Meeting/Retreat of the Board of Medical Assistance Services
600 East Broad Street, Conference Room 7A/B
Richmond, Virginia

December 13, 2016
Draft Minutes

Present:
Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Rebecca E. Gwilt, Esq.
Maureen Hollowell
Maria Jankowski, Esq.
Peter R. Kongstvedt, MD
Vice Chair
McKinley L. Price, DDS
Karen S. Rheuban, MD
Chair
Marcia Wright Yeskoo

Absent:
Mirza Baig
Alexis Y. Edwards

DMAS Staff:
Linda Nablo, Chief Deputy Director
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Karen Kimsey, Deputy Director for Complex Services
Ivory Banks, Program Operations Division Director
Dan Plain, Director of Health Care Services
Terry Smith, Director of Long-Term Care
Kathleen Guinan, Human Resources Director
Mukundan Srinivasan, Chief Information Officer
Abrar Azamuddin, Legal Counsel
Craig Markva, Director, Office of Communications, Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Cynthia B. Jones, Director
Scott Crawford, Deputy Director for Finance
Seon Rockwell, Director of Office of Innovation and Strategy
Bhaskar Mukherjee, Director of Office of Data Analytics
William H. Leighty, Retreat Facilitator

Guests:
Nicole Pugar, Williams Mullen
Ross Grogg, Kemper Consulting
Doug Davis, Xerox
Richard Grossman, Vectre
Mike Tweedy, Senate Finance Staff
Steve Ford, VHCA
Lindsay Walton, Macaulay & Jamerson, PC
Fred Helm, Kemper Consulting
Tyler Cox, HDJN
Rick Shinn, VACHA
Cecelia Kirkman, SEIU Healthcare

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 9:07 a.m. and welcomed everyone in attendance. Dr. Rheuban asked other members to introduce themselves and introductions continued around the room. Dr. Rheuban announced the proposed quarterly meeting dates for 2017: April 11, June 13, September 12 and December 12.

APPROVAL OF MINUTES FROM SEPTEMBER 13, 2016 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the September 13, 2016 meeting. Dr. Kongstvedt made a motion to accept the minutes and Mr. Cook seconded. The vote was **8-yes (Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Rheuban, and Yeskoo); and 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, briefly provided brief updates on the current status of several key projects including Addiction and Recovery Treatment Services (ARTS), the Commonwealth Coordinated Care Plus (CCC Plus) Program, Medallion 4.0 Medicaid Managed Care Program, and active RFPs. Information regarding these projects is available on the DMAS website. (See handouts attached.)

REPORT ON JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION FINDINGS

Ms. Jones provided highlights of the JLARC's report entitled, "*Summary: Managing Spending in Virginia's Medicaid Program*" attached. Based on this report, staff will be prioritizing and continuing to implement the JLARC recommendations. (See handout attached.)

UPDATE ON MEDICAID FORECAST

Scott Crawford, Deputy Director for Finance, explained the forecasting process and provided an update on the Medicaid forecast which included spending in current period ending June 30, 2016 and subsequent two years. Governor McAuliffe announced his budget Savings Plan for 2017 on October 13, 2016 and the 2018 reductions will be announced with the release of the Governor's Budget on December 16, 2016. (See handout attached.)

Dr. Price joined the meeting during this discussion.

REGULATORY ACTIVITY SUMMARY

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

OLD/NEW BUSINESS

None.

PUBLIC COMMENT

Cecilia Kirkman, SEIU Healthcare, provided comments to the Board regarding Medicaid expenditures for Level C residential treatment facilities and Medicaid's eligibility policy for Level C residential treatment and requested the Board consider this topic in their 2017 discussions.

RECESS

Dr. Rheuban asked for a motion to recess the meeting at 10:17 a.m. Dr. Kongstvedt made a motion to recess the meeting and Ms. Gwilt seconded. The vote was unanimous. **9-yes (Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, and Yeskoo); and 0-no.**

BMAS RETREAT

At 10:32 a.m., the Board resumed the meeting. Ms. Jones discussed the agenda for the retreat portion of the meeting and introduced the Director of the Office of Innovation and Strategy, Seon Rockwell.

OVERVIEW OF THE OFFICE OF INNOVATION AND STRATEGY (I&S)

Seon Rockwell, Director, provided an overview of the newly created Office of Innovation and Strategy (I&S) which was organized to provide collaborative thought leadership to catalyze and sustain continuous innovation of Virginia's Medicaid delivery system and to lead multiple facets of Medicaid health innovation to support DMAS' continued national presence as a recognized leader in the delivery of high quality, comprehensive health and support services. (See handout attached.)

OVERVIEW OF THE OFFICE OF DATA ANALYTICS (ODA)

In 2014, the General Assembly mandated the Department of Medical Assistance Services create a data analytics division. Mr. Bhaskar Mukherjee, ODA Director, explained the history of the development of the Office of Data Analytics from 2014 to the present, including its mission and strategy. The Office of Data Analytics provides a structured analytics environment that assures data integrity, data consistency, well documented research, and repeatability. The basic functions of the Division involve supporting infrastructure like the data warehouse and SAS analytics platform so that analyses can be presented in a format that is informative, accurate, and supportive of Agency decision making.

The ODA has implemented a fully functional data governance program in order to support the implementation of a data warehouse. The vision of this program is to guide the management of data as an Agency-wide asset, which is standardized, integrated, and used to enhance analyses and encourage data driven decision making. Currently, there is an active Request for Proposal to develop the data warehouse which is scheduled to be implemented in 2017. (See handout attached.)

LUNCH BREAK

After lunch break, the meeting resumed at 12:17 p.m. Ms. Jones introduced William H. Leighty, Retreat Facilitator.

ROLES OF THE BOARD

Mr. Leighty made opening comments and noted he was able to contact all but two Board members prior to the meeting to get their ideas about how they view their role as a BMAS member. From his conversations, he concluded there was a strong consensus that the Board members wanted to be helpful to the Department, had a desire to help others, and supported DMAS staff as a whole. Mr. Leighty explained his interpretation of the statutory authority of the role of the Board and there was discussion on the various ways Board members contribute and support staff in continuing to maintain Virginia's status as a national leader in the delivery of health care services to the citizens in the Commonwealth.

INFORMATION IDEAS FOR BMAS DASHBOARD

Mr. Leighty asked for suggestions and discussed what types of information BMAS members could be made available on a dashboard. At this time, the dashboard is being developed and will be included in discussions in 2017.

AGENDA TOPICS FOR 2017

The following topics were suggested for 2017 BMAS meetings:

POTENTIAL APRIL 2017 TOPICS

- Affordable Care Act (ACA) Update
- Director's Report
- Addiction and Recovery Treatment Services (ARTS)
- Dashboard Discussion
- Legislative Overview
- Mental Parity and Addiction Act of 2008
- Listening @ Town Hall
- Request For Proposals (RFP)

POTENTIAL JUNE 2017 TOPICS

- ACA Update
- Innovation
- Patient Centered Care (PCC) & Other Innovations
- Consumer Directed Services
- Appeals
- RFPs

POTENTIAL SEPTEMBER 2017 TOPICS

- ACA Update
- Small, Women and Minority Business (SWAM)
- Managed Care Plans
- Roll out Dashboard?

POTENTIAL DECEMBER 2017 TOPICS

- ACA Update
- Office of the Attorney General Fraud Program Update
- Medicaid's Relationship with the Department of Juvenile Justice
- Transition in State Government

ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting at 2:39 p.m. Dr. Kongstvedt made a motion to recess the meeting and Ms. Gwilt seconded. The vote was unanimous. **8-yes (Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Rheuban, and Yeskoo); and 0-no.**

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

September 13, 2016
Minutes

Present:
Mirza Baig
Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Alexis Y. Edwards
Maureen Hollowell
Maria Jankowski, Esq.
Peter R. Kongstvedt, MD
McKinley L. Price, DDS
Karen S. Rheuban, MD
Chair

Absent:
Rebecca E. Gwilt, Esq.
Marcia Wright Yeskoo

DMAS Staff:
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Scott Crawford, Deputy Director for Finance
Karen Kimsey, Deputy Director for Complex Services
Ivory Banks, Program Operations Division Director
Donna Proffitt, Pharmacy Manager
Kathleen Guinan, Human Resources Director
Mukundan Srinivasan, Chief Information Officer
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Cynthia B. Jones, Director
Kate Neuhausen, MD, MPH
Abrar Azamuddin, Legal Counsel

Guests:
Jennifer Wicker, VHHA
Tyler Cox, HDJN
Lauren Bates Ronu, MSV
Julie Galloway, MSV
Ross Arrington, MSV
Rick Shinn, VACHA
Kenneth McCabe, DPB
Cecelia Kirkman, SEIU Healthcare
Chris Surrell, VHC
Rebecca Miller, VHC
Hunter Jamerson, Macaulay & Jamerson

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:02 a.m. Dr. Rheuban asked other members to introduce themselves and introductions continued around the room.

APPROVAL OF MINUTES FROM JUNE 14, 2016 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the June 14, 2016 meeting. Dr. Kongstvedt made a motion to accept the minutes and Mr. Cook seconded. The vote was **7-yes (Coleman, Cook, Hollowell, Jankowski, Kongstvedt, Price, and Rheuban); and 0-no.**

Ms. Edwards joined the meeting after the vote.

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, briefly commented on the status of the Requests for Proposals (RFPs) on the Managed Long Term Services and Supports (MLTSS), the Medicaid Enterprise System (MES) and the Medallion 3.0 managed care contract and noted the ID/DD Waiver Redesign was implemented on September 1.

Ms. Jones asked the Deputy Director for Administration, Suzanne Gore, to provide an update on the BMAS Biennial Report due to the General Assembly in October. After Board discussion, it was agreed a draft of the report will be distributed to the Board for review and comment and then a conference call meeting to discuss the report would be established one week after distribution. It was also suggested the Board develop a cover letter which could include information such as the Board's support of Medicaid expansion for review and consideration.

Mr. Baig joined the meeting during this presentation.

INTRODUCTION TO THE OFFICE OF THE CHIEF MEDICAL OFFICER

Ms. Jones introduced and welcomed Dr. Kate Neuhausen. Dr. Neuhausen gave a detailed review of the newly created Office of the Chief Medical Officer and explained the role of the Medical Support Unit (MSU), and the Pharmacy Program. Dr. Neuhausen also gave highlights of several clinical and pharmacy innovations and shared the various DMAS and external committees and workgroups the Office is involved with. (see attached handout).

In light of the public health emergency imposed by the Zika virus and the need to speedily address the likelihood of Zika transmission to Virginia Medicaid and FAMIS enrollees, Dr. Neuhausen explained the recent intervention of DMAS to contact the Governor on behalf of the Board to request the approval to promulgate Emergency regulations to provide necessary coverage to the population most affected by this emergency.

Members were very engaged in discussions of the various pharmacy programs and interested in discussing these issues at a future meeting. Members were also encouraged to attend the

upcoming Pharmacy &Therapeutic (P&T) Committee and/or Drug Utilization Review (DUR) Board meetings scheduled in October/November.

PLANNING FOR A BOARD RETREAT/ BACKGROUND: ROLES AND RESPONSIBILITIES OF BMAS

Dr. Rheuban initiated the discussion planning for a Board retreat by asking Legal Counsel, Mr. Azamuddin, to provide a discussion of the role of the Board. Mr. Azamuddin provided a brief discussion of the role of the Board by pointing out specific areas of Section 32.1-325 for the Board to focus on and consider in their deliberations in planning for a retreat. Ms. Jones informed the Board that the Budget Bill was also a large part of the agency direction and a copy of the DMAS section in the budget was included in books for reference.

After members discussed expectations for planning for a retreat and offered suggestions, it was agreed to set a separate date/time for the retreat (in addition to the December meeting) in November.

Ms. Edwards left the meeting during this discussion.

REGULATORY ACTIVITY SUMMARY

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

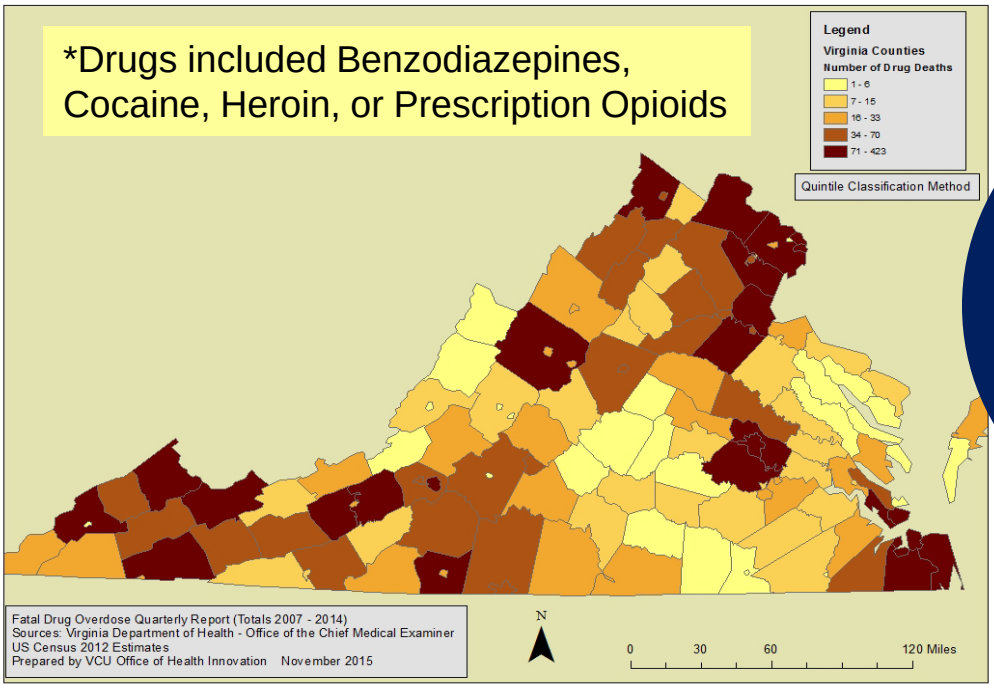
OLD BUSINESS

None.

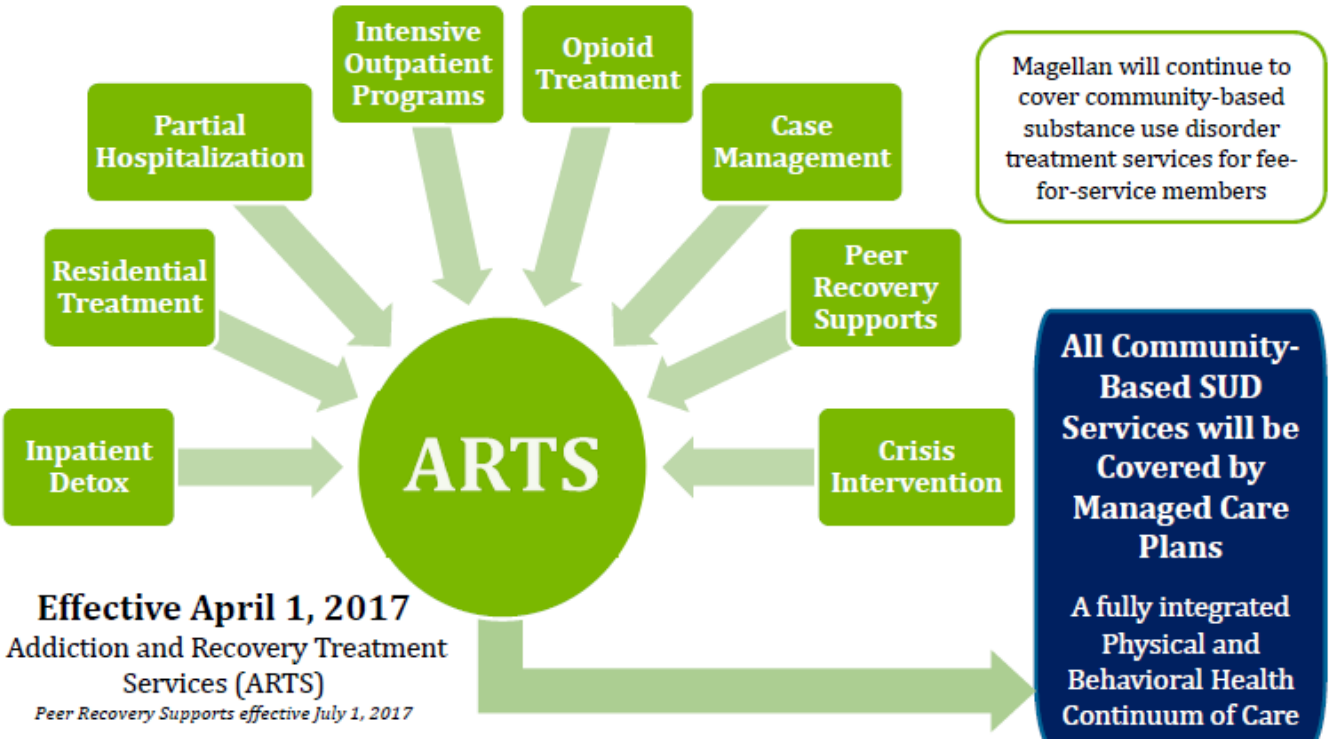
ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting at 12:20 p.m. Dr. Kongstvedt made a motion to adjourn the meeting and Mr. Cook seconded. The vote was unanimous. 7-**yes (Baig, Coleman, Cook, Hollowell, Jankowski, Kongstvedt, and Rheuban); and 0-no.**

The Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit: A Response to the Opioid Epidemic



In 2013 more Virginians died from opioid overdose than from car accidents



Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members

All Community-Based SUD Services will be Covered by Managed Care Plans

A fully integrated Physical and Behavioral Health Continuum of Care

Effective April 1, 2017
Addiction and Recovery Treatment Services (ARTS)
Peer Recovery Supports effective July 1, 2017

ARTS
Addiction and Recovery Treatment Services

http://www.dmas.virginia.gov/

The Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit: A Response to the Opioid Epidemic

Changes to DMAS's Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members

1. Expand short-term SUD inpatient detox to all Medicaid /FAMIS members
2. Expand short-term SUD residential treatment to all Medicaid members
3. Increase rates for existing Medicaid/FAMIS SUD treatment services
4. Add Peer Support services for individuals with SUD and/or mental health conditions
5. Require SUD Care Coordinators at DMAS contracted Managed Care Plans
6. Provide Provider Education, Training, and Recruitment Activities

Implementation Timeline

Phase 1: January 2017
- Network development and extensive training begins

Phase 2: April 2017
- Statewide Implementation

Phase 3: July, 2017
- Peer Support Services Implementation

Supporting the SUD benefit means keeping Virginia families together (#2 cause for VA children entering foster care) and helps adults return to work and contribute to their communities.

ARTS Addiction and Recovery Treatment Services

http://www.dmas.virginia.gov/

Commonwealth Coordinated Care Plus (CCC Plus)
A managed long term services and supports program
Frequently Asked Questions (FAQs)

What is Commonwealth Coordinated Care Plus (CCC Plus)?

CCC Plus is a new statewide Medicaid managed care program that will serve approximately 213,000 individuals with complex care needs through an integrated delivery model across the full continuum of care. Care management is at the heart of the CCC Plus high-touch, person-centered program design. CCC Plus focuses on improving quality, access and efficiency. CCC Plus is proposed to launch July 2017 and enrollment is required for qualifying populations.

Who will participate in CCC Plus?

Medicaid Members who…	Medicaid Providers who…
Receive Medicare benefits and full Medicaid benefits (dual eligible); includes members enrolled in Commonwealth Coordinated Care (CCC).	Offer Medicaid services to dual eligible Medicaid members (children and adults); includes individuals enrolled CCC.
Receive Medicaid LTSS (dual eligible and non-dual eligible) in a facility or through one of the home and community-based (HCBS) waivers, except Alzheimer's Assisted Living waiver. Individuals with the redesigned Developmental Disabilities waiver will enroll for their non-waiver services only.	Serve Medicaid members (dual eligible and non-dual eligible) who receive LTSS through certain HCBS waivers or nursing facilities.
Have full Medicaid coverage and are age 65 or older or are disabled. (These individuals will transition from the Medallion 3.0 program to CCC Plus.)	Serve Medicaid members (not dually eligible), including ABD individuals currently enrolled in the Medallion 3.0 program.

What choices will be available?

- All CCC Plus eligible individuals will be enrolled in a participating managed care health plan.
- CCC Plus members will have a choice between at least 2 health plans. Health plans are undergoing a competitive selection process and an announcement will be made once plans are chosen.
- CCC Plus members will be able to select their providers from their health plan's provider network.

Are optional benefits available?

DMAS is not mandating that participating CCC Plus health plans offer optional benefits; however, DMAS will encourage the health plans to give strong consideration to doing so. The structure of CCC Plus offers fiscal flexibility for the health plans so it is expected plans will offer optional benefits to members.

Commonwealth Coordinated Care Plus
(a managed long term services and supports program)
FAQs

How will CCC Plus affect stakeholders?

Medicaid Recipients	Medicaid Providers
All CCC Plus eligible recipients will be enrolled in a participating health plan.	Medicaid providers will verify eligibility and CCC Plus health plan enrollment.
CCC Plus Medicaid recipients will continue to have access to the full continuum of Medicaid services with the added benefit of care coordination and may have access to optional benefits.	Providers will work with health plans to coordinate services and obtain necessary service authorizations.
Some services may require authorization under the new health plan. Care coordinators will assist members to arrange services.	Providers will bill the health plans or the plan's subcontractor directly for services provided to CCC Plus individuals.

When does CCC Plus start?

Proposed timeline is subject to change

Region	Proposed Launch Date
Tidewater	July 1, 2017
Central	September 1, 2017
Charlottesville/Western	October 1, 2017
Roanoke/Alleghany & Southwest	November 1, 2017
Northern/Winchester	December 1, 2017
CCC Enrollees & ABDs transitioning from Medallion 3.0	January 1, 2018

Commonwealth Coordinated Care Plus
(a managed long term services and supports program)
FAQs

Will CCC Plus coordinate Medicare and Medicaid for the Dually Eligible?

Yes! One of the key features of CCC Plus will be the coordination of care between Medicare and Medicaid for dual eligible individuals. CCC members valued this important service and stakeholders requested that it be continued in CCC Plus. All health plans participating in CCC Plus will be required to coordinate care with the individual's Medicare plan and providers. CCC Plus plans will also operate Dual Eligible Special Needs Plans, also known as D-SNPs, which are a type of Medicare Advantage plan that coordinates Medicare and Medicaid services. Enrollees will be encouraged to enroll in their CCC Plus health plan's companion D-SNP to maximize coordination. *(CCC Plus plans must be approved as a D-SNP within 18 months of CCC Plus operation.)*

Why did Virginia decide not to continue the CCC program?

Virginia's financial alignment demonstration program (CCC) launched in March 2014, and is scheduled to sunset on December 31, 2017. CCC provided Virginia the unique opportunity to integrate health care services and supports for individuals who receive both Medicare and Medicaid, and was the first opportunity for Virginia to coordinate services for individuals with long-term services and supports (LTSS) under a managed care program.

To promote and build upon the goals of CCC for more Virginians, DMAS began planning to expand coordinated care by developing CCC Plus. Implementation of CCC and CCC Plus is consistent with the Virginia General Assembly's directive to transition the majority of the remaining Medicaid fee-for-service populations into a managed long term services and supports program.

Virginia is fully committed to maintaining a robust CCC program through the end of the Demonstration because, until CCC Plus implementation, dually eligible Virginians can only experience the unique benefits of care coordination through the CCC program. Everything DMAS has learned, and continues to learn, during the CCC Demonstration has directly informed the design of CCC Plus and will influence the implementation of CCC Plus going forward.

If CCC is ending December 2017, why should I still enroll?

By enrolling in CCC now, individuals will receive benefits not currently offered in fee-for-service Medicaid. Those benefits include care coordination between Medicare and Medicaid, as well as optional benefits such as vision or dental (note: optional benefits vary among CCC health plans).

The COMMONWEALTH FUND

What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?

Tags: state health policy (/publications/issue-briefs#f:tagsfacet=[state health policy])

November 18, 2016

Authors

Sara Rosenbaum, Sara Schmucker, Sara Rothenberg, Rachel Gunsalus

Citation

S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?* The Commonwealth Fund, November 2016.

ABSTRACT

Issue: President-elect Trump and some in Congress have called for establishing absolute limits on the federal government's spending on Medicaid, not only for the population covered through the Affordable Care Act's eligibility expansion but for the program overall. Such a change would effectively reverse a 50-year trend of expanding Medicaid in order to protect the most vulnerable Americans. **Goal:** To explore the two most common proposals for reengineering federal funding of Medicaid: block grants that set limits on total annual spending regardless of enrollment, and caps that limit average spending per enrollee. **Methods:** Review of existing policy proposals and other documents. **Key findings and conclusions:** Current proposals for dramatically reducing federal spending on Medicaid would achieve this goal by creating fixed-funding formulas divorced from the actual costs of providing care. As such, they would create funding gaps for states to either absorb or, more likely, offset through new limits placed on their programs. As a result, block-granting Medicaid or instituting "per capita caps" would most likely reduce the number of Americans eligible for Medicaid and narrow coverage for remaining enrollees. The latter approach would, however, allow for population growth, though its desirability to the new president and Congress is unclear. The full extent of funding and benefit reductions is as yet unknown.

BACKGROUND

Over the past half-century, Medicaid has transformed from a niche program to become a linchpin of the U.S. health care system. It is today the largest single insurer, serving nearly 73 million low-income and medically vulnerable individuals, many of whom would go without needed care or face severe financial hardship without this coverage.[1 (#/#1)]

The growth in the number of Americans enrolled in Medicaid—up from just 4 million people in 1965, the program's first year—reflects its role as a health care "first responder" in the face of broad demographic, social, and economic trends.[2 (#/#2)] These include: high poverty rates, which make it all but impossible for many people to pay anything above nominal amounts for their health coverage and care; an erosion in employer-sponsored coverage for low-wage workers; an aging population; and longer life spans for people with serious disabilities requiring ongoing care and support. Medicaid also has expanded to meet surging health care needs in the wake of natural and man-made disasters, ranging from the September 11th terrorist attacks to Hurricane Katrina, and to address public health crises such as infant mortality, HIV/AIDS and, most recently, the Zika virus.[3 (#/#3)] Finally, Medicaid is the largest source of financial support for health care providers serving medically underserved communities.

As the number of Americans enrolled in Medicaid has increased, so has the cost. Indeed, 70 percent of the growth in Medicaid spending is attributed to rising enrollment, especially in the wake of the Affordable Care Act's Medicaid eligibility expansion.[4 (#/#4)] On a per capita basis, however, Medicaid's annual spending growth rate remains relatively low, although recent evidence suggests that spending growth may be somewhat higher among newly eligible adults, who as a group are less healthy (at least partly owing to their previous lack of access to affordable care).[5 (#/#5)] To put this growth in perspective, in 1965 Medicaid cost a total cost of $900 million, half of which the federal government paid. Looking ahead to 2024, when Medicaid is expected to cover 77.5 million Americans, the total bill will be $920.5 billion. The federal government's share: 61 percent.[6 (#/#6)]

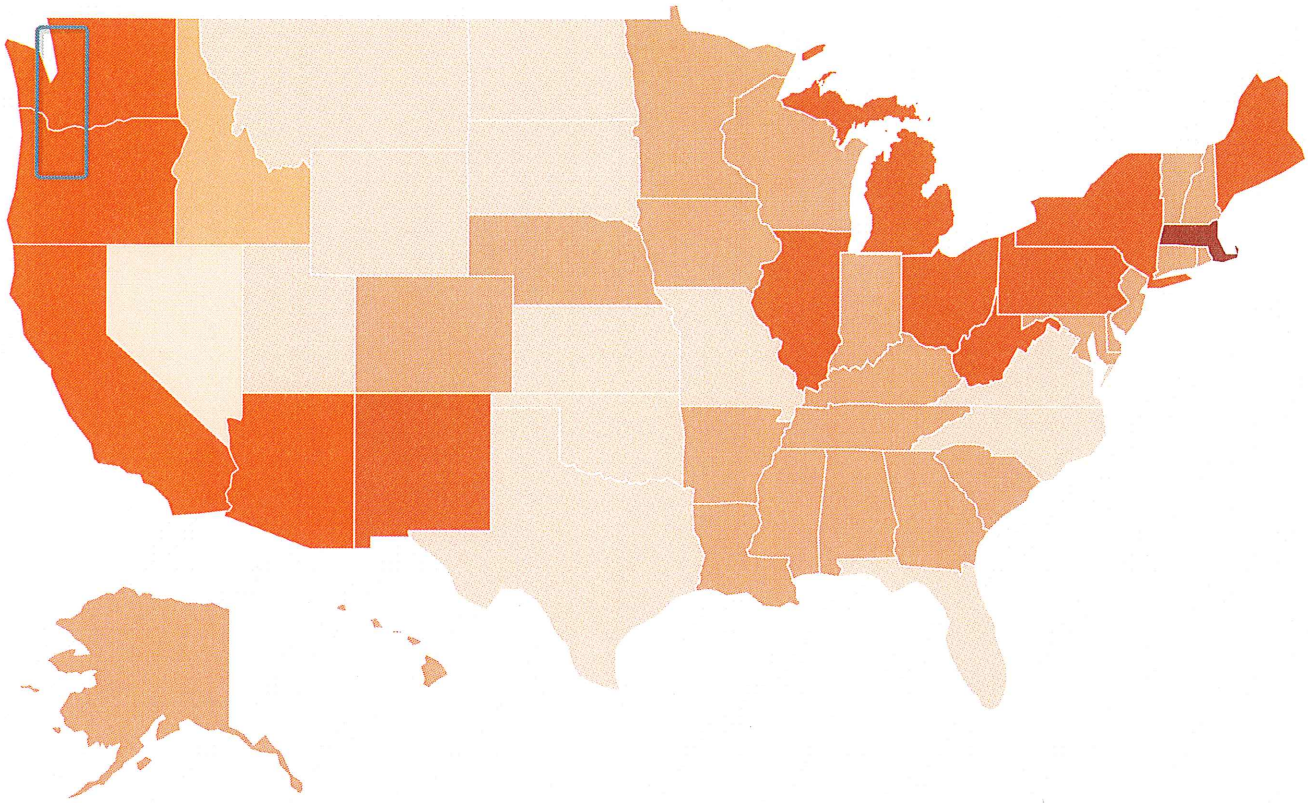
To fulfill its mission as a health care safety net, Medicaid has relied on open-ended federal funding, as well as significant contributions from states (see box). But the high cost of Medicaid and the fear of uncontrolled growth has led some conservative policymakers to call for establishing absolute limits on spending—in effect, reversing a 50-year trend of expanding Medicaid to protect some of the most vulnerable Americans. This issue brief explores the two most common proposals: block grants that set strict limits on total annual spending regardless of enrollment, and per capita limits on spending.

COST-SHARING WITH STATES

States share in the cost of Medicaid and must weigh these expenses against competing needs in an era of much tighter budgets. The pressures and choices are real, and states have acted aggressively to constrain annual increases in their share of Medicaid costs.[7 (#/#7)] As the maps below illustrate, states already vary enormously in the proportion of low-income residents eligible for coverage and in the amount spent per enrollee. These variations reflect underlying social, economic, and financial conditions in each state as well as affirmative policy choices state officials make about whom to cover, what services and benefits to include in their plans, and how to pay participating health care providers and managed care plans.

Medicaid Coverage of Nonelderly with Incomes <200% FPL

Medicaid Spending per Enrollee



30%–39% (13 states) 40%–49% (24 states) 50%–59% (12 states) 60%+ (1 state + DC)

Data: Coverage–Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of the Nonelderly (0-64) with Incomes up to 200% Federal Poverty Level (FPL), 2015, www.kff.org/other/state-indicator/nonelderly-up-to-200-fpl/; Spending–Kaiser Family Foundation, State Health Facts, Medicaid Spending per Enrollee (Full or Partial Benefit), FY2011, www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/.

CONTROLLING MEDICAID'S GROWTH: TARGETED STRATEGIES VERSUS ACROSS-THE-BOARD LIMITS ON SPENDING

Historically, federal and state policymakers have relied on targeted strategies to control Medicaid spending. These strategies zero in on specific drivers of cost, especially in areas where costs are escalating, and aim to reengineer services, making them more efficient and cost-effective. The approach reflects concerns that across-the-board spending limits would result in the denial of care to people in need. Notable examples of targeted cost-containment include reforms to lower outpatient prescription drug costs, expand access to preventive care, scale up managed care models, and create alternatives to long-term, costly institutional care. The approach also has included setting upper limits on certain expenditures, such as supplemental payments to hospitals that serve a disproportionate share of low-income people.

In addition, policymakers have imposed more stringent limits on the circumstances under which states can use health care provider taxes to finance their required share of Medicaid spending. These limits restrict the amount of money states have to invest in their Medicaid programs, which in turn restricts the amount of federal funding for which states can qualify.

Over the decades, these strategies have led to significant reductions in the cost of providing health care to individuals and eliminated unnecessary spending. For example, today about 80 percent of all Medicaid beneficiaries are served through some form of managed care.[8 (#/#8)] And cost-effective in-home and community-based care is now more common than long-term institutional care.[9 (#/#9)] The overall impact has been to make a growing national program more efficient, while still delivering quality health care.

Targeted cost-containment, however, does not address the primary source of increased spending on Medicaid: growing enrollment. Nor does it limit states' ability to deploy new technologies to improve coverage or the quality of care (like offering new vaccines or drug treatments), or introduce new efficiencies like electronic health records or updated management information systems. As a result, Republican leaders are calling for a very different approach to cost control.

In particular, President-Elect Donald Trump and House Speaker Paul Ryan have proposed to repeal the Affordable Care Act (ACA) and restructure Medicaid. The president-elect wants to replace Medicaid with block grants to states.[10 (#/#10)] Ryan's ideas are outlined in *A Better Way: Our Vision for a Confident America,* which devotes six of its 37 pages to Medicaid reform. While recognizing that Medicaid is a "critical lifeline for some of our nation's most vulnerable patients,"[11 (#/#11)] *A Better Way* nonetheless proposes to substantially scale back the federal contribution. The first step would be to roll back eligibility. States that had not already expanded their Medicaid programs by 2016 to cover nonelderly poor adults (19 states as of November 2016) would have no access to federal funds to support such expansion.[12 (#/#12),13 (#/#13)] States would then have a choice of complying with "default" limits on per capita spending set by the federal government or receiving support in the form of a block grant.

Other proposed changes include restricting the extent to which federal funds can be used to cover certain populations or services while eliminating federal funding for others. One example would be to withdraw federal funding for people who have served time in prison or in jail.

Block Grants as an Alternative to Flexible Spending

The federal government helps fund an array of public services—from housing to public health, education, and law enforcement—through grant programs that give states annual fixed amounts to spend on activities permitted under the terms of the program. Because the federal funds available to states are fixed amounts, they grow at a predictable, formula-driven rate from one year to the next—or not at all, if Congress does not appropriate funding increases. Such programs help support state health and social welfare activities; they do not entitle individuals to services, as does health insurance. Furthermore, they do not automatically take into account population growth, as would a per capita cap.

Providing federal funding for Medicaid using this type of approach (often referred to as a block grant) would disconnect the level of funding from the number of Medicaid beneficiaries and the cost of providing care. In other words, the federal contribution would remain the same, or grow only according to a preset formula, no matter how large the population in need becomes or how much a state actually must spend on health care for Medicaid recipients. To permit states to manage their Medicaid programs with a fixed amount of federal funding, the entitlement to coverage would need to be eliminated, and federal rules regarding eligibility, coverage, and payment would need to be substantially restructured or repealed. The Children's Health Insurance Program (CHIP) provides an example: The federal contribution is fixed and states are free to

scale back enrollment and coverage as needed to avoid budget shortfalls. (A special maintenance-of-effort provision in the ACA prevents participating states from changing CHIP eligibility before October 2019, but states can roll back benefits or increase cost-sharing.)

Proposals to fund Medicaid through block grants have a long history. In 1981, President Ronald Reagan proposed state-specific block grants based on historical levels of spending in each state. Congress rejected the proposal but did temporarily tighten the federal funding formula. With the country in the midst of a recession, even this relatively modest downward adjustment in federal funding triggered widespread reductions in enrollment as well as benefits at a time when the opposite was needed.[14 (#/#14)] This temporary spending reduction was repealed in 1984 through bipartisan budget legislation.

A little more than a decade later, in 1995, both the House and Senate passed a bill that would have funded Medicaid through block grants to states based on historic average levels of spending nationally, coupled with a complex growth formula that would set future spending levels well below the expected rate of growth in Medicaid. President Clinton vetoed the legislation in the face of widespread evidence regarding its adverse financial impact on state Medicaid programs and underlying state economies.[15 (#/#15)]

Since that time, block grant proposals have appeared intermittently. Most recently, in 2015, Senators Richard Burr of North Carolina and Orrin Hatch of Utah, both Republicans, and Congressman Fred Upton, a Republican from Michigan, introduced bills to repeal the Affordable Care Act.[16 (#/#16)] Both bills would have ended the ACA's Medicaid expansion funding for low-income adults and created block grants to states based on levels of spending prior to 2014.

The Congressional Budget Office (CBO) estimated that the proposed legislation would reduce federal spending by $1 trillion over 10 years.[17 (#/#17)] Much of the savings would come from denying access to Medicaid for roughly 14 million people—the estimated number of low-income Americans who would have been eligible for Medicaid by 2026. Additional savings would be achieved by reducing federal spending for the traditional Medicaid program by 4.3 percentage points. By 2026, according to the CBO, federal spending on Medicaid was expected to be one-third below projected spending levels. Although the House bill offered no details regarding the level of flexibility states would have in order to absorb the significant reductions in federal funding, it had enough support to be incorporated into the 2017 fiscal year budget that was released in 2016.

A Better Way offers no formula for how block grants would be calculated or trended forward, or what growth factors would be considered, other than to note that the (undefined) base year for purposes of calibrating the block grant would exclude the ACA expansion population and would transition beneficiaries in expansion states to "other sources of coverage." As a block grant, the formula presumably would be divorced from actual rises in enrollment and the cost of coverage, relying instead on a formula designed to produce predictable savings over time. Assuming that a new block grant proposal might mirror the 2017 House budget proposal, federal Medicaid funding could be expected to fall by a third in the tenth year of the proposal's implementation.[18 (#/#18)]

Per Capita Limits on Spending

Another way to control spending on Medicaid is to establish limits on per capita spending—per capita caps. These caps have the advantage of allowing funding to increase along with enrollment and underlying need, while setting an annual upper limit on federal spending per enrollee, and are supported by many advocates of Medicaid finance reform.[19 (#/#19)] President Clinton suggested this kind of cap prior to vetoing the 1995 congressional block grant proposal discussed above, but Congress rejected the idea.

Within this approach there are options: the federal government could set a single per-enrollee cap that applies to all Medicaid recipients, including children, adults, the elderly, and persons with disabilities; it could set different caps for each group; or it could exempt certain groups from the cap. However, since spending on elderly people and people with disabilities accounts for nearly two-thirds of total Medicaid spending,[20 (#/#20)] the per-enrollee limits would need to apply to these populations in order to generate significant savings. In addition, the cap or caps could be structured to apply to all Medicaid services or only certain services, with others such as prescription drugs being exempt. And how much growth over time to allow in the caps themselves is also an open question.

Limits on per capita spending are more accommodating, at least in theory, to increases in enrollment reflecting underlying need, but a fundamental trade-off remains: To save money at the federal level, the caps must keep spending below projected levels—in effect shifting the burden to states in much the same way that block grants do. Under caps as well as block grants, states will face a gap between the costs of providing coverage and the federal funds available to offset those costs. And as with block grants, federal rules pertaining to eligibility, coverage, and payment to providers would have to be altered, allowing states to narrow their programs and avoid significant budget deficits.

The effects of per capita caps could have significant consequences for people's health care and for insurers. For example, states might reduce already-low provider payment rates, forcing out many current providers and thus limiting access to care, a shift that research suggests would be especially detrimental for people who need specialized treatment and long-term care.[21 (#/#21)] If federal spending updates lag rising health care costs, states might reduce managed care payments below actuarially sound levels, triggering the demise of managed care plans. Or states might narrow eligibility to control costs, perhaps even eliminating coverage for the most needy and costly individuals.

Under Ryan's plan outlined in *A Better Way,* states that choose to operate their Medicaid programs within the federal caps (as opposed to receiving a block grant) would transition to a new funding formula. That formula would take effect in 2019 but would be calculated based on enrollment and costs in 2016—three years earlier. The plan would apply separate caps to each of the four major beneficiary categories (children, adults, elderly people, and people with disabilities), which would be permitted to grow, but at an unstated rate below "current law."[22 (#/#22)] Each state's allotment would apply the federal cap formula to the sum of its 2019 enrollment, adjusted for full-year equivalency (what the cost would be if every beneficiary remained enrolled in Medicaid for the full year) across all eligibility categories.

This plan does allow for population growth. But it fails to take into account that even within a single beneficiary category, some individuals are much more expensive to cover than others. In particular, the formula would treat people who are enrolled in Medicaid for part of the year as less expensive than full-time enrollees when, in fact, providing coverage to them can be more expensive if they enrolled because of a single, high-cost health episode. Nor does the plan explain how the high number of part-year enrollments would be taken into account in reaching an accurate picture of growth over time. Because the plan proposes to generate a predictive enrollment figure, rather than use actual enrollment, it could undercount enrollment. It also could fail to adequately adjust for short enrollment periods, which carry extremely high costs.

While *A Better Way* notes that the caps would reflect each state's expenditures for medical assistance and "non-benefit" expenditures, exactly which expenditures would be counted in the calculation is unclear. This is because the proposal notes that "[r]ecognizing the complexity of Medicaid financing, certain payment categories would be excluded . . . and would be calculated through a separate funding stream, such as payments to states for disproportionate share hospitals, graduate medical education payments, and other appropriate exclusions."

The proposal also would replace the actuarial soundness principles used to set managed care rates under current law with a new (undefined) "reasonable enforceable" premium test for nondisabled adults, as well as replace Medicaid's specific benefit and payment rules with state flexibility to adopt coverage designs that "promot[e] personal responsibility and healthy behaviors and encourag[e] a more holistic approach to care." The proposal does not explain which aspects of Medicaid's current coverage design would be eliminated or what an alternative design might look like.

What Counts as State Spending: An Unaddressed Issue

An important aspect of any proposal to reengineer federal funding for Medicaid is what will count as state spending for purposes of qualifying for federal funds. In fiscal year 2012, 69 percent of state Medicaid spending came from general revenues. States met their remaining obligations through local government contributions (16%), permissible health care –related taxes (10%), and other sources such as special dedicated revenues (5%).[23 (#/#23)] If block grants or caps designated any of these forms of financing as impermissible, states would be in a position in which they would not quality for every federal dollar otherwise available to them, causing federal outlays to fall even more than predicted. While easily overlooked, this crucial issue should be addressed in any proposal to create block grants or limit per capita spending—it remains unanswered in *A Better Way.*

CONCLUSION

As the country's largest insurer, Medicaid is subject to the same cost drivers that affect all providers of health insurance: population growth and demographic trends that increase enrollment, health trends that influence how often people need care and what kind of care they require, and advances in technology that drive up costs, among other factors. But unlike commercial insurers, government-funded Medicaid, in its role as first responder and safety net, is more vulnerable to these trends and to cost increases. For more than 50 years, Medicaid has been rooted in a flexible federal–state partnership, constantly restructured over time to meet current challenges.

Any attempt to restructure federal financing for Medicaid and replace flexibility with strict spending limits—whether in the form of block grants, per capita limits on spending, restrictions on what counts as state expenditures, or a combination of all three—would divorce funding considerations from the real-life needs that have informed federal and state Medicaid policy for half a century. Crucially, a per capita cap would permit population growth to occur. But the limit of lawmakers' appetite for continued growth in enrollment is unclear. Given how states responded to the relatively mild and temporary funding reductions the federal government enacted in 1981, sweeping changes like those currently under consideration are likely to produce far more substantial fallout.

Notes

[1] Center for Medicaid and CHIP Services, "Medicaid and CHIP: June 2016 Monthly Applications, Eligibility Determinations and Enrollment Report (https://www.medicaid.gov/medicaid/program-information/downloads/june-2016-enrollment-report.pdf)" (Centers for Medicare and Medicaid Services, Aug. 25, 2016).

[2] Centers for Medicare and Medicaid Services, *2013 Actuarial Report on the Financial Outlook for Medicaid (https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf)* (CMS, 2013).

[3] L. H. Sun, "Planning Care for Zika Babies Challenges U.S. Officials (https://www.pressreader.com/usa/the-washington-post/20160725/281513635512895)," *Washington Post,* July 25, 2016.

[4] Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP (https://www.macpac.gov/publication/june-2016-report-to-congress-on-medicaid-and-chip/)* (MACPAC, June 2016).

[5] Centers for Medicare and Medicaid Services, *2015 Actuarial Report on the Financial Outlook for Medicaid (https://www.cms.gov/Research-Statistics-Data-and-*

Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf) (CMS, 2015), Table 3.

[6] Ibid.

[7] J. Holahan and S. McMorrow, "Medicare and Medicaid Spending Trends and the Deficit Debate (http://www.nejm.org/doi/full/10.1056/NEJMp1204899)," *New England Journal of Medicine,* Aug. 2, 2012 367(5):393–95.

[8] Centers for Medicare and Medicaid Services, "Managed Care (https://www.medicaid.gov/medicaid/managed-care/index.html)" (CMS, n.d.).

[9] S. Eiken, K. Sredl, B. Burwell et al., Truven Health Analytics, *Medicaid Spending for Long Term Services and Supports (LTSS) in 2013: Home and Community-Based Services Were a Majority of LTSS Spending (https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-fy2013.pdf)* (CMS, June 2015).

[10] See "Healthcare Reform to Make America Great Again (https://www.donaldjtrump.com/positions/healthcare-reform)," Trump/Pence 2016 website.

[11] P. Ryan, *A Better Way: Our Vision for a Confident America (http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf)* (June 2016), p. 23.

[12] S. Rosenbaum, "Medicaid and Insuring the Poor: Where Are We Heading? (http://www.nejm.org/doi/full/10.1056/NEJMp1608552)" *New England Journal of Medicine,* Oct. 13, 2016 375(15):1405–7.

[13] P. Ryan, *A Better Way: Our Vision for a Confident America (http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf)* (June 2016), p. 26.

[14] D. G. Smith and J. D. Moore, *Medicaid Politics and Policy (http://www.transactionpub.com/title/Medicaid-Politics-and-Policy-978-1-4128-5674-4.html),* 2nd ed. (Transaction Publishers, 2015).

[15] Ibid.

[16] See C. Eibner and S. Nowak, *Evaluating the CARE Act: Implications of a Proposal to Repeal and Replace the Affordable Care Act (/publications/fund-reports/2016/may/evaluating-care-act)* (The Commonwealth Fund, May 2016).

[17] E. Park, "Medicaid Block Grant Would Add Millions to Uninsured and Underinsured (http://www.cbpp.org/blog/medicaid-block-grant-would-add-millions-to-uninsured-and-underinsured)," *Center on Budget and Policy Priorities Blog* (CBPP, March 15, 2016).

[18] Ibid.

[19] P. Ryan, *A Better Way: Our Vision for a Confident America (http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf)* (June 2016), p. 26.

[20] J. Paradise, *Medicaid Moving Forward (http://kff.org/health-reform/issue-brief/medicaid-moving-forward/)* (Henry J. Kaiser Family Foundation, March 2015).

[21] S. Rosenbaum, "Medicaid Payments and Access to Care (http://www.nejm.org/doi/full/10.1056/NEJMp1412488)," *New England Journal of Medicine,* Dec. 18, 2014 371(25):2345–47.

[22] Ibid.

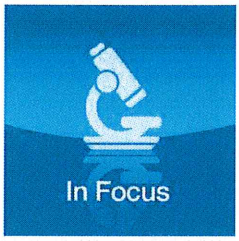
[23] Medicaid and CHIP Payment and Access Commission, "Non-Federal Financing (https://www.macpac.gov/subtopic/non-federal-financing/)" (MACPAC, n.d.).

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 16, 2016



RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

REVISITING REPUBLICAN GOVERNORS' 2011 MEDICAID REFORM PROPOSALS

This week, our *In Focus* section revisits a 2011 report from the Republican Governors Public Policy Committee Health Care Task Force. The report, titled *"A New Medicaid: A Flexible, Innovative and Accountable Future,"* was prepared with input from governors, secretaries of health and human services, Medicaid directors, and other senior policy staff in the 31 states (including two territories) with Republican governors at the time. Across these 31 states, 20 of the governors in office at the time of the report are still in office. Only three of the 31 states (Louisiana, Pennsylvania, and Virginia) now have Democratic governors in office, although Alaska's new governor is an Independent who expanded Medicaid this year. The report provides more than 30 recommended solutions across seven broad principles that would "increase Medicaid's efficiency and effectiveness as a part of the overall health care delivery system regardless of whether or not [the Affordable Care Act (ACA)] is repealed."

The solutions highlighted below align with some of the national policy positions coming from Congress and the incoming Administration, but also include additional ideas that the Republican governors offered for consideration. Given that these proposals are now five years old, some solutions are no longer relevant and are not included in the summary below. Additionally, certain concepts proposed in the Governors Public Policy Committee paper have since been incorporated into Medicaid waiver proposals, including value-based purchasing, health savings accounts, and bundled payments, with a mixed record of federal approval.

Principle #1: States are best able to make decisions about the design of their health care systems based on their respective needs, culture and the values of each state.

- Provide states the option to define and negotiate a broad outcome-based Program Operating Agreement (POA) with CMS. The only notification required would be when a state elects to update or change an agreed upon POA. States would publicly report the outcome measures established within the POA on a routine basis. CMS oversight should only be triggered when there is a significant deviation in the reported versus projected measure. The number of measures should be finite. Eliminate the onerous federal review process for operating the Medicaid program within each state, such as requiring waivers for designing systems, benefits, services, and payment and reimbursement rates. The relationship between the federal and state government should be based on the principles of value-based purchasing rather than rigorous, complex and lengthy processes.
- States can create a specific "dashboard" to measure accountability utilizing recognized measures of quality, cost, access and customer satisfaction that reflects the states' priorities and permits an assessment of program performance over time. Where possible, states will utilize the expertise of state, local and national organizations that have developed appropriate measures. In many cases, states already have developed extensive measures of quality and accountability, including customer satisfaction. These dashboards should utilize those processes instead of recreating onerous administrative burdens for states.
- Program integrity should be the responsibility of the state. Currently, common practice is to utilize federal contractors for program integrity initiatives, most of whom are not familiar with individual state programs and simply engage in "pay and chase," where claims are paid and then states seek payments afterward. Instead, states and their staffs should be able to utilize existing federal funding sources to proactively fight fraud and abuse activities.
- Require the federal government to take full responsibility for the uncompensated care costs of treating illegal aliens.

Principle #2: States should have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and hold states accountable for efficiency and quality health care. Such mechanisms may include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

- Allow states to pilot self-directed alignment structures for state and federal health care programs to reduce the incidence of cost-shifting from one program to another, encourage efficiency in complementary programs and ensure program integrity.
- If a state can demonstrate budget neutrality, provide states the ability to use state or local funding, now spent as match funding, for certain health services that would pay for Medicaid services or health system improvements that are currently not "matchable," but are cost effective and improve the value of the Medicaid program. This could include Health Information Exchanges, increased benefits for some individuals, improved care management and local care coordination, and pilot programs to test innovations.
- States should be encouraged to develop innovative programs to reduce chronic illnesses and the burden of associated health care costs to individuals and the taxpayers. Allow states to invest in alternative programs that reduce hospital emergency room visits and other community-based programs to reduce hospitalizations.
- Program integrity should be the responsibility of the states. In order to properly insure the taxpayers' investment in Medicaid is protected:
  - All sources of federal funding allocated to combat waste, fraud and abuse should be included in any block grant or alternative financing mechanism proposal.
  - An enhanced contingency fee should be paid to states for increasing their efforts to decrease waste, fraud and abuse. The current system's development matching rate of 90/10 should be allowed for improvements to states' current fraud and abuse, and eligibility systems. Innovative programs that show a positive return on investment for both the state and federal governments should be allowed without the onerous waiver process.
  - The entire appeals process for any recoupments and overpayments should be exhausted prior to paying the federal share of the recovery.

Principle #3: Medicaid should be focused on quality, value-based purchasing and patient-centered programs that work in concert to improve the health of states' citizens and drive value over volume, quality over quantity, and, at the same time, contain costs.

- Provide states with the flexibility, without requesting waivers or initiating the state plan amendment process, to pay providers based on meeting quality care and value-based criteria rather than the current fee-for-service approach. Allow innovative payment methodologies to encourage care coordination for all Medicaid eligibles, without exception. Other options could be capitated payments, shared savings, and incentive arrangements when such payments encourage coordination, reduce cost shifting and improve care delivery.

- Provide states with the ability to implement bundling projects. For example, a provider is paid an amount for a discrete event, such as hip replacement, and that provider pays other providers for all necessary care for the event, with providers sharing in savings.
- Give states the ability to use only one managed care organization if client volume in an area is insufficient to support two. CMS now requires at least two managed care organizations in each area.

Principle #4: States must be able to streamline and simplify the eligibility process to ensure coverage for those most in need, and states must be able to enforce reasonable cost sharing for those able to pay.

- Establish reasonable, rational and consistent asset tests for eligibility. Amend ACA's definitions of income to count child support payments (current law in Medicaid), and reverse the use of Modified Adjusted Gross Income (MAGI) in order to avoid new eligibility for higher-income Americans.
- Give states the flexibility to streamline and improve the eligibility determination system by contracting with private firms.
- Within a state's fair share of federal funding, there should be significant flexibility regarding how a state provides eligibility for its population in need.
- Eliminate the marriage penalty.

Principle #5: States can provide Medicaid recipients a choice in their health care coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace.

- Eliminate the obsolete mandatory and optional benefit requirements. Provide states the flexibility to design appropriate benefit structures to meet the needs of their recipients in a cost-effective and efficient manner as part of the state's negotiated plan.
- Eliminate benefit mandates that exceed the private insurance market benchmark or benchmark equivalent. Design benefit packages that meet the needs of specific populations, including allowing a plan that puts non-disabled populations into Section 1937 benchmark plans. Amend Section 1937 to include cost-sharing provisions and allow states the authority to enforce cost sharing.
- Purchase catastrophic coverage combined with an HSA-like account for the direct purchase of health care and payment of cost sharing for appropriate populations determined by each state.
- Provide states the option of rewarding individuals who participate in health promotion or disease prevention activities.
- Provide states with the ability to offer "value-added" or additional services for individuals choosing a low-cost plan or managed care plan (i.e., additional services and benefits offered by coordinated care companies for successful completion of healthy baby programs, or an adult dental benefit).
- Allow states the option of contributing to a private insurance benefit for all members of the family. Require all members of the family to participate in cost- effective coverage.

- Lower the threshold for premium payments to 100 percent FPL to encourage a sense of shared beneficiary ownership in health care decisions.

Principle #6: Territories must be ensured full integration into the federal health care system so they can provide health care coverage to those in need with the flexibility afforded to the states.

- The territories should be treated consistently, fairly and rationally in funding, services and program design.

Principle #7: States must have greater flexibility in eligibility, financing and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves.... [T]he innovative power of states should be rewarded by a shared-savings program that allows full flexibility to target and deliver services that are cost effective for both state and federal taxpayers.

- At a state's discretion, permit states to redesign Medicaid into multiple parts. Medicaid Part A would focus on preventive, acute, chronic and palliative care services; and Part B would focus on long-term supports and services (LTSS). This would enable a state to better manage the different needs between populations who only need LTSS. Eligibility for Part B would be based on income and functional screening of an individual's long-term services and LTSS needs.
- Engage in shared savings arrangements for dual eligible members when the state can demonstrate the Medicare program reduced costs as a result of an action by a state Medicaid program.
- Repeal restrictions that impede self-direction of long-term care supports and services (LTSS) and allow states the ability to design programs that meet their needs and are cost effective.
- At the state's option, replace Medicare cost-sharing with state- administered, 100 percent federal grants.
- Give states the flexibility to enroll more members, especially families, in premium assistance programs including Medicare benefits, when it is cost efficient. Medicaid should be the payer and insurer of last resort.
- Extend Medicare coverage of skilled nursing facilities by 60 days.

Link to Republican Governors Public Policy Committee Paper

http://www.finance.senate.gov/imo/media/doc/RGPPC%20Medicaid%20Report.pdf

UPDATE ON MEDICAID FORECAST AND BUDGET ISSUES

Presentation to the:
Board of Medical Assistance Services
December 13, 2016

Forecasting Process

- Section 310.A. of the 2016 Appropriations Act:

  "1. By November 1 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit a forecast of Medicaid expenditures, upon which the Governor's budget recommendations will be based, for the current and subsequent two years to the Chairmen of the House Appropriations and Senate Finance Committees.
  2. The forecast shall be based upon current state and federal laws and regulations."

- Each year, DMAS and DPB prepare independent forecasts using monthly level expenditure and utilization data

- The forecasts are comprised of over 100 different models that project utilization and cost per unit for each benefit category

- Manual adjustments are made to the forecast to reflect implementation of new programs, one-time payments, or other series not best projected with statistical models

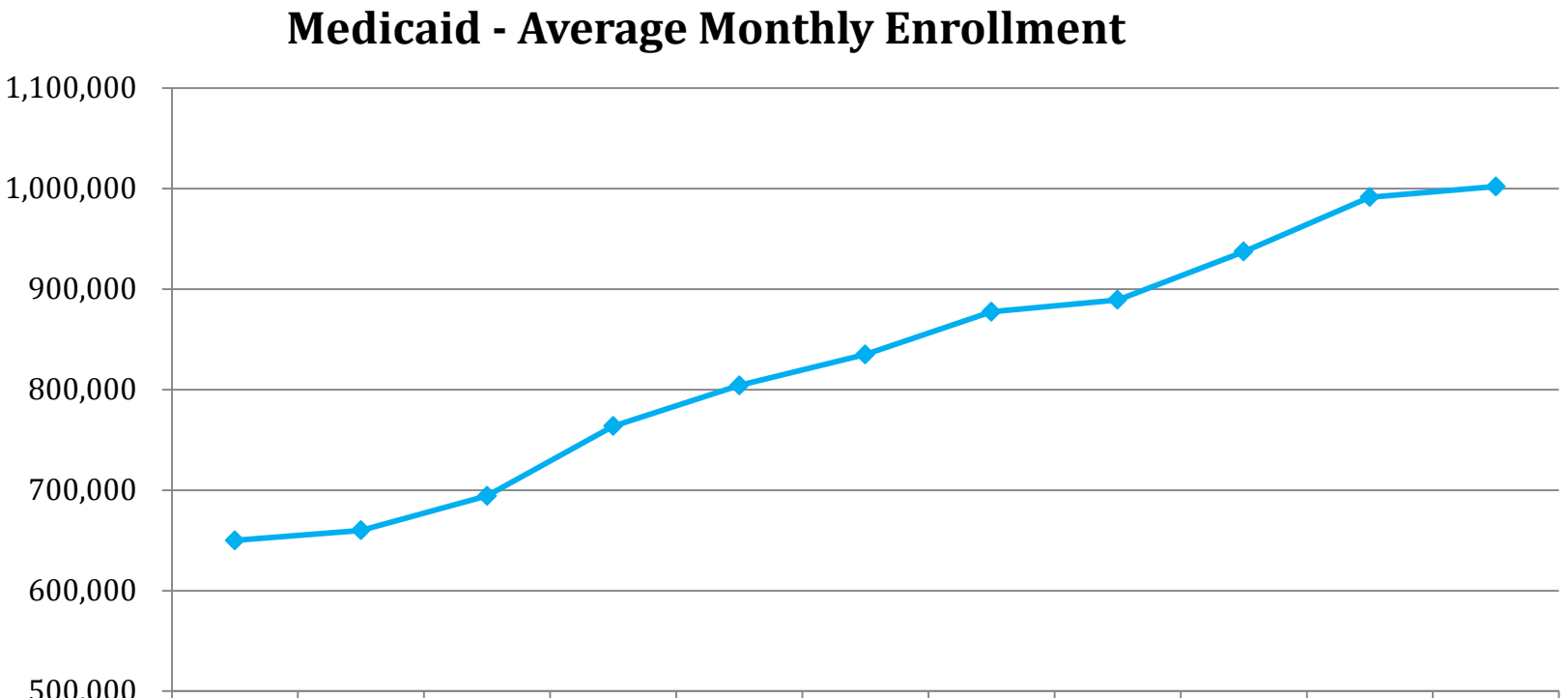
Forecasting Process

- Forecast projects spending in current and subsequent two years

- Forecast reflects:
  - Application of existing state laws and regulations
  - Changes in enrollment, utilization, inflation and acuity mix

- DMAS and DPB staff meet to compare and evaluate the individual forecasts and an official "Consensus" forecast is adopted

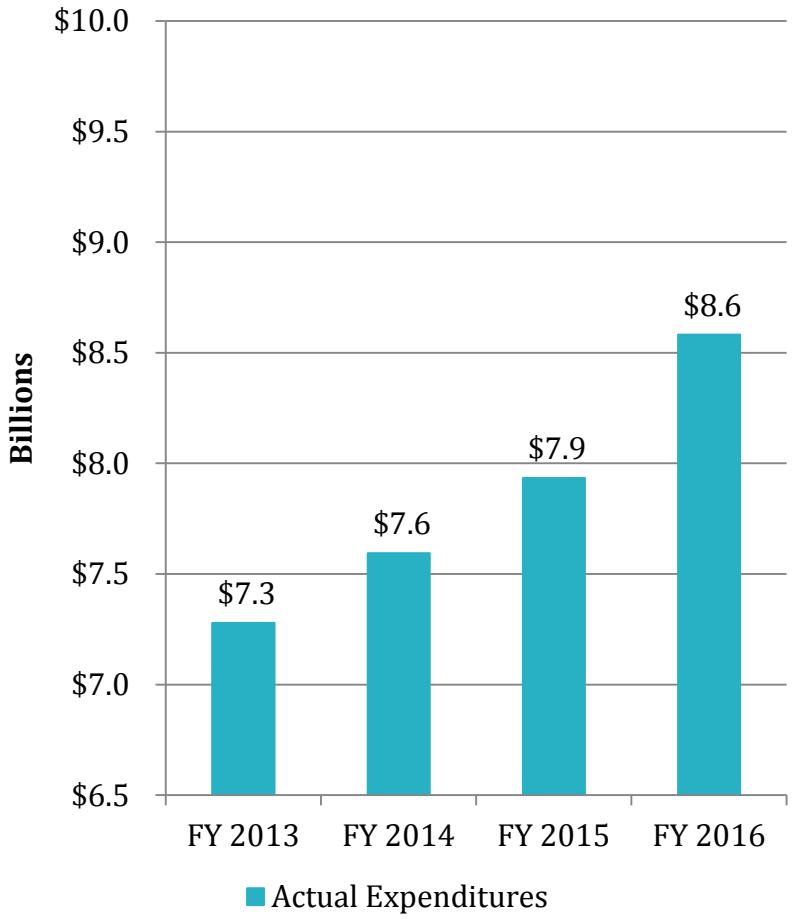
Enrollment



	SFY07	SFY08	SFY09	SFY10	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17 YTD
Monthly Enrollment	649,903	659,969	694,276	763,745	804,186	834,876	877,438	889,262	937,287	991,412	1,002,11
Annual Growth	-1%	2%	5%	10%	5%	4%	5%	1%	5%	6%	1%

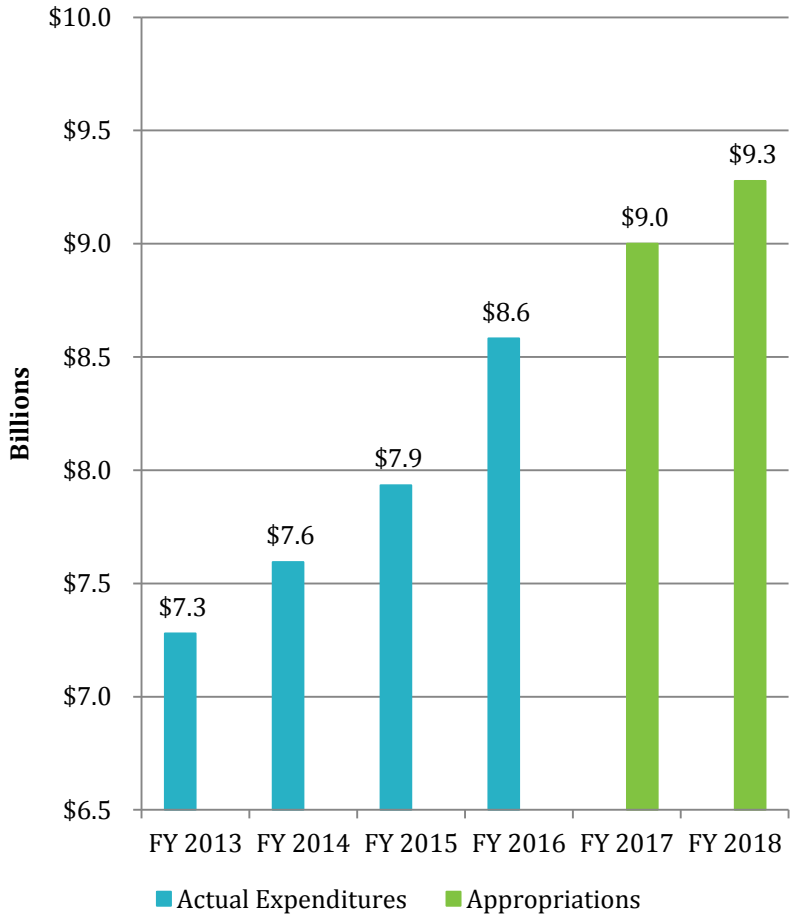
- Enrollment growth in FY15 and FY16 was substantial and appears to be slowing in FY17.
- Enrollment has grown 54% between FY07 and FY17 (November).

Recent Expenditure Trends



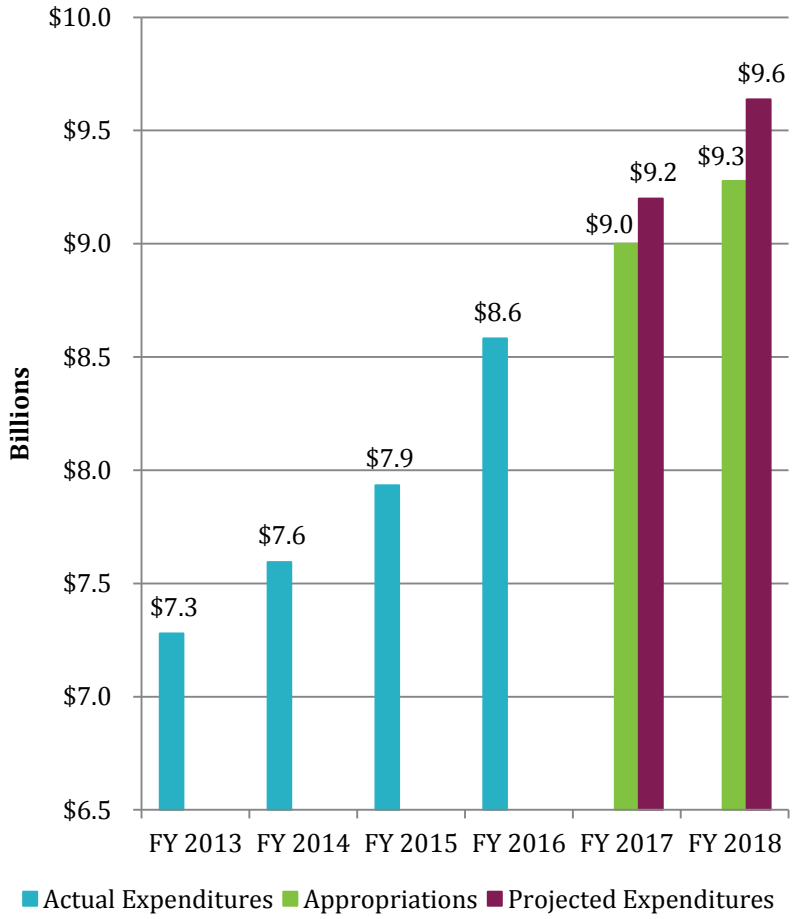
- Expenditure Growth Drivers, FY13-FY16:
  - Increasing enrollment growth
  - Increasing numbers of individuals on LTC waivers
  - Changes in utilization rates of services
  - Changes in acuity and health care needs of enrollees

Medicaid Funding: FY16



- 2016 Appropriations Act funded 5.4% growth in FY17 and 2.5% in FY18

Medicaid Funding: FY17 – FY18



- Updated forecast projects higher spending in FY17 and FY18

Funding Surplus/(Need)

		Appropriation ($millions)	Consensus Forecast ($millions)	Surplus/(Need) ($millions)
FY 2017	**Total Medicaid**	**$9,048**	**$9,242**	**($194.3)**
	State Funds	$4,609	$4,693	($84.3)
	Federal Funds	$4,439	$4,549	($109.9)
FY 2018	**Total Medicaid**	**$9,278**	**$9,637**	**($359.1)**
	State Funds	$4,728	$4,924	($196.3)
	Federal Funds	$4,550	$4,713	($162.8)
		FY17-FY18 Biennium State Funds Surplus/(Need)		**($281 GF)**

Figures may not add due to rounding

Major Forecast Drivers

	Changes in SFY 2017 Forecast Nov 2015 to Oct 2016		Changes in SFY 2018 Forecast Nov 2015 to Oct 2016	
	General Fund	Total Funds	General Fund	Total Funds
Medicare Part B and D Rate Increases	$24.2M	$34.1M	$65.0M	$91.9M
Behavioral Health (State Plan Option Services)	$31.5M	$63.1M	$54.6M	$109.2M
End of Decline in General Medical Care: Fee-for-Service	$38.8M	$77.5M	$38.3M	$76.7M
SFY Total of These Factors	**$94.5M**	**$174.7M**	**$157.9M**	**$277.8M**

Budget Cuts

- Governor McAuliffe announced his FY 2017 Savings Plan on October 13, 2016
- Included reductions of $2 million GF for DMAS' administrative budget, to be achieved by:
  - Reducing funds for contract re-procurements
  - Utilizing a higher federal matching rate for certain IT projects
  - Returning excess IT audit funds
  - Increasing efficiency in the Office of the Chief Medical Officer
  - Conducting DRG payment audits using agency staff
  - Conducting DME and pharmacy audits using agency staff
  - Adjusting scope of work for certain audit contracts
  - Managing the agency hiring process through delays in filling vacant positions
- Any FY 2018 reductions will be announced with the release of the Governor's Introduced Budget on December 16, 2016

Regulatory Activity Summary December 13, 2016
(* Indicates recent activity)

2016 General Assembly

(01) Home Health/DME Face to Face Requirements: This exempt regulatory action is required by 2016 budget language. Currently, there are no requirements in the DMAS' regulations that require physicians, who are ordering home health services or durable medical equipment, to have face-to-face encounters with their patients for the purpose of ordering these services. The regulatory changes will necessitate that physicians document the existence of a face-to-face encounter (including through the use of telehealth) with the Medicaid eligible individual prior to ordering home health or durable medical equipment services. This face-to-face encounter may be conducted by the physician, by a nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with State law, by a certified nurse-midwife as authorized by State law, or by a physician assistant under the supervision of the physician. This new requirement is established as a condition of payment for these services. The regulations are currently being drafted.

***(02) FAMIS Eligibility Changes:** This regulatory action was required by 2016 budget language. This regulation will serve to improve access to eligible individuals that may be served by the Family Access to Medical Insurance Security Plan (FAMIS) program. DMAS is currently circulating the corresponding regulations for internal review. This regulatory action was submitted to DPB on 10/27/2016 and forwarded on to the Governor's Office on 11/10.

***(03) Applied Behavioral Analysis:** This action establishes Medicaid coverage for behavior therapy services for children under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which is a mandatory Medicaid-covered service that offers preventive, diagnostic, and treatment health care services to young people from birth through the age of 21 years. The proposed regulations define the behavioral therapy service requirements, medical necessity criteria, provider clinical assessment and intake procedures, service planning and progress measurement requirements, care coordination, clinical supervision, and other standards to assure quality. These regulations have been drafted, subsequently circulated for internal review, and were submitted to the OAG on 8/4. Revised regulatory text was submitted to the OAG on 10/4 and 11/21. DMAS is awaiting OAG response.

***(04) Three Waiver Redesign:** This emergency regulatory action is required by 2016 budget language. The Individual and Family Developmental Disabilities Support Waiver is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver is changing to the Community Living Waiver (CL), and; the Day Support Waiver for Individuals with Mental Retardation is changing to the Building Independence Waiver (BI). This redesign effort, ongoing between DMAS, DBHDS, consultants, and stakeholders for the last two years, combines the target populations of individuals with both intellectual disabilities and other developmental disabilities and offers new services that are designed to

promote improved community integration and engagement. The regulatory action was OAG-certified on 8/18/2016 and DPB and the Secretary's Office approved the regulations on 8/22/16. The action was approved by the Governor on 8/24. The action was published in the Register 0n 9/19, with a public comment period through 10/24. One comment was submitted. A corresponding SPA was drafted and submitted to HHR on 8/24. The SPA was signed by the Sec. and submitted to CMS on 9/15/16. DMAS responded to informal questions on 10/18/16; received additional informal reimbursement questions on 10/28 and 11/2; and sent responses on 11/8/16. DMAS is currently awaiting further CMS input.

(05) Managed Long Term Care Services and Supports (MLTSS): This emergency regulatory action is required by 2016 budget language. The regulation changes will transition the majority of the remaining Medicaid fee-for-service populations into an integrated, managed long-term services and supports (MLTSS) program. DMAS intends to launch an MLTSS program that provides a coordinated system of care that focuses on improving quality, access, and efficiency. The regulations are currently being drafted and circulated for internal review.

(06) Barrier Crimes Not Permitted: This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations are currently being drafted.

***(07) Coverage in Approved Supportive Housing:** This fast-track regulatory action is required by the 2016 budget language. A SPA was initiated to implement the changes required by House Bill 675, approved March 29, 2016, which stated that DMAS was to provide Medicaid coverage to individuals living in approved supportive housing, and stated that DMAS "shall seek to amend the state plan for medical assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement the necessary changes pursuant to the provisions of this act." The SPA was submitted to the Secretary on 7/22/16 for review and subsequently filed with CMS on 7/26. The SPA was approved 10/17/2016. The corresponding Fast Track regulations were developed and circulated for internal DMAS review and submitted to the OAG for review on 12/7.

***(08) Low Dose Computed Tomography (LDCT) Lung Cancer Screening:** This emergency regulatory action is required by the 2016 budget language. This regulation will serve to provide coverage of LDCT lung cancer screening as a preventive measure for at-risk beneficiaries. The regulations were drafted and sent to OAG on 10/19/16 and became OAG certified on 11/4/16. The regs were submitted to DPB on 11/7; to HHR on 11/16; to the Governor on 11/20/16; and were signed by the Governor on 12/6. The regs will be published in the Register on 12/26, with comment period through 1/25/17.

***(09) No Coverage of Overtime Hours for CD Personal Assistance, Respite and Companion Services:** This final exempt regulatory action is required by 2016 session of the Virginia General Assembly. This action establishes that DMAS will not reimburse for more

than 40 hours per week for consumer-directed personal assistance, respite and companion services for any one provider or working for any one consumer. An attendant may exceed 40 hours of work in a week working for multiple consumers. This limit will not apply to live-in attendants consistent with the U.S. Department of Labor's requirements (Fact Sheet 79B). This change, which will eliminate inconsistencies regarding pay for services in excess of 40 hours, applies to EPSDT-covered attendant services as well as waiver-covered attendant services. The regulations were sent to the OAG on 9/26 and subsequently revised. 10/5 – sent Word version to Michelle – OAG rejected Final Exempt. A submission was sent to DPB on 10/18/16. DPB submitted the action to HHR for review on 11/1; the regs were forwarded to Governor on 11/3; and the Governor signed the regulatory action on 12/6. It will be published in Register on 12/26, with 30-day comment period to follow.

***(10) 2016 Institutional Provider Reimbursement:** This final exempt regulatory action is required by 2016 budget language. This action will serve to implement mandates in the Virginia budget making specialized care reimbursement fully prospective and modifying the inflation adjustment for hospital inpatient rates to 50% of inflation for FY17. The corresponding SPA (effective 7/1/16) will precede the regulatory changes. The SPA package was drafted and subsequently sent to HHR on 9/13/16. It was signed by HHR and submitted to CMS on 9/23. CMS has requested additional information. DMAS is currently drafting responses to CMS' inquiries.

***(11) 2016 Non-Institutional Provider Reimbursement:** This final exempt regulatory action is required by 2016 budget language. This action will serve to implement mandates in the Virginia budget modifying the inflation adjustment for hospital inpatient rates to 50% of inflation for FY17 and implement a supplemental payment for physicians affiliated with a children's hospital serving Northern Virginia. The corresponding SPA (effective 7/1/16) will precede the regulatory changes. The SPA package was drafted and subsequently sent to HHR on 9/20/16. It was then submitted to CMS on 9/30. CMS has requested additional information. DMAS is currently drafting responses to CMS' inquiries.

***(12) Addiction and Recovery Treatment Services:** This fast track regulatory action is required by the 2016 budget language. More Virginians died from drug overdose in 2013 than from automobile accidents. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS' claims history data showing large numbers of substance abuse diagnoses. As such, the proposed regulatory action implements a comprehensive program of community-based addiction and recovery treatment services in response to the Governor's bipartisan Task Force on Prescription Drug and Heroin Addiction's numerous recommendations. The regulations were drafted and submitted to the OAG on 11/14. They became OAG-certified on 11/30 and were submitted to DPB on 12/1. DMAS is awaiting a response.

***(13) Reconsideration of Final Agency Decision:** This emergency regulation made necessary and authorized by action of the 2016 Virginia General Assembly in enacting *Code of Virginia* §2.2-4023.1. That new section provides for establishment of a reconsideration process by which appellants can petition the agency director to reconsider the agency's Final Agency Decision made pursuant to the *Code of Virginia* §2.2-4020. The statute specifically authorizes the agency to promulgate emergency regulations to specify the scope of the reconsideration review. This emergency regulation adopts the process and timeline set forth in the statute and specifies the scope of review. The regulation was drafted and sent to the OAG on 8/4. The regulatory action was certified and sent to DPB on 10/13; forwarded to HHR on 10/23; and submitted to the Governor on 11/20/16. The Governor signed on 12/6/16 and the regs will be published in Register on 12/26, with comment period through 1/25/17. The corresponding SPA was drafted and began circulating as of 12/1/2016.

***(14) Coverage of Mosquito Repellant to Prevent Zika Virus:** This emergency regulatory action is required by the 2016 budget language. This regulation provides Medicaid coverage for mosquito repellants when they are prescribed by an authorized health professional for individuals of childbearing age in order to prevent the transmission of the Zika virus. Covering mosquito repellant could prevent Zika transmission and avert babies being born with microcephaly and other severe brain defects who could eventually need expensive waiver services. The regulation has been submitted to and was approved by DPB on 8/15; approved by the Secretary on 8/15 as well; approved by the Gov. on 8/16; was submitted to the Register on 8/16; and became effective on 8/22/2016. The regulatory action transitioned to the Proposed Stage and was submitted to OAG on 10/27/16.

2015 General Assembly

***(01) Pre-Admission Screening Changes:** This regulatory action is required by 2015 budget language. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services. These regulatory changes were drafted and reviewed internally, and submitted to the OAG. The OAG certified the regulations and they were sent to the DPB on 4/25/16. The regulatory action was submitted to HHR on 5/4 and to the Governor on 5/17. The regulations were published in the Register on 7/11 and became effective on 9/1/2016. The corresponding SPA was sent to HHR on 8/24, and then submitted to CMS on 9/15/2016. CMS approved the SPA on 11/21/2016. The regulatory action transitioned to the Proposed Stage and was submitted to OAG on 11/4/2016 and currently being reviewed.

***(02) Sterilization Compensation:** This regulation will allow DMAS to seek federal authority to exclude (for purposes of determining Medicaid eligibility) compensation provided to individuals who were involuntarily sterilized pursuant to the Virginia Eugenical Sterilization Act. A state plan amendment containing this change was approved by CMS on July 30, 2015 and an emergency regulation became effective on 11/23/2015. Proposed stage regulations were reviewed internally and, along with the Town Hall background document, were submitted to the Office of the Attorney General (OAG) on 4/5/16. The OAG certified the action on 6/17 and it was submitted to the DPB on 6/21/16. HHR certified the regulations

on 8/14 and submitted them to the Governor. The Governor signed the action on 9/23 and it was published in the Register on 10/17, with a public comment period through 12/16.

***(03) FAMIS MOMS Eligibility for State Employees:** This regulatory action will permit low-income state employees and their dependents to obtain coverage through FAMIS MOMS. The NOIRA for this package is being printed in the Register on 9/7/2015, which will open a 30-day public comment period. The comment period closed on 10/7/2015, and the proposed stage regulations were drafted and reviewed internally. They were submitted to the OAG on 1/22/2016 and became OAG-certified on 10/31. DPB is holding the regs in deference to other pressing projects.

***(04) Technology Assisted Waiver Changes:** This regulatory action will change the use of private duty nursing; change the staff experience requirement to include a training program; and remove the reference to exhausting private insurance coverage. The proposed stage was drafted, reviewed internally, and submitted to the OAG on 2/19/2016. The action was submitted to the DPB on 5/9. HHR certified the regulations on 6/23 and sent the package to the Governor's Ofc. for review on 7/8/16. The Governor signed on 10/7 and the regs were published on 10/31, with a public comment period through 12/30/16.

***(05) Institutional Provider Reimbursement Changes:** This action will eliminate inflation for inpatient hospital operating, graduate medical education, disproportionate share hospital, and indirect medical education payments in FY16. It will also implement the "hold harmless provision" for nursing facilities that meet the bed capacity and occupancy requirements, reimbursing with the price-based operating rate rather than the transition operating rate for those facilities. A prior public notice was published and a SPA was submitted to CMS on 9/15/2015. CMS sent informal questions about the SPA, and DMAS provided responses on 11/16/2015. CMS approved the SPA on 12/16/15. The fast-track stage package was drafted, reviewed internally, and submitted to the OAG on 4/21/2016. The OAG certified the regulations and they were submitted to DPB on 7/5/16. The regulatory action was submitted to HHR on 8/12/16; to Governor on 8/14/16; and signed by the Governor on 9/23/16. The item was published on 10/17/16, and the adoption period ended 11/16/16.

(06) Supplemental Payments to Medical Schools in Eastern VA: This action will update the average commercial rate calculation of supplemental payments for physicians affiliated with a publicly funded medical school in Tidewater effective October 1, 2015. A prior public notice was published and a SPA was submitted to CMS on 11/12/2015. CMS submitted informal questions that DMAS answered. CMS then submitted a request for additional information, which DMAS addressed on 4/19/16. CMS approved the SPA on 5/11/16. The corresponding VAC package is currently being drafted.

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

to the OAG on 4/18/16 to request a review status update. Additional information was sent to the OAG on 11/21 & 11/22/16. The action was certified on 11/22/16. The project will be submitted to DPB in early January, 2017.

***(08) Treatment of Annuities:** This action complies with a federal Deficit Reduction Act, which requires DMAS to treat annuities and income from annuities according to certain rules, for purposes of determining Medicaid eligibility. Regulatory changes were drafted and submitted to the OAG on 9/14/2015. The OAG certified this action on 11/22 and it was submitted to the Register. The regs will be published on 12/26/16 and will become effective on 1/25/17.

***(09) Property Sales at Less Than Tax-Assessed Value:** This action complies with federal changes by changing the Medicaid eligibility rules that relate to property sales at less than tax-assessed value. Regulatory changes were submitted to the OAG on 11/20/15. The action was OAG certified on 1/4/2016 and then submitted to DPB. DPB sent inquiries back to DMAS on 2/5, and responses were sent back to DPB on 2/9. The regulatory action moved to HHR on 2/10. The regulations were submitted to the Governor on 4/5/16. Following a meeting to further to discuss this action, the regulations were withdrawn.

***(10) Utilization Review Changes:** DMAS drafted a NOIRA to implement regulatory changes to more accurately reflect current industry standards and trends in the area of utilization review. The regulatory action was submitted to the OAG on 11/2/2015, and comments were received on 11/10. A revised ABD was sent to the OAG on 11/18. A NOIRA was sent to DPB on 11/30, and the regulatory action was moved to HHR on 12/4. The Governor signed the action on 12/11. The NOIRA was published in the Town Hall Register on 1/11/2016, with the comment period in place through 2/10. Following internal DMAS review, the regulatory action was submitted to the OAG on 6/23/16. Per request, further edits were made on 7/21, 8/4, 10/7, 10/28, and 11/15. The regulations remain under review with the OAG.

2014 General Assembly

(01) Hospital DSH Reduction: This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA was approved by CMS on 6/2/15 and a fast track regulatory action was submitted to the OAG for review on 7/16/15. DMAS received requests for additional information from the OAG and 9/17/2015; 10/5; 10/7; 1/13/2016. The OAG certified the action on 2/29. The submission went to the DPB on 3/9/2016. Following a meeting with DPB on 4/4, DPB certified the regulations and they were submitted to HHR on 4/18.

***(02) GAP SMI Demonstration Waiver Program:** The agency began work designing this new non-Medicaid program in early September in response to the Governor's directive. It provides a package of limited benefits to individuals who are 21 to 64 years old, uninsured, and residents of the Commonwealth. Some of the benefits are: physician, clinic, diagnostic outpatient procedures for both medical health conditions and behavioral health conditions related to diagnoses of serious mental illness. CMS approved the program in December, 2014. The emergency regulation action became effective 1/1/2015. The General Assembly proposed changes to this program in the 2015 budget and DMAS drafted a revised emergency regulation to incorporate these changes, which became final on 6/24/15. The proposed stage regulation, which incorporated the changes from both emergency regulations, was submitted to the OAG for review on 11/16/2015. DMAS revised the regulations, updated the Town Hall accordingly, and re-submitted the action to the OAG on 11/20/15. DMAS responded to OAG requests for revisions on 3/8/16 and 4/26. This regulatory action was re-submitted to the OAG on 5/23/16. DMAS submitted further updated info on 7/22 and received OAG revisions on 8/1. DMAS resubmitted info to the OAG on 9/13. The action was subsequently certified and sent to DPB on 9/20/16. Following a meeting with DPB on 10/25, and the submission of follow-up responses, DPB approval was secured on 11/3. HHR approved the action on 11/3; the item was sent to the Governor on 11/3; and the Governor signed the regulatory action on 12/6. It will be published on 12/26, with a comment period through 2/24/17.

2013 General Assembly

***(01) Consumer Directed Services Facilitators:** This Emergency/NOIRA complies with the *2012 Acts of the Assembly* Item 307 XXX that directed the DMAS to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home-and-community-based waiver enrollees. This regulatory package was certified by the OAG on 11/2/2015 and was signed by the Governor on 11/30/2015. Emergency regulations were published in the Register on 1/11/16, with NOIRA comment period from 1/11thru 2/10. This regulatory action was circulated for internal DMAS review on 2/24/2016. Following internal DMAS revisions, the regulatory action was submitted to the OAG on 5/9/2016. No SPA action is required. DMAS revised the regulations and resubmitted them to the OAG on 9/6. Per request, DMAS made additional OAG edits on 10/25/16. The regulatory action was OAG-certified on 11/1 and submitted to DPB on 12/8.

***(02) Changes to Institutions for Mental Disease (IMD) Reimbursement:** This Emergency/NOIRA is the result of the 2012 *Acts of the Assembly*, Chapter 3, Item 307 CCC, which directed DMAS to develop a prospective payment methodology to reimburse institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others. The SPA was approved on 6/2/15. This Emergency regulation became effective 7/1/14. The permanent replacement regulation was certified by the OAG and sent to DBP on 5/17/2016 and then on to HHR on 7/8/16. The Gov. signed the regulatory action on 8/19; it will be published in the Register on 9/19/16; and the public comment period will extend through 11/19/16. The project

transitioned to the Final Stage phase and the regulations; were submitted to submitted to DPB on 12/1/16; and submitted to HHR on 12/8/16.

***(03) Medicare-Medicaid Alignment Demonstration (FAD)/Commonwealth Coordinated Care (CCC):** This SPA is being implemented by CMS to streamline service delivery, improve health outcomes, and enhance the quality of life for dual eligible individuals and their families. Under the Demonstration's capitated model, DMAS, CMS, and selected managed care organizations (MCOs) have entered into three-way contracts through which the MCOs receive blended capitated payments for the full continuum of covered Medicare and Medicaid benefits provided to dual eligible individuals, including Medicaid-covered long term services and supports and behavioral health care services. The participating MCOs will cover, at a minimum, all services currently covered by Medicare, Medicaid wrap-around services, nursing facility services, Medicaid-covered behavioral health services, home and community-based long-term services and supports provided under the Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver. Robust care coordination, interdisciplinary care teams, and person-centered care plans are also mandatory services that must be provided through the participating MCOs. Virginia plans to offer the Demonstration from January 1, 2014, through December 31, 2016. This SPA was submitted to CMS 3/28/13 and was approved by CMS 6/12/13. The Emergency regulation took effect 12/10/2014. The proposed stage action of the permanent regulation was submitted to the OAG on 12/21/2015. In response to multiple OAG inquiries, the regulatory action underwent another internal review and subsequent revisions. The revised regulatory action was submitted to the OAG on 7/22/16 and certified on 7/22. The regs were submitted to DPB on 7/25. After a follow-up call with DPB on 9/6/16, the item was sent to HHR on 9/8/16; to the Governor on 9/21; and approved on 10/28. The regs were published in the Register on 11/28, with a comment forum through 1/27/17.

***(04) Repeal Family Planning Waiver Regulations:** The Family Planning program is a benefit to qualified low income families by providing them with the means for obtaining medical family planning services to avoid unintended pregnancies and increase the spacing between births to help promote healthier mothers and infants. The purpose of this amended regulation is to implement the change of the program from a demonstration waiver to the state plan option to be in compliance with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2011. This action had been placed hold, but has since been re-activated and the proposed stage was submitted to the OAG on 9/14/2015. The action was certified by OAG on 12/11/2015; submitted to DPB; and subsequently sent to HHR on 1/28/2016. The regulatory action was sent to the Governor on 4/5/2016 and signed on 6/3. The regulatory action was published in the Register on 6/27, with a public comment period that extended through 8/26, with no comments received. The project transitioned to the Final Stage phase, and following internal DMAS review, the regulations were submitted to DPB on 10/27/2016; to HHR on 11/4/16; and are currently with the Governor's Ofc., as of 11/20/16.

2012 General Assembly

***(01) Mental Health Skill-Building Services:** The Emergency/NOIRA complied with the *2012 Acts of the Assembly*, Chapter 3, Item 307 LL that directed programmatic changes to Community Mental Health services to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The *2012 Acts of Assembly*, Chapter 3, Item 307 RR (f) directed DMAS to implement a mandatory care coordination model for Behavioral Health. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Services. Emergency regulations became effective 10/10/13. DMAS received an extension, and the ER will last until 10/19/15. The proposed stage public comment period closed on 10/23/2015 and DMAS submitted final stage documents to the OAG on 2/12/2016. DMAS responded to a 3/22/2016 OAG request for revisions on 4/12/2016 and the OAG certified the regulatory action on 4/25/2016. The action was submitted to DPB on 4/25; to HHR on 5/10/2016; and to the Governor on 5/11/2016. The Gov. signed the regulatory action on 6/3; it was published on 6/27; and became effective on 7/27/16. The corresponding SPA package was drafted and began circulating on 8/8/16. The SPA was submitted to HHR on 8/24 and then on to CMS on 9/6/16. DMAS is currently in the process of responding to additional CMS inquiries.

(02) Appeals Regulations Update: This Emergency/NOIRA regulatory action complied with the legislative mandate (Item 307, III of the *2012 Acts of Assembly*) and addressed recent case law and administrative decisions. These actions have created the need to clarify existing appeals processes and codify emerging processes made urgent by court and administrative case decisions and the increasing volume of appeals generated by provider audits and other utilization review mandates. The SPA was approved by CMS 12/12/12. DMAS received an extension of the emergency regulation, and it was in effect from 1/1/14-12/30/15. The Governor signed the proposed stage regulation and a public comment period opened on 11/2/2015. The final stage regulation was drafted and sent to the OAG on 4/4/2016. DMAS responded to OAG inquiries on 4/20. The OAG approved this regulatory action on 4/28/2016 and it was submitted to DPB on 4/28/2016.

2011 General Assembly

***(01) Inpatient and Outpatient Rehabilitation Update:** This Fast-Track action resulted from internal agency review. DMAS updated 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 were repealed and some of the retained requirements formerly located in that Chapter were moved to Chapters 50 and 60. Outdated, duplicative, and unnecessary regulatory requirements in Chapter 130 were repealed. This regulatory package was published in the Register on 11/16/2015 and became effective on 1/1/2016. A corresponding state plan amendment containing affected parallel regulatory changes was circulated for internal DMAS review on 2/29/2016, prior to OAG submission. The corresponding SPA, SPA 16-001 was circulated for internal DMAS review on 2/29/2016 and subsequently submitted to CMS on 3/23/16. Per request, revisions were made to the SPA and it was re-submitted to

CMS on 3/28/16. Additional revisions were made at the request of CMS and revised info was submitted on 4/22/2016. More questions were sent by CMS via email on 5/10/2016. DMAS submitted informal SPA submission responses, in response to their Request for Additional Information (RAI). A conference call with CMS took place on 9/29 to further discuss DMAS' RAI responses. DMAS sent additional info to CMS on 10/13. Resulting inquiries were received from CMS on 11/3. DMAS sent further clarifying content on 12/7 and is awaiting a response to complete RAI.

2010 General Assembly

(01) Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications: This Emergency/NOIRA action complied with the 2010 Appropriations Act that required DMAS to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. The final regulations became effective 1/30/2015. A SPA was submitted to CMS on 3/25/15. CMS sent a Request for Additional Information on 6/10/2015 and DMAS submitted responses. During a subsequent conference call with CMS, on 10/20/2015, DMAS took this project off the clock in order to prepare additional changes requested by CMS. DMAS resubmitted SPA changes to CMS on 3/1/2016 and again on 5/5/2016, in response to additional follow-up questions. SPA was again taken off the clock to coordinate revisions, which are currently underway.

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.

JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

Summary: Managing Spending in Virginia's Medicaid Program

WHAT WE FOUND

Medicaid spending growth continues to pressure general fund budget, but spending per enrollee has been flat, accounting for inflation

Total inflation-adjusted growth of Medicaid spending per enrollee in Virginia was nearly flat—just 0.36 percent, adjusted for inflation—over the past five years (FY11–FY15). Total spending increased due to rising enrollment (16.5 percent enrollment increase). Enrollment growth was due to a variety of factors, including increased program awareness and additional waiver slots for individuals with intellectual and developmental disabilities.

Medicaid spending places increasing pressure on the state general fund budget, even though per enrollee spending growth has been flat in real terms. Medicaid general fund spending has grown by an average of 8.9 percent annually over the past 10 years, while total general fund spending increased by just 1.3 percent. Medicaid spending comprised 22 percent of the general fund budget in FY16, increasing from 14 percent in FY07.

WHY WE DID THIS STUDY

The General Assembly directed JLARC to review the cost-effectiveness of Virginia's Medicaid program. Medicaid spending increases have outpaced total state budget growth over the past 10 years, requiring a greater portion of the Virginia's budget resources.

ABOUT VIRGINIA'S MEDICAID PROGRAM

The Virginia Medicaid program provides medical, long-term care, and behavioral health services to more than one million individuals each year. The Department of Medical Assistance Services (DMAS), which administers the program, paid $8.2 billion for services in FY15, half of which was from the general fund.

LTSS eligibility screening process creates risk of unreliable results

The current process to determine functional eligibility for long-term services and supports (LTSS), and inadequate DMAS oversight, create the risk of unreliable screening results. The cost of services for this population is high ($2.35 billion in FY15), and reliable eligibility screening is critical to ensure equitable access to services for only eligible individuals. The tool used to screen applicants has never been validated for use on children, who comprise an increasing number of LTSS applicants and recipients. There are also more than 200 entities that perform screenings in Virginia, including hospitals and community-based teams, but consistent training for these teams is not provided or required. There is significant variation in screening results across these entities, with approval rates across community-based teams ranging from a low of 37 percent to a high of 98 percent in FY16.

Opportunities exist to provide more cost-effective LTSS services in the community

Once individuals are determined to be eligible for LTSS, they need to be provided appropriate services in the most cost-effective setting. Virginia has demonstrated success in recent years keeping recipients in the community (known as rebalancing), rather than in higher-cost institutional settings, but there are opportunities for further rebalancing. MCOs will be responsible for many aspects of rebalancing following the implementation of MLTSS. Other states use strong incentives for MCOs to serve recipients in lower cost community settings.

Under the current fee-for-service system, a conflict of interest exists for providers, who determine type and amount of LTSS services. A provider's financial interest may conflict with the state's interest in ensuring cost-effective and appropriate care. This conflict of interest will continue to some extent after DMAS transitions to its managed LTSS program.

DMAS has not prioritized opportunities to control spending in its managed care program

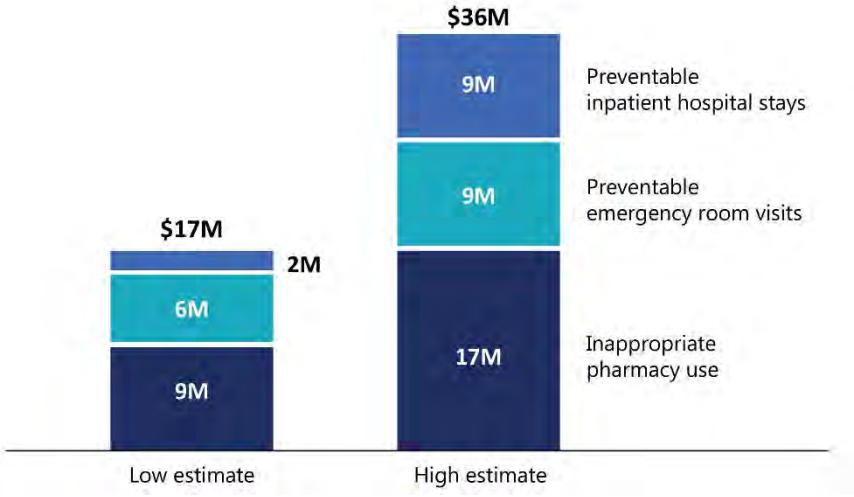
DMAS has historically taken a passive approach to MCO financial oversight, instead prioritizing efforts to oversee managed care quality. Focusing on quality can produce long-term cost savings, but this needs to be balanced with strategies to more directly control spending. DMAS has not maximized opportunities to control spending, and as a result, MCOs earn higher profits in Virginia than in other states.

DMAS currently does not obtain and analyze sufficient data to effectively oversee MCO spending. This limits its ability to ensure that capitation rates are not higher than necessary and that profit caps are effectively enforced. DMAS has also not enforced a majority of sanctions under its new contract compliance process.

DMAS has paid MCOs more than necessary and Virginia's profit cap is more lenient than other states

DMAS has not strategically set capitation rates paid to MCOs to ensure they are not higher than necessary, leading to larger than anticipated MCO profits. DMAS has not identified and adjusted MCO capitation payments for inefficient spending on preventable emergency room visits, hospital stays, and inappropriate pharmacy use. In FY16, Virginia could have saved $17–36 million by not paying MCOs for the inefficient provision of services. DMAS also does not adjust administrative spending for enrollment increases, and these adjustments would have reduced spending by as much as $8 million in FY16.

Virginia could have saved $17–36 million by not paying MCOs for inefficient health care services (FY16)



SOURCE: JLARC staff analysis of 2011-2015 MCO reports to Virginia's Bureau of Insurance, Milliman reports on Medicaid MCO financial performance, and interviews with DMAS staff.

DMAS uses a profit cap, but Virginia's cap is more lenient than other states. The profit cap is an effective tool to retroactively ensure the state does not overpay MCOs and limit the state's risk if capitation payments are higher than necessary. Virginia MCOs have made profits that are, on average, above actuarial and national benchmarks. Three other states use a profit cap similar to Virginia's, and all three require MCOs to repay funds at lower profit levels than Virginia.

WHAT WE RECOMMEND

Legislative action

- Direct DMAS to develop comprehensive training curriculum for individuals who screen applicants for LTSS eligibility and amend the Code of Virginia to require all screeners be trained and certified.
- Direct DMAS to identify the steps required to ensure that LTSS screenings performed by hospitals are done consistently and do not lead to unnecessary institutional placements.
- Direct DMAS to implement a more stringent, tiered profit cap for the Medallion program and implement a profit cap for the MLTSS program.

Executive action

- DMAS should develop consistent, mandatory training for LTSS functional screenings and test screening results for reliability.

- DMAS should implement a strong incentive, through a blended capitation rate, for MLTSS MCOs to serve recipients in the community.
- DMAS and its actuary should adjust Medallion capitation rates for expected efficiencies.
- DMAS should obtain and use robust spending, utilization, and population-specific data to improve its oversight of MCOs.

The complete list of 35 recommendations is available on page v.

INTRODUCING THE OFFICE OF INNOVATION & STRATEGY

BMAS Retreat

December 2016


WHEN DMAS
SUCCEEDS,
VIRGINIANS SUCCEED

The Office of Innovation and Strategy provides collaborative thought leadership to catalyze and sustain continuous innovation of Virginia's Medicaid delivery system.

The Office of Innovation and Strategy leads multiple facets of Medicaid health innovation to support DMAS' continued national presence as a recognized leader in the delivery of high quality, comprehensive health and support services.

Introduction

Office of Innovation & Strategy current focus areas:

DELIVERY SYSTEM

Delivery System

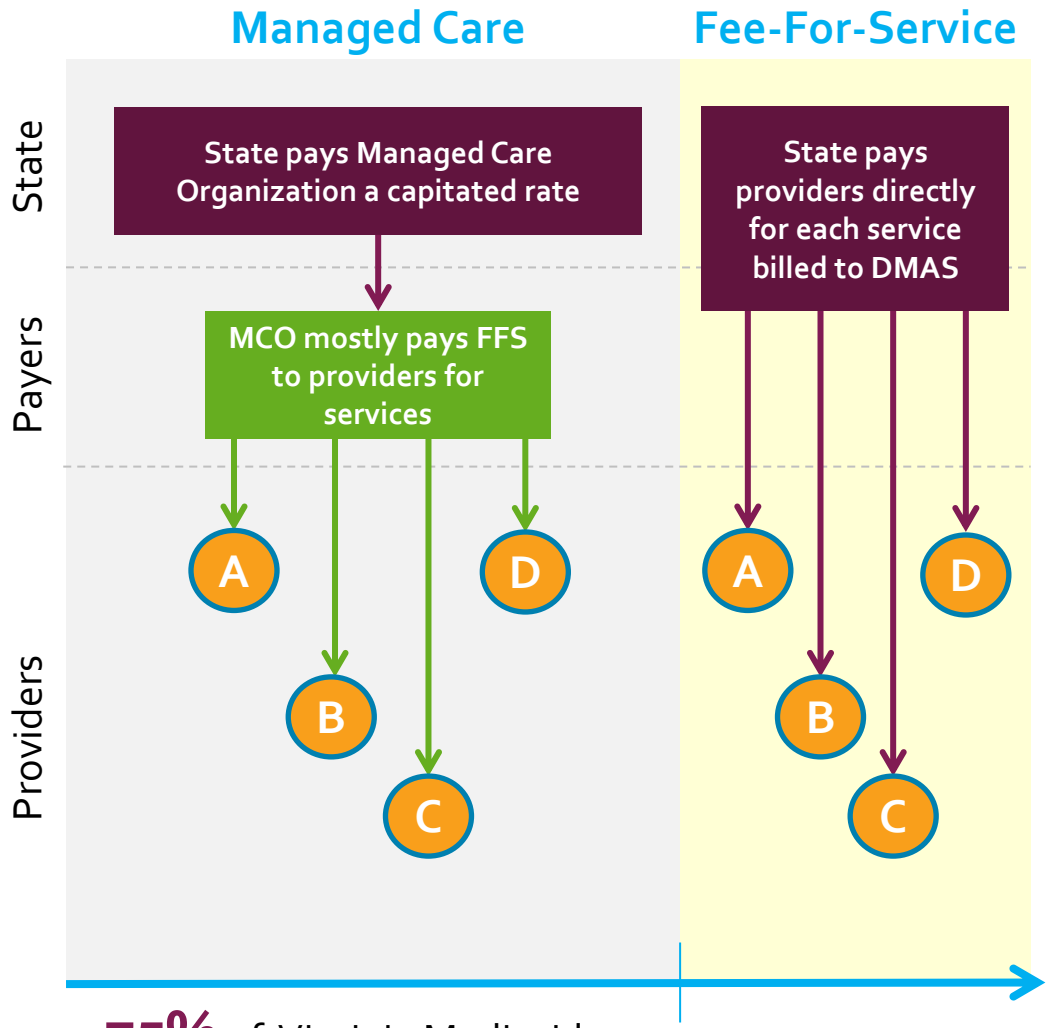
States are engaged in array of multi-payer delivery system reform and the impact is across the entire continuum of care

- Delivery models
- Value Based Payments
- Social Determinants
- Workforce

What is a delivery system?

A combination and organization of providers, health care settings, and resources that deliver health care services to meet the health needs of the Medicaid population

Virginia Medicaid Payment Models



75% of Virginia Medicaid members are in managed care

Benefits of Managed Care

- Offers a broader provider network
- Provides flexibility – can include services that cannot be provided in fee-for-service
- Actuarial soundness ensures rates are not too low
- Facilitates member navigation through health care system
- Medicaid is no longer a "welfare program" – it is health coverage
- Private sector shares risk with government

Managed care initiated health care reform, VBP drives payment reform to the provider level.

INTRODUCING VALUE-BASED PAYMENT

Introducing Value – Based Payments

Paying for value, not volume

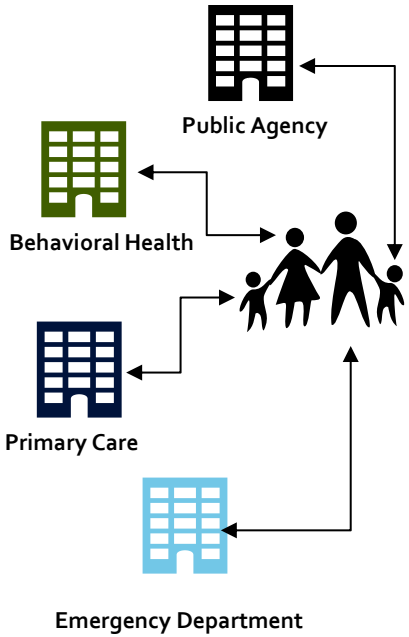
Value-based payment reform means creating payment structures that tie provider financial success to patient receipt of high-quality, efficient care

Challenges of FFS Model

Rewards Volume Instead of Value

- Reimbursement tied to **utilization**
- Limited provider **readiness** for APMs
- Financial incentives **not aligned** for interdisciplinary community-based care

Reinforces Care Silos



Social determinants frequently excluded

Impedes Collaboration

- Limited **infrastructure** for information sharing
- Lack of **provider partnerships** limits capacity for care transitions and care coordination
- **Institutional settings** are either the only resort for care or the path of least resistance

Contributing Factors

Current payment models contribute to…

Current fee-for-service payment models incent providers to produce greater volume of care, not greater value

Needed infrastructure investments at the provider level, such as upgraded technology for information sharing

The health care payment structure creates an inefficient cost growth trajectory and impacts quality outcomes

Reforming Virginia's delivery system means investing in providers and tying provider payments to quality outcomes

Value – Based Payments

Multiple drivers towards value-based payments

- Multiple **federal catalysts** towards value-based payments
  - HHS and CMS efforts
  - Recent MACRA legislation

- In addition to the federal government, **states** are also driving progression to alternative payments

> "…we have the opportunity to shape the way care is delivered and improve the quality of care system wide, while helping to reduce the growth of health care costs."
>
> - Secretary Sylvia Burwell, HHS
> New England Journal of Medicine
> 2015

Drivers of Reform

Federal and state catalysts transforming payment

ACA

ACO's, expanded pay-for-performance, CMMI testing alternative payment models

Medicare

Medicare working towards 90% payments in value-based models by 2018

MACRA

Merit-based incentive payment system (MIPS) and alternative payment models (APMs)

Other States

Arizona
Arkansas
Colorado
Iowa
Michigan
New York
Ohio
Oklahoma
Rhode Island
S. Carolina
Tennessee
Washington

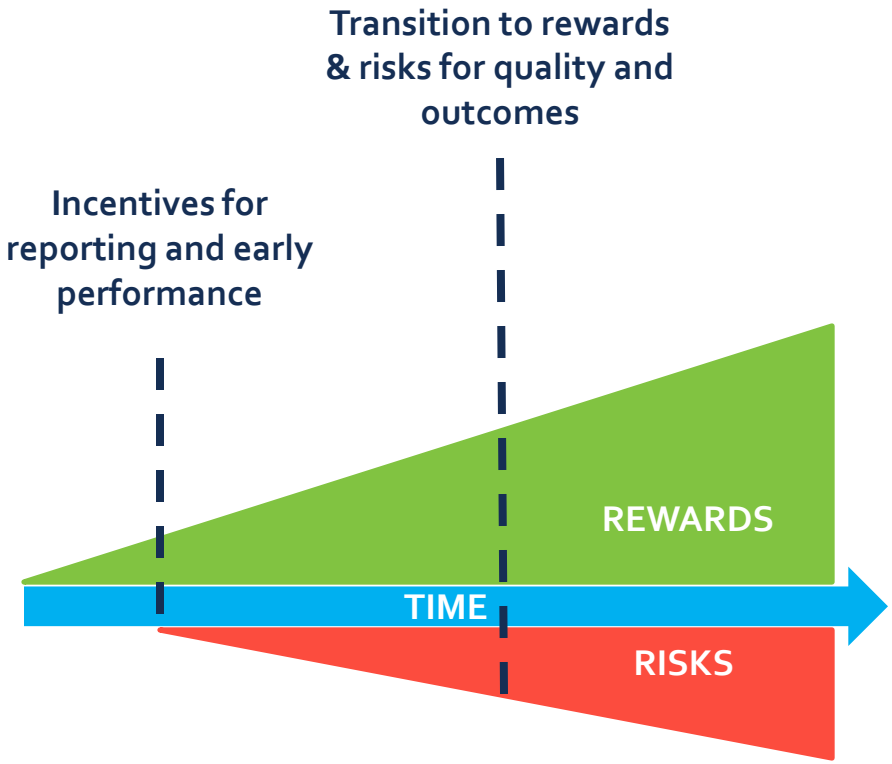
Payment Framework

Alternative Payment Model (APM) Framework provides a continuum of payment models

The Health Care Payment Learning & Action Network (HCP-LAN) was created to **drive alignment** in payment approaches across the public and private sectors of the U.S. health care system.

The HCP-LAN created a **common framework** for adoption and measurement of VBP across all payer types (Medicare, Medicaid, and Commercial)

Questions to Consider

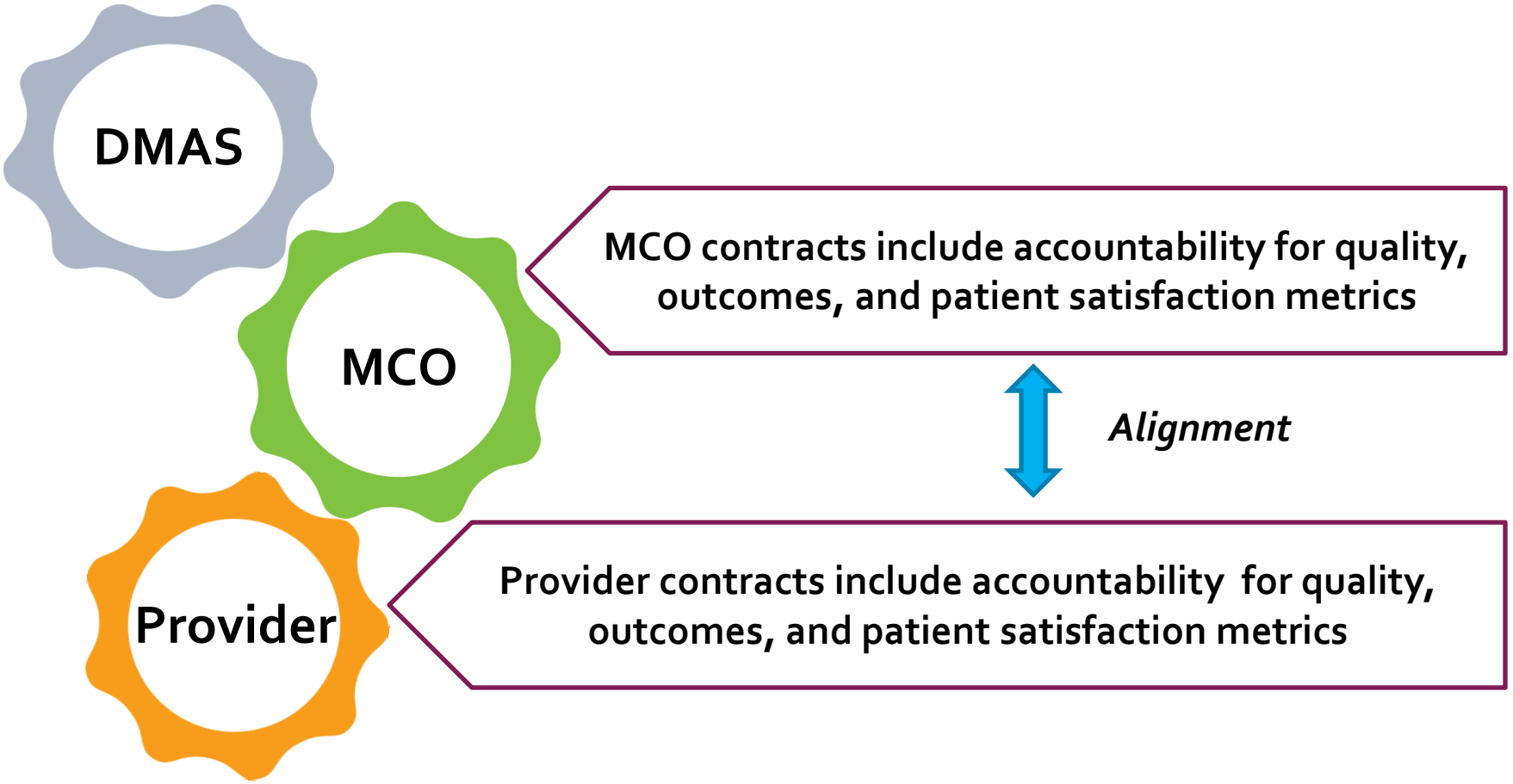


Performance Based Payments Increase with Time

Examples of High Priority Areas

- Utilization and Cost of Care
- Patient and Provider Satisfaction
- Percent of LTSS in the community
- Percent of Payments in VBP
- Increased Transparency
- Enhanced Care Quality and Access

Aligning Accountability Across Payers & Providers



Aligned metrics and accountability incentivizes both MCOs and Providers to deliver high-quality and efficient patient care

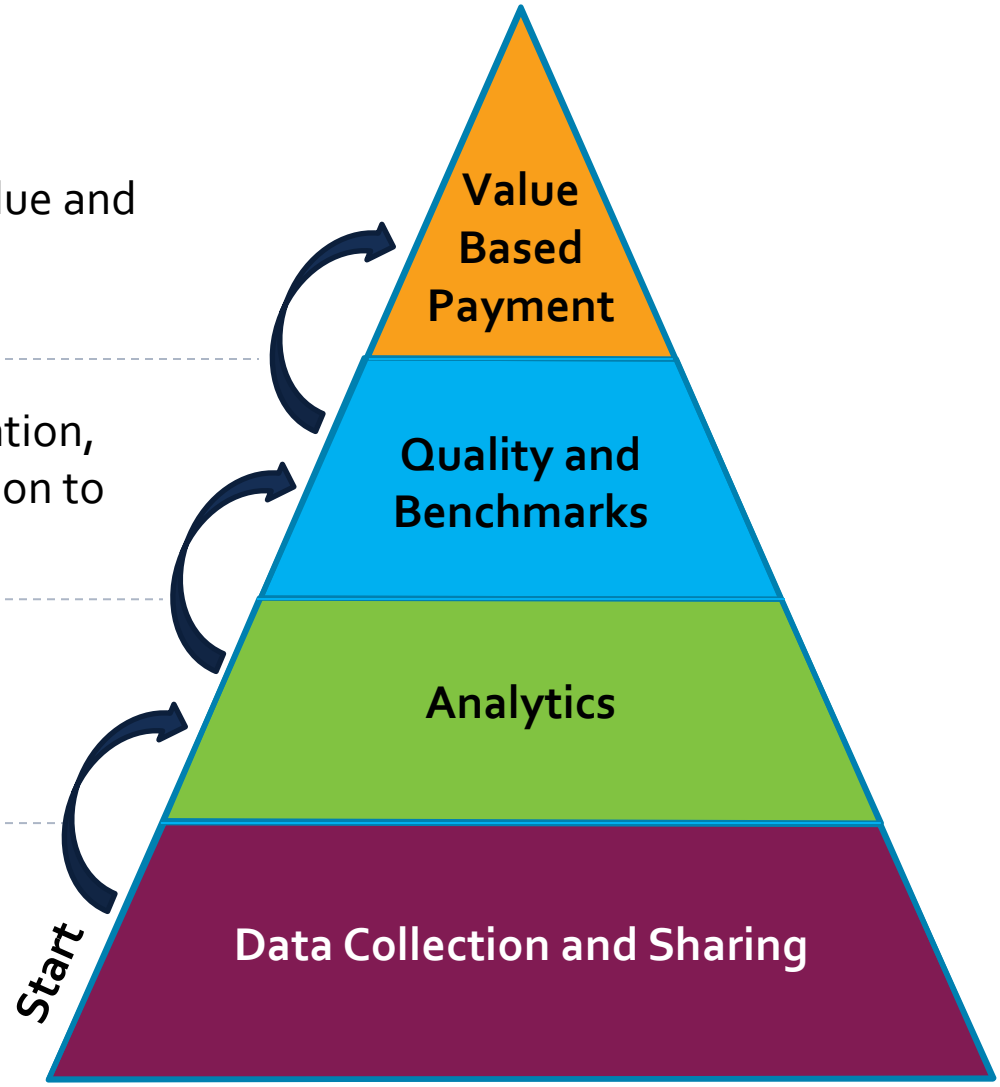
Payment Transformation Starts with Data

Transform payment methods to reward value and outcomes

Design and implement practice transformation, provider partnerships, and clinical integration to improve quality of outcomes

Build "timely" analytics tools

Build data collection tools and data sharing capabilities among medical, behavioral health, LTSS, and social determinants



The Time is Right for VBP

Virginia can achieve the greatest benefit of APMs by…

Incrementally leveraging the managed care procurements to align incentives with patient outcomes

Incenting and supporting providers across the entire health care delivery system to transform how care is delivered

Implementing sustainable solutions that are market-driven will offer lasting results

Current Efforts

Learning & Analysis:

1. Potentially Preventable Events Analysis (3M software)
2. CMS Innovator Accelerator Programs
3. VCHI Speaker Series
    1. Denver Health
    2. Maryland CRISP
    3. Oklahoma
    4. Michigan
4. VHHA Readmissions Initiative *(Home is the Hub)*
5. High Risk Pregnancy Analysis
6. National Conversation:
    1. HMA – Integrated Delivery System
    2. 3M Value-Based Care
    3. HCP-LAN Fall Summit
    4. NY DSRIP Learning Symposium

CMS Engagement:

1. SIM Request for Information (CMMI)
2. HCP-LAN Primary Care Payment Model
3. HCP-LAN Maternity Action Collaborative

MCO and Provider Engagement:

1. Medallion 3.0 – VBP Status Report
2. CCC Plus – Delivery System and Value-Based Payment
3. ARTS – Substance Abuse Care Coordination Value-Based Payment

Other:

1. Recruiting and hiring key staff
2. Medicaid Value Based Payment Roadmap
3. Community Health Worker Advisory Group
4. Housing and Social Determinants

STRATEGY

Agency Strategy

Supporting cross-divisional process alignment and external communications

Processes

- What are the end-to-end business process?
- Are new processes needed to support DMAS' goals and objectives for the future?

Communications

- How are we communicating with our stakeholders?
- How can we improve our website?

External and Internal Sources of Projects

Federal Sources

- CMS
- US Congress
- Court Decisions – (e.g. DOJ Settlement, Appeals)
- Federal Grant Opportunities
- OIG

State Sources

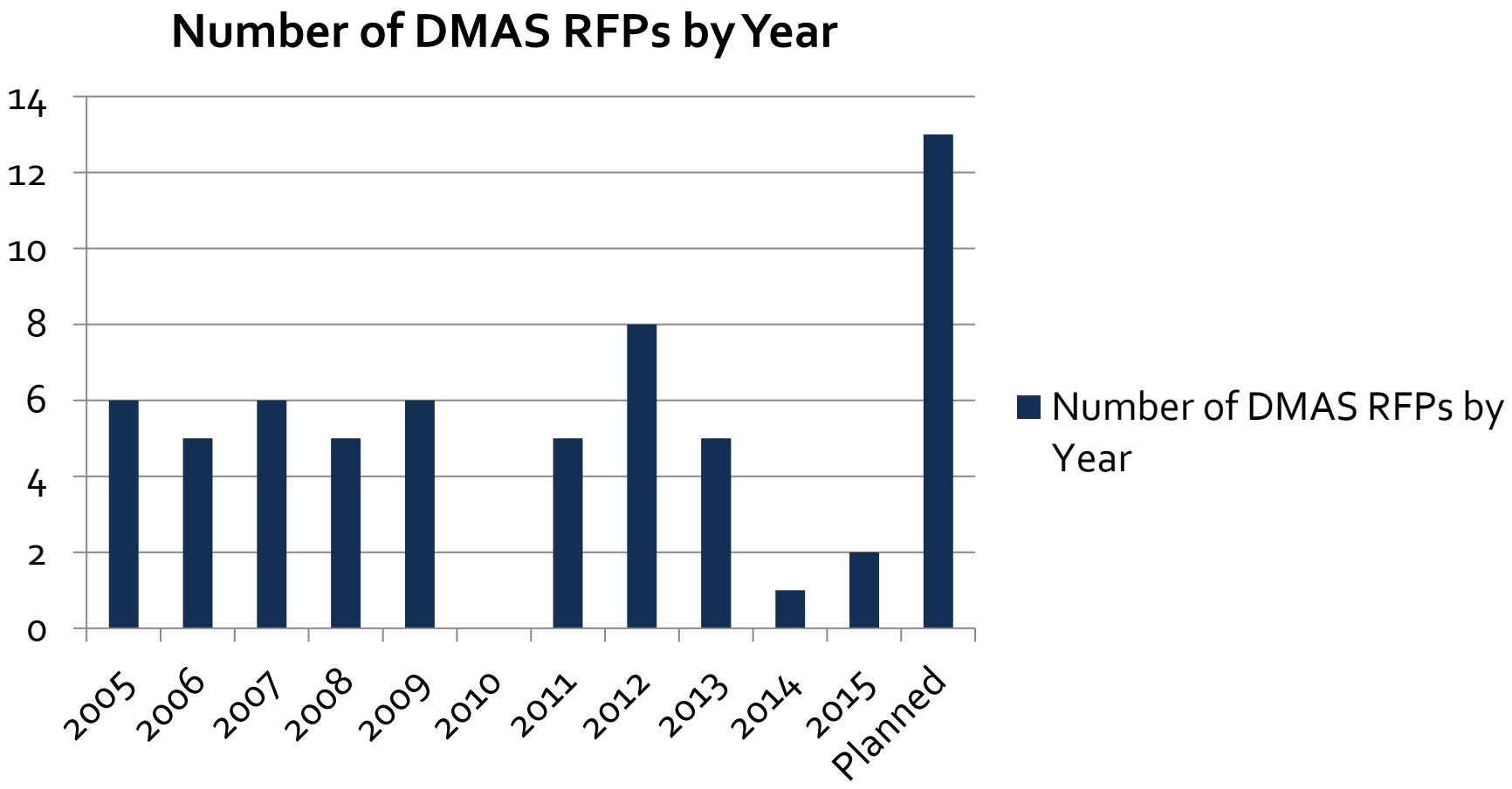
- Governor
- Virginia General Assembly
  - JCHC
  - JLARC
  - Money Committee Staff
- OSHHR
- BMAS
- Other State Agencies
- Vendors
- Stakeholders
- Enrollees
- APA

Internal DMAS

- Ongoing DMAS Operations
- DMAS Contract Expirations
- Ideas captured from other states, conferences, etc..
- Program Improvement (enhancements)
- Program Challenges

RFP Volume History

Unprecedented number of planned procurements



Strategic Alignment

The value of DMAS strategic alignment…

Optimize Strategic Roadmap

- Prioritize and Plan
- Leverage synergies

Coordinate Interdependencies

- Collaborate across divisions
- Row in the same direction

Manage Risks

- Facilitate discussion on people, operational, and financial risks

Initiatives Roadmap Development

Change the Business Projects

- Larger scale projects
- Transformation
- Major regulatory requirements
- Impacts the business model

Run the Business Projects

- Continuous improvement projects
- Supports general "running of the business"
- Smaller scale regulatory changes
- Improves internal operations

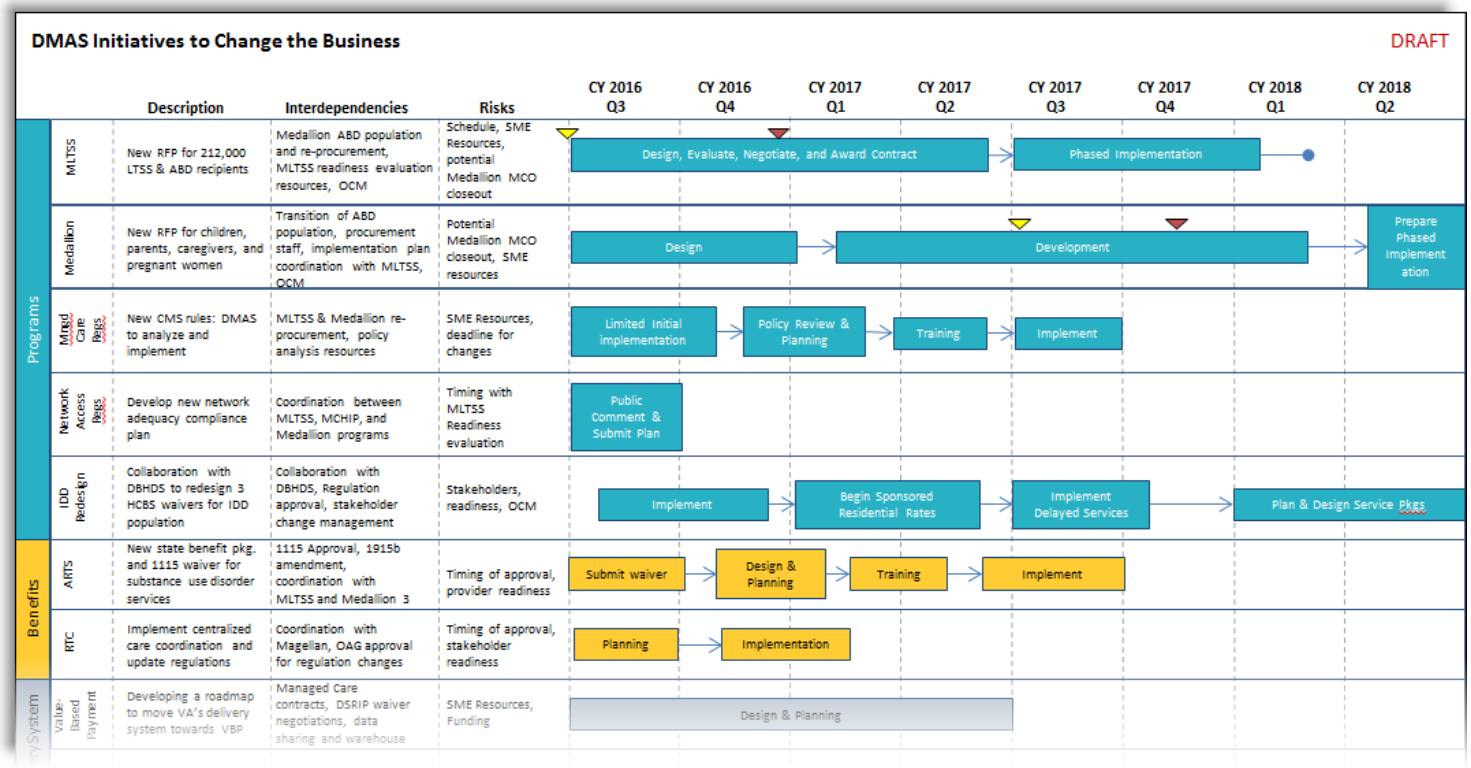
Daily Operations

- Ongoing functions and processes to support regular operations

Met with over 35 people – Deputies, Division Directors, Managers, and Project Managers

Strategic Roadmap

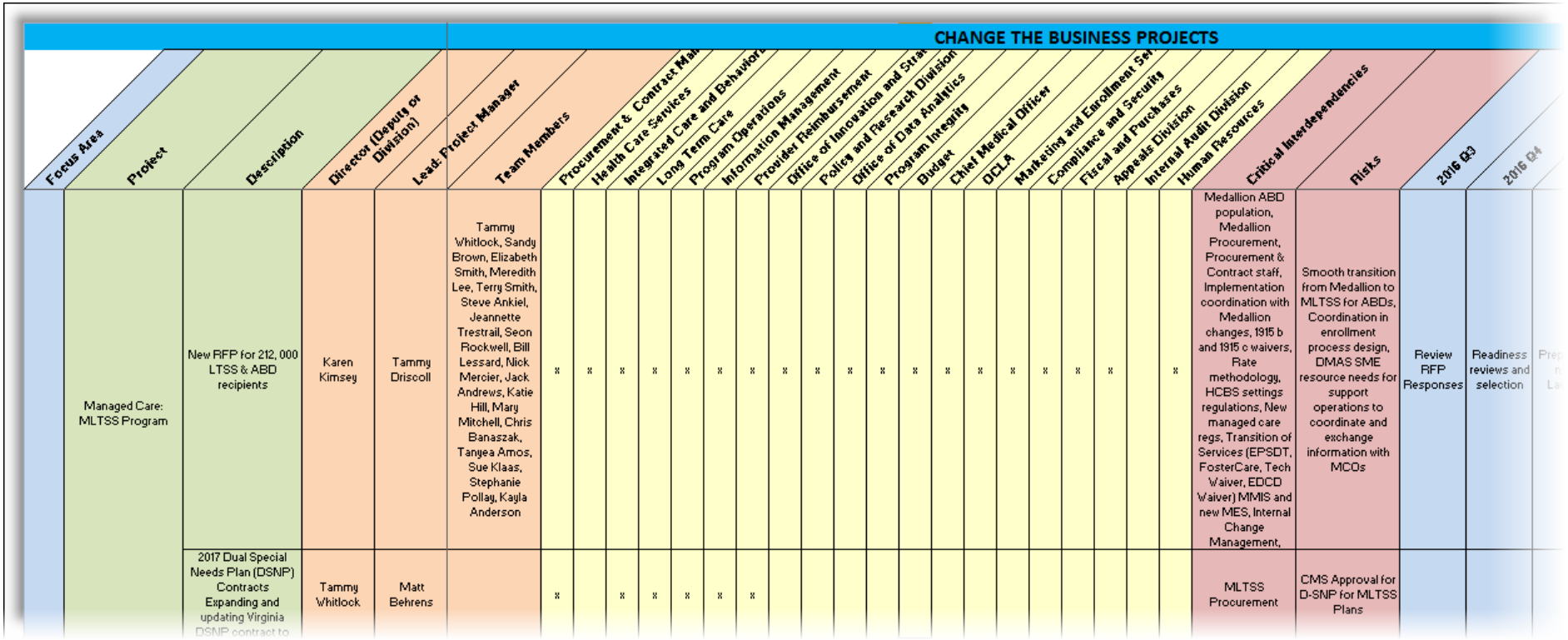
A high-level overview of DMAS initiatives



- Major "Change the Business" initiatives
- Key interdependencies
- Major milestones for next 8 quarters

Detailed Inventory of Initiatives

An in-depth look at DMAS initiatives



CHANGE THE BUSINESS PROJECTS

Focus Area	Project	Description	Director (Deputy or Division)	Lead Project Manager	Team Members	Procurement & Contract Mgt	Health Care Services	Integrated Care and Behavioral	Long Term Care	Program Operations	Information Management	Provider Reimbursement	Office of Innovation and Strat	Policy and Research Division	Office of Data Analytics	Program Integrity	Budget	Chief Medical Officer	DCLA	Marketing and Enrollment Ser	Compliance and Security	Fiscal and Purchases	Appeals Division	Internal Audit Division	Human Resources	Critical Interdependencies	Risks	2016 Q3	2016 Q4
	Managed Care: MLTSS Program	New RFP for 212, 000 LTSS & ABD recipients	Karen Kimsey	Tammy Driscoll	Tammy Whitlock, Sandy Brown, Elizabeth Smith, Meredith Lee, Terry Smith, Steve Ankiel, Jeannette Trestrail, Seon Rockwell, Bill Lessard, Nick Mercier, Jack Andrews, Katie Hill, Mary Mitchell, Chris Banaszak, Tanyea Amos, Sue Klaas, Stephanie Pollay, Kayla Anderson	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Medallion ABD population, Medallion Procurement, Procurement & Contract staff, Implementation coordination with Medallion changes, 1915 b and 1915 c waivers, Rate methodology, HCBS settings regulations, New managed care regs, Transition of Services (EPSDT, FosterCare, Tech Waiver, EDCD Waiver) MMIS and new MES, Internal Change Management,	Smooth transition from Medallion to MLTSS for ABDs, Coordination in enrollment process design, DMAS SME resource needs for support operations to coordinate and exchange information with MCOs	Review RFP Responses	Readiness reviews and selection
		2017 Dual Special Needs Plan (DSNP) Contracts Expanding and updating Virginia DSNP contract to	Tammy Whitlock	Matt Behrens		x		x	x	x	x	x														MLTSS Procurement	CMS Approval for D-SNP for MLTSS Plans		

- Dynamic inventory of initiatives
- Visual representation of interdependencies

Execution Excellence: Optimization

Opportunity to Optimize Strategic Roadmap

- Many concurrent efforts:
  - Over 40 Change the Business projects
  - Over 45 Run the Business projects
  - While maintaining daily operations
- DMAS dependent upon many external factors
- Success is dependent upon strong internal coordination

"DMAS is rebooting the whole agency at the same time"

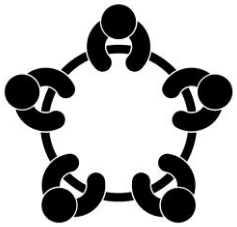
-Scott Crawford

WHAT'S NEXT

Next Steps

In the coming months, Innovation & Strategy will…

Support agency learning and advancement of delivery system reform



Facilitate cross-divisional collaboration to build DMAS' strategic roadmap for value-based payment

Lead an agency wide effort of mapping end-to-end processes

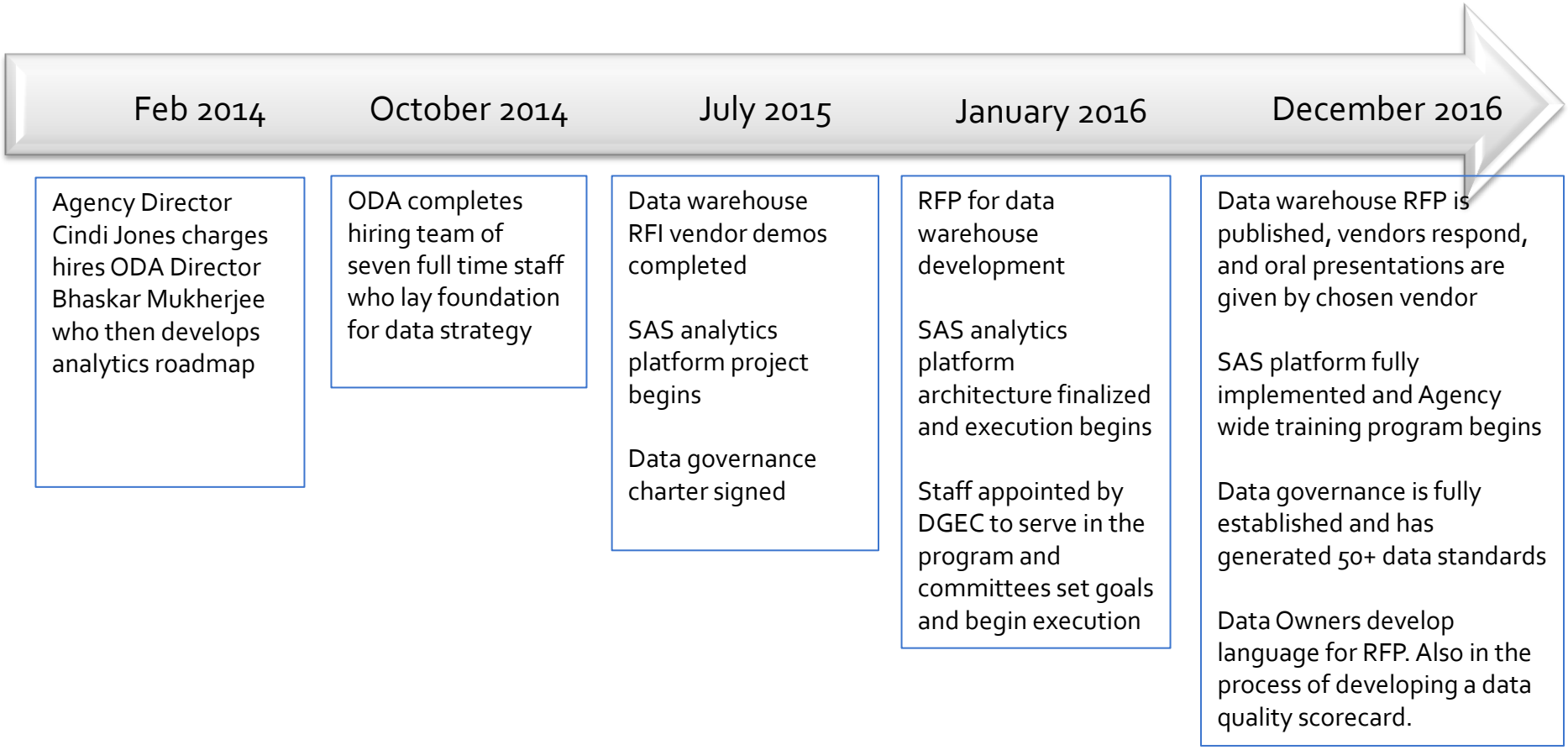
OFFICE OF DATA ANALYTICS

Bhaskar Mukherjee

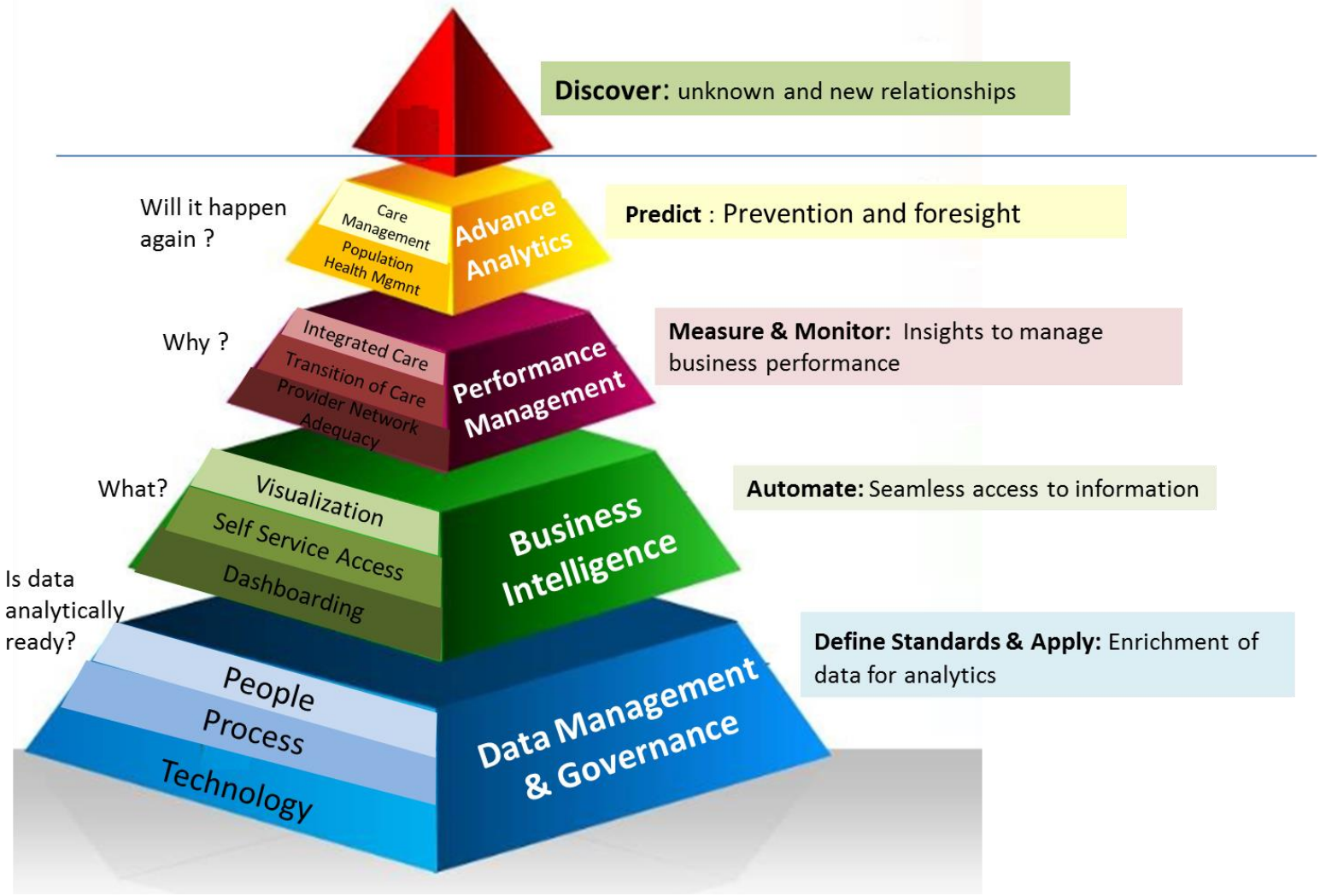
December 13, 2016

- A brief history
- Mission and strategy
- Integrated effort and success
- Data Governance program
- Data warehouse (single source of truth)
- Analytics platform
- Education and Training
- Future

A brief history

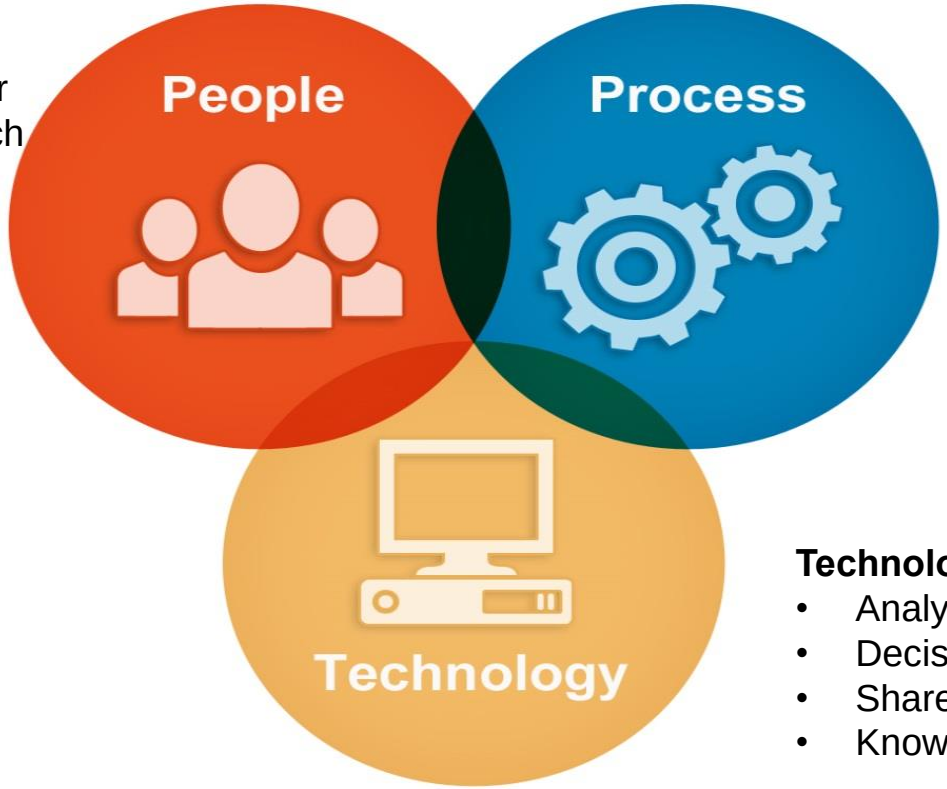


Mission and strategy



Mission and strategy

Investment in people
- Data Governance
- Data Stewardship
- Data Ownership
- Training, News Letter and Brown Bag Lunch



Analytic Processes
- Integrated Analysis
- Data Quality
- Metadata management
- Visualization
- Mining

Technology Support
- Analytics Platform
- Decision Support System
- SharePoint integration
- Knowledge Centre

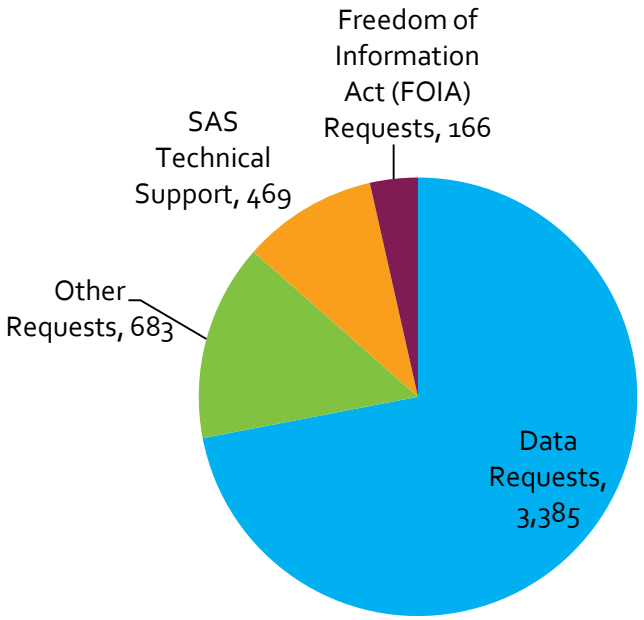
Integrated effort and success
Operational support

Office of Data Analytics provided **4,700+** hours of operational support to internal (DMAS) and external stakeholders

ODA Key Project Support Includes:

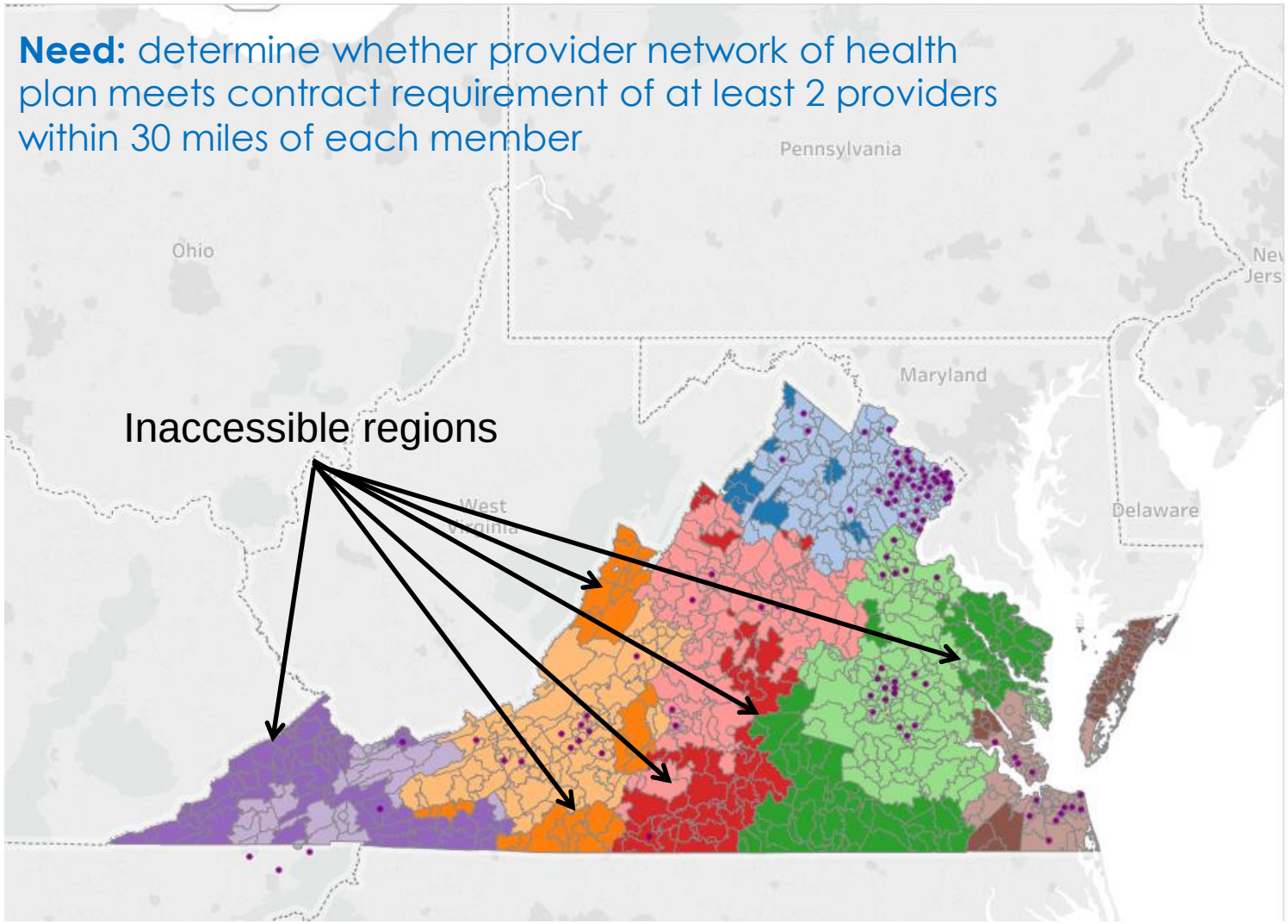
- CCCPlus Network Adequacy and Enrollment Projections
- Governor's Access Plan (GAP) Enrollment, Utilization, and Risk Modeling
- Hepatitis C treatment studies
- Addiction Recovery Treatment (ARTS) Network Adequacy
- Medicaid at a Glance/General Assembly support
- Dept. of Justice Brain Injury Fund settlement
- FAMIS Enrollment Analysis
- UVA Gun Study / NSF Duke Gun Study

ODA Hours of Operation Support
Mar 2014 - Dec 2016

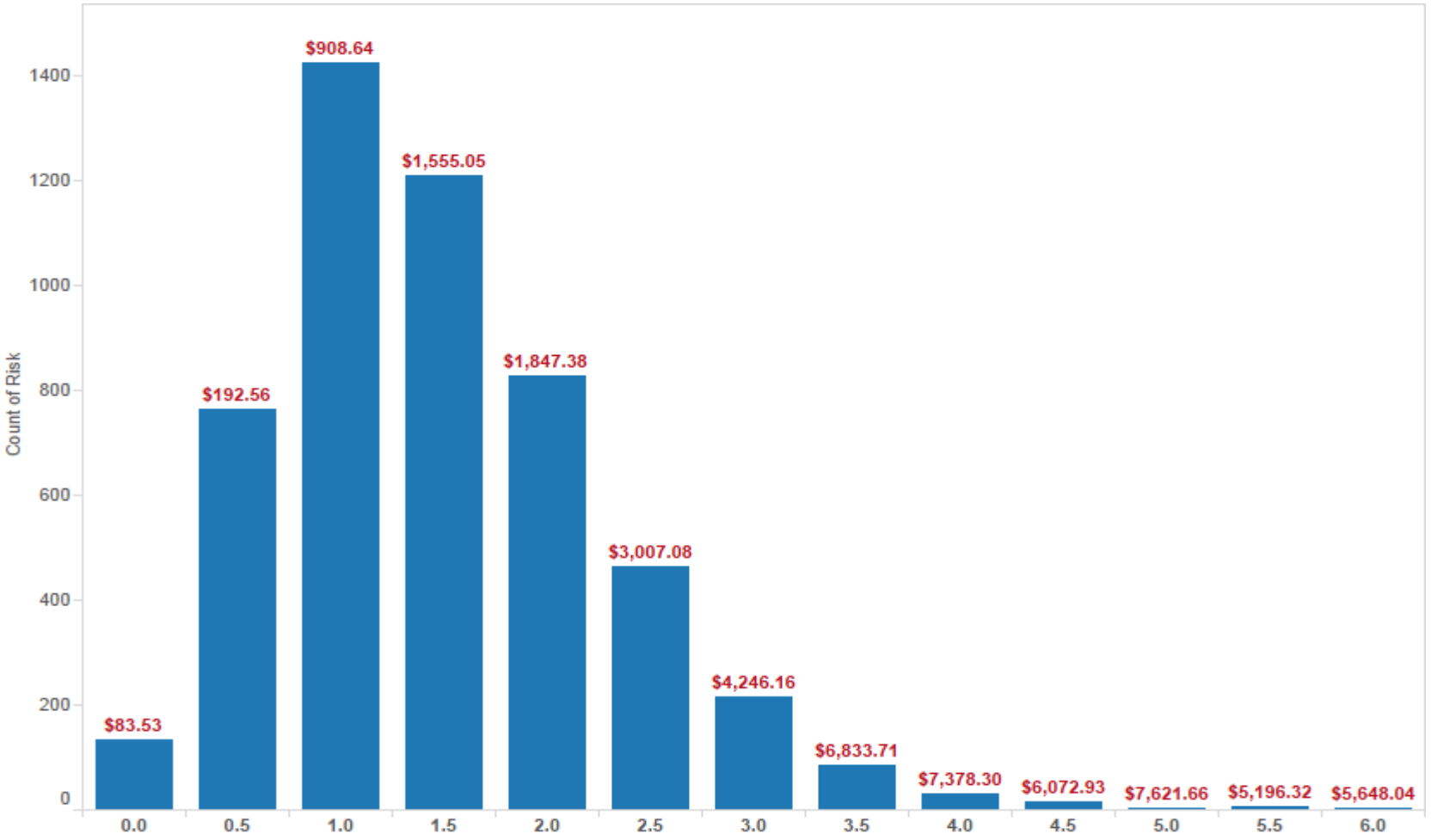


Integrated effort and success
Network adequacy

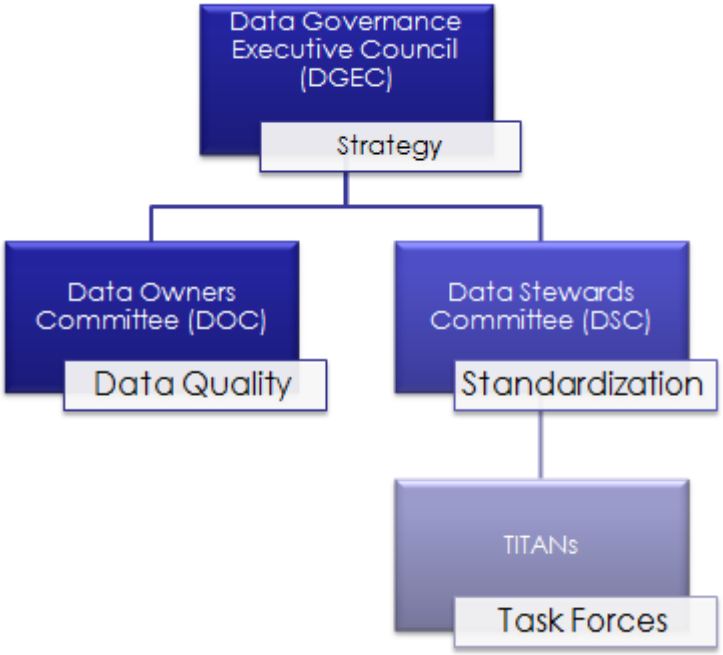
Need: determine whether provider network of health plan meets contract requirement of at least 2 providers within 30 miles of each member



Integrated effort and success
Governor's access plan reporting



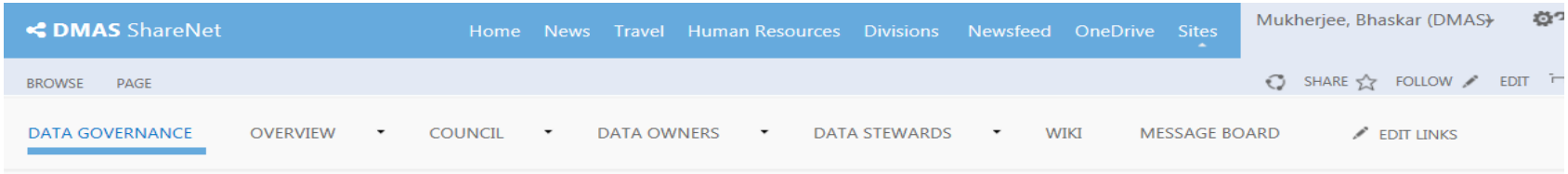
Data Governance program



***Vision of the data governance**:*

…to guide our management of data as an Agency-wide asset, which is standardized data, integrated knowledge, and use it to enhance analysis, in order to facilitate and encourage data driven decision-making.

Data Governance Knowledge repository



FIPS codes under 20,000 residents

Submitted and raitifed by the DMAS Data Governance Stewards on Friday, July 29, 2016

1. Term
2. Overview
3. Technical Definition
4. Relevant Data Elements and Data Sources
5. DMAS Policy
6. Federal and State Statutes or Regulations
7. Acronyms / Other Terms
8. See Also
9. References
10. External Resources
11. IDs and Links

Overview

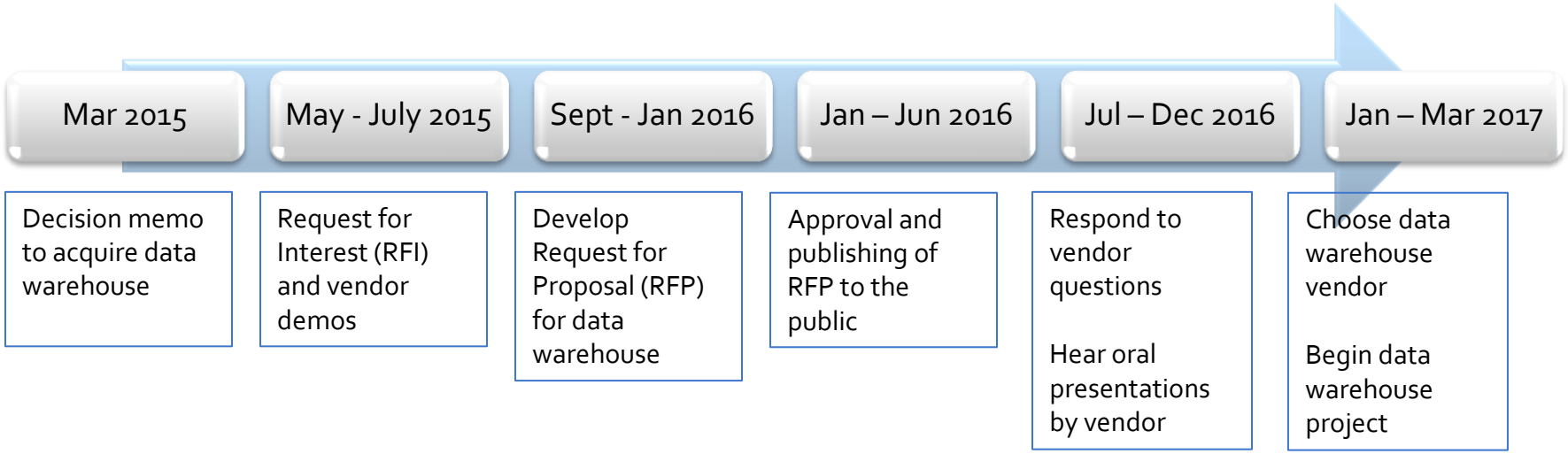
A Federal Information Processing Standard (FIPS) code has five digits and uniquely identifies counties and county equivalents in the US. This entry describes Virginia FIPS codes with less than 20,000 residents. It is the opinion of the Office of the Attorney General that any summarized data on Medicaid/CHIP members in geographic regions (e.g. cities, counties) with less than 20,000 total residents should not be made externally available. Rather, such FIPS codes must be grouped in a way that the geographic region being described is greater than 20,000 residents.

Technical Definition

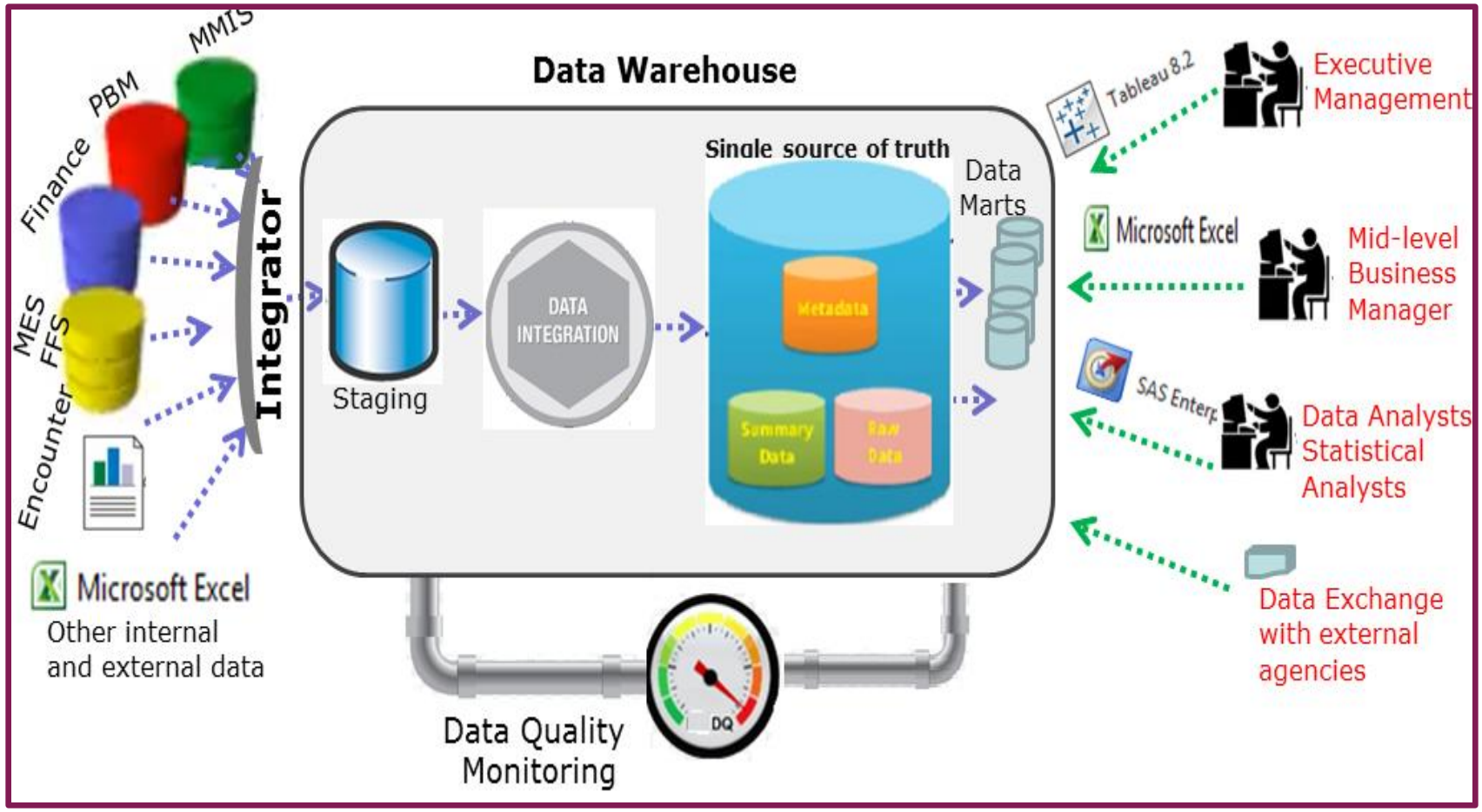
A Federal Information Processing Standard (FIPS) code has five digits and uniquely identifies counties and county equivalents in the US. For Virginia, all FIPS codes begin with 51, and the remaining three digits are specific to a county or county equivalent. For example, Alleghany is 005, but for purposes of visualization tools (e.g. Tableau) would be 51005.

To meet the privacy provisions of HIPAA when releasing external reports, the Virginia Attorney General's office has advised DMAS that FIPS codes for counties or county equivalents with 20,000 residents or less need to be

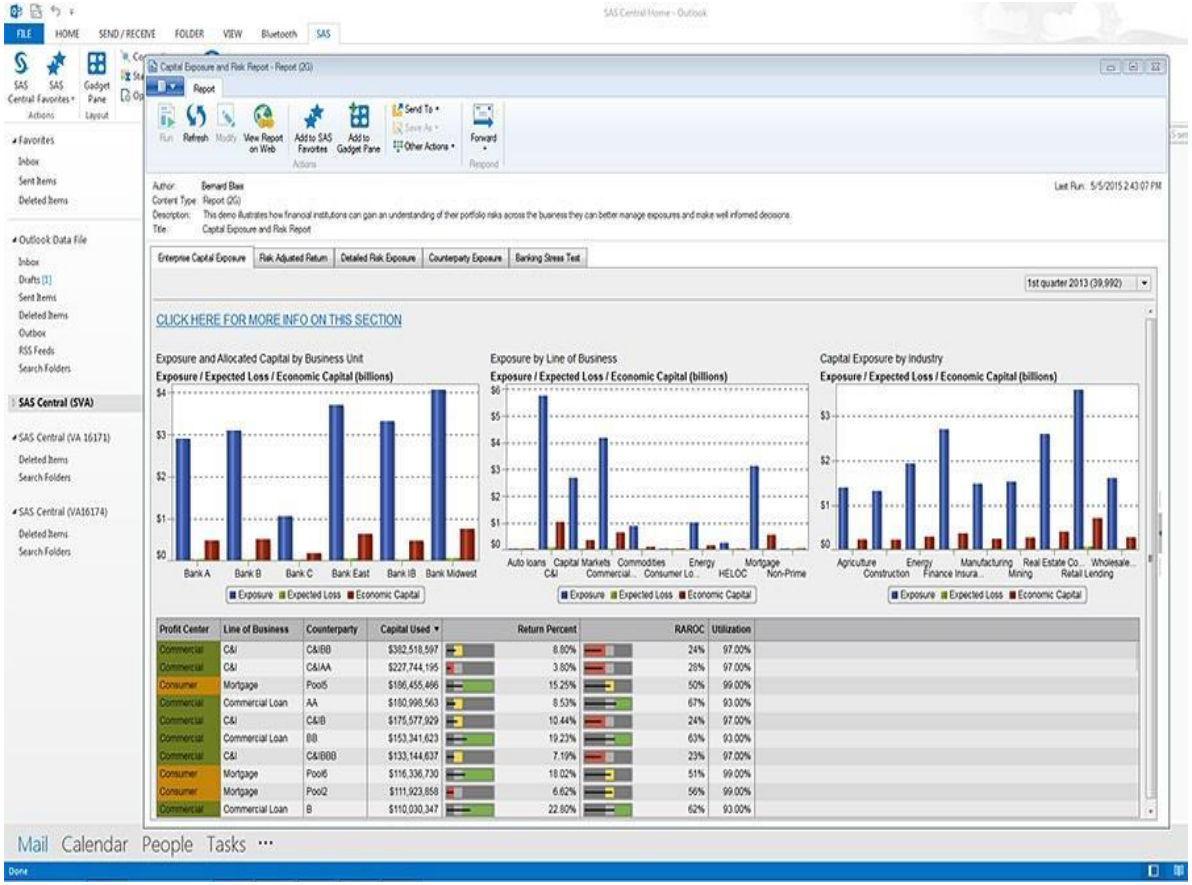
Data warehouse



Data warehouse
Single source of truth



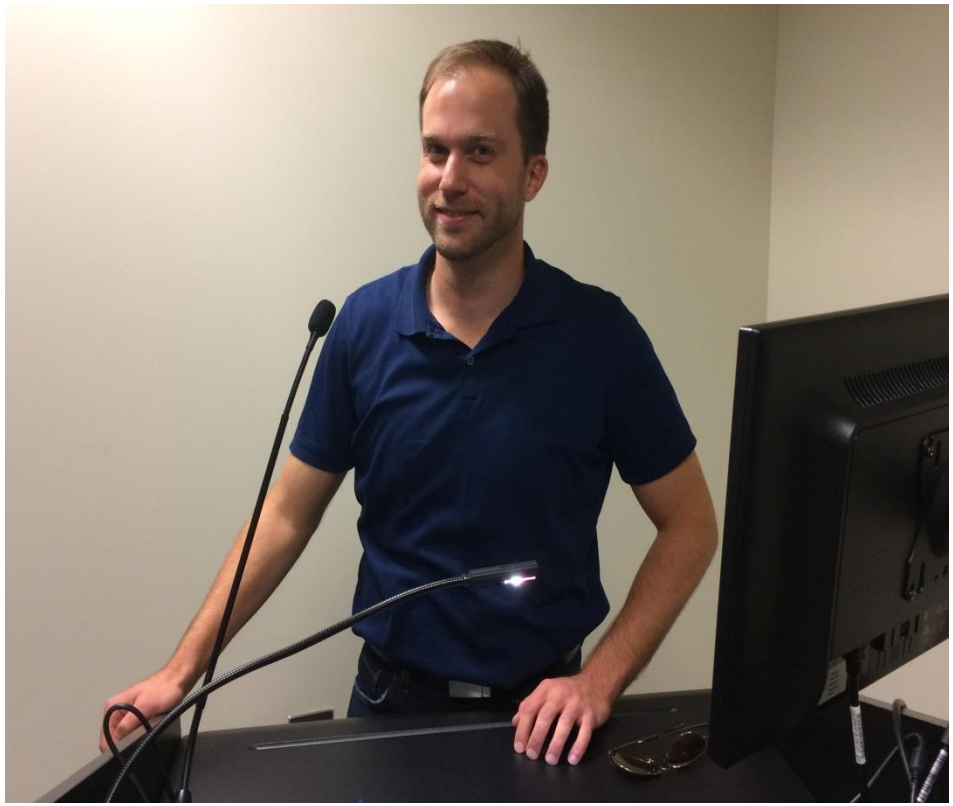
Analytics platform



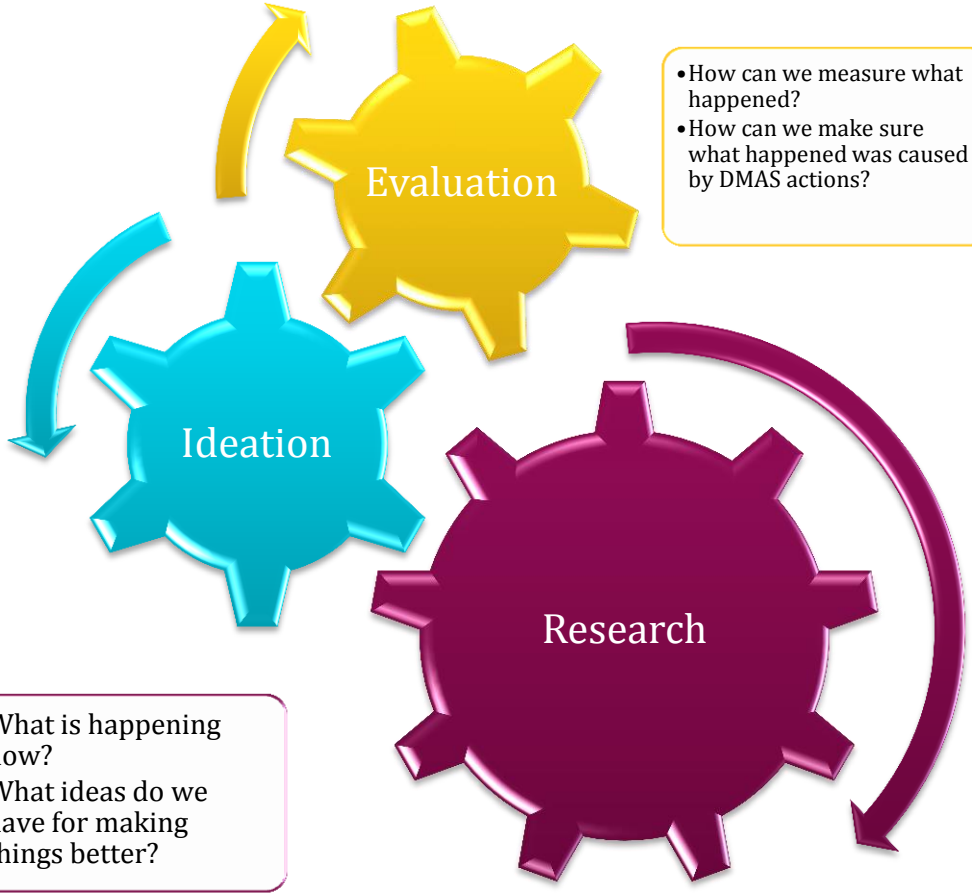
- Implemented in Nov 2016
- User Access Created
- Security Policies Created
- Migration of data Complete
- Power user migration completed
- Content development in progress

Education and Training

- 30+ users trained
- Training manual
- More advance training are scheduled
- Knowledge Centre for training in progress
- Informal hand on workshops
- Cheat Sheets for adaption of technology
- Advance automation tool training in planning
- SharePoint knowledge repository in progress



Future



- How can we measure what happened?
- How can we make sure what happened was caused by DMAS actions?

- How might DMAS make an impact?
- How we estimate impact and potential risk?

- What is happening now?
- What ideas do we have for making things better?