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

September 9, 2014
Final Minutes

Present:
Mirza Baig
Joseph W. Boatwright, III, M.D.
Vice Chair
Michelle Collins-Robinson
Brian Ewald
Maureen Hollowell
Maria Jankowski
Peter R. Kongstvedt, M.D.
McKinley L. Price, D.D.S.
Karen S. Rheuban, M.D.
Chair
Erica L. Wynn, M.D.
Marcia Wright Yeskoo

DMAS Staff:
Scott Crawford, Deputy Director for Finance
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:
The Honorable Terence R. McAuliffe
Governor of Virginia
The Honorable William A. Hazel, Jr., MD
Secretary of Health and Human Resources
Cynthia B. Jones, Director
Karen E. Kimsey, Deputy Director for Complex Care Services
Cheryl J. Roberts, Deputy Director for Operations
Elizabeth Guggenheim, Legal Counsel

Guests:
Ross Arrington, VCUHS
Ann Bevan, DMAS
Lois Brengel, DMAS
Robin Cummings, MSV
Tammy Driscoll, DMAS
Adrienne Fegans, DMAS
Suzanne Gore, Deputy Sec. HHR
Steve Ford, VHCA
Kathleen Guinan, DMAS
Jennifer Lee, Deputy Sec. HHR
Peter Lubinskas, DMAS

Guests:
Rebecca Mendoza, DMAS
Samuel Metallo, DMAS
Bhaskar Mukherjee, DMAS
Tucker Obenshain, McGuire Woods Consulting
Nicole Pugar, Williams Mullen
Rick Shinn, VACHA
Mukundan Srinivasan, DMAS
Bryan Tomlinson, DMAS
Mike Tweedy, DPB
Seta Vandegrift, DMAS
Tammy Whitlock, DMAS

CALL TO ORDER

The meeting was called to order at 9:59 a.m. by Dr. Rheuban. Dr. Rheuban welcomed Governor Terence J. McAuliffe. Governor McAuliffe provided brief comments on his 10-point plan that will extend the promise of health care to more Virginians and push Virginia further toward innovative solutions in his Healthy Virginia Care Plan released on September 8. (see attached

Plan handouts). He expressed appreciation to the Board for its support of the initiatives to improve the lives of Virginians. Dr. Rheuban asked members of the Board to introduce themselves to the Governor and then asked DMAS staff to stand.

APPROVAL OF MINUTES FROM JUNE 17, 2014 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the June 17, 2014 meeting. Ms. Hollowell made a motion to accept the minutes and Ms. Collins-Robinson seconded. The vote was unanimous. 11-**yes (Baig, Boatwright, Collins-Robinson, Ewald, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, Wynn, and Yeskoo); 0-no.**

DIRECTOR'S REPORT

Ms. Cynthia Jones, Director, directed the members to the draft BMAS Biennial report located in their notebooks and requested that they review and provide any comments by the end of the week. Upon completion of the review process, the report will be forwarded to be processed as a legislative document.

GOVERNOR'S SEPTEMBER 1, 2014 REPORT ON IMPROVING ACCESS TO HEALTH CARE

Dr. William A. Hazel, Jr., MD, Secretary of Health and Human Resources, Jennifer Lee, Deputy Secretary, and Director Jones provided more detailed discussion of the 10 actions for a Healthy Virginia as provided in the Governor's plan. In response to the discussion, Dr. Rheuban offered the following resolution:

> The Board of Medical Assistance Services recognizes that the lack of health insurance coverage for 995,000 citizens of the Commonwealth has created a critical situation that necessitates the implementation of emergency regulations to speedily address the medical needs of Virginia's uninsured population.
>
> The Board takes note of the fact that the populations for whom the lack of health insurance presents the greatest health risks are state employees who are currently excluded from state-sponsored family health insurance, pregnant women in need of dental services, those in need of coordinated behavioral health care through a behavioral health home program, and especially those suffering from serious mental illness.
>
> Be It Resolved: The Board fully supports the Governor's initiative to address the critical needs of these underserved populations, and therefore endorses the promulgation of Emergency regulations to quickly provide critical coverage to the populations most affected by this emergency.

Dr. Rheuban made a motion that the Board review/approve the above resolution. Mr. Ewald seconded. The vote was unanimous. 11-**yes (Baig, Boatwright, Collins-Robinson, Ewald, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, Wynn, and Yeskoo); 0-no.**

Dr. Price made a motion to send a letter to the Governor that the Board endorses measures to close the coverage gap and expand Medicaid. Dr. Wynn seconded. The vote was unanimous. 11-**yes (Baig, Boatwright, Collins-Robinson, Ewald, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, Wynn, and Yeskoo); 0-no.**

UPDATE ON COMMONWEALTH COORDINATED CARE PROGRAM

Karen Kimsey, Deputy Director for Complex Care Services, provided an update on the progress of the Commonwealth Coordinated Care (CCC) Program (see handout attached). Ms. Kimsey reported that beginning September 1, 2014, there were 20,824 individuals enrolled in the CCC program and more specific information would be available in the September CCC Update e-mailed to members and interested parties each month.

REPORT ON EXPEDITED MANAGED CARE ENROLLMENT

Cheryl Roberts, Deputy Director for Programs, explained the process being used to expedite an individual being identified as Medicaid eligible and their enrollment into the managed care organization. The expedited enrollment process should help reduce disruptions of care by minimizing the movement of individuals between the fee for service and the managed care delivery systems (see handout attached).

FOIA TRAINING

Elizabeth Guggenheim, Legal Counsel, provided *A Guide to the Freedom of Information Act for Members of Boards, Councils, Commissions, and other Deliberative Public Bodies; Access to Public Meetings under the Virginia Freedom of Information Act;* and the Board viewed a helpful training video of FOIA. The video (https://www.youtube.com/watch?v=50oddI3nUe0) is directed toward the Board of Visitors for colleges and universities; however, it is applicable to all boards of the Commonwealth.

REGULATORY ACTIVITY SUMMARY

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

OLD BUSINESS

None.

ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting. Ms. Hollowell made a motion to adjourn the meeting and Mr. Ewald seconded. The vote was unanimous. 11-**yes (Baig, Boatwright, Collins-Robinson, Ewald, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, Wynn, and Yeskoo); 0-no.**

A Healthy Virginia

Health Care Report

September 8, 2014

A Healthy Virginia

September 1, 2014

Dear Governor McAuliffe:

On June 20, 2014, you directed me to develop a plan to move health care forward in Virginia. Accordingly, I submit to you *A Healthy Virginia*, a 10-point action plan that extends the promise of health care to more Virginians and pushes Virginia further toward innovative solutions.

I have worked with Virginia's federal partners and health care stakeholders to identify some of the most pressing needs of the Commonwealth. These needs include strengthening coverage and access for children, veterans, and pregnant women; capitalizing on innovation opportunities; and optimizing the often fragmented systems of care that are currently in place.

Another issue, however, colors all of these initiatives, both directly and indirectly: mental health. As both a physician and your health and human resources secretary, I recognize that health and mental health are inextricably linked. The urgency of the need for accessible mental health care for Virginians cannot be ignored even in the absence of Medicaid expansion. *A Healthy Virginia* expands coverage to uninsured Virginians with acute mental health needs so that all Virginians can live, work, learn, parent, and participate fully in our great Commonwealth.

These initiatives are no substitute for Medicaid expansion. The need in our Commonwealth is great. Hundreds of thousands of our own citizens will continue to go without access to affordable health care until we close the coverage gap. This report introduces the initial critical steps that we can take to increase coverage, but it is only the beginning.

I also remain cognizant of the economic implications of a plan that does not include the federal funding that would accompany an expansion of Medicaid. As we implement *A Healthy Virginia*, I will continue to work with any and all willing leaders to develop solutions to bring our Virginia tax dollars back into the Commonwealth and close our coverage gap.

Sincerely,

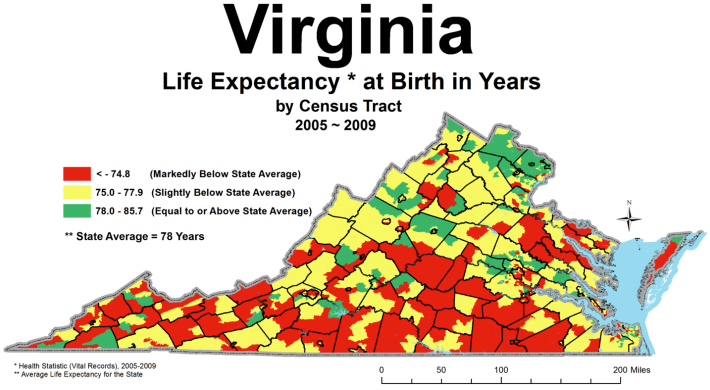
William A. Hazel, Jr., M.D.

A Healthy Virginia

Foreword

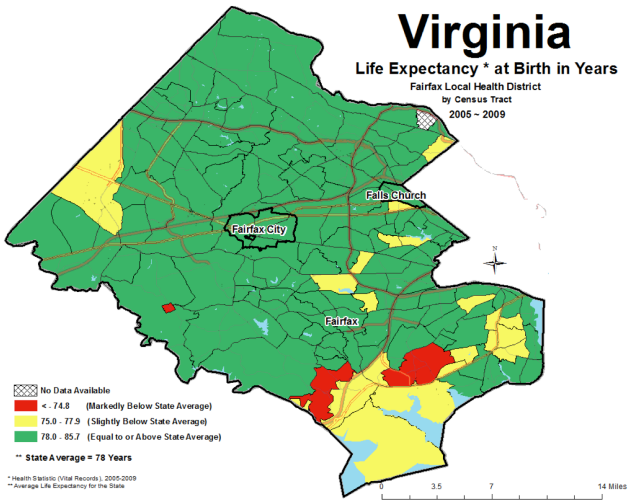
Our nation is in the midst of a health care transformation. Millions of people are obtaining insurance and access to care for the first time. Hospitals and providers are rethinking how they measure success, not based on the number of tests performed but on the number of human lives made whole.

In this exciting new world of health care, Virginia has become the ER waiting room. We are watching from behind a Plexiglass window as other states push down their uninsured rates. In Arkansas, the uninsured rate dropped more than 10 percentage points this year, to 12.4 percent. Next door in Kentucky, the rate dropped 8.5 percentage points to 11.9 percent. Meanwhile, Virginia's rate bumped up slightly to 13.4 percent.



We're watching as hospitals across the country see declines in unpaid medical bills – nearly a third among Arizona hospitals, a drop of $76 million in the first quarter of this year. In Virginia, one rural hospital has closed and other communities are praying they won't experience the same devastating loss.

Virginia's waiting room is filling up with uninsured men and women struggling with chronic diseases and relentless pain as years creep by without relief. They are still waiting for the doors to swing open and their names to be called. The misery is not spread evenly across the Commonwealth. A male resident of Fairfax County is likely to live nearly 9 more years than a man in Wise County. But even within the state's healthiest locality, life expectancy varies dramatically depending on the neighborhood.



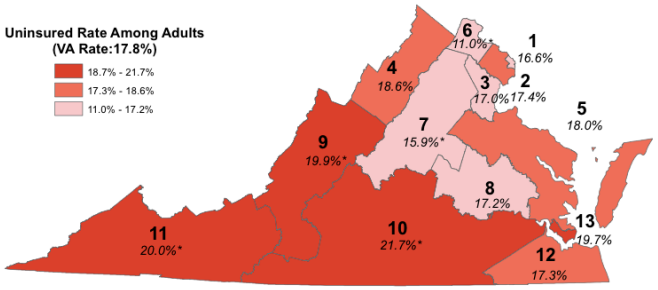
These disparities are driven by poverty, education, race, and ultimately by the availability or lack of access to health care. The results are unacceptable. Emporia's age-adjusted death rate for cancer, heart disease, and stroke, at 793 per 100,000 people, is more than three times that of Fairfax County. A map showing death rates across Virginia is strikingly similar to a state map of uninsured rates.

A Healthy Virginia

We are deeply concerned not just about when people die, but how well they live.

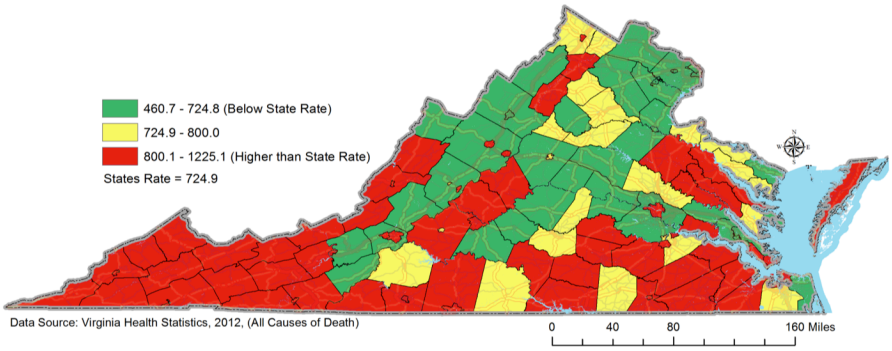
Two months ago, you instructed me to provide recommendations on how to move forward with improvements to health care in Virginia. You urged me to be bold and transformative. I now present *A Healthy Virginia*, a plan for better health care in the Commonwealth. Through existing sources of coverage that are available but underutilized, *A Healthy Virginia* reaches outward and extends a hand to those who already qualify for certain health care programs but have not yet accessed them. It offers services that have previously been unavailable to Virginians who have been left behind, especially Virginians who struggle with severe mental illness. It improves the quality of care for Virginians by leveraging federal dollars and support for innovations in Medicaid and across the entire health system. Finally, it addresses a major public health issue facing Virginia and the nation—prescription drug and heroin abuse.

Map 2: Uninsured Rate Among Adults (19-64) in Virginia by Area[1], 2012



Source: Urban Institute, May 2014. Based on the 2012 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.
1 Shaded areas represent regions of Virginia which are defined in terms of counties or a combination of counties (see "Guide to Regions in Virginia").
Notes: The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.
* indicates that the uninsured rate for the region is statistically different from the uninsured rate for the areas in the rest of the state at the 0.1 level.

Taken together, these initiatives will have a positive impact on the health of more than 200,000 Virginians. This plan not only extends the promise of health care to more Virginians, but also brings the Commonwealth closer to lasting transformation in the health care system. **This plan will reach more people in need by:**



- Providing medical and behavioral health services for uninsured people who have a serious mental illness.

- Promoting the availability of Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus insurance for children, with the first major media and outreach campaign in years.

- Taking an active role in this fall's open enrollment period for the Federal Marketplace through an intensive educational outreach and active assistance to our citizens as they navigate the Federal Marketplace.

- Enhancing the Cover Virginia point of entry for health care programs available to Virginians.

- Eliminating a technical barrier that now prevents eligible state employees from enrolling their children in FAMIS.

This plan will improve access to health care by:

- Providing dental services to low-income pregnant women to improve overall health outcomes for mothers and their newborn children.

- Becoming a stronger partner with the Veterans Health Administration to make sure that Virginia's veterans are receiving quality care in a timely manner.

This plan will pursue innovative solutions to health challenges by:

- Promoting regional models for health care delivery designed to provide better care at a lower cost.

- Pursuing health homes for individuals with mental illnesses through a collaborative system of primary, acute, behavioral and long-term services.

- Collaborating on strategies to reduce the number of deaths in Virginia due to overdose of prescription painkillers and heroin.

This plan must be recognized for what it is, and what it is not. It is an exercise in triage, a series of important measures designed to respond to the health care crisis that exists in the Commonwealth. It has a strong focus on expanding care for Virginians with severe mental illness to improve their health, quality of life and job security. It is also focused on making sure Virginians know what health care options are available to them and getting them enrolled in coverage that is currently available. And it pushes Virginia toward further reform and innovation.

This plan is not a comprehensive cure, nor is it a substitute for a full expansion of Medicaid in accordance with the Affordable Care Act. It contains significant reforms that help to deliver better care more efficiently to some, but not all, Virginians. While expanding the Medicaid program using federal funds is the most comprehensive and straightforward way to increase access to care, *A Healthy Virginia* offers hope to many Virginians who need it most. These recommendations fall within our legal boundaries, but we cannot forget our commitment to the Virginians who are still in the waiting room. This plan is a bridge to true reform. The larger goal will take time and courage.

We cannot take on that long-term goal or these more immediate measures alone. The heroic efforts of Teresa Gardner and Paula Meade with the Health Wagon, of Terry Dickinson and his army of kind-hearted dentists, of Stan Brock and his roving rural medical clinics aren't enough, either. We need hospitals, community clinics, schools, medical providers and every Virginian to join us in breaking down the barriers to quality health care.

We all want to live long and live well. That is the goal for every Virginian.

A Healthy Virginia
Reaching More People in Need

The Governor's Access Plan for Medical and Behavioral Health Services

Reaching Virginia's Uninsured with Serious Mental Illness

Importance to Virginians

Based on national prevalence rates, it is estimated that about 308,000 Virginia adults have had a serious mental illness (SMI) during the past year. This means that more than 6 percent of Virginians suffered a severe functional impairment as a result of SMI. About 54,000 of those with SMI are uninsured in Virginia and face profound difficulty in finding treatment.

Without treatment, SMI impacts every aspect of an individual's life; those with SMI are often unnecessarily hospitalized, are unable to find and sustain employment, struggle with housing, and suffer from social isolation. The physical health implications for those with SMI are alarming. Nearly half of individuals with SMI also have a co-occurring substance use disorder and face increased risk for medical conditions such as diabetes, heart disease and obesity. As a result, individuals with SMI die an average of 25 years earlier than those without.

The tragedy is that mental health disorders, substance use disorders, and the most common related medical conditions are all highly treatable. Effective treatment is available, and people do recover.

Enabling persons with serious mental illness to access both behavioral health and primary medical services would enhance, and in many cases, initiate the treatment of both conditions, allow care to be coordinated among all providers, and significantly decrease the level of impairment. This kind of care can be life-changing. With treatment, individuals with serious mental illness and related medical conditions can recover and live, work, parent, learn and participate fully in the community.

Goals

Virginia is launching a program to integrate primary and specialty care; diagnostic, laboratory, pharmacy and behavioral health community services and care coordination for Virginia's uninsured with SMI. This will provide access to treatment to many Virginians with SMI, reduce the frequency of emergency department visits and inpatient hospitalizations, and reduce overall health care costs.

The three key goals of the demonstration are to:

- Improve access to care for up to 20,000 uninsured Virginians with significant behavioral health needs.
- Improve physical and behavioral health outcomes.
- Serve as a bridge to closing the coverage gap for uninsured Virginians with serious mental illness.

A Healthy Virginia

Issue Background

Virginia has partnered with Magellan of Virginia since December 2013 to monitor and coordinate nontraditional behavioral health services (those expanded services available through Medicaid). Virginia and Magellan work together to coordinate medical and behavioral health care services for the individuals they both serve. This program will require coordination among the Department of Medical Assistance Services (DMAS), the Department of Behavioral Health and Developmental Services (DBHDS), health care partners, the behavioral health provider community, and Magellan. All of these providers and organizations are well-equipped to extend a coordinated service delivery system to Virginians with SMI.

Strategies for Success

Virginia will leverage this established infrastructure to implement the Governor's Access Plan (GAP) for Medical and Behavioral Health Services. Through the GAP Program, DMAS will partner with providers and Magellan of Virginia to coordinate and deliver a focused benefit package that includes primary, specialty, behavioral health, and substance abuse services for people who are uninsured and have a SMI. This program will leverage relationships with many community services boards and Federally Qualified Health Centers across Virginia. Based on available data detailing the number of uninsured adults in Virginia, it is estimated that up to 20,000 individuals may be served through this initiative.

This program will be a state-designed and administered program and not an expansion of Medicaid. Individuals will be referred to the program from a variety of sources, including community services boards, community mental health providers, medical providers, community organizations, law enforcement and hospitals.

The Governor's Access Plan for Medical and Behavioral Health Services will include the following features:

- The program will be available to individuals who have SMI.
- Eligibility and enrollment will be administered through private contractors who already contract with DMAS.
- Through a Section 1115 Waiver, DMAS will provide a limited benefit package of primary and specialty care; diagnostic, laboratory, pharmacy and behavioral health community services and care coordination.
- The demonstration will not pay for services beyond the limited benefit package. Services not covered by the program include (but are not limited to) inpatient, emergency, home health, nursing home, long-term care, routine dental, transportation or routine optometry services.
- This program will be administered by DMAS.
- This two-year program will run from January 2015 to January 2017 or until the coverage gap is closed.

Eligibility for participation in the program will be for individuals who:

- Are between the ages 19 through 64 years old;
- Are citizens or lawfully residing immigrants;
- Are not eligible for Medicaid, FAMIS, or Medicare;
- Are residents of Virginia;
- Have household incomes below 100 percent of the federal poverty level;
- Are uninsured;
- Are screened and within the criteria for having an SMI; and
- Are not residing in a long-term care, mental health, or penal institution.

Timeline

In late summer and fall of 2014, Virginia will develop a Section 1115 waiver proposal, receive public comments, and gain approval from the Centers for Medicare and Medicaid Services. The Governor's Access Plan will be developed during this time, and in January 2015, Virginia will begin screening and enrolling participants. Delivery of the benefit package of medical and behavioral health services is expected to begin in February 2015.

Measures of Achievement

Success will be measured by the number of uninsured individuals who were able to access care through this demonstration project and by the quality of their care, as measured by Healthcare Effectiveness Data and Information Set (HEDIS) quality measures. Virginia will report on outcomes and goals as required by the waiver. In addition, regular reports will be submitted to the Governor and the Virginia General Assembly on participation, costs, outcomes, and trends.

Covering our Children

Reaching More Children through Medicaid and FAMIS

Importance to Virginia

Early attention to wellness is crucial to ensuring that Virginia's children have the opportunity to become successful as adults. The promotion of good health enables parents and providers to identify medical conditions and developmental delays and seek interventions before those conditions hinder physical, social, emotional, and cognitive growth.

A lack of emphasis on health at an early age continues to impact individuals, families, and communities throughout a person's life. Lack of access to routine preventive care can contribute to missed school days and reduced academic proficiency. In addition to their effect on educational achievement, undetected medical conditions can lead to chronic diseases and ultimately, reduced productivity in the workplace. The negative consequences affect not only a community's economy, but its overall health. The failure to immunize children at the appropriate age, for example, can lead to the spread of infectious diseases.

We know the terrible consequences of neglecting children's health, yet Virginia is falling behind in providing insurance coverage for our youth.

Based on 2012 data, the Urban Institute reports that 87.5 percent of eligible children in Virginia are enrolled in the Family Access to Medical Insurance Security (FAMIS) plan or Medicaid (also referred to as FAMIS Plus). This is just below the national average of 88.1 percent and substantially below the level of many neighboring states with participation rates of 90 percent and higher, including: West Virginia (91.1 percent), Maryland (91.9 percent), Kentucky (90.2 percent), Tennessee (90.3 percent), and Washington D.C. (97.1 percent). Data for 2014 are already demonstrating that in states that have expanded Medicaid, the number of already eligible children who are being enrolled is growing faster than in states that did not expand. Unless we act, more and more children eligible for FAMIS and Medicaid today will go without health care.

Goal

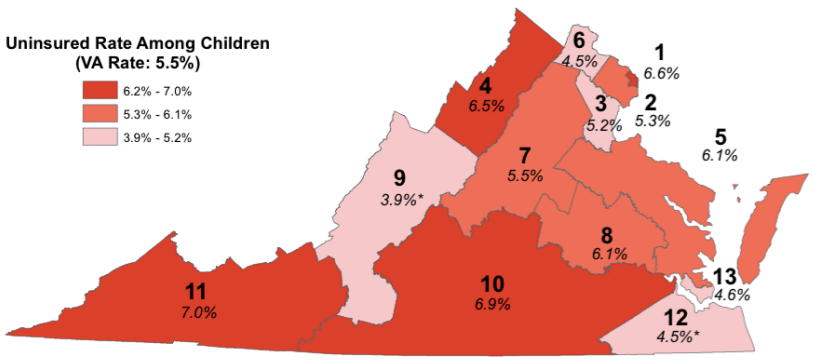
Virginia needs to turn this disturbing trend around. In the next two years, we will enroll an additional 35,000 eligible children into these programs. While that will not mean every eligible child in Virginia will be enrolled, it will halt the recent decline, and by the end of 2016, Virginia should have more than 90 percent of our eligible children enrolled, as many neighboring states do today.

A Healthy Virginia

Issue Background

Virginia currently covers approximately 580,000 children each month in FAMIS or Medicaid, but there are still more than 100,000 uninsured children across the Commonwealth. The majority of these uninsured children are likely to already qualify for coverage in FAMIS or Medicaid, but their parents are unaware, believe the application process is too difficult, or are reluctant to apply.

Map 3: Uninsured Rate Among Children (0-18) in Virginia by Area[1], 2012



Source: Urban Institute, May 2014. Based on the 2012 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.
1 Shaded areas represent regions of Virginia which are defined in terms of counties or a combination of counties (see "Guide to Regions in Virginia").
Notes: The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.
* indicates that the uninsured rate for the region is statistically different from the uninsured rate for the areas in the rest of the state at the 0.1 level.

When former Governor Mark Warner made enrollment of eligible children a high priority, Virginia was able to simplify the program, conduct an effective public outreach campaign, and train and support local outreach workers. As a result, we saw dramatic improvement in the number of Virginia's children with coverage.

In recent years, support for outreach and marketing of FAMIS and Medicaid in Virginia has been significantly curtailed, and we are seeing the negative effect as growth has slowed and now reversed.

Following years of almost uninterrupted growth since the FAMIS program was created in 1998, the average monthly enrollment of children in FAMIS and Medicaid has declined. The number of children eligible for these programs, however, has not. On average, almost 4,000 fewer children were receiving health care coverage through these programs each month in FY 2014 compared to FY 2013. This means too many children who could get coverage today are going without.

Strategies for Success

Virginia will mount an aggressive campaign to reach the parents of children who are eligible but not yet enrolled and help get them covered. Marketing research shows that reaching the parents of the remaining uninsured children will require aggressive and varied strategies. Virginia can get many more of our children covered by combining traditional media advertising with social media, additional outreach workers, and attendance at community events and health fairs. Virginia will also

place more emphasis on contacts with hard-to-reach populations, in addition to making policy and systems improvements.

Investments will be made in new materials, TV and radio advertisements, and people in the community who can directly help families enroll. We will place a special emphasis on outreach to non-English speaking parents, as children in these families have a lower rate of insurance even when they are eligible. In addition to doing a better job of informing parents, the Commonwealth will be examining our policies and improving our systems to continue making it easier for the families of these eligible children to apply and be approved.

Timeline

Virginia launched its marketing and outreach efforts during this year's back-to-school season. We will continue to ramp up marketing and media during the coming months.

Measures of Achievement

By the end of 2016, 35,000 more of Virginia's children will have access to vital wellness and health care services. DMAS will provide a monthly enrollment update to track the progress of this initiative.

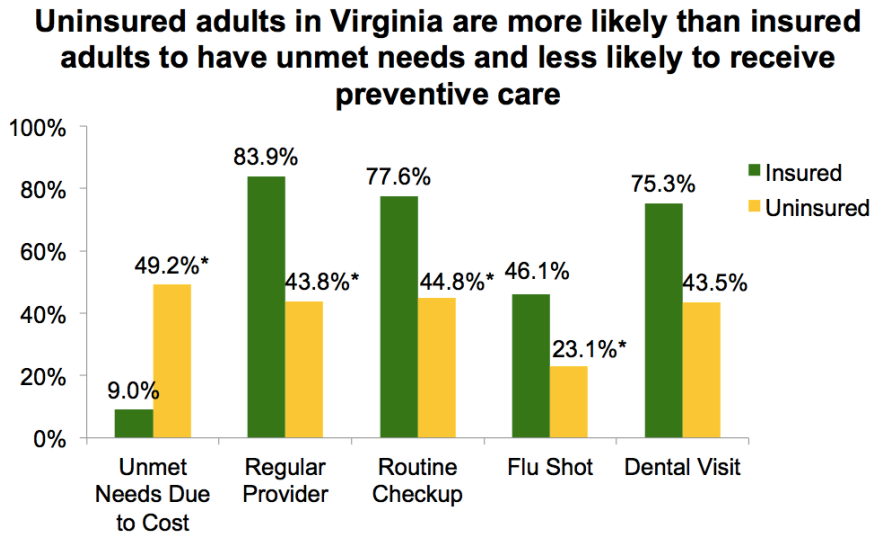
Supporting Enrollment in the Federal Marketplace

Reaching More Virginians during Open Enrollment

Importance to Virginians

This fall's upcoming open enrollment period for the Federal Health Insurance Marketplace offers a crucial opportunity to help Virginians obtain affordable, high-quality coverage and to demonstrate the need that exists across the Commonwealth for basic medical services.

Last fall's open enrollment period for the Federal Marketplace demonstrated the depth and urgency of the need that exists across the Commonwealth for access to health care. Though the previous administration did not actively engage in public education or outreach efforts during the initial enrollment period, 216,000 eligible Virginians were reported to have purchased new plans via the Federal Marketplace in 2013-2014. Many potential consumers, however, remain uninsured. As we approach the next open enrollment, more than 300,000 Virginians are estimated to have no health insurance but are eligible for tax credits on the Federal Marketplace.



*Note: Adults are age 19-64. Measures refer to access or utilization over the past 12 months. Estimates marked with * indicate the difference between the insured and uninsured estimates is significant at the .01 percent level.*

Source: Urban Institute, April 2014. Based on the 2012 Behavioral Risk Factor Surveillance System.

During this fall's open enrollment period for the Federal Marketplace, the Commonwealth is committed to a more aggressive approach to ensure that Virginians have the help they need to find the most appropriate and cost-effective health insurance plans available at healthcare.gov. Consumer education about the Federal Marketplace, as well as an enhanced network of consumer application assistance, will help thousands of Virginians to obtain insurance for the first time.

A Healthy Virginia

Goal

Over the next year, up to 160,000 additional Virginians will sign up for coverage through the Federal Marketplace.

Issue Background

Health insurance marketplaces are designed to help consumers access diverse and affordable options for health care coverage. As a partnership state, Virginia does not operate a state-based health insurance marketplace but works with the federal government on certain functions of the Federal Marketplace. Tax credits are available in the Federal Marketplace to eligible individuals and families with incomes between 100 and 400 percent of the federal poverty level ($11,670 to $46,680 annually for an individual).

In 2013, Virginia was awarded a $4.3 million federal grant to begin building a state-based health insurance marketplace. Virginia opted not to move forward with plans for its own marketplace, leaving the federal grant funds unspent. Rather than return the grant award, Virginia has obtained permission from CMS to use the funds for outreach and enrollment activities supporting the Federal Marketplace.

Strategies for Success

The strategies of this effort are twofold: to enhance available consumer application assistance in Virginia and to engage in a marketing campaign that will educate consumers about insurance options.

- **Consumer assistance.** Virginia will partner with the Virginia Poverty Law Center (VPLC) to enhance an existing network of consumer assistance for the 2014-15 Federal Marketplace enrollment period. VPLC was one of two designated Navigator organizations in Virginia during the initial open enrollment period, and its leadership possesses the knowledge and experience to take on this new challenge. VPLC will recruit and train local organizations throughout Virginia, building a robust network of volunteer Certified Application Counselors to help consumers with the often complex process of applying for health care coverage.
- **Public education and marketing.** During the previous administration, Virginia did not provide state-specific marketing or outreach about the marketplace to potential consumers. This communication vacuum posed a particular challenge in border areas of the Commonwealth where Virginians were exposed to sometimes confusing information about health care initiatives in neighboring jurisdictions. For the upcoming open enrollment period, a significant educational campaign about the Federal Marketplace and affordable coverage will be developed that will speak directly to Virginians.

Timeline

Prior to the November 15 start date of the open enrollment period, VPLC will begin active recruitment and training of certified application counselor organizations and individuals. VPLC will continue to support enrollment activities during and following the sign-up period. The marketing campaign will begin in November and intensify during early 2015.

Measures of Achievement

A successful enrollment campaign will be measured by the number of eligible Virginians who gain health insurance coverage through the Federal Marketplace and the impact on the state's uninsured rate. We seek to help enroll up to 160,000 additional Virginians through the Federal Marketplace.

Informing Virginians of their Health Care Options

Reaching more Virginians through Cover Virginia

Importance to Virginians

As evidenced by last fall's federal open enrollment period, applying for health coverage can prove a complex, even overwhelming, experience. People often experienced significant delays when they applied to programs for which they were not eligible. As a state, Virginia wants to ensure that people obtain coverage as expeditiously as possible. The application process is made much simpler if Virginians are guided to the right coverage option for them initially. This expedites processing of applications and makes the process move as smoothly as possible. To meet this need, Virginia is relaunching the central resource that helps individuals identify the health insurance program for which they are most likely to be eligible: the Cover Virginia website (coverva.org), as well as an accompanying call center.

Goal

Cover Virginia is currently a helpful source of information for uninsured Virginians seeking access to health care coverage. With such great unmet need in the Commonwealth, however, Virginia is making significant enhancements to the website to make it even more user-friendly and approachable. Virginia will ensure that the Cover Virginia website contains the most relevant health care information for Virginians, including the full range of options for those seeking coverage and services, and helps direct individuals to apply for their best coverage option.

Issue Background

Virginia launched the Cover Virginia website in October 2013. It offers basic information about FAMIS and Medicaid programs as well as resources for individuals trying to navigate all the new options available through the Affordable Care Act. Since the website launched, more than 220,000 visitors have accessed the site. In 2014, the number of visits per week increased to nearly 5,000. Many Virginians who could benefit from the information on the website, however, remain unaware of this resource.

Strategies for Success

In order to make it easier for Virginians to connect with the programs and services for which they qualify, the Commonwealth will provide additional education and links on the coverva.org website for the following insurance options:

- **Federal Health Insurance Marketplace.** The website will include direct access to the Federal Marketplace to expedite enrollment during the second open enrollment.
- **Department of Veterans Affairs**. The website will include information for veterans about available health benefits and how they can sign up for VA health care if they qualify.
- **The Virginia Chamber of Commerce's Virginia Benefits Market.** Coverva.org will promote other health insurance options, including the Virginia Chamber of Commerce's new private health insurance marketplace, the Virginia Benefits Market. This insurance exchange will allow small businesses to offer a menu of health and other benefits to their employees.
- **CommonHelp (www.commonhelp.virginia.gov)**. The website will direct Virginians interested in applying for Medicaid, FAMIS, and other public benefits to the streamlined, online application found on CommonHelp.

To best serve Virginians, the following enhancements to the site will be completed before the next Federal Marketplace open enrollment, beginning November 15, 2014.

- Develop an enhanced eligibility calculator to help users find the right health programs for themselves and their families.
- Provide prominent links on the Cover Virginia home page to guide users toward the appropriate health care programs for children and youth, adults, pregnant women, veterans and business owners.
- Include a prominent link to resources for one-on-one assistance for individuals needing help with applications.

Timeline

The initiatives mentioned above will be implemented by the November 15, 2014, open enrollment start date.

Measures of Achievement

Marketing and outreach staff at DMAS will use Google Analytics tools to monitor the online access habits of visitors to the Cover Virginia website. To measure the success of the enhancements, staff will set up analytics to measure the number of individual hits for websites including the Federal Marketplace, CommonHelp, Department of Veterans Affairs, and the Chamber's Virginia Benefits Market.

Making Dependent Coverage Affordable for Lower-Income State Employees

Reaching More Children through FAMIS

Importance to Virginians

State employees may cover their dependent children through their employee health insurance, but for many families this is not an affordable option. Employees who choose this option face an increase in their insurance premium contributions of approximately $100 to $200 per month. Even with the most comprehensive coverage, employees must also make copays of up to $40 for doctor visits. Virginia's state workforce includes a sizeable number of lower-income employees. Last year, more than 9,600 full-time state employees qualified for the Earned Income Tax Credit, a federal tax subsidy for lower-income working families. These health care premiums and copays represent a significant reduction in take home pay for many state workers. Some may be forced to opt for employee-only coverage; others may struggle to pay for rent or other necessities because of the additional cost for their children's insurance.

Goal

Virginia's FAMIS program provides affordable, comprehensive health coverage at a very low cost to qualifying families. Under existing Virginia policy, dependents of state employees who are eligible to enroll in the state's health plan may not receive coverage through FAMIS. We are eliminating this restriction, and by the end of 2014, new qualifying state employees will be allowed to enroll their dependent children in affordable health coverage through FAMIS. Abolishing this restriction will:

- Increase health insurance coverage for low-income children.
- Lower costs for the Commonwealth by leveraging federal funds available through FAMIS for those employees who choose to switch their children's coverage.
- Help hard-working state employees whose salaries have not kept up with the cost of living by offering a low-cost, quality health insurance option for their children.

Issue Background

Prior to the Affordable Care Act, federal law prohibited dependents of public employees from enrolling in the state's child health insurance program, known as FAMIS in Virginia. Now, states can receive federal approval from CMS to enroll children of eligible state employees in these programs as long as the state meets certain requirements.

Strategy for Success

By opening FAMIS to children of state workers, we can improve access to affordable, high-quality, comprehensive health care for children of lower-income state employees. A mother with one child may be eligible to enroll her son or daughter in FAMIS if the family's gross monthly income is no more than $31,460 annually. DMAS estimates that approximately 5 percent of state workers will be eligible. Assuming each of these state employees has an average of one child, 5,000 children could be covered.

Timeline

DMAS is working with the Department of Human Resource Management (DHRM) to seek approval from CMS to offer FAMIS to dependents of state employees. DMAS will work with DHRM to finalize an implementation plan by September 30, 2014. New eligible Virginia state employees will be able to begin enrolling their children in FAMIS in January 2015. Current employees eligible for FAMIS will be able to select this coverage during open enrollment in July 2015.

Measures of Achievement

Success will be measured by the number of state employee children who were previously uninsured but were able to obtain coverage through FAMIS, and by the state dollars saved by providing this new option.

A Healthy Virginia
Improving Access to Care

Providing Comprehensive Dental Coverage to Pregnant Women in Medicaid and FAMIS

Improving Access to Oral Health Care

Importance to Virginians

Good oral health is especially crucial during pregnancy. Virginia covers pregnant women in the Medicaid and FAMIS MOMS programs; however, the health needs of these women and their babies are not entirely addressed. Comprehensive dental services are not covered for pregnant women in the existing benefit package. Virginia mothers and their babies are at risk for significant health problems including preterm birth.

Goal

By providing a new dental benefit to women enrolled in Medicaid and FAMIS MOMS, Virginia will reduce the number of preterm births, cut down on emergency dental expenditures, decrease the state's cost of dental care for children, and improve the lives of these babies.

Issue Background

Currently, Virginia has 45,000 pregnant women enrolled in Medicaid and FAMIS MOMS. Without access to comprehensive dental care, these women risk having dental health issues go undiagnosed and untreated, needlessly putting their unborn babies in jeopardy. A pregnant woman's oral health is linked to her delivery, her baby's health, and even the costs to Virginia's Medicaid and FAMIS programs.

Pregnant women with periodontal disease may be up to eight times more likely to deliver prematurely. In fact, data has shown that 18 percent of all preterm births may be attributable to periodontal disease. Premature birth can cause a host of health problems for both mother and baby. It can also be the source of significant cost to the Commonwealth, as the costs in the first year of life for a preterm baby are more than 10 times that of a baby born at full term. According to the March of Dimes, an average preterm birth costs $50,000 in the first year of life.

The results of a lack of dental care for pregnant women extend beyond early delivery. Mothers can spread oral bacteria to their babies, putting those infants at risk of developing tooth decay themselves.

Strategy for Success

DMAS will implement comprehensive dental coverage for pregnant women in Medicaid and FAMIS MOMS.

Timeline

Virginia will begin covering comprehensive dental benefits to pregnant women in March 2015.

Measures of Achievement

Virginia will monitor the number of pregnant women who receive dental services under this new benefit.

Prioritizing the Health of Virginia's Veterans

Accelerating Veterans' Access to Care

Importance to Virginians

Since 2001, about 2.5 million U.S. troops have been deployed to Iraq or Afghanistan. More than 6,000 men and women have given their lives and more than 48,000 have been injured. Virginia has the honor of having the largest increase in its veteran population of any state since 2000. Much of this trend is driven by younger veterans of recent conflicts.

One in 10 Virginians is a veteran. The Commonwealth should help ensure a smooth transition when these men and women are ready to return to civilian life. This is even more important now as the numbers of veterans continue to grow in Virginia and drawdowns of troops from Afghanistan continue. Virginia must begin by meeting their most basic need—the need for timely, quality health care.

Unfortunately, over the last few months, reports have surfaced about weaknesses in the Veterans Affairs health care system—veterans waiting for appointments much longer than they should be and facing difficulty in accessing important services. A recent report showed that Virginia is last in the nation when it comes to the ratio of VA health facilities to veterans, at only 0.3 facilities per 10,000 veterans. Some veterans in Virginia are still waiting more than 60 days to get a primary care appointment at the VA. However, Virginia is not interested in casting blame on the VA. The responsibility of caring for veterans' health needs should not be the VA's to carry alone. Instead, Virginia is committed to working together as partners with the VA to find solutions.

Goal

All of Virginia's veterans should have access to timely, quality health care. Over the next 12 months, Virginia will aim to increase access to care for veterans across the Commonwealth by promoting partnerships with the VA and private health providers.

Issue Background

On August 7, 2014, President Obama signed into law a measure that will provide $16.4 billion in new funding to the VA system. The legislation directs $10 billion in emergency spending over three years to the VA to pay private providers to care for veterans who have been unable to schedule timely appointments at the VA or live too far away from a VA hospital or clinic.

Strategies for Success

In the next 60 days, Virginia will host leaders from the Veterans Health Administration in Virginia and hospital/health system leaders to explore ways they can work together to improve timely access to quality care for veterans. There will be a special focus on meeting specific needs for services that veterans have difficulty accessing. In areas where the VA system has robust resources, strategies will be examined for increasing veteran referrals and encouraging regular visits with medical providers. Also, Virginia will explore ways to improve health information technology connectivity between the VA system and private systems so that care can be better coordinated and enhanced.

Timeline

The summit will lead to a clear action plan for how Virginia's hospitals and provider community can work together with the VA system to improve care for veterans.

Measures of Achievement

The ultimate goal is to decrease veteran waiting times for appointments at the VA and identify access to alternative providers of care, when needed and appropriate. We are committed to ensuring that veterans across the Commonwealth have access to high-quality, long-term care and will continue to support construction of veteran care centers in Hampton Roads and Northern Virginia. The number of new partnerships facilitated between community providers and the VA will be an interim measure of success in achieving these goals.

A Healthy Virginia
Pursuing Innovative Solutions

Winning a State Innovation Model Grant
Seizing Opportunity to Transform Health Care Delivery

Importance to Virginians

Now is the time for innovation and transformation in health care. Promising models are being tested across the country. The Affordable Care Act has created new opportunities to bring more health innovation to Virginia, including support through new federal dollars. Since 2010, the federal government has awarded more than $575 million to 25 states. Prior to this year, Virginia had not even applied for this funding. The Commonwealth should take advantage of every opportunity to leverage these federal resources and transform our health care system to be more effective and less costly for all Virginians.

This administration is committed to improving the health of all Virginians. We must start by focusing on those who are most vulnerable and have no access to health care because they are uninsured. By reaching this population, Virginia will make the greatest impact on our state's overall health indicators and help those who need it most. But we should not stop there. We will strive to create meaningful transformation across every sector of our health care delivery system in the Commonwealth by also enhancing the quality and value of care for those who are covered now through private insurance, Medicare, Medicaid and FAMIS.

Goal

Virginia seeks to transform its health care delivery system to provide better care at lower costs. Virginia can achieve this through engaging a broad array of stakeholders, strengthening public-private collaborations, and aligning incentives to promote quality and value in a person-centered, integrated framework.

Issue Background

CMS provides support to states for the development and testing of models for health care delivery system transformation. This is known as the State Innovation Model (SIM) grant program. In this year's round of funding, CMS will award up to 15 states a maximum of $3 million apiece to design new health system innovation plans over a one-year project planning period.

Strategies for Success

In July, Virginia applied for $2.6 million in federal funding through the CMS State Innovation Model grant program. If funded, this grant would promote public and private collaboration, led by the Virginia Center for Health Innovation (www.vahealthinnovation.org), which will lead to meaningful

delivery system transformation in the Commonwealth. Virginia would receive both financial and technical support to convene stakeholders, enhance regional and statewide coordination, and develop tools and innovative strategies that lead to improved quality and reduced cost across every sector of the health system. We will set population health goals related to reducing cardiovascular disease and diabetes and lowering rates of tobacco use and obesity. We will focus on primary care transformation and delivering integrated care models that integrate behavioral health and oral health with primary care.

This grant award will enable Virginia to realize a broad vision for statewide health care transformation that improves the health of all Virginians while building a more robust behavioral health infrastructure to care for individuals living with mental illness and substance use disorders.

Timeline

Virginia submitted the grant proposal in July, and it is currently undergoing a competitive review process. CMS has said it expects to announce which states will be funded by October 31, 2014. If funded, the grant would run from January 1, 2015 through January 1, 2016.

Measures of Success

Success will be measured by the development of a robust and actionable plan for health innovation in Virginia that has the support of key stakeholders. The ultimate goal is to implement the plan and improve health outcomes through lasting systems change that benefits not only the uninsured, but also those Virginians covered by Medicaid, FAMIS, Medicare, Marketplace health plans, employer-based, and private health plans.

Creating Behavioral Health Homes

Strengthening Virginia's Behavioral Health System through Innovation

Importance to Virginians

Half of all individuals who are intensive users of the health care system have a behavioral health diagnosis. This means that in addition to their physical health needs, these individuals also require a level of care to meet their mental health needs. Many medical providers, however, often lack specialized experience to treat mental health conditions. As a result, adults and children who live with serious mental health conditions have difficulty obtaining timely, high-quality care.

Many seek help in emergency departments, often resulting in fragmented care that triages one problem at a time. Social factors such as poverty, transportation limitations, and homelessness place additional strain on overall health. Further complicating the picture is the fact that nearly 50 percent of individuals with an SMI also have a substance use disorder. It's not surprising, then, that Medicaid costs for individuals with both a chronic physical health disease and mental health diagnosis are 75 percent higher than those for people without a mental health diagnosis.

Goal

DMAS, in collaboration with the Department of Behavioral Health and Developmental Services, will establish health homes to coordinate care for adults and children who are insured through Medicaid and who have a serious mental illness or a serious emotional disturbance. These health homes will adopt a "whole person" philosophy for treatment that calls for team-based care of all primary, acute, behavioral health, substance abuse, and long-term services. Virginia will use health homes to enhance the treatment of both mental and physical health conditions and significantly decrease the level of impairment experienced by these individuals. This program could help up to 13,000 individuals in Virginia with serious mental illness.

Issue Background

The earliest effort to coordinate care for Virginians with SMI began in 2009. A New Lease on Life, a project of the Virginia Health Care Foundation, awarded $2 million to nine partnerships, each one comprised of a community services board (CSB) and either a Free Clinic or a community health center. The funding, distributed over three years, was used to support new providers and clinical staff. Those partnerships are now self-sustaining.

A second program, Enhanced Care Coordination (ECC), is a collaboration involving DMAS, CSBs, CMS and three managed care organizations as part of the Commonwealth Coordinated Care Program. The program is designed for individuals with an SMI and one or more chronic medical conditions who are eligible for both Medicare and Medicaid. ECC staff provides support to these

individuals by arranging transportation, accompanying them to primary care appointments, and assisting them to adhere to recommended treatments.

While these efforts and others in local communities are ongoing, they do not serve the entire eligible population of adults with SMI or children with serious emotional disturbances. The Affordable Care Act created an optional Medicaid benefit for states to establish health homes to improve care for adults and children with significant behavioral health needs. Health homes are not physical spaces, but refer to a model of care in which all an individual's primary, acute, behavioral health and long-term services are coordinated and integrated. Participating states can receive a federal financial match of approximately 90 percent for Medicaid administrative expenditures over 24 months (note this enhanced financial match, however, does not apply to covered treatment services).

Strategies for Success

DMAS is creating the Behavioral Health Home Pilot project to deliver integrated health home support for individuals who are in managed care or who are in the fee-for service delivery system. DMAS plans to partner with one or more health plans, CSBs, Federally Qualified Health Centers (FQHCs), Magellan of Virginia, and other key stakeholders to implement the project. The pilot project is designed to meet individuals where they are. This may include bringing primary care services on site at behavioral health clinics. Individuals eligible for the pilot would be automatically enrolled, with the opportunity for them to opt out if they did not want to participate.

Features of this pilot project will include:

- A focus on prevention and early intervention.
- Facilitation of joint treatment planning sessions among providers.
- Strategies to close gaps in care and address societal factors that discourage individuals from seeking medical services.
- Robust use of care management, outreach and community services.
- Carefully managed transitions in care and medications.
- Peer support specialists for assistance with social and lifestyle changes.
- Coordination of care through use of technology to share critical health information.
- Use of data to better understand health care needs.

Timeline

Virginia will phase in implementation of health homes, beginning July 1, 2015, in Southwest Virginia. In the Southwest, primary and specialty health care is limited and difficult to access, and the need for more intensive substance abuse treatment is urgent due to the high incidence of addiction to prescription pain medications.

Measures of Achievement

States that offer health homes are required to report to CMS on hospital readmission rates, measures of chronic disease management, assessment of quality improvements and clinical outcomes, and estimates of cost savings. Virginia will adopt those measures to determine the success of the Behavioral Health Home Pilot project.

Reducing Prescription Drug and Heroin Abuse

Stemming a Devastating Proliferation of Substance Abuse

Importance to Virginia

Across the country, more people now die from drug overdose each year than are killed in motor vehicle accidents or gun violence. In 2013, more than 900 Virginians died from an overdose. A majority of those deaths were related to prescription painkillers, while heroin-related deaths in Virginia nearly doubled from 2011 to 2013. The situation is especially dire in Southwest Virginia, where death from drug overdose has reached epidemic proportions. Central and eastern Virginia have the highest number of fatal heroin overdoses.

If we do not take action now to address prescription drug and heroin addiction in Virginia, the cost to the Commonwealth in health care, law enforcement, and most importantly, in lives lost, will continue to rise.

Goal

Virginia aims to significantly reduce the number of deaths in Virginia due to prescription painkillers and heroin.

Issue Background

The Centers for Disease Control and Prevention have identified a growing, deadly epidemic of prescription painkiller (opioid) abuse across the country. The rate of death from overdoses of prescription opioids in the U.S. more than quadrupled between 1999 and 2010.

Every day, more than 50 Americans die from overdosing on these drugs. In recent years, there has been a related surge in heroin use as people who are addicted to opioids turn to heroin, which is less expensive and easier to get. Although the overall rate of drug-induced death in Virginia is lower than the national average, sparsely populated Southwest Virginia has been disproportionately affected.

The region is home to only 1 percent of the state population, yet the Virginia State Police spent 25 percent of statewide drug investigation funds there. In Wise County, nearly 70 percent of the total police caseload is directly related to drug abuse.

The rates of emergency room visits and treatment admissions related to prescription drugs have risen dramatically, inflating health care costs for all of us at a time when we can least afford it.

Strategies for Success

Virginia has identified a number of action items, based on evidence of what has worked in other states, that the Governor can push forward immediately through executive action. This includes the

creation of a Task Force to Combat Prescription Drug and Heroin Abuse to assist the Governor in driving a coordinated, statewide effort to reduce drug-related deaths. Strategies will include:

- Educating the public about the dangers of misuse and addiction to prescription drugs.
- Leveraging Virginia's Prescription Monitoring Program to identify emerging trends.
- Educating prescribers on best practices for safe prescribing of opioids and treatment of chronic pain and addiction.
- Expanding methods for safe storage and proper disposal of prescription drugs.
- Working with law enforcement to implement best practices when responding to those with opioid addiction.
- Improving access to substance abuse treatment services.

Timeline

The Task Force will release an implementation plan, including a timeline with milestones and goals for preventing prescription drug and heroin-related deaths. The Task Force will decide and report on specific metrics that will be used to track progress in multiple domains.

Measures of Achievement

The goal is a reduction in the number of deaths due to prescription opioid and heroin abuse, particularly in the regions of the state that are disproportionately affected by these drugs.

More than 200,000 Lives Impacted

New health care coverage:

20,000 people with serious mental illness will have access to medical and behavioral health services.

35,000 children who are already eligible but not covered will be signed up for health insurance.

160,000 adults will receive information and support as they sign up for health insurance on the Federal Marketplace.

5,000 children of state workers will have the option to receive health insurance through the Family Access to Medical Insurance Security program.

New health services:

45,000 low-income pregnant women will receive comprehensive dental services.

13,000 adults and children with serious mental illness will benefit from coordination of their primary, acute, behavioral health, substance abuse and long-term care services.

Gov. McAuliffe is responding to Virginia's health care crisis by issuing an Executive Order and authorizing 4 emergency regulatory actions.

10 Actions for A Healthy Virginia

1. Covering people with serious mental illness through the Governor's Access Plan (GAP).
2. Signing up more children for Medicaid and FAMIS.
3. Signing up more Virginians for insurance on the Federal Marketplace.
4. Informing Virginians of their health options with an improved website.
5. Allowing eligible state workers to insure their children through FAMIS.
6. Providing dental benefits to pregnant women in Medicaid and FAMIS.
7. Accelerating veterans' access to care.
8. Transforming health care delivery through an innovation grant.
9. Improving coordination of care for people with serious mental illness.
10. Reducing prescription drug and heroin abuse.

A Healthy Virginia- Overview

Initiative	Overview	Impact Goal (or # of people)	Formal Action Required by Governor	Launch Date
1. Governor's Access Plan *(Coverage)*	Provide practitioner, Rx, lab and BH services to uninsured Virginians with severe mental illness	20,000	Authorization of Emergency for Required Regulatory Action*	January 2015
2. Health Homes for Behavioral Health *(Innovation)*	Develop health homes for current Medicaid enrollees (adults and children) with severe mental illness and/or substance use disorders	13,000	Authorization of Emergency for Required Regulatory Action	July 2015
3. Children's Outreach *(Outreach)*	Outreach for children who are already eligible for Medicaid and FAMIS but not yet enrolled	35,000		September 2014
4. Federal Open Enrollment *(Outreach)*	Federal grant funds for Federal Marketplace outreach and consumer assistance	160,000		September 2014
5. State Workers access to FAMIS *(Coverage)*	Allow children of state workers to enroll in FAMIS	5,000	Authorization of Emergency for Required Regulatory Action	January 2015 (New Employees) July 2015 (Current Employees)
6. Dental for Pregnant Women *(Coverage)*	Comprehensive dental for pregnant women in Medicaid and FAMIS MOMS	45,000	Authorization of Emergency for Required Regulatory Action	March 2015
7. Enhancement of Cover Virginia Website *(Outreach)*	Federal grant funds for enhancements to the Cover Virginia website	Increased website traffic		November 2014
8. Veterans *(Innovation)*	Accelerating access for veterans	Increase in the number of health access points		November 2014
9. Responding to the Substance Abuse Epidemic *(Innovation)*	Governor's Task Force to Address Rx Drug and Heroin Abuse	Reduced deaths from drug abuse	Issuance of Executive Order #27	Fall 2014
10. SIM Grant *(Innovation)*	State Innovation Model Grant (Anticipated award notice - October 2014)	Statewide Innovation Plan		January 2015

* Pursuant to Va. Code §2.2-4011(A)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

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www.dmas.virginia.gov

September 5, 2014

The Honorable Terence R. McAuliffe
Governor
Commonwealth of Virginia
P.O. Box 1475
Richmond, VA 23218

Dear Governor McAuliffe:

On behalf of the Board of Medical Assistance Services, I am writing to request your approval for the Department of Medical Assistance Services (DMAS) to promulgate Emergency regulations for the reasons more fully set out below. It has come to our attention that the lack of health insurance coverage for 995,000 Virginians has created an urgent situation that necessitates the implementation of emergency regulations to speedily address the significant medical needs of Virginia's uninsured population.

DMAS has taken note of the fact that the populations for whom the lack of health insurance presents the most critical health risks are those with serious mental illness, state employees who are currently excluded from state-sponsored family health insurance, pregnant women in need of dental services, and those in need of coordinated behavioral health care through a behavioral health homes program.

The primary concern is the need for accessible mental health care for Virginians who suffer with serious mental illness. It is estimated that about 308,000 Virginia adults have experienced a serious mental illness (SMI) during the past year. Of that number, approximately 54,000 are uninsured. While these individuals face profound difficulties in accessing treatment, almost half of them also have a co-occurring substance use disorders and have increased risk for medical conditions such as diabetes, heart disease and obesity. The average lifespan of an individual with SMI is 25 years shorter than those without.

More importantly, Virginia's recent history with the shootings at Virginia Tech, and the tragedy experienced by State Senator Creigh Deeds, point to the dire consequences that may arise from the lack of effective treatment of SMI. Providing persons with SMI access to behavioral health and needed medical services would help prevent the reoccurrence of such

tragedies, and it would provide a means for such individuals to recover and participate fully in the community.

The next critical issue is the denial of access for Virginia state employees to the FAMIS health insurance program. Virginia's state workforce includes a significant number of lower-income employees. Last year, more than 9,600 full-time state employees qualified for the Earned Income Tax Credit, a federal tax subsidy for lower-income working families. State employees may cover their dependent children through their employee health insurance, but for many families this is not an affordable option. Employees who choose this option face an increase in their insurance premium contributions of approximately $100 to $200 per month. Even with the most comprehensive coverage, employees must also make copays of up to $40 for doctor visits. These health care premiums and copays represent a significant reduction in take home pay for many state workers. Some may be forced to opt for employee-only coverage; others may struggle to pay for rent or other necessities because of the additional cost for their children's insurance. This reduced access to covered medical services creates increased health risks for the children of Virginia state workers. Current DMAS regulations exclude state employees from FAMIS eligibility. DMAS now seeks to remove this barrier to the FAMIS program and open up low cost comprehensive health care coverage for the dependent children of Virginia state employees.

The lack of access to dental care for pregnant women enrolled in Virginia's Medicaid and FAMIS programs is the third health care risk DMAS seeks to address via regulatory action. Virginia has 45,000 pregnant women enrolled in Medicaid and FAMIS MOMS. Neither of these programs currently provides a comprehensive dental care. As a result, these women risk having dental health issues go undiagnosed and untreated, needlessly putting their unborn babies in jeopardy. A pregnant woman's oral health is linked to her delivery and her baby's health. In the absence of effective treatment, dental issues can become medical issues, leading to significantly greater costs.

Finally, DMAS seeks Emergency regulatory authority to address the critical issues and costs associated with the often fragmented care provided to individuals with both medical and behavioral health needs. Half of all individuals who are intensive users of the health care system have a behavioral health diagnosis. Many medical providers, however, often lack specialized experience to treat mental health conditions. This often results in these individuals seeking access to care in emergency departments. As noted above, nearly 50 percent of individuals with an SMI also have a substance use disorder. Medicaid costs for individuals with both a chronic physical health disease and mental health diagnosis are 75 percent higher than those for people without a mental health diagnosis.

DMAS has determined that addressing this problem requires the establishment of health homes to coordinate care for adults and children who are insured through Medicaid and who have a serious mental illness or a serious emotional disturbance. The health homes model is based upon a "whole person" philosophy for treatment that calls for team-based care of all

primary, acute, behavioral health, substance abuse, and long-term services. Virginia will use health homes to enhance the treatment of both mental and physical health conditions and significantly decrease the level of impairment experienced by these individuals. This program could help up to 13,000 individuals in Virginia with serious mental illness.

DMAS has identified these four critical areas of need, and determined that the Agency has the capacity to deal with them via effective change. Given the gravity of the circumstances noted above and the availability of the means to address them through regulatory action, I therefore on behalf of the Board of Medical Assistance Services and pursuant to Virginia Code § 2.2-4011(A), request your approval for DMAS to promulgate Emergency regulations to provide necessary coverage to the population most affected by this emergency.

Sincerely,

Cynthia B Jones

Cynthia B. Jones, Director
Department of Medical Assistance Services

Virginia Department of Medical Assistance Services
Notice of Public Hearing and Public Comment Period

Under 42 CFR Part 431 and the final rule under PART 431 in the February 27, 2012 issue of the Federal Register, 77 FR 11678-11700, notice is hereby given that on:
(1) September 16th from 1:00-3:00pm
Location: the Fairfax County Government Center
Board of Supervisors Auditorium
1200 Government Center Parkway
Fairfax, VA 22035

and on

(2) September 17th from 1:00-3:00pm
Location: the Department of Motor Vehicles (DMV) Richmond Central Office
Conference Room 702
2300 West Broad Street Richmond, VA 23269

The Virginia Department of Medical Assistance Services (DMAS) will hold public hearings regarding the Virginia GAP Program for the Seriously Mentally Ill §1115 waiver application that will be submitted to the Centers for Medicare and Medicaid Services (CMS). This submission and desired approval will authorize the implementation of the GAP Program for a two year demonstration which will be implemented January 2015 through January 2017 or until Virginia implements a plan to provide health coverage for individuals up to 138% of the Federal Poverty Level. This notice also serves to open the 30 day public comment period, which closes October 7th at 4:30pm eastern standard time.

DMAS welcomes public comment on the entire GAP program for the Seriously Mentally Ill waiver proposal. We ask specific consideration be given to comments concerning: Eligibility Criteria, Benefits, and Enrollment.

Instructions for written Public Comment Submission:

Mail Submission– written comments shall be addressed to Molly Huffstetler, Department of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, VA 23219

Electronic Submission – for ease in compilation of comments, all submissions must be a Microsoft Word document, submitted as an email attachment to: 1115waiver@dmas.virginia.gov.

On June 20, 2014, Governor McAuliffe declared, "I am moving forward to get Virginians healthcare." To that end, he charged Secretary of Health and Human Resources, Dr. Bill Hazel, to create a detailed plan, outlining opportunities and implementation targets to provide Virginians greater access to physical and behavioral health care. A significant portion of the uninsured across the Commonwealth not only lack basic health care, but also suffer from conditions that lead to complex behavioral health needs. These health and behavioral health needs cannot continue to go unmet. Therefore Virginia proposes a §1115 demonstration waiver

to create a limited yet targeted benefit package of services that builds on a successful model of using existing partnerships to provide and integrate basic medical and behavioral health care services.

According to national statistics, in the past year, it is estimated that 20% of adults (age 18 years or older) experienced some form of behavioral illness and approximately 4.1% of Americans experience a serious mental illness (SMI). These figures are significantly higher among low income, uninsured populations. In addition, nearly 50% of individuals with a serious mental illness (SMI) also have a co-occurring substance use disorder. Also, individuals with SMI have an increased risk for co-morbid medical conditions such as diabetes, heart disease and obesity. Consequently, individuals with SMI have significantly decreased longevity, and in fact, die an average of 25 years earlier than individuals without a SMI.

The tragedy is that SMI, substance use disorders are the most common co-morbid medical conditions are all highly treatable. Effective treatment is available and people can recover. Without access to such treatment, individuals with SMI are often unnecessarily hospitalized, may be unable to find and sustain employment, struggle with affordable and available housing, become involved with the criminal justice system, and suffer with social and interpersonal isolation.

Enabling persons with SMI to access both behavioral health and primary health services will enhance the treatment they can receive, allow their care to be coordinated among providers, and significantly decrease the severity of their condition. With treatment, individuals with SMI and co-occurring or co-morbid conditions can recover and live, work, parent, learn and participate fully in their community.

The three key goals of this Demonstration are to:

1. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs;
2. Improve health and behavioral health outcomes of demonstration participants; and,
3. Serve as a bridge to Closing the Coverage Gap for uninsured Virginians.

Description of the current or new beneficiary groups that will be impacted by the demonstration

This demonstration will target participants who meet eligibility parameters resulting from a diagnosis related to serious mental illness (SMI). DMAS is working with stakeholders and behavioral health experts to determine the eligibility criteria and welcome public comments to assist in this process.

In addition to a SMI related diagnosis, individuals must meet ALL of the requirements outlined below to be eligible for the demonstration:

- Adult age 19 through 64 years old;
- U. S. Citizen or lawfully residing immigrant;
- Not eligible for any existing entitlement program including: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), or Medicare;
- Resident of Virginia;

- Household income that is below 100% of the Federal Poverty Limit (FPL);
- Uninsured;
- Screened and meet the criteria for SMI (as described above); and
- Not residing in a long term care facility, mental health facility, or penal institution.

Proposed Health Care Delivery System

The ultimate goal of this demonstration is to enable program eligible individuals with SMI to gain access to both behavioral health and primary health services. To implement this program quickly, the Department of Medical Assistance Services (DMAS) will utilize existing partnerships and provider networks. Virginians who meet the program eligibility criteria outlined above will receive a coordinated, limited, benefit package that includes both medical and behavioral health services.

Referrals for this demonstration will come from a variety of sources, including, but not limited to: self-referral, community mental health providers, health care providers, community organizations, law enforcement, jail/prisons (upon discharge), and hospitals. Once determined eligible, individuals will be enrolled into the program. Participants will receive benefits defined for the demonstration, and will do so through existing provider networks, paying the rates and using the same service authorization processes they currently use for the Medicaid and CHIP programs. DMAS anticipates that the benefits that are included in the demonstration, that are currently covered by the Behavioral Health Services Agreement (BHSA), will continue to be provided through the BHSA. DMAS' eligibility contractor will implement the eligibility rules, and the benefits and terms of payment will be specified in a contract document that will be executed with existing partners.

Through this demonstration, Virginia will seek to test the belief that integrating care coordination, primary care, specialty care, pharmacy, and behavioral health care for this uninsured population will result in better health and sustained living for participants. It is further believed that participants will also have fewer improper emergency department (ED) visits, less inpatient hospital utilization, less interaction with the criminal justice system, and reduce other often uncompensated health care costs.

Benefit and Cost-Sharing Requirements

As mentioned in the previous sections, the benefit package for this demonstration will be limited in scope, providing access to the most critical services for the SMI population. Specific benefits to be incorporated into the benefit package have not been finalized, though DMAS is working with stakeholders and experts to determine the appropriate package. DMAS welcomes public comments to assist in this process.

As with eligibility, the benefit package for the GAP Program will be defined after soliciting public comment and in consultation with experts. The final details and information will be incorporated into DMAS' official §1115 waiver application to CMS.

The lens through which DMAS is working to determine benefits includes:

- Providing access to a limited benefit package of primary care, specialty care, behavioral health community services, laboratory, pharmacy, diagnostic services, and care coordination.

- An understanding that the demonstration will not pay for any services beyond the limited benefit package such as inpatient and outpatient hospital visits, emergency department visits, home health, nursing home, long-term care, routine dental, non-emergent transportation, or routine optometry services.

- Program oversight and administration will be provided by the Virginia Department of Medical Assistance Services (DMAS)

- Administration of actual benefits and care coordination between health and behavioral health care services will be conducted by existing DMAS partners.

This demonstration does not include any cost-sharing requirements.

Increase or Decreases in Enrollment and Expenditures

Enrollment into the demonstration must be limited due to funding constraints, therefore this demonstration does not create a new entitlement program. Enrollment will not be capped but financial eligibility criteria may be reduced in the future, in order to stay within the funding allocated for this program. Additional terms under which any limits will be imposed will be further specified in the §1115 Waiver application, following the public comment period, through consultation with CMS.

Contracted partners will be paid an allocation for administration, in addition to actual expenses for medical claims. Specifics regarding the financing of the demonstration will be identified during the public comment process.

The estimate for the cost of services will be based on benefits covered, service utilization, and the rate of enrollment. DMAS has estimated that up to 20,000 individuals may receive services over the period of this demonstration at an average cost of $7,000 to $8,600 per individual. Fifty percent of the costs of this demonstration will be paid with federal funds.

The estimated total cost for State Fiscal Year (SFY) 2015 ranges from $60 to $80 million in total funds. In SFY 2016, estimated total costs are between $120 and $160 million. DMAS will monitor the utilization and cost data to ensure that the funds allotted for this project are not exceeded. This two year demonstration will be implemented from January 2015 through January 2017 or until Virginia implements a plan to provide health coverage for individuals up to 138% of the Federal Poverty Level.

To ensure budget neutrality as required by all §1115 waiver demonstrations, cost savings will come from the following:

- Effective management of uninsured individuals who experience SMI. This will enable eligible Virginians to remain in their communities, remain employed, and support them in efficient use of the health care system. Further, they will not need to seek to qualify for a disability determination, which would most likely result in enrollment into the Medicaid program.

- Once individuals who are under 138% of the FPL gain access to full health coverage, their previous access to health and behavioral health benefits (through this §1115 waiver demonstration), will have aided in stabilizing their health and behavioral health conditions. As a result, there will be a reduced cost to Medicaid or other full health coverage plan once they are enrolled.

Details of the Hypothesis

Virginia recognizes that while only one component to the health care reimbursement paradigm, publically funded payment sources are the most significant contributor in the overall health care system. Therefore, the central hypothesis of the Virginia GAP program for individuals with serious mental illness, is situated around a belief that managing care for the chronically uninsured population diagnosed with SMI and other comorbid conditions will improve health outcomes and lower costs to the overall health system.

Research illustrates that SMI and affiliated conditions are often treatable with proper benefits and services. Therefore, the Virginia GAP program will investigate the following hypothesis.

1) Effective management of uninsured individuals who experience SMI, will enable these Virginians to remain in the community, remain employed, and therefore not need to seek to qualify for a disability determination, which would most likely lead to enrollment into the Medicaid program or continuing to receive costly episodic and often uncompensated care.

2) Once individuals who live under 138% of the FPL gain access to full health coverage, their previous access to health and behavioral health benefits (through this §1115 waiver demonstration), will have aided in stabilizing their health and behavioral health conditions. As a result, there will be a reduced cost to Medicaid or other full health coverage plan once they are enrolled

Evaluation Parameters of the Proposal

The State's evaluation plan will be comprehensive and include the collection of claims and/or encounter data and relevant HEDIS quality measures.

The State will report on outcomes and goals as required by the waiver. In addition, the State will report to the Governor and the Virginia General Assembly on utilization, costs, outcomes, and trends.

Specific Waiver and Expenditure Authorities it is Seeking

As the specific components of the program are finalized during the public comment phase and in collaboration with federal partners, the final waiver and expenditure authorities seeking to be waived will be incorporated into DMAS' official §1115 waiver application to CMS.

1) Amount Duration and Scope of Services – Section 1902(a) (10) (B)
   Allowing Virginia to offer program participants a benefit package that differs from State Plan Services

2) Freedom of Choice – Section 1902(a) (23) (A)
   Allowing Virginia the flexibility to assign program participants to the most appropriate program partner.

3) Different Delivery Systems – Section 1902(a) (23)
   Allowing Virginia to provide different delivery systems for the population under this demonstration

4) Methods of Administration – Transportation – Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53
   Allowing Virginia, to the extent necessary, to not provide non-emergency transportation to and from providers for participants

5) Retroactive Eligibility – Section 1902(a) (34)
   Allowing Virginia to not offer participants retroactive eligibility for demonstration participation

6) Early Periodic Screening, Diagnoses, and Testing (EPSDT) – Section 1904(a) (4)
   Allowing Virginia to be exempt from the requirement to offer EPSDT services to 19 and 20 year olds

Regulatory Activity Summary for September 9, 2014
(* Indicates recent activity)

2014 General Assembly

***(01) Update Reference to ICD 9:** This Final-exempt action updates references in DMAS' regulations from the International Classification of Diseases (ICD), 9th edition to the 10th edition in compliance with federal requirements. This package was filed with Registrar's office 4/10/14 and became effective 6/5/14. This action was revised and it advances the effective date to 10/1/15. This regulatory package was certified by the Office of the Attorney General (OAG) on 8/28/14 and was filed with the Registrar. It takes effect 10/22/2014. This project will be removed from the next report.

(02) Discontinue Coverage for Barbiturates for Duals: This State Plan Amendment (SPA} Effective January 1, 2014, Section 2502 of the Affordable Care Act amends section 1927(d)(2) of the Social Security Act to exclude 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 submitted to CMS 3/24/14 and CMS approved on 4/23/14. The Fast-Track regulatory package is currently at Secretary's office pending approval.

***(03) No Inflation Reimbursement Methodology Changes**: This action affects hospitals, home health agencies, and outpatient rehabilitation providers. Chapter 2 of the *2014 Acts of the Assembly*, Item 301 CCC and IIII directed this change. The SPA has been approved internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

***(04) Supplemental Payments for County-Owned NFs**: This action provides supplemental payments to locality-owned nursing facilities who agree to participate. The SPA has been approved internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

***(05) 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 has been approved internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

***(06) 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 has been approved

internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

(07) 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 will be developed and submitted to the Secretary's Office for submission to CMS by 12/30/14. Changes to parallel administrative code sections are pending.

***(08) Affordable Care Act Appeals Process Changes**: This action implements federally mandated changes to the DMAS client appeals process. It has been adopted internally as a final exempt action and is pending certification by the OAG. No SPA is required for this rule change.

(09) Primary Care Rate Increase Vaccine Administration: This action adds to the State Plan rate increases for the administration of vaccines. The SPA has been submitted to CMS and is pending approval. The regulatory action is pending drafting.

***(10) 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 has been submitted to CMS and is pending approval.

(11) FAMIS Uninsured Waiting Period Elimination: This action eliminated the uninsured waiting period for children applying for Family Access to Medical Insurance Security (FAMIS) as required by the *2014 Acts of Assembly*. New federal regulations required Virginia to reduce its uninsured waiting period from 4 months to 90 days and add new waiting period exceptions. Imposing a waiting period on such a small number of children was determined not to be an effective policy so it has been eliminated to administrative burdens. This action brings Virginia's policy in line with that of 29 other states, including all of Virginia's contiguous neighbors.

(12) Discontinue Coverage of Barbiturates for Dual Eligible Individuals: This action was required by federal law and the agency's Fast Track action has been adopted internally and is pending approval by the Secretary's Office. A SPA will be required for the affected parallel State Plan sections.

2013 General Assembly

(01) Modified Adjusted Gross Income (MAGI) SPA: These SPAs create a new format developed by CMS to address a new eligibility determination system put in place under the Affordable Care Act. These SPAs begin the conversion of the current net income eligibility thresholds to the equivalent modified adjusted gross income (MAGI) thresholds in the Medicaid program and Children's Health Insurance Program (CHIP). These SPAs were submitted to CMS 10/1/13. Multiple SPAs have been

approved with a few still outstanding. Changes to parallel administrative code sections are pending.

(**04) 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 is currently being drafted.

***(06) 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 has been submitted to the OAG for certification. No SPA action is required.

***(07) Exceptional Rate for ID Waiver Individuals:** This Emergency/NOIRA will enable 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. Such individuals, who have long been institutionalized in the Commonwealth's training centers, 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. These affected individuals have exceptional medical and behavioral support needs. For providers to render services for such individuals, it is requiring substantially more staff time and skills than for individuals who have not been institutionalized for extended periods of their lives. This regulatory action has been approved by the OAG and is pending Secretary approval. The waiver change was approved by CMS on 4/23/2014.

(08) ICF/ID Ceiling: Cost Report Submission; Credit Balance Reporting: This Fast-Track modifies the Nursing Facility (NF) reimbursement methodology in three areas: (i) updates the calculation of per diem reimbursements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to account for state facilities' closures; (ii) makes a technical correction to an incorporation by reference included in nursing facility (NF) cost reporting requirements, and; (iii) updates NF credit balance reporting requirements to reflect more current Medicaid policies. This regulatory package is currently at the Secretary's office pending approval. A SPA of affected parallel State Plan sections will be required.

(09) Discontinue Coverage of Benzodiazepines-Barbiturates for Dual Eligible Individuals: This Fast-Track regulatory change proposes to eliminate coverage for both benzodiazepines and barbiturates for full benefit dual eligibles (eligible for both Medicare and Medicaid), who may now obtain both these drugs under Medicare Part

D drug coverage. This regulatory package is currently at the Secretary's office pending approval. A SPA of the affected parallel State Plan sections will be required.

(10) Enhanced Ambulatory Patient Group Outpatient Hospital Reimbursement Methodology: This Emergency/NOIRA action implements a prospective payment methodology for outpatient hospital services. The current cost-based methodology is out-of-date, inefficient and costly. DMAS is proposing to implement the EAPG methodology that is a more efficient and predictable reimbursement methodology for DMAS to pay hospitals that furnish services to Medicaid recipients in an outpatient hospital setting. This regulatory package was approved by the Governor's office 10/28/13, filed with the Registrar's office 11/6/13 and became effective 1/1/14. The Proposed stage package has been approved by DPB and is now at the Secretary's Office pending approval. SPA was approved by CMS 5/15/2014.

***(11) 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 drafted and sent to CMS for preliminary review. This regulatory package was filed with the Registrar's office 5/5/14, was published in the Register 6/2/14 and became effective 7/1/14. The Proposed stage is currently being drafted.

(12) Physician Primary Care Rate Increase Update: This SPA is a part of the Affordable Care Act, which Medicaid agencies and Medicaid managed care plans are required to pay Medicare rates for Medicaid primary care services furnished by eligible physicians in calendar years 2013 and 2014. States must make increased payments for services furnished by a physician, or under the personal supervision of a physician with a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty. Eligible physicians must attest to being board certified in one of these specialty designations or have furnished evaluation and management services and vaccine administration services that equal at least 60 percent of the eligible Medicaid codes billed in order to receive the higher reimbursement rates. The rates for vaccine and toxoid administration for eligible providers will increase from $11.00 per administration of a vaccine or toxoid to $21.24, which are the Vaccines for Children (VFC) regional maximum amount specified in the CMS final rule. Higher payments for Medicaid fee-for-service claims will be made in the form of lump sum quarterly supplemental payments. Two new vaccine products codes have been added to the HIB vaccine. This SPA was approved by CMS 5/23/13. Changes to parallel administrative code sections are pending.

(13) Supplemental Payments for services Provided by Type One Physicians-ACR Update: This SPA revises the maximum reimbursement to 190% of the Medicare rate for Type One physicians, based on updated information on the average commercial rate furnished by the providers which are affected by this change (state academic health systems). In response to the SPA that was submitted

to CMS on 3/27/13, CMS issued a request for additional information (RAI). The RAI response was submitted to CMS 3/27/14 and is pending approval.

*(**14) Medicare-Medicaid Alignment Demonstration (FAD)/Commonwealth Coordinated Care:** 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 6/1213. The Emergency regulatory package has been approved internally and by DPB and is now pending Secretary Office approval.

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 has been certified by the OAG, approved by DPB and is currently at the Secretary's office pending approval.

***(02) Supplemental Payments for Institutional/Non-Institutional Providers**: This Fast-Track action shall modify or establish supplemental payments for 1) physicians affiliated with Type One hospitals and state-funded medical schools, 2) hospitals and nursing homes affiliated with Type One hospitals and Type One hospitals. This regulation shall also modify indirect medical education (IME), and graduate medical education (GME) reimbursement for Type One hospitals. This regulatory package was approved by DPB on 6/5/2014 and is currently at the Secretary's office pending approval. SPA was approved by CMS 6/24/2013.

***(03) 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. Pursuant to 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. Item 307 RR (f) authorizes DMAS to promulgate Emergency regulations for this mandatory model. This regulatory package was approved by the Governor and submitted to the Registrars Office 10/10/13. The comment period ended 12/11/13. The Proposed stage has been internally approved and is pending completion of the OAG certification.

(04) Timely Claims Filing: This Fast-Track action creates a 13-month deadline in which Medicaid providers may resubmit denied claims for reconsideration by DMAS. There is currently no set deadline in DMAS regulations for such reconsiderations, which has the effect on both DMAS and providers dealing with open accounts for sometimes years at a time. This action brings closure to providers and the Agency by setting a generous 13-month resubmission policy. This regulatory package is currently at the Secretary's office pending approval.

***(05) 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. This regulatory package was approved by the Governor's office 10/30/13 and filed with the Registrar's office 11/1/13. The comment period ended 1/1/14 and became effective 1/1/14. The Emergency regulation expires on 6/30/15. The Proposed stage regulation has been approved internally and is currently pending OAG certification.

(06) Physician Medicare Percentage Payments for Type I Hospitals: This SPA revises the maximum reimbursement from 143% to 220% of the Medicare rate for Type One physicians, based on updated information on the average commercial rate furnished by the providers which are affected by this change (state academic health systems). A Type One physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10. These payments are calculated as the difference between the maximum payment allowed and regular payments. CMS has determined that the maximum allowed is the average commercial rate. The SPA was approved by CMS 6/29/12. An update to the percentage is being made and another SPA is currently being drafted. Changes to parallel administrative code sections are pending.

(07) DSH Shortfall Payments/IME and GME Reimbursement Changes for Type One Hospitals: This SPA increases Medicaid payments for Type One hospitals and physicians consistent with the appropriations to compensate for limits on disproportionate share hospital (DSH) payments to Type One hospitals that the department would otherwise make. In particular, the department has the authority to amend the State Plan to: (i) increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate as demonstrated by UVA and VCU; (ii) change reimbursement for Graduate Medical Education to cover costs for Type One hospitals; (iii) case mix adjust the formula for indirect medical education reimbursement for HMO discharges for Type One hospitals, and; (iv) increase the adjustment factor for Type One hospitals to 1.0. The SPA was approved by CMS 2/5/13. The Fast-Track regulatory package was filed with Registrar's office 4/25/14, published in the Register 5/19/14 and became effective 6/18/14. Project is completed and will be removed from the next report.

2011 General Assembly

(01) Collaboration Agreement Hospitals: These SPAs create supplemental payments for qualifying private hospitals. Qualifying hospitals must have signed a Low Income and Needy Care Patient Collaboration Agreement with a state or local government entity for purposes of providing health care services to low income and needy patients. Supplemental payments would be calculated as the difference between charges and regular payments. Supplemental payments to Disproportionate Share Hospitals (DSH), however, cannot exceed a separate limit that applies to them and total payments to all hospitals cannot exceed the UPL. These SPAs were submitted to CMS 12/20/11. The agency received requests for additional information and responses were submitted to CMS on 5/30/12 and 6/4/12. Additional questions were received from CMS. RAI responses submitted to CMS 11/28/12. DMAS is awaiting response from CMS. There were multiple SPAs (4) involved with this action and CMS approved 2 of the SPAs on 8/2/13 and 8/13/13.

***(02) Update Medicaid Works Program Income Limit:** This Fast-Track regulatory action implemented the Medicaid buy-in program, MEDICAID WORKS, as authorized by the 2011 General Assembly. House Bill 2384/Chapter 506 directed DMAS to increase the maximum allowable gross earnings for participants in the program to the maximum gross income amount allowed under the Ticket to Work and Work Incentives Improvement Act that does not trigger the collection of mandatory premiums. This amount is calculated to be $75,000 in gross annual earnings. This regulatory action will also adjust MEDICAID WORKS policy to mitigate the negative impact (loss of Medicaid eligibility) of higher earned income or higher unearned income as a result of participating in this work incentive program. Eligibility policy will be amended to enable a disregard for any increase in the amount of unearned income in the Social Security Disability Insurance (SSDI) payment resulting from employment as a worker with disabilities eligible for assistance under the Ticket to Work and Work Incentives Improvement Act, or as a result of a Cost of Living Adjustment (COLA) adjustment to the SSDI payment. Policy also will be amended to

enable a disregard for any unemployment insurance payments received by an enrollee as a result of loss of employment through no fault of his own. This regulatory package was approved by the Governor's office and filed with the Registrar's office 10/15/13. The comment period ended 12/5/13 and became effective 12/19/13. The SPA was submitted to CMS 12/30/13 and is pending approval.

(03) 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 is currently at the Secretary's office pending approval.

***(04) 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 the DMAS may be assigned to a single physician and/or pharmacy provider. This regulatory action was approved by the Governor's office 12/16/13 to be effective 12/16/13 and expires 6/15/2015. The fast-track stage has been internally approved and is currently under certification review by the OAG.

(05) Electronic Claim Submission Requirements: This Emergency/NOIRA action complied with the *2011 Acts of the Assembly*, Item 300 H that required DMAS to implement a mandatory electronic claims submission process, including the development of an exclusion process for providers who cannot submit claims electronically. This regulatory package was approved by the Governor 9/3/12 and filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. The Proposed stage regulatory package was approved by the Governor's office and filed with the Registrar's office 10/15/13. The comment period ended 1/16/14.The final stage regulatory package is currently at the Governor's office pending approval.

(06) Signature Requirement for Medical Records: This Emergency/NOIRA action complied with the *2011 Acts of the Assembly*, Item 297.TTTT requiring DMAS to specify that the documentation requirements for the signing and dating of medical records, both paper and electronic, by health care providers be a mandatory condition of Medicaid reimbursement. This regulatory package was approved by the Attorney General's office 3/210/12 and approved by DPB on 4/3/12. This package was approved by the Governor's office 10/30/13. Per project manager we will wait 60 days in order to get the appropriate notice out to providers.

(07) 2011 Exceptions to Personal Care Limit: This Emergency/NOIRA 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). This regulatory package was approved by the

Governor on 9/3/12 and was filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. (2011 General Assembly Item 297 CCCCC) The Proposed stage regulatory package is currently at the Governor's office pending approval.

(08) Early Intervention Part C Children Case Management: This Emergency/NOIRA regulatory action supported early intervention services, provided under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) which address developmental problems in young children. These services are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. This Emergency/NOIRA action was approved by the Governor's office 9/12/2012. The SPA was approved by CMS 9/25/2012. This project was changed to a Fast-Track action and is currently at Secretary's office pending approval.

2010 General Assembly

(01) Durable Medical Equipment (DME) Services Update: This Emergency/NOIRA complies with 2010 Appropriations Act to modify reimbursement for Durable Medical Equipment (DME), and modify the limit on incontinence supplies prior to requiring prior authorization. This regulatory package was approved by the Governor 6/30/10 and filed with the Registrar's office 7/1/10, became effective 7/1/10 and the NOIRA comment period ended 9/1/10. (Item 297 UUU and Item 297 WWW of the 2010 Appropriations Act). The Final regulation stage was approved by the Governor on 4/27/12 and became effective on 7/1/12. The SPA was submitted to CMS 8/20/12 pending approval. Informal comments were received from CMS 10/15/12 and the responses were forwarded to CMS. A second round of questions was received from CMS and the responses are currently being drafted.

(02) 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. This regulatory package was filed with Registrar's office 7/1/10. The State Plan Amendment was submitted to CMS on 9/28/10 and was approved 6/1/11. A new Emergency regulation was drafted based on the 2011 Appropriations Act to replace the previous one. Secretary's office approved 7/12/11.Governor approved 7/18/11 and became effective on 7/18/11. NOIRA comment period ended 9/14/11. The proposed stage package was approved by DPB 9/6/12 and approved by the Secretary 9/24/12. This proposed stage package was approved by the Governor's office on 1/14/13. The comment period ended 4/12/13. (Item YY of the 2010 Appropriations Act) The final regulations stage was internally approved, certified by the OAG on 6/19/2014 and is pending Secretary's approval.

(03) Inpatient Residential Treatment Psychiatric Services: This State Plan Amendment modifies the reimbursement methodology for inpatient residential psychiatric services provided by residential treatment facilities and freestanding psychiatric facilities. The SPA was submitted to CMS 6/29/10 pending approval. Received a request for additional information (RAI) from CMS 9/30/10. There is currently a matter of litigation pending and DMAS was granted an indefinite extension regarding the RAI response on this issue.

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 is currently at the Governor's office pending approval.

***(02) Elderly and Disabled Waiver 2009 Changes**: This initial Notice of Intended Regulatory Action (NOIRA) updates the Elderly or Disabled with Consumer Direction Waiver (EDCD) to accommodate changes in the industry and to provide greater clarity in these regulations. The NOIRA stage regulatory action was filed with the Registrar's office 10/2/09 and the comment period ended 11/25/09. The Proposed regulatory stage was approved by the Attorney General's office 12/6/10. DPB approved package 3/31/11. The Governor approved this package on 9/11/12 and it was filed with the Registrar's office 9/11/12. The public comment period ended 12/7/12. The final stage package is currently at the Governor's office pending approval.

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.

Department of Medical Assistance Services

Commonwealth Coordinated Care

Medicare & Medicaid working together for you

Karen Kimsey, Deputy Director of Complex Care and Services
Virginia Department of Medical Assistance Services

September 9, 2014

Commonwealth Coordinated Care
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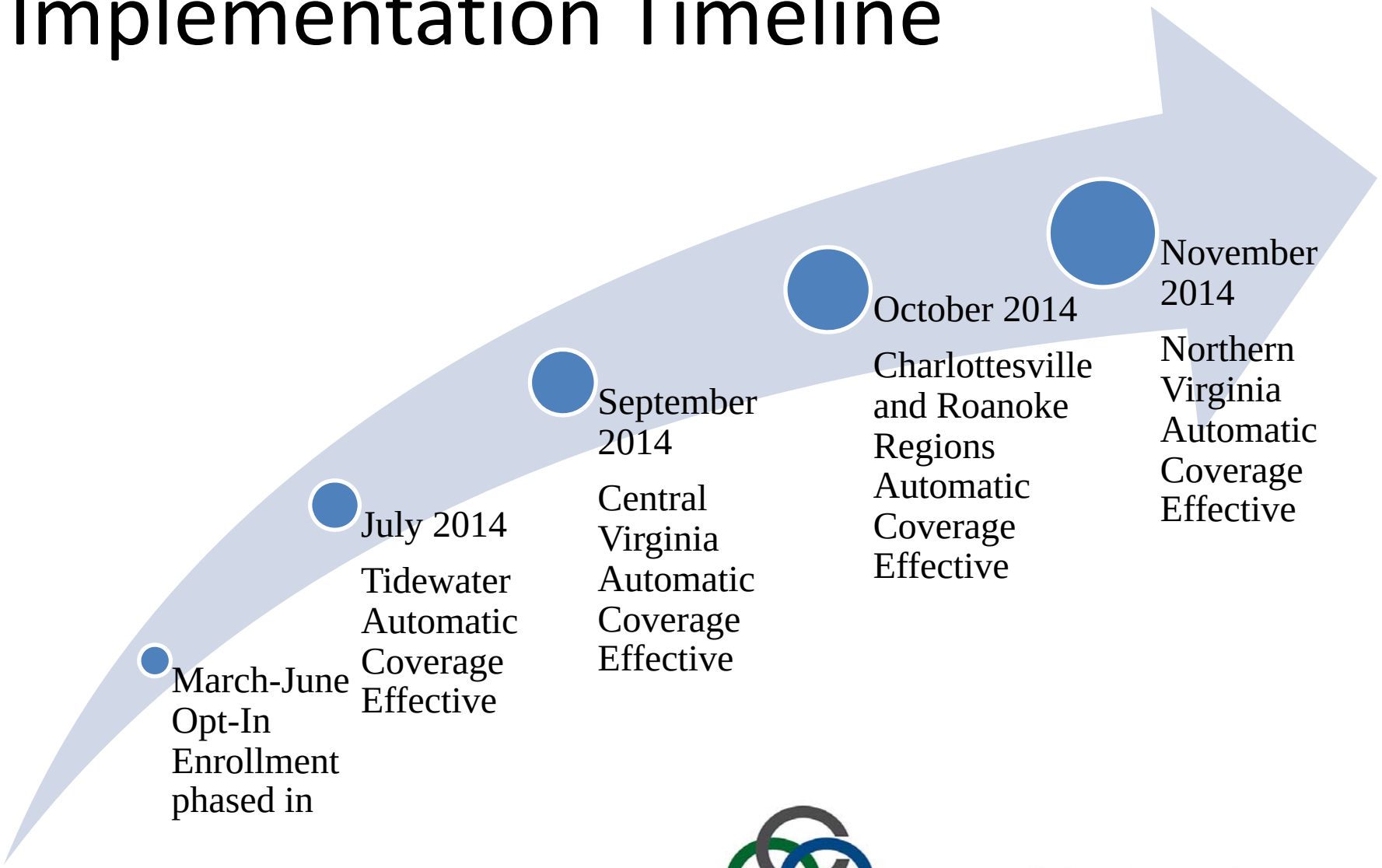
Implementation Update

WHERE ARE WE NOW?

Implementation Timeline



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The CCC Team has a few important updates to share with you today:

- Medicare-Medicaid Plan (MMP) participation has been updated for the following localities:
  - Roanoke Region
    - City of Radford is now open to automatic assignment.
    - Henry County and City of Martinsville now available for opt-in.
- The following localities have **1 MMP approved**: Eligible beneficiaries in these localities can opt-in to CCC but will not be automatically assigned while there is only one plan available.
  - Western/Charlottesville Region
    - Cities of Harrisonburg and Staunton
  - Northern Virginia Region
    - City of Alexandria
    - Arlington
    - City and County of Fairfax
    - City of Falls Church
    - Fauquier
    - Loudoun
    - Manassas Park City

**Please Note: In Northern Virginia-Culpeper, Prince William and City of Manassas have at least 2 MMPs available and will move forward with automatic assignment as scheduled for November 1, 2014.

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CCC Enrollment

20,824
Total Enrollees as of September 1

CCC Region	Total Population	Active Opt-ins	Auto-Assign	Opt-outs	Optout % Region
Central Virginia	23,140	1,437	11,377	5,509	23.80
Northern Virginia	13,963	207	8,449	595	4.26
Roanoke	11,818	346	6,258	1,653	13.99
Tidewater	19,101	1,050	8,288	6,812	35.66
Western/ Charlottesville	6,116	225	3,601	855	13.98
Total Members	74,138	3,265	37,973	15,424	20.80

Total population reflects all beneficiaries eligible for CCC at the beginning of the month and includes beneficiaries enrolled with a future effective date. This number includes those who may lose Medicaid eligibility or become newly excluded by the end of this month. Opt-out rate is calculated based on the total population.

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Enrollment Broker

MAXIMUS report (August 2014)	
Calls Received	11347
Calls Answered	10723
Abandon Rate	5.22%
Average Wait Time	57 seconds
Average Call Time	357 seconds
Outgoing Calls	698

- CCC Call Center calls are recorded providing the ability to monitor for continuous quality improvement
- Contract Monitor works with MAXIMUS on CSR scripts and education

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How the CCC Team is tracking implementation

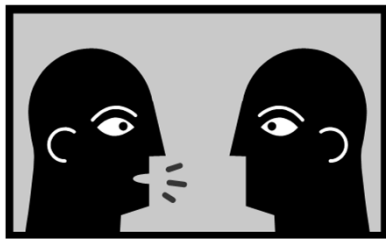
MONITORING AND EVALUATION

VICAP & Ombudsman

DMAS

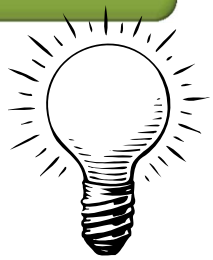
Partnership for outreach

Sharing beneficiary concerns & trends



Ombudsman

VICAP



Problem Resolution

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Contract Monitoring Team (CMT)

Weekly Contract Monitoring Team (CMT) Meetings with each health plan to review:

- Marketing Materials
- MMP Staffing
- Complaints
- Provider Training & Feedback
- Network Review
- Dashboard
  - Claims & Processing Time
  - Customer Service Line

Weekly Dashboard

Enrollment, Clinical/MDS, Call Center and Appeals Grievances

Reporting Period XX/XX/14 - XX/XX/14

MMP Name

Enrollment	For the Reporting Period	Total Effective 4/1	Total Effective 5/1	Total Effective 6/1	Total # Active Enrollment
# of opt-in enrollments (TC 61)					

# of disenrollments(TC 51) by code	Code 013	Code 014	Code 015	Code 026

Clinical/MDS	For the Reporting Period
# of outreach calls to new members	
# of home visits to new members	
# of completed HRAs	
# of completed Care Plans	

Totals to Date		% of Total Active Enrollment
Completed HRAs		#DIV/0!
Completed Care Plans		#DIV/0!

Call Center

Top 3 Most Frequent Call Topics

Appeals and Grievances

Appeals		Grievances	
# of new appeals		# of new grievances	
# of open appeals		# of open grievances	
# of closed appeals		# of closed grievances	

Appeals & Grievances Trends

Weekly Dashboard
Claims Processing and Provider Updates

Reporting Period XX/XX/14 - XX/XX/14 MMP NAME	Medicaid Behavioral Health Services	Medicaid Long-term Care Services	Medicaid Nursing Facility Days	Medicare Nursing Facility Days
Pre-Clearninghouse Claims				
Number of Claims Submitted				
Number of Claims Rejected				
Number of Claims Cleared				
Post-Clearinghouse Claims				
Number of Paid Claims				
Number of Denied Claims				
Number of Pended Claims awaiting formal review				
Number of Claims Processed				
Number of Paid Claims that exceeded 14 days				
Number of Paid Pended Claims that exceed 30 days to resolution				

Top Three Provider Complaint Topics

1

2

3

Provider Training and Testing Update

Provider Network and Readiness Updates

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Quality

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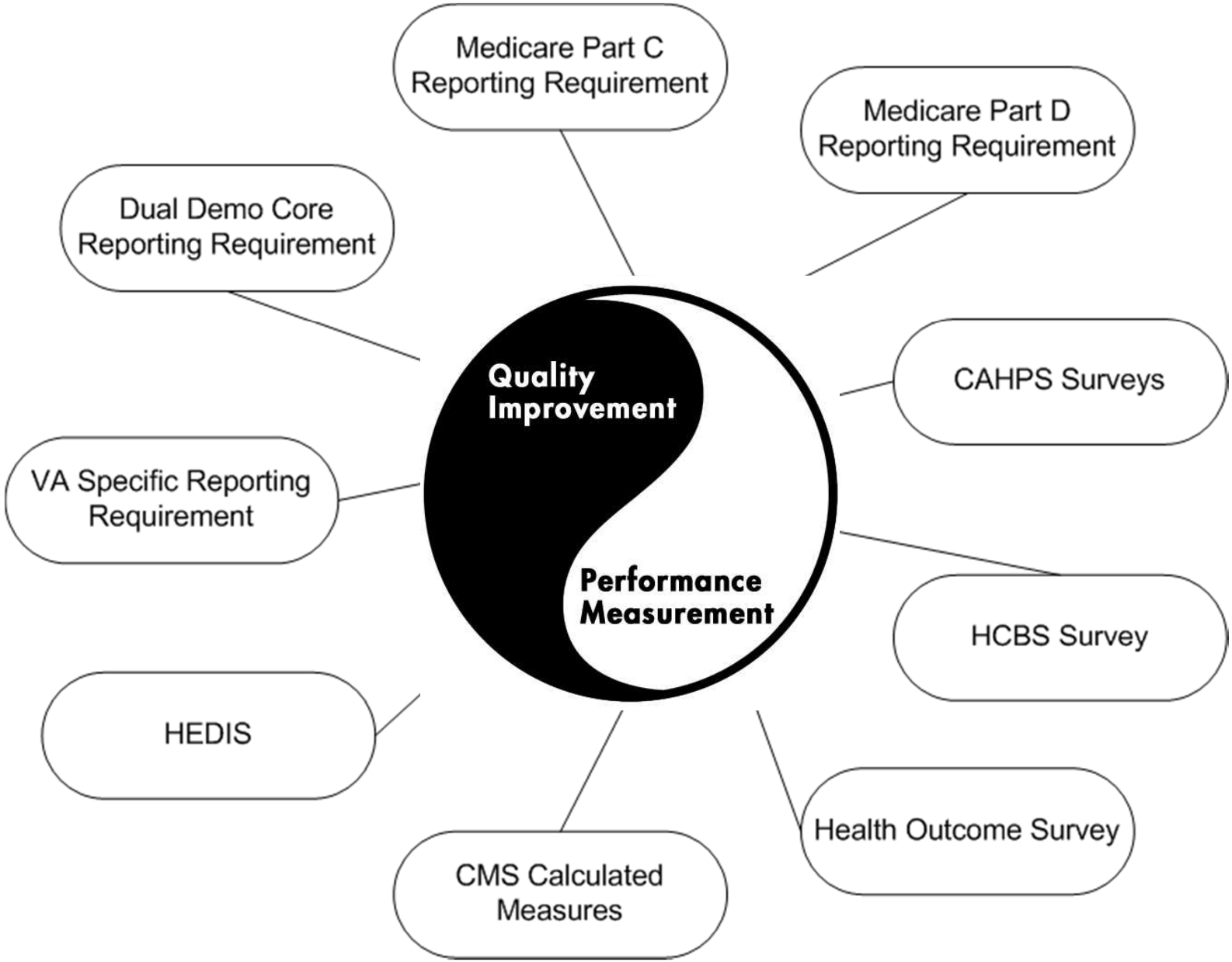

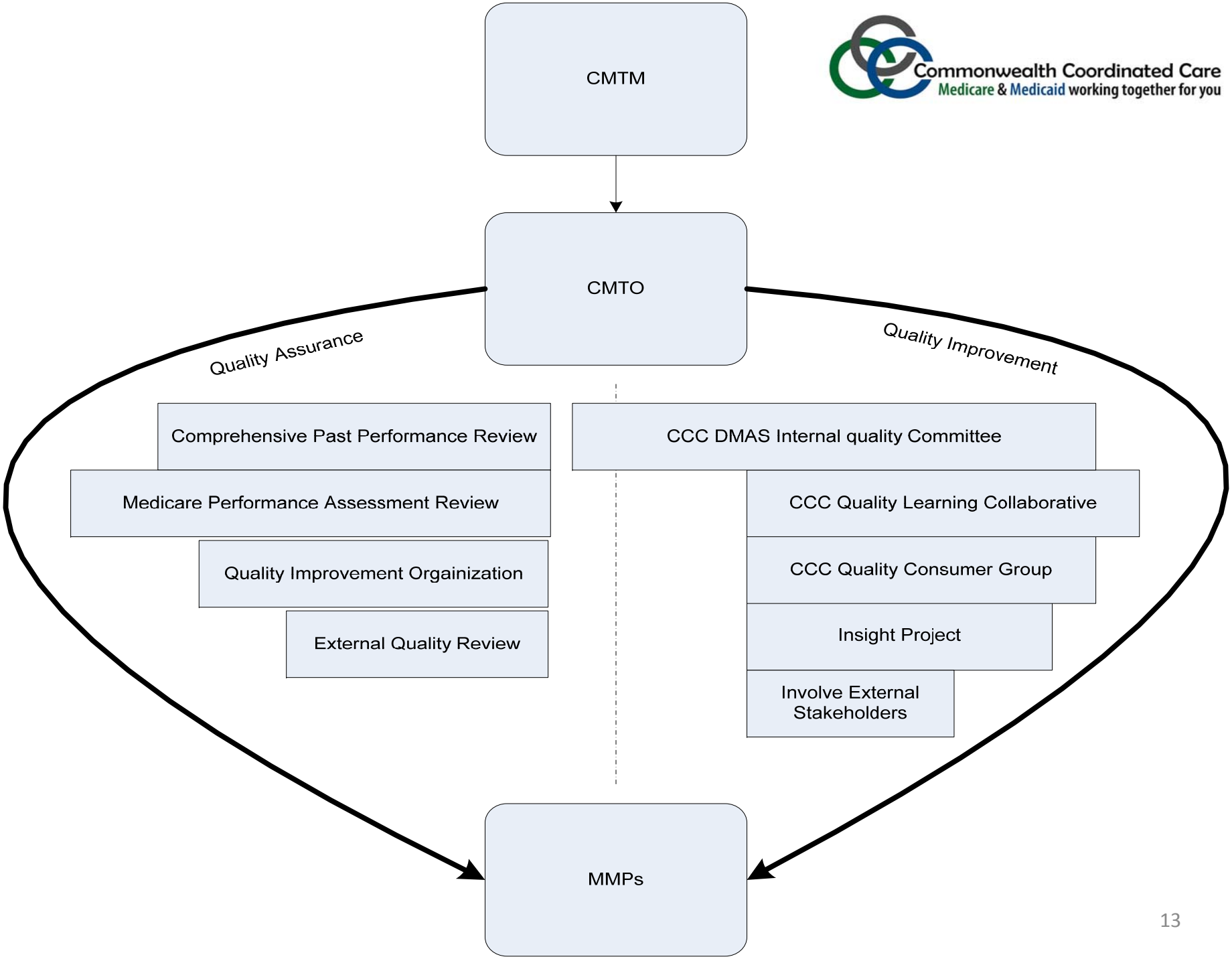
CMTM
CMTO
Quality Assurance
Quality Improvement
Comprehensive Past Performance Review
Medicare Performance Assessment Review
Quality Improvement Orgainization
External Quality Review
CCC DMAS Internal quality Committee
CCC Quality Learning Collaborative
CCC Quality Consumer Group
Insight Project
Involve External Stakeholders
MMPs

Evaluation

- Evaluation Advisory Committee:
  - 12 members representing aging, physical disability, nursing facility, ID/DD, hospital, and health plan communities
- DMAS/George Mason biweekly team meetings
- Interviews to collect data and develop in-depth understanding of the CCC Program
  - DMAS, Providers, MMPs
  - site visits: AAA, AD, CSB, Townhalls
  - Observations of MMP Care Management Activities
- Enrollee Survey Questionnaire
- Evaluation *Notes from the Field* reports posted to DMAS webpage http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx

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Education & Outreach Continues

OUTREACH

Ongoing Outreach

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CCC UPDATE CALLS
Every Tuesday 12:30-1:30pm and Friday 10am-11am
To join the call dial:
1-866-842-5779
Pass Code – 6657847797 #

Great forum! Stakeholders ask their questions and DMAS/MMPs learn about beneficiary & provider experiences with CCC

Monday Provider Calls (LTSS)		Friday Provider Calls	
Adult Day Services	1:30-2p Conference Line 866-842-5779 Conference code 7143869205	Hospitals and Medical Practices	11-11:30am Conference Line 866-842-5779 Conference code 8047864114
Personal Care, Home Health & Service Facilitators	2-2:30p Conference Line 866-842-5779 Conference code 8047864114	Behavioral Health	11:30am-12pm Conference Line 866-842-5779 Conference code 8047864114
Nursing Facilities	2:30-3p Conference Line 866-842-5779 Conference code 7143869205		

CCC Team conducting 7 calls every week

Cultivating Stakeholder Education

- Growing stakeholder email distribution list
- Monthly Stakeholder Updates
- Regional Townhall Meetings (upcoming events posted to DMAS website)
- Ongoing presentations by request
- MMPs worked together to combine provider training

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On the Web

Providers

- Background documents
- Tip sheets for auths & billing
- MMP Contacts
  - Department Leads (Provider Relations, Auth, etc)
  - Regional Care Manager Leads

Beneficiaries & Stakeholders

- Upcoming events
- CCC Overview information
- Comparison charts
- Copies of beneficiary letters
- Evaluation Information

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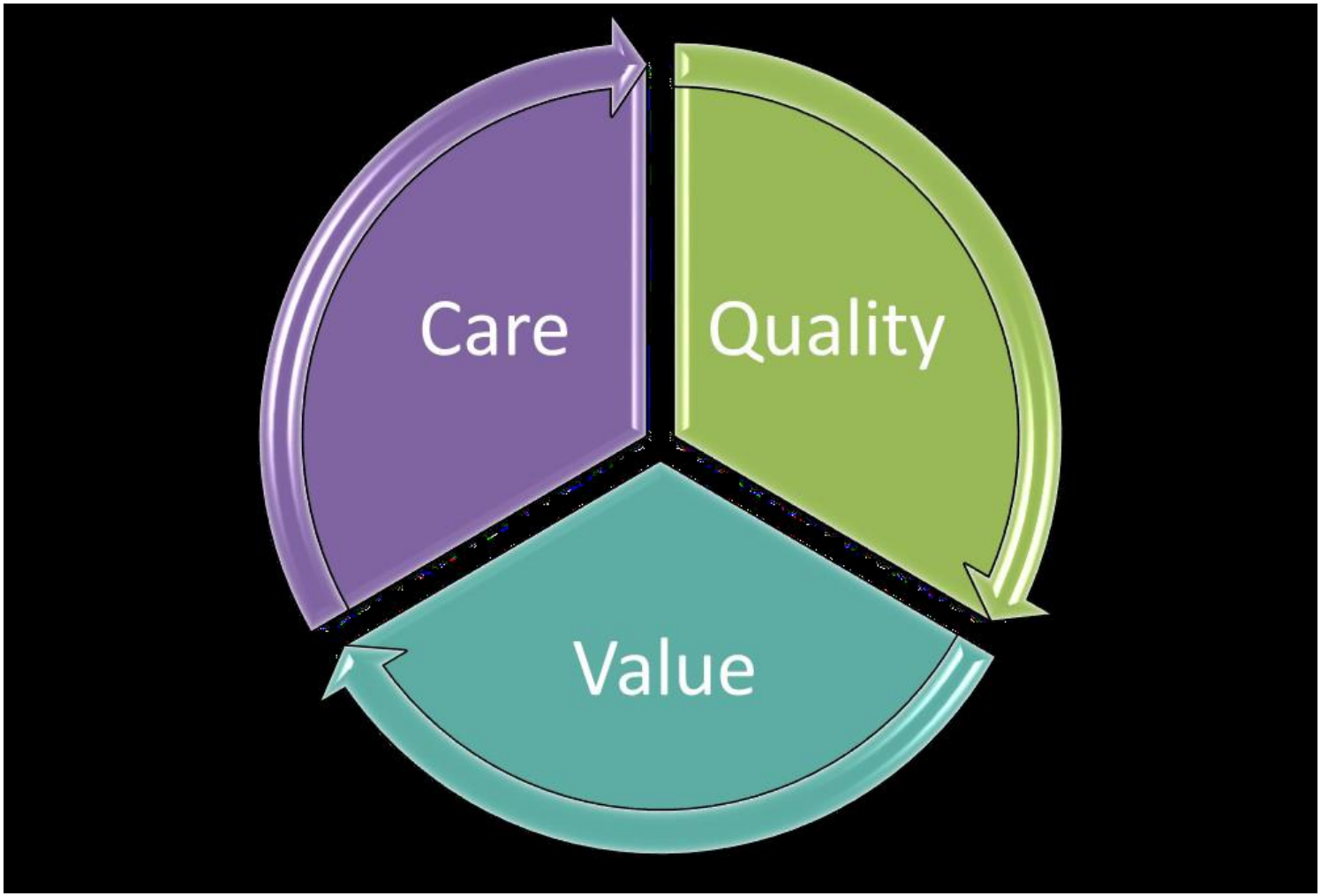
EXPEDITED ENROLLMENT
BOARD OF MEDICAL ASSISTANCE SERVICES
SEPTEMBER 9, 2014

Virginia Medicaid Managed Care





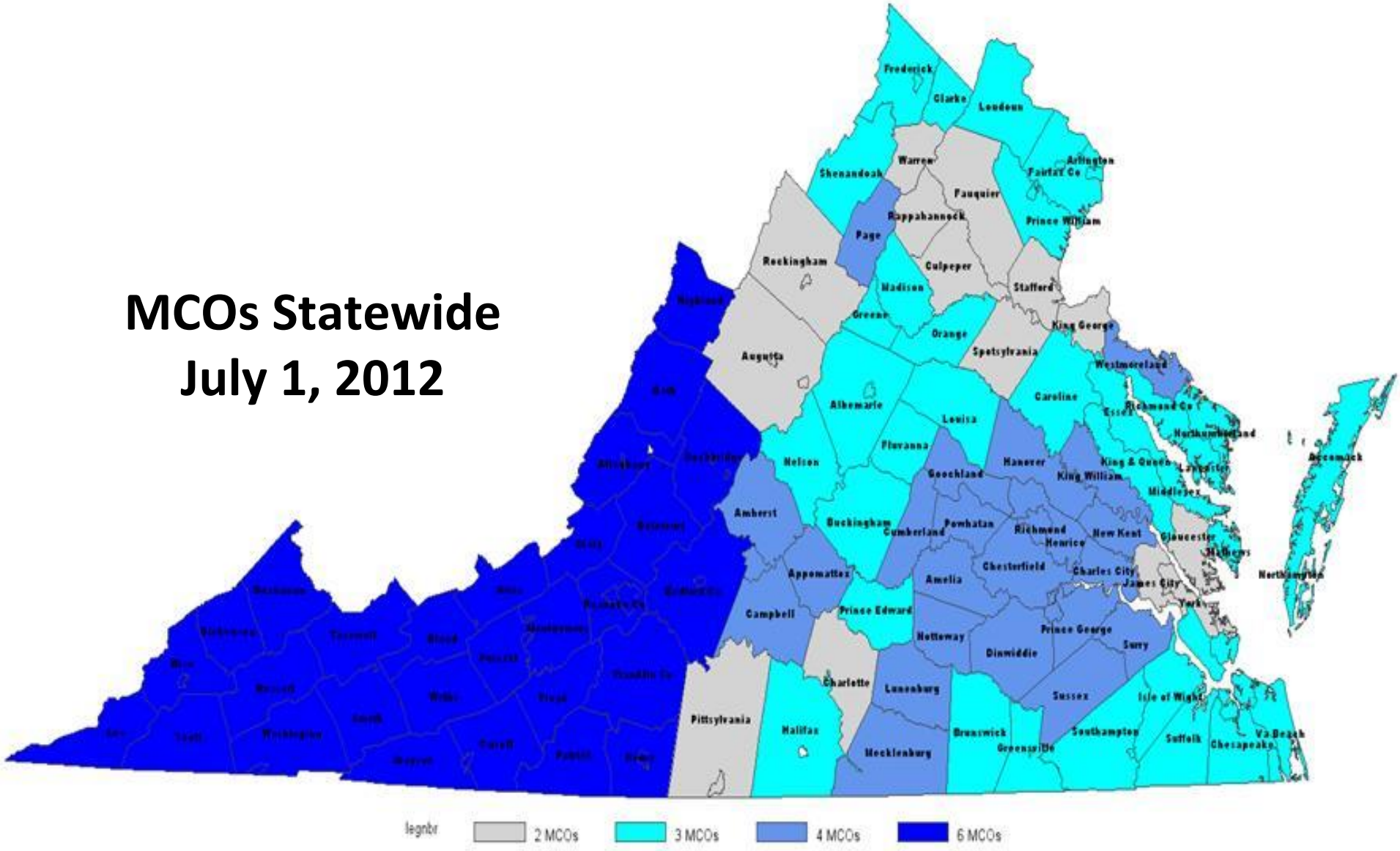

706,000 Enrollees in Managed Care Medallion 3.0 and FAMIS

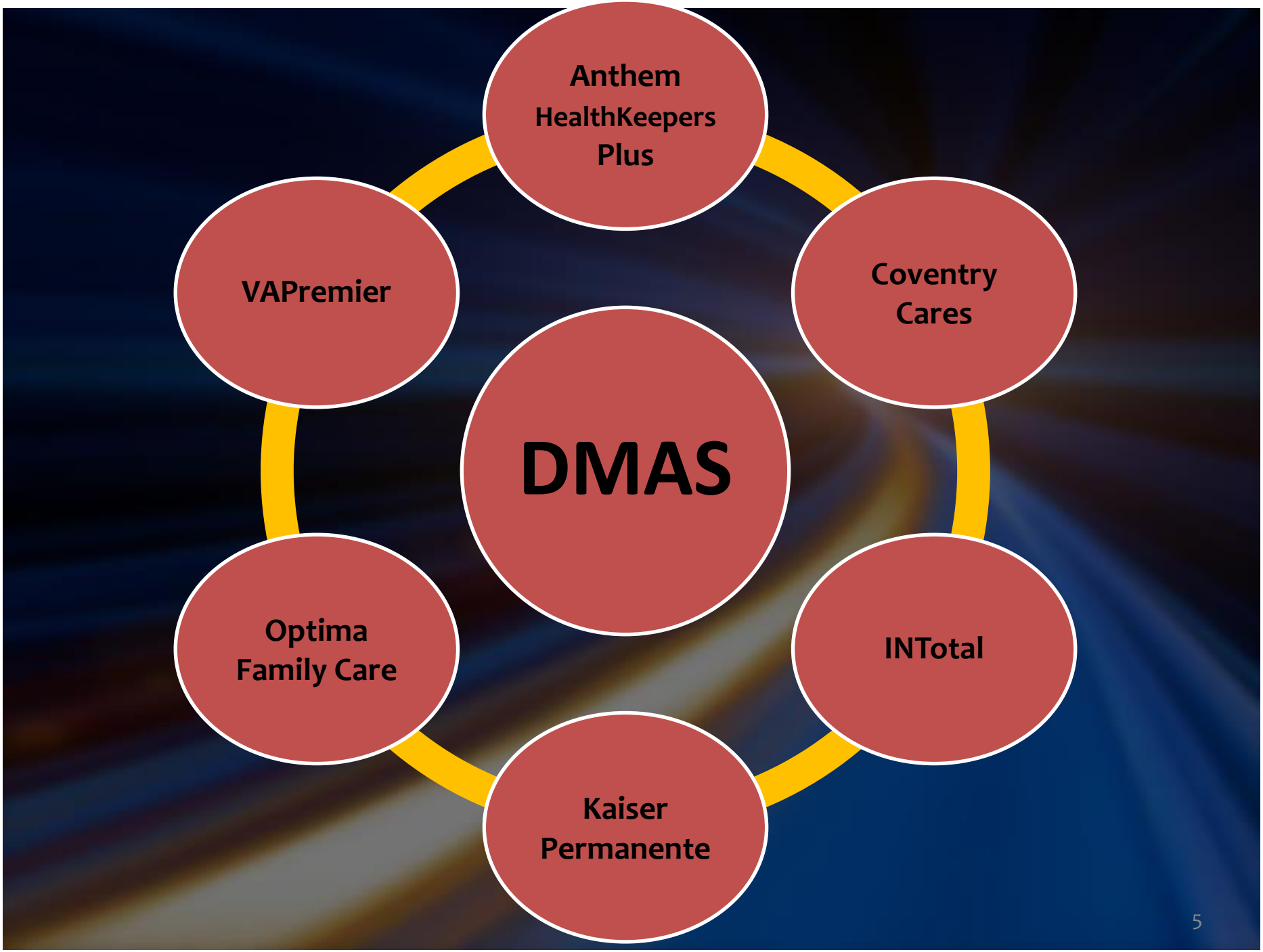



Virginia Department of Medical Assistance Services

Number of MCOs Per Locality

MCOs Statewide
July 1, 2012




Anthem
HealthKeepers
Plus
Coventry
Cares
INTotal
Kaiser
Permanente
Optima
Family Care
VAPremier
DMAS

Does It Work? Yes

Commonwealth gets a large ROI for the dollar:

- Call center - Maximus
- 24/7 nurse advice lines
- No copayments
- NCQA accreditation and HEDIS data
- Care management
- New innovations and technology
- Ability to create a credentialed network
- Staffing – numbers and expertise
- Local presence
- Focus on health outcomes - 90% of kids saw PCP in 2012
- Health plan drug rebates through ACA resulted in $550M to the Commonwealth

Is It Perfect ? NO!
But We Are Progressing

- DMAS and health plans are continually looking to improve programs, processes, populations, and outcomes
- Last year, the Department totally revamped the contract and added new reporting requirements
- We developed a plan partnership that encourages innovations like medical homes, special payment projects, as well as a quality initiative program
- This year, we completed adding foster care and adoption assistance children to the program and in December we will add eligible EDCD individuals
- A major focus was on improving the enrollment process

The Goal

- In an effort to ensure that newly eligible Medicaid individuals have quicker access to the managed care delivery system, on August 1st, the Department shortened the period of time between an individual being identified as Medicaid eligible and that individual's enrollment into a managed care organization (MCO)
- We anticipate that this new process will help reduce disruptions of care by minimizing the movement of individuals between the fee-for-service and the managed care delivery systems
- The Department is undertaking this endeavor for all populations that qualify for enrollment into managed care

- Shortening the enrollment period expedites access to primary care, care coordination and disease management services, 24-hour nurse advice lines, and access to specialty care
- This is especially important for members with chronic health conditions, pregnant women, and children in foster care
- Providers should notice less disruption in administrative functions such as billing and authorizations resulting from eligibility changes

The Old Process

The Expedited Process

Example takes 55 days

- 07/07: Individual determined to be Medicaid eligible
- 07/07: DSS enters eligibility information into system
- 07/18: 15-45 days after eligibility entered into system pre-assignment takes place
- 07/18: All individuals are pre-assigned to a MCO
- 07/28: Individuals notified by letter with pre-assigned MCO
- 08/16: Individual must call to make selection by deadline - No call = Enrollment into pre-assigned MCO
- 09/01: Effective date of MCO enrollment

Example takes 25 days

- 08/07: Individual determined to be Medicaid eligible
- 08/07: Letter sent to individual with MCO enrollment date, if eligible
- 08/11: Individual contacts Enrollment Broker with selection – effective 09/01
- 08/18: Managed care eligibility confirmed and individual assigned to MCO, if one not previously selected
- 08/21: Assignment letter mailed with MCO effective date of 09/01
- 08/31: Newly enrolled individual has until last day of the month to change MCOs effective for 09/01
- 09/01: Effective date of MCO enrollment

Other Enrollment Improvements

- Individuals who move to a different region will no longer be disenrolled from their health plan if their current MCO participates in the new region
- Individuals who lose Medicaid eligibility will be re-enrolled back in the same MCO if eligibility is re-instated between 19th and end of month
- Newly enrolled individuals will have until the last business day of the month to change MCOs, effective the first day of the next month

Other Enrollment Improvements

- In a limited number of cases, for a short time an individual may need to obtain prescription medications, however they may not have their new MCO ID card
- Pharmacists should verify plan enrollment via MediCall or ARS and then contact the assigned health plan for instructions to complete the transaction
- All health plans have established processes to handle any issues related to ID cards
- DMAS will track issues over the next 3 months to determine any further system enhancements

-
- Expedited enrollment will make a positive difference to
  - the members we serve
  - the providers who provide service
  - over all health care outcomes
- More improvements are on the horizon ….

ACCESS TO PUBLIC MEETINGS under the VIRGINIA FREEDOM OF INFORMATION ACT

I. STATUTORY GUIDANCE

The Virginia Freedom of Information Act (FOIA) is largely a procedural act, and the provisions relating to meetings set forth the procedures that a public body must follow in conducting an open meeting and convening in a closed meeting. This outline breaks down the procedural requirements, such as what is required in posting a notice and certifying a closed meeting, and provides practical advice for conducting meetings that comply with FOIA. Appendix A sets forth in detail the requirements for making a motion to convene a closed meeting. Appendix B describes commonly used meeting exemptions of general applicability.

II. OPEN MEETINGS GENERALLY

WHAT IS A MEETING UNDER FOIA?

A "meeting" is defined as "meetings including work sessions, when sitting physically, or through telephonic or video equipment pursuant to § 2.2-3708, as a body or entity, or as an informal assemblage of **(i) as many as three members** or (ii) a quorum, if less than three, of the constituent membership, wherever held, with or without minutes being taken, whether or not votes are cast, of any public body" **where the business of the public body is being discussed or transacted.** (Emphasis added.)[1]

WHAT IS NOT A MEETING UNDER FOIA?

1. The gathering of employees of a public body;
2. The gathering or attendance of two or more members of a public body at any place or function where no part of the purpose of such gathering or attendance is the discussion or transaction of any public business, the gathering or attendance was not called or prearranged with any purpose of discussing or transacting any business of the public body, **and** the public business is not discussed; or
3. The gathering or attendance of two or more members of a public body at a public forum, candidate appearance, or debate, the purpose of which is to inform the electorate and not to transact public business or to hold discussions relating to the transaction of public business, even though the performance of the members individually or collectively in the conduct of public business may be a topic of discussion or debate at such public meeting.[2]

[1] Statutory reference: § 2.2-3701. FOIA Council Opinions AO-4-00, AO-20-01, AO-40-01, AO-46-01, AO-02-02, AO-06-02, AO-13-03, AO-15-04, AO-20-04, AO-11-05, AO-02-06, AO-10-07, AO-12-08, AO-03-09, AO-05-11.

[2] Statutory references: §§ 2.2-3701, 2.2-3707(G). FOIA Council Opinions AO-4-00, AO-10-00, AO-46-01, AO-02-02, AO-13-03, AO-12-04, AO-12-08, AO-05-11.

MAY A PUBLIC BODY CONDUCT A MEETING BY CONFERENCE CALL OR OTHER ELECTRONIC METHOD?

Maybe. Prior to July 1, 2007, no **local** governing body or any other type of local public body was permitted to conduct a meeting through telephonic, video, electronic or other communication means where the members are not physically assembled to discuss or transact public business. However, **state** public bodies may conduct such meetings under specified circumstances. Since July 1, 2007, local and regional public bodies may also allow participation by their members via teleconference or other electronic means under certain limited circumstances.[3]

IF IT IS A MEETING, WHAT DOES FOIA REQUIRE?

If it is a meeting under FOIA, the law requires that:

1. Notice of the meeting be given;
2. The meeting must be open to the public; **and**
3. Minutes of the meeting must be taken and preserved.[4]

WHAT IS SUFFICIENT NOTICE?

Notice must contain the **date, time, and location** of the meeting. It is also helpful (but not required) to include the agenda for the meeting to inform the public generally of what topics will be discussed at the meeting. If a state public body includes at least one member appointed by the Governor, the notice must also indicate whether or not public comment will be received at the meeting and, if so, the approximate point during the meeting when public comment will be received.[5]

WHERE TO POST THE NOTICE?

FOIA requires that all public bodies post notices in two physical locations:

1. In a prominent public location at which notices are regularly posted, **and**
2. In the office of the clerk of the public body, or in the case of a public body that has no clerk, in the office of the chief administrator.

State public bodies must also post notice on their own websites and on the Commonwealth Calendar website. Electronic publication of meeting notices by other public bodies is encouraged, but not required.

NOTE: Electronic posting must be **in addition to** the physical posting detailed above.[6]

WHO ELSE IS ENTITLED TO NOTICE OF MEETINGS?

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[3] Statutory references: § 2.2-3708, § 2.2-3708.1. FOIA Advisory Opinions AO-1-01, AO-16-02, AO-21-04, AO-12-08, AO-07-09.

[4] Statutory references: §§ 2.2-3700, 2.2-3707. FOIA Council Opinions AO-40-01, AO-06-02, AO-17-02, AO-13-03, AO-15-04.

[5] Statutory reference: § 2.2-3707(C). FOIA Council Opinions AO-13-00, AO-3-01, AO-18-01, AO-43-01, AO-06-02, AO-23-03, AO-02-04, AO-06-07, AO-08-07, AO-03-09.

[6] Statutory reference: § 2.2-3707(C). FOIA Council Opinions AO-18-01, AO-43-01, AO-08-07, AO-03-09.

Any person who annually files a written request for notification with a public body is entitled to receive direct notification of all meetings of that public body. If the person requesting notice does not object, the public body may provide the notice electronically.

The request for notice shall include the requester's name, address, zip code, daytime telephone number, electronic mail address, if available, and organization, if any.[7]

WHEN TO POST THE NOTICE?

*For **regular meetings:*** The notice must be posted **at least three working days prior to the meeting.**

*For **special or emergency meetings:*** Notice, reasonable under the circumstance, of special or emergency meetings must be given at the same time as the notice provided members of the public body conducting the meeting. FOIA defines an emergency as "an unforeseen circumstance rendering the notice required by FOIA impossible or impracticable and which circumstance requires immediate action."[8]

MAY THE PUBLIC OR MEDIA RECORD THE MEETING?

Yes. Any person may photograph, film, record, or otherwise reproduce any portion of a meeting required to be open.[9]

MAY A PUBLIC BODY RESTRICT THE USE OF RECORDING DEVICES?

Yes. The public body conducting the meeting may adopt rules governing the placement and use of equipment necessary for broadcasting, photographing, filming, or recording a meeting to prevent interference with the proceedings.[10]

WHEN MUST AGENDA MATERIALS BE AVAILABLE TO THE PUBLIC/MEDIA?

At least one copy of all agenda packets and, unless exempt, all materials furnished to members of a public body for a meeting must be made available for public inspection **at the same time** the packets or materials are furnished to the members of the public body.[11]

ARE THERE ANY EXCEPTIONS FOR TAKING MINUTES?

Yes. Minutes are required to be taken only at open meetings; minutes are not required to be taken during closed meetings. Minutes are also not required to be taken at deliberations of:

1. Standing and other committees of the General Assembly;
2. Legislative interim study commissions and committees, including the Virginia Code Commission;
3. Study committees or commissions appointed by the Governor; or

[7] Statutory reference: § 2.2-3707(E). FOIA Council Opinions AO-3-01, AO-13-03, AO-23-03, AO-08-07.
[8] Statutory references: § 2.2-3707(C),(D). FOIA Council Opinions AO-13-00, AO-3-01, AO-18-01, AO-06-02, AO-08-07.
[9] Statutory reference: § 2.2-3707(H). FOIA Council Opinions AO-03-03, AO-10-05.
[10] Statutory reference: § 2.2-3707(H). FOIA Council Opinions AO-03-03, AO-10-05.
[11] Statutory reference: § 2.2-3707(F). FOIA Council Opinions AO-3-01, AO-35-01, AO-23-03, AO-05-12.

4. Study commissions or study committees, or any other committees or subcommittees appointed by the governing body or school board of a county, city or town, except where the membership of the commission, committee or subcommittee includes a majority of the members of the governing body.[12]

WHAT DO MINUTES HAVE TO LOOK LIKE?

Minutes are required (except as noted above) of all open meetings, and must include: the date, time, and location of the meeting; the members of the public body present and absent; a summary of matters discussed; and a record of any votes taken. In addition, motions to enter into a closed meeting and certification after a closed meeting must be recorded in the minutes.[13]

ARE MINUTES PUBLIC RECORDS UNDER FOIA?

Yes. Minutes, including draft minutes, and all other records of open meetings, including audio or audio/visual recordings, are public records and must be released upon request.[14]

IS THERE AN AFFIRMATIVE OBLIGATION TO POST MINUTES?

Yes, but **only for state agencies in the executive branch.**

All boards, commissions, councils, and other public bodies created in the executive branch of state government and subject to FOIA must post minutes of their meetings on the Commonwealth Calendar website.

Draft minutes of meetings must be posted as soon as possible but no later than 10 working days after the conclusion of the meeting. Final approved meeting minutes must be posted within three working days of final approval of the minutes.[15]

MUST ALL VOTES OF A PUBLIC BODY TAKE PLACE IN AN OPEN MEETING?

Yes. Any and all votes taken to authorize the transaction of any public business must be taken and recorded in an open meeting.

A public body may not vote by secret or written ballot.[16]

IS IT A FOIA VIOLATION TO POLL MEMBERS OF A PUBLIC BODY?

No. Nothing in FOIA prohibits separately contacting the membership, or any part thereof, of any public body for the purpose of ascertaining a member's position with respect to the transaction of public business. Such contact may be done in person, by telephone, or by electronic communication, provided the contact is done on a basis that does not constitute a meeting as defined in FOIA.[17]

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[12] Statutory reference: § 2.2-3707(I). FOIA Council Opinion AO-08-07.
[13] Statutory references: §§ 2.2-3707(I), 2.2-3712(A),(D). FOIA Council Opinions AO-25-04, AO-01-06.
[14] Statutory reference: § 2.2-3707(I). FOIA Council Opinions AO-13-03, AO-25-04.
[15] Statutory reference: § 2.2-3707.1.
[16] Statutory reference: § 2.2-3710(A). FOIA Council Opinions AO-9-00, AO-15-02, AO-01-03, AO-13-03, AO-01-05, AO-05-09, AO-07-09.
[17] Statutory reference: § 2.2-3710(B). FOIA Council Opinions AO-08-02, AO-15-02, AO-01-03, AO-07-09.

III. CLOSED MEETING PROCEDURES

WHAT DOES A PUBLIC BODY HAVE TO DO TO CLOSE A MEETING?

In order to conduct a closed meeting, the public body must take an affirmative recorded vote in an open meeting approving a motion that:

1. Identifies the subject matter for the closed meeting;
2. States the purpose of the closed meeting; **and**
3. Makes specific reference to the applicable exemption from the open meeting requirements.

The motion must be set forth in detail in the minutes of the open meeting.

A general reference to the provisions of FOIA, the authorized exemptions from open meeting requirements, or the subject matter of the closed meeting is not sufficient to satisfy the requirements for holding a closed meeting.[18]

WHAT MAY BE DISCUSSED DURING A CLOSED MEETING?

A public body holding a closed meeting must restrict its discussions during the closed meeting to those matters **specifically exempted** from the provisions of FOIA and **identified in the motion.**[19]

AT THE END OF A CLOSED MEETING, WHAT DOES THE PUBLIC BODY HAVE TO DO?

At the conclusion of any closed meeting, the public body holding the meeting must immediately reconvene in an open meeting and take a roll call or other recorded vote certifying that to the best of each member's knowledge:

1. Only public business matters lawfully exempted from open meeting requirements under this chapter, **and**
2. Only such public business matters as were identified in the motion by which the closed meeting was convened were heard, discussed or considered in the meeting by the public body.

The vote must be included in the minutes of the open meeting.

Any member of the public body who believes that there was a departure from the requirements of (1) or (2) above must state so prior to the vote and indicate the substance of the departure that, in his judgment, has taken place. This statement must also be recorded in the minutes of the open meeting.[20]

WHEN DO DECISIONS MADE IN A CLOSED MEETING BECOME OFFICIAL ACTIONS OF THE PUBLIC BODY?

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[18] Statutory reference: § 2.2-3712(A). FOIA Council Opinions AO-8-00, AO-19-00, AO-14-01, AO-38-01, AO-45-01, AO-08-02, AO-17-02, AO-02-04, AO-24-04, AO-01-05, AO-06-07, AO-13-07, AO-04-08, AO-13-09, AO-03-13.

[19] Statutory reference: § 2.2-3712(C). FOIA Council Opinions AO-8-00, AO-13-07, AO-13-09.

[20] Statutory references: § 2.2-3712(D),(E). FOIA Council Opinions AO-8-00, AO-17-02, AO-02-04, AO-06-07, AO-04-08.

Decisions become official when the public body reconvenes in an open meeting, reasonably identifies the substance of the decision, and takes a recorded vote on the resolution, ordinance, rule, contract, regulation, or motion agreed to in the closed meeting. Otherwise, no resolution, ordinance, rule, contract, regulation, or motion adopted, passed, or agreed to in the closed meeting is effective.

Public officers improperly selected due to the failure of the public body to comply with the other provisions of § 2.2-3711 will become *de facto* officers and, as such, their official actions are valid until they obtain notice of the legal defect in their election.[21]

CAN THERE BE A CLOSED MEETING WITHOUT FIRST HAVING AN OPEN MEETING?

No. A closed meeting can take place only within the context of an open meeting, even if the closed meeting is the only agenda item. A closed meeting motion must be made in an open meeting. After the conclusion of the closed meeting, the members of the public body must reconvene in an open meeting to certify that they restricted their discussion during the closed meeting to those matters specifically exempted from the provisions of FOIA and identified in the motion.[22]

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[21] Statutory references: § 2.2-3711(B),(C). FOIA Council Opinions AO-23-01, AO-38-01, AO-15-02, AO-01-03, AO-13-03, AO-24-04, AO-01-05, AO-13-09.

[22] FOIA Council Opinions AO-02-04, AO-06-07, AO-08-07, AO-13-09, AO-02-10.

APPENDIX A

How To Make A Motion To Convene A Closed Meeting

The Requirements

Section 2.2-3712(A) states that *[n]o closed meeting shall be held unless the public body proposing to convene such meeting has taken an affirmative recorded vote in an open meeting approving a motion that* ***(i) identifies the subject matter, (ii) states the purpose of the meeting and (iii) makes specific reference to the applicable exemption from open meeting requirements***. (Emphasis added.)

FOIA Council opinions have held that a motion that lacks any of these three elements is insufficient under the law and would constitute a procedural violation.[23] Here's a step-by-step look at how to put together a motion that meets all three requirements:

1. Identify the subject matter:

- The identification of the subject goes beyond a general reference to the exemption, and provides the public with information as to specifically why the closed meeting will be held. The subject matter describes the particular fact, scenario, or circumstances that will be discussed by the public body during the closed meeting.
- The specificity required for identification of the subject must be determined on a case-by-case basis. It involves balancing FOIA's policy of affording citizens every opportunity to witness the operations of government with the need of the public body to hold certain discussions in private. The identification of the subject need not be so specific as to defeat the reason for holding a closed meeting in the first place.
- Examples of identification of the subject: discussion of candidates for the appointment of a new city manager; discussion of the appropriate disciplinary action to take against a student for violation of school policy; discussion of probable litigation relating to highway construction.[24]

2. State the purpose:

- The purpose refers to the general, statutorily allowed meeting exemptions set forth at § 2.2-3711(A). Section 2.2-3711(A) states that *public bodies may only hold closed meetings for the following* ***purposes*** (emphasis added) and then sets forth the exemptions.
- Examples of purposes: personnel matters; student admissions or discipline; consultation with legal counsel.

[23] FOIA Advisory Opinions AO-14-01, AO-38-01, AO-45-01, AO-08-02, AO-24-04, AO-01-05, AO-06-07, AO-04-08, AO-13-09, AO-02-10, AO-03-13.

[24] Example of probable litigation taken from FOIA Advisory Opinion AO-14-01.

3. Make specific reference to the applicable exemption:

- All of the meetings exemptions can be found at § 2.2-3711(A). It is not enough to cite this general Code provision, because § 2.2-3711(A) includes 44 different exemptions. Instead, the citation must be as specific as possible.
- Examples of specific Code references: § 2.2-3711(A)(1); § 2.2-3711(A)(2); § 2.2-3711(A)(7).

Putting It All Together

Based upon the analysis above, here are three examples of motions to go into closed session that satisfy the minimum requirements of § 2.2-2712(A). It is always appropriate to include more information, and any motion should be tailored with additional facts describing the particular scenario being addressed by the public body.

1. I move that (insert name of public body) convene in closed session to discuss the candidates being considered for the appointment of a new city manager pursuant to the personnel exemption at § 2.2-3711(A)(1) of the Code of Virginia.
2. I move that (insert name of public body) convene in closed session to discuss the appropriate disciplinary action to take against an individual student for violation of school policy pursuant to the scholastic exemption at § 2.2-3711(A)(2) of the Code of Virginia.
3. I move that (insert name of public body) convene in closed session to meet with legal counsel about probable litigation relating to highway construction pursuant to the consultation with legal counsel exemption at § 2.2-3711(A)(7) of the Code of Virginia.

Remember, the appropriateness of any given motion is fact-based, and no "fill-in-the-blank" model motion will work in all situations. When drafting a motion, go down the checklist and ensure that you have included all three elements. Keep in mind the balancing required to keep citizens informed of the workings of a public body while maintaining the integrity of the closed session. Please do not hesitate to contact the FOIA Council to discuss these requirements or the sufficiency of a specific motion.

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APPENDIX B

Meeting Exemptions Of General Applicability

As of July 2011, FOIA contains more than 40 open meeting exemptions. Although many of these exemptions apply to specific agencies or to very content-specific discussions, there are several open meeting exemptions of general applicability that may be used by virtually all public bodies. The open meeting exemptions of general applicability are listed below, with the corresponding statutory citation, as a reference tool.

§ 2.2-3711(A)(1): Personnel. Provides an exemption for:

> Discussion, consideration, or interviews of prospective candidates for employment; assignment, appointment, promotion, performance, demotion, salaries, disciplining, or resignation of specific public officers, appointees, or employees of any public body; and evaluation of performance of departments or schools of public institutions of higher education where such evaluation will necessarily involve discussion of the performance of specific individuals. Any teacher shall be permitted to be present during a closed meeting in which there is a discussion or consideration of a disciplinary matter that involves the teacher and some student and the student involved in the matter is present, provided the teacher makes a written request to be present to the presiding officer of the appropriate board.

§ 2.2-3711(A)(2): Students. Provides an exemption for:

> Discussion or consideration of admission or disciplinary matters or any other matters that would involve the disclosure of information contained in a scholastic record concerning any student of any Virginia public institution of higher education or any state school system. However, any such student, legal counsel and, if the student is a minor, the student's parents or legal guardians shall be permitted to be present during the taking of testimony or presentation of evidence at a closed meeting, if such student, parents, or guardians so request in writing and such request is submitted to the presiding officer of the appropriate board.

§ 2.2-3711(A)(3): Acquisition & disposition of property. Provides an exemption for:

> Discussion or consideration of the acquisition of real property for a public purpose, or of the disposition of publicly held real property, where discussion in an open meeting would adversely affect the bargaining position or negotiating strategy of the public body.

§ 2.2-3711(A)(4): Privacy. Provides an exemption for:

> The protection of the privacy of individuals in personal matters not related to public business.

§ 2.2-3711(A)(5): Prospective business. Provides an exemption for:

Discussion concerning a prospective business or industry or the expansion of an existing business or industry where no previous announcement has been made of the business' or industry's interest in locating or expanding its facilities in the community.

§ 2.2-3711(A)(6): Investment of public funds. Provides an exemption for:

Discussion or consideration of the investment of public funds where competition or bargaining is involved, where, if made public initially, the financial interest of the governmental unit would be adversely affected.

§ 2.2-3711(A)(7): Legal advice. Provides an exemption for:

Consultation with legal counsel and briefings by staff members or consultants pertaining to actual or probable litigation, where such consultation or briefing in open meeting would adversely affect the negotiating or litigating posture of the public body; and consultation with legal counsel employed or retained by a public body regarding specific legal matters requiring the provision of legal advice by such counsel. For the purposes of this subdivision, "probable litigation" means litigation that has been specifically threatened or on which the public body or its legal counsel has a reasonable basis to believe will be commenced by or against a known party. Nothing in this subdivision shall be construed to permit the closure of a meeting merely because an attorney representing the public body is in attendance or is consulted on a matter.

§ 2.2-3711(A)(11): Tests & exams. Provides an exemption for:

Discussion or consideration of tests, examinations, or other records excluded from this chapter pursuant to subdivision 4 of § 2.2-3705.1.

§ 2.2-3711(A)(15): Medical. Provides an exemption for:

Discussion or consideration of medical and mental health records excluded from this chapter pursuant to subdivision 1 of § 2.2-3705.5.

§ 2.2-3711(A)(19): Public safety. Provides an exemption for:

Discussion of plans to protect public safety as it relates to terrorist activity and briefings by staff members, legal counsel, or law-enforcement or emergency service officials concerning actions taken to respond to such activity or a related threat to public safety; or discussion of reports or plans related to the security of any governmental facility, building or structure, or the safety of persons using such facility, building or structure.

§ 2.2-3711(A)(29). Contracts. Provides an exemption for:

Discussion of the award of a public contract involving the expenditure of public funds, including interviews of bidders or offerors, and discussion of the terms or scope of such contract, where discussion in an open session would adversely affect the bargaining position or negotiating strategy of the public body.

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E-MAIL AND MEETINGS: The VA Supreme Court has held that e-mails may constitute a "meeting" under FOIA if there is simultaneous e-mail communication between three or more board members. Avoid "reply to all" as a general rule. See FOIA Council handout entitled *"Email and Meetings"* available on the FOIA Council website.

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RECORDS

WHAT is a PUBLIC RECORD?

ALL writings and recordings that consist of letters, words or numbers, or their equivalent, set down by handwriting, typewriting, printing, photostatting, photography, magnetic impulse, optical or magneto-optical form, mechanical or electronic recording or other form of data compilation, however stored, and regardless of physical form or characteristics, prepared or owned by, or in the possession of a public body or its officers, employees or agents in the transaction of public business.

ALL public records are OPEN to the public UNLESS a specific exemption in law allows the record to be withheld.

FOIA AND MEMBERS OF PUBLIC BODIES

WHAT about RETENTION of PUBLIC RECORDS?

Public records MUST be retained according to retention schedules set by the Library of Virginia. The length of retention depends on the content of the record. After expiration of the applicable retention period, the records may be destroyed or discarded.

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E-MAILS

Emails that relate to the public business are public records, regardless of whether you use your home or office computer, text or other forms of social media. It is the **content** of the record, not the equipment used, that controls.

As such, these emails must be retained as required by the VA Public Records Act. For practical advice for email use, access and retention, see FOIA Council handout entitled *"Email: Use, Access and Retention"* available on the FOIA Council website.

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A Guide to the Freedom of Information Act for Members of Boards, Councils, Commissions, and other Deliberative Public Bodies

Prepared by the Virginia Freedom of Information Advisory Council

FOIA AND MEMBERS OF PUBLIC BODIES

POLICY OF FOIA

By enacting this chapter, the General Assembly ensures the people of the Commonwealth ready access to records in the custody of public officials and free entry to meetings of public bodies wherein the business of the people is being conducted. The affairs of government are not intended to be conducted in an atmosphere of secrecy since at all times the public is to be the beneficiary of any action taken at any level of government.

Unless a public body or public official specifically elects to exercise an exemption provided by this chapter or any other statute, every meeting shall be open to the public and all public records shall be available for inspection and copying upon request. All public records and meetings shall be presumed open, unless an exemption is properly invoked.

FOIA AND MEMBERS OF PUBLIC BODIES

MEETING REQUIREMENTS

What is considered a MEETING under FOIA?

ANY gathering, including work sessions, of the constituent membership, sitting (or through telephonic or video equipment pursuant to § 2.2-3708 or § 2.2-3708.1) as:

- the board, or
- an informal assemblage of
  - (i) as many as three members, or
  - (ii) a quorum, if less than three, of the constituent membership,

WHEREVER the gathering is held;

REGARDLESS OF WHETHER minutes are taken OR votes are cast.

NOTE: This requirement also applies to ANY meeting, including work sessions, of any subgroup of the board, regardless how subgroup is designated (i.e. subcommittee, task force, workgroup, etc.).

WHAT is *NOT* a MEETING?

- The gathering of employees; or
- The gathering or attendance of two or more board/council members at:
  - Any place or function where no part of the purpose of such gathering or attendance is the discussion or transaction of any public business, and such gathering or attendance was not called or prearranged with any purpose of discussing or transacting any business; OR
  - A public forum, candidate appearance, or debate, the purpose of which is to inform the electorate and not to discuss or transact public business.

FOIA AND MEMBERS OF PUBLIC BODIES

OTHER FOIA PROVISIONS

MINUTES: Minutes **ARE REQUIRED** for any meeting of the board/subgroup of the board.

VOTING: NO secret or written ballots are ever allowed.

POLLING: You MAY contact individual members **separately (one-on-one)** to ascertain their positions by phone, letter or email. REMEMBER: This exemption CANNOT be used in lieu of a meeting. REMEMBER ALSO: If you choose to use email to poll, you are creating a public record!

CLOSED MEETINGS: Allowed **ONLY** as specifically authorized by FOIA or other law and **REQUIRES** a motion stating the purpose, the subject *and* Code cite. [See § 2.2-3711 of FOIA for allowable purposes for closed meetings.]

E-MEETINGS: Are allowed for state public bodies under heightened procedural and reporting requirements (i.e. quorum must be physically assembled in one location, remote meeting locations must be open to the public, etc.). For all public bodies, limited individual participation by electronic means is allowed under certain circumstances (emergency or personal matter, medical reason, or distance in the case of regional public bodies). [See § § 2.2-3708 and 2.2-3708.1 of FOIA.]