CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

Meeting Minutes
September 7, 2023

A quorum of the full Committee attended the meeting at the Department of Medical Assistance Services (DMAS) offices at 600 East Broad Street, Richmond. A WebEx option was also available for members of the public to attend virtually.

The following CHIPAC members were present in person:

• Sara Cariano, Chair	Virginia Poverty Law Center
• Shelby Gonzales	Center on Budget and Policy Priorities
• Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
• Heidi Dix	Virginia Association of Health Plans
• Emily Roller	Virginia Health Care Foundation
• Irma Blackwell	Virginia Department of Social Services
• Kelly Cannon	Virginia Hospital and Healthcare Association
• Alexandra Javna	Virginia Department of Education
• Estella Obi-Tabot (interim)	Joint Commission on Health Care
• Jennifer Macdonald	Virginia Department of Health
• Martha Crosby	Virginia Community Healthcare Association

The following CHIPAC members sent a substitute to attend in person:

• Freddy Mejia (Emily King)	The Commonwealth Institute for Fiscal Analysis

The following CHIPAC members attended virtually in accordance with the committee's remote participation policy (Bylaws A3: principal residence more than 60 miles from the meeting location):

• Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services

The following CHIPAC members were not present:

• Dr. Nathan Webb	Medical Society of Virginia
• Michael Muse	League of Social Services Executives

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 announced that the meeting was being recorded. Attendance was taken by roll call.

II. CHIPAC Business

A. Review and approval of minutes from June 1 meeting – Committee members reviewed draft minutes from the June 1, 2023 meeting. Kelly Cannon (Virginia Hospital and Healthcare Association) made a motion to approve the minutes, Emily Roller (Virginia Health Care Foundation) seconded, and the Committee voted unanimously to approve the June 1 meeting minutes.

B. 2024 Meeting Schedule – Hope Richardson (DMAS Policy, Regulation, and Member Engagement Division) presented the following proposed 2024 CHIPAC meeting schedule:

Full Committee Meetings (1:00-3:30 pm)
Thursday, March 7, 2024
Thursday, June 6, 2024 (Virtual Meeting)
Thursday, September 5, 2024
Thursday, December 12, 2024 (Virtual Meeting)

Executive Subcommittee Meetings (10 am-12 pm)
Friday, January 12, 2024 (Virtual Meeting)
Friday, April 19, 2024
Friday, July 19, 2024 (Virtual Meeting)
Friday, October 18, 2024

Emily Roller made a motion to approve the meeting schedule, Heidi Dix (Virginia Association of Health Plans) seconded, and the Committee voted unanimously to approve the meeting schedule for 2024.

C. Membership Update – Cariano provided an update on committee leadership and membership.

She announced that Jeff Lunardi has departed his position at the Joint Commission on Health Care (JCHC) to accept the role of Chief Deputy Director at DMAS. JCHC is a mandated CHIPAC member organization in the Code of Virginia. Cariano explained that Estella Obi-Tabot was representing JCHC at the meeting and the Commission would continue to send alternates to CHIPAC while a hiring search is conducted for the new permanent director.

Cariano stated that Ali Faruk, Families Forward Virginia, has departed his position at Families Forward to accept a position at DMAS. Cariano also announced that Emily Griffey has departed Voices for Virginia's Children for a new role. Cariano explained that the Executive Subcommittee is nominating Emily Moore to serve as the new representative for Voices for Virginia's Children and directed committee members to Moore's bio and member questionnaire in the meeting packet. Kelly Cannon made a motion to approve Moore for membership, Emily Roller seconded, and the committee voted unanimously to approve.

Finally, Cariano announced that she will be stepping down from her role as CHIPAC chair. Cariano is departing her position at Virginia Poverty Law Center and starting a position as director of the DMAS Eligibility Policy and Outreach division. Cariano stated that the Executive Subcommittee will meet in October to discuss committee leadership and membership and will bring recommendations to the December CHIPAC meeting for committee approval.

III. Virginia Children's Health Coverage Programs in a National Context (Tricia Brooks, Georgetown University Center for Children and Families)

Cariano introduced Tricia Brooks, Research Professor at the Georgetown Center for Children and Families, to present on opportunities to improve Virginia's Medicaid and FAMIS coverage for children. Brooks began with a comparison of children's Medicaid and CHIP upper income eligibility limits by state, presenting data from the Kaiser Family Foundation & Georgetown Center for Children and Families 2023 50-State Survey on Medicaid and CHIP Eligibility, Enrollment, and Cost-Sharing Policies. She explained that Virginia's upper income eligibility limit of 205% of the federal poverty limit (FPL) for eligibility in Medicaid and FAMIS is on the low end compared to other states, even though the cost of living is high in Virginia. The lowest upper income eligibility limit for a state is 190% FPL. Virginia's neighboring states all have higher income limits, ranging from 218% FPL to 324% FPL. More than a third of states have children's upper income eligibility limits at or above 300% FPL. The median upper income limit is 255% FPL and the highest state upper income limit is 405% FPL.

Brooks explained that Virginia is more in line with nationwide averages in its income eligibility limit for pregnant women. Virginia's limit of 205% FPL is only slightly below the national median of 207% FPL. However, Maryland's upper income limit for pregnant women is 264% FPL and Washington, DC's is 324% FPL. The highest state income limit for pregnant women is 380% FPL and the lowest is 138% FPL. Virginia is one of only seven states that use enhanced CHIP funding to cover pregnant adults (Colorado, Kentucky, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia).

Brooks stated that Virginia has maximized the use of federal funding to cover immigrant child and maternal populations. Virginia is among 35 states that have waived the 5-year waiting period for immigrant children and 26 states that have waived the 5-year waiting period for pregnant women. Virginia is also one of 20 states that have adopted the "unborn child" option, allowing coverage of pregnancy regardless of status. Other states are using state funds to expand immigrant coverage: 12 states cover all children regardless of immigration status; 11 states cover targeted adult groups.

Brooks then reviewed Medicaid and CHIP child participation rates. She stated that Virginia's rate has increased from 89% in 2013 to 90.7% in 2016 to 93% in 2019. However, compared to neighboring states, participation in most states dropped between 2016 and 2019. Brooks stated that she would attribute the growth trend in Virginia to the state's 2019 Medicaid expansion, as it is well documented that expanding coverage for parents frequently leads to enrollment growth for children.

Brooks explained that Virginia's child uninsured rate also declined between 2017 and 2021, and that the Medicaid continuous coverage requirement during the COVID-19 public health emergency likely contributed to this recent decline.

Brooks then discussed continuous eligibility for children. She stated that the continuous coverage requirement during the COVID-19 public health emergency demonstrated that stable coverage reduces churn and lowers uninsurance rates. She explained that household income fluctuates more for low-income earners than for higher income earners, which can cause children in low-income households to cycle on and off health insurance coverage. Lack of stable coverage for children can lead to increased emergency room utilization and poor access to preventive care, which can impact health and development of children. Brooks explained that the Consolidated Appropriations Act (CAA) requires states to implement 12-month continuous eligibility for children in Medicaid and CHIP effective January 1, 2024. Before implementation of the CAA, Virginia is one of 24 states without continuous eligibility. Brooks explained that Oregon and Washington have been approved by CMS to offer multi-year continuous eligibility for children up until age 6, through Section 1115 waiver authority. Several additional states are moving on similar action. Brooks commended Virginia on its implementation of 12 months postpartum continuous coverage for pregnant women.

Brooks explained that research has shown annual renewals are the time when children are most likely to lose Medicaid and CHIP coverage, often for procedural reasons, even though they may still be eligible. She explained that states with higher *ex parte* (automated) renewal rates have lower procedural disenrollments and less churn, as well as greater administrative efficiency. Brooks stated that Virginia has above average rates of ex parte renewals and is one of 13 states in the 2023 KFF survey that reported a 50-75% success rate. Brooks explained that with two months of unwinding data available, Virginia is tied with Maryland for the second highest ex parte rate at 53%, behind only Arizona at 65%.

Brooks stated that Virginia is one of 27 states that has SNAP and TANF integrated with their Medicaid system, and one of only 14 states with integrated childcare assistance, an approach she considered preferable. She said that as Virginia moves to a state-based exchange, integrating Medicaid onto the state-based platform has proved challenging for many states. Brooks stated that Virginia's online Medicaid account offers broad functions. She recommended that Virginia consider adding functionality for authorized representatives. She also recommended that Virginia ensure mobile friendliness of accounts and applications. Finally, she recommended Virginia consider creation of a portal for navigators and assisters, explaining that portals allow navigators/assisters to submit the application and renewal data online. This creates efficiencies for the state, reduces manual entry errors, and promotes enrollment and retention. Brooks stated that Virginia is one of 22 states without an online portal for assisters/community partners. She pointed to Kentucky as an example of an assister portal with robust functionality that provides a good model for other states.

Brooks stated that Virginia gets an "A+" for its cost-sharing policies for Medicaid and CHIP. She explained that many years ago, Virginia dropped its premiums for child

coverage and is now one of 24 states that do not charge CHIP premiums or enrollment fees. Brooks said that a number of states temporarily suspended cost-sharing during the unwinding, but Virginia took this a step further and effective July 2022 became one of 21 states to discontinue copayments and cost-sharing for children. Brooks stated that Virginia has not adopted presumptive eligibility allowing specific qualified entities to temporarily enroll individuals who are screened as eligible.

Brooks then discussed Early and Periodic Screening, Diagnosis and Treatment (EPSDT). She explained that in Virginia, the FAMIS plan provides preventive care and screenings, but does not provide the full EPSDT benefit. Some thirty-five states do provide full EPSDT benefits to both Medicaid and CHIP children. Brooks stated that offering EPSDT streamlines parent education, state plan administration, and service delivery for Medicaid and CHIP managed care organizations and providers. Brooks explained that merging FAMIS into the Medicaid crossover group would have many advantages, including providing EPSDT for all enrolled children. It would improve overall ease of administration, enable the state to access federal drug rebate dollars for FAMIS children, enable FAMIS children to access Vaccines for Children, avoid funding cliffs associated with capped federal funding, and provide greater security of coverage for all enrolled families. Brooks stated that 19 states cover all children in Medicaid, including Illinois, Maine, and North Carolina that most recently transitioned their “separate CHIP” children to Medicaid.

Brooks then discussed quality improvement. She reminded the Committee that reporting all Child Core Set Quality Measures in Medicaid and CHIP will be mandatory in 2024. States will be required to disaggregate data based on a variety of factors (age, language, gender, race, ethnicity, health plan, etc.). Brooks recommended that the state track and trend outcomes, review quality improvement strategies, and ensure that quality improvement projects prioritize children and are enforced in the managed care contracts.

Brooks highlighted important points to keep in mind during the unwinding period. She stated that careful and well-planned unwinding implementation is of critical importance because eligible children are more likely to lose coverage at renewal than any other time. She explained that parents may not realize their children likely remain eligible even if adults in the family are not. Brooks also recommended that Virginia and other states consider making permanent some of the temporary unwinding strategies that have shown success. Brooks commended Virginia on its outstanding performance in ex parte rates during unwinding. She highlighted the fact that Virginia’s share disenrolled is much lower than the national median (37.5% versus 54.75%). Brooks posed the question of why FAMIS and other states’ CHIP programs are not growing during the unwinding period.

Brooks commended Virginia for being one of only about 10 states consistently reporting outreach expenditures under CHIP. Outreach is a required activity in CHIP.

Brooks concluded by recommending that Virginia consider the following opportunities to improve children’s coverage:

- Multi-year continuous eligibility for young children

- Cover ALL children
- Raise income eligibility for children (Median of states = 255% FPL)
- Brand and market programs as continuum of coverage options
- Develop and launch an assister portal
- Offer EPSDT services for all children, or merge FAMIS into the Medicaid crossover group
- Improve quality through ongoing consumer research and engagement in review of quality metrics and improvement plans
- Pay attention to unwinding outcomes, boosting outreach and assistance will likely be needed to reconnect kids to coverage

IV. Virginia Medicaid Unwinding Update (Jessica Annecchini, Senior Policy Advisor for Administration, DMAS)

Jessica Annecchini, DMAS Senior Policy Advisor for Administration, provided an update on Virginia's unwinding from the continuous coverage requirement. Annecchini presented a snapshot of DMAS's unwinding dashboard as of August 30. (The dashboard is updated weekly.) As of August 30, 130,861 members were closed and 678,121 members were renewed with ongoing coverage. Annecchini explained that the dashboard recently received a refresh led by Virginia's Healthcare Analytics Division. She explained that Virginia has retained the flexibility that a pending appeal automatically grants the individual reinstated coverage. She stated that almost all closures occur at the end of the month except for reasons such as a member's death.

Annecchini explained that "completed" means one of two things has occurred: either the member's coverage was closed or they were renewed and their coverage continues. She stated that even though there have been only four months of renewals due, DMAS has now completed renewals for almost 40 percent of the entire Medicaid population, for a total of 808,982 members determined as of August 30.

Annecchini reviewed information on the top closures by eligibility grouping. She explained that the highest closures happened among non- aged/blind/disabled (ABD) adults (LIFC/expansion), followed by children, and then those in limited coverage groups (MSP/Plan First/Incarcerated Coverage/Emergency Medicaid). Annecchini summarized top closure reasons. 79,835 members were closed for non-procedural reasons (ineligible) and 51,027 members were closed for procedural reasons (did not return a renewal form or verifications needed to determine eligibility). This total is through unwinding out of the 2,166,381 members identified in the unwinding cohort. Annecchini stated that the ex parte baseline before March 2020 was around 50% for both cases and members.

Annecchini shared data related to member appeals. She stated that there are still zero client appeals overdue and applauded the Appeals division's work. She summarized requests for information, including FOIA, constituent, and legislator requests.

V. DMAS Foster Care Update (Christine Minnick, Child Welfare Program Specialist, DMAS Health Care Services Division)

Christine Minnick, Child Welfare Program Specialist in the Maternal-Child Health Unit of DMAS' Health Care Services Division, provided an update on DMAS activities to strengthen health care support for foster children and youth. She announced that last month DMAS concluded a two-year quality improvement project with CMS that was focused on improving timely access to health care services for youth in foster care in Virginia.

Minnick began by providing background on Medicaid coverage for foster youth. She stated that according to Virginia Administrative Code (VAC), foster care is defined as 24-hour substitute care for children placed away from their parents or guardians for whom the Title IV-E agency has placement and care responsibility. Children in foster care placement are eligible for Medicaid unless they are not Virginia residents or they have income or other financial resources that make them ineligible. For eligibility and identification purposes, foster care children are assigned to the aid category 076: this is how DMAS and the MCOs know they are in foster care. Minnick reported that, according to August enrollment data, there were 6,136 children enrolled in Medicaid through foster care, with approximately 95% at any given time enrolled in managed care.

Minnick explained that children in foster care have higher rates of physical and behavioral health care needs compared to those without a history of foster care involvement, and have higher utilization of certain categories of health care services than the non-foster care population. She stated that because of these complex health care needs, it is important for children in foster care and entering foster care to receive timely initial medical assessments so they can be connected to services. Moreover, Virginia DSS foster care regulations and the VAC state that the service worker shall ensure that the child receives a medical examination no later than 30 days after initial placement.

From July 2021 through July 2023, DMAS participated in a quality improvement affinity group convened by CMS, along with representatives from the Virginia Department of Social Services and the Medicaid MCOs, to drive measurable improvements and help expand the agency's understanding of data-driven quality improvement and tests of change. The team developed and implemented pilot tests to gather data and test the success of interventions. The Virginia team's AIM statement was that by December 2023 they would increase the rate of children entering foster care who received an initial medical exam within the first 30 days.

Minnick shared information about the affinity group's process and a sample of the data they collected and tracked. She explained that in order to develop intervention and improvement strategies, the team engaged system experts and stakeholders to gather baseline data and to "process map" the general steps that take place in the transfer of information when a child enters foster care, from the time that custody is transferred to local DSS to when the foster care worker and eligibility workers complete the Medicaid application and the MCO is notified of the child's eligibility.

Minnick explained that one of the first findings of the Virginia team was that close to three-quarters of the youths entering foster care were already enrolled in Medicaid managed care, just in another eligibility category. Because of this, and because the team wanted to leverage MCO care coordination as part of their quality improvement strategy, they decided to focus the project only on that approximately 75 percent of youth who were already enrolled in Medicaid and in an MCO when they entered foster care.

The Virginia team also found that because of the way the system is set up, the process of MCO outreach is often occurring too late and without all the information needed to make an impact on the first 30 days of custody. DMAS decided the focus needed to be timely notification of the assigned MCO when a youth enters foster care.

As part of the project, DMAS and its MCO partners developed pilot tests of "warm hand-offs" of foster care information to avoid the delay in the system. Under this process, information is exchanged between local DSS agencies or VDSS and DMAS; DMAS identifies the assigned MCO to notify them that a youth has entered foster care and needs assistance scheduling their initial medical examination; and the MCO begins care coordination and outreach, then reports back their outcome data.

Minnick explained that Bedford County DSS shared its intake process, which already involved a secure email handoff of information to CSA and between the foster care unit and the benefits or eligibility unit. Minnick shared data from the warm handoff pilot test conducted in Bedford County, in which DMAS tracked timeliness of notification and timeliness of MCO contact with member. Over time, the data showed that the warm handoff test was consistently successful in decreasing the number of days between MCO notification and successful contact with the member. Since January 2023, 100 percent of exams were completed within 30 days in Bedford.

Minnick shared several reflections on the project. She stated that process flow mapping helped the team realize that timeliness of Medicaid enrollment and MCO notification of new foster care members was an important factor in making improvement toward the AIM statement. The warm handoffs removed information silos and improved coordination. The project allowed MCOs to collaborate directly with the local DSS agency around a common member goal. The project also improved the local DSS agency's understanding of care coordination, and it supported participating MCOs in developing relationships, identifying barriers to successful care coordination, and brainstorming possible solutions.

Minnick stated that DMAS and partners plan to continue discussing and testing current and new ideas for reducing enrollment and/or MCO notification time when a member enters custody of DSS. The team also plans to use interagency work groups through the Foster Care Partnership to continue quality improvement projects around appropriate and timely medical care for youth in DSS custody.

VI. Medicaid School Health Services Expansion Status Update (Hope Richardson, DMAS Policy, Regulation & Member Engagement Division; Lynn Hamner, DMAS

Program Operations Division)

Hope Richardson, DMAS PRME Division, introduced DMAS' new school services lead, Lynn Hamner. Richardson provided an overview and status update on expanded Medicaid reimbursement of school-based health services. First, she explained that under the Medicaid school-based services program, DMAS reimburses with federal Medicaid dollars the state and local expenditures incurred by school divisions, also called local education agencies (LEAs), in providing health services to Medicaid/FAMIS-enrolled students. Richardson stated that the LEAs' spending constitutes the state share that draws down federal Medicaid dollars. Richardson described the cost-based reimbursement formula used to reimburse schools for these services. First, the school spends money providing student health and support services. A statewide random moment time study (RMTS) is conducted to determine the percentage of staff time spent directly with students providing services. The proportion of students with medical assistance (Medicaid or FAMIS) is also factored into the formula. This formula determines the allowable expenditures.

Richardson then explained the changes underway for school services. She stated that pursuant to legislation passed in 2021 General Assembly session, DMAS is working with the Centers for Medicare and Medicare Services (CMS) to expand the options for schools to receive federal Medicaid and CHIP cost-based reimbursement. Whereas reimbursement was previously limited to special education services provided to students with an Individualized Education Program (IEP), with SPA approval, Medicaid reimbursement is now available for the costs of providing covered services to all Medicaid and FAMIS enrolled students – not just those with an IEP, and for services outside of the IEP. Richardson explained that there is significant potential for increased Medicaid reimbursement to schools through this expansion. FY22, Virginia schools were reimbursed by Medicaid for providing direct services to 50,000 students enrolled in Medicaid/FAMIS with an IEP. However, statewide, more than 850,000 Virginia children are currently enrolled in Medicaid and FAMIS. Although these children are not all enrolled in public schools, the scale of the Medicaid and FAMIS child population provides increased potential for the schools to receive reimbursement for services to many more children outside the IEP.

Virginia's School Services State Plan Amendment (SPA) adds licensed school counselors and substance use treatment practitioners, and licensed behavior analysts and assistant behavior analysts to the list of professionals whose time spent providing services may be eligible for reimbursement. The SPA allows schools to include the costs associated with adaptive behavior therapy (ABA) and substance use treatment services in cost settlement. Existing services currently allowed (for cost reporting) for students with an IEP will be allowed for all general education students (speech, occupational therapy, physical therapy, audiology, behavioral health, nursing, personal care, physician/PA/NP services). The SPA also revises Virginia's reimbursement methodology for specialized transportation to reduce administrative burden for LEAs.

Richardson stated that these changes allow schools to be reimbursed for services they are already providing to Medicaid/FAMIS enrolled students and have the potential to assist schools reinvest state and local funding into other activities to support student

health. She explained that CMS recently issued extensive new guidance on Medicaid school services that provides additional flexibilities and steps states can take to streamline processes and ease administrative burden for schools, and that DMAS is still reviewing this federal guidance and determining next steps.

VII. Agenda for December 7, 2023 CHIPAC Meeting

Cariano invited members to submit ideas and requests for the agenda for the December 7 CHIPAC meeting to the executive subcommittee, for discussion at their October 13 subcommittee meeting.

VIII. Public Comment

Cariano invited public comment. LeVar Bowers submitted a comment via the chat, asking how school-based services would impact MCO capitation rates. Richardson responded that the school-based services DMAS described during the meeting are a fee-for-service carve-out and do not factor into the capitation rates. She stated that there are some services children receive in schools that are covered by the Medicaid managed care organizations (MCOs), but these have a different reimbursement and delivery model.

IX. Closing

The meeting adjourned at 3:01 p.m.