



Children's Health  
Insurance Program  
Advisory Committee  
of Virginia



# MEETING MINUTES

---

**Meeting Minutes**  
**September 10, 2020**  
**1:00-3:00 pm**

*This meeting was held virtually due to the ongoing COVID-19 public health emergency.*

**The following CHIPAC members were present:**

- Denise Daly Konrad
  - Carla Hegwood
  - Christine McCormick
  - Ashley Everette Airington
  - Freddy Mejia
  - Lisa Dove
  - Quyen Duong
  - Michael Cook
  - Sara Cariano
  - Michael Muse
  - Dr. Nathan Webb
  - Lisa Specter-Dunaway
  - Jennifer Wicker
  - Shelby Gonzales
  - Katharine Hunter
- Virginia Health Care Foundation
  - Virginia Department of Health
  - Virginia Association of Health Plans
  - Voices for Virginia's Children
  - The Commonwealth Institute for Fiscal Analysis
  - Virginia Community Healthcare Association
  - Virginia Department of Education
  - DMAS Board Member
  - Virginia Poverty Law Center
  - Virginia League of Social Services Executives
  - Medical Society of Virginia
  - Families Forward Virginia
  - Virginia Hospital and Healthcare Association
  - Center on Budget and Policy Priorities
  - Department of Behavioral Health and Developmental Services

**The following CHIPAC members sent substitutes:**

- Victor James sent Dr. Suzanne Powers
  - Sherry Sinkler-Crawley sent Ashley Carter-Johnson
- Virginia Chapter of the American Academy of Pediatrics
  - Virginia Department of Social Services

**The following CHIPAC members were not present:**

- Dr. Tegwyn Brickhouse
  - Michele Chesser
- VCU Health
  - Joint Commission on Health Care

## **Meeting Minutes**

### **Welcome**

Denise Daly Konrad, CHIPAC Chair, called the meeting to order at 1:10 pm. Konrad welcomed Committee members and members of the public, and DMAS staff gave a brief overview of the WebEx meeting format and procedures and informed the attendees that the meeting was being held virtually due to the ongoing COVID-19 public health emergency. Konrad reminded members of the top three goals for quarterly meetings that the Committee identified during the strategic planning process: (1) Providing information and updates about the status and performance of the Medicaid and FAMIS programs for children and families; (2) providing a venue for members to share ideas and engage in open-ended conversation about Medicaid and FAMIS or other initiatives related to Virginia's children; and (3) providing structured opportunities for decision-making, to include developing recommendations for DMAS leadership and the Secretary of Health and Human Resources.

### **I. DMAS Update**

Konrad explained that the order of items in the agenda would be shifted to accommodate a scheduling conflict for DMAS staff, and that the meeting would begin with the DMAS Update then proceed to CHIPAC Business.

Sarah Samick, Senior Policy Advisor for Administration and Acting Deputy Director of Administration, gave the DMAS update. She explained that as of September 1, over 136,000 new Medicaid members had been enrolled since the start of the public health emergency in March, and the agency had been seeing approximately 4,800 new members enrolling each week. Samick reminded CHIPAC members that Medicaid and FAMIS enrollment data can be accessed by visiting the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov). She stated that the agency has secured many flexibilities to assist members during the COVID-19 crisis. These include continuation of coverage requirements, waiving out-of-pocket costs or copays for members, and delaying action on any changes that may have occurred. Additional flexibilities include suspension of the integration requirement for incarcerated individuals and allowances for individuals who may have traveled to other states to help care for family members or loved ones, considering them to be temporarily absent, thus maintaining their enrollment.

Samick explained that DMAS received guidance from the Centers for Medicare and Medicaid Services (CMS) in June that pregnant women who reach the end of their postpartum period and children who turn age 19 who are enrolled in the FAMIS/FAMIS MOMS programs, or who are lawfully residing non-citizens (CHIPRA-214), must be redetermined for other Medicaid coverage. If the individual is determined to no longer be eligible, coverage must be closed and a referral to the Marketplace will occur. For this reason, as of July 31, FAMIS MOMS coverage is no longer being extended past the 60-day postpartum eligibility period, FAMIS youth coverage is no longer being extended past the 19<sup>th</sup> birthday, and lawfully residing youth and postpartum women will not receive coverage beyond the normal eligibility period. Samick stated that DMAS is working diligently with DSS to ensure that all of these individuals are being reevaluated and, if eligible, are being moved to another category such as expansion, or if they are not eligible, receiving referrals to the Marketplace.

Samick stated that on July 26 the automated process for annual renewals resumed. For those cases that do not complete the automated process, paper applications are being mailed. The process happens at the end of each month. Due to the continuation of coverage provisions during the PHE, individuals who do not return their renewals will not have any adverse action taken against them. In addition, for any household that returns an application that would result

in a closure or a reduction in coverage, DMAS has given instruction to local departments of social services not to take any action at this time. The new renewal forms that DMAS designed last year with input from stakeholders were adopted in June.

Samick explained that in response to the public health emergency (PHE), DMAS has implemented a new process to allow application assisters to help Virginians apply for coverage without face-to-face interaction. Application assisters can now receive authorization through verbal consent to assist an applicant in completing the application. Prior to the PHE, this type of consent was required to be in writing.

Samick described Appeals flexibilities in light of the PHE. For the duration of the public health emergency, the timeline for members to file an appeal will be extended; additionally Medicaid eligibility and coverage under the individual's health plan will continue while the appeals process is underway. All hearings for members and providers will be held by telephone during the period of emergency. Flexibilities that have been put into place to assist providers include the ability to request a hardship exemption from normal deadlines and the extension of all deadlines after an appeal has been filed.

Samick informed the Committee about a new initiative called Project Cardinal, to merge Virginia's two Medicaid managed care programs: Commonwealth Coordinated Care Plus (CCC+) and Medallion 4.0. She explained that with over 90 percent of Virginia's Medicaid members currently served through managed care, DMAS has been directed by the General Assembly to begin an effort to evaluate its Medicaid delivery systems and produce a plan for establishing a combined Medicaid managed care program. The effort will include a thorough assessment of DMAS' current managed care contracts, organizational structure, regulatory authorities, IT systems, and other processes. The ultimate goal of the project is to create a single, streamlined managed care program that links seamlessly with the fee-for-service program. Samick stated that development of the initial plan will continue through November 2020 and culminate in a report to the General Assembly. Tentative phased implementation of the project will take place from December 2020 to July 2022.

Samick also gave an overview of DMAS' current work, in collaboration with DOE, to develop recommendations to the General Assembly on how Medicaid-funded school health services might be expanded beyond special education, i.e., beyond the IEP, or individualized education plan. She explained that currently, Virginia schools are reimbursed for their local expenditures with federal Medicaid dollars, coordinated through DMAS and its contractor, for school health services that they provide to Medicaid and CHIP-enrolled children as part of the students' IEP plans. Recent federal guidance opened a pathway for Medicaid to also reimburse for additional school services outside the IEP, and many states are exploring this or moving forward with State Plan amendments to enable this. Samick stated that DMAS has been researching what other states have done in this area and developing recommendations on best steps forward for Virginia. The legislative report on this topic is due in December.

Janice Holmes, Operations Manager, DMAS Eligibility and Enrollment Services, provided an update on Cover Virginia, the call center and application processing. She stated that currently the Cover Virginia call center is experiencing high call volume; call volume has been elevated since the end of July. This is primarily because of the special renewal mailing, as well as a voter registration mailing. For the month of August, the call center ended the month with volumes 25 percent above the contractual forecast. Holmes explained that there have been some challenges, and the contractor is currently in the process of hiring additional staff in preparation for open enrollment and to mitigate some of the high volume. Call wait times are averaging about 30 minutes. Cover Virginia is also allowing callers to leave a call-back number

and receive return calls if they do not want to be placed on hold. Due to the COVID-19 public health emergency, 90 percent of staff are working from home, which is challenging. Holmes stated that the situation is improving as staff adapt to the new set-up. The call center continues with all quality assurance monitoring and management of the teams who are taking calls.

Holmes stated that Cover Virginia received 24,523 applications for processing in the second quarter of 2020. Volumes remain high, but within the forecast. Holmes explained that DMAS and Cover Virginia are projecting that there will be higher application volume continuing into open enrollment. Initial reviews are taking 9 to 10 business days. Eligibility determinations are being completed timely, within the 45 days if not sooner.

Hope Richardson, Senior Policy Analyst, DMAS Policy Planning and Innovation Division, provided a Communications and Outreach update. Richardson shared that the Back to School enrollment campaign proceeded despite the challenges presented by the pandemic. She shared an image of the flyer that was distributed to 1.5 million households at the end of July. Richardson shared that the COVID-19 information pages on both the English-language and Spanish-language CoverVA website are being regularly updated with relevant information. She stated that after a brief hiatus, the Cover Virginia media campaign resumed in June and will remain active through September.

Will Frank, DMAS Senior Advisor for Legislative Affairs, provided a General Assembly and Special Session update. He stated that the GA returned in mid-August for a Special Session. Previously during the regular session, the GA had approved a budget for the biennium. However, between when they adjourned in March and returned in April (for veto session), the COVID-19 public health emergency (PHE) was declared. While the budget that passed in March included many new investments, particularly related to Medicaid, the revenue outlook shifted dramatically with the onset of the PHE, leading the Governor and GA to “un-allot” most of the new discretionary spending in the budget, approximately \$2.2 billion in new spending, essentially freezing these expenditures until a later time when legislators could return with a better understanding of the fiscal impact of COVID-19 on the state’s economy. For DMAS, un-allotted items included lifting the “40 quarters” work requirement for legal permanent residents and extending FAMIS MOMS postpartum coverage from 60 days to 12 months.

The Governor’s proclamation calling the GA into a Special Session indicated that the session would focus on revisiting the budget, planning the Commonwealth’s response to COVID-19, and addressing criminal and social justice reform. Frank stated that little is known about when the Special Session will end. Usually in a regular session, more is known about the timing and schedule and how long the session will last. The un-allotted items were not re-allotted in the budget the Governor introduced for the Special Session. Frank stated that the House had introduced member amendments, and it appears the Senate will not have member amendments. It was not known when the money committees would take up discussions of the budget. Frank stated that about 400 bills had been introduced; most of the bills deal with law and social justice reform or COVID response. Many of the bills DMAS has been reviewing are related to telehealth.

At the conclusion of the DMAS update, questions were invited from the Committee. Freddy Mejia with the Commonwealth Institute asked whether there had been additional guidance from the federal government about extending the enhanced federal funding match rate that is effective during the public health emergency (PHE). He asked whether DMAS was aware of the timing of any further extensions. Richardson stated that the federal PHE had been extended through October and that that extension was made at the last minute, so it is possible that any further extension might also occur close to the expiration date of the current

extension. Richardson stated that the enhanced FMAP applies through the end of the quarter in which that date falls, i.e., through the end of December 2020.

Mejia asked whether it is known how many have remained enrolled in Medicaid and CHIP due to the continuation of coverage provision, i.e., how many would have been discontinued from coverage had it not been for this provision. Richardson stated that enrollment across eligibility categories has grown by more than 136,000 members during the PHE to date and that she would check to see if DMAS has a means of estimating how much of the enrollment gain is driven by individuals who continued in coverage that they would otherwise have lost if not for the continuation of coverage provision.

Sara Cariano, Virginia Poverty Law Center, asked if DMAS had baseline numbers on what the average per-week enrollment growth was prior to COVID. Lauryn Walker, Senior Advisor to the Chief Deputy and Acting Director, DMAS Office of Data Analytics, stated that DMAS would probably be able to estimate those numbers but that one of the challenging aspects of tracking that information pre-COVID was that there is a typical cycle of enrollment numbers going up and down over the course of the month. There would be predictable increases in enrollment at the first of the month that would decline by the end of the month. She stated that another way of measuring this is to look at the current enrollment compared to pre-COVID projected enrollment. Walker stated that it is challenging to answer the question of how many members are remaining enrolled due to the continuous coverage provision because we do not have a definitive way of knowing who would have been redetermined eligible and who would not, without actually reevaluating each member. Walker explained that, in this economic environment, a higher percentage would be expected of individuals remaining eligible and enrolled upon redetermination. But it is difficult to estimate the scale of that increase in member eligibility.

Mejia stated that when the PHE ends, and given the timing of Open Enrollment, it would be helpful to understand the number of individuals who may need to find other coverage and understand their coverage options. Walker agreed that planning for that transition will be very important and stated that DMAS is anticipating this challenge and creating a careful plan to ensure that every member will have the opportunity to be reevaluated and referred to other coverage if not eligible for renewal in a Medicaid/FAMIS coverage group.

Ashley Airington, Voices for Virginia’s Children, asked about school-based health services and whether the update provided was related to the federal “free care” rule reversal. Richardson stated that in short, yes, DMAS has been charged by the legislature with exploring whether Virginia should use the flexibility in the new federal guidance that lifts the “free care” rule in order to expand Medicaid-funded school services for eligible children outside of special education. Richardson stated that DMAS is charged with making recommendations to the GA on which services Medicaid could fund outside of the IEP.

## **II. CHIPAC Business**

- A. Review and Approval of Minutes** – Minutes from the July 20, 2020 quarterly meeting were reviewed. Michael Cook moved to approve the minutes, the motion was seconded and the Committee voted unanimously to approve.
- B. Review and Approval of Proposed 2021 Meeting Dates** – The Committee reviewed the proposed meeting schedule for 2021 and voted unanimously to approve the schedule. The approved schedule is as follows.

Full Committee meetings:

March 4, 2021  
June 3, 2021  
September 2, 2021  
December 2, 2021

All full committee meeting dates are first Thursdays. In-person meetings are scheduled for 1:00 to 4:30 pm. In the event that a meeting is held virtually, the meeting is shortened to 1-3 pm.

Executive Subcommittee meetings:

February 5, 2021  
May 7, 2021  
August 6, 2021  
November 5, 2021

All Executive Subcommittee meetings are first Fridays. Executive Subcommittee meetings will take place from 10 am to 12 pm, with the exception of the February 5 meeting, which will take place from 12:30-2:30 pm.

- C. Membership Update** – Konrad gave an update on committee membership. She informed the committee that several members have renewed their terms, but that otherwise there have been no changes to the membership. Konrad said that the Executive Subcommittee has extended invitations to two individuals to serve as members of the Executive Subcommittee. Konrad reminded the Committee that the Executive Subcommittee continues to seek new members to the Executive Subcommittee and is seeking a membership chair; the position is currently vacant.
- D. Dashboard** – Richardson introduced Dr. Laura Boutwell, DMAS Director of Quality and Population Health, to discuss the children’s preventive health section of the CHIPAC Dashboard and the updated HEDIS data. Dr. Boutwell directed members’ attention to the footnote in this section of the Dashboard. She stated that for the HEDIS reporting year 2019 -- which is calendar year 2018 -- for the well child visit rate, adolescent well visit rate, and immunizations, there were a number of major changes that occurred in Virginia’s managed care programs that affected these measures. In particular, this was the first full reporting year for the CCC+ program. In addition, calendar year 2018 saw the transition from Medallion 3.0 to Medallion 4.0. During this transition, the managed care populations not only shifted between Medallion and CCC+, but also as Medallion 4.0 launched, the transition occurred in a staggered fashion with the regional rollout. There is also a different set of MCOs participating in the Medallion 4.0 program compared to Medallion 3.0. Dr. Boutwell stated that for these reasons, calendar year 2018 should not be trended to previous years. She explained that during this transition, the agency has learned more about how the rates are calculated, in particular when there are two separate programs, and because of the changes noted in how the rates were calculated, DMAS has updated its data reporting guidelines for the MCOs to get greater clarity on the program-specific rates for the HEDIS measures and improve data going forward.

Sara Cariano, Virginia Poverty Law Center, asked about children’s rates of well visits and vaccinations during the COVID-19 pandemic. She stated that, nationally, these numbers have seen large declines with the onset of the public health emergency and asked whether DMAS

has a strategic plan for improving the numbers for Virginia Medicaid/CHIP. Dr. Boutwell responded that DMAS has been in communication with the health plans on this issue and has requested that the plans provide information on the impact they are seeing on well child visits and immunizations. The plans have been working to address the drop in immunization rates that has been identified as a national concern, particularly with flu season and the start of the academic year approaching.

### **III. VDSS Update**

Ashley Carter-Johnson, Medical Assistance Consultant, provided an update from the Virginia Department of Social Services. Carter-Johnson stated that VDSS is continuing to work closely with DMAS through the public health emergency by instructing workers not to close or reduce coverage for individuals receiving Medicaid. DSS is also helping workers address workload issues through automated processes and workload reports. Carter-Johnson reported that for the automated renewal or “ex parte” batch run for the month of August, 75 percent of cases that were selected for ex parte were successfully processed through the automated batch. Caseworkers are provided an exception report to manually process cases that were not successful through the automated run. Carter-Johnson stated that as Virginia prepares to “unwind” emergency authorities at the end of the public health emergency, workers are being provided with a workload report. This report provides workers with the number of renewals that they can anticipate at the end of each month through the end of the year. This will assist agencies with preparation and management of workload. Carter-Johnson explained that DSS has also created an automated process for the CHIPRA-214 and CHIP cases that will automatically redetermine eligibility for those individuals who would normally have “aged out” or whose coverage would have expired at the end of their postpartum period. Finally, in anticipation of the fall workload, the central office is preparing by providing best practices and hiring part-time staff to assist local agencies with their workloads to ensure that applications are processed timely.

Sara Cariano, VPLC, asked about the improvement in the ex parte rate and what has led to the higher success rate. Carter-Johnson responded that the ex parte rate improved partly because agencies have caught up with backload and partly because DSS has added electronic data sources from which VaCMS can do an automated comparison. More cases will now successfully complete the automated ex parte process by comparing electronic sources. Michael Muse, Virginia League of Social Services Executives, asked if there was an update on when VDSS would be providing follow-up information about requests that local agencies have submitted to receive additional funding for overtime. Carter-Johnson said that this information would be forthcoming from leadership in the division of Benefit Programs.

### **IV. Data and Racial Disparities Discussion**

Konrad introduced the discussion by explaining that the Committee has expressed an interest in better understanding available DMAS and state agency data pertaining to the health of children and pregnant women. She stated that CHIPAC members have also indicated that a healthy equity lens for this data is of special interest. Richardson introduced DMAS panelists Lauryn Walker, Senior Advisor to the DMAS Chief Deputy and Acting Director of the Office of Data Analytics; Andrew Mitchell, Senior Policy Advisor in the Office of the Chief Medical Officer; and Emily Creveling, Maternal and Child Health Manager in Division of Health Care Services.

Walker began with a summary of key data sources DMAS is able to access and some of the limitations to consider with the data. Walker stated that the main source of data for

demographic information is application data that DMAS receives from DSS. These data are typically self-reported, although this also includes system-generated data that results from automatic checks of applications against other data sources. The applications data provides information such as race and ethnicity. Race/ethnicity is an optional category; applicants are not required to provide this information. Phone numbers and addresses would also be applications data; however, in many cases all or some of the contact information will have changed since the member's initial application. Walker explained that this is a challenge faced by all Medicaid agencies and that, depending upon the pathway through which an individual applies, DMAS may receive different types of data on the back end of the application process. Walker stated that when DMAS began a process of closely examining race and ethnicity data in the last several years, the agency noticed large shifts in how race and ethnicity data were reported to DMAS for the Medicaid Expansion population versus other eligibility categories. Part of this likely has to do with the methods by which a person applies: for example, applicants may provide more -- or different -- information when applying themselves online versus when applying by phone with a representative. There may be different levels of accuracy and completeness depending on the modalities through which enrollees applied.

Walker continued that another data source is capitation payments. This is data from the managed care organizations, which can include demographic data such as region and age. These data tend to be more complete; however, it should be noted that DMAS only has capitation payment data for members enrolled in managed care, not for the fee-for-service population. Additionally, Walker explained, there is claim information that is gathered from the medical visit itself. This can include demographic data such as gender and address. This information does not always match the information from the application data, so decisions must be made regarding which source the agency feels more confident in.

Walker explained that a final category of data from which DMAS gets demographic information is from outside sources. One project that the Office of Data Analytics has been working on is putting together a research data bank. ODA hopes to link these data to Census data. Census data tends to lag behind a year, so it can be a bit dated, but it can be very useful. Additionally, the Office of the Chief Medical Officer has been working on a project to look at sources that provide general social determinants of health information, such as the VDH opportunity index and sources such as the Robert Wood Johnson Foundation.

Walker stated that DMAS has formed a Health Equity Workgroup. Part of the workgroup's charge will be taking a closer look at data on racial disparities. The workgroup is undertaking a major initiative to inventory the agency's data on race and ethnicity, to understand the completeness level of data across sources, and to better understand the way the data is gathered; for example, to understand how the application itself and the way the questions about race and ethnicity are structured, or the options given, impact the data that is received. The workgroup will also look at general distributions and assess the validity of the data.

Walker continued that in the context of COVID-19 response in particular, the agency is doing a comparison of race/ethnicity data to primary language data to see if this comparison can be used to get a more complete picture of populations such as the Hispanic population. Additionally, Walker stated that DMAS is in communication with other states facing similar challenges who are all working on ways to better understand demographic data in state Medicaid programs and develop best practices. Finally, Walker described efforts underway to examine Birth Outcomes Study data to better understand any differences by region, race/ethnicity, age, etc., within the population, as well as to compare this with national benchmarks.



Andrew Mitchell, Senior Policy Advisor in the Office of the Chief Medical Officer, DMAS, presented data gathered from the Addiction and Recovery Treatment Services (ARTS) program on racial and ethnic differences in diagnosis and treatment of substance use disorders (SUD) among Medicaid pregnant women. Mitchell explained that since the launch of the ARTS benefit, DMAS has worked with VCU to conduct several analyses on the impact of ARTS. Earlier this year, VCU looked at the ARTS benefit and SUD treatment of pregnant women. Mitchell stated that SUD is associated with a variety of poor neonatal outcomes, from premature gestational age to low birthweight to developmental delays. It is also one of the leading contributors to maternal mortality and morbidity. He explained that DMAS wanted to examine how rates of diagnosis and treatment varied by race and ethnicity. Mitchell stated that SUD is generally considered an underdiagnosed condition. The findings from the ARTS data indicate that, despite nationwide data indicating that the prevalence of substance use disorders is generally equivalent across most races and ethnicities, within the DMAS ARTS data, the rate of diagnosis for white women is approximately one-third higher than that for African-American women. Among those diagnosed with a substance use disorder, there were further disparities; the rate of treatment for white women, for both SUD and for opioid use disorder specifically, is higher than that for African American women and for women of other non-white racial and ethnic groups. Mitchell explained that the VCU data provides a nuanced picture that also includes disparities by region of the state.

Emily Creveling, Maternal and Child Health Manager, DMAS Health Care Services Division, gave the Committee an overview of a project DMAS is participating in with sister agencies VDH and DBHDS through a grant from the National Academy for State Health Policy (NASHP). Creveling explained that the NASHP workgroup decided to look at the entry point to substance use disorder services for pregnant women, i.e., SUD screenings. The group wanted to understand who was being screened for SUD and who was not, and to identify underlying reasons and best practices on the ground. The group partnered with VCU Health in Richmond (an urban setting in the central region) and with Ballard Health in the far southwest rural region. Both pilot sites are in regions disproportionately impacted by substance use and misuse. The group worked to understand how racial disparities and stigma around addiction impact care. Based on the ARTS data previously presented from the VCU evaluation as well as Medicaid claims data, DMAS and partner agencies were aware of racial disparities in SUD diagnosis and treatment. The workgroup wanted to better understand from providers how they were working to mitigate these disparities, and how addiction stigma plays a role in screening and access to care. Creveling stated that because of the cross-section of expertise of the participating agencies, the workgroup was able to examine the issue using a public health lens, a child welfare lens, and a Medicaid/health care lens. A very large proportion of the births in the far southwest occur in Ballard Health hospitals, so for this region, the workgroup focused on how screenings were occurring in the inpatient hospital labor and delivery setting. For the Richmond region and VCU Health, the workgroup looked at how screening was occurring in the OB/Gyn and primary care outpatient settings.

Creveling explained that prior to the COVID-19 public health emergency (PHE), the workgroup planned to conduct focus groups to understand opportunities for provider education on screenings in outpatient settings, and how racial disparities impact care (i.e., who is screened, how questions are asked, and how patients are linked to care). Due to the PHE, the focus groups have not yet been conducted, but the workgroup hopes to be able to continue this work in the future.

Carla Hegwood, Title V Maternal and Child Health Services Block Grant Director for Virginia and VDH representative to the CHIPAC, described VDH efforts to examine data through a racial equity lens. Hegwood explained that the block grant provides approximately \$24 million

in federal and state funding to address maternal and child health issues. There are five priority populations: women of reproductive age, pregnant women and infants; children; adolescents; and children and youth with special health care needs. Hegwood explained that every five years a mandatory state maternal-child health needs assessment is done. The assessment is very broad in scope. Virginia is required to document population needs for each of the five populations, to estimate program capacity and partnerships, document community assets, and to develop a state strategic plan. Virginia is completing the assessment this year and will be submitting the state action plan for the period 2021-2025.

Hegwood explained that in completing the assessment, Virginia adopted a racial equity lens for the needs assessment. Each program manager was asked to complete a toolkit from the Government Alliance on Race and Equity. This provided an opportunity to think through the core functions of the public agency and examine data, disaggregating data by race and ethnicity, looking for data gaps, looking at how resources are being allocated, how power is being shared, and whether resource allocation is responsive to community voice. The team collected data through a community partners survey and an internal prioritization survey and compared community priorities with the priorities identified by public health professionals. The agency also conducted a direct adolescent health survey to learn about adolescents' health care needs and barriers to accessing care.

Hegwood explained that there was a robust qualitative data collection process including conducting over 170 key informant interviews and regional focus groups and holding a stakeholder meeting in the Eastern Shore area. The data collection process included a focus on special populations such as Spanish-speaking people, refugee and immigrant communities, foster care youth, incarcerated women, women of color broadly, the LGBTQ+ community, and women who have experienced infertility. For the analysis of quantitative data, they tracked 15 national performance measures set by the Maternal and Child Health Bureau, disaggregating the data by race and ethnicity for each of the metrics. The team identified metrics for which Virginia was underperforming. In analyzing the disaggregated data, the team worked to identify subpopulations that might be facing challenges, in order to center the experiences of those most at-risk. This work helped to guide priorities for the coming five-year grant cycle. VDH is also working on data visualizations using a national composite metric known as concentrated disadvantage. Hegwood explained that another measure potentially of interest to CHIPAC is VDH's Health Opportunity Index, which helps to identify areas for targeted investments in maternal and child health. VDH created a visualization comparing concentrated disadvantage with key outcomes such as preterm birth and maternal and infant mortality and morbidity. They found that there were increased rates of negative outcomes in areas of concentrated disadvantage.

Konrad noted that there were only 10 minutes remaining in the meeting and proposed that the group reconvene the panelists from DMAS and VDH for a continuation of the discussion at the December 3 meeting. She invited brief clarifying questions.

Michael Cook, BMAS, requested that the agencies consider adding to the conversation in December a discussion of whether social determinants of health such as food needs and housing issues were being identified.

## **V. Agenda for the December 3 CHIPAC meeting**

The Committee discussed agenda items for the December 3 CHIPAC meeting. Konrad stated that, since a wealth of information was presented during the data and racial disparities discussion but the amount of time for open conversation had been very limited, the Committee

would invite DMAS and VDH participants to attend the December 3 meeting to engage in a continued conversation and to respond to questions from CHIPAC members.

**VI. Public Comment**

Public comment was invited, but there were no comments.

**Closing**

The meeting was adjourned at 3:00 pm.