

**Meeting of the Board of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia**

**December 8, 2015
DRAFT Minutes**

Present:

Brian Ewald
Michael H. Cook, Esq.
Alexis Y. Edwards
Maureen Hollowell
Karen S. Rheuban, M.D.
Chair
Erica L. Wynn, M.D.
Marcia Wright Yeskoo

Absent:

Mirza Baig, Vice Chair
Maria Jankowski
Peter R. Kongstvedt, M.D.
McKinley L. Price, D.D.S.

DMAS Staff:

Cheryl Roberts, Deputy Director for Programs
Abrar Azamuddin, Legal Counsel
Craig Markva, Manager, Office of Communications,
Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of
Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of
Communications, Legislation & Administration

Speakers:

Cynthia B. Jones, Director
Linda Nablo, Chief Deputy Director
Suzanne Gore, Deputy Director for Administration
Scott Crawford, Deputy Director for Finance
Karen E. Kimsey, Deputy Director for Complex Care Services
Terry Smith, Division Director, Long-Term Care

Guests:

Cecelia Kirkman, SEIU
W. Scott Johnson, First Choice Consulting, LLC
Rick Shinn, VA Community Healthcare Association
Nicole Pugar, Williams Mullen
Lindsay Berry, Anthem
Hunter Jamerson, Macaulay & Burtch, PC
Richard Grossman, VECTRE
Anne Beven, DMAS

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:07 a.m. Other members were asked to introduce themselves and introductions continued around the room. Dr. Rheuban requested members to submit their Conflict of Interest Training and disclosures if they have not already done so. Dr. Rheuban also announced the proposed meeting schedule for 2016: April 12, June 14, September 13 and December 13.

APPROVAL OF MINUTES FROM SEPTEMBER 8, 2015 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the September 8, 2015 meeting. Ms. Hollowell made a motion to accept the minutes and Mr. Ewald seconded. The vote was unanimous. **6-yes (Cook, Edwards, Ewald, Hollowell, Rheuban, and Yeskoo); 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, welcomed members and shared highlights of accomplishments during 2016 and briefly shared highlights of the four major initiatives being focused on for the future of Medicaid: Managed Long Term Services & Supports (MLTSS), Delivery System Reform Incentive Payment (DSRIP), MMIS Reprourement, and Medicaid Expansion.

ELECTRONIC PREADMISSION SCREENING (E-PAS) PROGRAM UPDATE

In response to legislation passed by the 2014 General Assembly and 2015 budget language requesting DMAS report on the progress of meeting the requirements for completion of preadmission screenings (PAS) within 30 days of an individual's request for screening, Terry Smith, Division Director for Long-Term Care, provided a report on the timeliness of achieving this goal. DMAS has automated this process and is now collecting daily data on this new electronic system called ePAS which is used to track requests and identify jurisdictions unable to complete screenings within 30 days of a request. The goal is to have assessments completed in a timely manner by all assessors. (See attached handout)

Dr. Wynn joined the meeting during this presentation.

WAIVER REDESIGN REPORT

Karen Kimsey, Deputy Director for Complex Care, provided an overview of the steps taken in cooperation with the Department of Behavioral Health and Developmental Services (DBHDS) to redesign the Medicaid Intellectual and Developmental Disability Waivers. The report was submitted to CMS in November; the waiver amendments were submitted in December. The full report will be posted on Reports to the General Assembly (<http://lis.virginia.gov>). (See attached handout)

UPDATE ON MEDICAID FORECAST

Mr. Scott Crawford, Deputy Director for Finance, gave an overview of budget actions since the 2015 General Assembly Session. Mr. Crawford explained this budget forecast includes the past

three biennial budget sessions FY 2016-2018 and explained how various factors affect the forecasting process. The Governor's budget is expected to be released on December 17. (See attached handout)

Ms. Yeskoo left the meeting.

2016 GENERAL ASSEMBLY SESSION/1115 WAIVER – DSRIP/MLTSS

Ms. Suzanne Gore, Deputy Director for Administration, explained the agency legislative process and role during the session. As the agency does not promote legislation, Ms. Gore explained how DMAS staff will inform the Board with weekly updates on major legislation affecting Medicaid during the 2016 General Assembly Session which convenes on January 12, 2016.

Ms. Gore provided information regarding Virginia's efforts to seek waiver authority to combine two initiatives (MLTSS and DSRIP) into one comprehensive waiver to assist in streamlining the administration of the waiver. Both initiatives are available on line for review and public comments are requested. (See attached handout)

REGULATORY ACTIVITY SUMMARY

The Regulatory Activity Summary is included in the Members' books to review at their convenience (See attached).

OLD BUSINESS

Dr. Rheuban presented a draft version of a letter to the Governor in support of the expansion of the Medicaid program. After discussion, Dr. Rheuban made a motion to forward a letter to the Governor and members of the General Assembly and Mr. Cook seconded. The vote was **6-yes (Cook, Edwards, Ewald, Hollowell, Rheuban, and Wynn); 0-no.**

ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting at 11:58 a.m. Mr. Ewald made a motion to adjourn the meeting and Ms. Hollowell seconded. The vote was **6-yes (Cook, Edwards, Ewald, Hollowell, Rheuban, and Wynn); 0-no.**



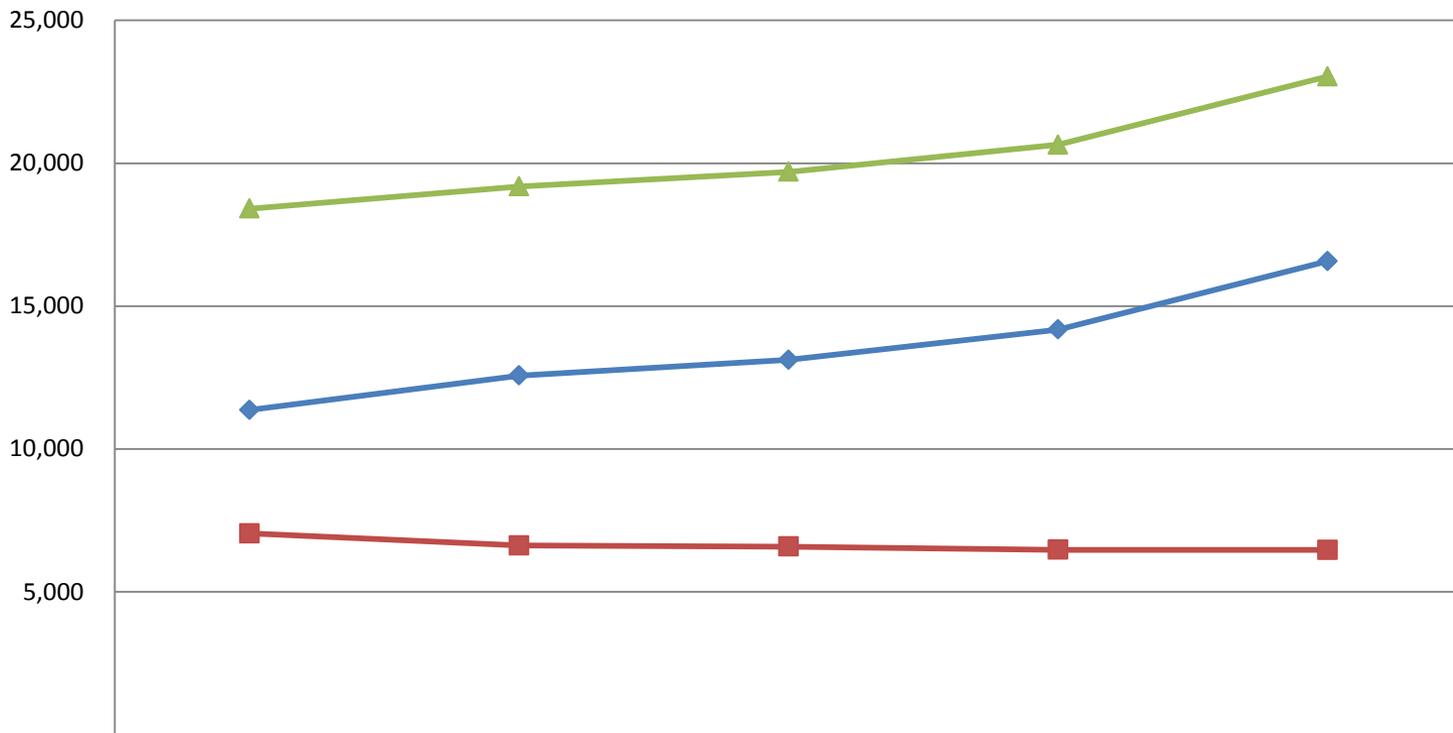
UAI Timeliness: Achieving the Goal

Electronic Preadmission Screening (ePAS)

DMAS Board
~~December 8, 2015~~

Terry A. Smith, Director
Division of Long-Term Care

**Virginia 2011 -2015
Preadmission Screenings
Total Screenings Regardless of Placement
Local Health Departments (32% Increase overall &17% Increase last year)
vs. Acute Care Hospitals (23% Decrease overall & 0% Decrease last year)**



	2011	2012	2013	2014	2015
Total Acute Hospital	7,044	6,621	6,582	6,469	6,464
Total Local Preadmission Screening	11,365	12,567	13,116	14,179	16,572
Grand Total	18,409	19,188	19,698	20,648	23,036

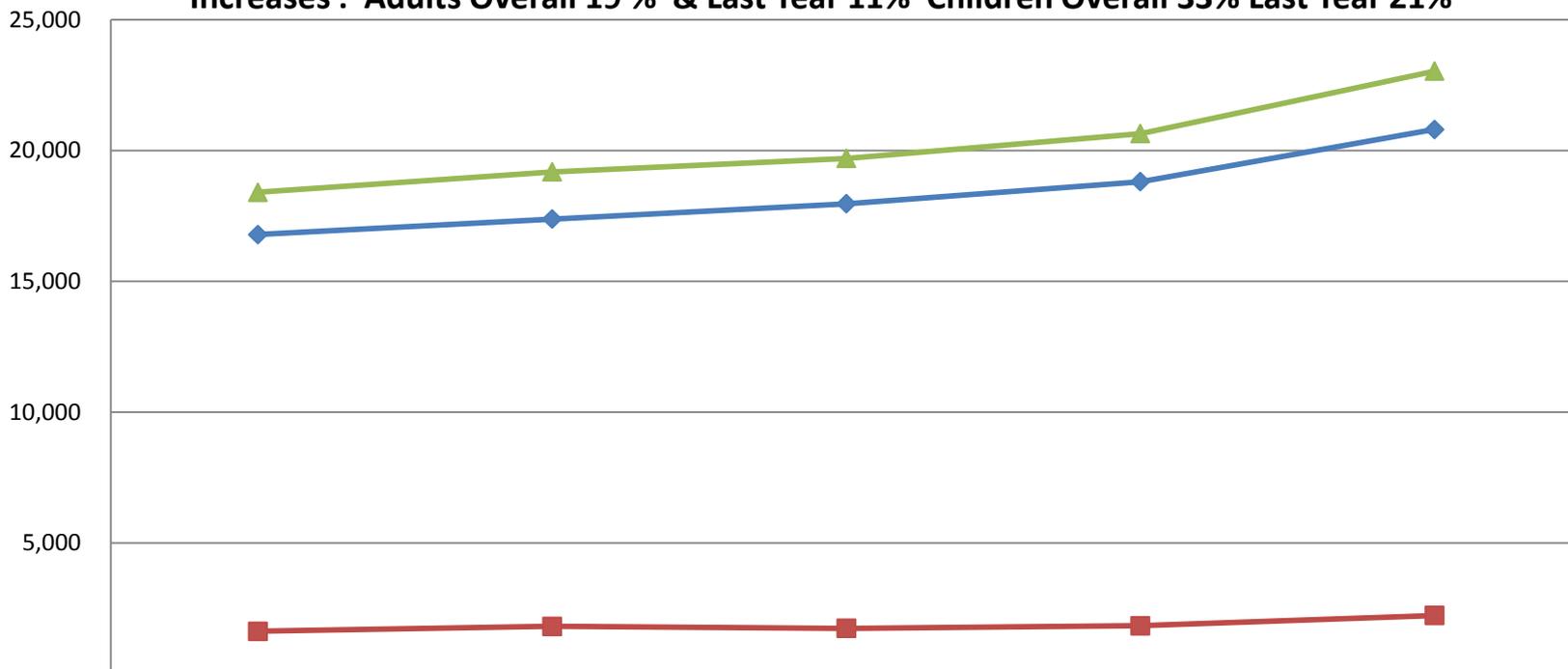
Location

- Gradual increases are seen in community screenings and gradual decreases are seen in hospital screenings

Virginia 2011-2015 Preadmission Screenings

Adult vs. Children Screenings Regardless of Placement

Increases : Adults Overall 19 % & Last Year 11% Children Overall 33% Last Year 21%



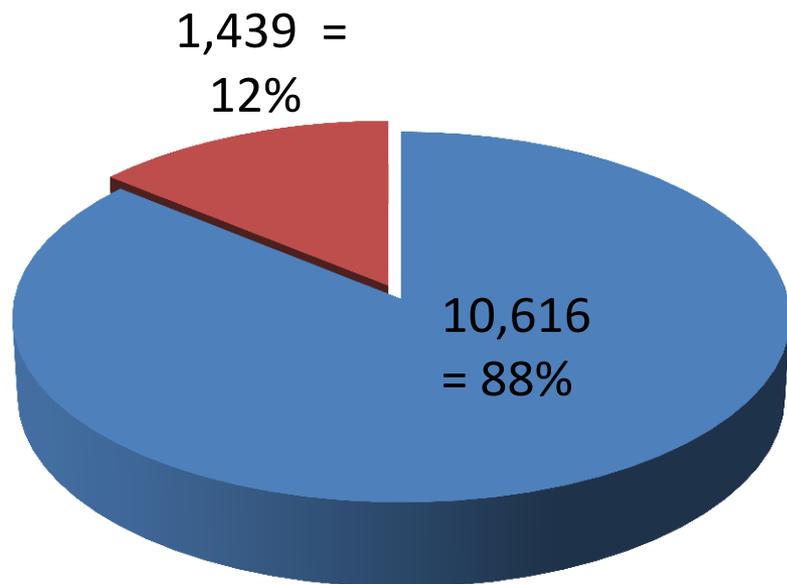
	2011	2012	2013	2014	2015
Adults	16,788	17,380	17,965	18,812	20,807
Children	1,621	1,808	1,733	1,836	2,229
Total	18,409	19,188	19,698	20,648	23,036

Number of Screenings

In 2015 due to the implementation of ePAS and efficiencies there has been a rise in the number of screenings

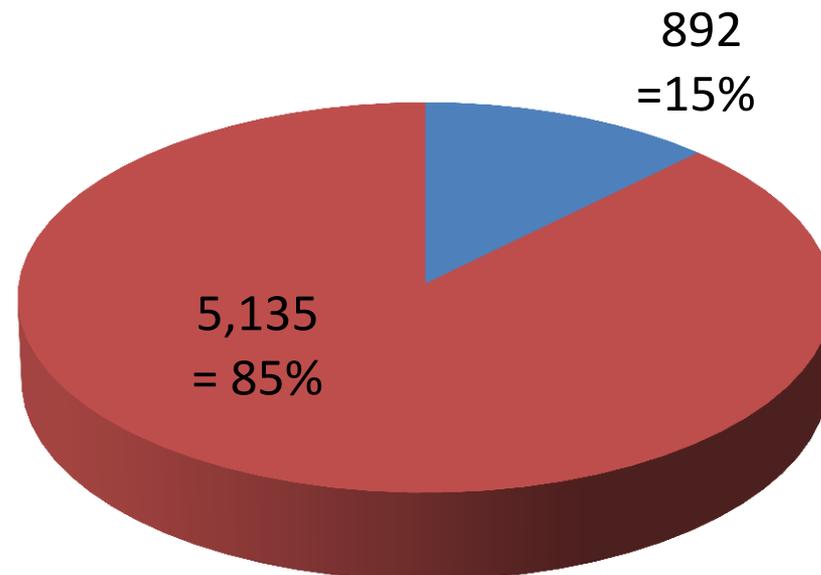
2015 Local Community Based Screenings Resulting in Recommended Placements

Community Based Services Nursing Facility



2015 Acute Care Hospitals Screening Resulting in Recommended Placements

Community Based Services Nursing Facility





Legislative and Budget Mandate Background

- PAS is the gateway to Virginia's Medicaid funded long-term care services and supports (LTSS);
- In response to House Bill 702 (Session 2014), and Budget language QQQQ (Session 2015) VDH, DARS and DMAS collected and analyzed PAS data to learn current trends;
- While the statewide number of preadmission screenings has remained constant for the past three years, there have been significant differences between hospital and community based screenings.



State Level Interagency Coordination

Under the direction of the Office of the Secretary of Health and Human Resources (OSHHR), the following goals were identified to enhance the PAS process:

- Reduce PAS processing time (from request to claims payment);
- Make business process changes soon to support above;
- Work within current law; and,
- Remain budget neutral.

An interagency oversight group was named to coordinate activities to meet the Secretary's goals.



Tracking and Monitoring

- DMAS, in collaboration with VDH and DARS, developed and implemented a two-pronged approach to tracking and monitoring requests and completion for screenings.
- In the absence of an automated system, VDH initiated a manual reporting system in September 2014 to secure “benchmark” data from each of the 119 community PAS teams.
- The manual data was problematic and inconsistent.
- DMAS is now collecting daily automated data on ePAS to track the requests and identify jurisdictions unable to complete screenings within 30 days of the request
- DMAS is posting a monthly status report on the DMAS website and VDH is emailing an electronic file to each locality.



Electronic Pre-admission Screening (ePAS)

- ePAS is a paperless, automated reimbursement and tracking system for all entities contracted by DMAS to perform PAS.
- In collaboration with the DMAS contractor Xerox, DMAS developed and tested ePAS during the early spring of 2015.
- On April 17, 2015, DMAS issued a Medicaid Memo to all providers of long-term care supports and services and acute care hospitals describing the new ePAS system.



Training and Technical Assistance

DMAS, VDH and DARS developed a training and technical assistance plan to:

- to inform community based teams (CBTs) of the Code requirements for the PAS Process,
- define for the first time in regulations timeframes and reporting requirements for responding to requests for screenings; and
- solicit from CBTs best practices in place to enhance the PAS process.
- training was provided via WebEx to over 1800 individuals including both community based assessors and hospitals.
- training has been posted on agency website.



ePAS Time Frames

**May & June
2015**

- ePAS opened to voluntary data entry and claims processing

July 1, 2015

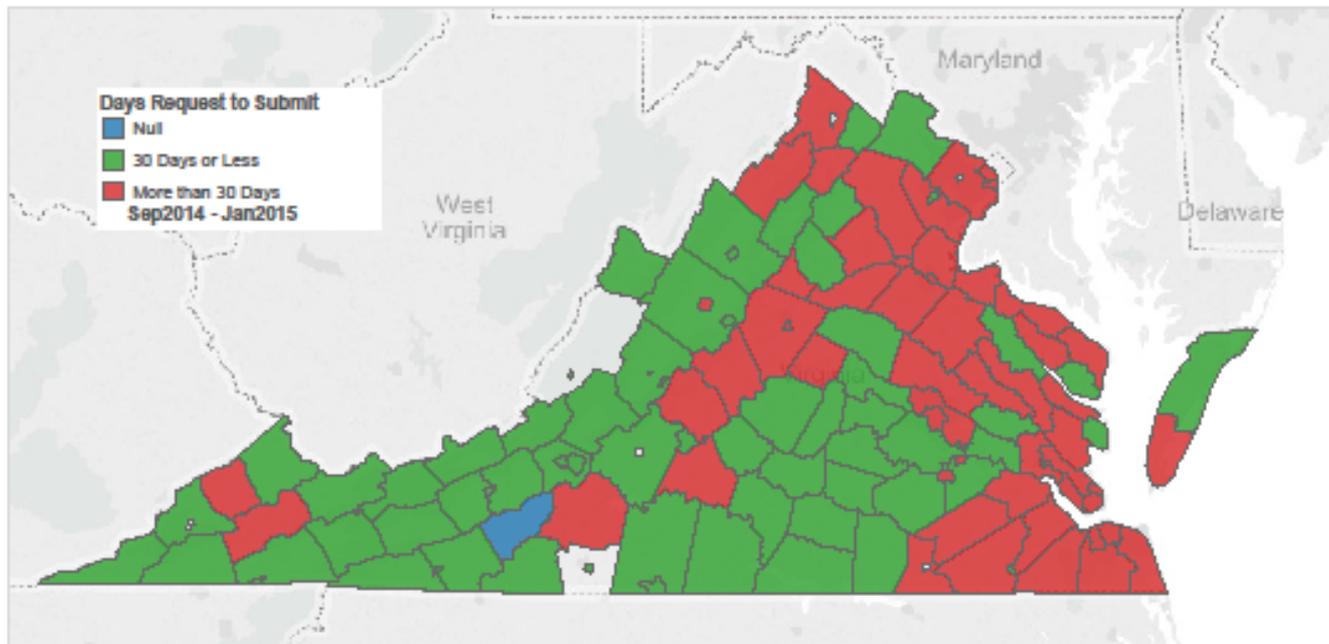
- DMAS required all community screenings to be submitted electronically via ePAS

**December 1,
2015**

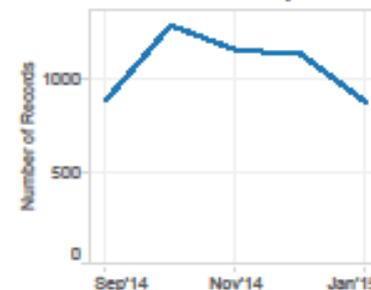
- DMAS requires all hospital screenings to be submitted electronically via ePAS

September 2014 – January 2015 VDH Localities' Self-reported Data

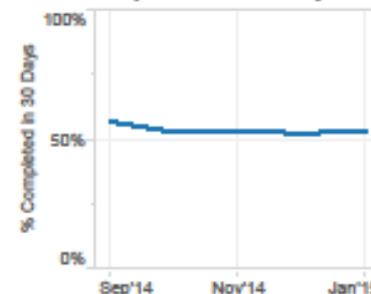
Preadmission Screenings: All



Total No. of PAS Completed



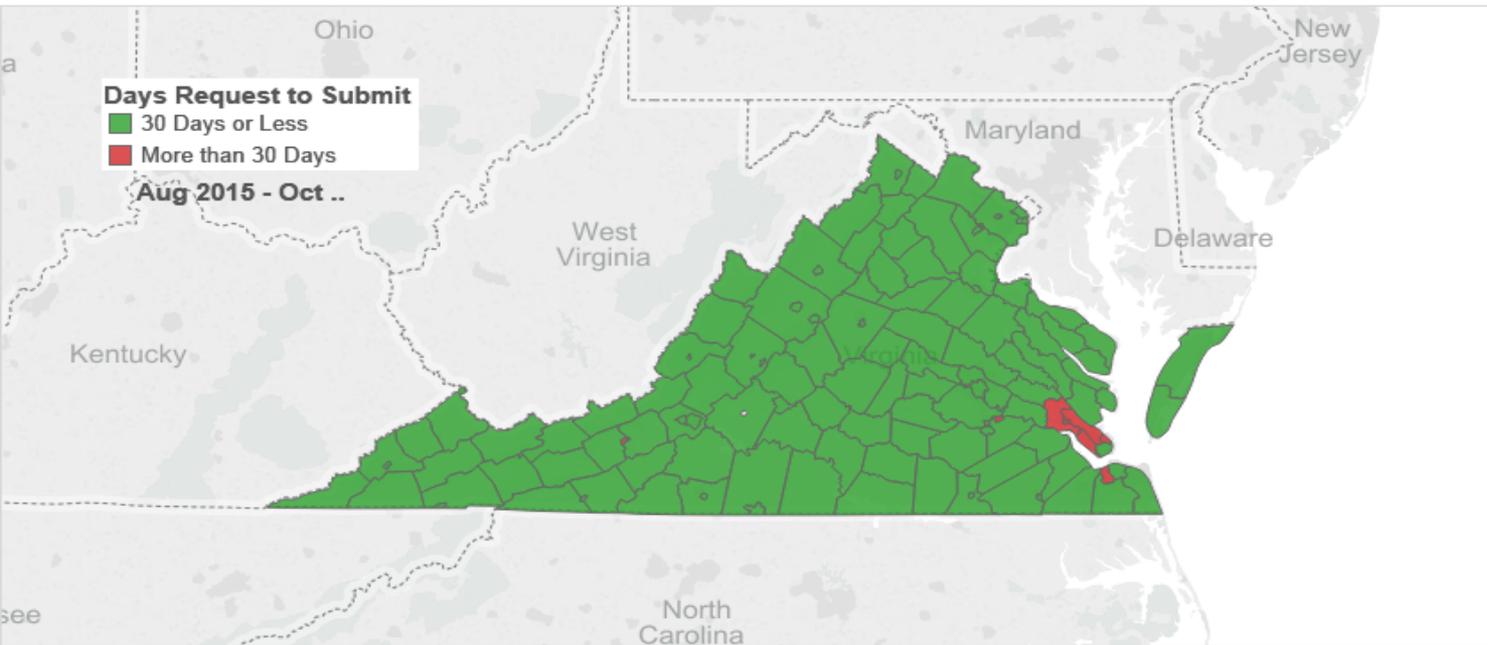
% Completed in 30 Days



Monthly Breakout



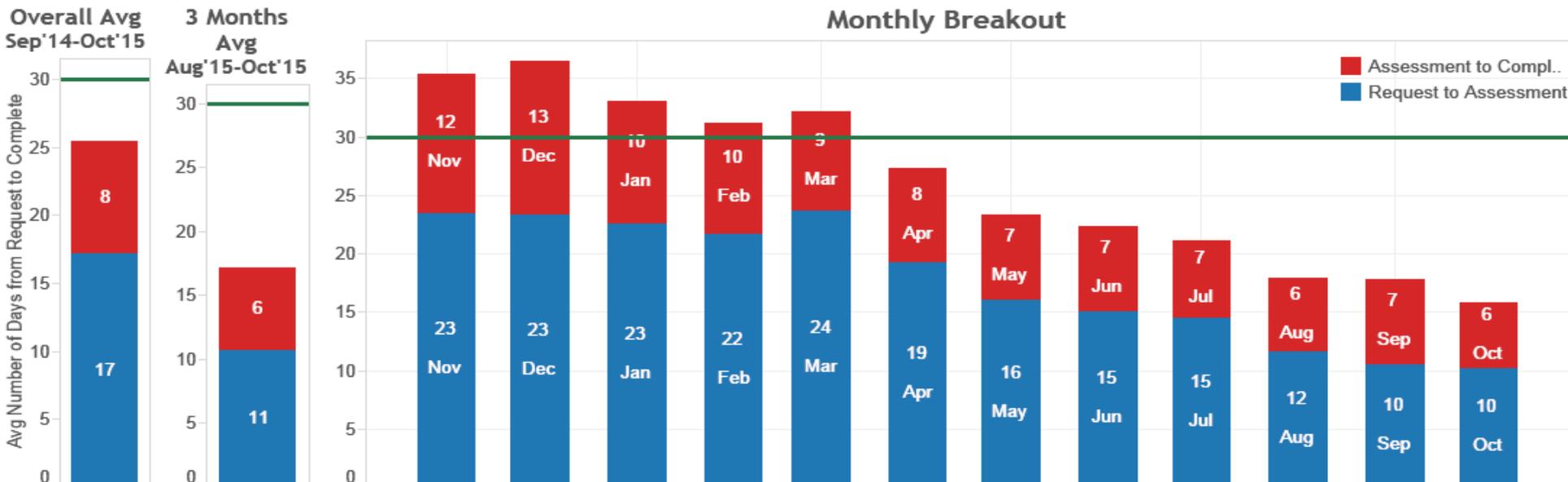
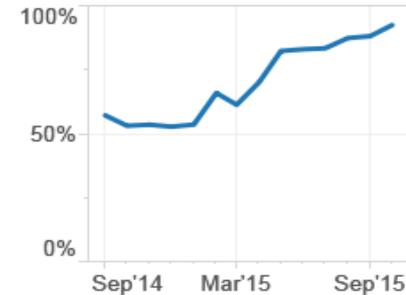
Preadmission Screenings: All



Total No. of PAS Completed



% Completed in 30 Days





ePAS Highlights

December 2014 – October 2015

Topic	Manual 12/14 – 06/15	Automated 8/15- 10/15
Average Days To Complete PAS	36	17
Percent of PAS Completed within 30 Days	57%	89%
Total Average Monthly Screenings	1,156	2,028



Longer-Term Actions Planned

- Process improvements, actions that are part of the DMAS work plan, in collaboration with VDH and DARS, to meet the legislative requirements include:
- Defining essential terms through guidance and in regulations for successful PAS tracking – terms such as “request for screening”, “transfers”, etc.;
- Providing periodic training on new and existing requirements
- Federal funding has been sought for automated training on assessments, person-centered planning and logistics of the system
- Analyzing data and providing agencies with feedback on performance.



Next Steps – Coordination at All Levels

Automated Systems MMIS

- System enhancements ongoing
- “Top three” assessment system changes submitted as EWO to Xerox will be completed no later than January 2016.

Reporting

- Dashboard measures refined
- Tableau reader was installed on all VDH and Idss computers

Emergency Regulations

- Emergency regulations under development with VDH, DARS, DMAS, local and hospital representatives



Next Steps – Coordination at All Levels

Manuals Revisions

- UAI Manual (DARS) updated
- Nursing Facility and Preadmission Screening Manuals
DMAS

Report to General Assembly

- Report to Senate Finance and House Appropriations completed and submitted

Children's Screenings

- Contract for children's screenings under review by Executive Management at DMAS



Next Steps – Coordination at All Levels

DMAS will, in coordination with our state and local partners:

- Support the direction of the OSHHR to DMAS, VDH and DARS, to accomplish the four goals identified earlier;
- solicit input from PAS teams; and
- Provide ongoing feedback, in coordination with VDH and DARS, of the progress made toward accomplishing the goals of the Secretary and implementing the budget directive.



The Goal

- The goal is to have assessments completed in a timely manner by December 2015 for 95% of all assessors



Department of Labor Final Rule Home Health Care Rule

November 16, 2015

Nichole Martin, Manager
Division of Long-Term Care



Department of Labor (DOL) Final Rule

- **October 1st, 2013**
 - DOL released Final Rule (29 CFR, Part 552); Major effects :
 - Expansion of FLSA minimum wage and overtime protections to additional previously uncovered domestic service workers (Companionship Exemption).
 - States that administer or contract services must determine if they are “**third party**” or “**joint employers**” .
 - Travel must be reimbursed under certain circumstances.

Implementation Delayed

- **December 22, 2014**, U.S. District Court vacated the third party regulation amended by the Home Care Final Rule.
- **January 14, 2015**, U.S. District Court vacated the Final Rule’s narrowed definition of companionship services.



Department of Labor (DOL) Final Rule

- **August 21, 2015**
 - U.S. Court of Appeals issues a unanimous decision upholding the validity of U.S. DOL's Rule.

Implementation Begins

- **November 12, 2015.**
 - Effective date of DOL Final Rule
 - From November 12 through December 31, 2015, DOL continues in the second phase of its previously announced time-limited non-enforcement policy.



Department of Labor (DOL) Final Rule

- Fiscal Employer Agent Services
 - Development of a standard system enhancement program to include:
 - Ability to calculate and pay overtime premium
 - Ability to prevent overtime reimbursement to attendants who meet the live-in exemption requirements
 - Ability to calculate travel time reimbursement
- DMAS intends full compliance on January 1, 2016.



Statewide Transition Plan

Assuring Settings Compliance

November 16, 2015

Teri Morgan, Supervisor
Division of Long-Term Care



Statewide Transition Plan (STP)

- On January 16, 2014 the Centers for Medicaid and Medicare Services (CMS) issued new regulations for the provision of Medicaid Home and Community-Based Services (HCBS).
- In response, states were required to submit a STP to CMS by March of 2015.
- The focus of a STP is how the state's HCBS will become compliant with the rules settings provisions.



Statewide Transition Plan (STP)

- The Commonwealth submitted its STP for all 1915(c) HCBS waivers in March of 2015; 1915(c) waivers include the following:
 - Intellectual Disability (ID) Waiver
 - Individual and Family with Developmental Disabilities (DD) Supports Waiver
 - Day Support Waiver (DS)
 - Elderly or Disabled with Consumer Direction Waiver (EDCD)
 - Technology Assisted (Tech) Waiver
 - Alzheimer's Assisted Living Waiver



Statewide Transition Plan (STP)

- A STP is considered the vehicle through which states determine their compliance with the regulation's settings provisions.
- The STP describes the actions the state will take to assure full and ongoing compliance with the regulation.
- The Commonwealth will not be finished with its assessment of compliance for all 1915(c) waiver settings until March of 2016. An undated STP, including the results of the state's assessment, will be submitted to CMS in March of 2016.



Statewide Transition Plan (STP)

- The Commonwealth's assessment of compliance includes the following activities:
 - A review of regulations, standards, policies and licensing requirements
 - Identification of setting types for each service
 - Provider self-assessments
 - Interviews with individuals and family members
 - On-site assessments
 - Review of service definitions
- The Commonwealth will have until March of 2019 to bring settings into compliance.

My Life, My Community: Medicaid Intellectual and Developmental Disability Waiver Redesign

Report to the Board of Medical Assistance Services

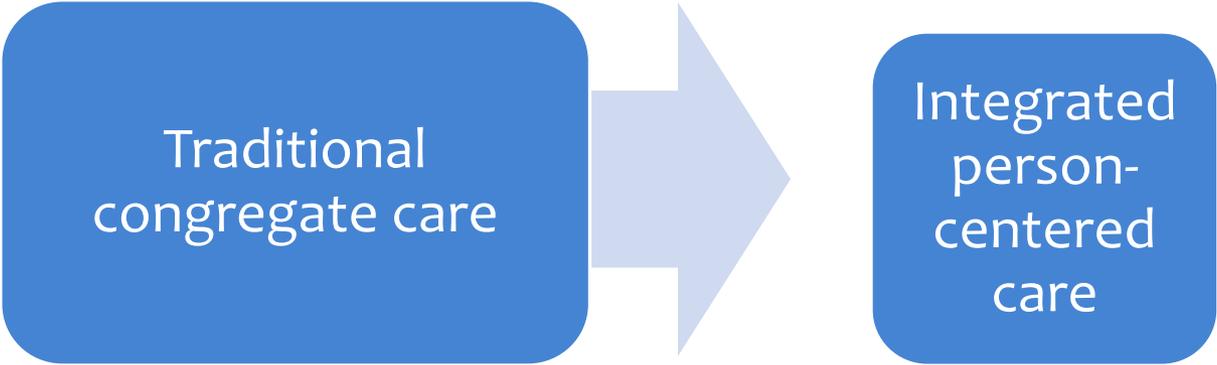


Karen Kimsey
Deputy Director for Complex Care
December 8, 2015

Redesign Mandate

Services for individuals
with developmental disabilities

Traditional
congregate care



Integrated
person-
centered
care

Redesign Mandate



- Americans with Disabilities Act



- Supreme Court Olmstead Decision



- US Dept. of Justice Settlement Agreement



- CMS “HCBS Final Rule”

Redesign Necessary

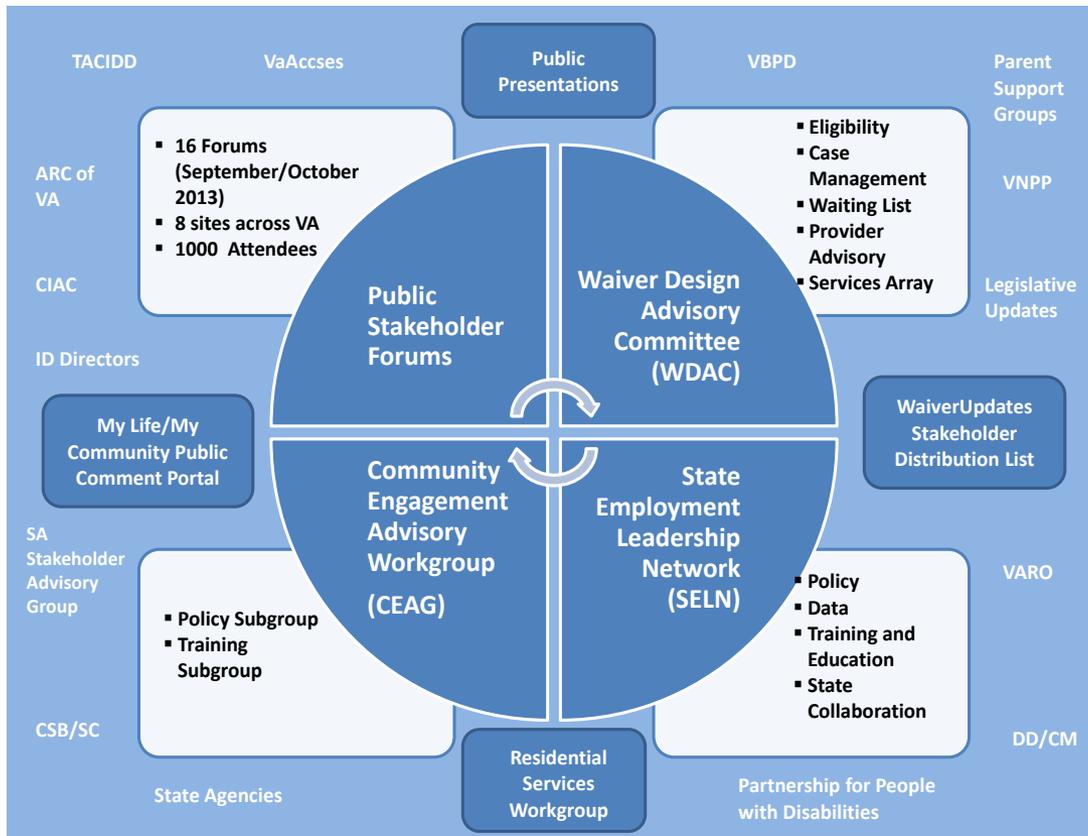
Comply with elements of the DOJ Settlement Agreement.

Provide community-based services for individuals with intense medical and behavioral support needs.

Expand opportunities that promote smaller, more integrated independent living options with needed supports.

Incentivize providers to adapt services and business models in support of the values and expectations of the community integration mandate.

Redesign Process



* DMAS and DBHDS collaborated over two years engaging expertise of consultants and stakeholders.

Waiver Amendments

The Community Living Waiver

(replaces ID waiver)

- Remains a comprehensive waiver that includes 24/7 residential services for those who require that level of support.
- Includes services and supports for adults and children, including those with intense medical and/or behavioral needs.

Waiver Amendments

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The Family and Individual Supports Waiver

(replaces DD waiver)

- Supports individuals living with their families, friends, or in their own homes.
- Supports both children and adults with some medical or behavioral needs.

Waiver Amendments

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(replaces DD waiver)

- Supports individuals living with their families, friends, or in their own homes.
- Supports both children and adults with some medical or behavioral needs.

The Building Independence Waiver

(replaces DS waiver)

- Supports adults 18 and older who are able to live in the community with minimal supports.
- Remains a supports waiver that does not include 24/7 residential services. Individuals will own, lease, or control their own living arrangements.

Rate Methodology

- * Quality services are incentivized through increased compensation to providers for supporting individuals with greater needs and providing services in more integrated and/or smaller settings.
- * Rates for services were established based on analysis of market costs, service definitions, and provider requirements.
- * Rates were published in April 2015.

Eligibility and Slot Assignments

- * Diagnostic and functional eligibility are confirmed by the local CSB.
- * Support needs are determined using the *Supports Intensity Scale*; individual choices and preferences are determined through person-centered planning.
- * A single statewide waiting list is maintained with individuals grouped into three categories of priority needs.
- * Regional assignment committees, comprised of community members and coordinated by DBHDS, determine waiver slot assignments.

Phase I Implementation – July 2016

- * Redesigned waivers and new services,
- * Non-diagnosis specific eligibility,
- * Assessment of needs and implementation of supports levels,
- * Single statewide waitlist, and
- * Data collection of service utilization.

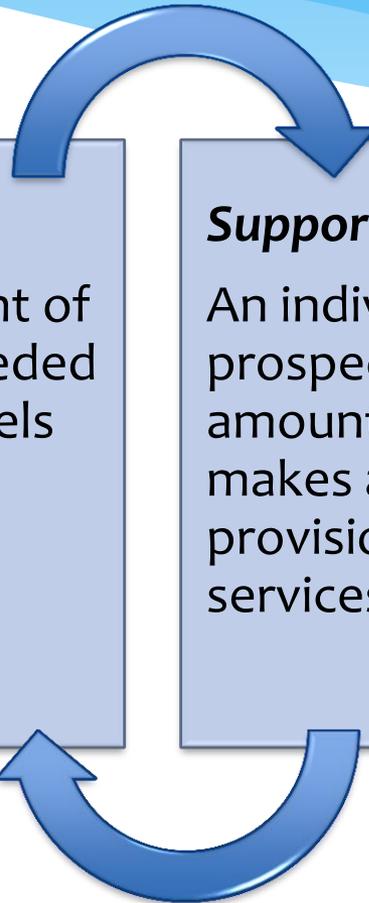
Phase II Implementation – July 2018

Service Package:

A profile of the mix and extent of services anticipated to be needed by individuals with similar levels of needs and abilities.

Supports Budget:

An individually-based, prospectively determined amount of funds that the state makes available for the provision of HCBS waiver services to an individual.



Actions Pending

- * Submission of report on the IDD Redesign submitted to CMS – November 2015
- * Submission of waiver amendments to CMS (December 2015).
- * CMS approval of waiver amendments and rate methodology.
- * General Assembly response to proposal and budget request (2016 Session).



Update on Medicaid Forecast and Budget Issues

Presentation to the:
Board of Medical Assistance Services

December 8, 2015

Forecasting Process

- Section 32.1-323.1 of the *Code of Virginia* mandates:

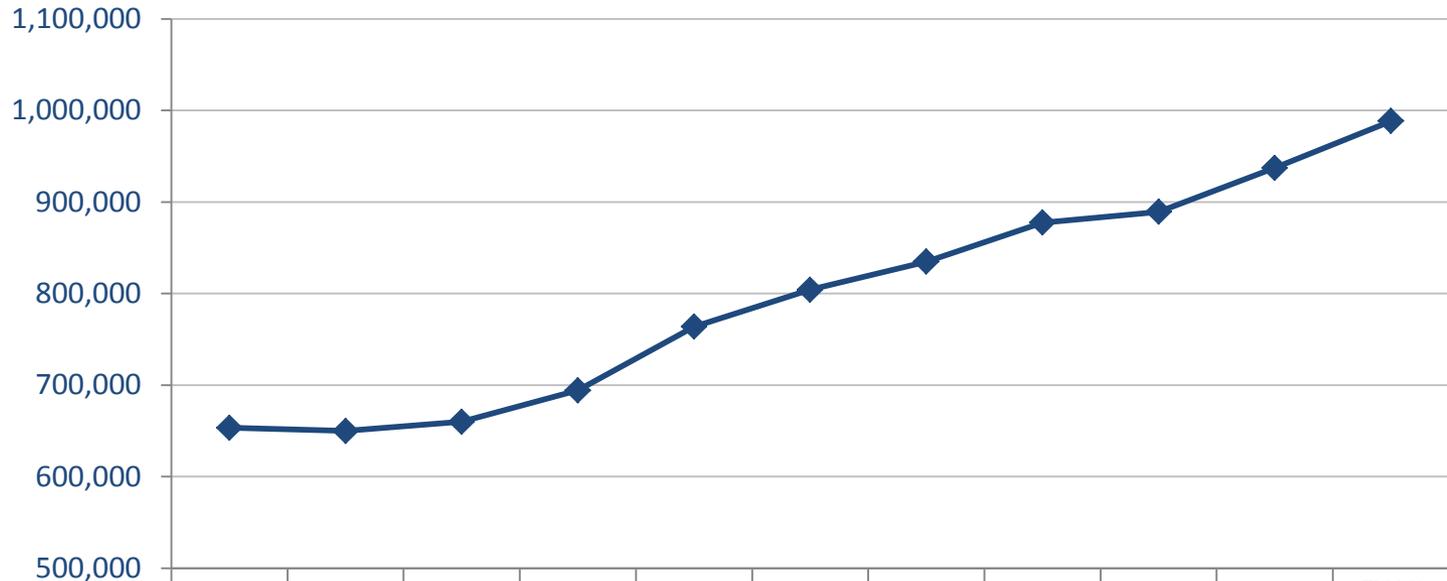
“By November 15 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit an estimate of Medicaid expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and to the Senate Committees on Finance and Education and Health, and to the Joint Legislative Audit and Review Commission.”
- Each year, DMAS and DPB prepare independent forecasts using monthly level expenditure and utilization data
- The forecasts are comprised of over 100 different models that project utilization and cost per unit for each benefit category
- Manual adjustments are made to the forecast to reflect implementation of new programs, one-time payments, or other series not best projected with statistical models

Forecasting Process

- Forecast projects spending in current and subsequent two years
- Forecast reflects:
 - Application of existing state laws and regulations
 - Changes in enrollment, utilization, inflation and acuity mix
- The two agencies meet to compare and evaluate the individual forecasts and an official “Consensus” forecast is adopted
- Due November 15 to Governor and General Assembly
 - October 15th Preliminary Forecast provided to Executive Branch

Enrollment

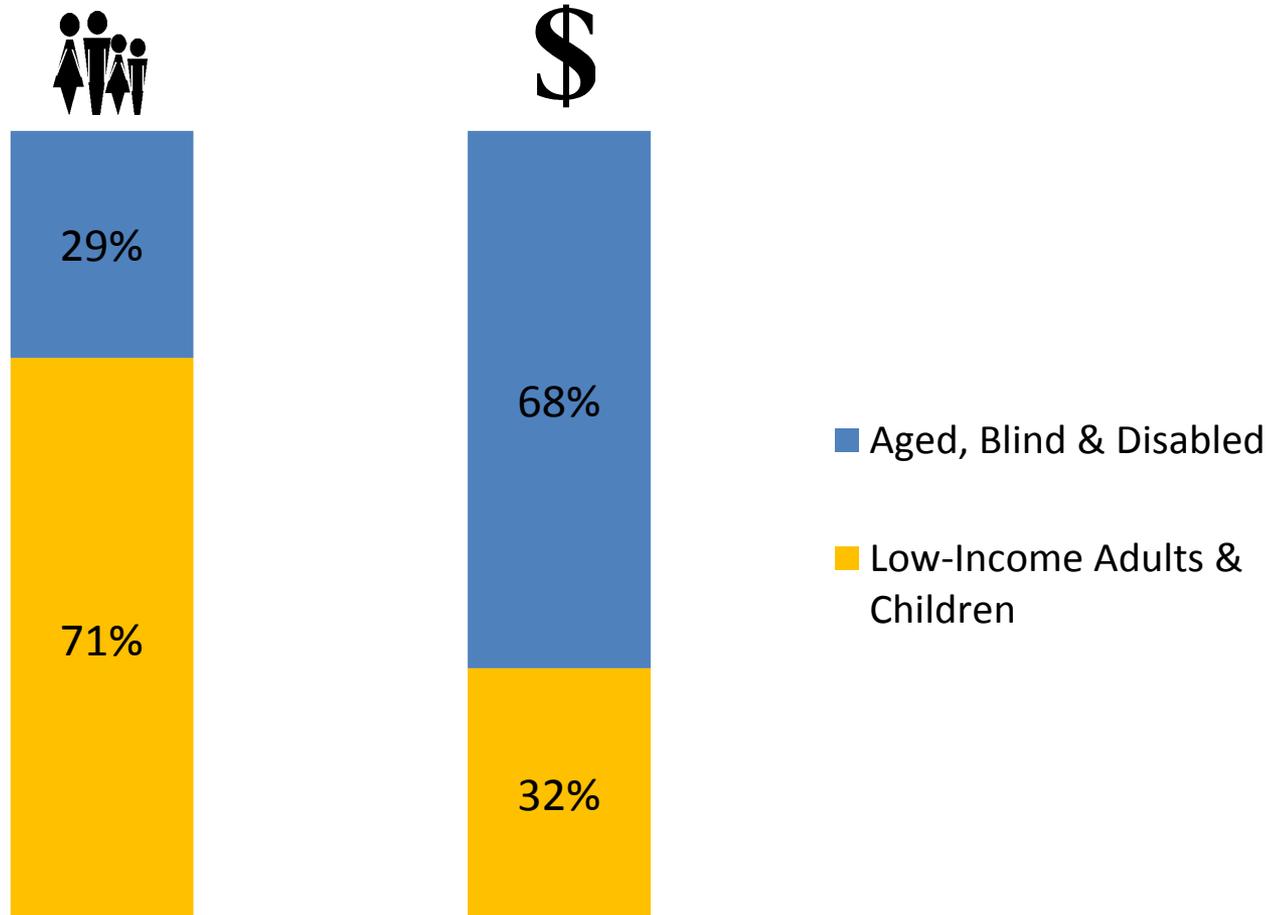
Medicaid – Average Monthly Enrollment



	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16 YTD
Monthly Enrollment	653,377	649,903	659,969	694,276	763,745	804,186	834,876	877,395	889,262	937,287	988,366
Annual Growth	6%	-1%	2%	5%	10%	5%	4%	5%	1%	5%	5%

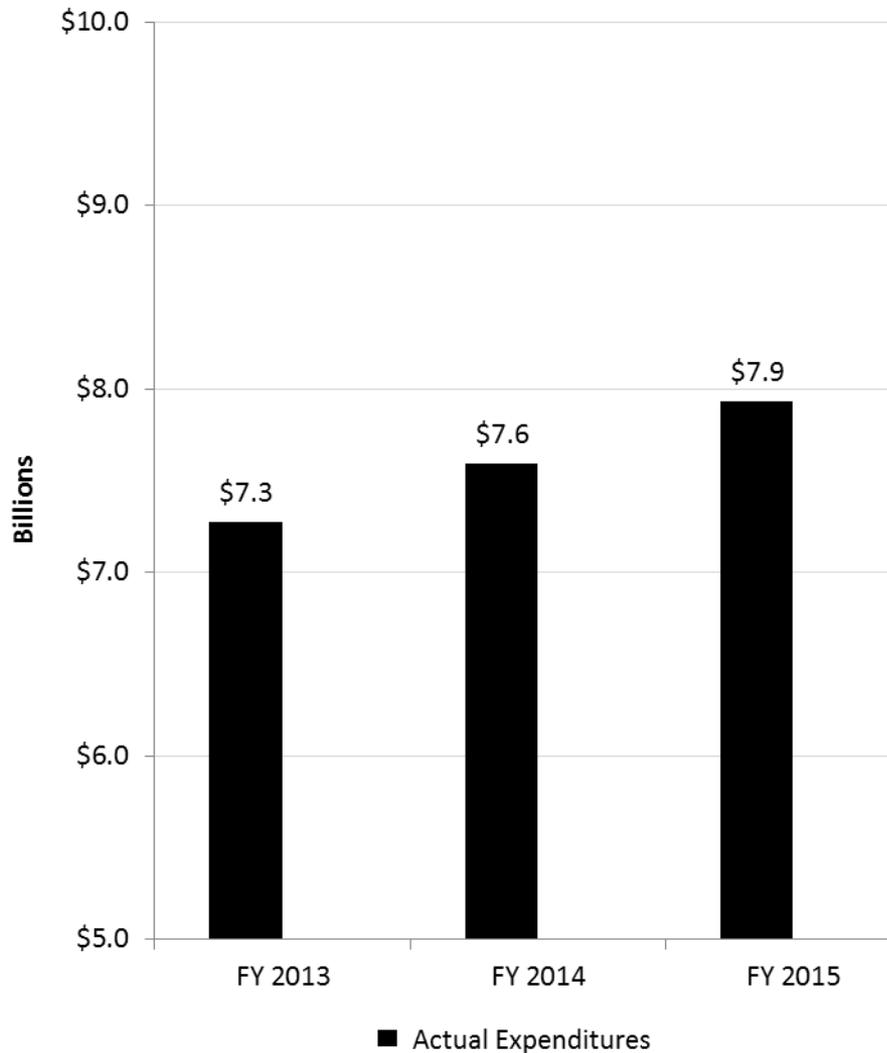
- Enrollment growth in FY15 was substantial and appears to be continuing into FY16.
- Enrollment has grown 51% FY2006 – FY2016 (October)

Enrollment v. Cost



- 30% of Medicaid enrollment is responsible for almost 70% of the expenditures

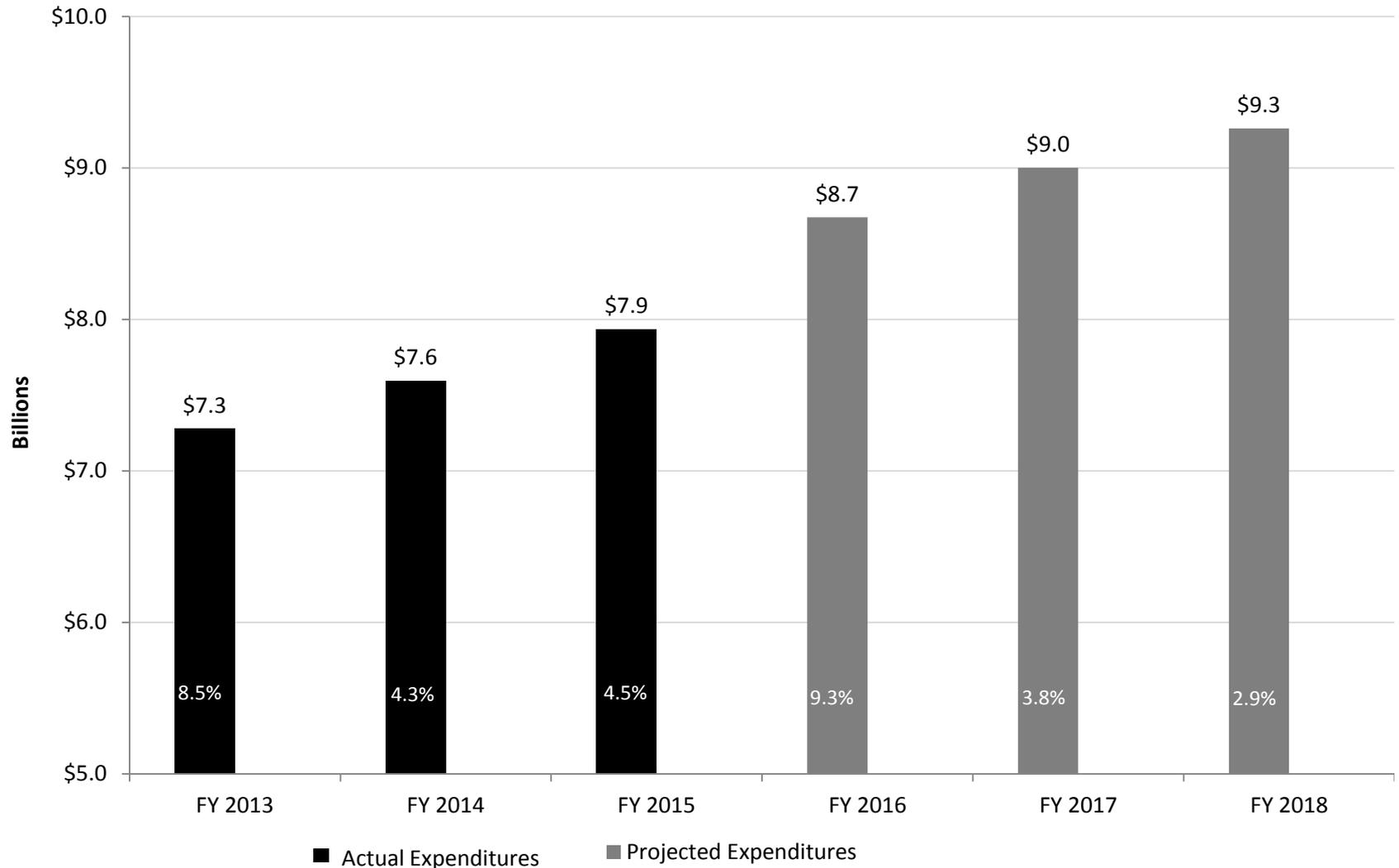
Official Medicaid Forecast



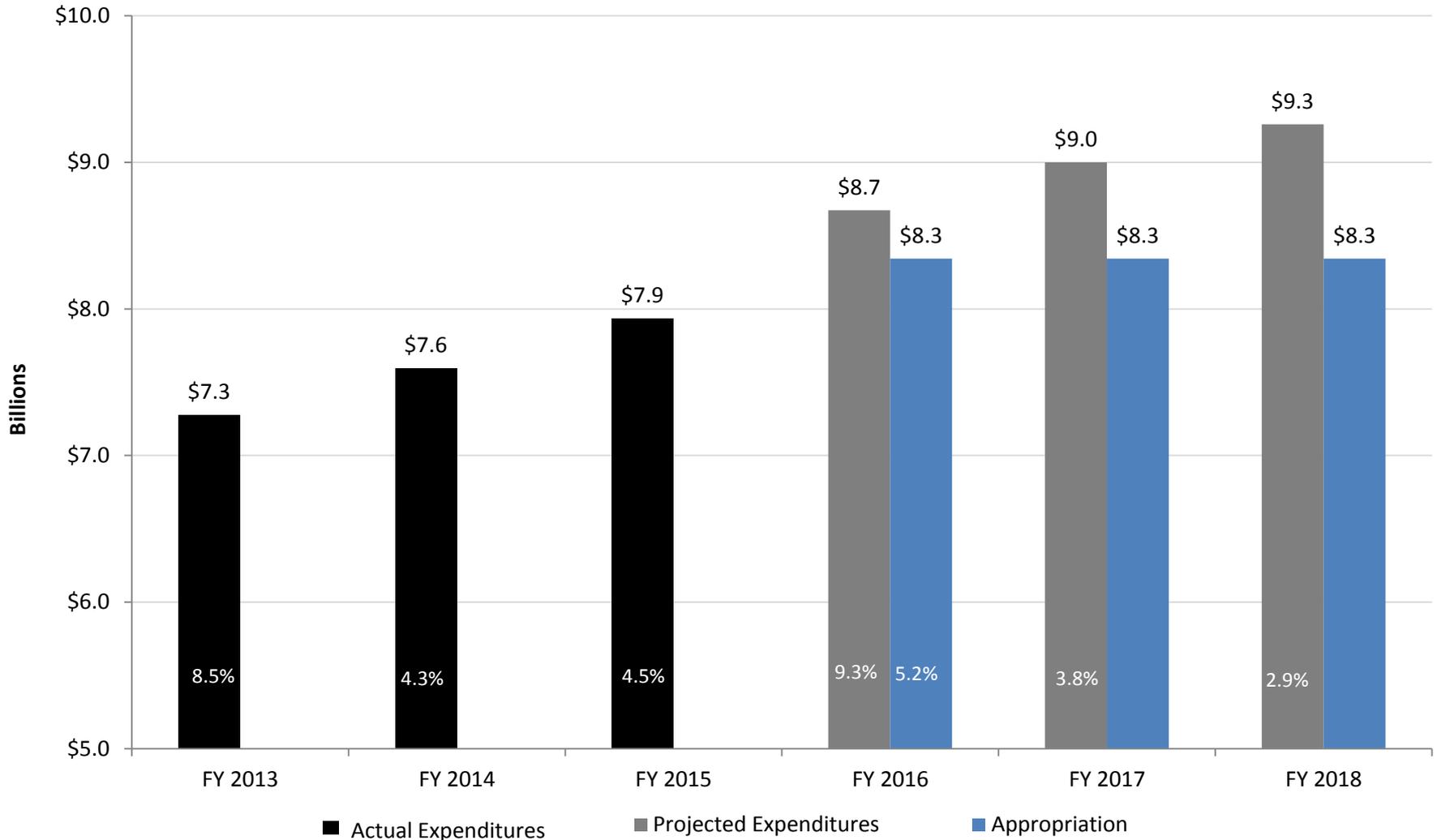
Expenditure Growth Drivers FY13-FY15

- Increasing enrollment growth
- Increasing numbers of individuals on LTC waivers
- Changes in utilization rates of services
- Changes in acuity and health care needs of enrollees

Official Medicaid Forecast



Base Medicaid Budget



Funding Surplus/(Need) based on Official Medicaid Forecast

		Appropriation (\$millions)	Consensus Forecast (\$millions)	Surplus/(Need) (\$millions)
FY 2016	Total Medicaid	\$8,343	\$8,673	(\$330.5)
	State Funds	\$4,258	\$4,425	(\$166.6)
	Federal Funds	\$4,085	\$4,249	(\$163.9)
FY 2017	Total Medicaid	\$8,343	\$9,001	(\$657.8)
	State Funds	\$4,258	\$4,586	(\$327.4)
	Federal Funds	\$4,085	\$4,415	(\$330.4)
FY 2018	Total Medicaid	\$8,343	\$9,261	(\$917.7)
	State Funds	\$4,258	\$4,720	(\$461.7)
	Federal Funds	\$4,085	\$4,541	(\$456.0)

FY16 Caboose	(\$167 GF)
FY17-FY18 Biennium	(\$789 GF)

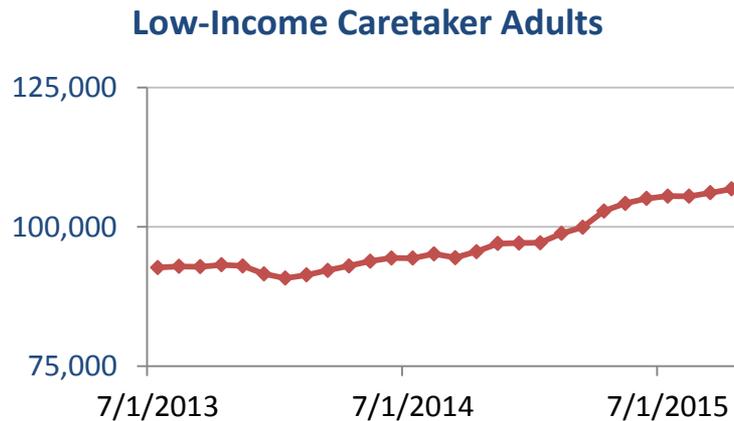
Figures may not add due to rounding

Explanation

➤ Steeper Enrollment Growth Began in FY15

- Higher than expected enrollment of low-income adults

Kaiser 50 State Medicaid Budget Survey Report 2015: “... enrollment and total Medicaid spending grew an average of 5.1 percent and 6.1 percent, respectively, in non-expansion states, with the increase in enrollment **largely due to increased participation of previously eligible parents and children** [emphasis added].”



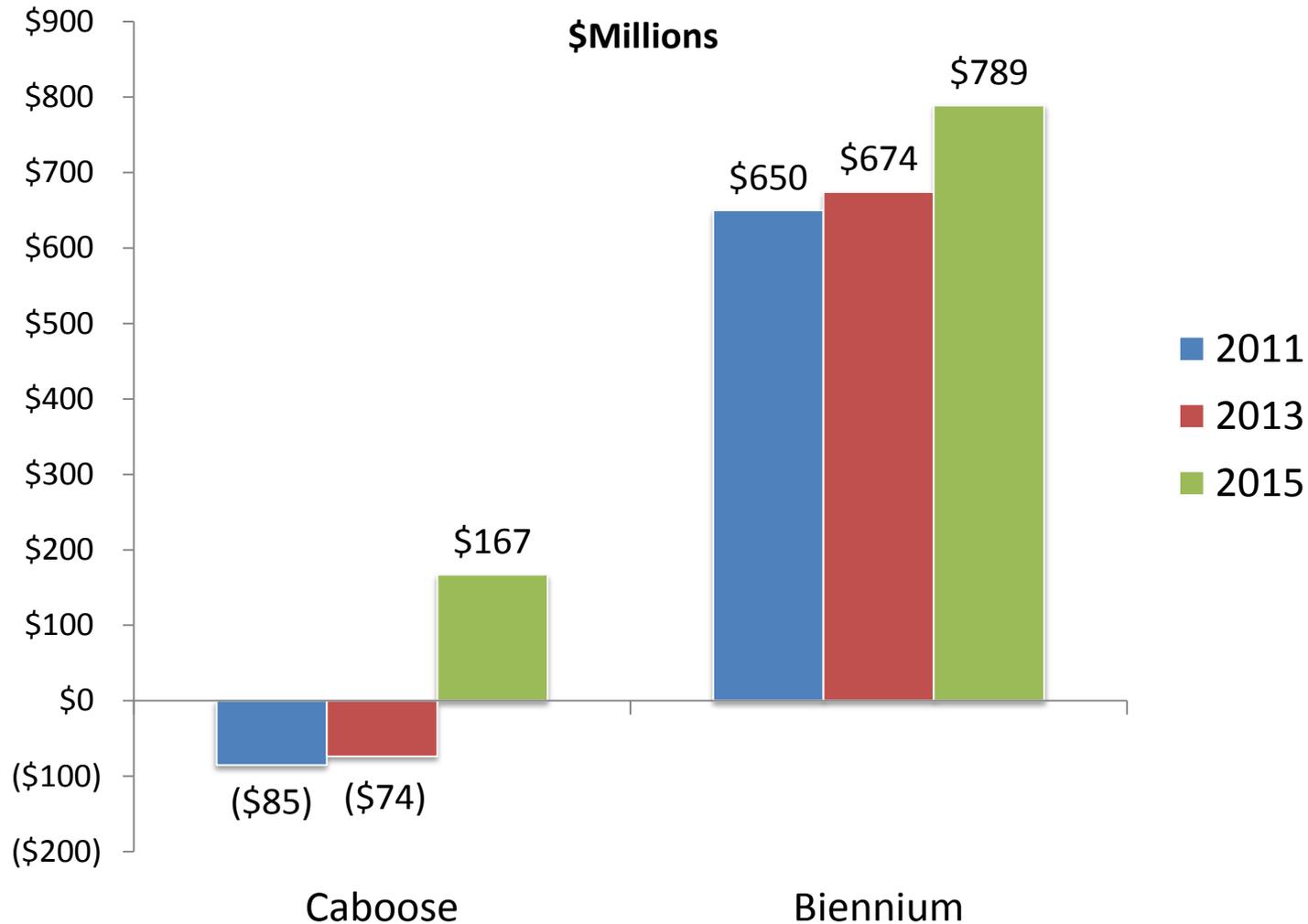
Explanation

➤ Projected Expenditures for FY16 are higher than projected last year

	<u>FY16</u>	<u>FY17</u>	<u>FY18</u>	
• Higher Enrollments of Low-Income Adults	(\$94M)	(\$94M)	(\$94M)	Total
	(\$47M)	(\$47M)	(\$47M)	GF
• DSH and Medicare Part D payments carried over from FY15	(\$130M)	\$0	\$0	Total
	(\$73M)	\$0	\$0	GF
• 15% increase in Medicare Part B Premiums effective Jan 2016	(\$14M)	(\$41M)	(\$49M)	Total
	(\$7M)	(\$20.5M)	(\$24.5M)	GF
• Federal DSH Disallowances	(\$26M)	(\$40M)	\$0	Total
	(\$26M)	(\$40M)	\$0	GF
• Implementation of DOL CD-Attendant Overtime Rule	(\$16M)	(\$32M)	(\$32M)	Total
	(\$8M)	(\$16M)	(\$16M)	GF
• 11.6% increase in Medicare Part D “Clawback” rate effective Jan 2016	(\$9M)	(\$18M)	(\$18M)	Total
	(\$9M)	(\$18M)	(\$18M)	GF

➤ Primarily one-time increases (“level-shifts”) as opposed to increasing growth trends

Medicaid Forecast Surplus/Need: Past Three Biennial Budget Sessions





Accelerating Delivery System Transformation in Virginia

Combined Section § 1115 Waiver
MLTSS and DSRIP

Update for the Board of Medical Assistance Services
December 8, 2015
Suzanne S. Gore
Deputy of Administration



Agenda

Introduction

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Comprehensive 1115 Waiver

Virginia seeks federal authority for two initiatives:

1 Medicaid Managed Long-Term Services and Supports

- Transitioning administrative for three home and community based services waivers
 - Alzheimer's waiver (Alzh)
 - Elderly or Disabled with Consumer Direction (EDCD)
 - Technology Assisted Waiver (Tech)
- Enrollment into selected health plans

2 Delivery System Reform Incentive Program



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MLTSS Strategy

Managed Long Term Services and Supports (MLTSS) will build on the successes of Virginia's Medicare-Medicaid enrollee demonstration - *Commonwealth Coordinated Care*.

Virginia seeks to:

Strengthen Model

Include Additional Populations

Operate Statewide



Mandate enrollment of eligible individuals into selected managed care plans.

These plans will be competitively selected to ensure access and high-quality care.



MLTSS Person Centered Delivery Model

The MLTSS strategy is to provide a person-centered, coordinated system of care that focuses on improving quality, access (including enhanced community capacity) and efficiency through value based payment models





MLTSS Included Populations

MLTSS includes the following populations:

Duals who are excluded from the CCC Demo

- Full Medicaid and any Medicare benefits
- Nursing facility and home and community based services (HCBS) waiver participants
- Approximately 46,000 individuals

Non-Duals with LTSS

- Nursing facility and HCBS waiver participants
- Waiver individuals in Medallion 3.0 (HAP)
- Approximately 18,000 individuals

CCC Demo Population

- Approximately 28,000 enrolled and 38,000 not enrolled
- Will transition to MLTSS after CCC demo ends, beginning January 1, 2018, and using a transition plan developed with CMS that ensures continuity of care

**Individuals enrolled in the ID, DD, and DS Waivers will continue to receive their HCBS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these Waivers. Individuals residing in ICF-ID facilities will be excluded from MLTSS until after the completion of the redesign*



HCBS Waiver Participants

The populations enrolled and services included in three home and community-based service (HCBS) waivers will be included in the MLTSS program.

DMAS seeks to **streamline administration** of multiple waiver authorities by transitioning the administrative authority of these § 1915(c) HCBS waivers.

The proposed migration of waiver authority will alter **neither eligibility nor services under the included HCBS waivers:**

- Alzheimer's waiver (Alzh)
- Elderly or Disabled with Consumer Direction (EDCD)
- Technology Assisted Waiver (Tech)



MLTSS Proposed Program Launch

MLTSS proposed launch includes a phased region approach:

Year	Date	Regions	Total Population*
2017	March 1, 2017	Tidewater	8,000
	May 1, 2017	Central	11,000
	July 1, 2017	Charlottesville/Western	13,000
	September 1, 2017	Roanoke/Alleghany	4,500
	September 1, 2017	Southwest	12,500
	November 1, 2017	Northern/Winchester	13,500
2018	Starting in January 2018	CCC Demonstration (Transition plan is to be determined with CMS)	67,000
Total		All Regions	129,500

Source – VAMMIS Data; *Approximate totals based upon MLTSS targeted population as of June 2015



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Delivery System Reform Incentive Payment (DSRIP) Progression

DSRIP presents a Strategic Opportunity for Virginia's Medicaid Program



- The **transformation priorities** in Virginia's Medicaid Program through DSRIP is driven by many factors
- **Clear objectives** supporting the case for change must be strong to drive support from CMS
- CMS expects the investment to achieve readiness for **value based payment**



DSRIP Goals

DSRIP presents a Strategic Opportunity for Virginia's Medicaid Program

Goal 1: Improved Beneficiary Health

Focusing on prevention and better management of health

Goal 2: Improved Beneficiary Experience

Interactions with both traditional health care providers and non-traditional community resources including experience related to access and the ease of obtaining care

Goal 3: Bend the Cost Curve

Change the trajectory of Medicaid spending through the reduction of preventable care, unnecessary care, or care delivered in unnecessary high-cost settings



DSRIP Strategy

Delivery System Reform Incentive Payment (DSRIP) Program will provide funding to optimally serve Medicaid's most complex enrollees through strengthening and better connecting the provider network. Transformation is achieved through a high-performing partnership of Medicaid providers (Virginia Integration Partners) working with health plans.

Features of Virginia Integration Partners (VIPs)

The partnership includes private and public medical, behavioral health, and long-term services and support providers and also includes care navigation and supports

Partnership receives funding to integrate care, data, processes, and communication to offer high-touch, person centered care

Funds to support the establishment of partnerships including the initial governance structure and processes. Funding will be obtained through achievement of outcome measures

Health systems focused on addressing Medicaid enrollees' complex needs will coordinate these partnerships

Initially supports high-utilizers and high-risk Medicaid enrollees

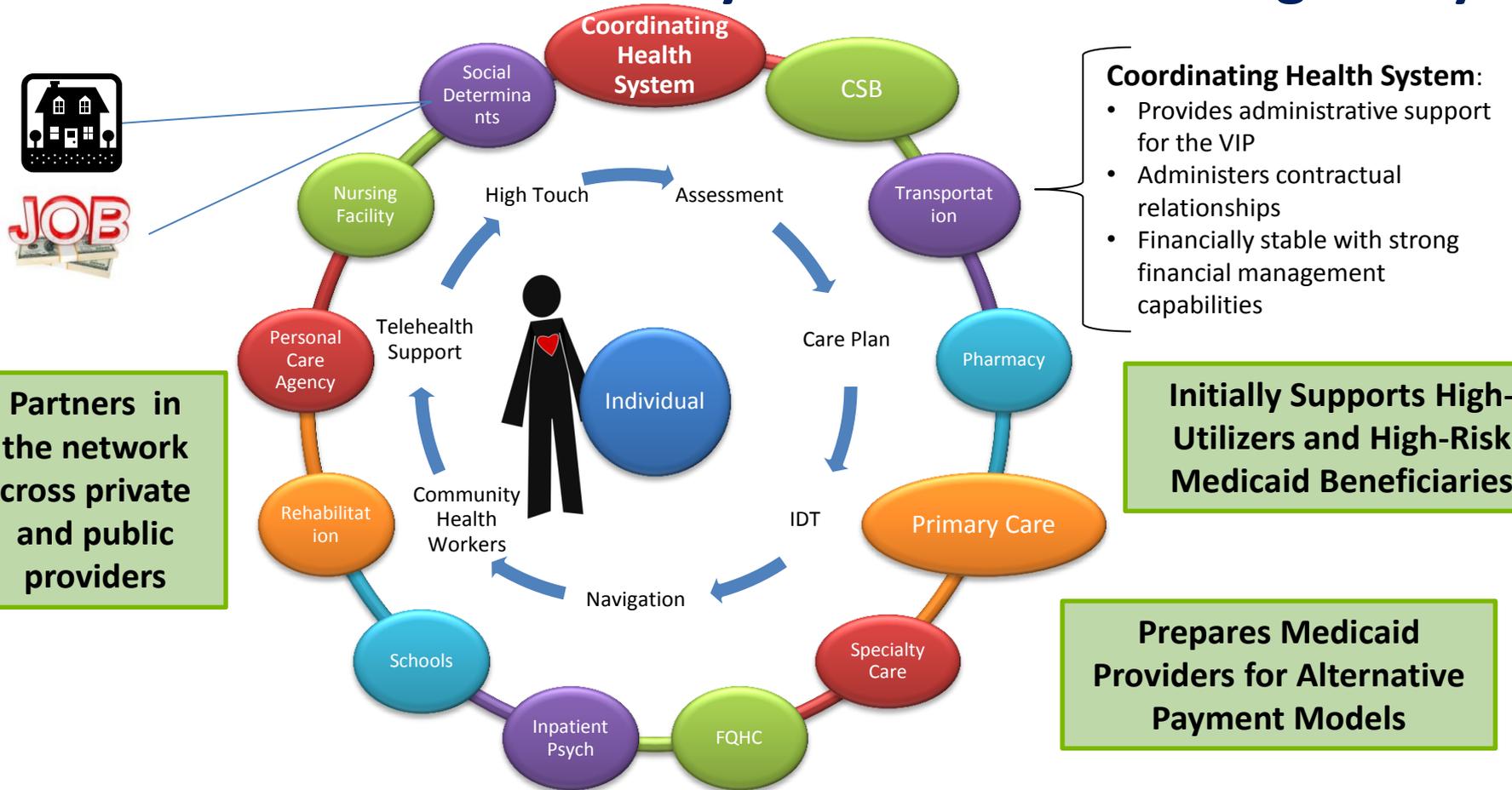
VIPs will achieve ongoing sustainability through transition to an Alternative Payment Models

VIP providers will be supported to transition to alternative payment models for additional Medicaid enrollees



Illustration: Virginia Integration Partners Network

VIP Network with Health System as Coordinating Entity





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Virginia's Anticipated Waiver Submission Timeline

**1115 Waiver Stakeholder
Outreach and Public Comment**

June – December

**1115 Waiver
Application
Submitted to CMS**

Winter

1115 Waiver Negotiations

**Estimated through
Fall of 2016**



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For More Information and to Submit Public Comment

INFORMATION:

- MLTSS updates are available on-line at:
http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx
- Delivery System Reform Incentive Payment (DSRIP) updates are available on-line at: http://www.dmas.virginia.gov/Content_pgs/dsrip.aspx

PUBLIC COMMENT:

- Submit Public Comment on Combined Strategy: MLTSS, DSRIP, HCBS Waiver Administrative Simplification (Tech, Alzh, EDCD) online at:
1115waiver@dmas.virginia.gov

Regulatory Activity Summary December 8, 2015
(* Indicates recent activity)

2015 General Assembly

***(01) Expand Alzheimer's Waiver:** This regulatory action was required by 2015 budget language. This regulation will more broadly define eligible individuals that may be served by the Alzheimer's Assisted Living waiver program. The final exempt regulation became effective on 9/9/15.

***(02) Pre-Admission Screening Changes:** This regulatory action is required by 2015 budget language. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services. These regulatory changes are currently being drafted.

***(03) Sterilization Compensation:** This regulation will allow DMAS to seek federal authority to exclude (for purposes of determining Medicaid eligibility) compensation provided to individuals who were involuntarily sterilized pursuant to the Virginia Eugenical Sterilization Act. A state plan amendment containing this change was approved by CMS on July 30, 2015 and VAC changes were submitted to the Governor for signature on 11/3/2015.

***(04) FAMIS MOMS Eligibility for State Employees:** This regulatory action will permit low-income state employees and their dependents to obtain coverage through FAMIS MOMS. The NOIRA for this package is being printed in the Register on 9/7/2015, which will open a 30-day public comment period. The comment period closed on 10/7/2015, and the proposed stage regulations are being drafted.

***(05) Technology Assisted Waiver Changes:** This regulatory action will change the use of private duty nursing; change the staff experience requirement to include a training program; and remove the reference to exhausting private insurance coverage. The NOIRA was published in the Register on 11/16/2015, and a public comment period is open through 12/16/2015.

***(06) Non-Institutional Provider Reimbursement Changes:** This regulatory action combines three separate items required by 2015 budget language. First, this regulatory action will eliminate the requirement for pending, reviewing, and reducing fees for emergency room claims. Second, it will increase supplemental payments for physicians affiliated with freestanding children's hospitals with more than 50 percent Virginia Medicaid inpatient utilization effective July 1, 2015. Third, it will establish supplemental payment for state clinics operated by the Virginia Department of Health (VDH) effective July 1, 2015. A prior public notice was published and a state plan amendment (SPA) was submitted to CMS on August 31, 2015. CMS sent informal questions about the SPA, and DMAS provided responses on 10/23/2015.

***(08) Institutional Provider Reimbursement Changes:** This action will eliminate inflation for inpatient hospital operating, graduate medical education, disproportionate share hospital,

and indirect medical education payments in FY16. It will also implement the "hold harmless provision" for nursing facilities that meet the bed capacity and occupancy requirements, reimbursing with the price-based operating rate rather than the transition operating rate for those facilities. A prior public notice was published and a SPA was submitted to CMS on 9/15/2015. CMS sent informal questions about the SPA, and DMAS provided responses on 11/16/2015.

***(09) Supplemental Payments to Medical Schools in Eastern VA:** This action will update the average commercial rate calculation of supplemental payments for physicians affiliated with a publicly funded medical school in Tidewater effective October 1, 2015. A prior public notice was published and a SPA was submitted to CMS on 11/12/2015.

***(10) MAGI:** This action implements Modified Adjusted Gross Income (MAGI) thresholds in the Medicaid program and Children's Health Insurance Program (CHIP) in accordance with federally mandated eligibility determination requirements created under the Affordable Care Act. Multiple state plan amendments were submitted to CMS and approved in November and December, 2013. This final exempt regulation copies the state plan changes into state regulations. The final exempt regulations and Town Hall background document were submitted to the Office of the Attorney General (OAG) on 6/22/15.

***(11) CHIP Eligibility – Same Sex Marriage:** This action changes the Virginia state plan to recognize same-sex couples as spouses for purposes of determining CHIP eligibility. The CHIP state plan amendment was submitted to CMS on 6/25/15. CMS asked DMAS to withdraw the SPA, stating that the state plan change was not necessary due to the U.S. Supreme Court decision issued on 6/26/2015 in the *Obergefell vs. Hodges* case. DMAS withdrew the SPA on 8/21/2015.

***(12) Medicaid Eligibility – Same Sex Marriage:** This action changes the Virginia state plan to recognize same-sex couples as spouses for purposes of determining Medicaid eligibility. The Medicaid state plan amendment was submitted to CMS on 7/30/15. CMS asked DMAS to withdraw the SPA, stating that the state plan change was not necessary due to the U.S. Supreme Court decision issued on 6/26/2015 in the *Obergefell vs. Hodges* case. DMAS withdrew the SPA on 9/1/2015.

***(13) Treatment of Annuities:** This action complies with a federal Deficit Reduction Act, which requires DMAS to treat annuities and income from annuities according to certain rules, for purposes of determining Medicaid eligibility. Regulatory changes were drafted and submitted to the OAG on 9/14/2015.

***(14) Hospital Presumptive Eligibility:** In 2014, DMAS submitted a SPA to CMS to permit certain hospitals to make presumptive eligibility determinations for individuals seeking to be treated at those hospitals. The SPA was approved on July 28, 2015, and DMAS drafted related regulatory changes. These were submitted to the OAG on 10/29/2015.

***(15) Supplemental Payments for Private Hospital Partners:** CMS approved SPAs permitting DMAS to make supplemental payments to private hospital partners, and DMAS

has drafted related regulatory changes. These changes were submitted to the OAG on 10/26/2015.

(16) Property Sales at Less Than Tax-Assessed Value: This action complies with federal changes by changing the Medicaid eligibility rules that relate to property sales at less than tax-assessed value. Regulations have been drafted and are being reviewed internally prior to being submitted to the OAG for certification.

(17) Reimbursement Changes for Fee-For-Service Providers and Services that Are Reimbursed on a Cost Basis: CMS approved SPAs so that DMAS reimbursed fee-for-service providers, and services based on a cost basis, according to certain requirements. DMAS drafted regulatory changes, which are being reviewed internally before being submitted to the OAG for certification.

(18) Utilization Review Changes: DMAS has drafted a NOIRA to implement regulatory changes to more accurately reflect current industry standards and trends in the area of utilization review. The documents are being reviewed internally before being posted on the Town Hall.

(19) Recovery Audit Contractor: DMAS has drafted a State Plan Amendment to reflect that Virginia will not have a Recovery Audit Contractor (RAC) in place for a limited time while that contract is re-procured. DMAS entered into negotiations with the prior RAC but the negotiations were unsuccessful, and the contractor eventually determined that it would not renew the contract for the option year. The SPA is being reviewed internally before being sent to HHR for review.

2014 General Assembly

***(01) Discontinue Coverage for Barbiturates for Duals:** This SPA, effective January 1, 2014, enacts Section 2502 of the Affordable Care Act which amended section 1927(d)(2) of the *Social Security Act*. It excluded from Title XIX coverage for all conditions for barbiturates, by removing barbiturates and agents when used to promote smoking cessation from the list of drugs a state Medicaid program may exclude from coverage or otherwise restrict. The SPA was approved by CMS on 4/23/14. The Fast-Track regulatory package became effective on 10/11/2015.

(02) Supplemental Payments for County-Owned NFs: This action provides supplemental payments to locality-owned nursing facilities who agree to participate. The SPA was approved by CMS on 12/5/2014 and changes to parallel administrative code sections are awaiting approval by the Secretary.

(03) Hospital DSH Reduction: This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA was approved by CMS on 6/2/15 and a fast track regulatory action was submitted to the OAG for review on 7/16/15.

***(04) NF Price Based Reimbursement Methodology:** This action changes the cost-based methodology with the priced based method and was mandated by Chapter 2 of the *2014 Acts*

of the Assembly, Item 301 KKK. The SPA was approved by CMS on 5/4/15. Fast Track changes to parallel administrative code sections are being reviewed by the Governor.

(05) Hospital APR-DRG Methodology Change: This action changes the APR-DRG grouper for hospital reimbursement and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 VVV. The SPA was approved by CMS on 6/2/15 and changes to parallel administrative code sections are being reviewed by the Secretary.

***(06) Type One Hospital Partners' Supplemental Payments:** This action provides supplemental payments to Type One hospitals (state-owned teaching hospitals) qualifying partners and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 DDDD. The SPA was approved by CMS on 1/27/2015. The VAC action was signed by the Governor on 11/13/2015 and will be published in the Register on 12/14/2015. The regulations will become effective on 1/29/2016.

***(07) GAP SMI Demonstration Waiver Program:** The agency began work designing this new non-Medicaid program in early September in response to the Governor's directive. It provides a package of limited benefits to individuals who are 21 to 64 years old, uninsured, and residents of the Commonwealth. Some of the benefits are: physician, clinic, diagnostic outpatient procedures for both medical health conditions and behavioral health conditions related to diagnoses of serious mental illness. CMS approved the program in December, 2014. The emergency regulation action became effective 1/1/2015. The General Assembly proposed changes to this program in the 2015 budget and DMAS drafted a revised emergency regulation to incorporate these changes, which became final on 6/24/15. The proposed stage regulation, which will incorporate the changes from both emergency regulations, was submitted to the OAG for review on 11/16/2015.

***(08) HIV Premium Assistance Program:** The agency published a notice of periodic review for this small program and is initiating a rule making action. The changes to be made are: (i) individuals will no longer have to be unable to work; (ii) income considered during the eligibility determination process will be that of only the individual and spouse (rather than family), and; (iii) liquid countable assets is being expanded to include more types beyond the limited list in the regulations. The agency drafted a Fast Track action for the VAC changes, which became effective on 10/22/15. No SPA is required.

***(09) GAP FAMIS Coverage of Children of State Employees:** The agency began work developing this FAMIS expansion in early September in response to the Governor's directive. It provides FAMIS coverage for the children of state employees who have low incomes. The emergency regulation became effective 1/1/2015. The permanent, proposed stage regulation is being published in the Register on 11/30/2015 with a public comment period through 1/29/2016.

***(10) GAP Dental Services for Pregnant Women:** The agency began work developing this Medicaid service expansion in early September in response to the Governor's directive. It provides complete, with the exception of orthodontia, dental service coverage to the 45,000 Medicaid-eligible pregnant women. The emergency regulation became effective on 3/1/2015 and CMS approved the SPA on 5/18/15. The permanent replacement regulation was signed

by the Governor on 11/13/2015. It will be published in the Register on 12/14/2015 and a comment period will be open through 2/12/2016. The regulation will then enter the final stage.

***(11) MEDICAID WORKS:** This action is tied to item (02) in the 2011 General Assembly section below. As a result of CMS approval of the agency's SPA for the 2011 action, the agency modified the VAC to maintain the parallel contents between the Plan and VAC. A Fast Track action will become effective on 12/16/2015.

***(12) Mandatory Managed Care (Medallion 3.0) Changes:** This emergency regulation action requires individuals who receive personal care services via the Elderly or Disabled with Consumer Direction waiver to obtain their acute care services through managed care. It also shortens the time period for pregnant women to select their managed care organizations and complete the MCO assignment process. This emergency regulation became effective on 1/1/2015. The permanent replacement regulation was signed by the Governor on 11/13/2015. It will be published in the Register on 12/14/2015 with a comment period that will run through 2/12/2016. The regulation will then enter the final stage.

***(13) MFP First Month's Rent:** This Fast Track action permits the coverage of the first month's rent for individuals who qualify for assistance from Money Follows the Person assistance as they leave institutions and move into their communities. This is permitted by federal law and has been requested by community advocates. The VAC action will become effective on 1/1/2016.

2013 General Assembly

***(01) Targeted Case Management for Baby Care, MH, ID, and DD:** This SPA incorporates the reimbursement methodology for targeted case management for high risk pregnant women and infants up to age 2, for seriously mentally ill adults, emotional disturbed children or for youth at risk of serious emotional disturbance, for individuals with intellectual disability and for individuals with developmental disability. The SPA package was approved by CMS 12/19/13. The final-exempt VAC package was submitted to the OAG on 11/12/2015.

***(02) Consumer Directed Services Facilitators:** This Emergency/NOIRA complies with the *2012 Acts of the Assembly* Item 307 XXX that directed the DMAS to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home-and-community-based waiver enrollees. This regulatory package was certified by the OAG on 11/2/2015 and is being reviewed by DPB. No SPA action is required.

***(03) Exceptional Rate for ID Waiver Individuals:** This Emergency/NOIRA enables providers of congregate residential support services, currently covered in the Individual with Intellectual Disabilities Waiver (ID waiver), to render, in a more fiscally sound manner, services to individuals who have complex medical and behavioral care needs. Some of these individuals have long been institutionalized in the Commonwealth's training centers, and are being moved into community settings over the next several years in response to the settlement of the lawsuit brought against the Commonwealth by the Department of Justice. For

providers to render services for such individuals, it is requiring substantially more staff time and skills. This regulatory action has been approved by the Governor and was submitted to the Registrar for publication on 11/13/14. The waiver change was approved by CMS on 4/23/2014. An emergency regulation is effective until 5/1/16. The proposed stage regulation was published in the Register on 11/16/2015 with a public comment period through 1/15/2016.

***(04) Cost Report Submission; Credit Balance Reporting:** This Fast-Track modifies the Nursing Facility (NF) reimbursement methodology in two areas: (i) makes a technical correction to an incorporation by reference included in NF cost reporting requirements, and; (ii) updates NF credit balance reporting requirements to reflect more current Medicaid policies. This regulation was published in the Virginia Register on 11/16/2015 and will become effective on 12/16/2015. A SPA of affected parallel State Plan sections has been drafted and is circulating through the agency.

***(05) Changes to Institutions for Mental Disease (IMD) Reimbursement:** This Emergency/NOIRA is the result of the 2012 *Acts of the Assembly*, Chapter 3, Item 307 CCC, which directed DMAS to develop a prospective payment methodology to reimburse institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others. The SPA was approved on 6/2/15. This Emergency regulation became effective 7/1/14. The permanent replacement regulation is awaiting OAG certification.

***(06) Medicare-Medicaid Alignment Demonstration (FAD)/Commonwealth Coordinated Care (CCC):** This SPA is being implemented by CMS to streamline service delivery, improve health outcomes, and enhance the quality of life for dual eligible individuals and their families. Under the Demonstration's capitated model, DMAS, CMS, and selected managed care organizations (MCOs) have entered into three-way contracts through which the MCOs receive blended capitated payments for the full continuum of covered Medicare and Medicaid benefits provided to dual eligible individuals, including Medicaid-covered long term services and supports and behavioral health care services. The participating MCOs will cover, at a minimum, all services currently covered by Medicare, Medicaid wrap-around services, nursing facility services, Medicaid-covered behavioral health services, home and community-based long-term services and supports provided under the Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver. Robust care coordination, interdisciplinary care teams, and person-centered care plans are also mandatory services that must be provided through the participating MCOs. Virginia plans to offer the Demonstration from January 1, 2014, through December 31, 2016. This SPA was submitted to CMS 3/28/13 and was approved by CMS 6/12/13. The Emergency regulation took effect 12/10/2014. The proposed stage of the permanent regulation is circulating through the agency prior to OAG submission.

***(07) Repeal Family Planning Waiver Regulations:** The Family Planning program is a benefit to qualified low income families by providing them with the means for obtaining medical family planning services to avoid unintended pregnancies and increase the spacing between births to help promote healthier mothers and infants. The purpose of this amended regulation is to implement the change of the program from a demonstration waiver to the state

plan option to be in compliance with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2011. This action was put on hold, but has been re-activated and the proposed stage was submitted to the OAG on 9/14/2015.

2012 General Assembly

***(01) EPSDT Behavioral Therapy Services:** The NOIRA action promoted an improved quality of Medicaid-covered behavioral therapy services provided to children and adolescents who may have autism spectrum disorders and similar developmental disorders. The proposed changes will differentiate Medicaid's coverage of behavioral therapy services, including applied behavior analysis, from coverage of community mental health and other developmental services and establish provider qualifications and clear criteria for Medicaid payment. This regulatory package was approved by DPB 11/27/12 and submitted to the Registrar's office 12/12/12 for publication in the *Virginia Register* 1/14/13 and the comment period ended 2/13/13. The proposed stage regulation was reviewed by the Governor's office, which asked that it be revised to account for Board of Medicine regulations that now govern the providers of behavioral therapy services. DMAS is currently revising the regulations.

***(02) Mental Health Skill-Building Services:** The Emergency/NOIRA complied with the *2012 Acts of the Assembly*, Chapter 3, Item 307 LL that directed programmatic changes to Community Mental Health services to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The *2012 Acts of Assembly*, Chapter 3, Item 307 RR (f) directed DMAS to implement a mandatory care coordination model for Behavioral Health. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Services. Emergency regulations became effective 10/10/13. DMAS received an extension, and the ER will last until 10/19/15. The proposed stage public comment period closed on 10/23/2015 and DMAS is currently drafting the final stage documents.

***(03) Appeals Regulations Update:** This Emergency/NOIRA regulatory action complied with the legislative mandate (Item 307, III of the *2012 Acts of Assembly*) and addressed recent case law and administrative decisions. These actions have created the need to clarify existing appeals processes and codify emerging processes made urgent by court and administrative case decisions and the increasing volume of appeals generated by provider audits and other utilization review mandates. The SPA was approved by CMS 12/12/12. DMAS received an extension of the emergency regulation, and it is in effect from 1/1/14-12/30/15. The Governor signed the proposed stage regulation and a public comment period opened on 11/2/2015.

2011 General Assembly

***(01) Inpatient and Outpatient Rehabilitation Update:** This Fast-Track action resulted from internal agency review. DMAS is updating its regulations for both inpatient and outpatient rehabilitation services, including services provided in Comprehensive Outpatient Rehabilitation Facilities (CORFs). In addition, several sections of regulations in Chapter 130 are being repealed and some of the retained requirements formerly located in that Chapter are being moved to Chapters 50 and 60. Outdated, duplicative, and unnecessary regulatory

requirements in Chapter 130 are repealed. This regulatory package was published in the Register on 11/16/2015 and will become effective on 1/1/2016.

***(02) Client Medical Management (CMM):** The Emergency/NOIRA action was designed to assist and educate beneficiaries in appropriately using medical and pharmacy services. Members who use these services excessively or inappropriately, as determined by DMAS, may be assigned to a single physician and/or pharmacy provider. DMAS received an extension of the emergency regulation, which is effective 12/16/13 to 12/15/2015. The fast-track stage was published in the Register on 10/19/2015 and will become effective on 12/3/2015.

***(03) 2011 Exceptions to Personal Care Limit:** This action complied with the legislative mandate to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services (which includes supervision time). The final stage documents were signed by the Governor on 11/6/2015. They were published in the Register on 11/30/2015 and will become effective on 12/20/2015.

2010 General Assembly

***(01) Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications:** This Emergency/NOIRA action complied with the 2010 Appropriations Act that required DMAS to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. The final regulations became effective 1/30/2015. A SPA was submitted to CMS on 3/25/15. CMS sent a Request for Additional Information on 6/10/2015 and DMAS submitted responses. During a subsequent conference call with CMS, DMAS took this project off the clock in order to prepare additional changes requested by CMS.

2009 General Assembly

***(01) Social Security Number Data Match for Citizenship and Identity:** This Fast-Track change conforms to CHIPRA of 2009 which offers states a new option to assist Medicaid applicants and recipients in the verification process. Section 211 of CHIPRA gives states the ability to enter into a data match with the Social Security Administration to verify the citizenship and identity of Medicaid applicants and recipients who claim to be United States citizens. Because provision of a Social Security number is already a condition of eligibility for Medicaid, adoption of this option will remove a barrier to enrollment and will result in a more seamless application process for most Medicaid applicants and recipients. This regulatory package was published in the Register on 12/2/2015 and will become effective on 12/15/2015.

Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.