

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

**June 13, 2022 Minutes**

<b>Committee Members</b>	<b>DMAS Staff</b>
Ghadah Aljamali	Sarah Hatton, Deputy of Administration
Karin Anderson	Tammy Whitlock, Deputy for Complex Care Services
Olatunji Fakunmoju	Cheryl Roberts, Interim Agency Director, Deputy for Operations
Geoffrey Short	Christina Nuckols, Director, Strategic Communications
Michelle Meadows	Emily McClellan, Division Director, Policy, Regulation and Member Engagement
L.J. Tisdale	Brian McCormick, Division Director for Constituent, Legislative and Intergovernmental Affairs
Sabrina Redd	Hope Richardson, Senior Management Analyst, Policy, Regulation, and Member Engagement Division
Craig Thomson	Daniel Plain, Division Director Health Care Services
Elvira Prince	Jason Rachel, Division Director Integrated Care
	Rebecca Dooley, Senior Advisor, Director's Office; Strategic Communications Manager, Office of the Chief of Staff
	Will Frank, Senior Legislative Affairs Advisor
	Ashby Brenner, ITS Asset Specialist (Zoom administrator)
	Dalia Tejada-Halter, Outreach and Member Engagement Specialist (Bilingual) (meeting organizer and facilitator)
	Natalie Pennywell, Outreach and Community Engagement Manager (meeting organizer)
	Walter Burton, Policy Specialist (meeting organizer)
	Jesús Pérez, Spanish Translator (PowerPoint administrator)
	Kristin Lough, Hearing Officer (prepared minutes)
	Kyle Resurreccion (assisted in preparing minutes)

## **Welcome and Call To Order**

Natalie Pennywell called to order the meeting of the Medicaid Member Advisory Committee (MAC or Committee) at 10:07 a.m. on Monday, June 13, 2022, via Zoom online meeting platform. Ms. Pennywell explained that the meeting had a full agenda and emphasized that Committee members would have time to ask questions and share feedback during the meeting. She then introduced the DMAS Deputy of Administration, Sarah Hatton.

### **Welcome**

*Welcome – Cheryl Roberts, Interim Agency Director, Deputy for Operations  
Sarah Hatton, DMAS Deputy of Administration*

Deputy of Administration Hatton greeted the Committee and thanked the Committee for their participation in the virtual MAC meeting. Ms. Hatton explained that the August 2022 meeting would be hybrid, that members are welcome to join in person, and that DMAS hopes to have future meetings fully in person.

Deputy Hatton introduced Interim Director Cheryl Roberts. Ms. Roberts explained how important DMAS members are to the Agency, including their access and needs. Ms. Roberts asked the members to comment, ask questions in the meeting, and evaluate whether the information provided is sufficient.

### **Member Introduction**

Ms. Pennywell called roll to identify the MAC members present.

### **Review and Vote to Approve Minutes from Meeting on April 11, 2022**

Each of the MAC members was provided a copy of the April 11, 2022 meeting draft minutes, and the draft minutes were also posted on the Committee's webpage on DMAS' website and the Virginia Town Hall website.

The members adopted the minutes.

Ms. Pennywell introduced the Cardinal Care Transition presentation and *Jason Rachel, Division Director for Integrated Care*.

## **Presentation – Cardinal Care Transition & Consumer Information Feedback by Motivf**

### **Cardinal Care Transition**

*Jason Rachel – Division Director for Integrated Care*

*Daniel Plain – Division Director for Health Care Services*

Mr. Rachel explained that DMAS would merge the CCC+ and Medallion4.0 programs into Cardinal Care, which is one contract for healthcare. The purpose is to align the two programs and make administration simpler and more effective. DMAS used the health plans, agency staff and national consultants to evaluate and pick the best of each contract and merge them into one to create Cardinal Care. The contract for the plan is important to make certain that all members have access to the best program possible.

Regarding enrolling members into Managed Care Organizations, historically, Medallion 4.0 has a regional, calendar-based, rolling open enrollment, where the 90-day open enrollment period is a specific period annually based on the member's address. CCC+ uses the Medicare open enrollment period from October through December for all members. The Cardinal Care program will use the regional, calendar-based, rolling open enrollment for all managed care members. This will add some simplicity to the process, especially where there are households that might have Medallion 4 and CCC+ members. This enrollment process will become effective in January 2023. Currently, when a member needs to change MCOs, a member is disenrolled from their current MCO to fee for service until the member can enter a new MCO at its next open enrollment period. This can be disruptive for the member and the provider. However, Cardinal Care Continuity of Managed Care enrollment would allow someone, for example, to move from traditional services into a nursing facility without disenrolling in their health plan or experiencing a disruption of services.

Under the Medallion4 and CCC+ programs, there were over 400 reports coming in, six times per year, creating over 2400 reports to review. Cardinal Care will allow greater accountability and ease of oversight. Under Cardinal Care, DMAS has enhanced or improved accountability, and reduced the reports to approximately 110 reports coming in six times per year, creating only 660 reports to more thoroughly review. The branding opportunity changes from CCC+ and Medallion4 to Cardinal Care, including new Medicaid cards, to reduce the confusion in identifying a member's care.

DMAS expects the health plan's interactions with members to be responsive. Instead of creating a care plan for a member based on pre-determined standards, the health plan will be required to respond to what is happening to a member as it happens. DMAS has identified two primary care levels, care coordination, and case management. Care coordination includes an assessment and baseline care, and the opportunity to reach out to the health plan. This will be available to all members. Care management will be split into three levels – 1) low intensity, 2) moderate intensity. and 3) high intensity, which includes an assessment, baseline care, the opportunity to reach out, and increasingly more complex care as the member requires.

This change will allow the care to shift with the member's needs, providing a holistic approach to care. Mr. Rachel introduced Daniel Plain, Division Director of Health of Care Services.

Mr. Plain stated that members had given feedback regarding changes they would like to see. Under Cardinal Care, high-quality healthcare access will continue, members and providers will not see any disruptions, DMAS will continue to contract with all MCOs, and the current CCC+ and Medallion 4.0 requirements will continue. Mr. Plain indicated that a soft roll-out of Cardinal Care was scheduled to start July 1, 2022, but will begin September 1, 2022, for some members, based on a delay in the state budget. The program will fully launch on January 1, 2023, including new ID cards, re-branded documentation, and a shift to the new regional open-enrollment periods.

### **Medicaid and Brand Perception Survey**

*Rebecca Dooley – Senior Advisor, Director's Office; Strategic Communications Manager, Office of the Chief of Staff*  
*Gabby Valle – Motivf*

Ms. Dooley introduced the Medicaid and Brand Perception survey. Motivf created a digital communications assessment for members, providers, stakeholders, and partners to identify Medicaid branding and recognition. Ms. Dooley introduced Gabby Valle of Motivf.

Ms. Valle shared that this project is to inform DMAS as it works to improve information access and enrollment resources on Virginia Medicaid. She noted that DMAS and Cover Virginia websites were the most recognized in their survey responses and asked MAC members whether that was true for them. Some responses included:

- Craig Thomson indicated that the websites had changed significantly over the past year.
- Sabrina Redd pointed out that people use the website, but they are not easy to navigate.
- L.J. Tisdale noted that he has specific feedback regarding pain management treatment and the prior approval process.
- Michelle Meadows indicated that in her community, the Cover Virginia website would not be easily recognized.
- Craig Thomson specified that if the website is intended to replace the call center, that would be fine, but there should be a guidebook on how to use the often-changing website. It was noted that the website was not intended to replace the call center.

Last year, it was easy to submit a question through the website regarding a specific complaint with a response from DMAS staff. This process has since changed, but the Cover Virginia call center application process was very user-friendly. Ms. Valle informed the MAC that responses from the survey regarding challenges included that information from the Cover VA call center was insufficient;

there was a digital equity gap, like when a member lacked computer access; the members did not know where to go; members needed assistance; and members could not find information on the websites. Ms. Valle asked members to complete the survey if they had not, and informed members that there would be dialogues regarding the changes, as appropriate, prior to returning information to DMAS. Finally, Ms. Valle noted that Motivf would reach out to members to join the dialogues and asked that MAC members complete the survey and communicate their contact information to participate in the dialogues.

Questions raised by Committee Members included:

Olatunji Fakunmoju asked, in response to the care and Cardinal Care model, do the groups have 100 key performance indicators monthly? Is there a score per member after a comprehensive assessment to categorize someone's needs when identifying who does and does not need more care? When the comprehensive assessment is performed, does anyone evaluate soft, non-clinical data like whether someone is receiving adequate care? Is data collected from one level to the other to see what is changing in the member's health status? In changing from predictive modeling to responsive modeling, how do you manage the differences in lack of care or continuity of care? Are there any targeted reports that would proactively enhance care?

Mr. Rachel answered that the 400 to 100 figure is about specific reports that DMAS will receive from the health plans, containing anywhere from one key performance indicator to several. Mr. Rachel stated that the reviews would evaluate formal caregivers and informal caregivers, which varies significantly across individual situations, along with risk and stability regarding to those care levels. The evaluation will include quantifiable data, like medical numbers, and softer data like the informal network of care being provided, creating a full health risk assessment to give the care manager and health plan clarity about the member's situation. The parties can then review these evaluations over time and identify changes as they occur. Certain groups of individuals will enter the care levels based on the assessments, and some groups will be mandatory based on specific health needs, like ventilator use. DMAS hopes to respond to data as available, and predict potential changes that could result in higher care needs, allowing increased response and reducing or eliminating gaps in care.

## **Presentation – Virginia General Assembly Update**

*Will Frank – Senior Advisor for Legislative Affairs*

Mr. Frank told the MAC that this General Assembly session was interesting and technically not done yet. The General Assembly (GA) timeline started on December 16, 2021, when Governor Northam introduced his final budget. On January 12, 2022, the GA convened, and on January 15, 2022, Governor Youngkin was inaugurated. On February 16, 2022, the bills in the GA crossed over from House to Senate and vice versa, and March 12, 2022, was sine die, the last day of the regular session, which ended without a budget. On April 4, 2022, the GA convened a special session, but nobody had yet agreed on the budget, so the members met, ended the meeting, and left Richmond. On April 27, 2022, there was a veto session, but still, no budget and on June 1, 2022, the GA came back with a budget, and held a special session to vote on the budget. The budget has since gone to the Governor, who can sign or amend the budget. DMAS is hearing that the Governor will add amendments to the budget, and GA members may return Friday, June 17, 2022, to respond to the budget amendments.

DMAS monitors introduced legislation, reviews the legislation and budget language for Secretary and Governor, and communicates position recommendations to them. DMAS also communicates the Governor's positions to the GA and provides expert testimony and technical assistance to legislators on legislation.

During the GA session, 2633 bills were introduced. DMAS had to evaluate 21 bills, 11 of which are still alive, and the Governor has signed 9 of the 11 (with 2 of the 11 having a fiscal impact and carried over to the special session and were passed). Nine bills failed, and DMAS commented on another 23 bills assigned to other agencies and tracked 82 other bills.

Mr. Frank outlined several bills affecting Medicaid, including House Bill (HB) 241 – brought by Delegate Dawn Adams, which requires DMAS to cover durable medical equipment (DME), like chairs, passed and will require a work group. HB680 – provided for targeted case management for individuals with severe traumatic brain injury – passed last week. HB800 – individuals in the custody of correctional facilities must get limited coverage Medicaid. This policy is already in place, but now it is codified in the Virginia Code. HB987 – brought by Delegate Tran, states that program information regarding Medicaid sent to members must expand language access on the documentation. Senate Bill (SB) 426 – requires DMAS to pay for telehealth and remote patient monitoring. SB594 – provides for Medicaid participant payment for opioid treatment and has been passed and signed by the Governor. SB663 – another bill regarding telehealth originating site payment. HB925 and SB405 – regarding medically necessary prosthetic devices.

Questions raised by Committee Members included:

Craig Thomson noted behavioral health advocates are saying they have been told that reimbursed and covered follow-up psychiatric appointments must be in person or on a platform similar to Zoom. Is that accurate?

Tammy Whitlock stated that it is inaccurate, and telehealth is very strong in the behavioral health field.

Craig Thomson said that some individuals receiving this type of care could be challenging to locate, especially when unhoused, and non-verbal body cues can be crucial in mental health evaluations. Mr. Thomson thanked the MAC for the answer.

Mr. Fakunmoju asked if there were any outstanding issues that providers are raising that DMAS could compartmentalize and use within DMAS? Telemedicine is wonderful, and home-based care should be forthcoming.

Ms. Whitlock answered that the behavioral health providers are not shy to report issues to DMAS. She noted that the workforce shortage is the biggest and most frequent complaint. The increased reimbursement rates, which will be approved in the new budget, should help with some of the issues. The rate increases are monumental, and DMAS is grateful to the GA for them. Ms. Pennywell thanked everyone for their questions and introduced Hope Richardson.

### **Presentation – Maternal Health Care Access: DMAS Program Overview and Updates**

*Hope Richardson – Senior Management Analyst, Policy, Regulation, and Member Engagement Division*

Ms. Richardson summarized pregnant and post-partum care changes through FAMIS and FAMIS Moms programs. Pregnant women can obtain Pregnant Woman Medicaid with income up to 143% of the federal poverty level (which is equivalent to \$34,085 for a household of three). FAMIS Moms is available to uninsured women with income up to 200% of the federal poverty level (which is equivalent to \$47,212 for a household of three). More information is available at <https://coverva.org/en/our-programs>. Coverage includes prenatal checkups, screening and testing, other general and specialty care, prescriptions, screening and treatment for behavioral health and substance use disorders, dental care, non-emergency transportation to appointments, and breastfeeding and post-partum family planning services. In the future, community doula care will be covered. Doula support services are evidence-based, reduce the use of epidurals and C-sections for delivery, and can increase the incidence of breastfeeding following birth. Pregnant women do not have cost-sharing, like copays, for these services. A newborn born to a Medicaid-eligible woman will be Medicaid eligible for the first year of life.

Ms. Richardson explained that the six MCOs provide pregnant women care and will continue to do so as Cardinal Care is rolled out. All programs have a risk assessment component to identify members who may have a higher risk for adverse health outcomes and care coordinators to help manage that care. The plans are required to regularly report on their activities and maternal health outcomes. Virginia is the third state to extend Medicaid and FAMIS coverage for a full year postpartum, effective July 1, 2022. During the Public Health Emergency (PHE), most Medicaid members have had continuous coverage since March 2020. Still, the system changes will ensure that coverage includes FAMIS Moms and lawfully residing immigrant pregnant women. When the PHE ends, the system changes will be in place to ensure the 12-month postpartum continuing coverage is in place for eligible members. The 12-month postpartum coverage is in place even if the member's income or household changes and will be in place regardless of the covered group.

Extending postpartum can reduce maternal mortality, which has been increasing nationwide. Disparities resulting in maternal mortality are often based on race and ethnicity. Black women are three times more likely to die than white women postpartum and one and a half times more likely to die during pregnancy than white women. The state will address high-risk and chronic health conditions through this program.

FAMIS Prenatal Coverage is available for individuals who did not have insurance prior to the Medicaid application and primarily for individuals who did not meet immigration status requirements. This program offers prenatal coverage through labor and delivery and 60 days postpartum. FAMIS Prenatal recipients will not receive 12 months of coverage postpartum, as neither the state nor federal government authorized the extra care. The coverage is not restricted to simply prenatal care, members will receive access to the same set of plans and provider networks as FAMIS Moms and Pregnant Women. There are no copays or cost-sharing with FAMIS Prenatal.

Virginia will be studying and reporting the impact of the extended coverage to the federal government over the next seven years.

Questions raised by members included:

Karin Anderson asked to confirm that behavioral healthcare is also available to pregnant women, and Ms. Richardson answered that pregnant women would receive behavioral healthcare.

Olatunji Fakunmoju asked if DMAS could ask the MCOs what need they have to evaluate improvement and care disparity, specifically to identify what may have occurred to cause maternal mortality both pre- and post-partum.

Ms. Richardson stated that the goal is to enroll members as soon into pregnancy as possible. Research shows that if the mom receives postpartum care, the baby also receives healthcare. DMAS will be looking at age, race, and location disparities to identify what DMAS can do to identify the programs and care for all.



Ms. Pennywell thanked Ms. Richardson for the presentation and opened the meeting to public comment.

### **Public Comment**

L.J. Tisdale outlined his experiences with DMAS, and most have been positive since 2019, but there have been some setbacks and outlined those concerns.

Sabrina Redd indicated that she would prefer the MAC have more time for questions between presentations so that the members can ask questions and provide advice based on experiences, mainly because the dialogue helps identify solutions.

Craig Thomson observed one of his experiences and thanked DMAS for Medicaid expansion.

Sarah Hatton thanked members for the recommendations and noted that time for the discussions is critical for planning and preparations.

### **Adjournment**

Ms. Pennywell thanked the Committee for joining and stated that DMAS would evaluate the MAC members' questions and comments to create agenda topics for future meetings.

Ms. Pennywell thanked members for their participation and adjourned the meeting at 12:04 p.m.