CHIPAC
Children's Health Insurance Program Advisory Committee of Virginia

MEETING MINUTES

Meeting Minutes
September 1, 2022
1:00-3:30 pm

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

The following CHIPAC members were present in person:

• Sara Cariano	Virginia Poverty Law Center
• Ali Faruk	Families Forward Virginia
• Shelby Gonzales	Center on Budget and Policy Priorities
• Emily Griffey	Voices for Virginia's Children
• Jeff Lunardi	Joint Commission on Health Care
• Jennifer Macdonald	Virginia Department of Health
• Freddy Mejia	The Commonwealth Institute for Fiscal Analysis
• Dr. Susan Brown	American Academy of Pediatrics, Virginia Chapter
• Heidi Dix	Virginia Association of Health Plans
• Alexandra Javna	Virginia Department of Education
• Michael Muse	Virginia League of Social Services Executives
• Emily Roller	Virginia Health Care Foundation
• Hanna Schweitzer	Dept. of Behavioral Health and Developmental Services

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

• Irma Blackwell (Jessie Watkins)	Virginia Department of Social Services

The following CHIPAC members were not present in person:

• Dr. Tegwyn Brickhouse	VCU Health
• Kelly Cannon	Virginia Hospital and Healthcare Association
• Michael Cook	Board of Medical Assistance Services
• Tracy Douglas-Wheeler	Virginia Community Healthcare Association
• Dr. Nathan Webb	Medical Society of Virginia

I. Welcome

Sara Cariano, CHIPAC Chair, called the meeting to order at 1:02 pm. Cheryl Roberts, Acting Director of DMAS, welcomed the committee and expressed support for CHIPAC's mission and appreciation for their work. Attendance was taken by roll call. Cariano explained that, due to new legislation that took effect the day of the meeting (September 1), only members attending in person could be recorded as present for this meeting. Members could attend online as a member of the public but their votes could not be counted.

II. CHIPAC Business

a. **Review and Approval of Minutes** – Committee members reviewed draft minutes from the June 9 meeting. Heidi Dix, Virginia Association of Health Plans, made a motion to approve the minutes. Emily Griffey, Voices for Virginia's Children, seconded, and the Committee voted unanimously to approve.

b. **Membership Update** – Cariano welcomed the newly appointed CHIPAC representative from the Virginia Department of Education, Alexandra Javna. No confirmation vote was required as VDOE is a statutory member of the Committee.

   Cariano nominated Freddy Mejia, The Commonwealth Institute, to serve as CHIPAC Vice Chair. Ali Faruk, Families Forward Virginia, made a motion to approve Mejia as Vice Chair, Jeff Lunardi, Joint Commission on Health Care, seconded, and the Committee voted unanimously to approve.

c. **Committee Discussion and Vote on Virtual Meetings and Remote Participation Policy** – Hope Richardson, DMAS Division of Policy, Regulation and Member Engagement, gave an overview of new state legislation and FOIA Council guidance requiring public bodies to approve a policy on virtual meetings and remote participation. Richardson directed members to a draft amendment to the CHIPAC bylaws in the meeting packet that set out a proposed policy for the Committee. She explained that under the new legislation that took effect that day (September 1, 2022), public bodies, including CHIPAC, are required to have an approved policy in place before allowing all-virtual meetings or remote participation by members. Richardson stated that the Committee could vote on the draft amendment/policy at the meeting in order to have a policy in place, which would not preclude future adjustments to the policy. Alternatively, the Committee could opt not to approve the proposed policy and to delay holding all-virtual meetings or allowing remote member participation until a vote was held at a future meeting to approve a final policy. Richardson also recommended putting a more in-depth discussion of the policy on the agenda for the next Executive Subcommittee meeting and invited interested members to attend for that discussion.

   Richardson explained that under the proposed policy, the Committee could hold two nonconsecutive "all-virtual" meetings per year. These meetings would be announced as virtual in advance. Public access would be provided by electronic communication

means, no physical quorum would be required, and all members could vote and participate just as they would for an in-person meeting.

Richardson explained that for the two remaining meetings per year that were not all-virtual, individual members could be approved to participate remotely if they met one of three exceptions: a temporary or permanent disability or other medical condition of the member, a family member's medical condition requiring the member to provide care for the family member, or a principal residence more than 60 miles from the meeting location.

Lunardi asked for clarification regarding "personal exceptions" allowable under the state legislation and whether the draft policy included this type of exception. Richardson clarified that the new legislation does allow for personal exceptions but that a public body is not required to include this type of exception in their remote participation policy. She stated that the draft policy before the Committee did not include personal exceptions.

Lunardi asked if members not attending in person and not approved to attend virtually would be allowed to watch the meeting online. Richardson confirmed that for in-person meetings, members without an approved exception could watch virtually as a member of the public but could not vote or be counted as officially present.

Jennifer Macdonald, Virginia Department of Health, asked about voting during virtual meetings. Richardson explained that voting during all-virtual meetings would be the same as in person, and a physical quorum would not be required. For in-person meetings, a physical quorum is required for any votes to be held, but if an individual member meets the criteria and is approved to attend remotely, that member can vote and participate in the same way that they would if attending in person.

Members suggested that the Committee might consider changing the draft policy's use of the term "medical condition" to "health condition" as a broader and more inclusive term. Richardson stated that the policy mirrors the language of the state legislation, and pointed out that the nature of the medical/health condition would not be disclosed. Dix further explained the legal reasoning behind the "medical condition" language of the policy using the same terminology as the Code of Virginia. Cariano stated that members would not need to provide detail of a medical or health condition to the committee.

Ali Faruk asked if it was the committee goal to approve the policy today. Cariano confirmed that was the goal, since the committee could allow virtual options only with an approved policy in place. She reminded the committee that the policy could be altered at any time after being approved.

Members inquired about public emergency meeting guidance. Richardson clarified that the proposed policy applied to virtual meetings held outside of a declared public emergency and that separate legislation and rules applied to virtual meetings during a public emergency.

After further discussion, the committee decided to vote on the draft policy without changes and tasked the executive subcommittee to review the policy in their next meeting, including personal exemption language that might be added, discuss adjustments needed to the policy, and bring any proposed amendments to the next full committee meeting for follow-up discussion and vote. Mejia made a motion to approve, Gonzales seconded the motion, and the committee voted unanimously to adopt the policy and task the executive subcommittee with reviewing for potential future revisions.

Members asked if in-person meetings would continue to be held at the DMAS building. Richardson answered that the Committee currently plans to hold the meetings at DMAS offices at least through 2023 but invited members to contact DMAS staff or the executive subcommittee with any concerns or to propose other meeting locations.

d. **CHIPAC Meeting Schedule for 2023** – Proposed meeting dates for 2023 were reviewed. Emily Griffey, Voices for Virginia's Children, made a motion to approve the schedule. Faruk seconded, and the Committee voted unanimously to approve.

i. **Approved 2023 Meeting Schedule**

1. CHIPAC Full Committee Meetings for 2023
    a. Thursday, March 2 (1:00 – 3:30 pm)
    b. Thursday, June 1 (1:00 – 3:30 pm)
    c. Thursday, September 7 (1:00 – 3:30 pm)
    d. Thursday, December 7 (1:00 – 3:30 pm)

2. CHIPAC Executive Subcommittee Meetings for 2023
    a. Friday, January 20 (1:00 pm – 3:00 pm)
    b. Friday, April 14 (10:00 am – 12:00 pm)
    c. Thursday, July 13 (10:00 am – 12:00 pm)
    d. Friday, October 13 (10:00 am – 12:00 pm)

III. Project BRAVO / ARTS Updates (DMAS)

The DMAS Behavioral Health Division, joined by Dr. Alexis Aplasca of the Department of Behavioral Health and Developmental Services (DBHDS), provided a Medicaid behavioral health policy update, including updates on the progress of the Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes) and ARTS (Addiction and Recovery Treatment Services) projects/programs.

Laura Reed, DMAS Behavioral Health Senior Program Advisor, shared behavioral health statistics in Virginia compared to national averages, including prevalence of diagnosis of a major depressive episode in youths, adults reporting any mental illness, adult substance use disorder, youth substance use disorder, and adults reporting symptoms of depression and anxiety during COVID-19. Reed explained that Virginia's ranking for many of these statistics is near the national average.

Dr. Alexis Aplasca, Deputy Commissioner for Clinical and Quality Management at DBHDS, provided an update on Project BRAVO and enhancement of Virginia's Medicaid-funded behavioral health service array. She described the six services rolled out through Phase 1 of Project BRAVO on July 1 and December 1 of 2021. The goal of the initial phase of services was to build out the highest levels of care in the system in order to serve patients in crisis. The services are assertive community treatment (a "hospital without walls" approach), intensive outpatient, partial hospitalization, comprehensive crisis services (including mobile crisis response, community stabilization, 23-hour crisis stabilization, and residential crisis stabilization units), multisystemic therapy (MST), and functional family therapy (FFT). MST and FFT, which rolled out December 1 of 2021, are youth-focused, highly evidence-based therapies.

Dr. Aplasca gave an overview of BRAVO's accomplishments and challenges over its first year of activity. She then explained BRAVO's future steps including service learning collaboratives, continuing to build out the crisis system, metrics and evaluation, and opportunities for expansion. Systems-focused future directions include addressing widespread concern of the impact of COVID-19 on youth isolated and without regular community, and integration of behavioral health care into existing primary and long-term care. Dr. Aplasca explained the Crisis Now model of crisis services and its implementation in Arizona. She presented objectives of developing and aligning with the Crisis Now model and how it would fit into the BRAVO continuum. The objective in implementing the Crisis Now model is the development of a community-based, trauma-informed, recovery-oriented crisis system that responds to crises in the community and prevents out-of-home placements. Dr. Aplasca described the new nationwide 988 hotline and how it fits into a community-based crisis response.

Ashley Harrell, DMAS Behavioral Health Senior Program Advisor, presented on plans to better integrate healthcare services for co-occurring mental health and substance use disorders (SUD). Harrell stated that there is a high rate of co-occurrence of mental health and SUD conditions; Medicaid plays a significant role as it is the largest payer for substance use disorder nationally, and approximately 40% of individuals with an opioid use disorder are enrolled in Medicaid. For this reason, changes in the Medicaid system can drive improvements in the broader healthcare system, including for patients who are commercially insured. Harrell detailed effective behavioral therapies for treating co-occurring disorders including assertive community treatment (a high-intensity, team-based treatment delivered in the community for individuals with serious mental illness), MST and FFT, and comprehensive crisis services. Providers and crisis teams trained in integrated care strategies will be prepared to help individuals in crisis who are using substances.

Dr. Aplasca clarified that the crisis services model would not restrict providers' ability to provide services. The needs of the person experiencing the crisis would drive determinations around the services and level of care. Dr. Alyssa Ward, DMAS Behavioral Health Clinical Director, commented on the success of crisis treatment in other states, especially in youth populations, and the vision of similar results in Virginia.

Ali Faruk, Families Forward Virginia, asked whether state resources were being allocated for effective workforce development and training of providers. Dr. Ward responded that DMAS acknowledges the need for resources but cannot speak to the direction of the commonwealth's leadership. Faruk commented that advocating for those resources could be a task for CHIPAC. Dr. Aplasca stated that COVID-19 has had a major impact on the behavioral health workforce. Griffey commented about the need for training in implementing the new types of services and making providers across systems aware of the continuum of services now available. Dr. Ward agreed with Griffey's comments and stated that DMAS is interested in forging community partnerships to enable additional systems training and orientation. Dr. Susan Brown, American Academy of Pediatrics, Virginia Chapter, commented on increasing public knowledge of the new crisis services and the 988 hotline.

Harrell highlighted recent work enabled through the SUPPORT Act grant, an approximately $5 million grant from the federal Centers for Medicare and Medicaid Services (CMS) to increase SUD provider capacity in Virginia. A focus of the grant was services for pregnant and parenting individuals with SUD. One goal for the agency summarized in a recent document available here is to improve access to peer recovery supports for individuals with mental health conditions and SUD. This includes increasing the number of peer recovery support specialists who are mothers in recovery with shared life experience as pregnant and parenting women. Harrell stated that DMAS has partnered with Virginia Commonwealth University (VCU) as independent evaluator for the ARTS benefit and shared highlights from VCU's evaluation report on diagnosis and treatment of substance use disorders in pregnant women covered by Medicaid. She noted that, among the findings, treatment rates for Medicaid-enrolled pregnant women with opioid use disorder increased considerably from 2017 to 2018, from 58% to 76%. In addition, the report found that disparities persist in treatment: Black women with SUD diagnoses while pregnant were less than half as likely to receive any treatment prior to delivery (20%) compared to white women (44%).

IV. Behavioral Health Utilization Dashboard

Reed presented on DMAS' Behavioral Health Service Utilization and Expenditures dashboard, available on the DMAS website. Reed explained that the dashboard is intended to improve Medicaid data transparency, but is also a powerful tool for DMAS to review data internally and identify trends and areas for improvement.

Metrics investigated include utilization of specific behavioral health services pre-COVID compared to now, how utilization trends could reduce burden on state psychiatric hospitals and emergency departments, measuring the expansion of access to BRAVO services, improving coordination of care for youth in foster care and reducing the need for residential treatment. Reed gave a virtual tour of the dashboard and highlighted notable trends.

Griffey commented on the decline in spending and utilization of behavioral health services delivered in schools during the pandemic, particularly therapeutic day treatment (TDT). She stated that, going forward, it is important to investigate ways to

meet children's behavioral health needs in the school setting post-pandemic, across systems, including investments in the educational system as well as investment in Medicaid school services/resources. Reed followed up by using the dashboard to show utilization and expenditures on two other services—intensive in-home and behavior therapy. Reed explained that these two services remained stable or increased instead of experiencing the large drop that TDT did over the same time period; it is possible that many of the children previously receiving TDT accessed these services during the pandemic. In addition, outpatient psychotherapy experienced a large amount of growth during the pandemic, perhaps partly due to the availability of access to these services through telehealth modalities.

Mejia commented on the decline in the average expenditures per member receiving TDT over the course of the pandemic. Dr. Ward explained that DMAS is working together with stakeholders to explore potential adjustments to the structure of the benefit to ensure children receive the appropriate level of behavioral health supports in school while also remaining integrated in the classroom instructional setting as much as possible. She stated that the system-wide priority should be to make the most robust and appropriately distributed investment in behavioral health services possible, across all payers, including but not limited to Medicaid.

Dr. Brown asked for further details on services for the 0-3 age group population and impacts of the pandemic on early intervention services during the pandemic. Dr. Ward responded recommending use of the dashboard for further investigation and highlighted the importance of enabling reimbursement that supports dyadic services to caregivers and children in this age group.

V. Behavioral Health HEDIS Dashboard

Dr. Laura Boutwell, Director of the DMAS Office of Quality and Population Health (QPH), presented on the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used set of performance measures in the healthcare industry, and the reporting dashboard developed by DMAS. HEDIS measures are developed and owned by the National Committee for Quality Assurance (NCQA). Virginia Medicaid managed care organizations are accredited by NCQA and are required to report HEDIS measures annually. The Behavioral Health HEDIS dashboard on the DMAS website was developed to demonstrate the quality of care of Virginia Medicaid, to provide transparency to members, stakeholders, and regulators, and to demonstrate accountability of Virginia Medicaid. The current dashboard utilizes the HEDIS 2020, also known as measurement year (MY) 2019, rates as a baseline year of reporting, and DMAS will update the dashboard annually.

Dr. Boutwell gave a static tour of the dashboard, which can be found on the DMAS website, with a focus on behavioral health care for children and adolescents. She explained that in alignment with DMAS' Quality Strategy, the performance benchmark for the MCOs is the national 50th percentile, meaning that the MCOs must perform in the top 50% for quality measures. Dr. Boutwell also provided an overview of DMAS' External Quality Review (EQR) activities with its EQR partner, Health Services

Advisory Group (HSAG) related to behavioral health and children's/maternal health services.

Mejia asked about the timeline for inclusion of race and ethnicity data in publicly available DMAS data and reports. Dr. Boutwell responded that for the current year's data collection, the MCOs will report race and ethnicity data for several measures, and DMAS plans to expand the number of measures including this information in future years. Gonzales asked whether the data on race and ethnicity comes from providers, applications, or other sources. Dr. Boutwell answered that the dashboard's race and ethnicity data comes from information reported in Medicaid applications, but that MCOs collect their own information and are often able to update this information more readily after a member is enrolled. She explained that DMAS is in ongoing conversations with NCQA regarding requirements for sourcing of race/ethnicity data and will continue to ensure compliance with NCQA requirements while working to improve the accuracy of demographic information.

VI. Agenda for December 8 CHIPAC Meeting

The committee discussed the agenda for the next meeting December 8. Cariano listed topics members have expressed an interest in, including an update on children's vaccinations, a report on DMAS efforts to improve rates of well child visits for young children, an update on Cardinal Care, a follow-up on recently implemented maternal health projects and programs, a timeline for unwinding from the public health emergency, coverage options for immigrant children, and follow-ups on other previous presentations of the past year.

Mejia stated that it would be helpful to have information at the meeting about children's health-related budget requests and priorities. Gonzales suggested inviting guest speakers to discuss potential children's coverage expansions. Faruk suggested a later follow-up discussion on reducing children's behavioral health hospitalizations and disproportionate impact on foster youth.

VII. Public Comment

Cariano invited public comment before the committee but there was no public comment.

VIII. Closing

The meeting adjourned at 3:23 p.m.