VIRGINIA MEDICAID MEMBER ADVISORY COMMITTEE

ANNUAL REPORT - 2021

Introduction

The Virginia Department of Medical Assistance Services (DMAS) provides services and programs for approximately 1.9 million people in the Commonwealth of Virginia. DMAS is the single state entity responsible for Virginia's Medicaid program, children's health insurance program, and Medicaid waivers.

Approximately four percent of the Medicaid population is in fee-for-service (a method in which doctors and other health care providers are paid directly by DMAS for each service performed) with the remaining majority receiving care through the two DMAS managed care programs: Medallion 4.0 and Commonwealth Coordinated Care Plus. Managed care is the delivery of health care services emphasizing the relationship between a primary care provider (PCP) and the Medicaid member. The goal of managed care is to have a central point through which all medical care is coordinated. DMAS' mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

In 2019, DMAS launched the Medicaid Member Advisory Committee (MAC), comprised entirely of Medicaid members or their authorized representatives, to give voice to Medicaid members' experiences, observations, and recommendations. Since its inception, the MAC has been made of Medicaid members and representatives who desired to be a part of a team effort to review and offer recommendations to improve the delivery of quality health care services and programs.

As a part of its outreach and continuing effort to improve and enhance the delivery of Medicaid services and programs, Karen Kimsey, Director of DMAS, has stated that the Agency is committed to providing a public platform for Medicaid members to share their perspective and observations about Virginia's Medicaid program. The robust participation of DMAS leadership and staff illustrates DMAS' investment in and commitment to the MAC.

DMAS Deputy for Administration Sarah Hatton, who serves as the committee's *ex officio* member, provides management and oversight of the MAC initiative. MAC meetings generally take place on a quarterly basis.

DMAS posts the date, time, location and or means of access, and agenda for each meeting on Virginia Townhall (http://townhall.virginia.gov/). Each meeting reserves a period for public comment. To promote even greater public access and participation, DMAS ensured that closed captioning services were provided at the meetings.

As it concerns the Virginia Medicaid Program, translation and interpretation services are available in all languages through Cover Virginia at 1-855-242-8282.

The following report examines and documents the work of the 2021 MAC. To see reports for 2019 and 2020, please visit:

- https://www.dmas.virginia.gov/media/2566/2019-mac-report.pdf
- https://www.dmas.virginia.gov/media/2898/report-mac-2020.pdf

2021 Committee Background

In 2021, the MAC was comprised of eleven (11) new individuals representing a diversity of Medicaid members or authorized representatives from across the Commonwealth of Virginia. They are:

Ghadah Aljamali

Karin Anderson

Olatunji Fakunmoju

Michelle Meadows

Elvira Prince

Summer Sage

Donna Broussard Segura

Matthew Shapiro

Geoffrey Short

Donald Williams

LaToya Yuille

The 2021 MAC

Building upon the work of the inaugural MAC, the 2021 MAC members embraced the idea of examining Medicaid issues and offering insight and recommendations for enhancing the delivery of Medicaid programs and services in the Commonwealth of Virginia. The individuals who made up the 2021 MAC represented themselves, children, autistic individuals, parents, individuals with serious medical conditions, nursing home residents and spoke to areas of concern and interest to an even broader Medicaid population. Some of the reasons that these members wanted to be a part of the MAC are as follows:

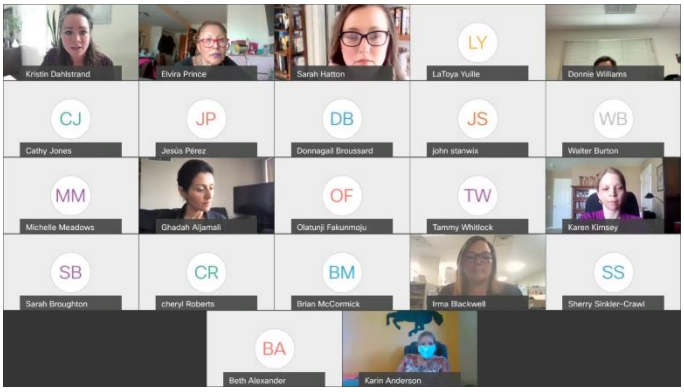
- To offer a broad range of Medicaid members' perspectives, reflections and suggestions to the table;
- To help make Medicaid increasingly accessible to Virginians; and
- To discuss issues ranging from programs, services, processes, etc., and recommend options for consideration for improving, enhancing the Medicaid program.

Due to the continuing COVID-19 federal Public Health Emergency (PHE), as well as the decision to continue ensuring the health and well-being of Medicaid members and agency personnel, all MAC 2021 meetings were conducted virtually using Web-Ex. DMAS periodically asked MAC members to recommend topics for consideration for agenda meetings. In addition, to help facilitate meaningful, respectful interaction within the meetings MAC Policies and Procedures were shared with and agreed upon by the committee members. *See Attachment A.*

April 12, 2021 MAC MEETING

Director Kimsey and Deputy Director Hatton welcomed and encouraged MAC members to share their considerations for improving Virginia's Medicaid program. During the course of their introductions, MAC members expressed excitement and their interest in providing feedback to DMAS. These members desired and anticipated to be a constructive part of an effort to show the importance of having access to affordable quality health care. Some members expressed powerful and moving occurrences in their lives or the lives of loved ones (i.e., life without health care coverage, the unfortunate and untimely passing of a loved one, which pointed to the need to access to quality health care).

Moreover, members wanted to be a part of the effort to help ensure that Medicaid members were not in position of having to choose between health care and food and/or rent or other essentials. Various members expressed their appreciation for being able to access the Medicaid program and noted, among other things, the benefit of Medicaid expansion. Members also expressed a desire to learn more about the Medicaid program.



DMAS provided the advisory committee with a broad overview of Virginia's Medicaid program:

- Medicaid is governed by both federal and state authorities and that multiple state and federal agencies play a role in Medicaid;
- Medicaid receives a mix of state general funds and matching federal funds for a total budget of approximately $17.4 billion;
- Medicaid is health insurance for low-income individuals: Children, Pregnant Women, Older Adults, Individuals with Disabilities and Income Eligible Adults;
- Medicaid covers a wide variety of services, which may include Long Term Services & Supports, Behavioral Health, Addiction and Recovery Treatment Services, Dental Care, Primary Care, and Acute Care;
- Newly eligible adult enrollees will receive coverage for all Medicaid covered services including evidence-based, preventive services;
- During the COVID-19 federal PHE, DMAS implemented a number of policy and procedural changes to improve coverage, enable new flexibilities to expedite enrollment, ensure members maintain health care coverage, and to provide an even greater level of support;
- Medicaid expansion, begun in 2019, provides health and economic security to nearly 540,000 Virginians;
- Information about the Managed Care Programs – Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0; and
- Provided information about Medicaid waivers, noting that waivers give states flexibility to implement new programs and provide additional services that may not normally be available under the traditional Medicaid program

In response to the inquiries raised by MAC members, Director Kimsey shared that Medicaid is willing to consider holistic care and that DMAS desires to work with federal partners to approve that care.

Further, replying to an inquiry, Director Kimsey confirmed that there is a standing prescription for every Virginian to receive NARCAN, medication that is used for the emergency treatment of known or suspected opioid overdose as needed. Director Kimsey also stated that Medicaid covers NARCAN nasal spray, naloxone syringe and vial, and Naloxone Carpuject without prior authorization. She noted that expedited review might be available for individuals entering substance abuse treatment.

Additionally, a presentation by the Virginia Department of Social Services summarized as among its Medicaid responsibilities the following:

- Determination of initial and continuing eligibility for Medicaid & FAMIS and enrollment of eligible persons;
- Case maintenance;
- Referral of individuals with inappropriate coverage or payments to DMAS Recipient Audit Unit (RAU); and
- Referral of certain individuals to the Health Insurance Marketplace

June 14, 2021 MAC MEETING

Capturing the essence, desire, and tenor of the first meeting to build upon and make better various Medicaid programs and services, this meeting encompassed the following subjects, presentations and questions:

- Project Behavioral Health Redesign for Access, Value, and Outcomes (BRAVO), which is to be implemented over a number of years, encompasses DMAS redesigning of the behavioral health program. Ms. Laura Reed, Behavioral Health Senior Program Advisor, explained that the prior system focused on high acuity, which is reactive and crisis driven, relying on intensive services for acute problems.

Moving forward, DMAS seeks to provide care in the least-restrictive environment, increase preventive care, and implement proven, evidence-based practices. Ms. Reed summarized that DMAS was in Phase 1 of BRAVO, which includes broadening services, will be implemented in stages over the course of years, and would seek to reflect a much more balanced approach to the continuum of behavioral health services.

System Transformation Excellence and Performance (STEP-VA), part of Virginia Department of Behavioral Health and Developmental Services (DBHDS), is working to increase access, quality, consistency and accountability across Community Service Boards (CSB).

BRAVO would be putting critical services in place over time:

- Partial Hospitalization Program (PHP) – few providers offer and few members receive this service. It would reduce people having to receive hospitalization by providing 4-6 hours of care per day in a day program setting with a psychiatrist running the treatment plan.

- Intensive Outpatient Program (IOP) – provides care 2-3 days per week, for 2-3 hours at a time. The care has a clinical focus and is run by medical providers such as a doctor or nurse practitioner.

- Assertive Community Treatment (ACT) – is an evidence-based treatment plan intended to provide robust community care. ACT is a wrap-around service in a team environment providing several services following a national model. Ms. Reed indicated that many CSBs are already providing this care, and BRAVO is creating a Medicaid rate to pay for the service.

- Comprehensive Crisis Services (Mobile Crisis, Intervention, Community-Based, Residential, 23 Hour Observation)

    a. Mobile Crisis – generally two individuals dispatched from a CSB to help individuals in acute distress.

    b. Community-Based – care in the community for individuals who need more time to stabilize, but who do not need to be in hospital.

    c. 23 Hour Observation – observation in a clinic setting for individuals who do not need hospitalization, but who need a place to stabilize.

d. Residential –reduced care rather than or prevention of hospitalization.

- Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) – both are evidence-based practices for youth. The goal of MST and FFT is to prevent residential care, and for incarcerated youth, to keep youths in the community with families rather than in a residential treatment position. Currently, a part of the continuum and paid for by the Department of Criminal Justice Services and Office of Children Services (bringing on a Medicaid rate in order to sustain and grow these services across the state).

It was also shared that the Virginia Department of Social Services (VDSS), DBHDS, Office of Children Services, the Department of Juvenile Justice, and DMAS are working together to increase support of providers for children's services, though it was acknowledged that the enhanced care would not happen overnight and that additional supports for provider services was necessary. Among the efforts to bolster provider support is VDSS bringing up contracts to help sustain provider training. Also, state agencies are contracting with Virginia Commonwealth University to bring online the Center for Excellence (hub for evidence based practices and training). Also, there will be a public database that will allow the public to see what services providers offer.

Additionally, among the issues raised by the Committee were:

- Whether BRAVO services required Medicaid member to be on waiver, CCC+ or DD waiver – and the response was no, as services are available to all Medicaid members

- Whether DMAS had looked at Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and pharmacy data to see if they can aggregate data to determine what care did and did not work; and

- Whether providers get credit and develop processes to determine type of care.

In response, Tammy Whitlock, Deputy of Complex Care Services replied that DMAS has looked at the data over 8-10 years. She stated that DMAS conducted a study a few years ago, and that data drove the changes under BRAVO. She further noted that the services prior to BRAVO were not evidence-based and therefore, DMAS cannot determine the impact of the services because providers cannot validate that information through data. Ms. Whitlock observed further that DMAS wanted to see what the outcomes are and see if BRAVO improves care and reduces costs. It was further noted that DMAS had a workgroup with stakeholders and providers who were excited about rates and services.

❖ *New Health Coverage Rules For Green Card Holders (lawful, permanent residents) Effective April 1, 2021.*

Susan Martin, Senior Policy Analyst, summarized that effective April 1, 2021, the need for 40 working quarters for Lawful Permanent Residents to qualify for Virginia Medicaid was eliminated. While Virginia follows federal mandatory rules, the 40 working quarters requirement was an optional rule and as such, allowed Virginia to adopt or not.

Ms. Martin further explained that a Medicaid applicant who is a Lawful Permanent Resident or green card holder who *resided* in the United States for at least 5 years could now qualify for full coverage Medicaid if they met the other eligibility requirements for Virginia Medicaid. It was further stated that the five-year residence requirement is a federal requirement established in 1996. Therefore, a Lawful Permanent Resident who has resided in the United States for five years (and who meets financial and non-financial eligibility requirements) could qualify for doctor visits, prescriptions, hospital care,

long-term supports and other Medicaid services. In addition, as of July 1, 2021, DMAS will cover dental services for adult recipients lawfully residing and children under 19 would receive full coverage, with no waiting or work requirement. Ms. Martin explained that pregnant women, regardless of immigration status, would also qualify for full coverage Medicaid if they meet all other non-financial and financial Medicaid requirements.

Ms. Martin outlined the humanitarian statuses, including refugees and asylees, and a few other status, that may be eligible for full Medicaid for the first 7 years after entry into the country, if they meet all non-financial and financial Medicaid requirements. Should such individuals have their immigration status converted to lawfully permanent resident they may be eligible for Medicaid under that umbrella, presuming they meet all other eligibility requirements. Ms. Martin noted that individuals with other documented status or no immigration status or no documentation may be eligible for emergency medical services with no waiting period or work requirement. She concluded by indicating that those emergency services applicants must also meet all other non-financial and financial requirements.

Next, committee members were asked how they learned about the Medicaid program and how they obtained the information. They responded:

Word of mouth;

Internet;

Local social services agencies;

Publications; and

Networking

Committee members observed how difficult it was to sometimes locate Medicaid information. Members were encouraged to make recommendations to DMAS for improved options to access Medicaid information.

During the meeting, Mr. Stanwix also outlined the organizational structure of DMAS. He presented the Committee with the DMAS Executive Leadership Team and a brief overview of the divisions they oversee.

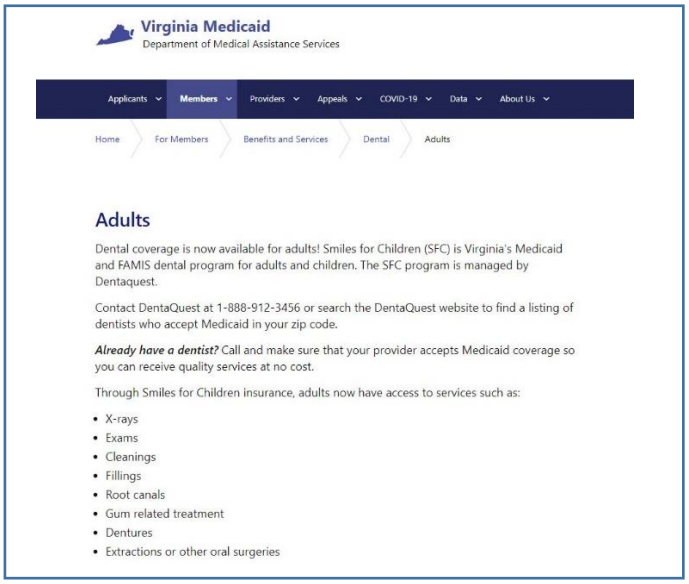
August 9, 2021 MAC Meeting

Deputy of Administration Hatton greeted the Committee and thanked the Committee for their participation in the virtual MAC meeting. Deputy Hatton shared that Governor Ralph Northam lifted the state of emergency in Virginia, but that the federal health emergency would continue until at least October 18, 2021. Deputy Hatton stated that because of that, DMAS could continue to provide some flexibilities to members. *See* https://www.dmas.virginia.gov/covid-19-response/

Mr. Stanwix outlined the DMAS core values: service, collaboration, trust, adaptability, and problem solving. He also referenced that the Committee Policies and Procedures had discussion guidelines, which include being hard on the problem, not on each other. Mr. Stanwix noted that the Policies and Procedures also state that the Committee should give thoughtful consideration to the health and support needs of diverse individuals, and asked that the members consider those individuals in the MAC discussions.

❖ *Presentation - Adult Dental Benefit*

Deputy for Programs, Cheryl Roberts, stressed the importance of dental health and urged parents to utilize children dental benefits. She pointed out that Virginia Medicaid provides better and easier dental care than most private healthcare plans. The Smiles for Children program covers preventive, orthodontia, and restorative services. She noted that Virginia Medicaid utilizes DentaQuest, rather than a Managed Care Organization (MCO), to administer the adult dental healthcare program, which was implemented using feedback from dentists. She indicated that the Virginia dental coverage is rated in the top 10 Medicaid dental programs in the country. Virginia began covering dental care for pregnant women in March 2015.



Deputy Roberts explained that Medicaid Expansion increased the number of adults in Medicaid. She indicated that dental health affects blood pressure, respiratory, dementia, birth outcomes, diabetes, and obesity. It was also noted that without dental care, individuals would visit the emergency room for pain and sometimes receive opiates. She stated that this created increased emergency room costs as well as possible opiate addiction. Deputy Roberts outlined the detriments of poor dental care, including depression from insecurity, as well as difficulty obtaining jobs with poor dental work. On July 1, 2021, Virginia expanded Medicaid dental services for approximately 750,000 members.

Dr. Zachary Hairston shared that oral health equals overall health. Dr. Hairston discussed silver diamine that can arrest, or stop, tooth decay. The mantra for adult dental care is prevention and education, periodontal maintenance, and to build around what is salvageable. The new benefit can allow up to three cleanings annually. Restorations also help maintain oral health. Periodontal maintenance includes supporting the bones and gums to maintain a healthy smile. Dr. Hairston indicated that proper dental care allows individuals to chew better, have better smiles, and provide access to better jobs. Dr. Hairston indicated that the available services include cleaning, preparation, and dental prosthetics like dentures and bridges or partials. Dr. Hairston specified that adults receive all care provided to children and pregnant women, except for orthodontics, and that all other benefits transfer to the adult dental care for those leaving the children and pregnant women coverage. There is no annual maximum for care per member.

Dan Plain, Division Director of Healthcare Services, expressed gratitude for the General Assembly and Governor, as well as collaboration with many interested groups, who supported providing dental care to adult Medicaid recipients.

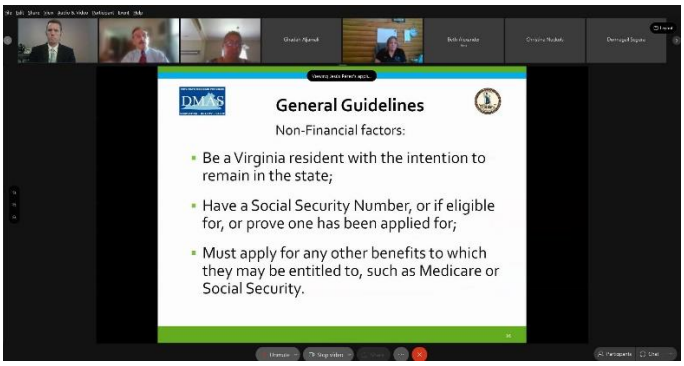
Mr. Plain discussed working with many providers to expand the providers and network for adult recipients, and that 75% of providers are seeing adults. DMAS sees members receiving cleanings, fillings, and other care, and DMAS has already added 60 new dentists to provide this care. Mr. Plain encouraged members to find dentists through DentaQuest, and indicated that there should only be a short wait before being able to receive an introductory visit.

Various committee members lauded the availability of a range of dental services and care. Information about locating dental providers using the on-line system was also shared and explained.

In response to an inquiry concerning whether the new dental coverage could cover old bills that existed prior to July 1, 2021, Mr. Plain answered that the coverage could only provide funding for care provided on or after July 1, 2021. Mr. Stanwix further clarified that the limitations are due to when funding for the new benefit became available.

- *Presentation - Medicaid Income Eligibility & Renewal Process*

Victor Grand stated that Medicaid eligibility analysis can sometimes be a complex process. The Center for Medicare and Medicaid Services (CMS) create guidance for Medicaid policy, and the state Medicaid agency, DMAS, creates Medicaid policy in Virginia.



Most income guidelines are changed annually, and some are tied to federal cost of living adjustments (COLA). The local Departments of Social Services (DSS) and a central processing unit with a large call center process initial applications and income evaluations. The local DSS manages renewal applications every year once a recipient begins receiving Medicaid, and provide a renewal application 60 days prior to the renewal deadline.

Mr. Grand outlined various covered groups that may provide Medicaid coverage for applicants. The first step of the analysis is determining whether the recipient is covered under Families and Children (F&C) or Aged, Blind, and Disabled (ABD). F&C covers children under 19, Modified Adjusted Gross Income (MAGI) Adult are eligible individuals from 19 to 64 years old, pregnant women, former foster care children, and Low Income Families with Children (LIFC). ABD covered groups cover aged individuals over age 65, individuals determined disabled by the Social Security Administration (SSA), individuals receiving Medicare Savings Programs (MSPs), which are limited benefits paid to assist in the cost of Medicare, and long-term care (LTC) recipients. Mr. Grand outlined non-financial criteria including Virginia residency, a Social Security number, certain citizenship, legal presence, and special immigration status, and having applied for all benefits for which the applicant could be eligible.

Mr. Grand indicated that the eligibility analysis includes earned income, like wages, and stated that the eligibility analysis includes gross income before any taxes or deductions. Mr. Grand also outlined unearned income, like SSA benefits, pension, and retirement income. For ABD covered groups, Mr. Grand explained that the eligibility analysis must also evaluate resources, like homes, vacation property, checking accounts, retirement accounts, and other countable resources. This does not include personal belongings. However, once the recipient sells the personal belongings, the funds received would be a resource.

Mr. Grand discussed the Medicaid renewal process, and the desire to provide continuity of coverage. Commonly, members lose coverage because they do not provide the necessary information at the renewal process. Renewal processing has been on hold since March 2020 due to COVID and the federal PHE. Mr. Grand indicated that the financial requirements are the same for an initial application as for a renewal. Many workers can complete renewals electronically for certain recipients, and will complete renewals without contacting recipients if possible. If the worker cannot complete the renewal electronically, the worker will send a request for information to the recipient.

Questions raised by Committee Members included:

How do individuals end coverage based on increased income? Response - During the federal (PHE), DMAS will only remove Medicaid coverage for individuals who pass away or leave the state, or if someone requests to be removed from Medicaid.

How does the transition off Medicaid occur? Mr. Grand replied that the worker would gather that information electronically or reach out to the recipient to receive income evaluation.

A committee member inquired about former foster youth. She stated that many times the support foster youth receives from parents that have adopted them stops when they turn 18. She asked whether there is any chance this may change and adopted children may be able to get Medicaid until age 26 as well.

Kelly Pauley, Eligibility and Enrollment Manager, responded, "the child should be evaluated for all other covered groups before being closed. They may meet MAGI Adult (expansion) coverage. During the federal PHE, no one should be closed unless they move out of state, request it or do not meet citizenship requirements. Adopted children would not meet the criteria to be considered a former foster care child. They have to be in foster care as of the 18th birthday." Mr. Grand reiterated that the child should be evaluated for all other covered groups before being closed as they may meet MAGI Adult criteria.

A member indicated that she remembers checking a box to use her tax return in the renewal. She asked if that means she does not have to do anything for renewal. She also asked how she could change that choice, if she does not remember what was checked. Mr. Grand replied that if the member no longer wants the worker to use that information, the member should reach out to the local department of social services worker.

A committee member asked if the renewal was always once per year. Mr. Grand said a renewal would occur annually in a typical setting. Ms. Dana Thierry pointed out that if a recipient indicates a change, the renewal could occur more quickly than annually. The member further asked how individuals in a nursing facility without a family representative could complete a renewal. Ms. Thierry indicated that those individuals would often authorize the nursing facility to complete a renewal for them.

A member seeking clarification asked if renewals are currently automatic during the PHE. Deputy Hatton replied that the federal PHE is extended at least through October 18, 2021 *[note: and has since been extended until January 2022]*. She indicated that DMAS cannot end coverage during the federal PHE, and that local agencies will evaluate all cases once the PHE ends.

- *Overview on Unexpected Medical Bills Received by Members*

A committee member described a situation in which an incarcerated individual gave birth while incarcerated and who had Medicaid. The member explained that the individual went into a diversion program after incarceration, and the program checked the individual's credit report, which showed outstanding medical bills for the delivery. In order to be responsive and more specifically address the issues involving this scenario, Ms. Thierry pointed out the eligibility email box for questions, Vamedicaidquestions@dmas.virginia.gov. She indicated that Medicaid might be able to pay the bill with a delayed enrollment letter provided to the billing providers, but could not definitively provide an answer until the matter was more thoroughly researched.

Another member observed that sometimes the denial of payment is incorrect and that the provider does not complete the necessary steps. The member shared what they had experienced regarding a bill that was contested. Eventually, the member appeared in court regarding the bill. The member noted that the provider never sent him a bill, just sent the bill straight to the court system. The member shared that the incident appeared to be an instance of predatory

billing by the provider who may have been seeking a higher payment from him (a Medicaid member) as opposed to what the provider would have received from Medicaid's payment/reimbursement. This member won the court case (DMAS did pay the bill).

December 13, 2021 MAC meeting

In response to various inquiries from Medicaid members and to provide updates on various issues, this meeting included presentations on:

❖ *Medicaid Application Proposed Changes*

Kelly Pauley, Manager, Eligibility & Enrollment Services Division, shared that the Centers for Medicare and Medicaid Services (CMS) provided a template application for all states to follow when creating a Medicaid application. Virginia adapted the application and created online versions, which are intended to match as much as possible, and then provide the updated application to CMS for approval.

Among the enhancements were:

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

Among the questions asked by the MAC members was an inquiry on why certain demographic information was being sought. DMAS shared that CMS was seeking demographic information but that 1) it was not necessary to answer the demographic request/question in order for the application to be processed for a determination of eligibility and that DMAS would make this clearer in the application and 2) DMAS would advise CMS that concerns about the demographic inquiry had come up.

Ms. Pauley asked the MAC members to further review the proposed application and to submit observations/questions for consideration by DMAS.

❖ *Health Insurance Premium Program (HIPP) and HIPP for Kids*

Tiaa Lewis, Director of Program Operations, summarized that there are two basic eligibility requirements for the HIPP program:

- at least one family member must have full coverage Medicaid and
- the family must have credible health insurance coverage, which may include employer-provided health insurance coverage.

The HIPP for Kids program is available if the applicant is under 19 and the employer contributes to the cost of insurance. A HIPP for Kids applicant would not be eligible if they have a high-deductible plan, as the federal government would not reimburse for high-deductible plans. If an applicant were not eligible for HIPP for Kids, the HIPP program would then evaluate the applicant for HIPP coverage.

In response to questions about information being available regarding HIPP/HIPP for Kids, Ms. Lewis stated that while DMAS has made information available to potential applicants, HIPP would be willing to visit and explain the HIPP program to any advocacy programs who would be interested in learning more.

❖ *DMAS Response to COVID-19*

Richard Rosendahl – Director of Health Economics and Economic Policy, provided data and background which included DMAS reporting nearly 137,000 Medicaid members with confirmed COVID-19 cases, and nearly 1.5 million COVID-19 tests administered to members, which (by percentage) are consistent with state and national averages. Over 640,000 Medicaid members are fully vaccinated, and 37% of all members have at least one vaccine dose. Of eligible members, 49% have at least one vaccine dose. However, over 728,000 Medicaid members are unvaccinated.

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

Andrew Mitchell, Senior Policy Advisor, stated that telehealth coverage has increased thirty-fold during COVID-19. Prior to COVID-19, a patient had to physically go to a clinic and have a telehealth visit with a remote provider, and the visit had to include both audio and video. Once COVID-19 began, any Medicaid covered service could be delivered via telehealth if appropriate.

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

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

Ms. Natalie Pennywell, MPH CHES – Outreach and Community Engagement Manager, observed that increased care for prenatal care, comprehensive dental care, and Afghan refugees has improved member experiences. The Member Outreach team has continued to support a communication plan including traditional media, social media, noticing, and stakeholder communications. The Member Outreach team intends to utilize managed care organizations (MCO) to improve outreach and assistance activities through the MCO members.

Potential communication sources include post cards, posters in providers' offices, factsheets from local DSS offices, member-focused factsheets, a toolkit for stakeholders, and a COVID unwinding FAQ. DMAS will present this information at stakeholder meetings. The Cover Virginia and DMAS websites also include information about COVID-19 unwinding and updates as well.

CONCLUSION

The work of the MAC is still at its beginning stage. In their desire to become contributing members of the MAC, the various members have exhibited a drive and tenacity to examine, explore and ask questions about services and programs and to urge and recommend various avenues and efforts that would further build upon the delivery of quality and accessible health care within Virginia's Medicaid program. As it moves into 2022, the MAC does so based upon a foundation of exacting questions, review of policies and procedures, and the promotion of services designed to better meet the needs of Virginia's Medicaid population.

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To learn more about the 2021 MAC, including accessing quarterly meeting minutes, reference documents, and other information, please visit:

https://www.dmas.virginia.gov/for-members/member-advisory-committee/2021-meetings/

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DMAS thanks Governor Ralph Northam, Secretary Daniel Carey and the leadership and staff at HHR, Secretary Kelly Thomasson and the leadership and staff at the Office of the Secretary of the Commonwealth, and Director Karen Kimsey and the leadership and staff of DMAS, Commissioner Duke Storen and the leadership and staff at the Virginia Department of Social Services, and our many state and local partners. Special thanks is given to the members of the MAC who have given their valuable time, work, and articulation of their life experiences in order to be a part of the effort to improve Virginia's Medicaid program.