EFRC Quarterly Meeting

>> KAREN KIMSEY: Hello everyone. This is Karen Kimsey, Director of the Medicaid program. We're here for our EFRC. I think we're going to begin in just a minute or two. We have a virtual gathering here, a mixed hybrid mode, so I think we're waiting to make sure we have a quorum in person before we get started, so we will start in a few minutes at the cue of the individuals in the room. Just want to appreciate everybody's patience as we wait and get settled into this new hybrid mode.

I just received an update. We're just waiting for one more individual to show up, and as soon as they are, we will be able to get started. Thank you again for your patience.

Hello everyone, this is Karen. Just wanted to touch base with you one more time. I apologize for the delay in the start. In order to have the meeting, we have to have a public quorum of a certain number of

individuals, and we're waiting for one more individual to arrive, which is why we're delaying the meeting. We appreciate your patience, and we will get started as soon as we can.

Okay. Chris, will we ready?

>> Yes, good morning, Director Kimsey, we have a quorum.

>> KAREN KIMSEY: Hello. Just to let people know. Chris, we hear you, but it's a little bit of a quiet in the background, so if there are individuals who are in the meeting, public and physically, we'll need to speak up. But I just wish to say good morning, and hello to everyone. I am Karen Kimsey, the director of the Medicaid program here, and here is my distinct honor to welcome you all to our third external financial review council for this year. Members of the council, we're so glad to have you here, as well as our members of the DMAS team who are here to present to you, and the audience in particular. As you can tell, we are still in hybrid mode. Some are attending in person, and some are attending virtually, however as directed by the OID, we are required to have a quorum of four appointed members present in person, and today we appreciate Dr. Carey, Secretary of Health and Human Resources, Mike Tweety, Susan Massal from the house appropriations and as well as Jloft for attending so we can have our quorum today.

Also wish to acknowledge our chief health economist, Mr. Rich Rosenthal. He is on the call just starting this week with us with over ten years of executive level experience and leadership in this area, including managed care, and we wish to welcome him here with us today, and you will get to know him more as he sets up time and meetings with you.

Just a couple of important updates for you, and then we'll turn it over to the team. We have much to share for you today.

One, we just received fresh off the press just a few moments ago, we did receive the Federal Government approved the PHE through January 16th of 2022, which will give an additional 145 million general fund dollars for the fiscal year and to the quarter of fiscal year 2022. So, very excited about that. The team will be working and adjusting numbers as appropriate with you.

Also, our team has been working diligently to help facilitate Medicaid enroll meant for Afghan evacuees. We expect up to 20,000 families to be enrolled in the Medicaid program in this coming year, and our teams are actually on site at the bases and in the hotels helping people apply. Huge shout out to that team for that hard work.

We're also working diligently, thank you, to members of the counsel, a well as our stakeholders and teams, we have been executing 65 policy

adjustments and Medicaid, not excluding, but limited to four American rescue plan act projects, also including 12.5% increase, a one (Inaudible) payment for person of care attendants, $5 per diem to the nursing centers, and 10 million to prepare for the eventual unwinding of our individuals on eligibility perspective for the public health emergency. So, more for you to come on that for you today.

Also wish to just to acknowledge here today that the team from DMAS we wish to recognize Secretary Carey for his steadfast support for us not only leading us through Medicaid expansion, but also through the COVID public health emergency. We have a tiny token of appreciation for him at the agency right now, just wishing to thank you, again, for all that you have done for us over this last four years, and a steadfast appreciation for your leadership. So, thank you. We're sorry we're not there in person to clap for you. But I wish to also secretary, sir, if you have any comments, we would love to hear them, and then I will turn it over to Mr. Chris Gordon, our CFO.

>> Carey, thank you, and thank you to all of DMAS hospitality and your (Inaudible) most thank you (Inaudible) especially here over the last 20 plus months perseverance getting the job done. I don't know where -- well, Medicaid, base Medicaid as well as Medicaid (Inaudible) so

many individuals that are services because of had (Inaudible) thank you to your team (Audio cutting in and out). Thank you.

>> KAREN KIMSEY: Okay. Chris, we'll turn it over to you, and also just want to acknowledge, we're having a difficult time hearing comments echoed in the room, so I'm not sure if Alan is there, anybody can help with improving the sound quality at this time, but we'll also turn it over to the team. Chris, for some remarks if you can and also to the team for presentation. If we need to, we can also drive it virtually, if that would help.

>> Good morning. Alan is here working on the volume piece.

>> KAREN KIMSEY: That's better.

>> Alan: Yeah, we'll speak into the mics. I apologize.

So, good morning everyone. Thank you, Director Kimsey and Dr. Carey. We'll have the agenda up on the screen real quick so you can follow along and then we'll transition into our presentations.

Just to do a quick overview, today we have an expenditure review, as required, financial review counsel, (Inaudible) will be providing that along the (Inaudible). And we'll also talk a little bit about bringing (Inaudible) to forces and then we'll round it out with Debbie Roberts and Debbie Whitlock talking about the changes care of managed care contract.

Lastly we'll (Inaudible) and then of course we'll have questions.

During the presentations, folks who are members of the (Inaudible) questions at any time, it's your prerogative. You can ask people who on screen, who are attendees, if you will, or folks in the room, some of your questions.

What that, I will turn it over to (Inaudible) Harper to go over (Inaudible).

>> DONITA HARPER: Good morning everyone, I hope you can hear me. As Chris stated, my name is Donita Harper I am the interim budget director and I will be joined with Rob Chapman who is our chief economist and be presenting our Medicaid expenditures as of our first quarter ending September 2021.

Next slide, please.

The agenda for today we will be discussing 2022 state fiscal year to date expenditures. We'll be comparing the Medicaid forecast to the actual expenditures, and then we will be over a fluctuation analysis where we will discuss a plus or minus 10% variance and drivers based on comparison of forecast expenditures, and then finally we'll give you some highlights of the forecast of fiscal year '22 through '24 forecast.

I'll be turning it over to Rob Chapman and he'll be discussing the

next slides. Thank you.

>> Rob: Thank you, Donita. Thank you, everyone. It's been quite a year, and the last year from the last forecast, and I think at this point last year we would have no idea that we would be continuing to be virtual, as we are now, or at least in a hybrid mode, and some of that is reflected a bit in this presentation, as we are in the middle of forecast development, and we'll be finalizing the forecast for the November 1st of this year in a couple of weeks.

As you said, this has been quite a year, and we can see that demonstrated on this first graph of our forecast actuals, or actuals vs. forecast, and in particular in this graph on the top hereof total enrollment. This -- the forecast numbers here are actually from the forecast from last November. They haven't been updated son's then. We are working on an updated forecast, and as Karen mentioned, we have many populations that we are working on getting into the forecast appropriately, so new populations, Afghanistan evacuees among them. At this time last year, we expected the public health to (Inaudible) to be ending. We had just gotten information that it was going to be extended to January of 2021, just like we have just gotten information that it's going to be extended to January of 2022 this time around.

With that expectation of it ending in January 2021, we had built into our population forecast a decrease as we would work through redetermination at the end of maintenance of effort. So, you can see the gap there between that expectation and in our current enrollments. This enrollment as of September in Medicaid of 1.7 million individuals. I think if you add in chip in there and move into October, we're pushing 1.9 million, and so it's a good percentage of the population of Virginia is enrolled in Medicaid or CHIP through our programs at DMAS.

The expenditures in the lower part of this slide are a bit updated. They don't reflect the new forecast. As I said, that will be official as of November, but they have been updated in total funds through Chapter 552, which was signed at the end in the spring.

We are slightly below those numbers and we'll get into some of those reasons a bit later on in this presentation.

You can see the pattern, I think, is people ask about this particular pattern, the rate assessment or the rate assessment payments are live. We have that sort of quarterly pattern of large payments expected in the middle month of any quarter.

I guess we can move on from there.

The next two slides breakout the (Inaudible) same company meant on

this, the enrollment, of course, was expected to drop, and it has not, as the public health emergency has been extended, and we will be updating that as I said for the upcoming November 1st forecast. We're in the middle of that right now.

And we can move ahead to Medicaid expansion.

Again, we are certainly below what we expected at this point last year. That expected jump in there that you can see in last year's forecast was what we put in there for open enrollment between December and January where we expected a jump in enrollments. We didn't see -- that was based on the previous years jump in open enrollment with MOE and with all that's going on, that open enrollment jump has been muted quite a bit last year, and we don't expect too much of an open enrollment jump this year. As I said, MOE is with the public health emergency extending to this upcoming January. That means that the maintenance of effort will also continue into January, and so we would expect that our population would continue to grow, whether in expansion or in base through that point, after which, as we redetermine individuals over the following year, or I think we're working on an expectation of working through those numbers over ten months, that our population will drop heading forward from that.

With the public health emergency being continued into January, that allows us, as Karen said, that allows us to gain the enhanced Federal match through the end of March, March 31st, which gives us an extra quarter of more -- of general funds that won't be needed as they'll be paid by Federal fund through the -- through March 31st. So, we are working on updating the forecast to reflect that. Last year we were in a special session so we were working with multiple forecasts last year, as well, so there is certainly uncertainty again this year. Going to move forward.

With, again, the public health emergency, some of these items aren't necessarily updated at this level, and so we have been talking about these in these meetings over the past year. Last year we expected that we would be returning to normal in a lot of the fee for service categories. Fee for service expenditures have been lower for a couple reasons. For just utilization and elective surgeries and appointments drove down some of that fee for service utilization, but also our members with maintenance (Inaudible) are staying in managed care longer. We have reduced -- we don't really have churn of people coming in and out of the program with maintenance of effort, as members are not being disenrolled, so our fee for service has been lower than expected throughout the spring and it

continues today as we still find ourselves in maintenance of effort, and in the public health emergency. And that includes the in-patient hospital, out-patient hospital clinic services. All other as a category on the accuracy report that had also lower.

The continuation of maintenance effort also affects the Medicare premiums, Medicare premiums are based on the EF map, or on the enhanced F map, and so when that continues out our premiums stay low as we only pay the state share of those.

Another area that we're looking at very closely, and have seen decreases in the fee for service side are long-term care services, including nursing facility. Nursing facilities is an interesting case. It had nursing facility both within fee for service and managed care was low into the middle of spring. It did rebound back over all of those, and though there has been blip with the Delta variant of it decreasing again, we do expect nursing facility to eventually get to a relatively normal pre-pandemic level, but the timing of that is certainly extended out as the public health emergency continues.

Waiver services, as well. Waiver of the community waiver services in long-term care. Those have taken longer to return to normal as the public health emergency continues.

Supplemental rate payments, that is more of a payment timing issue, and we expect to -- we will, of course, we're reforecasting all of these as we speak in the next couple of weeks.

Above forecast, a couple this has really since July is what we're talking about and compared to the forecast from last November, we are a bit of a forecast in transportation as we did have a rate change and p increase in April, and so the payment months of July, August, and September are higher than we had in the forecast last year.

Hospital payments are slightly above forecast from last year, and in behavioral health, really that's being driven by payment timing or the delay in getting the fund from CSA for the PRTF facilities, and that should return -- well, we are reforecasting it in general. So, we will get that back in line.

Can move forward a slide.

Similar story in expansion. Again, a lot of the fee for service areas have been below forecast for the last six months or so as the public health emergency has continued, and a similar story on those that are above forecast. Transportation with the rate change in April. Behavioral health is, again, a driven mainly by the PRTS, and the supplemental rate assessment payments is really a -- we are reforecasting those and do have

issues of payment timing of when we make those and when they hit the books in the state accounting system.

We can move forward one slide.

>> I think there was a question, Rob. Susan.

>> Hi, Rob. Can you hear me?

>> Rob: Barely. It's very quiet, but I'll do my best.

>> Okay. How about now? Is that better?

>> Rob Chapman: A little better.

>> Just go back to (Inaudible) how is it that (Inaudible).

>> Rob: You probably heard my dog better than I can hear you. (Laughter)

>> Base Medicaid.

>> Rob: Base Medicaid. Can you go back one slide.

>> Yeah. How is it that you have declining inpatient and outpatient hospitals and yet you have increased payments? Is that what that is? Is one utilization and the other is payments?

>> Rob: Certainly the -- on the left side there, on the below forecast, the inpatient hospital and outpatient hospital, those are the place payment and it's fee for service. So, certainly in-patient hospital and out-patient hospital are mostly within managed care. So, that's down

for members staying in managed care longer with the public health emergency.

The hospital payments are the lump sum payments, and really follow a different pattern, and I think it's relatively (Inaudible) these are the payments that we've made in this first quarter compared to what we forecast last year, and that would include any of the dish or GME or any of those payments. And again, we are reforecasting those now, but this quarter was a bit above what we forecast last year.

>> Okay. Thanks.

>> Rob: Okay. Which gets us into what we're working on right now, with the new forecast. We have -- we are busy as ever. I think that one year we're going to have a regular forecast where it's -- where we don't have all the program changes and whatnot, but certainly not this year. We have a lot of program and a lot of outside items that are affecting the forecast as we've talked about several of them already.

Forecast drivers of this forecast as we've been working through it, we have lower managed care rate changes this past July than we did -- than expected in last year's forecast. That's both in medallion 4 and in CCC plus. Those were reported out to this group in messaging last May when the rates were finalized for the -- for July of '21.

Decrease utilization. That is really what we've been talking about with the fee for service side of the in-patient and out-patient hospital. Nursing facility fee for service, and the waiver services, that's down from forecast, again, driven by the public health emergency and keeping people in managed care.

Lower population is -- doesn't really connect with forecast population charts, but really it's the number of capitation payments as we extended out the maintenance of effort, we would extend our expected capitation payments kind of in a linear fashion. In particular, low income base adults haven't grown quite at that pace. They're certainly growing with maintenance of effort, but not quite at that pace, and so that's a little bit lower than what we had built into the forecast and what we've updated as maintenance of effort has been moved forward.

Kick payments is expected to be lower. Again, these are fee for -- payments in base Medicaid Kick payments are lower than expected, and then we have our regular forecast adjustments, all 89 forecast series that we make our adjusted up or down, dependent on new data of the last year.

We have some items as Karen mentioned, most of these that we are working to get into the forecast as appropriately as possible, though some

of this information is new and changing and hopefully we'll have them pretty much put together by November, but it is influx.

One is not in flux anymore. We weren't sure if -- we weren't completely sure if the public health emergency was going to be extended to January. That has now happened, as if we understood that information as of Monday, and so as we were looking at this even last week, we weren't sure -- we weren't sure of how to build the forecast both ways on that.

Afghanistan evacuees. We understand that there is two populations really that were modeling out, a population of short term evacuees, that will be in the state, and enrolling in Medicaid, and by Medicaid, for this it's children, MedX, even famous, wherever they can be enrolled, they may be enrolled. That is expected to be a larger group of the short-term evacuees, and then we expect a smaller population would settle permanently and would be permanent additions to Medicaid roll. So, we are working through that, and we get new information weekly, if not daily on that.

We are expecting to make an enrollment shift of moving members from base Medicaid into MedX in November. These are members who have since the maintenance of effort or public health emergency have turned 19 or even 20 at this point. They are currently enrolled in base Medicaid, but are

eligible to be enrolled in Medicaid expansion, as well as pregnant women who have gone past their two-month postpartum period and are el ledge am for MedX with equal benefits, we are expected to move a number into MedX.

With the next item is with the enhanced FMAP going through the end of March, we will initiate an accelerated payment of capitation payments. Particularly we pay our capitation payments in the first week following the following month of the coverage month. When we have an opportunity, as this with an enhanced Federal match, we are able to make what would have usually been paid in the first week of April and make it paid as a capitation payment cycle in the last week of March. That means we would have two cycles within the month of March, and we would get the enhanced, the extra 6.2% Federal match on that one month's worth of payments, and then we wouldn't have capitation payments made in April.

We did this year's ago with the ARRA, when that ended, we made an accelerated payment. That happened across a fiscal year, which had its own complications, but this is as long as the public health emergency and not extended further after January, and it very well may be. This falling in the middle of the year should be a little easier on us.

The last item is we planned to lay on top of the forecast and these are the ARPA increases to rates for home and community-based waiver, and

mental health services. With the special session in this past August, we've -- are working through increasing rates by 12 1/2% for those community-based services, and that is paid bay even further enhanced Federal funding on waiver and other community-based mental health services, as well. So, with that funding not coming from -- directly from the general fund, we're laying that on top of the based forecast.

And the final item we haven't mentioned yet, we are still -- we are keeping an eye on it. We understand that there is very -- a good potential of getting a permanent or a, maybe not a permanent, but not an enhanced, but an actual FMAP change from our usual 50/50, as we've been for years, getting that moved up to Federal share of 50.65%. That is not official and we don't expect it to be official until after November, so we do not have that being put into the forecast, but we do expect that is a very real potential. We expect it would go into effect next October, based on the Federal fiscal year, but again, we are looking on that, and when that happens, we would have to adjust forecast and any cost estimates to direct that funding to be coming more from the Federal side than the state side.

>> Rob, can you hear me?

>> Rob: Yes.

>> All right. Just a quick question for you, or a note.

>> Rob: We lost -- or I lost you.

>> Can you hear me?

>> Rob: Yes.

>> KAREN KIMSEY: Yes, we can, but it's very -- it's like you're in a tunnel.

>> Can you hear me? No?

>> KAREN KIMSEY: We can, it's just soft, and if Rob can't hear it, I can hear you, and I can help repeat the question if needed.

>> Well, it's rather just a comment, just to make sure people understand the consequence of what impractical implications of the forecast driver. So, the delayed FMAP that we're talking about, it will increase surplus general fund savings this year, however, it will not cross out the maintenance of effort into the future. So, that means our pause on general fund, if we work to the maintenance effort, et cetera, is actually going to be pushed out. So, we were expecting to do that this year. It will push it out.

Another thing I wanted to highlight, too, just from a practical implication, is the November enrollment transfer. So, what we're doing there, and deputy (Inaudible) deputy administration is on the call, she

can speak into this remotely, as well, we're removing (Inaudible) because of the (Inaudible) are in base Medicaid, we're moving them to Medicaid expansion, and part of that is because some of those individuals might be 19 or 20 since the start of pandemic and were no longer able to keep them in base, but we're actually moving them to a higher level. So, that will actually transfer saving, great savings to general fund, but it will transfer the cost to Medicaid expansion.

Deputy (Inaudible) can you speak into that?

>> Hi, Chris. Hi everyone. I'm sorry, I'm having a terrible time hearing, and I know we were moving people to expansion, but I didn't catch what the question is.

>> KAREN KIMSEY: He was just asking if you can provide some clarification, Sarah Hatton, we know there are population of individuals who are being carried over right now through the MOA that we're going to be shifting in another category. Could you speak to that, please.

>> Sarah: Absolutely. Sure. Initially when the Federal PHE began, we were not moving anyone, and earlier this fall we did receive clarification from CMS that these individuals, we can move them without redetermining these individuals if they have become 138% of the FPL, so for those individuals we were able to make that assumption, that they were

still within that income bracket. We are able to move them from that regular Medicaid as 50/50 match rate over to expansion. I think when Rob last looked it was going to be, I can't remember the exact savings, but I think somewhere about four-and-a-half million per month to move those who have reached the end of their post partum period and those who are turned 19 (Inaudible). Continue in that 50/50 match rate.

We do have an automated run that will continue through the end of the PHE that will pick up these individuals and move them.

Lynette, I saw your question. I don't have it in front of me, but I think it's somewhere around a combined 32 to 34,000 individuals will be the first big run that will be picked up and moved, and of course each month it will just be those individuals who reach the end of their postpartum or who turn age 19.

>> Rob: Thank you, very much. Thank you, Chris, for bringing up the other impact of MOE and the public health emergency being extended, that does help us with the, at least financially with the enhanced FMA extending on, but it does mean that our maintenance of effort will be delayed a bit, and that as we -- that unwinding rules out into further into fiscal year '22, then we had if that wasn't extended.

Key takeaways. Again, we went through the forecast to actual. This

is the last time that we'll be basing forecast to actual on the forecast done last year. We are updating it, again, for November 1. We are slightly below forecast, but again, that's relatively old news at this point with that prior forecast.

The other big key takeaway is that the public health emergency has been extended to January 16th, and that affects our program in many ways. Probably the biggest financial impact is the enhanced FMAP continuing to the end of March, but it does affect our enrollment as well. The last is that we are right in the middle of forecast development right now. This is a big year, meaning that this is a typical need year for the upcoming biennium, our au appropriations are capped at -- not capped, but are set at our appropriations that we have for fiscal year '22, with a growing program. Those outer years are compared to that without having developed appropriation for them specifically, and so every other year we have a big need and this is one of those years. It is -- so, we do expect to have need in the outer years, though, as you see some of the forecast drivers have driven down some of the need in fiscal year '19. But we are in the middle of that, and expect to have that as required to be completed by November 1st and we'll have more information on that as we get there.

>> KAREN KIMSEY: Thank you, Rob.

Rob: Thank you.

>> KAREN KIMSEY: Are there any other questions -- Chris, can you hear us?

>> Chris: Yeah, we can hear.

>> KAREN KIMSEY: All right. It's better.

>> KAREN KIMSEY: Would you like me to drive on the next topic Chris, so people can hear it a little bit easier for the next discussion we'll be talking about with the team changes in managed care programs and contracts with the MCOs, and I will be turning it over to our Cheryl Roberts, deputy, when it lock, deputy of care.

>> Normally we only do contract changes as everyone knows on July 1st. However, we always give ourselves the option of doing mid-year contract changes normally driven by service dates. In this case we have two new services coming in before July 1st, and that generated the mid--year contract changes. We always used that opportunity then to do any cleanup work that we had. Go to the next one, Limor.

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>> Cheryl Roberts: To assure everyone we did not spend any money. I know that is always what Kenny asks. No money are we trying to spend unless it was -- I actually allocated it in the budget process. This is

actually a short list. Most of the things were minor changes, for example, adding the service language in the covered service chart, not that we're adding the service, but clarifying. Clarifying TPL. Making sure that our plans understood that they had to work with us on the PRSS, which is one of our MS modules.

The other one is to say to the plans that if you have any organization changes, any operational or contracting changes, you have to give us notice, prior notice. As you know, that we have seen many, many changes over the last couple of years, including the last one of Magellion and Molina, so we just want to know ahead of time so we have the ability to approve, and of any other things that we could actually change in terms of contract alignment between the two programs.

Next.

But, the real reason we did this was for the two services. The first one is the one on the medallion side, which is the community doula coverage. We will be No. 4 in the country, Karen is smiling, No. 4 in terms of providing doula services. Our goal is to be able -- we've been working, as you know, with VDH. VDH has half of the project, which is certification. We have to do the delivery service piece. Our goal is to get Federal approval by November, in November, and then to be able to

enroll doulas in January, the latest. So, there is contract language that is explicit to the plan, and they've been active in this in terms of us putting in this service type and the service. Doula. And Tammy is working on behavioral health, of course.

>> Tammy Whitlock: Yes, thank you, Cheryl. So, as you all know, we talked to you last time about our Bravo services that went into effect on 7/1. We had four services go into effect, and then on December 1st we have the services you see on the screen, functional family therapy, multi-systemic therapy, and then our crisis service. And this is kind of a reworking of the entire crisis system to allow mobile crisis and other things and the intent of all of these services, if you remember, is to help with the bed crisis situation right now. That is going on. These are going to effect December 1st. The plans have been intrinsically involved. We have -- we are going to all of the plans in early November to make sure everybody is ready to do an operational readiness with them, and so there is a lot of work that has gone on behind the scenes, and with the stakeholders, as well, on these services and DBHDS. It looks like three services, and might not be a big deal, but I will tell you the crisis piece is a very big deal, so we are hopeful that the uptake on that will be great, because it is beneficial to our members.

Then you see, I think Karen and others, Rob, talked about the 12 and a half percent for our HCVS services. Our home community-based waiver services. This affects almost all of the waiver services, and the community mental health services, as well as early intervention. So, we wanted to make sure that early enter ven shun didn't get left out. It's a pivotal service for our 0 to 3 population. So, we are working now. We released a memo, a bulletin, I believe last week, and we are steadfast in trying to get some answers from CMS to see how they're going to let us pay retro to July 1st, so that's been a topic of discussion in the agency. So, we are continuing to work with our stakeholders and make sure that many are already aware, as you know, we have some savvy stakeholders, and some have already billed for continue creased services and gotten paid. So, it working. So, we just got -- we're just going to stay diligent and make sure that everything is running smoothly for that.

And then lastly, you may -- there is a flexibility that was supposed to be reinstated late in August, and that has caused a little bit of couldn't controversy, I will say, in that it's a face-to-face requirement. As you know, and we all know, that people have varying levels of comfort on face-to-face. That includes our members and our providers, so we are working diligently with the administration to come up with the best way to

reinstate what we feel need to be reinstated. We want to make sure our members get seen. Some of our members have not been seen for quite some time during the pandemic face-to-face, but we also want to be cognizant of the fact that members have a choice whether to let somebody into their home or not, and providers need a way to document that and to still be providers. So, we are working with our administration and Dr. Walker Harris has been instrumental to help us with this, and we are trying to come up with the best solution with everyone involved. So, stay tuned on that. We are still working on that, and that is a hot topic at DMAS right now, and we will continue to let you know and update you once we have a final decision on that.

And that's all I had. Questions?

>> KAREN KIMSEY: Thank you, Tammy and Cheryl, for that update, and that presentation. And just want to open the line to see if folks have any questions for them.

As you can see, we have much underway, in terms of making sure that we're balancing our compliance with the programs and changes and implementing all that we have been doing and directed to do to help take care of our members during pandemic, not only to I can take care of them, but also to open up new and exciting services, including the dental

benefit most recently, we're talking about that. As you can see, we have a lot going on here, but not only are we doing that, implementing the new changes and expanding coverage and services, we are also dutifully monitoring and working to be as open and transparent as we can be, related to our managed care program systems, and just our program in general. So, we're here with Dr. Lauryn Walker, very pleased to have her here as senior advisor, er economic policy to give you a presentation that we've all been working on together for you all on our latest trends and managed care. Turn it over to Dr. Walker.

>> Dr. Walker: Thank you. Can you all hear me, being the presentation in the room, just want to make sure the folks on the line can hear me.

>> Yes, we can. Thank you.

>> Dr. Walker: I want to present on a few topics. Go on to the next slide.

So, as the Veterans of this group know, we always start this presentation with some updates on items that we've done on the website or on some different dashboards. So, I wanted to start this one by introducing our new behavioral health data page. We're very excited about this. We've been working with Deputy Whitlock's team very hard on this

and Christina Knuckles to get some new information out to folks about our behavioral health services.

We created a here a new web page, if you go to the new website, hit data. The very first item there is behavioral health and you can see all the resources there on your right. This is a series of reports that look at the quality of our behavioral health services, as well as some information about our provider networks trend. So, I'm e going to walk-through a few of them, but there is everything in one place here, so it's easy for folks to access information about our behavioral health quality access.

Next slide, please.

So, this is one in particular that I wanted to highlight. So, we've added a new dashboard to this web page, and this dashboard is sharing information about our behavioral health providers per capita. So, we have some information here about numbers in each city, but also about the members that are in that city as well so you can get a sense of how adequate our networks are in that area. For instance, while we have many providers in fair max county, we also have many members in Fairfax county to this map and dashboard is intended to help you all get a sense of where we might have provider shortages and where we have adequate providers.

So, the list here on the left are the types of providers that we include on that dashboard. So, we have information about our arts providers, information about CMHRS, but we also have information about our outpatient mental health as well as psychiatry and other licensed professionals.

This is we've made some updates to our other general dashboard. These have been up quite a while now with expansion, but we've added information about health plans to our enrollment information. So, we used to provide that information many years ago, what the enrollment was for each health plan by different eligibility groups. That is now back on our website. We've added it to our dashboards. Next.

All right. So, excuse me, I will go into some updates on our expenditures and utilization. These slide will also likely look fairly familiar to the veterans of this group. We've been using this type of format since we started COVID, but just to orient folks that may be less familiar to how this graph works.

So, we've been monitoring our expenditures throughout COVID using what we call incurred but not reported. So, essentially what that means is that we take a look at what providers and what our MCOs have actually submitted to us in terms of spending, but should try to get a more realtime assessment of what that expenditure might look like if we were to

get a sense of what the total expenditure would be. We look at the historical data and create an estimate to understand what in the last few months, even knowing that they haven't actually submitted that information to us, we expect that our expenditures look like this. So, the light blue bar here is what as has actually been reported to us. The dark blue bar is what is incurred but not being reported. That estimated amount.

As you can see, when you look over the course of starting pre-COVID, pre-pandemic all the way to July, you can see that the total expenditures have actually started to increase. So, you can see that especially starting in April of 2020, that is no surprise, as Rob was mentioning, we have had a pretty significant increase in our enrollment. So, our total expenditures have actually increased, but the purple line here up at the top, I really want to draw people's attention to, this is the per capita spend. So, on an individual bases, even though our enrollment has caused our total spend to go up, the purple line here shows that our per capita spend has been decreasing somewhat during the pandemic. Next slide.

So, I've brought it out here into the two different MCO programs. So, you have the medallion 4 program here where you can see there is a pretty significant droop in expenditures, and this chart is now entirely per capita spend so we can get a Spence of the individual utilization.

You can see a pretty significant drop early on in the pandemic for medallion 4, and a good recovery, but there is still some difference from pre-pandemic. In CCC plus, we never had quite a significance of drop, with the pandemic utilization was much more stable in that particular program, but there were some areas where that did change, and I will show that in the next slide.

Go this slide gives you a sense of what types of service areas have been the most impacted. And for those of you that have following along on the paper or the email that was sent out by Limor earlier, this is a slightly updated slide, so we will send those around afterward, but I have two slide here.

This is specifically looking at medallion 4, and you can see here that there are some areas that really stand out as significant drops in per capita spending. Outpatient has been pretty significant across the board, so that is outpatient hospital services, when we're looking at physician services or Doctor's offices, those are categorized under professional services, so you can see here from medallion 4, there was a writ tee significant drop in both of them.

And then we also have broken it out here in expansion and non-expansion. So you can see the difference, because those populations

have had slightly different experiences during the pandemic.

Next slide. One of the things that is pretty striking is medallion 4 and CCC plus have had pretty significant differences in how the utilization has changed for members in those two different programs. So, you saw medallion 4 had many more decreases. CCC plus has actually had some increases in their expansion population. One of the things that we did find was that our CCC plus expansion population is much older, and they also have many more (Inaudible) conditions, so the expansion population that is NCC plus tend to look more like CCC plus than they do a medallion expansion. Next slide.

Any questions on the expenditures before I move on to some other contract updates?

So, this isn't nine years. Are you talking about the total chart? Sorry. You said medallion, the expenditures went down over the course of the last several quarters, is that what you're looking at? Oh, that is a typo. I apologize for that. That is supposed to be 2020. Thank you for flagging that. That is a typo. This is looking just July to December of 2020. So, comparing the pandemic to pre-pandemic. I apologize for that. Thank you for catching that.

Any other questions? Okay.

So, next update here is cardinal care. Just want to give a few brief updates on where we are with that project. This is just to reorient everyone to what cardinal care is. So, there has been an update to the appropriations act that we are to unify the two programs, UCC plus and medallion 4 into a single cardinal care program. Go to the next slide.

The purpose of this is really threefold. One, because we believe it will add value to our members. They will not need to know if they are in RCC plus or in medallion. There will not be gaps in care for them if they transfer from one program to another, which we have seen has caused some disruptions for our members and their care. But it also add values to our provider with the hope that we are able to streamline many of the administrative burdens, so instead of having to contract six times for each health plan, you have six. Many providers are having to contract 12 different times because they cared for members in both programs. So, we're hoping to be able to alleviate that administrative burden.

Go then, the last part is that it lasts value for DMAS on the Commonwealth. This is allowing our agency to take a look at how we can improve our oversight of the program, so how can we better use our resources to make sure that we're looking at a population focus, as opposed to just a program focus. And that really allows us to improve how

we are able to target our oversight in particularly vulnerable populations. Next slide.

And this is just a quick status update and make sure everyone understand the timeline here. So, there are many components to and the contract change come in many parts. Right here you can see everything in Green. These are the items that are already done in terms of the process of moving from a two MCO program state into a singular program. The items in orange here, those are the ones that are happening right now. There are multiple GA reports that are currently being circulated, and then there is also, we're working with our actuary to make sure that we better understand and that we have a good sense of what will happen to our rates in the out years, as we combine these two programs.

And then, just for this group, a couple of items I want to highlight on our timeline here. We are expecting to get drafts to the OAG and to DPB in early January for their review. We do have to have a review with CMS before we can have final contract, and so as you can see here, we are expecting to have that review in April. So, at that point, once we've been able to go through those various levels of reviews with those various stakeholders, we are working with our current MCO stakeholders along the way so we have their engagement. They will also be taking another look as

a final contract review so everyone is on board and ready to start July 1 with a combined contract.

Next. Then this is just a little plus update that I wanted to give folks. Weave been getting many questions lately about how our vaccination efforts have been going. So, I wanted to give a quick update to this group on some of our vaccine efforts, as well as just generally how has COVID been impacting our members in terms of their cases-caseload.

So, a few items on here that I want to caveat just a little bit. So, we have confirmed cases, about 120,000. Now, we only get information on members who have a confirmed case that is also billed to Medicaid. So, what that means is that members who may have their treatment paid by another program, especially our Medicare members, so our 65 plus, who are clearly disproportionately at risk for COVID, we do not necessarily have information on them unless something was billed to Medicaid. So, this 120,000 is likely an underestimate of the caseload that we've had in Medicaid.

During that time, we've also had 1.2 million tests that have been billed to Medicaid, so this is really more less of a caseload and more of a this is what Medicaid is covering for the Commonwealth.

And in terms of vaccination, we have about 650,000 members who have

received at least one dose. That is to say, we have many more members left to go. So, this is just looking at our eligible members.

There will be a whole new group when we start to have children able to get vaccinated that we're going to need to work on what our strategies will be to get five to 11 year old vaccinated.

One of the things that I do want to say here is that while 46% of our eligible members have received a vaccination, that means that more than half have not. And while that is clearly below the rest of the Commonwealth, it is much higher than what we have seen in other Medicaid agencies across the country. So, even though we are all really anxious to get that 46% higher, and have done many efforts in different populations to do so, in terms of where we land across the country this from Medicaid rates, 46% is actually much higher than is otherwise expected.

Yes. Yes.

>> Clarification. (Inaudible) children (Inaudible).

>> So the percentages include 12 plus. So, I'm not including the children that are not yet eligible.

>> KAREN KIMSEY: Lauryn, we can't hear the questions being asked so if you could repeat the question, that would be helpful.

>> Sure. Sorry about that.

>> KAREN KIMSEY: Thank you.

>> Susan was asking if the percentages s here, if that 46%, does that include children, and that is not including children who are not yet eligible for the vaccine. So the 46% includes 12 years olds and older who are currently eligible.

>> KAREN KIMSEY: Thank you.

>> Lauryn: All right. Next slide. So, this gives a little bit more of a breakdown by age group. We have seen that our older adults are actually the most likely to get vaccinated, and in fact our most vulnerable populations are populations on our waivers, as well as our populations in facilities, they actually have significantly higher vaccination rates. We've been able to get those vaccinations up to as high as 70% in many of those cases. But when we break it down to age group, we do see that the children, the 12 to 19, tend to be lagging behind the rest of our population in terms of getting vaccinated. So, we have been doing multiple back to school efforts, as people have been getting normal vaccinations going back to school, we are working to include the COVID vaccine in many of those efforts. And we'll continue to be focused on the 12 to 15-year-olds to get those numbers back up.

All right. Next slide.

Then, the last part here is breaking down by geography. So, where are people left to get vaccinated? You can see that the Northern Virginia area has the highest rate of vaccination, so they are at about 47% total. So, again, by total I mean 12 year olds plus, but they are at about 47% vaccinated, whereas our Southwest region has the lowest rate of vaccination, which is 37%.

And that wraps it up. I do have on here for folks that have been looking at the other utilization slide and the other format, I put them all in here for take-home if people are interested.

>> KAREN KIMSEY: Perfect. Thank you so much. And just wanted to thank you, Lauryn, really appreciate it. It's just amazing amounts of information. I think it really speaks to the hard work being led by the teams to be in terms of our utilizing the data that we have now to tell the story that are in those particular areas, and also from the program project and implementations and changes that we're making in order to have a better program for our members and their families, as well as for us administratively in administering it.

Would love to open up the floor for people that have questions, and I know questions have been asked along the way. Are there any other additional ones that people would like to ask?

>> Karen, this is Susan. Can you hear me?

>> I'll repeat the question for you.

>> On the vaccination status, is there any way to -- obviously if you haven't gone to see your physician, you know, understand away from the office, I can see how you, you know, you may not go in and get vaccinated, necessarily, but are there some people that have got vaccinated in the mass vaccination effort that we just aren't counting? I'm not talking about our Medicare population.

>> So, the question Karen, so we found the one mic in here that works, so apologies. So, we found it.

Susan's question, Susan Master's question, on vaccines, she understand if folks haven't govern to see the doctor, they won't get vaccinated, but have we missed or are there individuals that got vaccinated at mass vax clinics that we haven't counted? Do you want to speak to that, Lauryn?

>> Yes, Dr. Walker. Would you like to speak to that one.

>> Lauryn: The answer is yes, there are many more people that we can reach who have eligible. We have done several campaigns. I think we have kind of exhausted the care coordination route and I think we've exhausted the newsletter, mailings, et cetera.

We held several mass vaccinations, I think what we're really up against at the moment is vaccine hesitancy. That seems to be where we're really hitting the wall right now. And so -- and Christina may want to speak as well to some of this. We are currently working with VDH to better identify smaller populations both within Medicaid as well as in the state as a whole where do we see most hesitancy? There may be some areas where we have more options in a more narrow targeted way that we haven't investigated yet, and so we're now working with VDH to try to combine our state-wide data with the Medicaid data to better identify smaller groups (Inaudible).

>> Cheryl Roberts: I think the question was are we missing -- are we missing vaccinations, because for example, if you're seeing people doing things at festivals, how are you going to get that information? I think (Inaudible) can answer that question

>> KAREN KIMSEY: It's the VDH data question.

>> We do have that question. Sorry. We have been getting the VDH data of anyone who received a vaccine. We've been receiving that data since about April, so we include every single person who has gotten a vaccine, unless they got a vaccine through a trial, we do get that information. Are

>> KAREN KIMSEY: And also, if I may, you know, just for we can touch upon, just to let you know, and (Inaudible) was speaking to this, but the team is working on, as she was saying, and Dr. Bachery, Cheryl is on as well, like we're looking at strategies, too. How can we best reach people. What are those issues and how can we give them the information that they need, but the reality is in some cases, we are hearing from members that they're being over saturated and getting very aggravated with us with the repeated requests for vaccines, so we're also dancing a delicate line where we're balancing the need to present information for them to make informed choices, but at the same time, not overwhelming them to the point where they no longer respond to the care managers who are reaching out to them. So, Chethan and Cheryl, or Tammy, on that particular piece. We don't think it will be as difficult with the children, because we can get to the parents and help them get vaccinated. Parents are really waiting to get this vaccine approved.

>> Chethan: I'll say a word. I apologize, my voice is a little on the Fritz right now, but yeah, first of all, Lauryn thank you for that wonderful presentation. I think what is nice is we've been very empowered with data, to answer your question, Susan, we get our data directly where we have limitations around counting COVID-19 cases, we do not have

(Inaudible) VDH immunization agency, so we would capture CDC as Lauryn was mentioning.

We have been thinking about this program a lot and definitely welcome your thoughts, because we're in an uncertain space where we find ourselves, we've exhausted a lot of our potential strategies that are at our fingertips, namely our MCO coordinators, amazing communication outreach by Christina and by our MCOs, text messages, letters, emails, phone calls, you name it and as director (Inaudible) was referencing, sometimes it's been a little bit overload for some of our members. We haven't heard a lot of complaints, but we've heard some complaints, so you know, we've done a lot of that communication and so the folks who are, you know, there are so many ways of thinking about these populations, but the folks who would be willing to get it have largely gotten it in terms of access. It's open at pharmacies. So, right now we think it's very much a targeted approach to folks who are uncertain and really don't know, you know, and need really intensive engagement to move from uncertainty to decisiveness, right, because they've never thought about vaccine efficacy or effectiveness before. So, we're learning quite frankly and taking a hard look at our strategy part of what we've done better than a lot other Medicaid states, and we've been talking -- yesterday I talked with North

Carolina and today with Ohio. So, we're better than those states, but clearly we're not good enough, right, when we compare to the state average. So, a lot of room to grow. So, we're thinking about what we can do next.

I think I'll just say one word and stop, is that I think it will be a lot of one to one conversations, and I think this is where our providers, and our Gwen our faith communities and folks can have those conversations and help people move from this place of fear and uncertainty around COVID in general, to, you know, it's worth it to have the shot, here are some examples and testimonies, and we'll take the time to work with you. It may not be one conversation, but maybe two or three. So, I think that's where we are.

I'll stop and see if others have (Inaudible).

>> Sure. Thank you, Chethan for that. Maybe to generalize the issue. That was a big breakthrough for VDH to be able to take the viz data, not just for Medicaid, but for commercial care ears and others to allow com pains in a HIPAA compliant way to allow outreach if you're commercially insured with anthem or optima or someone else, or in Medicaid, the ability to do campaigns as to who is vaccinated and who is not, compare those who are eligible and those have not had. So, we didn't

do it to billing data, did it to actual registry and that was a key requirement for anyone participating with a mass vac site or individual doctor's office or a free clinic, is you had to enter the data that we needed. So, we're very confident of that.

Chethan, if someone lives in a boarder communicate it too e to other states and may have been vaccinated in another state, there may be a small number of that group that may have not made it into this; is that correct, or have we developed a solution for that?

>> CHETHAN BACHIREDDY: Yeah, I will defer to Lauryn on this. I don't think we have. I don't know, Lauryn, if you have thoughts on that.

>> Lauryn: We do get some of that, because we actually are seeing -- sorry. We actually are seeing many of our (Inaudible) especially early on, many of our are boarder residents are actually getting vaccinated in West Virginia, and we are getting some of that data. Do we have all of it? I don't think we can answer that question, but we are at least getting a fair amount of that information, that makes us pretty confident that we have good information on our vaccinations.

>> One other comment just about the -- our ability to encourage Medicaid members to be vaccinated. Yes, we're better than much lower performing states, but it's not where we need it to be. I mean, we've got

almost 82 plus percent of all 18 and above in Virginia, we're the 13th best vaccinated state in the country, and that's reflected in our DMAS population, but that gap, we're over 70% in our 12 and older population, and so that's one of the reasons, you know, our infections have been lower, but we still got a ways to go in this very vulnerable population. So, just some comments in context. Thanks.

>> Thank you, sir

>> KAREN KIMSEY: Thank you, secretary, we appreciate that, and we whole heartily acknowledge that. I think some of our conversation is some of the things that we are using to help outreach members we thought would be effective are not as effective, and other states are clearly struggling with our vulnerable populations, as well, so any -- we are continuing the search and work. We agree with you. Any thoughts are warmly welcomed for advice and approaches that may be more you meek than what we described.

>> Director Kimsey, this is Chris. I want to ask the folks in the room if -- so, Mr. Vcroft, do you have any additional questions?

>> Was just wondering about (Inaudible).

>> All right, Mr. Bcroft's question, this is for Deputy Roberts. He is asking, Eric Bcroft is asking about the dental utilization, dental program, and how that utilization has been going July 1st since we kicked

off. So, deputy Roberts.

>> In the end, I will tell everyone that second to expansion the dental services is probably going to be considered one of the phenomenal things we did in this administration. Great numbers so far. We have 65,000 (Inaudible) 103 visits already. And this is just been out. So, except for Mike and Kenny are going oh my, yes, 103 visits since July 1st. So, do we want more dentists? The answer is yes.

>> Deputy Roberts, can you clarify the question here. 103 or 103,000.

>> 103,000 visits.

>> Okay. That was the question in the room.

>> 103,000 visits since July 1st. Phenomenal services.

What we're looking at is we would like to have more dentists, obviously, so we're constantly recruiting, because we don't want delays. And some of the things we're seeing in COVID is affecting obviously some hospitalizations and for dental surgery. So, good news. Good news is we're making sure that people get services they needed desperately, we're going to need more dentists in our network. So, actively recruiting for the dentist to meet the need.

>> Mr. Bcroft, do you have any follow up.

Mr. Tweety, any questions. Dr. Curie? Ms. Masser? From the public folks in the room, any comments?

All right, we'll turn it back to you.

>> KAREN KIMSEY: Also want to give opportunity for people online, as well, just in case, and we have director Timberlake on the call, as well, I see. Just want to make sure there were no additional thoughts or comments from our partners at DPB and Kenny McCabe who has been in strew machine tal in our partnership along this way with all things that we're working on. So, just huge shout out to him for working so closely with us our teams.

>> I'm good. Great presentation. Thank you. Sorry, Dan.

>> It's okay, Kenny. Thanks, Karen. I don't have any questions either

>> KAREN KIMSEY: Thank you, director. Appreciate that.

Okay. Well, this --

>> Open for public comment.

>> KAREN KIMSEY: Yes, sir.

>> Yes. Good afternoon. My name is LeVar Bowers, and I was listening to the vaccination data, and I believe it was -- it was either executive subcommittee meeting on are the advisory board meeting with

(Inaudible) when I heard the initial data as it relates to the percentage of Medicaid recipients in the state of Virginia who has been vaccinated, and to be quite honest, I lost sleep by hearing those numbers. It was a shock. So, when I lose sleep, I tend to activate, so I had this kind of crazy idea, just thought of an initial call we care, and within that, the sole focus targets Medicaid recipients and kind of what you guys are discussing many this meeting, in addition to that idea was then to take it into the community and so we've been able to get really, really good support behind, and it's been a public/private partnership, so we're having our first event in Oliver crossing Mosely housing community area. It will be a five star event. Director Kimsey, you probably wouldn't know, some of your team members, DMAS, from the dental benefits department, they're preparing hundreds of bags for us so we can give out to educate people on the new adult benefits for the dental program. Of course, with the DMAS star showing that informing people of some of the things in addition if they don't already have incorporated with their insurance. I had a meeting yesterday with one of our local COOs, with one of our health network systems, so we are working on the dental vans. General health screens, as you guys know, those core services, the utilization definitely went down as your data is showing in this meeting,

and so it's been a phenomenal experience. I do not know what I have gotten myself into (Laughter), but --

>> KAREN KIMSEY: Go ahead.

>> Levar: It's been an amazing experience. My background has been behavior health, that has been my entire career, but I do have a unique understanding of many of our undeserved communities, as I grew up in one, and so I do kind of understand what makes us tick, and so we're going to have food trucks. We have face painting for, hopefully, in collaboration with the ent did of health, they're saying hopefully by November 3rd we'll have the children vaccines approved, but we're actually going inside the community. We have a (Inaudible) street which you guys know if you're in the Richmond area, very high crime area. It's been a testament to the efforts of a lot of different people, and like I said, in both public, as well as private sector, endorsing, supporting, sponsoring. I mean, it has been a complete overflow for us to try to work and improve some of this disparity when it comes to health equity in some of these communities. Some of it is access. Some of it are, you know, barriers and hesitancy, so we have different teams going out, challenging some of those cognitive distortions for some of my clinical people to kind of get people, you know, if you drink and smoke cigarettes, you don't know what is in that,

so we can't look at vaccines and say, I don't know what is in it so I don't want to I can take it and we are consuming other things that have even greater impact on our body, so we've been doing a lot of that, and we're hoping this model can be something that can expand and then I think I will be able to sleep better knowing that this population, we don't want them to be forgotten. And like I've been telling the different partners I've been doing presentations, thank you for the data, DMAS was getting me the data. Your team has been phenomenal, director Kimsey in providing me what I needed in order to put together these presentations to go to some of our corporate partners and sponsors to try to get the resources we need to really make this thing go. So, I did want to put that out there. You know, I'm not going to get too much into the logistical things, because I think there are things we can do on a state level if we were to come together both through public/private partners. You have HUD. There are different resources flying around everywhere. I think we can really develop a good model that we can address this problem through education, through access. And like I said, I mean, I would love to see this be successful. There will be some press and media around it. The department, Virginia Department of Health, they've been Tau nominal. They're going to be advertising. It will be a hub for that day. Whoa e

have streets blocked off. We have private security. Richmond police department also will be involved and engaged. They're going to be partners in this event, so we're excited. So, on November 6th, it's from 11 o'clock to 4 o'clock. For those who pray, please pray for good weather and success of the event, and like I said, we're working on developing a model, and I strongly believe that model can only work if there is public and private partnership in a lot of different people from a lot of different areas coming together to collectively solve this issue and hopefully to improve not only with vaccination rates, but also other health out comings that we probably know that are underlined that are not being addressed, as well. So, that's my spiel. Don't want to take up too much time. I do thank you guys for what you do. These meetings are very informative for me. I'm really a student, and so I do thank you for the opportunity and time to share that.

>> KAREN KIMSEY: Oh, absolutely, Mr. Bowers. We're so grateful to you have here in the audience and participating with us and attending our meetings, and also for all the work that you're doing. And for the folks on the group, as I understand, Mr. Bowers has been a provider with us, too, and helps to care for our members, so we really do appreciate the think out of the box, like how do we meet people where they are, in their

communities, and look forward to it. Yes, and we also confer with you. We lose sleep over this, too, as well, and we are very excited that our stars are actively participating. I saw some of the bags that they're taking pictures of and sharing that with us. Just all the hard work you are doing, as well as others in the community to help get people informed and educated, to help make those decisions for themselves and their families. So, we look forward to seeing the results of the big event in November, and also, how we can replicate that in other areas and thank you so much for that. You're absolutely right. It matters very much for our populations on health equity to get the availability of these vaccines to them in a manner of which they can understand and feel safe. So, we appreciate all that you and your team are doing to help make this happen, and also all the other partners, and look forward to continuing our partnership with you.

Are there any other -- also to the team, who is helping to make sure this information happens, and also for our other stakeholders, that is what we are here for. That is why our data is here. We want to help make the difference, make things happen in the communities, so please continue to let us know how we can help support in these amazing efforts.

Are there any other comments for public comment that you would like

to share or people would like to say? We have a few minutes left. About 13 minutes left for this meeting before we wrap up.

Okay. Well, just wish to thank everyone for their participation today, and also so wish to thank everyone on the group who presented to the EFRC and look forward to catching up with you at the next EFRC meeting. More to come. Until then, take care and stay safe and healthy.

All right. Bye-bye.

(Concluded at 1:48 PM)