CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

AGENDA

March 2, 2023, 1:00-3:30 PM

This meeting will be preceded by a new member orientation from 12:00-1:00 PM.

The meeting will be held in person at Dept. of Medical Assistance Services offices, 600 East Broad Street, Richmond, First Floor Conf. Rooms 1A/B.
Members of the public may attend either in person or virtually.

Click Here to Join Meeting Remotely via WebEx
Meeting # (Access Code): 2430 263 9548 **Meeting Password:** Q34Wbu7nAtY
Dial in (Phone): +1 517-466-2023 (US Toll) +1 866-692-4530 (US Toll Free)
Remote Conference Captioning Link: https://www.streamtext.net/player?event=HamiltonRelayRCC-0302-VA3778

I. Welcome *1:00 pm*

II. CHIPAC Business *1:05-1:15 pm*

A. Review/approval of minutes from December 8 meeting
B. Membership update

III. Continuous Coverage Unwinding and New Federal Legislation *1:15-2:15 pm*

A. Continuous Coverage Unwinding
B. 2023 Consolidated Appropriations Act (CAA) – Key Provisions Affecting Medicaid and CHIP Children and Youth
C. VDSS Update on P-EBT Provisions of CAA

IV. General Assembly Update *2:15-2:45 pm*

A. Legislative Update – Will Frank, Senior Advisor for Legislative Affairs
B. Budget Update – Cat Pelletier, Operations Lead for Finance

V. Committee Discussion of Legislative and Policy Priorities *2:45-3:00 pm*

VI. Agenda for June 1 CHIPAC Meeting *3:00-3:05 pm*

VII. Public Comment *3:05-3:15 pm*

Reasonable accommodations will be provided upon request for persons with disabilities or limited English proficiency. Please notify the DMAS Civil Rights Coordinator at (804) 482-7269, or at civilrightscoordinator@dmas.virginia.gov, at least five (5) business days prior to the meeting to make arrangements.

DMAS BUILDING SECURITY PROCEDURES:

1. Enter through the main entrance on Broad Street.
2. Go to the first floor visitor's center (glass walled area). You will be asked to provide valid identification and will then be issued a visitor's badge. You must display the badge at all times while on site at DMAS.
3. All visitors will be escorted at all times by a DMAS employee while on site. At the end of the visit, you will return your badge to the visitor's desk and sign out.
4. Face coverings are not mandatory, but we encourage guests and staff to use face coverings.

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

DRAFT
Meeting Minutes
December 8, 2022

A quorum of the full Committee attended the meeting virtually through WebEx.
The WebEx link was also made available for members of the public to attend virtually.

The following CHIPAC members were present virtually:

• Sara Cariano	Virginia Poverty Law Center
• Shelby Gonzales	Center on Budget and Policy Priorities
• Emily Griffey	Voices for Virginia's Children
• Freddy Mejia	The Commonwealth Institute for Fiscal Analysis
• Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
• Heidi Dix	Virginia Association of Health Plans
• Michael Muse	Virginia League of Social Services Executives
• Emily Roller	Virginia Health Care Foundation
• Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services
• Irma Blackwell	Virginia Department of Social Services
• Kelly Cannon	Virginia Hospital and Healthcare Association
• Dr. Nathan Webb	Medical Society of Virginia
• Ali Faruk	Families Forward Virginia
• Michael Cook	Board of Medical Assistance Services
• Jeff Lunardi	Joint Commission on Health Care

The following CHIPAC members sent a substitute:

• Jennifer Macdonald (Dr. Vanessa Walker Harris)	Virginia Department of Health

The following CHIPAC members were not present:

• Dr. Tegwyn Brickhouse	VCU Health
• Alexandra Javna	Virginia Department of Education

I. **Welcome** – Sara Cariano, CHIPAC Chair, called the meeting to order at 1:03 p.m. Cariano welcomed committee members and members of the public and explained that the meeting would be all-virtual.

DMAS Director Cheryl Roberts welcomed committee members and gave opening remarks regarding the Governor's behavioral health initiative. She explained that an additional priority for DMAS is preparing for the eventual end of the COVID-19 public health emergency (PHE) and unwinding process. She also highlighted the upcoming DMAS transition to the Cardinal Care managed care delivery system, including future re-procurement of the managed care contracts. Director Roberts encouraged CHIPAC members to share their feedback and opinions regarding procurement.

Attendance was taken by roll call.

II. CHIPAC Business

A. **Membership items** – Cariano explained that Tracy Douglas-Wheeler from the Virginia Community Healthcare Association (VCHA) was stepping down from her position as CHIPAC representative and recommended Martha Crosby, VCHA Programs and Business Lead, to serve as representative. Cariano explained that, because VCHA is not a mandated member organization, a vote was required to approve Crosby as a member. She directed members to review Crosby's bio and member questionnaire in the meeting packet. Crosby introduced herself and summarized her professional background and interest in CHIPAC's work. Kelly Cannon, Virginia Hospital and Healthcare Association (VHHA), moved to approve Crosby as a member of the Committee, Cariano seconded, and the committee voted unanimously to approve.

B. **CHIPAC bylaws** – Hope Richardson, DMAS Division of Policy, Regulation, and Member Engagement, provided an explanation of proposed amendments to the CHIPAC bylaws to reflect the current practice of the committee. (The amendments to the bylaws are included in the publicly posted 12/8/22 meeting packet on the DMAS website.) Cariano explained that the Executive Subcommittee voted at its October meeting to recommend approval of the changes. Cariano moved to accept the updates to the bylaws, Cannon seconded, and the committee voted unanimously to approve.

C. **Review and approval of minutes from September 1 meeting** – Committee members reviewed draft minutes from the September 1 meeting. Cannon made a motion to approve the minutes, Cariano seconded, and the Committee voted unanimously to approve the September 1 meeting minutes.

D. **CHIPAC meeting schedule for 2023** – Cariano explained that the approved schedule of meetings for 2023 was in the meeting packet. She stated that the Executive Subcommittee had voted to recommend making CHIPAC's June and December meetings all-virtual as permitted under the Committee's new remote participation policy. Emily Roller, Virginia Health Care Foundation, moved for the

full committee to approve June and December as the all-virtual meeting dates; Jeff Lunardi, Joint Commission on Health Care, seconded; and the committee voted unanimously to approve the virtual meeting schedule for 2023.

III. Managed Care Procurement Discussion

Cariano introduced Dan Plain, Director of the Health Care Services Division at DMAS, to discuss the transition to Cardinal Care and managed care re-procurement. Plain explained that Cardinal Care is a re-branding of the current programs and does not significantly change the delivery system, benefits, networks, or health plans, but will streamline the existing programs by combining the CCC Plus, Medallion, and fee for service programs into a unified Medicaid program. Cardinal Care will roll out in early 2023.

Plain stated that the re-procurement is an opportunity to build on Virginia's managed care foundation through new requirements and program components in the health plans as well as updated evaluation criteria to reflect current priorities of Virginia Medicaid stakeholders and policymakers. Plain then went over the current status of the Medicaid delivery system and recent achievements including Cardinal Care, Project BRAVO, twelve-month postpartum coverage, the community doula benefit, mobile vision services, public health emergency flexibilities, and unwinding preparations. Re-procurement was announced in October and the agency and administration are targeting July 2024 for the implementation of the new program.

Plain invited CHIPAC members and meeting attendees to provide stakeholder input by Friday, December 16, based on three prompts: (1) What are the strengths of the current Medicaid managed care delivery system that DMAS should maintain or build upon? (2) Are there opportunities to enhance member and provider experience, better collaborate with key partners, and enhance outcomes? (3) Is there anything that DMAS is not currently doing that the agency should consider incorporating through this future procurement?

IV. Data & Quality Updates: Children's Vaccinations & Preventive Health

DMAS Division of Health Economics and Economic Policy (HEEP); Office of Quality and Population Health

Cariano introduced Rich Rosendahl, DMAS Chief Health Economist, to present on children's vaccination rates and preventative health measures. Rosendahl presented COVID-19 vaccination rates in Medicaid children with a full year of data on the child population ages 5-11 and six months of data on children under 5 years. He stated that 5 percent of eligible children in the 1-5 age group have received at least one dose; 37 percent of eligible children ages 5-11 have received at least one dose; 58 percent of children ages 12-15; 66% of children ages 16-20; and 73% of members 21 and older have received at least one dose. The older age groups have higher rates of vaccination as they have been eligible for vaccines longer. Vaccination among members enrolled due to pregnancy is 59%.

Rosendahl explained that regional vaccination data indicates the Northern/Winchester region has the highest vaccination rate and the Southwest region has the lowest rate. Cannon asked about vaccination rates for the Medicaid population versus statewide vaccination rates. Rosendahl explained that Medicaid rates have lagged behind state rates, especially when looking at younger populations. He stated that DMAS will continue to monitor vaccination rates and provide updates, and that managed care organizations are continuing efforts to increase vaccination rates.

Dr. Laura Boutwell, Division Director for the Office of Quality and Population Health, presented on HEDIS (Healthcare Effectiveness Data and Information Set) measures for maternal and child health for 2020. She explained that the HEDIS measures are developed and owned by the National Committee for Quality Assurance (NCQA). Virginia Medicaid managed care organizations are required to be accredited by NCQA and report HEDIS measures. Dr. Boutwell presented data for measurement year (MY) 2020 compared with MY2019 and explained that NCQA gave MCOs flexibility in reporting MY2019 data because of the pandemic and related data issues.

The maternal health HEDIS measures reported are timeliness of prenatal care and postpartum care. Timeliness of prenatal care is defined as the percentage of live births for which the mother received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment. There was a slight decline in this measure between 2019 and 2020. Postpartum care is defined as the percentage of live births for which the mother had a postpartum visit on or between seven and 84 days after delivery. For this measure there was a slight increase, potentially due to the public health emergency's continuous coverage requirement, which has led to Medicaid members maintaining stable enrollment for longer.

Next, Dr. Boutwell presented on children's preventative care HEDIS measures, including well child visits. Well Child Visits in the First 30 Months of Life is a two-part measure that first estimates the percentage of children who had six or more well child visits with a primary care provider (PCP) during the first 15 months of life, then estimates the percentage of members who turned 30 months old during the measurement year and had two or more well child visits with a PCP in the last 15 months. The 15-30 month measure is new for MY2020. The measure for well child visits during the first 15 months declined from 2019 to 2020, likely due to COVID.

Dr. Boutwell then presented the Child and Adolescent Well-Care Visits HEDIS measure, defined as the percentage of members 3-21 years of age who had at least one comprehensive well care visit with a PCP or OB/Gyn practitioner during the measurement year. This is a new measurement for MY2020.

The next preventative care measurement presented was Childhood Immunization Status – Combo 3. The classic HEDIS immunization measure is the percentage of children 2 years of age who received Combo 3 vaccines. This measure declined slightly during MY2020, likely due to COVID and data access issues. However, Immunizations for Adolescents increased, in contrast with national trends. This is the percentage of adolescents 13 years of age who had at least one meningococcal vaccine on or between the member's 11th and 13th birthday, at least one tetanus,

diphtheria toxoids and acellular pertussis vaccine (Tdap) and have completed Combo 1 or 2.

Dr. Boutwell gave an update on the development of the HEDIS dashboard and walked through the display of new data. The dashboard for MY2020 is now live on the DMAS website at https://www.dmas.virginia.gov/data/managed-care-hedis-dashboards/. Dr. Boutwell announced that the HEDIS dashboard will be updated with MY2021 data in early 2023 and will include trending (MY2019-MY2021).

Cariano asked about the collapsed measurement of well child visits for all children aged 3-20 and expressed concern that this may make it difficult to target interventions by age group. Dr. Boutwell responded that while the new NCQA collapsed measure does significantly broaden ages, DMAS has the potential to look back at the data using older specifications for those measures for internal monitoring. Cariano asked about reasons for lower rates of well child visits and whether members are seeing their doctor but the visit may not meet criteria to be classified as a well child visit, or if members are potentially receiving care in other settings rather than seeing a Medicaid-enrolled provider/pediatrician. Dr. Boutwell answered that she was not sure about what was driving the visit rates but that they were seeing an increase for MY2021 and targeted outreach to parents of young children may be an effective intervention option.

Dr. Vanessa Walker-Harris, VDH, asked if, when looking at the dashboard data, there was a way to understand what actions were being driven by that data. Dr. Boutwell recommended reviewing the annual technical report that summarizes the interventions being made in response to the data. Ali Faruk, Families Forward Virginia, asked if there was a national goal or standard for youth vaccinations. Rosendahl responded that he would reach out to the Office of the Chief Medical Officer for further information. Cariano brought up a question from the chat asking if the low COVID vaccination rates could lead to long-term health issues for Medicaid children considering emerging research about long COVID symptoms. Rosendahl acknowledged recommendations for receiving COVID vaccination and opportunities for increasing vaccination status of Medicaid members.

Cariano asked if there were any specific pushes for Medicaid members to get the flu vaccine given the early onset of the flu season this year. Plain responded that DMAS could poll MCOs and follow up with additional information. Michael Cook, Board of Medical Assistance Services (BMAS), asked if there were plans to approach trusted partners within communities with low vaccination uptake rates, such as faith-based organizations, to increase these rates. Plain answered that health plans have been working with community partners as part of their vaccination strategy. Heidi Dix, Virginia Association of Health Plans, commented that the health plans have been especially focusing on these types of community connections in Petersburg and are starting to see success as a result of that work.

Anthem HealthKeepers: Strategies to Improve Well Visits and Vaccination Rates

Cariano introduced Kimberly White, Director of Whole Health at Anthem HealthKeepers Plus, a Virginia Medicaid managed care plan, to present vaccination

data and strategies to improve rates. White reported that vaccination of kindergarteners with Dtap, polio, MMR, and chickenpox is at 88.6% across the state and new data from fall 2022 shows a rate of 89.3%. Vaccination of seventh graders with Dtap, Hep B, MMR, and HPV and meningitis is at 86.5% with fall 2022 data. The lowest vaccination rate is usually HPV and the second dose of meningitis. Vaccination of 12th graders with meningitis and HPV declines with older ages and one of the lowest areas has only a 23.1% rate. White presented vaccine exemption data from 2009 to 2020 showing a rise in religious exemptions that has remained fairly high. Nationwide vaccination data of ages 13-17 by race showed that overall vaccination rates are lowest for HPV and second doses of meningitis. Vaccination rates by insurance coverage and public vs. private schools show similar trends with low meningitis and HPV rates. To look more into HPV vaccination rates, Virginia data was compared with national data. White explained that national rates are increasing, and Virginia rates are following that increase and, in some cases, exceeding it.

Next, White presented nationwide COVID-19 data showing that Black and Hispanic children had lower rates of testing but were significantly more likely to be infected and hospitalized and have a higher number of deaths. Barriers to vaccination and preventive care could be a reason for these disparities. At the state level, barriers to access include lack of transportation, misinformation, and lack of education from providers leading to an increased likelihood of serious illness.

Anthem's efforts to improve well child visits and immunizations involve a multifaceted approach with member and provider initiatives. Member initiatives include care coordinator outreach leveraging HEDIS Gap in Care reports; texting campaigns; mailings, including birthday reminders to complete well child visits; age-out immunization outreach targeting members who need immunizations who are about to age out to get immunized in a timely manner; and partnerships with DSS offices across the state to ensure new foster care members complete a doctor's visit within 60 days of enrollment. Provider initiatives include education through HEDIS booklets and quick reference guides, provider quality incentive programs for key preventive measures, supplemental data reporting, and targeted partnerships with providers. White stated that Anthem has partnered with multiple providers over the last several years to support vaccination clinics and well-child visits in an effort to get more members vaccinated, including assisting with scheduling, identification and outreach to members, transportation coordination, member education, and PPE donations to providers. Anthem has also partnered with communities through churches and schools to improve COVID vaccination rates.

Dr. Walker-Harris asked if Anthem has partnered with any local health district for the school-based clinics. White answered that Anthem has utilized existing relationships within communities and local school systems, and that more partnership data needs to be gathered and shared to enable a more targeted focus and public health strategy. Cannon asked how care coordinators could help members access medications for flu and RSV considering current localized shortages. White explained that care coordinators and clinical teams could work with the member's parent or guardian to locate pharmacies with a supply of needed medications.

Cariano brought up a question from the chat regarding the efficacy of giving gift cards to members as an incentive for getting vaccinated. White answered that gift cards were provided as an incentive but that data is not yet available about the effectiveness of this approach.

V. Maternal Health Updates

DMAS Health Care Services Maternal-Child Health Unit

Natasha Turner, DMAS Doula Program Analyst, shared updates on the implementation of the Medicaid doula benefit. Turner explained that community doulas are non-medical professionals who provide continuous physical, emotional, and informational support to pregnant women prenatally, throughout pregnancy, during labor and delivery, and in the postpartum period. Research has shown that pregnant individuals who receive doula care are more likely to have a healthy birth outcome, a positive birth experience, and a higher likelihood of vaginal birth and breastfeeding initiation.

Turner explained that the Medicaid doula benefit provides four prenatal visits, four postpartum visits, attendance at labor and delivery, and “linkage to care” incentives. She stated that currently there are 65 state certified doulas and 37 Medicaid doula providers. The first doula services were provided in August and the first births were in October. Currently there are 90 Medicaid members receiving doula services and there have been 10 babies born with the support of a doula. Goals to improve the doula benefit include infrastructure and support to engage doulas and build a network of providers. The second goal is focused on collaboration, partnership, and buy-in between MCOs, state agencies, providers, and community stakeholders. Turner said that all six Medicaid health plans have been supportive and engaged in the doula program and some have provided scholarships for training and conducted outreach within their network. Finally, she introduced Medicaid’s first two community doulas, Sequoi Phipps-Hawkins and Larissa Joos.

Maryssa Sadler, DMAS Maternal Health Operations Analyst, presented current agency initiatives to support parenting and postpartum Medicaid members through Baby Steps Virginia. Baby Steps Virginia addresses the five focus areas of eligibility and enrollment, outreach and information, connections, new and improved services and policies, and oversight. Since 2021, DMAS has been involved in the National Academy for State Health Policy (NASHP) Maternal and Child Health Policy Innovation Program (MCH PIP) focusing on racial disparities in maternal mortality. The MCH PIP is currently focused on provider and member outreach through collaboration with sister agencies and MCOs to increase awareness of the new benefits. Cariano brought up a question from the chat asking which division the Baby Steps program was a part of. Sadler answered that it is a part of the Maternal Health Unit within the Health Care Services division.

Virginia Premier: Maternal and Child Health Programs

Cariano introduced Chantel Neece, Director for Member Outreach, Social Determinants of Health, and Community Benefits, from Virginia Premier Medicaid

managed care plan. Neece presented on Virginia Premier's current maternal and child health outreach programs and initiatives. Healthy Heartbeats is an outreach initiative for members with low-risk pregnancies, utilizing 17 dedicated staff who are certified community health workers. High risk pregnancies are engaged through a specialized case management team. The Watch Me Grow program supports a continuum of care from the postpartum period on to ensure the new baby and other children in the household remain connected with managed care, medical services, and social services. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are being shared through community partnerships. Data collection efforts are in place to help identify pregnant individuals as early as possible in the pregnancy so there can be a greater impact on care and birth outcomes. Other components include behavioral health, access to community and government services, continuity of care, long-acting reversible contraceptives (LARC), baby showers, preferred partnerships for education and support, and home visits.

Dr. Walker-Harris asked about care management and referrals for pregnant members with chronic disease and comorbidities. Neece answered that high-risk individuals receive education and care specific to their needs. Faruk asked if there has been an increase in WIC participation due to MCO efforts to connect members with resources. Neece explained the assessment process in which members are identified as needing WIC and other services or benefits.

VI. Agenda for March 2, 2023 CHIPAC Meeting

Cariano announced that the March 2, 2023 meeting will be an in-person meeting. A new member orientation will take place directly before the meeting to provide an overview of the purpose, scope, and history of the committee for members who have joined recently.

Cariano invited discussion about the agenda for the March CHIPAC meeting. Freddy Mejia brought up the topic of targeted outreach and engagement for children who are at risk of being disenrolled and losing health coverage after the end of the PHE. Heidi Dix requested an overview of any developments from the legislative session. Cariano suggested reviewing school-based services and WIC.

VII. Public Comment

Cariano invited public comment but none was made.

VIII. Closing

The meeting was adjourned at 3:30 p.m.

CHIPAC Quarterly Enrollment Dashboard

Table 1 - CHIP and Medicaid Child Enrollment

PROGRAM	INCOME	# Enrolled as of 1-01-23	# Enrolled as of 2-01-23	Net Increase This Month	% of Total Child Enrollment
FAMIS (separate CHIP program) *Children 0-18 years*	> 143% to 200% FPL	81,521	82,298	777	10%
CHIP MEDICAID EXPANSION *Children 6-18 years*	> 100% to 143% FPL	101,904	102,917	1,013	12%
Total CHIP (Title XXI) Children		**183,425**	**185,215**	**1,790**	**22%**
FAMIS Plus* *Children 0-5 years* *Children 6-18 years*	≤ 143% FPL ≤ 100% FPL	654,491	658,441	3,950	77%
Adoption Assistance & Foster Care *Children < 21 years*	FPL N/A	16,187	16,219	32	2%
Other Medicaid Children** *Children < 21 years*	FPL N/A	43	44	1	0%
Total MEDICAID (Title XIX) Children		**670,721**	**674,704**	**3,983**	**78%**
TOTAL CHILDREN		**854,146**	**859,919**	**5,773**	**100%**

***** *Children under 19 enrolled in a Medicaid Families & Children Aid Category. This count does not include the CHIP Medicaid Expansion group.*
****** *This includes children under 21 enrolled in Medicaid under the care of the Juvenile Justice Department or in an intermediate care facility (ICF-MR).*

Table 2 - CHIP Premium Assistance Enrollment

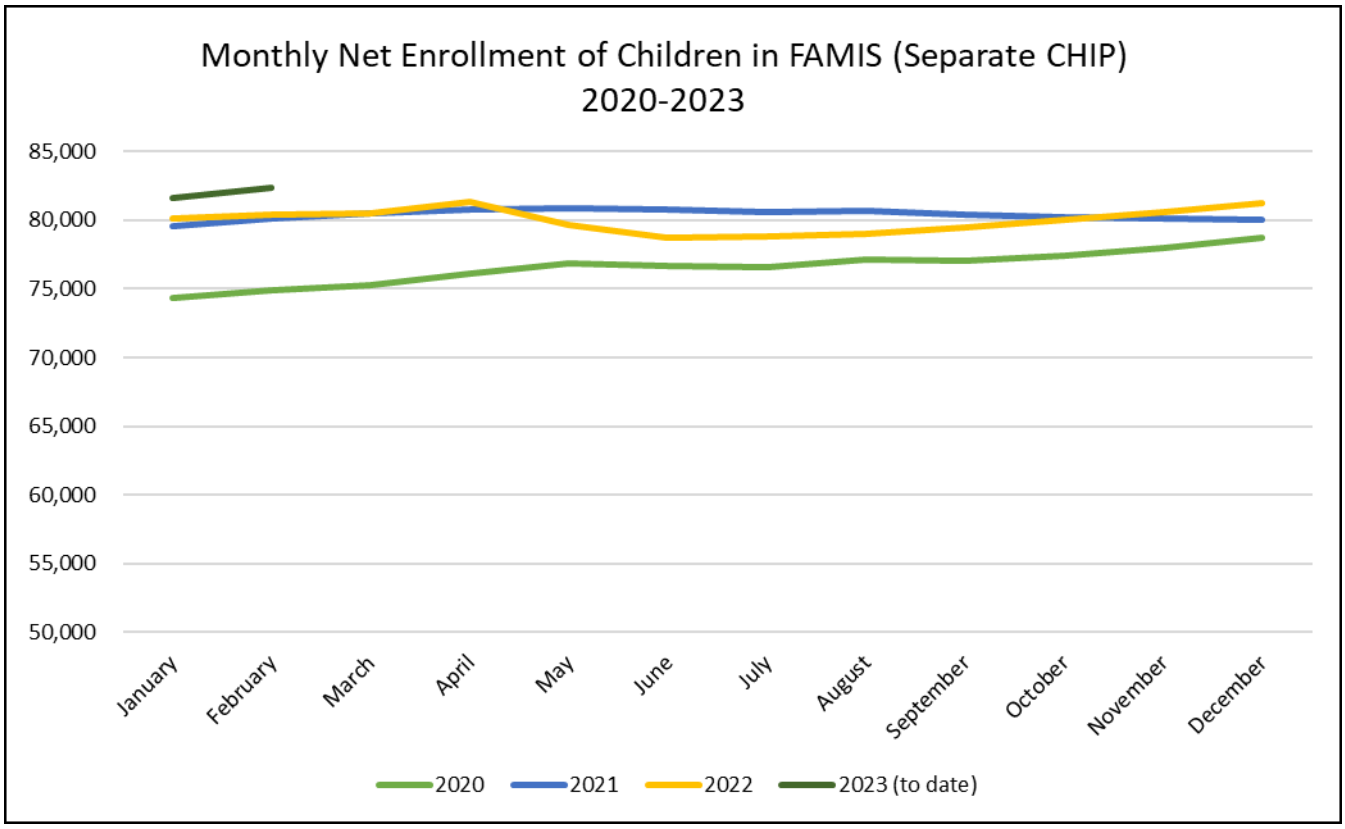
PROGRAM	INCOME	# Enrolled as of 1-01-23	# Enrolled as of 2-01-23	Net Increase This Month
FAMIS *Select* *FAMIS Children < 19 years*	> 143% to 200% FPL	46	45	-1

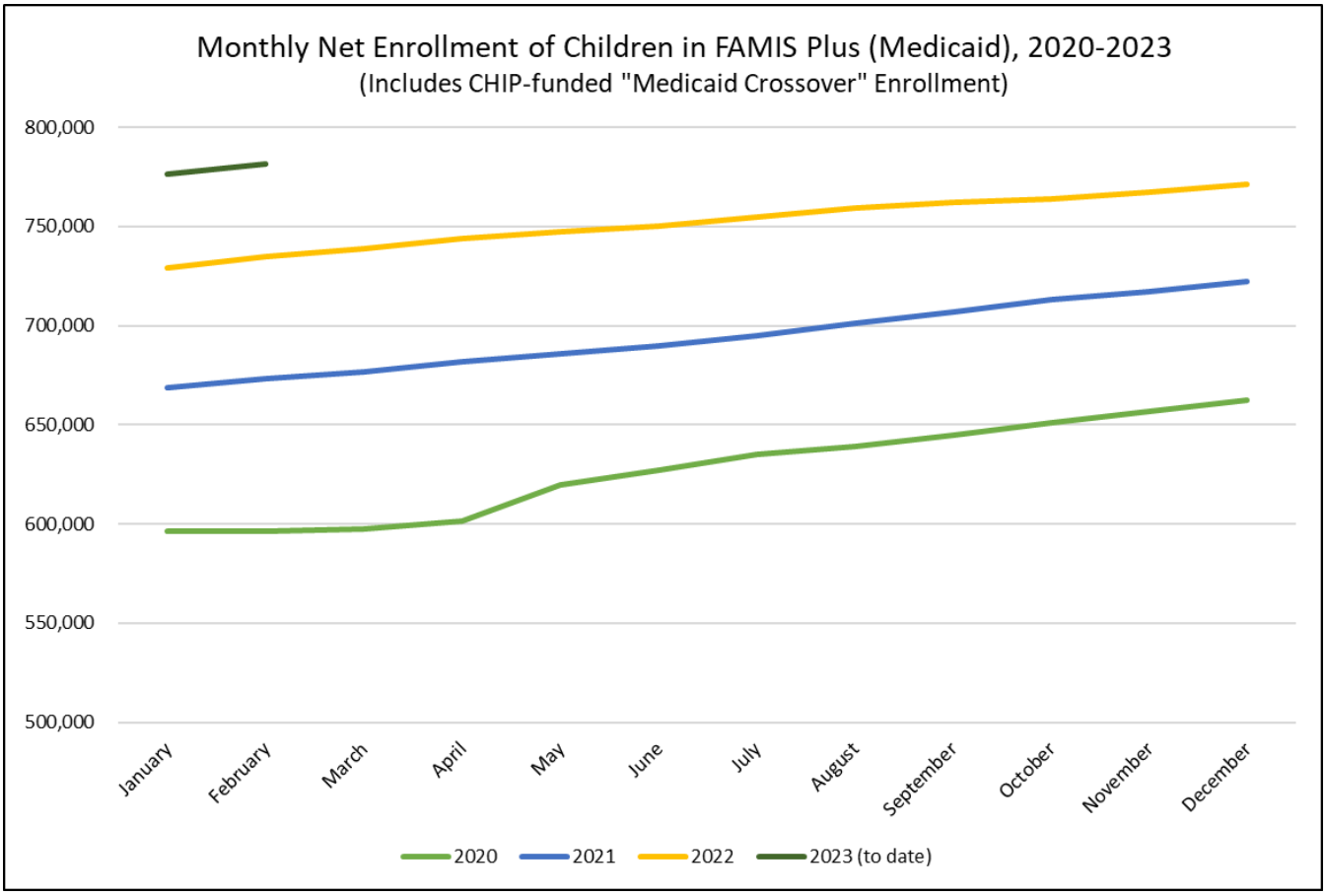
Table 3 - Pregnant Women's Enrollment

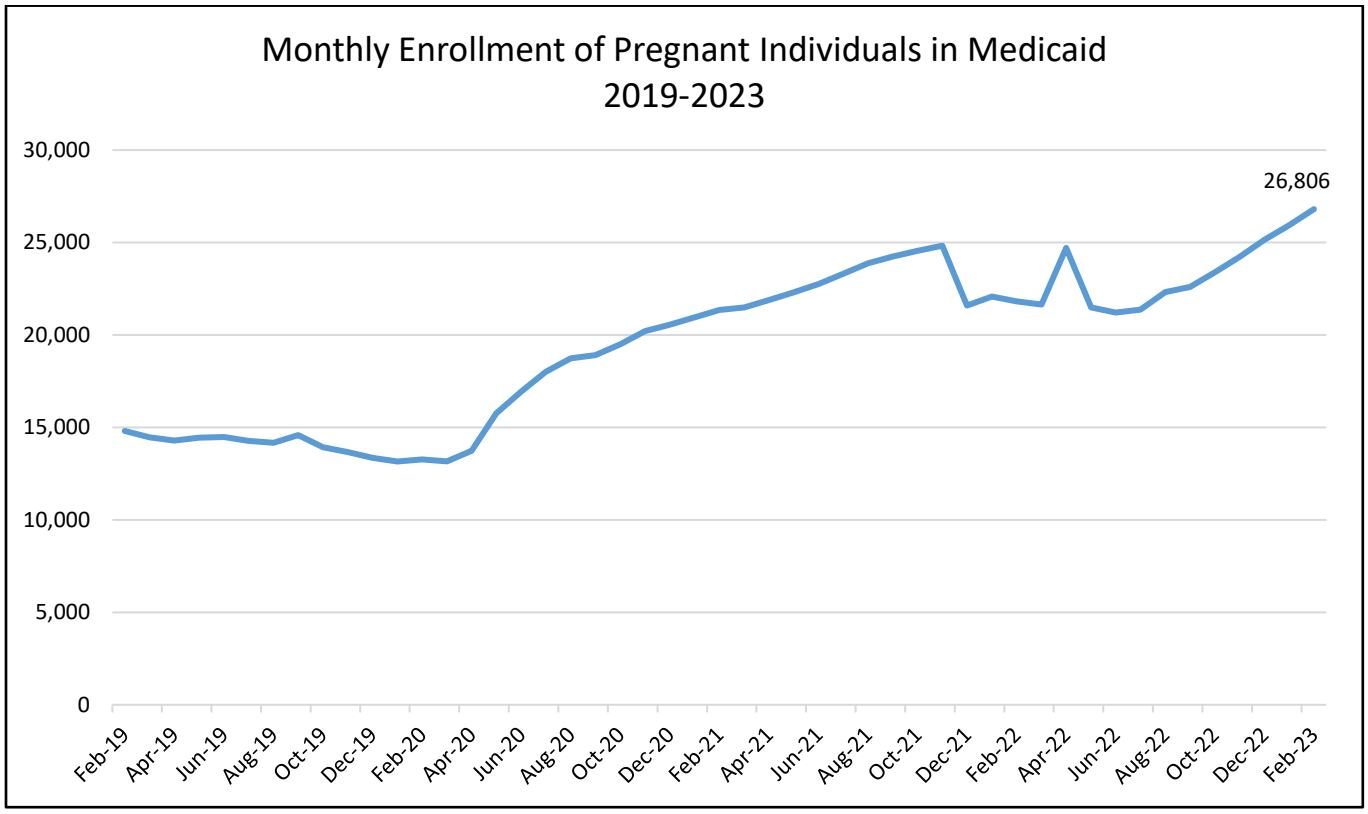
PROGRAM	INCOME	# Enrolled as of 1-01-23	# Enrolled as of 2-01-23	Net Increase This Month	% of Total Pregnant Women Enrollment
CHIP Pregnant Women *(Total Includes FAMIS MOMS & FAMIS Prenatal Coverage)*	> 143% to 200% FPL	7,460	7,759	299	22%
Medicaid Pregnant Women	≤ 143% FPL	25,937	26,806	869	78%
TOTAL Pregnant Women		**33,397**	**34,565**	**1,168**	**100%**

Table 4 - Family Planning Enrollment

PROGRAM	INCOME	# Enrolled as of 1-01-23	# Enrolled as of 2-01-23	Net Increase This Month
Plan First *Men & Women*	≤ 200% FPL	49,993	50,352	359


Monthly Net Enrollment of Children in FAMIS (Separate CHIP)
2020-2023
85,000
80,000
75,000
70,000
65,000
60,000
55,000
50,000
January
February
March
April
May
June
July
August
September
October
November
December
2020
2021
2022
2023 (to date)


Monthly Net Enrollment of Children in FAMIS Plus (Medicaid), 2020-2023
(Includes CHIP-funded "Medicaid Crossover" Enrollment)
800,000
750,000
700,000
650,000
600,000
550,000
500,000
January
February
March
April
May
June
July
August
September
October
November
December
2020
2021
2022
2023 (to date)


Monthly Enrollment of Pregnant Individuals in Medicaid
2019-2023
30,000
25,000
20,000
15,000
10,000
5,000
0
26,806
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
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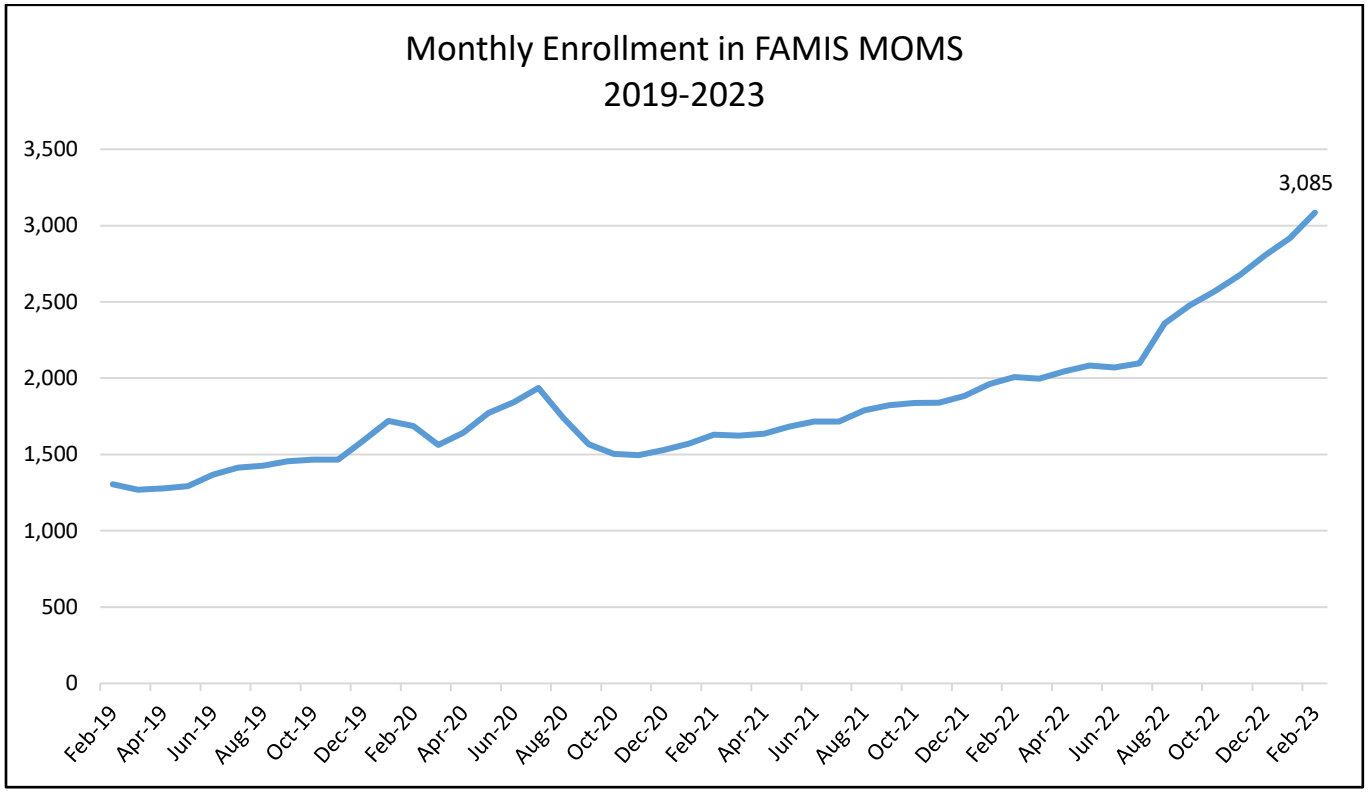
Oct-22
Dec-22
Feb-23


Monthly Enrollment in FAMIS MOMS
2019-2023
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,085
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
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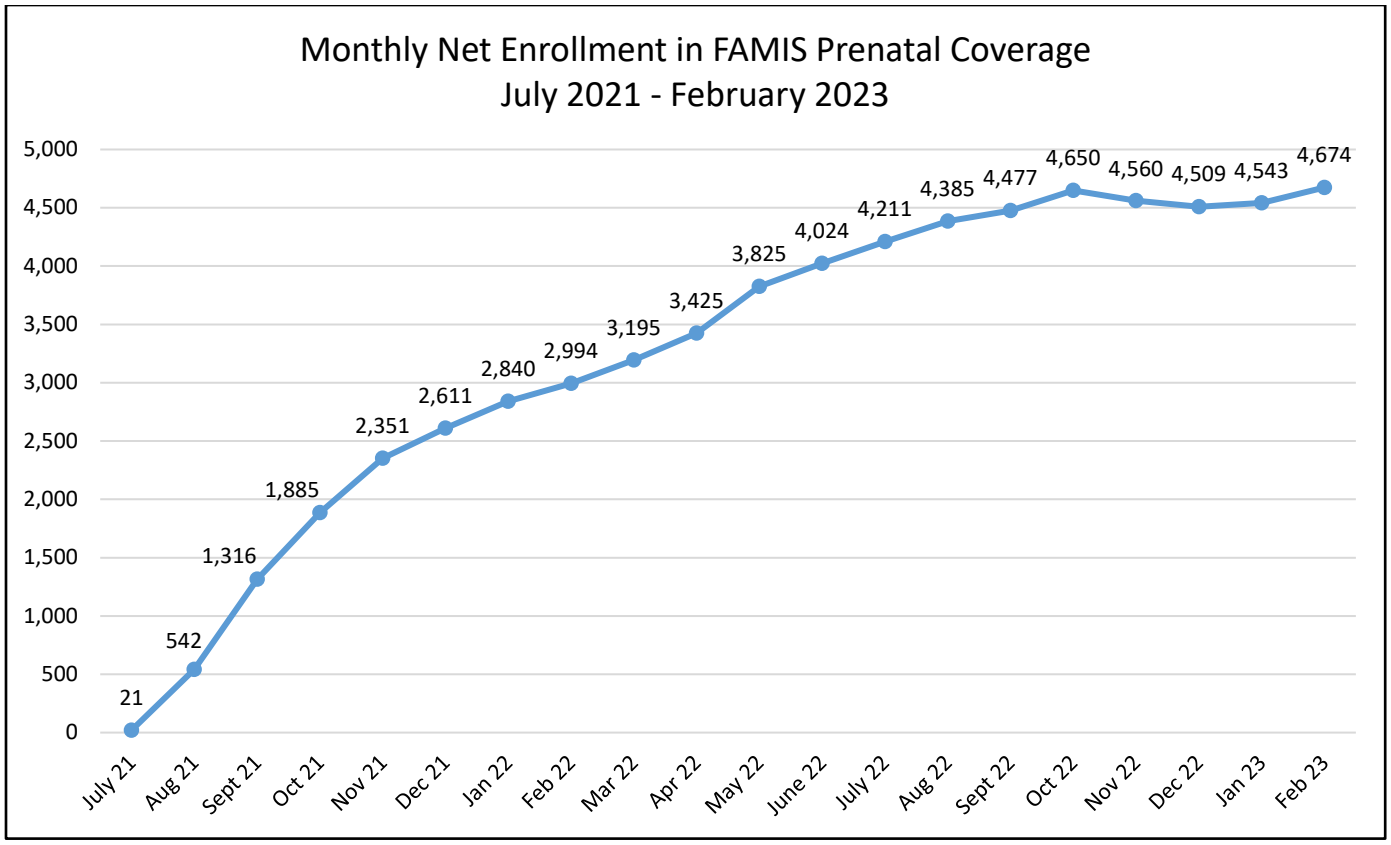
Feb-23


Monthly Net Enrollment in FAMIS Prenatal Coverage
July 2021 - February 2023
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
21
542
1,316
1,885
2,351
2,611
2,840
2,994
3,195
3,425
3,825
4,024
4,211
4,385
4,477
4,650
4,560
4,509
4,543
4,674
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Feb 23

CHIPAC MEMBER CONTACT LIST 2023

	Organization	Representative	Contact info
1.	Joint Commission on Health Care*	Jeff Lunardi Executive Director 3-year term: Dec. 2020 – Dec. 2023	Joint Commission on Health Care P.O. Box 1322 Richmond, VA 23218 804-786-5445 JLunardi@jchc.virginia.gov
2.	Department of Health*	Jennifer O. Macdonald Director, Division of Child and Family Health 3-year term: March 2021 – March 2024	Virginia Department of Health 109 Governor Street Richmond, VA 23219 (804) 864-7729 Jennifer.Macdonald@vdh.virginia.gov
3.	Department of Education*	Alexandra Javna Student Services Specialist, Office of Student Services 3-year term: Sept. 2022 – Sept. 2025	Virginia Department of Education Office of Student Services P.O. Box 2120 Richmond, VA 23218 (804) 786-0720 alexandra.javna@doe.virginia.gov
4.	Virginia Department of Behavioral Health and Developmental Services*	Hanna Schweitzer VMAP Program Administrator Office of Child and Family Services 3-year term: Dec. 2021 – Dec. 2024	Virginia Department of Behavioral Health and Developmental Services P.O. Box 1797 Richmond, VA 23218 hanna.schweitzer@dbhds.virginia.gov
5.	Virginia Health Care Foundation*	Emily Roller Director, Health Insurance Initiatives 3-year term: Dec. 2021 – Dec. 2024	Virginia Health Care Foundation 707 East Main Street, Suite 1350 Richmond, VA 23219 (804) 828-5804 emily@vhcf.org

** Member organizations required per Code of Virginia*

3-2-23

6.	Virginia Department of Social Services*	Irma Blackwell Medical Assistance Program Manager 3-year term: March 2021 – March 2024	Division of Benefit Programs Virginia Department of Social Services 801 East Main Street, Richmond, VA 23219 (804) 584-6763 i.blackwell@dss.virginia.gov
7.	Virginia Poverty Law Center	Sara Cariano Policy Specialist and Lead Navigator *Chair* 2-year term: March 2022 – March 2024	Virginia Poverty Law Center 919 East Main Street, Suite 610 Richmond, VA 23219 (804) 332-1432 Sara@vplc.org
8.	DMAS Board Member	Michael H. Cook Chair, Board of Medical Assistance Services Partner and Co-chair, Health Care Group, Liles Parker PLLC 2-year term: June 2022 – June 2024	Liles Parker, PLLC 2121 Wisconsin Avenue, NW Suite 200 Washington, DC 20007 (202) 298-8750 MCook@lilesparker.com
9.	Medical Society of Virginia	Dr. Nathan Webb, MD, MS, FACOG Assistant Professor, Department of Obstetrics & Gynecology 2 year term: Dec. 2021 – Dec. 2023	VCU Health P.O. Box 980034 Richmond, VA 23298 (804) 828-1809 Charles.webb@vcuhealth.org
10.	Center on Budget and Policy Priorities	Shelby Gonzales Director, Enrollment and Outreach 2-year term: March 2022 – March 2024	Center on Budget and Policy Priorities 1125 1st Street NE Washington, DC 20002 (202) 408-1080 gonzales@cbpp.org

11.	VCU Health	Dr. Tegwyn H. Brickhouse, DDS, PhD Chair, Dept. of Dental Public Health and Policy VCU School of Dentistry 2 year term: Dec. 2021 – Dec. 2023	Dept. of Dental Public Health and Policy 1101 E. Leigh Street Richmond, VA 23298 (804) 827-2699 thbrickhouse@vcu.edu
12.	Virginia League of Social Services Executives	Michael J. Muse Director 2-year term: March 2022 – March 2024	Stafford County Social Services P.O. Box 7 Stafford, VA 22555 (540) 658-8744 Michael.muse@dss.virginia.gov
13.	Families Forward Virginia	Ali Faruk Policy Director 2-year term: December 2021 – December 2023	Families Forward Virginia 8100 Three Chopt Road, Suite 212 Richmond, VA 23229 afaruk@familiesforwardva.org
14.	The Commonwealth Institute for Fiscal Analysis	Freddy Mejia Deputy Director of Policy *Vice Chair* 2-year term: June 2022 – June 2024	The Commonwealth Institute for Fiscal Analysis 1329 E. Cary St. #200 Richmond, VA 23219 (804) 396-2051 x106 freddy@thecommonwealthinstitute.org
15.	Voices for Virginia's Children	Emily Griffey Chief Policy Officer 2-year term: March 2022 – March 2024	Voices for Virginia's Children 1606 Santa Rosa Road, Suite 109 Henrico, VA 23229 (804) 649-0184 Emily@vakids.org

16.	Virginia Association of Health Plans	Heidi Dix Senior Vice President of Policy 2-year term: March 2022 – March 2024	Virginia Association of Health Plans 1111 E. Main Street, Suite 910 Richmond, VA 23219 (804) 648-8466 heidi@vahp.org
17.	Virginia Chapter of the American Academy of Pediatrics	Dr. Susan Brown 2-year term: March 2022 – March 2024	(804) 363-7732 Gollobrown@gmail.com
18.	Virginia Hospital and Healthcare Association	Kelly Cannon Senior Director, VHHA Foundation 2-year term: June 2022 – June 2024	Virginia Hospital and Healthcare Association 4200 Innslake Drive, Suite 203 Glen Allen, VA 23060 (804) 212-8721 kcannon@vhha.com
19.	Virginia Community Healthcare Association	Martha Crosby Programs and Business Lead 2-year term: December 2022 – December 2024	Virginia Community Healthcare Association 3831 Westerre Parkway, Suite 2 Henrico, VA 23233-1330 (804) 237-7677 mcrosby@vcha.org

HISTORY

Children's Health Insurance Program Advisory Committee of Virginia

In 1997, over 100 organizations came together to form the Virginia Coalition for Children's Health to ensure that Virginia would take full advantage of the newly established S-CHIP program, to provide health insurance for the uninsured children of lower income working families. The Coalition worked during the 1998 General Assembly Session to ensure that Virginia adopted a program that provided the best package of benefits for the greatest possible number of uninsured children. Recognizing that legislation alone would not ensure that children enrolled, the Coalition also launched the statewide *SignUpNow* outreach initiative.

At the initiation of the Governor, the 2000 Virginia General Assembly passed legislation that renamed and significantly reshaped the existing CMSIP (Children's Medical Security Insurance Program) into the FAMIS (Family Access to Medical Insurance Security) plan. This legislation required the Department of Medical Assistance Services (DMAS) to maintain an Outreach Oversight Committee composed of representatives from community-based organizations engaged in outreach activities (such as *SignUpNow*), social services eligibility workers, the provider community, health plans, and consumers. The Committee was tasked with recommending strategies to improve outreach activities and to streamline and simplify the application process.

In the 2004 session of the Virginia General Assembly, legislation was passed that eliminated the Outreach Oversight Committee and established the present-day Children's Health Insurance Program Advisory Committee—CHIPAC. The scope of CHIPAC was broadened significantly from that of the Outreach Oversight Committee. CHIPAC is now charged with assessing the policies, operations, and outreach efforts for both FAMIS and FAMIS Plus (children's Medicaid). In addition, the Committee evaluates enrollment, utilization of services, and the health outcomes of children eligible for these programs. CHIPAC has the authority to report on the current status of the programs and make recommendations to the Director of DMAS and the Secretary of Health and Human Resources.

§ 32.1-351.2. Children's Health Insurance Program Advisory Committee; purpose; membership; etc

The Department of Medical Assistance Services shall maintain a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee shall consist of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

The Department of Medical Assistance Services shall enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced price school lunches or for services through the Women, Infants, and Children program (WIC) in order that the eligibility of such children for the Virginia Plan for Title XXI of the Social Security Act may be determined expeditiously.

2000, cc. 824, 848;2002, c. 329;2004, c. 301;2009, cc. 813, 840.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Children's Health Insurance Program Advisory Committee (CHIPAC)

Organizations Represented by Current Membership

ADVOCACY ORGANIZATIONS	GOVERNMENTAL AGENCIES, BOARDS & ORGANIZATIONS	PROVIDERS & PROVIDER ASSOCIATIONS	OTHERS
○ Virginia Poverty Law Center ○ Voices for Virginia's Children ○ Families Forward Virginia ○ The Commonwealth Institute for Fiscal Analysis	○ Joint Commission on Health Care* ○ Department of Social Services* ○ Department of Health* ○ Department of Education* ○ Virginia Department of Behavioral Health and Developmental Services* ○ Virginia League of Social Services Executives ○ Board of Medical Assistance Services (DMAS Board)	○ Virginia Chapter of the American Academy of Pediatrics ○ VCU Health ○ Medical Society of Virginia (OB Physician) ○ Virginia Community Healthcare Association ○ Virginia Association of Health Plans ○ Virginia Hospital and Healthcare Association	○ Virginia Health Care Foundation* ○ Center on Budget and Policy Priorities

** Member organizations required per Code of Virginia*

CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEMBER RESPONSIBILITIES

MISSION OF THE COMMITTEE

The mission of the Children's Health Insurance Program Advisory Committee is to advise the Director of the Department of Medical Assistance Services (DMAS) and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS programs to address the health needs of children.

COMMITTEE MEMBER RESPONSIBILITIES

- Attend all full committee and subcommittee meetings, retreats, and other CHIPAC functions.
- When an absence is unavoidable, it is expected that the member will authorize a knowledgeable substitute to attend and vote on his/her behalf. Please inform the chairperson and DMAS staff in advance of the meeting of the name of the person substituting on the member's behalf.
- Be informed about CHIPAC's mission, bylaws, policies, and projects.
- Review agenda and supporting materials prior to meetings.
- Serve on subcommittees or task forces; offer to take on special assignments and present at meetings.
- Suggest possible nominees to the committee who can make a significant contribution to the work of CHIPAC.
- Keep up to date on developments in CHIP and Medicaid and in the field of maternal and child health.
- Follow conflict-of-interest and Freedom of Information Act (FOIA) policies.

PERSONAL CHARACTERISTICS TO CONSIDER

- Ability to listen, analyze, think clearly and creatively, and collaborate with other committee members.
- Willingness to prepare for and attend all committee meetings, engage in committee discussion, and follow through on projects for the committee.
- Commitment to contributing to and advancing the mission, goals, and work of CHIPAC.

BYLAWS

CHIPAC Bylaws

ARTICLE I – NAME

The name of the committee is the Children's Health Insurance Program Advisory Committee, hereinafter known as the Committee.

ARTICLE II – MISSION OF THE COMMITTEE

The mission of the Committee is to advise the Director of the Department of Medical Assistance Services (DMAS) and the Secretary of Health and Human Resources on ways to optimize the efficiency and effectiveness of DMAS programs to address the health needs of children.

ARTICLE III – LEGAL BASE AND POWERS AND DUTIES OF THE COMMITTEE

Legal Base: Code of Virginia, § 32.1-351.2:

> *The Department of Medical Assistance Services shall maintain a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee shall consist of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge of and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.*

ARTICLE IV – MEMBERSHIP OF THE COMMITTEE OF THE DEPARTMENT

Section 1. Composition (as stipulated in the Code of Virginia):

The Committee shall consist of no more than 20 members and shall include a member from each of the following appropriate entities:

- The Joint Commission on Health Care,
- The Department of Social Services,
- The Department of Health,
- The Department of Education,
- The Department of Behavioral Health and Developmental Services, and
- The Virginia Health Care Foundation.

Other members may come from various provider associations and children's advocacy groups or may be individuals with significant knowledge of and interest in children's health insurance issues.

Section 2. Terms:

A. Appointments

1. Organizational Members Mandated in the Code of Virginia
   Membership from six organizations is mandated in the Code of Virginia. A representative of a mandated member organization shall serve a term of three years. After three years, that representative may be reappointed at the discretion of the organization, or the organization may appoint another representative to serve on the Committee. If the representative leaves his/her position or can no longer serve on the Committee, the mandated member organization shall appoint another representative to complete his/her term.

2. All Other Committee Members
   The Committee will make recommendations to the Director of DMAS to fill the other fourteen membership positions. The Director of DMAS maintains final authority to invite individuals or groups to serve on the Committee.

   Committee members other than representatives of the mandated member organizations shall serve for a term of two years. Members may serve no more than four consecutive two-year terms. A person appointed to fill a vacancy during a term may serve three additional consecutive terms. If a person cannot complete his/her term, the Committee will recommend appointment of a replacement to the Director of DMAS.

B. Absences

1. Organizational Members Mandated in the Code of Virginia
   If a mandated member organization's representative misses two consecutive meetings of the Committee (without providing a substitute), inquiry shall be made of the organization to ascertain whether they desire to appoint another representative.

2. All Other Committee Members

For all other Committee members who miss two consecutive meetings (without providing a substitute), the Committee may ask the member to resign and recommend a replacement to serve the remainder of the member's term. If a person misses three or more meetings without providing a substitute during his/her term, he/she may be asked to resign and the Committee would then recommend a replacement to serve the remainder of the member's term.

C. Substitutes

1. If a person is unable to attend a meeting, they may send an appropriate substitute in their place. The member is responsible for letting the Chairperson or appropriate DMAS staff know of such substitution, if possible, in a reasonable time frame.

2. The substitute will be understood to have the authority to vote on behalf of the person/organization they are representing on matters before the Committee on the day of the meeting.

Section 3. Authority of Individual Members:

No member of the Committee shall at any time act or purport to act on behalf of or in the name of the Department or the Committee without prior authority from the Committee and the Department.

ARTICLE V – ORGANIZATION

Section 1. Officers of the Committee:

The officers of the Committee shall be a Chairperson and a Vice-Chairperson.

Section 2. Selection of Officers:

A. The Chairperson shall be elected by the Committee from among its membership in odd-numbered years. The Chairperson shall serve for a term of two years. The incumbent shall be eligible to serve an additional consecutive term of two years.

B. The Vice-Chairperson shall be elected by the Committee from among its membership in even-numbered years. She/he shall serve for a two-year term. The Vice-Chairperson shall also be eligible to serve an additional consecutive term of two years.

C. Elections for Chairperson and Vice-Chairperson shall be held in the month of December, with the term of office beginning at the start of the new calendar year. In the case of the Chair being vacant, the Vice-Chairperson shall serve as the temporary Chairperson until the next Committee meeting, at which time a new election shall be held to fulfill the remainder of the original term.

Section 3. Duties of Officers:

A. The Chairperson shall preside at all meetings of the Committee, shall be a member ex officio of all standing subcommittees, and shall perform such other duties as may be imposed by action of the Committee or as set forth in other sections of these policies and procedures.

B. The Vice-Chairperson shall serve in the absence of the Chairperson of the Committee and shall perform such other duties as may be imposed by action of the Committee or as set forth in other sections of these regulations.

Section 3. Executive Subcommittee:

A. The Executive Subcommittee shall consist of the Chairperson, the Vice-Chairperson, Chairpersons of any existing subcommittees, and one or more at-large CHIPAC members appointed at the discretion of the CHIPAC Chair.

B. The Executive Subcommittee shall carry out functions as assigned by the Committee in keeping with the purposes of the Committee. The Executive Subcommittee may assist Department staff in problem solving and decisions.

C. The Executive Subcommittee may be called to meet as needed and at the request of the Chairperson.

Section 4. All other subcommittees:

A. Subcommittees shall be appointed by the Chairperson whenever they are deemed necessary by the Committee. A subcommittee shall be restricted to its assigned task, shall report its recommendations to the Committee, and shall be dissolved when its report is complete and accepted by the Committee unless otherwise provided by the Committee.

B. Subcommittees may invite others with topic expertise who are not serving on the full Committee to participate as advisors or consultants in subcommittees. Only full Committee members or their substitutes will be counted in the quorum and can vote.

C. The chair of any subcommittee must be a member of the full Committee.

ARTICLE VI – MEETINGS OF THE COMMITTEE

Section 1. Regular Committee Meetings:

A. A gathering, whether physical or by electronic means, of three or more Committee members discussing or transacting Committee business is considered a meeting.

B. The Committee shall meet at the call of the Chairperson, but no less than four times a year.

C. Meetings will be held quarterly in March, June, September, and December.

Section 2. Special Meetings:

A. Special meetings may be called by the Chairperson, upon the written request of any three members of the Committee, or by the Director of the Department of Medical Assistance Services.

B. Notice to all Committee members stating the time, place and purpose of the special meeting shall be e-mailed as early as possible, but in no case less than five working days prior to the meeting.

Section 3. Agendas:

A. The agenda for each meeting of the Committee shall be prepared by the Department in consultation with the Chairperson. Copies of the tentative agenda shall be provided in hard copy or electronically to each member at least three working days prior to each regular meeting.

B. Copies of the agenda and materials provided to the Committee members shall be available to the public at the same time they are made available to the Committee members.

Section 4. Meetings to be Public:

A. All regular and special meetings of the Committee shall be open to the public, provided that the Committee may meet in Closed Meeting to consider matters as permitted by the Freedom of Information Act (Va. Code §2.2-3711). Such Closed Meetings shall be held when feasible after all items of business on the agenda have been conducted.

B. Notice of a regular Committee meeting shall be posted publicly at least three working days prior to the meeting.

Section 5. Citizen Participation:

A. Individuals or representatives of groups may speak on agenda topics at a publicly announced time on the agenda during each meeting, provided the Chairperson has approved this request prior to the meeting being called to order. Such individuals or group representatives will be allotted up to ten minutes to present their information to the Committee. At the discretion of the Chairperson or by majority vote of the Committee, such time limit may be extended as appropriate.

B. After the Committee has dispensed with items on the agenda, members of the public will be permitted to speak during a designated public comment period. Each individual/group shall be allotted up to two minutes to make their comment. At the discretion of the Chairperson or by majority vote of the Committee, such time limit may be extended as appropriate.

C. Except in emergencies, the Committee shall not attempt to decide upon any question before examining and evaluating the information any person requests the Committee to consider. The appropriate subcommittee of the Committee shall be given an opportunity to examine and to evaluate all such information and to recommend action before the Committee makes a decision.

Section 6. Quorum:

A majority of the filled Committee member positions shall constitute a quorum for the transaction of business at a full Committee meeting. For a subcommittee meeting, a quorum shall consist of at least half of the subcommittee membership.

Section 7. Voting:

If a quorum exists, an affirmative vote of a majority of the Committee members present is required for the Committee to act. All votes must be recorded and take place in an open meeting.

Section 8. Closed Meetings:

A. A closed meeting may be held within an open meeting under certain conditions. There must be an affirmative vote during an open meeting to hold a closed meeting. The motion to approve the closed meeting must include the following: (1) the subject of the closed meeting, (2) the purpose of the closed meeting, and (3) the reference to the applicable exemption from the open meeting requirements.

B. Following the closed meeting, the Committee must reconvene an open meeting and take a vote to affirm that they restricted their discussion during the closed meeting to only those items specifically mentioned in the closed meeting motion. A decision made during a closed meeting only becomes official once the Committee reconvenes an open meeting and votes on the decision.

Section 9. Remote Participation and All-Virtual Meetings:

A. Remote Participation of Individual Members

Consistent with § 2.2-3708.3 of the Code of Virginia, effective September 1, 2022, an individual member of the Committee may participate remotely instead of attending a meeting in person if, in advance of the public meeting, the member notifies the CHIPAC Chair and DMAS staff of the following:

1. The member has a temporary or permanent disability or other medical condition that prevents the member's physical attendance;
2. A family member's medical condition requires the member to provide care for such family member, thereby preventing the member's physical attendance; or
3. The member's principal residence is more than 60 miles from the meeting location identified in the required notice for the meeting.

The member and the Committee must follow the Procedure for Remote Participation Approval outlined below. When an individual member participates remotely under this process, the Code of Virginia requires that a quorum of the Committee be physically assembled at the primary or central meeting location. Members participating remotely may participate in discussions, make motions, vote, join in closed meetings, and otherwise participate fully as if they were physically present. A separate set of requirements apply to all-virtual meetings, described below under All-Virtual Meetings Policy.

B. Procedure for Remote Participation Approval

1. Request: The member requesting to participate remotely must notify the Chair and DMAS staff on or before the day of the meeting. The member must include the reason for the request for remote participation, citing one of the specific reasons listed above.

2. Approval: Approval shall be granted unless a member's participation would violate this policy or the provisions of § 2.2-3708.3. If a member's participation from a remote location is challenged, then the Committee shall vote whether to allow such participation.

3. Documentation: The following information must be included in the meeting minutes:

a. The fact that the member participated through electronic communication means and the reason as listed in A.1, 2, or 3 above.

b. Notwithstanding the disclosure requirement, the specific medical condition(s) or related clinical information affecting the member requesting remote participation shall not be publicly disclosed.

c. If a member's participation from a remote location is disapproved because such participation would violate this policy, such disapproval shall be recorded in the minutes with specificity.

4. Limitation: There is no limit on the number of times per calendar year an individual member may participate remotely.

5. Consistent Application of Policy: In accordance with § 2.2-3708.3 of the Code of Virginia, this policy shall be applied strictly and uniformly, without exception, to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

The policy for remote participation and procedures for approval shall also apply to meetings of any subcommittee designated by the Committee to perform delegated functions or to advise the Committee.

C. All-Virtual Meetings Policy

Consistent with § 2.2-3708.3 of the Code of Virginia, effective September 1, 2022, the following policy defines the circumstances under which an all-virtual public meeting of the CHIPAC will be allowed. All-virtual meetings may be held at the option of the Chair or by vote of the full Committee. No more than two (2) all-virtual meetings shall be held per calendar year, such meetings must be non-consecutive, and the following requirements must be met.

1. An indication of whether the meeting will be in-person or all-virtual shall be included in the required meeting notice along with a statement notifying the public that the method by which the Committee chooses to meet shall not be changed unless the Committee provides a new meeting notice in accordance with the provisions of § 2.2-3707.

2. Public access to the all-virtual public meeting shall be provided via electronic communication means.

3. The electronic communication means used shall allow the public to hear all members of the Committee participating in the all-virtual meeting and, when audio-visual technology is available, to see the members as well.

4. A phone number or other live contact information shall be provided to alert the Committee if the audio or video transmission of the meeting provided fails. Committee staff shall monitor such designated means of communication during the meeting, and the Committee shall take a recess until public access is restored if the transmission fails for the public.

5. A copy of the proposed agenda and all agenda packets and, unless exempt, all materials furnished to members shall be made available to the public in electronic format at the same time that such materials are provided to members.

6. The public shall be afforded the opportunity to comment through electronic means, including by way of written comments, when public comment is customarily received.

7. No more than two members of the Committee shall be together in any one remote location unless that remote location is open to the public to physically access it.

8. If a closed session is held during an all-virtual public meeting, transmission of the meeting to the public shall resume before the Committee votes to certify the closed meeting as required by subsection D of § 2.2-3712.

9. Minutes shall be taken as required by § 2.2-3707 and shall include the fact that the meeting was held by electronic communication means and the type of electronic communication means by which the meeting was held.

Section 10. Recordings of the Meeting:

A. Typed minutes of each meeting shall be maintained as a public record in the custody of the Department of Medical Assistance Services. These minutes shall be sent to each Committee member and approved at the next full Committee meeting.

B. Draft minutes will be posted on the Department of Medical Assistance Services web site and on a central electronic calendar maintained by the Commonwealth within ten days of the meeting. Approved minutes will be posted within three days of the meeting at which they were approved.

Section 11. Adjourned Meetings:

Meetings may be adjourned as the business of the Committee requires. At the time of adjournment, the time, date, and place of the continuation of the meeting or next meeting shall be determined and announced.

Section 12. Parliamentary Procedure:

Robert's Rules of Order shall prevail except as otherwise provided herein.

ARTICLE VII – REPORTING

The Committee shall, at its discretion, report on the current status of the FAMIS programs and submit recommendations to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

ARTICLE VIII – AMENDMENTS

These bylaws, except those quoted from the enabling statute, may be amended at any meeting of the

Committee by a simple majority.

ADOPTED by the Committee December 8, 2022.

July 15, 2022

The Honorable John Littel
Secretary of Health and Human Resources
1111 East Broad Street, 4th Floor
Richmond, VA 23219
john.littel@governor.virginia.gov

Cheryl Roberts, JD
Acting Director, Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
cheryl.roberts@dmas.virginia.gov

Dear Secretary Littel and Acting Director Roberts:

We, the members of the Children's Health Insurance Program Advisory Committee (CHIPAC), are writing to recommend the below measures for inclusion in the Department of Medical Assistance Services' upcoming budget request package and Governor's 2023 budget. *

CHIPAC is made up of a diverse group of stakeholders committed to promoting maternal and child health in Virginia. Established in 2004 by the General Assembly, CHIPAC's charge includes assessing the policies, operations, and outreach efforts for both FAMIS and FAMIS Plus and evaluating enrollment, utilization of services, and the health outcomes of children eligible for such programs (Code of Virginia §32.1-351.2). Our mission states that we shall advise "on ways to optimize the efficiency and effectiveness of DMAS' programs that address the health needs of children."

The four recommendations below align with this mission by streamlining the administration of the FAMIS Plus and FAMIS programs, reducing the administrative complexities families encounter when applying for and renewing coverage, and expanding coverage to children who currently have no access to affordable and comprehensive health coverage, including a robust mental health benefit package. These steps are even more crucial as Virginia and other states prepare to return to normal Medicaid operations at the conclusion of the federal Public Health Emergency (*PHE*). We encourage the Commonwealth to adopt these recommendations.

** CHIPAC members who are staff of the Joint Commission on Health Care, the Virginia Health Care Foundation, and state agencies provided technical expertise on the options below. They did not support or oppose any specific recommendation.*

12 Month Continuous Eligibility for Children in FAMIS and FAMIS Plus

Continuous eligibility will benefit the state by reducing the administrative complexity and cost associated with the disenrollment and reenrollment process.[i] Many children lose coverage due to a modest increase in household income or for administrative reasons. Often, they are still eligible or regain eligibility within a few months and must reapply. As we anticipate the end of the federal PHE and associated Medicaid Maintenance of Effort requirement, Virginia should take all available steps to ease administrative burden and ensure a smooth transition back to normal operations.

Providing 12 months of continuous eligibility to FAMIS Plus and FAMIS enrolled children also results in better health outcomes due to uninterrupted access to preventative services, primary care, and

treatment. It fosters the development of a patient-physician relationship, allowing the child's health and development to be tracked and medical needs to be identified and addressed earlier.[ii]

Twenty-four states have adopted this option for all Medicaid- and CHIP-enrolled children. An additional nine states have continuous eligibility for a subset of these children.[iii] Virginia currently provides continuous eligibility to pregnant women through 12 months postpartum and to children born to Medicaid/CHIP enrolled individuals until age 1.

Create a State-funded Program to Cover Income-Eligible Children Regardless of Immigration Status

Virginia has adopted the federal option to cover legally residing children in FAMIS and FAMIS Plus. However, per federal rules, children without legally residing status are only eligible for Emergency Medicaid, which covers emergency services only. These children are also prohibited from purchasing private insurance through the Marketplace, even at full cost, and many do not have access to employer plans.[iv] It is estimated that 48% of FAMIS and FAMIS Plus income eligible children in this category are uninsured.[v] As a result, many struggle to access preventative and ongoing health care, leading to long-term negative health outcomes. Conversely, the provision of medical assistance has been shown to decrease infant mortality, improve childhood health, decrease Emergency Department visits and hospitalizations as adults, increase economic security, and improve school attendance and educational achievement.[vi]

Further, only 62% of FAMIS and FAMIS Plus eligible legally residing immigrant children are enrolled, versus 90% of eligible U.S. born children. [vii] Recent analysis of the uninsured by the Virginia Health Care Foundation shows that the uninsured rate among non-citizens ages 0-64 is 26.6%, compared to 5% for citizens. Creating a program for children regardless of immigration status would provide coverage to children with no current option and create a welcome mat for those currently eligible and not enrolled.

The program would also support Virginia's health care safety net, which is currently providing care to ineligible and eligible but unenrolled children through Federally Qualified Health Centers, emergency departments and school divisions. General relief and CSA funds are also used to provide mandatory health care to children without legal status in foster care. A state-funded program covering these children would provide comprehensive coverage and offset the costs currently being absorbed by these other entities.

Merge FAMIS Program with Children's Medicaid, retaining higher CHIP federal match

Virginia currently operates a children's Medicaid program (covering children 0-5 years with income < 143% FPL and 6-21 years with income < 100% FPL); a CHIP-funded Medicaid program ("MCHIP," covering children 6-18 years with income >100% and <143% FPL); and a separate CHIP program called FAMIS ("SCHIP," covering children 0-18 years with income >143% and <200% FPL).

Moving the FAMIS children into MCHIP would reduce the burden of administering separate programs and alleviate compliance challenges associated with administering SCHIP, such as tracking out-of-pocket limits and ensuring compliance with federal mental health parity law. It would also: ensure that all children enrolled in Virginia's medical assistance programs have equal access to benefits, such as non-emergency medical transportation, Early Periodic Screening Diagnosis and Treatment, and complex care services; transition children in FAMIS Select to the more robust premium assistance program available for Medicaid children.; and allow Virginia to collect significant federal drug rebates that are only available under Medicaid.[viii]

Increase Income Limit for FAMIS and FAMIS MOMS (Virginia's CHIP Programs)

Virginia's current income limit for FAMIS and FAMIS MOMS is 205% FPL. Only 2 states, Idaho and North Dakota, have lower limits for children's CHIP coverage. The national median upper income limit for children's CHIP coverage is 255% FPL, 266% FPL in Medicaid Expansion states. More than a third of states, including neighboring states Maryland and West Virginia, cover children at or above 300% FPL.[ix] The Affordable Care Act's Health Insurance Marketplaces offer less robust cost-sharing subsidies for those with incomes ≥200% FPL, resulting in significantly higher deductibles and out-of-pocket maximums. Increasing the FAMIS and FAMIS MOMS income eligibility limits would cover more Virginians and smooth the transition between these coverage types and Marketplace coverage.

Virginia has made great progress toward improving child health since the inception of CHIPAC, much thanks to the efforts of DMAS and the Virginia Department of Social Services. We thank you for your consideration of these items to continue this great work and look forward to our continued partnership with the Administration.

Please don't hesitate to reach out to discuss these recommendations, or any other ways in which CHIPAC can support your work, by contacting Sara Cariano, CHIPAC Chairperson (sara@vplc.org or 804-332-1432).

Sincerely,

Children's Health Insurance Program Advisory Committee (CHIPAC) Members:

Center on Budget and Policy Priorities
Families Forward Virginia
Medical Society of Virginia
The Commonwealth Institute for Fiscal Analysis
VCU Health
Virginia Association of Health Plans
Virginia Chapter of the American Academy of Pediatrics
Virginia Community Healthcare Association
Virginia Hospital and Healthcare Association
Virginia League of Social Services Executives
Virginia Poverty Law Center
Voices for Virginia's Children

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