

Medicaid Member Advisory Committee Meeting
Department of Medical Assistance Services
In Person and Via Zoom Videoconferencing

August 8, 2022 Minutes

Committee Members	DMAS Staff
Summer Sage	Sarah Hatton, Deputy of Administration
Ghadah Aljamali	Tammy Whitlock, Deputy for Complex Care Services
Karin Anderson	Christina Nuckols, Director, Strategic Communications
Olatunji Fakunmoju	Chethan Bachireddy, Chief Medical Officer
Geoffrey Short	Nichole Martin, Director – Office of Community Living (presenter)
Michelle Meadows	Brian McCormick, Director – Legislative and Intergovernmental Affairs
Elvira Prince	Natalie Pennywell (meeting organizer and facilitator)
Sabrina Redd	Walter Burton (meeting organizer)
Craig Thompson	Dalia Tejada Halter (meeting organizer)
	Kristin Lough (prepared minutes)
	Alyssa M. Ward, Ph.D., LCP, Behavioral Health Clinical Director (presenter)
	Sonya Scott, Zoom Administrator

Welcome and Call To Order

Natalie Pennywell called to order the meeting of the Medicaid Member Advisory Committee (MAC or Committee) at 10:09 a.m. on Monday, August 8, 2022, via Zoom online meeting platform. Ms. Pennywell explained that the meeting had a full agenda and emphasized that Committee members would have time to ask questions and share feedback during the meeting. She then introduced the DMAS Deputy of Administration, Sarah Hatton.

Welcome

Welcome – Sarah Hatton, DMAS Deputy of Administration

Deputy of Administration Hatton greeted the Committee and thanked the Committee for their participation in the virtual MAC meeting. She explained that Acting Director Cheryl Roberts was out, but that she would review the minutes after the meeting. Deputy Hatton thanked everyone for attending both in person and virtually, and indicated that the program would discuss Project Bravo, waivers, and behavioral health. Deputy Hatton turned the meeting back to Ms. Pennywell.

Member Introduction

Ms. Pennywell asked members to introduce themselves, indicate where they are in Virginia, and who they represent on the MAC. The committee members, residing in different regional areas from around the state, introduced themselves and stated who they are representing.

Review and Vote to Approve Minutes from Meeting on June 14, 2021

Each of the MAC members were provided a copy of the June 13, 2022, meeting draft minutes, and the draft minutes were also posted on the Virginia Town Hall website.

MAC member Karin Anderson made a motion to accept the draft minutes from the June 13, 2022, meeting. MAC member Geoffrey Short seconded the motion to accept the minutes. Ms. Pennywell offered the Committee the opportunity to provide objections or changes to the minutes. The Committee then voted to approve the minutes with a unanimous vote.

Presentation – Waiver 101

Nichole Martin, Director – Office of Community Living

Ms. Martin thanked members for participating in the MAC. Home and Community Based Services (HCBS) waivers are for long-term services and support (LTSS), also known as 1915(c) waivers, provided within the home and community rather than an institutional setting. Home and Community Based Services waivers allow the Medicaid program to waive certain requirements:

- State wideness (though not done in Virginia)
- Comparability of services – make services available to only certain groups of people who are at risk for institutionalization.
- Income and resources- provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent.

The state must:

- demonstrate that the waiver will not cost more than providing care in an institution.
- ensure the state will continue to protect the members' health and welfare.
- provide adequate and reasonable provider standards to meet the needs of the population.
- make certain that the services follow an individualized and person-centered standard of care.

To be eligible for a waiver, the individual must be Medicaid eligible, and they must meet the criteria for institutional level of care.

The Commonwealth Coordinated Care Plus (CCC+) Waiver serves all ages and does not have a waiting list; it is the largest waiver in Virginia and provides care in the home and community rather than in a nursing facility or other specialized care medical facility. Personal care, private nursing, respite, assistive technology and environmental modifications, and adult day care services are available through CCC+. The individual recipient must have a medical need for waiver services, and the medical need must meet the institutional level of care. CCC+ eligibility criteria: Individual must need a nursing facility, specialized care or long-stay hospital visit.

Medical professionals, while evaluating medical need, use the Uniform assessment instrument (UAI) to evaluate the individual's functional capacity, like activities of daily living, medical or nursing need, and imminent risk of placement.

Individuals can access waivers through their local Department of Social Services or Health Department when living in the community. While in the hospital, individuals can obtain screening through the hospital Social Worker or Discharge Planner. The screening team will screen the individual, discuss the type of care needed and available, and give a list of providers for the individual to contact and begin care.

Developmental Disabilities (DD) Waivers include three sub-category waivers, and there is currently a waitlist to obtain these waivers. DD Waivers provide employment and alternate day options, self-directed, residential, crisis support, medical and behavioral support, and additional options for recipients.

- The Building Independence Waiver currently serves 330 individuals and is available for adults age 18 and older living independently in their home or apartment. Often these individuals receive non-waiver-funded rent subsidies.
- The Family and Individual Support Waiver serves about 4400 individuals with a medical need who live with family or friends. There are no age limits for the Family and Individual Support Waiver.
- The Community Living Waiver serves about 11,700 individuals and includes residential supports and medical, behavioral, and non-medical supports. The Community Living Waiver is also available to individuals of any age.

To access DD waivers, all members must start through the Community Services Board (CSB), meet eligibility criteria including developmental disability diagnosis and the level of care as evaluated by the Virginia Individual Developmental Disability Survey (VIDES). Individuals must accept services within 30 days of offering, and be Medicaid eligible. If individuals meet these criteria, they go on a single waitlist that serves each of the three sub-categories.

The waitlist as of June 24, 2022, had 2,910 individuals in Priority I, who are projected to need services within a year. Priority II individuals should need services within 1-5 years, and there are 6,004 people on that list. Priority III individuals will need services in more than 5 years, and 4,912 individuals are in this group. The DMAS website has webpages for waiver information, and CCCPlusWaiver@dmas.virginia.gov is available for specific questions.

Questions presented by members included:

Karin Anderson asked if waivers included foster children, and Ms. Martin stated that it depends on the needs of the foster child. She also sought to confirm which program did not have a waitlist, and Ms. Martin answered that only CCC+ does not have a waitlist. Ms. Anderson inquired if the severity of the diagnosis or diagnoses helps move someone up the waiting list, and Ms. Martin indicated that was correct.

Craig Thompson noted that this presentation is helpful, and that in representing the unhoused population who had to receive therapy, including shock therapy, to understand the care they could receive upon discharge from the temporary therapy. He indicated that the wrap-around care options assisted individuals with care needs including coexisting intellectual disability and substance use disorder diagnoses.

Olatunji Fakunmoju requested information about the level of compliance for care and care coordination. How do you provide the community with the level of services needed within the community? Could the state help these individuals get placement in facilities while waiting for their position in the waiting list? Ms. Martin responded that the UAI scoring is a portion of evaluation, and when a slot becomes available, the CSB provides it to a person within their community according to highest need. Currently 16,000 slots are funded. DMAS must provide assurances to Centers for Medicare and Medicaid Services (CMS) regarding the care provided.

Sabrina Redd indicated that families in crisis in hospital services do not know how to access waiver services. Ms. Redd noted that her experience, though several years old, indicated a lack of knowledge from stakeholders that waivers exist, or even how to become eligible for waiver services. Families do not understand what it means to have nursing home level care needs, and Ms. Redd encourages DMAS to get information into communities about actual eligibility criteria, as well as information about how to get onto the waitlist or receive services.

Presentation – Behavioral Health Update: Project Bravo

Dr. Alyssa Ward, Clinical Director – Behavioral Health

Dr. Ward stated that, at DMAS, behavioral health used to cover only mental health, until DMAS added addiction treatment. Mental health is now referred to as “Project Bravo,” (Behavioral Health Redesign for Access Value & Outcomes). See <https://www.dmas.virginia.gov/for-members/benefits-and-services/behavioral-health/>. The Behavioral Health division hopes to bring the two parts together for whole-person care. Behavioral Health supports other decisions by interpreting and applying Medicaid policy, and by interacting with most divisions within DMAS as well as recipients and stakeholders. Magellan of Virginia helps the division to manage residential services, and the division oversees Magellan of Virginia for service authorizations and claims payments for fee-for-service recipients. The division writes policy, updates existing policy, manages state law and incorporates it into Medicaid policy.

DMAS is the largest payer of behavioral health services in Virginia and about one third of members receive behavioral health services. The nature of DMAS federal funding means that we also necessarily have to define and rationalize the services we pay for and how we pay for them in our state plan. Because of our sphere of influence as a payor, we work on nearly any implementation involving Behavioral Health services that happens in the system. We are always advocating for the needs of our members within the larger system, as well as simplification and ease of access in our complex system of care. Licensed health professionals are the only mental healthcare providers who can receive payment for care under most private health insurance providers. DMAS will pay qualified health professionals for some care.

When COVID occurred, technological utilization and enhancements allowed DMAS to increase care for individuals in many ways, including rolling out telehealth, including audio-only care, and YouTube videos. Providers indicated that telehealth increased care, attendance and engagement for recipients. The division wants to increase dedicated telehealth spaces, expand telehealth, and improve telehealth opportunities as people leave their homes post-COVID.

Project Bravo, which began in 2018, aims to provide holistic care outside of Community Services Boards and make sure it is financially sustainable. High Fidelity Wraparound is high-intensity care coordination serving a youth with highest needs. Virginia has been paying for High Fidelity Wraparound through a grant and CSAs, but there is no billing process through Medicaid. Bravo intends to create a Medicaid rate to increase providers and ensure payment is available for recipients. Bravo

should allow individuals to receive the level of care, and shift between different levels of care, that was not available in previous Medicaid models.

Bravo has introduced assertive community treatment, which is a team-based approach for high level care in the community; intensive outpatient care; partial hospitalization; and comprehensive crisis services. Comprehensive crisis services includes four levels – 1. someone to talk to, like 988 (crisis lifeline), for which DMAS does not pay for, 2. Someone to respond, like a mobile crisis response teams, 3. Community stabilization, also called a warm handoff, meaning the first provider shakes hands with the next provider for the individual recipient, and 4. Somewhere to stay, providing contained environments for 23 hours to give someone a place to re-center without entering or prior to entering residential treatment. Assertive community treatment also includes multi-systemic therapy and functional family therapy.

DMAS is experiencing the same workforce concerns that most industries have, where professionals are leaving positions. The future goals include service-learning collaborative projects to learn how things are working and to learn what members and providers need. It would also seek to build out the crisis system, which is the safety net to the safety net for needs; identify metrics and evaluation; and request budget increases to expand services for members. Ongoing programs include Project Bravo; Marcus Alert to remove police presence to crisis response whenever possible; the bed crisis, which has been ongoing for a decade, but increasing during COVID; 988, similar to 911, but for mental health, which is available with or without insurance; (System Transformation Excellence and Performance) Step-VA; and the Department Of Justice Settlement regarding DD services.

With a similar program, Arizona saw about 80% of crises were resolved via phone, and about 70% of mobile responses were resolved in the community. This led to few people resorting to hospitalization. Virginia has seen similar numbers. Objective: The development of a community-based, trauma-informed, recovery-oriented crisis system that responds to crises where they occur and prevent out-of-home placements. Dr. Ward hopes that Behavioral Health Urgent Care becomes a regular service option in the future.

Observations / Questions raised by Committee Members included:

Mr. Thompson, noting the impact upon members, shared that he is aware of medical providers who provide diagnostic testing to individuals, but then the providers do not provide written reports of the testing. He feels this is because there is no recourse for the medical provider not providing those reports. Response – individually, those professionals can be reported to the Department of Health Professions for failing to provide those written reports. Dr. Ward asked Mr. Thompson to speak more about the issues later.

Mr. Fakunmoju indicated that some providers, especially psychologists, would only provide reports to other medical professionals. Dr. Ward agreed that some providers would write a raw data report that remains in the file, but also write a plain language report to provide to the families. Mr. Thompson indicated that families would have to obtain the raw data and provide it to another provider to clarify the data for the initial provider. Dr. Ward indicated that the plain-English written reports are an expectation for payment and indicated that it is a concerning case and asked to speak to Mr. Thompson more about it after the MAC.

Mr. Thompson stated that providers prefer Magellan because they feel they receive higher pay with fee-for-service model rather than the Managed Care Organization model. Dr. Ward noted that MCO contracts pay fee-for-service rates as a minimum, and she would like to know more information about that preference.

Ghadah Aljamali stated that Project Bravo is a great program, but asked where holistic care providers and supplements fit into Project Bravo, because DMAS will not pay for that care. Dr. Ward indicated that Medicaid care continues to expand.

Ms. Anderson asked whether individuals receive continued care from DMAS during COVID, and then asked whether those individuals will receive assistance to obtain healthcare on their own. Response – not all of the closures will be bad closures, as some people will be able to afford healthcare. However, the unwinding will take about a year, and all individuals will have the opportunity to provide information to DMAS about their situation prior to any Medicaid closures.

Ms. Pennywell then opened the meeting to public comment.

Public Comment

Mr. Thompson thanked the MAC program for the opportunity to appear in person. Medicaid expansion has been lifesaving in many ways, and personally resulted in early detection of specific illnesses. The ability to access specialty practices at medical colleges, especially those not near the recipients' homes has been very beneficial to recipients. Medicaid expansion alleviates the stressors of Community Services Board care “donut hole” when moving between communities.

Ms. Pennywell thanked Mr. Thompson for his comment, and asked for additional public comment. Hearing none, Ms. Pennywell moved onto adjournment. Ms. Pennywell introduced Deputy Hatton for closing remarks.

Closing Remarks

Deputy Hatton thanked all members for joining and turned the meeting back to Ms. Pennywell to adjourn.

Adjournment

Ms. Pennywell thanked members for their participation and adjourned the meeting at 12:10 p.m.