

Medicaid Member Advisory Committee Meeting
Department of Medical Assistance Services
Via WebEx Videoconferencing

Approved By Unanimous Vote

Committee Members	DMAS Staff
Donald Williams	Karen Kimsey, Department of Medical Assistance Services Director
Summer Sage	Sarah Hatton, Deputy of Administration
Ghadah Aljamali	Andrew Mitchell, Senior Policy Advisor
Karin Anderson	Kelly Pauley, Manager, Eligibility & Enrollment Services Division
Olatunji Fakunmoju	Brian McCormick, Division Director for Constituent, Legislative and Intergovernmental Affairs
Geoffrey Short	Natalie Pennywell, Outreach and Community Engagement Manager
Elvira Prince	Jessica Anecchini, Senior Administration Project Coordinator
	Nichole Martin, Director, Office of Community Living
	Rich Rosendahl, Director of Health Economics and Economic Policy
	Tiaa Lewis, Director of Program Operations
	Angie Vardell, Senior Program Advisor
	Dalia Tejada Halter, Outreach and Member Engagement Specialist
	Beth Alexander (WebEx administrator)
	John Stanwix (meeting organizer and facilitator)
	Walter Burton (meeting organizer)
	Jesús Pérez (PowerPoint administrator)
	Kristin Lough (prepared minutes)

Welcome and Call To Order

John Stanwix called to order the meeting of the Medicaid Member Advisory Committee (MAC or Committee) at 10:01 a.m. on Monday, December 13, 2021, via WebEx online meeting platform. Mr.

Stanwix explained that the meeting had a full agenda and emphasized that Committee members would have time to ask questions and share feedback during the meeting. He then introduced the DMAS Director, Karen Kimsey.

Welcome

Welcome – Karen Kimsey, Director of DMAS

Director Kimsey greeted the Committee and thanked the Committee for their participation in the virtual MAC meeting. Director Kimsey thanked all members for attending the meetings virtually, and indicated the intent to keep members safe and the hope to see the MAC in person in the future.

Director Kimsey indicated that the day's agenda would include a discussion of the new Medicaid application and the importance of the application. She also noted that the team would discuss the Health Insurance Premium Payment (HIPP) program, and the DMAS response to the COVID-19 pandemic. Director Kimsey thanked the members for joining and working with the MAC and turned the meeting to Deputy Director Sarah Hatton.

Welcome – Sarah Hatton, Deputy of Administration

Deputy Hatton thanked the MAC members and DMAS staff for attending and working on the MAC engagement initiative. She reminded the members of a previous presentation of the Medicaid renewal application and sought similar feedback for the Medicaid application presentation. Deputy Hatton asked the members to read the annual report and provide feedback, as it would be published on the DMAS website. Deputy Hatton turned the meeting back to John Stanwix.

Member Introduction

Mr. Stanwix asked members to introduce themselves, indicate where they are in Virginia, and whom they represent on the MAC. The committee members, residing in different regional areas from around the state, introduced themselves and stated whom they represent. Mr. Stanwix introduced Kelly Pauley to present the proposed Medicaid application changes.

Presentation – Changes To Eligibility Application

Kelly Pauley, Manager, Eligibility & Enrollment Services Division

Ms. Pauley introduced the ongoing efforts of the DMAS Eligibility & Enrollment team (Eligibility and Enrollment), including updating the Medicaid application. Ms. Pauley stated that Centers for Medicare

and Medicaid Services (CMS) provided a template application for all states to follow when creating a Medicaid application. Virginia adapted the application and created online versions, which are intended to match as much as possible, and then provide the updated application to CMS for approval.

Eligibility & Enrollment evaluated the most-used languages in the Commonwealth, and increased font size for readability. Eligibility & Enrollment included voter registration and non-discrimination requirements, citizenship and taxpayer status, as well as authorized representative and application assistor information in the Medicaid application. Ms. Pauley indicated that the Eligibility & Enrollment team updated the rights and responsibilities to be clear, but also simple enough that the applicants would be able to read and understand them. The Eligibility & Enrollment team also updated the “who can sign” section to indicate who must sign, when, and what documentation, if any, is needed.

The Eligibility & Enrollment team has sought feedback from DMAS staff, state and local Department of Social Services (DSS) staff, Virginia Healthcare Foundation, Poverty Law Center, and now MAC members to improve the application. After receiving and including the feedback from the MAC members, the Eligibility & Enrollment team will send the updated Medicaid application to CMS for approval.

Ms. Pauley asked the MAC members to read the application and ensure that it makes sense to them. Ms. Pauley walked through Steps 1, 2, and 3 of the application. Changes include a three-column format, and questions to reduce extra supplemental pages like health plan selections. Long-Term Care Services and Support (LTSS), U.S. citizenship questions, and whether the applicant is incarcerated could all lead to supplemental documentation. CMS sought information about Hispanic demographics specifically, which spurred a question from a Committee Member about why such information was being requested. DMAS shared that CMS asked that the information be collected. DMAS also noted that answering that question was not required in order to process the application and that DMAS would further revise the application to make this clearer. It was further noted that DMAS would inform CMS that members have asked why the information is being requested. The application now also includes employment information and other income questions in each of the three columns to prevent supplemental documentation. The employment information and other questions are also set out for each of the three possible retroactive months, and the application now includes a place to indicate possible income deductions.

Step 4 asks if the applicant is an American Indian or Alaska Native, which would trigger supplemental documentation. Step 5 asks about other health insurance coverage. Ms. Pauley noted that applicants could have Medicaid and additional health insurance, but that DMAS needs to know about the additional health insurance, as Medicaid would only pay for needs not covered by the other insurance.

Step 6 describes who must sign and provides a space for signing. Rights and responsibilities in the application explain that DMAS would forward information to the health insurance marketplace for evaluation for private insurance if a Medicaid application was denied. Ms. Pauley emphasized the importance of providing the correct address and updating it immediately so that DMAS can contact the applicant. DMAS could evaluate the entire application electronically if the applicant’s information was

verifiable electronically, including through tax return information, and a DMAS contractor could also process the application. The Medicaid application is a legal contract, there are penalties for lying on the application and applicants may be required to repay coverage received incorrectly. Ms. Pauley described the process for collecting from estates of Medicaid recipients who pass away after age 55. She also expressed the importance of providing information about non-custodial parents who may provide financial support to the applicants. The application must include information about a right to appeal if an applicant is denied.

Ms. Pauley encouraged the MAC members to read the Medicaid application and provide feedback to DMAS about the draft application prior to submission to CMS for final review and publication. Mr. Stanwix asked that MAC members provide feedback and questions about the Medicaid application

Questions raised by Committee Members included:

Why must Hispanic individuals answer the specific Hispanic questions on the Medicaid application? How would individuals who are not Mexican, like a Peruvian or Salvadorian applicant, properly answer the question?

Can Medicaid recipients have private health insurance and Medicaid? It would be helpful to have private coverage for services not covered by Medicaid.

Could Medstar, available to Maryland Medicaid recipients, also be available to Virginia Medicaid recipients?

Ms. Pauley answered that the federal government sought the information about Hispanic heritage. Deputy Director Hatton answered that she has heard similar questions in the past and noted that answering the question was not required in order to become eligible for Medicaid. She further stated that DMAS could make this clearer in the application. Deputy Hatton stated that DMAS would point out the question to CMS. She stated that DMAS would also highlight the importance of clarifying the question for individuals from Latin American countries who do not identify as Hispanic. Deputy Hatton also requested that the MAC Members report feedback on formatting in the Medicaid application as well as the questions and wording.

Ms. Pauley indicated that FAMIS recipients, subject to a higher income limit, are not eligible for private insurance and Medicaid, but that other recipients may be eligible for both.

Mr. Stanwix asked for more information about Medstar and that DMAS would review it.

Mr. Stanwix then introduced Tiaa Lewis, Director of Program Operations, to discuss the HIPP program.

Presentation – Health Insurance Premium Program (HIPP)
and HIPP for Kids

Tiaa Lewis, Director of Program Operations

Ms. Lewis reiterated that Medicaid recipients may have private insurance and Medicaid, and explained that Medicaid may help pay premium costs through the HIPP program. There are two basic eligibility requirements for the HIPP program: 1) at least one family member must have full coverage Medicaid and 2) the family must have credible health insurance coverage, which may include employer-provided health insurance coverage. The HIPP program begins with a Medicaid application and approval, and then a short HIPP application, which is available online and on paper. The applicant must provide insurance and income verifications for DMAS to evaluate and confirm eligibility.

An applicant is first evaluated in the HIPP for Kids program, which is available if the applicant is under 19 and the employer contributes to the cost of insurance. A HIPP for Kids applicant would not be eligible if they have a high-deductible plan, as the federal government would not reimburse for high-deductible plans. If an applicant were not eligible for HIPP for Kids, the HIPP program would then evaluate the applicant for HIPP coverage. The HIPP eligibility requirements include 1) a family member enrolled in full Medicaid, 2) the health plan must be cost effective, and 3) the plan cannot be a high-deductible health plan.

Ms. Lewis explained that HIPP for Kids reimburses the full the premium and cost sharing, but the HIPP reimbursement will not exceed a capitation rate for the region. Exclusions for HIPP include high deductible health plans as defined by the Department of Treasury, health insurance plans with three or more non-Medicaid eligible members, individuals with Medicare Parts A and/or B, and individuals who are eligible for Commonwealth Coordinated Care (CCC) Plus.

Questions and feedback raised by Committee Members included:

The HIPP Program is an unknown entity and resource in the disability community, including among advocates and providers. Can DMAS provide more information about the HIPP program to those individuals and programs?

The eligibility information is not easily available to the public, so an individual must pay for private health insurance first, which then disincentives parents of children already receiving Medicaid coverage. Is there a way to plug in possible private health insurance information and identify whether a family would be HIPP eligible without a Medicaid application?

With regard to CCC+, does eligibility for the program mean eligible for CCC+, eligible for a CCC+ waiver, or on the wait list for a waiver?

Ms. Lewis indicated that the HIPP program has provided eligibility information to potential applicants, but also tries not to make the application process too confusing. She indicated the CCC+ program is relatively new, and stressed that the information would be clearer about CCC+ eligibility and HIPP eligibility. Ms. Lewis indicated that the HIPP program would be willing to visit and explain the HIPP program to any advocacy programs who would be interested in learning more

Mr. Stanwix then introduced the DMAS COVID-19 response presentation.

Presentation – DMAS Response to COVID-19

Richard Rosendahl – Director of Health Economics and Economic Policy

Nichole Martin – Director, Office of Community Living

Andrew Mitchell – Senior Policy Advisor

Natalie Pennywell, MPH CHES – Outreach and Community Engagement Manager

Mr. Rosendahl reminded the MAC members about the DMAS growing online dashboard information available online including demographic, enrollment, and cost resources. DMAS reports nearly 137,000 Medicaid members with confirmed COVID-19 cases, and nearly 1.5 million COVID-19 tests administered to members, which (by percentage) are consistent with state and national averages. Over 640,000 Medicaid members are fully vaccinated, and 37% of all members have at least one vaccine dose. Of eligible members, 49% have at least one vaccine dose. However, over 728,000 Medicaid members are unvaccinated. Members under age 19 are eligible for a COVID-19 vaccine beginning at age 5, but members age 5-11 were only eligible for vaccines effective October 20, 2021, which explains a lower rate in that age range.

Ms. Martin introduced the COVID-19 response in LTSS in both nursing facilities and home-based care. The flexibilities for members included approving telehealth services to reduce face-to-face visits as appropriate and reducing LTSS screening for individuals moving from hospitals to LTSS services. DMAS provided retainer payments for adult day health centers, which temporarily closed due to COVID-19 related regulations. DMAS increased reimbursement for spouses, parents, and legal guardians providing personal care services. Additionally, DMAS used CARES Act funds to stabilize providers during reduced care. Most of the flexibilities have since ended, but ones that have continued include allowing additional time for training and onboarding provider employees. Additionally, waiver members may stay on waivers even if they do not receive one service per month, but those members are monitored to confirm their ongoing health and safety. DMAS has provided flexibility for congregate settings, like group homes, to limit visitors due to COVID-19 safety.

Ms. Martin explained that certain General Assembly bills also applied to LTSS response to COVID-19. A budget bill required DMAS to evaluate whether telehealth services could continue permanently. Another bill mandated that DMAS create a telehealth workgroup, which reported recommendations regarding virtual supports to the Governor on November 1, 2021.

Ms. Martin indicated that the federal Public Health Emergency (PHE) had been extended to at least January 16, 2022. Although the state PHE expired on June 30, 2021, some services had a grace period through the end of August 2021.

Mr. Mitchell continued a discussion of telehealth and stated that telehealth coverage has increased thirty-fold during COVID-19. Prior to COVID-19, a patient had to physically go to a clinic and have a telehealth visit with a remote provider, and the visit had to include both audio and video. Once COVID-19 began, any Medicaid covered service could be delivered via telehealth if appropriate. With the occurrence of the public health emergency, patients typically do not need to go to a brick and mortar location (originating site) to attend a virtual visit, so now the visits may occur wherever it is convenient to the patient. Audio-only telehealth visits have been allowed during the pandemic.

Telehealth has increased rapidly among African-American members and other non-white recipients. Telehealth can scale rapidly for behavioral health and other clinical services, but broadband access does shape access. DMAS will continue evaluating audio-only compared to video and audio requirements. Policymakers' interests continue to increase with regard to telehealth because of COVID-19. Future telehealth plans include:

- Continued reimbursement parity for telemedicine
- Continued originating site flexibilities
- No distinction between providers authorized to bill in-person vs. via telemedicine
- Expanded set of services authorized for synchronous audio-visual telemedicine
- Around 50 new services will be covered on permanent basis
- Addition of Remote Patient Monitoring for high-risk populations
- DMAS policy revisions posted for public comment until November 12:
<https://www.dmas.virginia.gov/media/3930/telehealth-services-supplement-updated-10-12-2021-draft-3.pdf>
- Addition of clinically appropriate audio-only, virtual check-ins
- Policies in development

Ms. Pennywell indicated that increased care for prenatal care, comprehensive dental care, and Afghan refugees has improved member experiences. The Member Outreach team has continued to support a communication plan including traditional media, social media, noticing, and stakeholder communications. The Member Outreach team intends to utilize managed care organizations (MCO) to improve outreach and assistance activities through the MCO members. Potential communication sources include post cards, posters in providers' offices, factsheets from local DSS offices, member-focused factsheets, a toolkit for stakeholders, and a COVID unwinding FAQ. DMAS will present this information at stakeholder meetings. The Cover Virginia and DMAS websites also include information about COVID-19 unwinding and updates as well.

Questions and feedback raised by Committee Members included:

Has a General Assembly bill been proposed to make the 1915(c) Waiver Appendix K amendment permanent?

Where can members obtain COVID-19 tests for traveling?

In terms of vaccination distribution throughout the state, what is causing the disparate vaccination rates? Are the booster shots and omicron variant affecting vaccination coverage? How is DMAS responding to both? Schools are not providing much information about vaccinations, and they should engage in the process for younger recipients and younger Virginians.

Is there a reason why the LTSS PACE program was not discussed?

How was DMAS able to penetrate telehealth care into the rural areas, and how does broadband connectivity affect that care? Is DMAS helping members receiving rural broadband through federal programs?

Ms. Martin indicated that Appendix K is in effect for six months after the end of the federal public health emergency. Family and other caregivers approved to provide paid services during the period may potentially end after the pandemic, but no decision has been finalized yet. She added that DMAS is reticent to put an end date on the care exception because the end of the PHE is unclear.

Mr. Mitchell did not have the information immediately available, but would provide more information after the meeting to the member who asked the question about COVID-19 testing for travel. This inquiry was followed up on after the meeting with the member and the following was shared:

DMAS current coverage policy includes 2 stipulations for commonly billed tests:

- the test is recommended by a healthcare provider (your managed care organization [e.g., Anthem] can provide you a list of providers that could be available/convenient for you)
- the test has an Federal Drug Administration Emergency Use Authorization (EUA) or FDA approval at the time the test is administered

If those conditions are met, DMAS would cover reimbursement to a provider under travel circumstances.

Additional information may be found at:

<https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid+Memo+2021.06.30b.pdf>.

Mr. Rosendahl did not have data or information regarding the causes of disparate vaccination rates based upon regions within the state, but agreed it was an interesting question that could be researched further.

Ms. Martin acknowledged that she did not discuss PACE specifically, but that it was included in the LTSS data presented. Director Kimsey indicated that DMAS does not identify managed care separately from other sections of the program, as Virginia Medicaid health insurance has shifted to primarily be covered through managed care. Some drop in LTSS coverage, especially within a facility, is due to fear from facilities to admit any new patients for fear of COVID exposure for all recipients. Director Kimsey noted that telehealth was very helpful to individuals, especially to southwest Virginians, and said that Governor Northam has been working at the state level and using federal funding to increase rural broadband access. DMAS will be following and utilizing the access and telehealth care as much as possible for members.

Review Draft Annual Report and Vote to Approve Minutes from Meeting on August 9, 2021

Each of the MAC members were provided a copy of the August 9, 2021, meeting draft minutes, and the draft minutes were also posted on the Committee's webpage on DMAS' website, as well as on the Virginia Town Hall website.

MAC member Geoffrey Short made a motion to accept the draft minutes from the August 9, 2021, meeting. MAC member Donnie Williams seconded the motion to accept the minutes. Mr. Stanwix offered the Committee the opportunity to provide objections or changes to the minutes. The Committee then voted to approve the minutes with a unanimous vote.

Each of the MAC members received a copy of the Virginia Medicaid Member Advisory Committee Annual Report - 2021.

MAC member Geoffrey Short made a motion to accept the Annual Report. MAC member Donnie Williams seconded the motion to accept the Annual Report. The Committee then voted to approve the Annual Report with a unanimous vote.

Mr. Stanwix then opened the meeting to public comment.

Public Comment

Ms. Aljamali asked whether Medicaid will reimburse out-of-pocket payments made by Medicaid recipients, or if Medicaid will only reimburse those payments for HIPP recipients. She asked where she can get more information and who to contact to get more information about that. Mr. Stanwix indicated that DMAS would reach out to Ms. Aljamali and get more information after the meeting.

Mr. Stanwix thanked Ms. Aljamali for her comment, and asked for additional public comment. Hearing none, Mr. Stanwix asked if Director Kimsey had closing remarks before moving onto adjournment.

Adjournment

Director Kimsey thanked the MAC members and teams for presenting a wonderful meeting and member questions. Mr. Stanwix thanked the Committee for joining, and he stated that DMAS would evaluate the MAC member questions and comments to create agenda topics for future meetings.

Mr. Stanwix thanked members for their participation and adjourned the meeting at 12:06 p.m.