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

**April 9, 2013**

**Minutes**

**Present:**
Joseph W. Boatwright, III, M.D.
Michelle Collins-Robinson
David B. Darden
Kay C. Horney
Barbara H. Klear
Karen S. Rheuban, M.D.
J. Mott Robertson, Jr. M.D.

**Absent:**
Brian Ewald
Monroe E. Harris, Jr., D.M.D. (Chair)
Ashley L. Taylor, Jr.
One vacant position

**DMAS Staff:**
Cheryl J. Roberts, Deputy Director for Operations
Elizabeth McDonald, 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
Scott Crawford, Deputy Director for Finance
Steven E. Ford, Deputy Director for Administration
H. Bryan Tomlinson, Director, Health Care Services

**Guests:**
W. Scott Johnson, First Choice Consulting
Chris Whyte, Vectre Corporation
R. J. Gilson, Xerox
Susan M. Matthews, Med Insurance
Rick Meidlidger, Johnson & Johnson
Emily O'Brion, McGuireWoods Consulting
Ralston King, Whitehead Consulting
Hunter Jamerson, Macaulay & Burtch
Mira Signer, NAMI Virginia

## Call to Order

The meeting was called to order at 10:00 a.m. by Cynthia B. Jones, Director of the Department of Medical Assistance Services, who announced that a quorum was present. Ms. Jones also noted that both the Chair of the Board, Dr. Monroe E. Harris, and the Vice-Chair were absent, and that the By-Laws did not address this situation. However, after consulting with legal counsel, Ms. Jones was informed that a Board member could move that she preside over the meeting until the first order of business, which is the election of officers, was completed. Board member, Ms. Klear, so moved and it was seconded by Dr. Robertson.

The vote was **7-yes (Boatwright, Collins-Robinson, Darden, Horney, Klear, Rheuban, and Robertson); 0-no.**

## Election of Chairman/Vice Chairman

Ms. Jones presided over the election of the Board Officers and noted that the Board bylaws require the election of officers for the Board the first meeting after March 1st of each year. She opened the floor to accept nominations for Chair. Ms. Klear made a motion to nominate Dr. Rheuban as Chair and Dr. Boatwright seconded. Hearing no further nominations, the nominations were closed. The vote to elect Dr. Rheuban as Chair was **7-yes (Boatwright, Collins-Robinson, Darden, Horney, Klear, Rheuban, and Robertson); 0-no.**

Ms. Jones opened the floor to accept nominations for Vice Chair. Ms. Horney made a motion to nominate Dr. Boatwright and Dr. Rheuban seconded. Hearing no other nomination, the nominations were closed. The vote to elect Dr. Boatwright as Vice Chairman was **7-yes (Boatwright, Collins-Robinson, Darden, Horney, Klear, Rheuban, and Robertson); 0-no.**

## Selection of Secretary

Ms. Jones then opened the floor to accept nominations for Board Secretary. Mr. Darden made a motion to accept Mamie White as Board Secretary and Dr. Boatwright seconded. The vote to elect Ms. White as Secretary was **7-yes (Boatwright, Collins-Robinson, Darden, Horney, Klear, Rheuban, and Robertson); 0-no.**

Ms. Jones stated that the Secretary of the Commonwealth, as well as the Secretary of Health and Human Resources, were aware of the two provider (Darden and Harris) and three non-provider (Horney, Klear, Murray) positions whose terms had expired or had resigned. She announced Mr. Darden's resignation effective April 30 and commented that these positions may be filled by the next meeting in June.

## Approval of Minutes from December 4, 2012 Meeting

Dr. Rheuban asked that the Board review and approve the Minutes from the December 4, 2012 meeting. Dr. Robertson made a motion to accept the minutes and Dr. Boatwright seconded. The vote was unanimous. **7-yes (Boatwright, Collins-Robinson, Darden, Horney, Klear, Rheuban, and Robertson); 0-no.**

## DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Jones provided a brief overview on the Medicaid reform language (Budget Language Item 307#20c attached) and projects currently in progress. She also reported that the Governor's health care team is working very hard with the Secretary of Health and Human Services (HHS) and other key staff to evaluate all options for reforming the Virginia Medicaid program.

## NEWBORN ENROLLMENT

Ms. Michelle Collins-Robinson inquired about the status of the newborn enrollment pilot project implemented in March in the Clinch Valley region to get newborns enrolled more efficiently and quickly while the mother is in the hospital. Mr. Darden commented that the project was operational and running smoothly. Mr. Ford stated the project is moving toward the next phase of quality assurance.

## VIRGINIA MEDICAID MANAGED CARE 2012 ANNUAL REPORT

Mr. H. Bryan Tomlinson, Director of Health Care Services, provided highlights from the 2012 Managed Care Annual Report and shared brief comments on a number of improvements implemented in 2012. Mr. Tomlinson announced the next provider public forum conference May 15, 2013, at 9:00 a.m. – 11:00 a.m. in Abingdon at the Virginia Highlands Community College. To review report, go to: http://www.dmas.virginia.gov/Content_atchs/mc/apr-f8.pdf.

## DMAS BUDGET/BUDGET REDUCTIONS

Mr. Scott Crawford, Deputy Director for Finance, gave an overview of the current status of the 2013-2014 General Assembly budget actions since the last update at the December BMAS meeting.

Dr. Robertson asked a question about Item 10, Optional Family Planning Services and Group, reported in the regulatory activity summary for April 9, 2013, regarding the new eligibility group and the option for States to begin providing family planning services and supplies to individuals found to be eligible under this new group (FAMIS Moms and Plan First). He noted that the regulatory package was at the Attorney General's office pending approval and could not go forward as a Final Exempt. Mr. Steven Ford, Deputy Director for Administration, explained that DMAS has secured the State Plan authorization for the program.

## GENERAL ASSEMBLY UPDATE

As the majority of the General Assembly update was addressed in the previous presentations, Mr. Ford stated that the 2013 legislation was minimal with most issues addressed in the budget language this year. He inquired if the agency legislative process and role during the session was acceptable to the members and asked for feedback to further improve the process.

## OLD BUSINESS

None.

**Regulatory Activity Summary**

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

Ms. Jones commented that once the new members are appointed, there will be a more detailed discussion of the regulation process in a future meeting.

**New Business**

**Adjournment**

Dr. Rheuban thanked members who have served and now rotating off for their service to the Board, and adjourned the meeting at 11:42 a.m.

**Item 307** #20c

**Health And Human Resources**
Department Of Medical Assistance Services — Language

**Language:**
Page 280, after line 14, insert:
"JJJJ.1. The Department of Medical Assistance Services shall seek federal authority through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to implement a comprehensive value-driven, market-based reform of the Virginia Medicaid/FAMIS programs. This reform shall be implemented in three phases as outlined in paragraphs 2, 3 and 4. The department shall have authority to implement necessary changes when feasible after federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

2. In the first phase of reform, the Department of Medical Assistance Services shall continue currently authorized reforms of the Virginia Medicaid/FAMIS service delivery model that shall, at a minimum, include (i) implementation of a Medicare-Medicaid Enrollee (dual eligible) Financial Alignment demonstration as evidenced by a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (CMS), signing of a three-way contract with CMS and participating plans, and approval of the necessary amendments to the State Plan for Medical Assistance and any waivers thereof (ii) enhanced program integrity and fraud prevention efforts to include at a minimum: recovery audit contracting (RAC); data mining; service authorization; enhanced coordination with the Medicaid Fraud Control Unit (MFCU); and Payment Error Rate Measure (PERM); (iii) inclusion of children enrolled in foster care in managed care; (iv) implementation of a new eligibility and enrollment information system for Medicaid and other social services; (v) improved access to Veterans services through creation of the Veterans Benefit Enhancement Program; and (vi) expedite the tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services.

3. In the second phase of reform, the Department of Medical Assistance Services shall implement value based purchasing reforms for all recipients subject to a Modified Adjusted Gross Income (MAGI) methodology for program eligibility and any other recipient categories not excluded from the Medallion II managed care program. Such reforms shall, at a minimum, include the following: (i) the services and benefits provided are the types of services and benefits provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care; with the exception of non-traditional behavioral health and substance use disorder services; (ii) reasonable limitations on non-essential benefits such as non-emergency transportation are implemented; and (iii) patient responsibility is required including reasonable cost sharing and active patient participation in health and wellness activities to improve health and control costs.

To administer this reformed delivery model, the department is authorized to contract with qualified health plans to offer recipients a Medicaid benefit package adhering to these principles. Any coordination of non-traditional behavioral health services covered under contract with qualified health plans or through other means shall adhere to the principles outlined in paragraph RR. e. This reformed service delivery model shall be mandatory, to the extent allowed under the relevant authority granted by the federal government and shall, at a minimum, include (i) limited high-performing provider networks and medical/health homes; (ii) financial incentives for high quality outcomes and alternative payment methods, (iii) improvements to encounter data submission, reporting, and oversight; (iv) standardization of administrative and other processes for providers; and (v) support of the health information exchange.

The second phase of reform shall also include administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social

Security Act and outline agreed upon parameters and metrics to provide maximum flexibility and expedited ability to develop and implement pilot programs to test innovative models that (i) leverage innovations and variations in regional delivery systems; (ii) link payment and reimbursement to quality and cost containment outcomes; or (iii) encourage innovations that improve service quality and yield cost savings to the Commonwealth.

4. In the third phase of reform, the Department of Medical Assistance Services shall seek reforms to include all remaining Medicaid populations and services including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems. The department shall begin designing the process and obtaining federal authority to transition all remaining Medicaid beneficiaries into a coordinated delivery system. A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

5. The Department of Medical Assistance Services shall provide a report to the Medicaid Innovation and Reform Commission on the specific waiver and/or State Plan changes that have been approved and status of implementing such changes, and associated cost savings or cost avoidance to Medicaid/FAMIS expenditures.

6.a. The Department shall seek the approval of the Medicaid Innovation and Reform Commission to amend the State Plan for Medicaid Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act. If the Medicaid Innovation and Reform Commission determines that the conditions in paragraphs 2, 3, 4, and 5 have been met, then the Commission shall approve implementation of coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act.

b. Upon approval by the Medicaid Innovation and Reform Commission, the department shall implement the provisions in paragraph 6.a. of this item by July 1, 2014, or as soon as feasible thereafter.

7.a. Contingent upon the expansion of eligibility in paragraph 6.a., there is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Health Reform and Innovation Fund, hereafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and any moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. For purposes of the Comptroller's preliminary and final annual reports required by § 2.2-813, however, all deposits to and disbursements from the Fund shall be accounted for as part of the general fund of the state treasury.

b. The Director of the Department of Medical Assistance Services, in consultation with the Director of the Department of Planning and Budget, shall annually identify projected general fund savings attributable to enrollment of newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA, including behavioral health services, inmate health care, and indigent care. Beginning with development of the fiscal year 2015 budget, these projected savings shall be reflected in reduced appropriations to the affected agencies and the amounts deposited into the Fund net of any appropriation increases necessary to meet resulting programmatic requirements of the Department of Medical Assistance Services. Beginning in fiscal year 2015, funding to support health innovations described in Paragraph 3 shall be appropriated from the Fund not to exceed $3.5 million annually. Funding shall be distributed through health innovation grants to private and public entities in order to reduce the annual rate of growth in health care spending or improve the delivery of health care in the Commonwealth. When the department, in consultation with the Department of Planning and Budget, determines that the general fund expenses incurred from coverage of newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA exceed any associated savings, a percentage of the principle of the Fund as determined necessary by the Department and the Department of Planning and Budget to cover the cost of the newly

eligible population shall be reallocated to the general fund and appropriated to the department to offset the cost of this population. Principle shall be allocated on an annual basis for as long as funding is available.

8. In the event that the increased federal medical assistance percentages for newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA is modified through federal law or regulation from the methodology in effect on January 1, 2014, resulting in a reduction in federal medical assistance as determined by the department in consultation with the Department of Planning and Budget, the Department of Medical Assistance Services shall disenroll and eliminate coverage for individuals who obtained coverage through 42 U.S.C. § 1396d(y)(1) [2010] of the PPACA. The disenrollment process shall include written notification to affected Medicaid beneficiaries, Medicaid managed care plans, and other providers that coverage will cease as soon as allowable under federal law from the date the department is notified of a reduction in Federal Medical Assistance Percentage.

9. There is hereby appropriated sum sufficient nongeneral funds for such costs as may be incurred to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act.

KKKK.1. The Director of the Department of Medical Assistance Services shall continue to make improvements in the provision of health and long-term care services under Medicaid/FAMIS that are consistent with evidence-based practices and delivered in a cost effective manner to eligible individuals.

2. In order to effect such improvements and ensure that reform efforts are cost effective relative to current forecasted Medicaid/FAMIS expenditure levels, the Department of Medical Assistance Services shall (i) develop a five-year consensus forecast of expenditures and savings associated with the Virginia Medicaid/FAMIS reform efforts by November 15 of each year in conjunction with the Department of Planning and Budget, and with input from the House Appropriations and Senate Finance Committees, and (ii) engage stakeholder involvement in meeting annual targets for quality and cost-effectiveness."