REPORT OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Mobile Vision Clinics Pilot Recommendations (Chapter 552, Item 313.JJJJJJ., 2021)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 16

COMMONWEALTH OF VIRGINIA
RICHMOND
2021

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)
www.dmas.virginia.gov

October 27, 2021

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

General Assembly of Virginia

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Mobile Vision Clinics Pilot Recommendations

This report is submitted in compliance with the Virginia Acts of the Assembly – HB1800, Item 313.JJJJJJ. which states:

"The Department of Medical Assistance Services, shall convene a work group to plan for implementing a pilot program to provide mobile vision clinic services to Medicaid, FAMIS and MCHIP children in a school-based setting. The work group shall be comprised of Medicaid managed care organizations, mobile vision providers, school districts with and without these services, the Virginia Department of Education and others as appropriate. The work group shall determine the scope and design of the pilot program, including:

i. the referral process for initial and follow-up services
ii. who shall provide the services,
iii. how parents or legal guardians will be notified,
iv. the role of school districts and the Department of Education in screening and referring children to the program,
v. reimbursement rates for services that consider access, quality, and cost effectiveness of services provided,
vi. detailed cost estimates of the pilot program, and
vii. a mechanism for evaluating the pilot program

The Department shall report on the recommendations of the workgroup by October 15, 2021 to the Governor and General Assembly."

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK
Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Mobile Vision Clinics Pilot Recommendations

A Report to the Virginia General Assembly — *October 15, 2021*

Report Mandate:

313 JJJJJJ. The Department of Medical Assistance Services, shall convene a work group to plan for implementing a pilot program to provide mobile vision clinic services to Medicaid, FAMIS and MCHIP children in a school-based setting. The work group shall be comprised of Medicaid managed care organizations, mobile vision providers, school districts with and without these services, the Virginia Department of Education and others as appropriate. The work group shall determine the scope and design of the pilot program, including:

i. the referral process for initial and follow-up services
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vi. detailed cost estimates of the pilot program, and
vii. a mechanism for evaluating the pilot program

The Department shall report on the recommendations of the workgroup by October 15, 2021 to the Governor and General Assembly.

Overview of Mobile Vision Clinics Workgroup

As directed through Item 313 JJJJJJ., Chapter 1289, 2021 Virginia Acts of Assembly, the Department of Medical Assistance Services ("DMAS") convened a workgroup inclusive of mobile vision clinic stakeholders with the goal of developing a pilot proposal for children in the Medicaid program. These meetings were each an hour and a half in duration and were held on June 29th, July 20th, August 19th, and September 9th. Participants included representatives from each of the six Medicaid managed care plans (Aetna, Anthem, Molina, Optima, United, and Virginia Premier); the Department of Education ("DOE"); school districts (Roanoke, Albemarle, and Chesterfield counties); mobile vision clinic providers (Conexus, Vision to Learn); DMAS; managed care plan vision subcontractors (VSP, EyeMed); and pediatricians, optometrists, and ophthalmologists. In the initial meeting, workgroup participants were invited to submit feedback detailing preferences and considerations surrounding the pilot option, and this helped shape ongoing discussion. At the final meeting, participants were asked to provide final feedback on the pilot options (see Attachment D).

Medicaid and CHIP Vision Services and Delivery Systems

As of September 1, 2021 over 770,000 children are provided health care coverage through Virginia's Medicaid managed care programs. These programs

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 500,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

cover children across Medicaid and CHIP populations and are inclusive of a vision benefit that provides vision screenings, exams, and eyeglasses (with some limitations for the CHIP population). The majority of these children (~80%, 620,976) are eligible for the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit, which includes replacement eyeglasses and ongoing periodic screening requirements. Full EPSDT benefits are not available for the CHIP population. The Centers for Medicare and Medicaid Services (CMS) EPSDT guidelines state at a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.

Expenses surrounding the provision of covered vision services for Medicaid and CHIP children are factored into the capitation rates paid to managed care organizations (MCOs) on a per member per month basis. Also included in capitation payments as a covered service is non-emergency transportation for members, such as to visit an eye professional for vision services. MCOs also engage in a variety of care management activities in support of holistic member health and positive health outcomes.

All Virginia Medicaid MCOs subcontract with vision vendors (EyeMed, VSP, and March Vision) to manage their vision benefit, and these vision vendors enroll providers into their networks, negotiate reimbursement rates, and other carry out other administrative functions.

Vision benefits are detailed in § 8.2MM of the Medallion 4.0 contract and in the Attachment 5 of the CCC Plus contract. In recent years, the Medallion contract has added requirements surrounding increasing vision access and utilization for children, asking that the MCOs work to gradually increase screening and eye examinations rates for all children between the ages of three to eighteen (3-18) using the American Academy of Pediatrics' recommendations.

Mobile Vision Clinic Research

A recent Johns Hopkins Medicine article states that while roughly a quarter of children need glasses, in high poverty areas across the United States, as few as 5% of children who need glasses actually have them due to various logistical and transportation challenges (Setting Sights Higher: 50,000 Vision Tests and the Impact on Baltimore's Children, February 11, 2021).[1] According to a longitudinal study between Johns Hopkins education school and a Baltimore mobile vision clinic, the researchers purport they are able to demonstrate the positive impact glasses provide on academic achievement through the provision of school-based vision care. This study is currently in the process of being published.

In the 2015 Maternal and Child Health Journal article "Parent, Teacher, and Student Perspectives on How Corrective Lenses Improve Child Wellbeing and School Function," the researchers state that low-income and minority children are disproportionately affected by uncorrected poor vision.[2] The article details a qualitative evaluation of a Vision to Learn program in Los Angeles in which participants described significant stress related to uncorrected poor vision, underscoring the importance of addressing healthcare needs that might affect school performance. The researchers acknowledge that barriers to accessing corrective lenses are similar to those for other health services, but they state that school-based vision programs address many of those barriers that disproportionately affect low income and minority students. They further conclude that ensuring appropriate access to and use of corrective lenses is a simple and effective way for pediatricians to address health disparities.

Pandemic Impacts on Children's Vision

According to the June 1, 2021 Wall Street Journal article "The Pandemic Made Kids' Eyesight Worse, Doctors Say," the coronavirus pandemic has resulted in more children with new or worsening vision problems.[3] Eye doctors lay some of the blame on increased screen time, as they know that focusing up close and not being outside increased the rate of myopia.

Department of Education Vision Screening Requirements and Processes

Pursuant to § 22.1-273 of the Code of Virginia, public schools in Virginia are statutorily required to conduct student vision screenings at set intervals. With some exceptions, these screenings occur in kindergarten, and grades two, three, seven and ten as well as for all students new to the school district. Schools must schedule these screenings within the first sixty administrative working days of the school year.

The mandate for schools is to conduct initial vision screenings, which are different from clinical eye assessments, and to identify children in need of a referral to an optometrist or ophthalmologist. School vision screenings are either performed using vision

charts or an approved digital photo-screening method. Individual school districts have authority over how they provide mandated vision screenings. School nurses frequently perform the screenings, however some schools partner with non-profits such as the Lions' Club or Conexus to help complete the screenings. Additionally, schools may use their PTA or partner with a local school of nursing to help complete the screenings. Whenever a student does not receive a passing result on the screening, parent(s) or guardian(s) are required to be notified in writing. Some schools include with this notice a list of eye professionals, as well as any supplementary information recorded through the screening.

After schools complete their required screenings and inform the parents of their child's results, it is up to the parent(s) or guardian(s) to obtain eye examinations and any additional treatments. Some school districts, however, enter into contracts that provide access to follow-up eye examinations through a mobile vision van. Such programs partner with optometrists to conduct non-dilated vision assessments and provide eyeglasses or vouchers for children identified as having a vision deficit. While dilated vision exams are considered the standard of care and essential to a comprehensive eye exam, the dilation procedure (eye drops) can be difficult to administer with children in the school setting, and the post-exam blurred vision can last for several hours after the exam. For these reasons, participating schools often choose non-dilated exams.

Recommended Mobile Vision Clinic Pilot Proposal

In developing a pilot proposal for mobile vision clinics, the following foundational goals were identified: 1) increasing access to vision services for children in underserved areas across the Commonwealth to address disparities, 2) working within the context of existing Department of Education processes and Medicaid authorities, and 3) developing an evaluation component informing the potential to scale the mobile vision clinic program statewide in the future.

To accomplish these goals, DMAS recommends that an initial two year pilot program be funded for one to three mobile vision service providers. Approved providers would be able to meet defined baseline service requirements in urban and rural localities defined by DMAS in conjunction with the Virginia Department of Health (VDH), as underserved. The pilot program will be reviewed by an external evaluator and compared across localities lacking mobile vision services in schools. To support the implementation of a mobile vision pilot, DMAS submitted a budget decision package for the Managed Care Organization (MCO) Proposal option detailed in this report.

Managed Care Organization (MCO) Proposal

To accomplish the initial two year pilot program, DMAS recommends that the General Assembly allocate state general funds to be competitively awarded by DMAS, through an RFP process, to subsidize the operational costs of a mobile vision clinic at target schools and to provide services to all referred children regardless of insurance coverage throughout the pilot period. General fund dollars supporting pilot program infrastructure would be supplemented by Medicaid reimbursement of eligible covered services to selected providers. It is recommended that, timing and resource-dependent, the RFP process selects providers to begin the 2022-2023 academic year.

Referral Process for Services

As this pilot option could be partially funded outside of the state Medicaid agency, referrals into this pilot program would not be limited to Medicaid or CHIP-eligible children and include all students at target schools that have been identified through initial Department of Education mandated screenings as needing a follow-up vision appointment.

Service Provider Requirements

Following review of Centers for Medicare and Medicaid Services (CMS) requirements surrounding potential Medicaid reimbursement of mobile vision services offered in a school setting and a 2016 Request for Proposal to provide mobile vision services at Chicago Public Schools in Illinois through the Department of Public Health and discussions with Department of Education staff and DMAS-contracted managed care plans, DMAS recommends the following provider requirements for this pilot option:

1) Documentation of existing agreements with at least one urban and one rural school district in localities designated as under-resourced due to constraints such as a transportation, geographical barriers, or a limited network of Medicaid-participating optometrists and ophthalmologists.
2) Capacity to provide a comprehensive vision exam in compliance with recognized clinical standards that is conducive to a school setting. The exam must be inclusive of a thorough inspection of the optic nerve, macula, vascular

tree and retinal surface with either a fundus lens and biomicroscope, a binocular indirect ophthalmoscope, and/or a wide-angle retinal imaging system (See Attachment A: Elements of a Comprehensive Eye Exam & Attachment B: Equipment List for Comprehensive Eye Exam).

3) Completion of successful enrollment into the Medicaid program and credentialing and enrollment with Virginia's Medicaid managed care health plans (See Attachment C: Mobile Vision Provider Credentialing Process).
4) Administrative infrastructure necessary to coordinate with school systems, determine insurance eligibility for children serviced, bill individual MCOs for services rendered to eligible children, provide referrals to ophthalmologists (when necessary), provide education and care instructions to students and families, and report data as required for reporting purposes.
5) Evidence of program sustainability after the conclusion of the pilot program and that the pilot project can be replicated (scalable) statewide.

Parent and Legal Guardian Notification

When possible, the workgroup recommends that mobile vision clinic providers work with participating school districts to develop opt-out processes for parents or guardians related to consent for a child's participation in the program. Opt-out processes have been demonstrated to increase program participation in existing mobile vision programs and reduce the administrative burden on schools related to follow-up, however opt-in processes might be necessary related to identifying Medicaid coverage to bill for enrolled children. The selected provider(s) would also be required to develop and disseminate follow-up and educational materials for parents or guardians.

If a selected mobile vision clinic provider is a qualified non-profit organization, and is also contracted by the school district to do the initial vision screenings, then it is subject to additional statutory responsibilities surrounding requirements for communication following the vision screening. According to Va. Code § 22.1-273, such organizations must inform parents of the results in a relevant and informative format designed to increase parental awareness and encourage attention. The parents should also receive information regarding follow-up resources related to eye examinations and eyeglasses. The selected mobile clinic provider(s) will be responsible for providing to parents or guardians the written results of the exams as well as any accompanying documentation/education.

Role of School Districts and DOE in Screening and Referring Children to the Program

This pilot program will align with existing state requirements that schools screen both children in kindergarten, 2nd or 3rd, 7th, and 10th grades, as well as children new to a school district. Under this pilot program, school districts would continue their regular processes for mandated vision screenings, and based on the results of these initial screenings, refer children in need of a secondary assessment to the mobile vision clinic.

Reimbursement Rates for Services

Through this pilot proposal, mobile vision clinics are responsible for facilitating data matching activities in order to identify Medicaid and FAMIS eligible children and bill their assigned MCOs for eligible services provided. Beyond Medicaid reimbursement, an additional subsidy would be provided to cover the cost of services to uninsured or underinsured students, as well as cover the general administrative and operational costs connected with mobile service provision. Medicaid reimbursement rates would be negotiated between MCO vision vendors and the selected mobile vision clinic(s), and are factored into existing MCO capitation payments.

Services eligible for Medicaid reimbursement include vision exams, eyeglasses (components that were not donated to the clinic), and fittings. The program will require clinics to submit to DMAS utilization information regarding donated eyeglasses and/or their components given to Medicaid children.

For children requiring eyeglasses, two pairs will be provided so that one pair may remain in the classroom. The provider must offer a minimum range of frames in multiple colors from which the students may choose, and the provider must conduct fittings for the students when eyeglasses are delivered.

Cost Estimates of the Pilot Program

This pilot aims to serve a minimum of 5,000 children and a maximum of 15,000 children across mobile vision clinic providers for each year of the pilot program. Funding is needed over the two years of the pilot to cover the ongoing costs for:

- One FTE to coordinate and manage the pilot program;
- External evaluation of the pilot program findings and outcomes; and,
- Stipend to cover both operational expenses and reimbursement for eye exams, eyeglasses, and

fittings for children lacking Medicaid or FAMIS coverage.

Mechanism for Evaluating the Program

To understand the feasibility of ongoing reimbursement for mobile vision clinic services, DMAS will contract with an external evaluator to develop a report inclusive of, but not limited to, the following: 1) number of students served and services rendered, 2) comparisons between participating students in rural and urban localities and students in rural and urban localities without a mobile vision clinic, and 3) satisfaction survey results. Findings from this evaluation will help determine the extent to which the goals of the pilot have been met or not met and considerations for potentially expanding this program in future years.

CMS Considerations for the Managed Care Organization (MCO) Proposal:

Health Services Initiatives (HSI) funds are a CHIP resource that states such as Delaware have deployed to help support Medicaid mobile vision clinic activities by covering the costs of services to uninsured children. Even though HSI funds may not be used to pay for services that are covered by insurance, including Medicaid or CHIP, DMAS is aware of this resource. DMAS first explored the use of HSI funds to support the mobile vision clinic efforts of Vision to Learn (now Conexus) in 2018, though this project was tabled due to internal capacity issues arising out of the state's authorization of Medicaid Expansion. Seeing HSI funds in Virginia have already been allocated towards statewide poison control efforts and the FAMIS Prenatal Benefit, MCO reimbursement is the most feasible option.

Other Considerations for the MCO Proposal:

Under Virginia law, schools operate independently and the Department of Education cannot require schools to contract for mobile vision clinic services. The mobile vision provider(s) will need to execute separate agreements with each participating school throughout the duration of the pilot. Additional local and state level DOE resources might be needed to develop MOUs or other agreements if the pool of mobile vision clinic providers lacks existing relationships with both urban and rural localities identified as underserved for the purposes of this pilot.

There is also a conflict in preferences for the provision of vision assessments; in order to bill Medicaid for a comprehensive eye exam clinical standards mandate dilation of the eye, however dilation would require extending time students spend out of the classroom and poses administrative challenges. Solutions to this issue include use of wide angle technology that bypasses the need for dilation, or billing for procedure codes that are not inclusive of a dilated eye exam.

Additionally, this pilot proposal requires coordination and data matching between DMAS, DOE, and the mobile vision clinic provider to determine Medicaid eligibility of children served through the program and identifying which of the six Medicaid managed care plans eligible children are enrolled with for billing purposes. The workgroup has learned through Vision to Learn's experience nationally that ongoing facilitation of data matching and eligibility determination activities, as well as proactively obtaining insurance information on permission slips from parents as an alternative, can be challenging.

Mobile Vision Clinic Pilot Alternatives

Fee-For-Service (FFS) Reimbursement Under Existing Procedure Codes:

As a second potential pilot option, DMAS recommends that mobile vision clinic providers bill Medicaid FFS under existing procedure codes for vision services. This option would require identifying appropriate codes for services rendered to ensure comparability of services across providers, with a place of service modifier indicating the school as the location for services. Through this pilot option, mobile vision providers can bill for fittings and the acquisition of frames and lenses not donated by a third party. They can also bill Medicaid for vision assessments, using the proper codes and modifiers to differentiate between non-dilated eye exams and comprehensive eye exams.

Referral Process for Services

Children in participating school districts who do not pass their in-school mandated vision screening will be referred to the mobile vision clinic, which will conduct a secondary assessment to determine their need for glasses. Mobile vision clinic service providers will also be expected to have a process to provide additional referrals to ophthalmological services, as needed, with notice to the parent(s) or guardian(s) and Medicaid health plan (if applicable).

Service Provider Requirements

1) Documentation of existing agreements with school districts in localities designated as under-resourced due to constraints such as a transportation, geographical barriers, or a limited

network of Medicaid-participating optometrists and ophthalmologists.

2) Completion of successful enrollment into the Medicaid program and credentialing.
3) Administrative infrastructure necessary to coordinate with school systems, determine insurance eligibility for children serviced, bill DMAS for services rendered to eligible children, provide referrals to ophthalmologists (when necessary), provide education and care instructions to students and families, and report data as required for reporting purposes.
4) Evidence of program sustainability after the conclusion of the pilot program and that the pilot project can be replicated (scalable) statewide.

Parent and Legal Guardian Notification

Based on mobile vision clinic experience in other states, the workgroup recommends that where possible, mobile vision clinic providers work with participating school districts to develop opt-out processes for parents or guardians related to consent for a child's participation in the program, instead of an opt-in process. The goal of an opt-out process is to help maximize program participation and reduce the administrative burden on schools, however opt-in processes might be necessary related to identifying Medicaid coverage to bill for enrolled children.

If a selected mobile vision clinic provider is a qualified non-profit organization and is also contracted by the school district to do the initial vision screenings, then it is subject to additional statutory responsibilities surrounding requirements for communication following the vision screening. According to Va. Code § 22.1-273, such organizations must inform parents of the results in a relevant and informative format designed to increase parental awareness and encourage attention. The parents should also receive information regarding follow-up resources related to eye examinations and eyeglasses. The selected mobile clinic provider(s) will be responsible for providing to parents or guardians the written results of the exams as well as any accompanying documentation/education.

Role of School Districts and DOE in Screening and Referring Children to the Program

This pilot program will align with existing requirements that DOE screen both children in kindergarten, 2nd or 3rd, 7th, and 10th grades as well as children new to a school district. Under this pilot program, DOE and school districts would continue their regular processes for mandated vision screenings, and based on the results of these initial screenings, refer children in need of a secondary assessment to the mobile vision clinic.

Reimbursement Rates for Services

DMAS recommends funding to reimburse mobile vision clinic providers for vision assessments and eyeglasses using existing fee-for-service rates for Medicaid-enrolled children. The program will require clinics to submit to DMAS utilization information regarding donated eyeglasses and/or their components given to Medicaid children. The clinics shall not receive Medicaid funds for vision screenings as those services are provided through the Department of Education.

This pilot proposal has the potential to result in duplicate payments for vision services as a comprehensive children's vision benefit is already included in MCO capitation payments. As of September 2021, 98.5% of Medicaid and FAMIS children are enrolled with a MCO. As it would be a challenge to back out school-based vision services from capitation payments, DMAS would need to work with CMS to identify alternative means to reimburse for mobile vision services under fee-for-service and still be eligible for Federal Financial Participation (FFP) to receive the federal match. To monitor school-based claims and remove some payment duplication, DMAS would update its SFY23 managed care contract to exclude payments for vision services provided where school is the location of the service, requiring mobile vision clinics to use a place of service code or modifier to identify school-based vision claims.

The workgroup also recommends allocating state-only funds to cover costs related to mobile vision clinic exams and eyeglasses provided to children outside of the Medicaid and FAMIS programs.

Cost Estimates of the Pilot Program

Mobile vision clinic providers will be tasked with facilitating comprehensive vision assessments and providing a wide range of available eyeglasses for children referred to the program. The goal is to provide services to between 5,000 and 15,000 children each year of the pilot program.

For children requiring eyeglasses, two pairs will be provided so that one pair may remain in the classroom. The provider must offer a minimum range of frames in multiple colors from which the students may choose, and the provider must conduct fittings for the students when eyeglasses are delivered.

Funding is needed over the two years of the pilot to cover the ongoing costs for:

- Reimbursement for eye assessments, eyeglasses, and fittings;
- Up to two full-time DMAS employees to coordinate with CMS, manage the pilot program, and prepare and submit state plan amendment(s) and regulatory change(s);
- Contract modifications for external evaluation of the pilot program.

Prior utilization from a metro-Richmond area mobile vision clinic is instructive in providing a model for cost estimates. A 2021 analysis of the Conexus Mobile Clinic conducted by Virginia Commonwealth University's School of Medicine reflected a referral rate close to 1/3 of students screened at select schools in the metro Richmond area between 2018 and 2021. In other words, close to one third of the students screened for vision deficits needed a referral to an eye professional for further diagnosis. The Conexus Mobile Clinic saw a large percentage of those students referred out from their vision screenings, and roughly 78% of those students needed eye glasses or a referral outside of the clinic. Thus, a majority of the students who received vision services from the mobile clinic received eyeglasses or a referral for additional examination.

Mechanism for Evaluating the Program

To understand the feasibility of ongoing reimbursement for mobile vision clinic services provided in the school setting, DMAS will contract with an external evaluator to develop a report inclusive of, but not limited to, the following: 1) number of students served and services rendered, 2) comparisons between students participating in the pilot and those without access to a mobile vision clinic, and 3) satisfaction survey results. Findings from this evaluation will help determine the extent to which the goals of the pilot have been met or not met and considerations for potentially expanding this program in future years.

CMS Considerations for FFS Reimbursement Under Existing Procedure Codes:

DMAS consulted with CMS to see if they have approved Mobile Vision Clinics in other states that use a fee-for-service model based on either bundled payments for vision services or separate reimbursement for each vision service. CMS shared that CMS has not approved a mobile vision clinic, specifically, and that generally for a mobile vision clinic pilot program that the state should ensure the services comport with 42 CFR § 440.120(d) the Medicaid eyeglasses benefit.

As Virginia is already receiving matching federal funds for vision services provided through its managed care program, fee-for-service reimbursement of mobile vision services might not be eligible for FFP and require financing through state-only funds. These services cannot be carved out of the managed care plan costs because a provider would be serving children in a fraction of schools in a specific area, especially considering that the pilot would not be providing services to all Medicaid and FAMIS children (only those in target schools) and do not provide the full range of EPSDT vision services in accordance with EPSDT regulations.

Other Considerations for FFS Reimbursement Under Existing Procedure Codes:

Clinical Standards for Vision Assessments: Throughout workgroup discussions it has been identified that Conexus does not utilize dilated eye exams in its school-based vision clinics, and that schools also prefer non-dilated eye exams as a means to limit out-of-classroom time. Comprehensive, dilated exams are the clinical standard, and many students receiving mobile vision services might still need to be referred to an ophthalmologist or optometrist to obtain a comprehensive eye exam.

MCO infrastructure: Virginia's Medicaid program has evolved to be largely managed care as MCOs have the resources and capacity to actively monitor utilization of services, provide follow-up and referral resources where needed, and holistically monitor member healthcare needs. As this pilot proposal operates outside of existing managed care infrastructure, additional coordination and data sharing agreements would be required for MCOs to monitor and track members receiving school-based vision services. For instance, under current school-based vision screening practices, MCOs do not receive notice of member children who do not pass school-facilitated vision screenings.

Summary of Additional Pilot Option Research

In addition to the above pilot options, the workgroup explored additional options for a pilot program to provide mobile vision clinic services to Medicaid, FAMIS, and MCHIP children.

The first of these options considered the use of a global FFS mobile vision clinic procedure code specific for services provided within the school setting. This option would have required DMAS to contract with its actuary to conduct rate development and submit a state plan amendment to CMS for approval. Another option

considered using state general fund dollars to directly subsidize the cost of contracting with mobile vision clinic providers and to supplement existing funding for vision screening services. Services under that option would not be eligible for federal financial participation. A third option considered funding the mobile vision clinic through charitable donations. Many mobile vision clinics receive in-kind donations from eyeglass and lens companies, and MCOs and vision vendors also have charitable foundations. As previously discussed, use of HSI funds was also investigated to subsidize the cost for mobile clinic vision services for children not enrolled in Medicaid or FAMIS.

Lastly, the workgroup discussed using a Section 1115 demonstration waiver to implement the pilot program. Section 1115 of the Social Security Act provides the ability for experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Certain provisions of Medicaid law are waived to give states the flexibility to design and improve their programs. The Department's research and conversations with CMS indicate that an 1115 waiver would be administratively burdensome and resource intensive. An 1115 waiver would involve high administrative costs, additional staffing, MES/IT changes, costs associated with CMS oversight, financial and actuarial costs, and reporting costs. These costs are prohibitively expensive, and it would be difficult to demonstrate budget neutrality seeing comprehensive vision services are already provided to children under Virginia's State Plan.

[1] Amy Entwisle, Setting Sights Higher: 50,000 Vision Tests and the Impact on Baltimore's Children, Johns Hopkins Medicine (February 11, 2021), https://www.hopkinsmedicine.org/news/articles/setting-sights-higher.

[2] Rebecca N. Dudovitz et al., Parent, Teacher, and Student Perspectives on How Corrective Lenses Improve Child Wellbeing and School Function, Maternal & Child Health Journal, December 2, 2015.

[3] Sumathi Reddy, The Pandemic Made Kids' Eyesight Worse, Doctors Say, Wall Street Journal, June 1, 2021.

Attachment A: Elements of a Comprehensive Eye Exam

Comprehensive eye exams are critical, not only to correct and preserve vision, but also for the early detection of systemic disease. The following elements are required for all comprehensive eye health examinations.

Element 1: Reason for Visit
What is expected: The member should be directly questioned as to why they presented for the encounter. The member should also be asked about issues with their eyes and vision or other problems that may be related to the visual system. The answers to these questions should be documented in the medical record.

Element 2: Review of Systems
What is expected: Each of the following systems should be queried and the members' response recorded. For all positive responses, additional questioning may be indicated. • Cardiovascular • Constitutional • Endocrine • Gastrointestinal • Head • Hematologic/Lymphatic • Immunologic • Integumentary • Musculoskeletal • Neurological • Psychiatric • Respiratory

Element 3: Medications and Allergies
What is expected: Medication name and dosage for all drugs or supplements the member is taking should be recorded. If no medication, this should be indicated on the chart as none and not left blank.

For allergies related to medications, the name should be listed as well as the adverse effect the member experienced. If the member experiences environmental or food allergies, these should be noted as well. If no allergies are reported, the chart should indicate this.

Element 4: Ocular History; Family History; Orientation, Mood and Affect
What is expected: A detailed list of the member's previous eye problems and procedures should be listed. The family history should query medical problems including diabetes, hypertension, thyroid problems and cancer in addition to eye problems such as cataracts, glaucoma, and macular degeneration. The members should be asked if they know the day, date and their current location. The clinician should note the validity and assess whether the member's mood or affect is normal or abnormal.

Element 5: Entering Visual Acuity at Distance and Near
What is expected: A measurement of visual acuity both uncorrected and with the member's habitual correction should be performed at both distance and near.

Element 6: Entering Tests, Including Vital Signs and External Examination
What is expected: Measurement of height, weight, body mass index, blood pressure (for members age 13 and older), pulse, testing of pupil response, direct, consensual, swinging flashlight, extra ocular muscle testing, cover test, visual field, confrontation or, automated test.

Element 7: Refraction
What is expected: The refraction is the subjective test that allows for the member's visual perception of the physical refractive error. Auto-refraction, by itself, is not an acceptable measurement

Element 8: Near Point Testing
What is expected: Testing may include measurements of accommodation and/or convergence as well as additional testing as determined by the provider (e.g. evaluation of saccadic eye movements).

Element 9: Current Optical Prescriptions
What is expected: The current glasses prescription should be measured and recorded in the refractive testing area.

Element 10: Corneal Curvature
What is expected: The measurement should be recorded in the refractive testing area when indicated.

Element 11: Bio-microscopy
What is expected: Use of the slit lamp biomicroscope to inspect all anterior segment eye structures including the lids and lashes, tear film, cornea, anterior chamber, angle grade, iris and lens. The documentation must be individualized based on the findings of the examination. Cloned language in electronic health records should be carefully reviewed and revised to be consistent with the rest of the documentation in the record.

Element 12: Intraocular Pressure
What is expected: The type of instrument used as well as the time of measurement should be included with the numerical finding.

Element 13: Optic Nerve Head Evaluation
What is expected: The optic nerve must be visualized, and details recorded at each visit. The details of the evaluation of the Optic nerve should include all aspects of the nerve itself, including cup to disc ratio, disc margin, disc size, color, thickness and vessel caliber. The exam may be performed with a minimum of a fundus lens, or a direct ophthalmoscope, indirect ophthalmoscope, or photographically.

Element 14: Dilated Fundus Examination
What is expected: A thorough inspection of the optic nerve, macula, vascular tree and retinal surface with a fundus lens and biomicroscope, a binocular indirect ophthalmoscope and/or a wide-angle retinal imaging system. Document the method of examination. Although retinal imaging is acceptable in some cases, it is not a substitute for a binocular physical retina examination. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.

Element 15: Diagnosis
What is expected: These can be a refractive diagnosis such as Myopia, Astigmatism, Emmetropia, Hyperopia, or Presbyopia or medical eye diagnoses such as Cataract, Corneal Dystrophy, Choroidal Nevus or Glaucoma. Pertinent systemic medical diagnoses such as diabetes should also be listed.

Element 16: Assessment, Management and Treatment Plan
What is expected: In this section, the provider should summarize the overall examination, and clarify the points that need to be managed. The treatment/management plan should spell out the steps to be taken to address the chief concerns identified in the clinical findings. In healthy members, this can be as simple as, “Normal Exam, return in 1 year for re-examination.” For a member with refractive error, the verbiage can include the diagnosis and be stated as “Myopia, order glasses to be used for distance only, return in 1 year.” For members with pathology, this section should be more specific and address member education, glasses, contact lenses, low-vision aids, medications prescribed with directions for use, referrals, recommended testing, time frames and follow-up schedules. Other clinicians, reviewers, and any party evaluating this clinical encounter will look to this section to determine the important clinical points of the case and identify the plan of action and recommended follow-up.

Element 17: Legible Records

What is expected: Records that are easily deciphered, following a consistent examination sequence, that are complete and document all findings, clinical decisions and any continuity of care recommendations. If using electronic medical records, it is important to review any “pre-populated” and/or “cloned” default data for accuracy, attest to the doctor personally reviewing history and medications and review all recorded data to ensure it reflects the examination findings and recommendations. A signature is required on all charts, if electronic it needs to be time and date stamped.

Attachment B: Equipment List for Comprehensive Eye Exam

1) Visual Acuity Testing Charts
    - Distance
    - Near
2) Color Vison Plates
3) Stereo Plate
4) Hand Equipment (Occluders, Saccade/ Pursuit targets, PD stick, Maddox rod, Prism bars, Flippers)
5) Blood Pressure Measuring Device
6) Height and Weight Measuring Device
7) Keratometer
8) Lensometer
9) Refractor
    - Phoropter or Trial Frame and Lens
10) Biomicroscope (Slit Lamp)
    - Slit lamp condensing lenses (78, 90)
    - Gonio lenses
11) Tonometer
12) Ophthalmoscope (Direct and Indirect)
    - Condensing lenses (20. 28)

Attachment C: MCO Streamlined Mobile Vision Provider Credentialing Process

CAQH ProView
CAQH ProView will be used to obtain necessary information to complete credentialing. The use of CAQH ProView will expedite the credentialing process as well as decrease the amount of paperwork. Electronic submission of required documentation is mandatory.

Up-to-date versions of the following items are needed on CAQH ProView:

1. CAQH Application Release to MCO (Managed Care Organizations)
2. CAQH Attestation within the last 3 months;
3. Certificate of Insurance showing Professional Liability Coverage (malpractice insurance);
4. State License including Diagnostic Pharmaceutical Agent (DPA) License or Therapeutic Pharmaceutical Agent (TPA) License;
5. Copy of DEA and CDS (if applicable);
6. Board Certification (if applicable);
7. Vitae/Resume, including work history (only needed for initial credentialing).

Supplemental Documentation Requirements

1. Proof of vendor's ability to bill Medicaid (and/or MCO); and deliver services based on Medicaid reimbursement model.
2. Internal Revenue Service 501c (3) tax exempt determination letter as applicable
3. Copy of vendor's Articles of Incorporation
4. Copy of the vendor's most recent financial statement
5. If vendor received $500,000 or more in federal funds during fiscal year, submit a copy of the relevant audit.
6. Reference letters for all community eye referral sources vendors intend to use.

Mobile Unit Requirements

1. Summary list of mobile vision equipment necessary to complete a comprehensive eye examination.
2. A valid driver's license showing the driver to be at least 18 years of age.
3. An MVR (Motor Vehicle Record) from the DMV showing no more than two chargeable accidents or moving violations in the last three years, no more than (-2) DMV points, nor can their driver's license have been suspended or revoked for moving traffic violations in the previous five years.
4. A criminal background check showing no conviction of any crime as defined in VA Code 37.2-314(B)
5. All vehicles shall be equipped with a working fire extinguisher (Class A, B, C) that is secured within easy reach of the driver.
6. Vehicles must comply with all applicable laws, regulations and ordinances of

federal, state and local agencies in the jurisdictions in which the vehicles are used.

7. All vehicles must be titled and licensed by the Department of Motor Vehicles.

Medicaid ID Requirement
Per Federal Rule 42.CRF 438.602 the 21st Century Cures Act requires billing, rendering and prescribing providers be enrolled with their State Medicaid agency in order to receive payments from managed care plans.

Credentialing Process
Upon receipt of all NCQA, federal and state requirements, including data, licenses and certificates are electronically confirmed by the applicable regulatory agencies. The provider's complete credentialing documentation is forwarded for review and consideration.

- If consideration is favorable, the provider is approved.
- If the consideration is not favorable, the information is returned with recommendations for further review.

Re-Credentialing Process
All providers are re-credentialed every three (3) years. All NCQA, federal and state requirements are re-verified. Documentation received is presented for review and consideration. A Provider Services Agreement will stipulate automatic yearly renewal. The provider must forward a current photocopy of his or her yearly state license renewal and malpractice insurance to MCO vision vendor on an annual basis. Failure to provide updated information may affect claims payments. Membership in good standing is re-confirmed.

MCO Credentialing Process
Health plans may perform Primary Source Verification on their own or in parallel. In order to comply with any state and/or health plan specific policies, vendor may be required to provide all pertinent credentialing documents on more than one occasion.

National Provider Identifier
In accordance with 45 CFR § 162.410, providers rendering services are required to have a National Provider Identifier.

Disclosure of Criminal Conviction, Ownership and Control Interest
In accordance with 42 CFR, Part 455, Subpart B and as required by CMS, individual physicians and other healthcare professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest, prior to payment for any services rendered to Medicare or Medicaid enrollees.

Prior to participation, all potential providers must accurately complete and sign a Disclosure of Ownership and Control Interest Statement Form. This information must also be provided within **thirty-five (35) days** of a request for the information. If a provider or health care professional is a member of a group practice, both the individual

member and group practice must submit a signed Statement attesting to the requirements under these regulations.

In compliance with federal regulations, providers may experience suspended payments if providers fail to comply and have not submitted valid and complete disclosure of information as required.

Verification of Information
Providers are required to verify the accuracy of their information included in the MCO's provider directory on a quarterly basis per CMS.

Attachment D: Stakeholder Feedback on Pilot Options

DOE Comments to Mobile Vision Workgroup

DOE/Schools have limited capacity to support options listed by this workgroup. DOE/School divisions meet their legal requirements for vision screening in schools.

School utilize local community resources to provide support to students/families who have failed school related screening. This service is FREE. Vouchers for eye exams and glasses are readily available in most school communities.

For the options listed below clear communication is essential to the success of any option moving forward.

- What is the school's role, mobile vendor?
- Who is going to be responsible to get all the moving parts and pieces: parental consent?
- What happens with non-Medicaid students receiving services?
- How will Medicaid and non-Medicaid students be identified?
- Communication has to be clear and concise; what it is and what it is not.

Option A:	Doesn't identify vision services that schools may do or what vendors may provide. If Medicaid will only reimburse a portion of the vision services bill, will the school be responsible for the balance? Example: If the actual coast of examination/eyeglasses for students is $150, the reimbursable rate may be a percentage of the actual cost, leaving schools to absorb the deficit.
Option B: MCO proposal	**This has the least fiscal impact on schools. Payment bypasses schools**
Option C: Bundled payment	If schools are contracting with these
Option D:	Slide 11 (#3) Incorrect Statement *DOE already covers and pays for vision screening in schools.(language)* Mandated vision screenings are required for students in KG, 2 or 3rd grade and 7 and 10th grade. DOE does not pay for any vision screening. Trained school health staff, community groups such as lions Clubs, volunteers conduct this screening in each school community.
Option: F Use of Health Services Initiative Funds	Barriers include determining who is enrolled in FAMIS

MCO Feedback through Virginia Association of Health Plans

Column1	Column2	Column3	Column4
	FFS & Bundled FFS (Conexus Proposal)	**MCO Proposal**	**General Funds/Charitable/HSI**
Works with Existing MCO Platform in Virginia Under the 1915 (b) Waiver	no	yes	no
Vision Already Included in MCO Rates	no	yes	no
Whole Person Medical Model in Place	no	yes	no
Referrals for Specialist Care	no	yes	no
Meets Medical Standard of Care for Eye Exams	no	yes	no
Sustainable Approach with Current Funding	no	yes	no
Scalable to a Statewide Approach	no	yes	no
RFP Process to Include Multiple Competing Mobile Vision Providers	no	yes	no
Mobile Vision Providers Credentialed & Bill via MCOs	no	yes	no
Adds Significant New Costs	yes	no	yes
Duplication of Services	yes	no	yes
Needs CMS Approval	yes	no	no
Has Been CMS Approved in the Past	no	yes	n/a
MCO Charitable Contributions if providing a covered service	no	n/a	no
Addresses Increasing Well Checks for Children	no	no	no
Supports and ensures care coordination	no	yes	yes

Conexus Feedback on Workgroup Pilot Proposals

Thank you for the opportunity to comment on the DMAS Mobile Vision Clinic Workgroup's pilot options. Conexus appreciates DMAS's efforts to plan for implementing a pilot payment process to provide mobile vision clinic services to Virginia's Medicaid and FAMIS students as directed by the General Assembly. We are pleased with your support for helping to improve access to children needing vision services and to see increased utilization of vision services. We are committed to strengthening educational opportunities through healthy vision and look forward to DMAS's recommendations to implement a *payment* pilot that enhances children's access to and utilization of vision services and treatment.

Over the last two years, Conexus delivered its vision screening program to nearly 114,000 students identifying more than 35,000 students in need of follow up vision care (31%). In some Title I schools the rate is even higher with close to 40% of students needing vision correction. Ten years of data collected from Conexus and studied by VCU faculty and students confirms that uncorrected vision disproportionately affects communities and children of color. **Accessibility to follow-up vision care in these communities is challenging and students often are not able to easily access follow up care. Available data indicate that only 5-7% of Medicaid enrolled children in the Richmond area accessed their vision benefit in a given year.** A recent telephone survey conducted of vision providers in the Richmond area indicated that a number of practices and providers listed as part of managed care organization vision networks do not currently accept Medicaid patients.

Conexus recognized accessibility as a barrier to follow-up vision care and through more than $800,000 in private funding over three years developed, piloted, and implemented mobile vision clinic services. From 2018-2020, the clinics have delivered 3,700 school eye exams and glasses (if prescribed) to students in Richmond and Petersburg City schools and Chesterfield County Title I schools. The Conexus mobile vision clinic has achieved 99% program utilization in both Chesterfield Title I and Petersburg City schools, a nearly unheard-of accomplishment in the Medicaid community. Fortunately, Conexus can continue mobile vision services for the 2021-2022 school year as school divisions are using one-time COVID-related federal funds to provide the clinic services for their students.

This workgroup was intended to help address reimbursement for Medicaid enrolled children as private philanthropy is not a long term solution to pay for benefits these children are entitled to - even though they are not accessing them. It is imperative that the pilot program ensures a sustainable payment mechanism so students can continue to receive these services that are critical to their academic success.

Recommended Strategy

We have provided comments below on each of the pilot options as outline by DMAS, but in an effort to ensure the best outcome for Virginia's students, we recommend a combination of options: Starting with Option A during the 2022-2023 school year and then transitioning to Option C after the State Plan Amendment for the bundled payment is approved. Long-term, the bundled payment could be included in managed care with

the bundled payment and rate mandated in the MCO contract. But working it out first in fee-for-service, as proposed by DMAS, is highly recommended. This combination of DMAS strategies would help address the immediate needs of children, establish a national model, and provide for vision to be integrated with physical health over the long term.

Feedback and Considerations

Pilot Option	Pros	Cons	Comments
Option A **FFS Reimbursement Under Existing Procedure Codes**	• • Existing codes already in place Modifiers may help to streamline the process • Data sharing improves program coordination and helps address the MCO's concern that a child may receive extra eye exams. • DMAS has more management and control over the pilot. • Fee for Service would enable DMAS to more easily monitor the utilization of mobile services. Current FFS rates are sufficient to deliver services. •	• It may take some time to obtain CMS approval of a State Plan Amendment if needed. • Additional DMAS resources are needed. However, an increase in utilization will typically create a need for additional resources if that is the ultimate goal. This may not be avoidable under any model. In addition to individual claim submission, it would require extra administration from a mobile vision provider to share data with the MCOs. However, with collaboration from all parties, this should be workable. The MCOs have expressed concern about children receiving an extra vision exam. It is not clear what the current financial exposure for vision services is • for the MCOs, however, to estimate the risk we could look at last year's Conexus mobile clinic total Medicaid utilization. Based on that, the collective maximum financial risk for duplicate exams would have been for 1,730 exams and that is if every child received both a school based and MCO covered in-office exam. With the current EyeMed exam rate of $40 for exam and $15 for dispensing this would potentially total $95,150 in claims for duplicate exams. This is objectively a	Unclear as to how long CMS approval will take. Not sure whether DMAS has existing staff that could support mobile clinic oversight or if it would need to request a new staff person.

		small amount considering that the collective MCO capitation payments exceed $10 billion a year.	

Option B
 	
MCO Proposal
	• Could expand the pool of mobile vision providers and increase access to care if there is a new payment option.
	No changes to CMS authority.
	•
		• Unclear on how many elements of this proposal would work. See comments. Current provider credentialing process at all subcontractors does not allow
		• mobile clinics. This would need to change.
			• Proposal made reference to a "clinical standard for comprehensive eye exams in schools." We would want to ensure RFP requirements wouldn't exclude the current evidenced based program. If this implies that dilated eye exams must be performed, then this option is infeasible in a school environment.
			
			• Unclear how the supplemental funding would be structured.
			  • Unclear how sustainable this funding would be.
			  • Unclear which entity would issue the RFP? VAHP?

Option C **Bundled Payment Reimbursement**	• Rate development can be determined based on existing FFS rates. • New provider "type" opens the school based mobile field up to more providers thus achieving increased benefit utilization (one of the stated purposes). • Using a singular bundled code creates ease of claims processing and reduces longterm administration for mobile providers, DMAS, and the MCOs. Data sharing improves children's vision services. • CMS approval of this process opens the door nationwide for mobile vision providers, improving utilization. •	• • Timeline involved with CMS Timeline involved with system change • This is not a guaranteed solution since there is no precedent. • Additional DMAS resources are needed– however, increasing utilization will typically create a need for additional resources. If that is the ultimate goal, this will not be avoidable under any model.	Unclear as to how long CMS approval will take.
Option D **General Fund**	• Students would receive services and the provider would be reimbursed. • Funding would be appropriated specifically for school-based Mobile Vision Clinics.	• Requires funding appropriation through House, Senate and Governor. Reluctance of legislators to fund an item that is already funded through DMAS • appropriation. Would likely need a data sharing agreement with DMAS and the MCOs to • ensure that the MCOs are not paying for a service the child already received. MCOs would also likely want this information to ensure that they are fulfilling their responsibilities under EPSDT. Vision services are an entitlement service for children. Would be subjected to a General Fund appropriation every year and could be vulnerable to budget reductions. This doesn't create a long term sustainable policy solution.	While this may seem attractive because it removes reimbursement from DMAS and MCOs, it is likely to meet significant opposition since vision services for students is already a covered service through Medicaid (though not currently paid).

Option E **Alternative Funding Through MCO Contributions**	• This could serve as a shortterm solution. • Process would be similar to other foundation-funded grant programs many mobile vision clinics already have in place.	• Would not necessarily be a longterm sustainable solution. • MCO's have said they are unable to donate to support a program that provides a Medicaid reimbursable service.	This option could serve as a bridge solution as more sustainable reimbursement plans are developed. Even though MCOs have concerns about funding a service that is currently reimbursable, it begs the question, if it is reimbursable, the why is the Mobile Vision Clinic not able to be reimbursed?
Option F **Use of Health Services Initiative Funds**	• Would potentially allocate additional funding toward accessibility of vision services for all children.	• Does not resolve the underlying issue that Medicaid/CHIP reimbursement is unavailable to mobile vision providers. Unclear • whether sufficient HSI funding remains.	
Option G		• Maintains the current administrative structure and rates of the MCO's vision provider contract. These administrative requirements and rates are unworkable for mobile vision providers delivering services to schools.	Unclear what General Assembly or Governor directive would be needed if DMAS required enrolment of mobile vision clinics in MCO networks.

Tuesday, June 29, 2021 from 3:00-4:30*

AGENDA

- Welcome and Introductions (10 minutes) – Brian McCormick
- Budget Language Overview/Purpose (10 minutes) – Scott Cannady
- Conexus Overview (25 minutes) – Conexus Staff
- DOE Comments (10 minutes)– Amy Edwards/Diane Allen
- MCO Discussion (15 minutes)– MCOs
- Next Meeting July 20 Goals – (10 minutes) Brian McCormick

**Reference Google Meets Invitation for Meeting Contact Details*

Workgroup #1 June 29, 2021 Meeting Notes

- **Welcome and Introductions**

Attendees

DMAS: Rebecca Anderson, Scott Cannady, John Kenyon, Tiaa Lewis, Brian McCormick, Kim Moulden, Garima Oza, Dan Plain, Andrea Wilson

MCOs: Ira Bloomfield (Aetna), Karl Loewe (Aetna), Lindsay Berry Winter (Anthem), Ann Vaughters (Molina), Randy Ricker (Optima), Randy Dovel (Optima), Janine Woldt (United), Tameeka Smith (United) John Muraca (United), Mark Mattingly (Virginia Premier), Felicia Campbell (Virginia Premier)

Conexus: Tim Gresham, Robin Mead, Andrea Booker, Laura Fornash (McGuire Woods), Kate Petersen (McGuire Woods), Suzanne Gore (State Health Partners)

Brian McCormick reviewed the agenda and the purpose/role of the work group. There will be three to four work group meetings to develop the scope and design of the pilot program and develop a report to the Governor and General Assembly (due Oct. 15, 2021).

- **Budget Language Overview**

Scott Cannady reviewed the following budget language and Kim Moulden presented a grid to solicit initial feedback from workgroup members that was forwarded to the work group following the meeting. Due to DMAS no later than July 16th, DMAS will aggregate this input to use in guiding future discussions and recommendations.

The Department of Medical Assistance Services, shall convene a work group to plan for implementing a pilot program to provide mobile vision clinic services to Medicaid, FAMIS and MCHIP children in a school-based setting. The work group shall be comprised of Medicaid managed care organizations, mobile vision providers, school districts with and without these services, the Virginia Department of Education and others as appropriate. The work group shall determine the scope and design of the pilot program, including (i) the referral process for initial and follow-up services (ii) who shall provide the services, (iii) how parents or legal guardians will be notified, (iv) the role of school districts and the Department of Education in screening and referring children to the program, (iv) reimbursement rates for services that consider access, quality, and cost effectiveness of services provided, (v) detailed cost estimates of the pilot program, and (vi) a mechanism for evaluating the pilot program, The Department shall report on the recommendations of the workgroup by October 15, 2021 to the Governor and General Assembly.

- **Conexus Presentation (sent previously)**
- **MCO Discussion**
  - Aetna prefers pilot involve MCOs as opposed to carve out for purposes of coordinated member care.
  - Anthem also advocated for managed care model, and noted previous work both trying to fit Conexus under Anthem foundation as well as trying to incorporate Conexus as participating provider. Hoping to get to a successful public/private partnership by adapting existing models.
  - Molina asked clarifying questions of Conexus to establish that dilated eye exams are not provided by Conexus mobile clinics (if this is deemed necessary a referral will be made), that infrastructure does not currently exist to inform PCPs of screening or exam results (have name and birthday of kids but no other information, open to ideas here), and that children get sent home with prescription (copy also goes to school nurse), any referral information, and wearing instructions.

- Optima addressed the connection between child vision screening and the social determinants of literacy and education.
- United asked about the geographical target for this pilot (if potentially looking to move beyond Central Virginia where Conexus currently operates) and asked if Conexus has credentialing experience with any payers connected with Medicaid. Brian McCormick added that the geography of the pilot is a downstream question, and Conexus responded that they only ever bill one code and both VSP and EyeMed have said doctors didn't need to be credentialed separately if already listed as EyeMed or VSP providers.
- Virginia Premier agreed that there are significant unmet vision needs in Virginia.

Next Meeting Goals

Brian thanked the work group members for participating and asked that stakeholders submit feedback on the grid that Kim Moulden will send after the meeting. We're looking for input and ideas to aggregate a starting point in developing the work group recommendations. Include any questions, known issues or considerations to guide the project plan and ultimately the final report to the Governor and General Assembly. As DOE was unable to attend this meeting, they have been asked to provide feedback through the grid and at the next meeting.

Follow Up

Requested documents sent immediately following the meeting on 6/29 included a copy of the budget language, the stakeholder feedback grid, and slides from the Conexus presentation.

Workgroup meeting #2 will be held on July 20, 2021 at 2:00 to 3:30.

Mobile Vision Work Group

Tuesday, July 20, 2021
2:00-3:30

AGENDA

- Welcome and Introductions (5 Minutes) – Brian McCormick, DMAS
- Recap of Last Meeting (10 Minutes) – Brian McCormick
- Learning Sessions (60 Minutes)
  - Vision To Learn (20 Minutes) –Damian Carroll, VTL
  - DOE Requirements (10 Minutes) – Tracy White, DOE
  - Vendor Requirements (15 Minutes) – EyeMed
  - Regulatory Authority, Policy Activity and Pilot Options (15 Minutes) – Scott Cannady, Kim Moulden, DMAS
- Discussion and Next Steps (15 Minutes) – Brian McCormick
- Next Meeting: August 19th 10:00-11:30 AM

*Reference Google Meets Invitation for Meeting Contact Details

Workgroup #2 July 20, 2021 Meeting Notes

- **Welcome and Introductions – Tiaa Lewis, Division Director, Program Operations**

  Attendees
  DMAS: Rebecca Anderson, Pat Arevalo, Scott Cannady, Rob Chapman, John Kenyon, Tiaa Lewis, Jessica MacKenzie, Kim Moulden, Garima Oza, Dan Plain, Tina Weatherford, Andrea Wilson, Riva Kamat
  MCOs: Ira Bloomfield (Aetna), Karl Loewe (Aetna), Lindsay Berry Winter (Anthem), Taylor Rhodes (Anthem), Ann Vaughters (Molina), Randy Ricker (Optima), Randy Dovel (Optima), Blair Hedgepeth (Optima), Janine Woldt (United), Tameeka Smith (United) John Muraca (United), Chantel Mitchell (United), Mark Mattingly (Virginia Premier), Felicia Campbell (Virginia Premier), Valerie Hicks (Virginia Premier)
  Conexus: Tim Gresham, Robin Mead, Andrea Booker, Laura Fornash (McGuire Woods), Kate Petersen (McGuire Woods)
  EyeMed: Dr. Joe Wende, Lisa Grantham, Tim Holmes, Scott Kirk
  Department of Education: Amy Edwards (DOE), Tracy White (DOE), Charlene Vail (Roanoke County Public Schools), Eileen Gomez (Albemarle County Public Schools)
  Other Stakeholders: Suzanne Gore (State Health Partners), Doug Gray (Virginia Association of Health Plans), Damian Carroll (Vision to Learn)

- **Recap of June 29th Meeting**
  Scott Cannady gave a brief overview from the last meeting.

- **Vision to Learn Presentation,** Damian Carroll, National Program Director
  Mr. Carroll gave an overview and history of the program, including eye exams for kids who are referred from an initial screening (~25% of kids). They have been able to successfully get credentialed as a provider group through FFS as well as a MCO contracted provider (through MCO vision subcontractors like Davis, Superior, March, and working with VSP in California). Have MOUs with school districts and provide screening and exams on-site to students. They bill through the portal and double check the student coverage (Medicaid eligible and also haven't billed for a similar service in the past year), then submit claims for reimbursement. Verifying Medicaid coverage can sometimes be a challenge due to not finding an exact match with spelling (also have DOB). Glasses provided through various partnerships, and include a variety of choices.

- **Schools/DOE Requirements - Tracy White**
  Ms.White from DOE reviewed the state legislation in place to provide vision and hearing screenings for students in kindergarten, 2nd or 3rd, 7th, and 10th grades and the requirement that these screenings (inclusive of hearing) be scheduled within the first 60 days of the school year. Tracy also invited Eileen Gomez from Albemarle County Public Schools and Charlene Vail with Roanoke County Public Schools to the discussion. Partnerships utilized (Lion's Club, Conexus, PTAs, community volunteer groups) were discussed as well as tools available to schools for providing these mandated screenings (try to couple with hearing screenings to minimize out of classroom time). If a student fails an initial screen, they try to rescreen or reassess before sending letters home to the parent indicating need for referral to health care provider for additional follow-up. Follow-up and referrals also discussed, where sometimes school nurse needs to get a social worker or counselor involved, or interpreters to speak to families, depending on need and resources available to the school. At the

end of the school year schools submit data to DOE in three areas: # of students that are screened, number of students referred, and disposition/results of kids referred for screenings.

- **EyeMed Presentation – Dr. Joe Wende**
  Dr. Wende gave an overview and background of EyeMed, one of the three vision subcontractors utilized by Virginia Medicaid MCOs. He reviewed processes surrounding provider recruitment, contracting and credentialing, network compliance and reporting. In Virginia EyeMed has 800 practitioners in their vision network and reimburses through EFT transactions. EyeMed also has a presence in North Carolina, Arkansas, Nevada, New York and Massachusetts.

- **Regulatory Authority & Policy Activity - Kim Moulden**
  Ms.Moulden with DMAS reviewed the regulatory landscape and considerations surrounding various pilot options. Reviewed current vision services and contract provisions surrounding EPSDT and FAMIS, authorities for a pilot mobile vision program, FFP considerations, and discussed the lack of available CHIP HIS funding in Virginia.

- **Meeting Adjourned**

Mobile Vision Work Group

Thursday, August 19, 2021

10:00-11:30

AGENDA

- Welcome and Introductions (5 Minutes) – Brian McCormick, DMAS
- Additional School System Overview – Elizabeth Stowers, Bellwood Elementary School (10 Minutes)
- MCO Programs – MCOs (15 minutes)
- VSP Discussion – VSP Staff (10 minutes)
- Pilot Discussion – (20 minutes)
  - Conexus (10 minutes)
  - MCOs (10 minutes)
- Funding – Rob Chapman (5 minutes)
- Research/Report Discussion – Scott Cannady/Kim Moulden/Jessica McKenzie
- Next Meeting: September 2, 2021 @ 10:00-11:30

**Reference Google Meets Invitation for Meeting Contact Details*

Workgroup #3 – August 19, 2021 Meeting Notes (Still in draft form)

- **Welcome and Introductions – Dan Plain, Division Director, Health Care Services**

Attendees

DMAS: Rebecca Anderson, Pat Arevalo, Sarah Broughton, Scott Cannady, Rob Chapman, John Kenyon, Tiaa Lewis, Jessica MacKenzie, Brian McCormick, Kim Moulden, Garima Oza, Dan Plain, Tina Weatherford, Andrea Wilson, Riva Kamat

MCOs: Lindsay Berry Winter (Anthem), John Moore (Anthem), Ann Vaughters (Molina), James Johnson (Molina), Randy Ricker (Optima), Randy Dovel (Optima), Tameeka Smith (United), John Muraca (United), Scott Edmonds (United), Linda Hines (Virginia Premier), Mark Mattingly (Virginia Premier), Felicia Campbell (Virginia Premier)

Conexus: Tim Gresham, Robin Mead, Andrea Booker, Laura Fornash (McGuire Woods), Kate Petersen (McGuire Woods)

VSP Vision: J. Ameba, Courtney Asmo, Suzanne Brehm, GE Hiatt, Felicia Jackson, W. Marks, Annie Mayo, Caryn Ng, Terri Wilson

DOE: Amy Edwards, Elizabeth Stowers (Bellwood Elementary School)

Other Stakeholders: Suzanne Gore (State Health Partners), Doug Gray (Virginia Association of Health Plans), Ann Ritchey (Vision to Learn)

- **Overview of Chesterfield Schools and Conexus - Elizabeth Stowers, Bellwood Elementary School**

Ms. Stowers gave an overview and history of the vision program at Bellwood through her role with Communities in Schools of Chesterfield. She has worked with Conexus for four years and sees an immediate improvement as kids get their glasses. The kids love being able to select their own glasses and receive replacements if broken or scratched.

- **Overview of MCO Vision Programs – Doug Gray, VAHP**

Mr. Gray provide a high-level overview of the health plans vision benefits which are all very similar. MCO Covers: EPSDT vision screenings 12 and 24 months, glasses once every two years. He reviewed the MCO contract language regarding vision benefits and discussed outreach.

- **VSP Presentation – Annie Myers**

Ms. Myers gave an overview and background of VSP benefits and services, their national relationship with MCOs and Conexus. They are currently in contract negotiations with Vision to Learn; however, there are technology incompatibilities between the companies. There was further discussion around the backend operations and administration hurdles they are trying to get through.

- **Conexus Pilot Option Discussion – Suzanne Gore, State Health Partners**

Ms. Gore gave an overview of the services and benefits Conexus provides for school aged children. She also discussed the barriers to receiving needed glasses and other services. She stated that a payment pilot is need to get to a sustainable, billable benefit through a phased-in approach over a three-year period. She stated that procedure codes and payment rates already exist at DMAS; state and federal authority already exist; and the pilot needs to be started based those existing codes, rates and authorities. They would like to see the pilot operationalized in Richmond, Petersburg and Chesterfield during the first year.

- **MCO Pilot Option Discussion – Tameeka Smith, UnitedHealthCare**

Tameeka Smith from UnitedHealthcare presented on the MCO Pilot Program. VAHP supports the exploration of a managed care mobile vision pilot in Virginia that seeks to test improving access to vision care and positive, quality outcomes for school age children. Ensure there is no duplication of effort; ensure no kid gets left behind and consider the social determinants of health when considering the pilot; program centered on students with a number of different venders; there are other organizations that already work with the MCOs to provide vision services to Medicaid kids.

- **Funding Sources – Rob Chapman**

Mr. Chapman gave an overview of the funding models available to include FAMIS and MCHIP.

- **GA Report – Scott Cannady**

Mr. Cannady stated that staff will begin to put together the report on Monday, Aug. 23rd and will provide a detailed, high-level outline that will be discussed at the next meeting.

Meeting Adjourned

Workgroup meeting #4 will be held on September 9, 2021 at 9:00 – 10:00.

Workgroup #4 – September 9, 2021 Meeting Notes

Attendees

DMAS: Tina Weatherford, Andrea Wilson, Brian McCormick, Dan Plain, Jessica Mackenzie, Kim Moulden, John Kenyon, Pat Arevalo, Rebecca Anderson, Rob Chapman, Tiaa Lewis, Tanyea Darrisaw, Sarah Broughton

DOE: Amy Edwards, Tracy White

MCOs: Randy Ricker (Optima), Scott Edmonds (United), Adrianne Ferrer (United), James Johnson (Molina), Lindsay Berry (Anthem), Jerry Mammano (Aetna), Mark Mattingly (Virginia Premier), Ann Vaughters (Molina), Ira Bloomfield (Aetna), Felicia Campbell (Virginia Premier), Randy Dovel (Optima)

Conexus: Tim Gresham, Robin Mead

Other: Doug Gray (VAHP), Suzanne Gore (State Health Partners), Laura Fornash (McGuire Woods), Kate Petersen (McGuire Woods)

- **Welcome and Introductions – Dan Plain, Division Director, Health Care Services**

- **Summary of Pilot Options – Dan Plain, Division Director, Health Care Services**

Dan Plain presented a slide deck detailing seven pilot proposal options inclusive of individual considerations for each. These options included: FFS reimbursement under existing procedure codes, the MCO proposal of a competitive RFP with selected providers reimbursed through existing managed care infrastructure, FFS bundled payment reimbursement with new mobile vision procedure code, general fund allocation to directly reimburse school-based mobile vision clinic providers, alternative funding through charitable contributions, use of Health Services Initiatives (HSI) funds, and mandatory MCO enrollment of mobile vision clinic providers.

- **Next Steps – Scott Cannady**

Workgroup members were asked to provide feedback on the six mobile vision clinic pilot proposals by COB on Thursday, September 16th. This feedback will be attached to the final report submitted to the General Assembly.

- **Meeting Adjourned**