite representatives from the managed care organizations to attend or present at a future CHIPAC meeting.

Janice Holmes, Operations Manager, DMAS Eligibility and Enrollment Services, provided an update on Cover Virginia, the call center and application processing. Holmes explained that

Cover Virginia is continuing operations while preparing for a new contractor to take over effective April 2021. Maximus U.S. Health and Human Services will be taking over Cover Virginia operations, including the call center and central processing unit (CPU) as well as CoverVA.org. Holmes stated that the Cover Virginia call center is currently experiencing long hold times. Ninety percent of staff are teleworking. Holmes explained that DMAS continues to work with the current vendor to improve staff performance and shorten wait times. The call center has recently brought back the option for a caller to leave a message and receive a call-back within 24 hours. In addition, new hires are in training to increase staffing, and 100 percent of calls are recorded for quality monitoring.

Holmes stated that since the beginning of Open Enrollment on November 1, Cover Virginia has seen a significant increase in applications coming from the Federal Marketplace. She reported that there were over 19,000 applications received at the CPU for processing within the first four weeks of Open Enrollment. These volumes significantly exceed the forecast, which was made in spring 2021, prior to the beginning of the public health emergency. Holmes stated that initial reviews are occurring within 12 business days, and eligibility determinations remain timely and contractually compliant.

Jill Hanken, VPLC, asked Holmes if emergency measures might be considered to ensure that all those who are attempting to enroll can do so, given that only two weeks remain of Open Enrollment. Hanken raised concerns about errors in Marketplace determinations this year, particularly in the area of immigration status. Pryor responded that DMAS shares these concerns and that the agency is looking at any measures that may be available to ensure that all qualifying individuals who need to are able to access coverage.

Hanken asked whether the public health emergency will be extended beyond the end of January, and inquired about DMAS' plans for the "unwinding" process post-PHE. She asked about new guidance from the Centers for Medicare and Medicaid Services (CMS) indicating that benefits could be reduced during the PHE and the ongoing maintenance of effort, and asked whether DMAS had any plans to implement such reductions. Pryor responded that DMAS does expect that the public health emergency will be extended beyond January. She explained that Virginia prefers to err on the side of maintaining full coverage protections for Medicaid members for the duration of the PHE, and that DMAS does not plan to allow benefit reductions. Pryor stated that there is still no clear guidance from CMS on the unwinding plan. DMAS is awaiting guidance from the federal government, but to the extent possible in the absence of this guidance, DMAS is planning for systems changes and other preparations that will need to take place in order for unwinding to be implemented smoothly post-PHE.

Shelagh Greenwood, DMAS Outreach and Consumer Communications Manager, gave an update on Communications and Outreach. Greenwood explained that DMAS implemented the 2020 Back to School Campaign in July and August. Greenwood explained that the campaign looks very different than in previous years due to the pandemic. Although 1.5 million flyers were still printed, DMAS gave schools increased flexibility in how to distribute the flyers to families, in order to accommodate remote schedules. Greenwood stated that during the public health emergency, DMAS has enhanced digital and social media outreach. She informed the Committee that there is a landing page on the website dedicated to sharing COVID-19 information.

Daly Konrad announced to the Committee that Greenwood would be retiring from DMAS at the end of December. She thanked Greenwood for her many years of service to Virginia's children and families and to the CHIPAC, and congratulated her on her retirement.

V. VDSS Update

Niani Vines, Medical Assistance Consultant for the Central Region, provided an update from the Virginia Department of Social Services. Vines stated that VDSS is continuing to work with the local social service agencies on plans for unwinding emergency procedures once the public health emergency ends and what types of business processes will be implemented to facilitate unwinding and decrease workload for the local agencies. She explained that when the PHE began in March, workers were instructed not to process renewals. As time has gone by, some automated processes were put in place. LDSS have been instructed that they could continue processing renewals as long as the case did not close altogether or get moved from full coverage to a lower coverage group.

Vines stated that prior to resuming the renewal process, there were approximately 667,000 renewals that were due through February 2021. Now that the renewal process has resumed, 295,000 renewals due between March and February 2021 have been completed. The automated processes are assisting local workers in decreasing workload. Vines explained that VDSS will have to submit a mitigation plan to CMS explaining how they plan to assist the local agencies in catching up on renewals that have not been processed at the end of the PHE. She stated that VDSS will continue to update workload reports to track the number of renewals due each month.

Jill Hanken, VPLC, asked whether VDSS is tracking cases that were able to be renewed ex parte. Vines responded that an automated process occurs two months in advance of when the renewals are due, and a report is generated through the case management system that workers can pull that will show all renewals that went through the automated system for their agency. In this report, local agencies can see how many ex parte renewals failed, how many went through the process, and the reason for any failed renewals so that workers can reconcile the issue manually. Vines stated that, historically, about 60% of ex parte renewals are successfully auto-renewing.

Hanken asked about cases that are erroneously closed. Vines responded that a case can still be closed if the applicant/member requests to disenroll/withdraw, or if someone moves out of state or is deceased. She explained that if a case is improperly terminated and is not one of these exceptions, that VDSS is researching and working to resolve these issues for the recipient.

V. Agenda for the March 4, 2021 CHIPAC meeting

Konrad asked if members had ideas for agenda items for the March 4 CHIPAC meeting. Lanette Walker, Virginia Hospital and Healthcare Association, said that she would be interested in continuing to monitor enrollment and utilization trends. Bern'Nadette Knight, Department of Behavioral Health and Developmental Services, stated that she was interested in continuing to receive updates on the DMAS Health Equity Workgroup.

VI. Public Comment

Public comment was invited, but there were no comments.

Closing

The meeting was adjourned at 3:20 pm.