

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

**April 14, 2015
DRAFT Minutes**

Present:

Mirza Baig
Michael H. Cook, Esq.
Alexis Y. Edwards
Maureen Hollowell
Maria Jankowski
Peter R. Kongstvedt, M.D.
McKinley L. Price, D.D.S.
Karen S. Rheuban, M.D.
Chair
Erica L. Wynn, M.D.
Marcia Wright Yeskoo

DMAS Staff:

Linda Nablo, Chief Deputy Director
Cheryl Roberts, Deputy Director for Programs
Abrar Azamuddin, Legal Counsel
Seon Rockwell, Sr., Programs Advisor to Deputy Director of
Administration
Craig Markva, Manager, Office of Communications,
Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of
Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of
Communications, Legislation & Administration

Absent:

Brian Ewald

Speakers:

Cynthia B. Jones, Director
Beth Bortz, President/CEO for the Virginia Center for
Health Innovation
Scott Crawford, Deputy Director for Finance
Brian McCormick, Director of Policy and Research
Karen E. Kimsey, Deputy Director for Complex Care Services

Guests:

Nicole Pugar, Williams Mullen
Rick Shinn, VACHA
Mary Lynne Bailey, VHCA
Lindsay Berry, Anthem
Richard Grossman, Vectre Corporation
Scott Johnson, First Choice Consulting
Sara Heisler, VA Hospital & Healthcare Association
Heidi Dix, Troutman Sanders Strategies
Tucker Obenshain, McGuireWoods
Ralston King, Astra Zeneca

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:03 a.m. Dr. Rheuban expressed gratitude to Michelle Collins-Robinson and Dr. Joseph Boatwright for their service on the Board and

welcomed two new Board members Alexis Y. Edwards and Michael H. Cook, Esq. Other members were asked to introduce themselves and introductions continued around the room.

APPROVAL OF MINUTES FROM December 9, 2014 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the December 9, 2014 meeting. Dr. Rheuban made a motion to accept the minutes and Dr. Price seconded. The vote was unanimous. **6-yes (Baig, Cook, Edwards, Price, Rheuban, and Yeskoo); 0-no.**

Election of Chairman/Vice Chairman

Dr. Rheuban then turned the meeting over to Ms. Jones for the election process. Ms. Jones noted that the Board bylaws require the election of officers for the Board the first meeting after March 1st of each year and opened the floor to accept nominations for Chair.

Ms. Hollowell and Dr. Kongstvedt joined the meeting just prior to the voting. Dr. Price made a motion to nominate Dr. Rheuban as Chair and Ms. Yeskoo seconded. Hearing no further nominations, the nominations were closed. The vote to elect Dr. Rheuban as Chair was **7-yes (Baig, Cook, Edwards, Hollowell, Kongstvedt, Price, and Yeskoo); 0-no.**

Ms. Jones opened the floor to accept nominations for Vice Chair. Dr. Rheuban made a motion to nominate Mr. Baig for Vice Chair. Dr. Price seconded. Hearing no other nomination, the nominations were closed. The vote to elect Mr. Baig as Vice Chairman was **7-yes (Cook, Edwards, Hollowell, Kongstvedt, Price, Rheuban and Yeskoo); 0-no.**

Selection of Secretary

Ms. Jones then opened the floor to accept nominations for Board Secretary. Dr. Price made a motion to accept Mamie White as Board Secretary and Dr. Kongstvedt seconded. The vote to elect Ms. White as Secretary was **8-yes (Baig, Cook, Edwards, Hollowell, Kongstvedt, Price, Rheuban and Yeskoo); 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, welcomed the new members and provided a quick overview of the Medicaid program highlighting the three pillars for Medicaid and health reform: quality, access and costs. Of note, Ms. Jones stated that Medicaid programs across the country have changed/reformed more in the last two years than any time in its 50 year history which is this year. Ms. Jones remarked the presenters and presentations following her comments would address many of the current issues in more detail.

The June 9, 2015 Board meeting has been cancelled due to scheduling conflicts; therefore, Dr. Rheuban asked staff to poll members as soon as possible for another date in June/July for a retreat. Dr. Rheuban also requested that members plan to meet for at least 4 to 6 hours.

Ms. Jankowski and Dr. Wynn joined the meeting during this presentation.

STATE INNOVATION MODEL GRANT (SIM)

Ms. Jones introduced Ms. Beth Bortz, President and CEO of the Virginia Center for Health Innovation (VCHI), who presented on Virginia's State Innovation Model (SIM) Design Strategy. Ms. Bortz discussed how the Virginia State Innovation Model (SIM) grant provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and CHIP beneficiaries and residents of participating states. She provided an overview of Virginia's efforts to work with stakeholders to improve the patient experience and population health while reducing costs for all Virginians and the current status of the grant. For more information, the website for InnoVate Virginia is <http://innovatevirginia.org/>. (see attached handout)

OVERVIEW OF 2015 GENERAL ASSEMBLY BUDGET ACTIONS

Mr. Scott Crawford, Deputy Director for Finance, gave an overview of budget actions since the 2015 General Assembly Session. Unlike in past years, the General Assembly finished its work on time, and the Commonwealth has a budget that has already been signed by the Governor prior to the veto session. Mr. Crawford explained amendments to the current budget for FY 2015-2016 that would affect Medicaid utilization and inflation forecasts. (see attached handout).

After Mr. Crawford's presentation, Dr. Kongstvedt asked how has Virginia Medicaid been affected by the specialty drug spending as it relates to Hep-C. Ms. Jones responded that Virginia has not found it to be the 'budget buster' in this state as it has been in other states. Ms. Jones informed the Board that she has requested information on this topic from staff and would share her findings with the entire Board once it is available.

2015 GENERAL ASSEMBLY UPDATE

Ms. Jones introduced Mr. Brian McCormick, Division Director for Policy and Research. Ms. Jones emphasized that much of the legislation this year was in the budget and it would be beneficial to read the budget. Mr. McCormick gave an overview of the relevant agency bills passed during the 2015 General Assembly Session affecting Medicaid. (see attached handouts)

A HEALTHY VIRGINIA UPDATE

Ms. Jones presented an update on Secretary Hazel's plan to improve health care in Virginia called *A Healthy Virginia* introduced in June 2014 and supported by the BMAS members. Ms. Jones asked staff to send the project update to members monthly. See attached presentation and April 2015 project report.

STATUS OF THE COMMONWEALTH COORDINATED CARE (CCC) PROGRAM

Ms. Karen Kimsey, Deputy Director for Complex Care, provided the current status of the CCC program since it was implemented March 2014. Ms. Kimsey explained the benefits, current enrollment, and program challenges, opportunities and successes. Ms. Kimsey stated due to the positive feedback received, CCC will continue to examine options for inclusion of more dually eligible population into the program and plans to seek public input into the development of a Request for Proposal (RFP) in the future. (see attached handouts)

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 12:13 p.m. Mr. Baig made a motion to adjourn the meeting and Dr. Price seconded. The vote was unanimous. 10-yes (**Baig, Cook, Edwards, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, Wynn and Yeskoo**); 0-no.

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

**December 9, 2014
DRAFT Minutes**

Present:

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

Absent:

Mirza Baig
Maria Jankowski

DMAS Staff:

Cheryl Roberts, Deputy Director for Programs
Brian McCormick, Director of Policy
Elizabeth Guggenheim, Legal Counsel
Craig Markva, Manager, Office of Communications,
Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of
Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of
Communications, Legislation & Administration

Speakers:

Linda Nablo, Chief Deputy Director
Suzanne S. Gore, Deputy Director for Administration
Scott Crawford, Deputy Director for Finance
Karen E. Kimsey, Deputy Director for Complex Care Services
Rebecca Mendoza, Division Director, Maternal & Child Health

Guests:

Tyler Cox, HDJN
Nicole Pugar, Williams Mullen
Rick Shinn, VACHA
Steve Ford, VHCA
Lindsay Walton, Mccaulay & Burtch
Richard Grossman, Vectre Corporation
Robins Cummings, MSV
Sarah Rose Wells, MSV

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:02 a.m. and asked members to introduce themselves. Then, introductions continued around the room. Dr. Rheuban noted the meeting schedule for 2015: April 14, June 9, September 15 (due to Labor Day holiday on September 7) and December 8.

Dr. Rheuban noted the passing of Stephen Bowman, Senior Staff Attorney with the Joint Commission on Health Care, and stated Mr. Bowman was a champion for the underserved and will be greatly missed.

APPROVAL OF MINUTES FROM SEPTEMBER 9, 2014 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the September 9, 2014 meeting. Ms. Collins-Robinson made a motion to accept the minutes and Dr. Boatwright seconded. The vote was unanimous. **7-yes (Boatwright, Collins-Robinson, Ewald, Kongstvedt, Price, Rheuban, and Yeskoo); 0-no.**

DIRECTOR'S REPORT

In Director Cynthia Jones' absence, Dr. Rheuban introduced Ms. Linda Nablo, Chief Deputy Director, to provide the Director's Report.

Ms. Nablo mentioned recent staff changes and congratulated Suzanne Gore and Brian McCormick, who have been hired to fill the positions of Deputy Director for Administration and Policy Director, respectively.

Ms. Nablo briefly discussed several updates and programmatic changes:

- Beginning December 1, 2014, MajestaCare is no longer offered as a managed care health plan for Medicaid members. Individuals who had MajestaCare will continue to have Medicaid and their coverage has been changed to other health plans which are already in place.
- Effective December 1, 2014, the Department of Medical Assistance Services (DMAS) launched the Health and Acute Care Program (HAP). This new initiative, which affected approximately 2,400 individuals, will allow HAP eligible individuals to receive their primary and acute care services through the managed care delivery model.
- Currently, the Commonwealth Coordinated Care (CCC) program currently has approximately 26,000 enrollees.
- DMAS staff is continuing to work collaboratively with the Department of Behavioral Health and Developmental Services (DBHDS) to redesign the Intellectual Disability (ID) and Individual and Family Development Disability Support (DD) waiver.
- A 2015 initiative will be focused on developing a plan to move the remaining long-term care members into managed care.

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

Ms. Suzanne Gore, Deputy Director for Administration, provided highlights and information on the progress of the 10 STEP action plan as delineated in the Governor's *A Healthy Virginia Plan*

implemented on September 1. Some of the needs addressed in the plan include strengthening coverage and access for children, veterans, and pregnant women; capitalizing on innovation opportunities; and optimizing the often fragmented systems of care currently in place. (see attached handout)

THE GOVERNOR'S ACCESS PLAN (GAP) FOR THE SERIOUSLY MENTALLY ILL

Ms. Karen Kimsey, Deputy Director for Complex Care Services, provided information on the Governor's Access Plan (GAP) scheduled to launch in early January of 2015. This is the first step of the 10 point action plan toward *A Healthy Virginia*. If approved by CMS, the GAP §1115 Demonstration Waiver will provide a targeted benefit package for a selected group of uninsured, low income Virginians who have a serious mental illness. (see handout attached).

UPDATE ON MEDICAID FORECAST

Mr. Scott Crawford, Deputy Director for Finance, gave an overview of the current year's budget cycle and the Medicaid budget and forecast for fiscal year 2015 through 2016 (attached). Mr. Crawford stated that once the forecast was completed, the Governor will introduce his proposed budget. The Governor's budget is scheduled to be introduced December 17, 2014.

ELIGIBILITY AND ENROLLMENT TRANSFORMATION

Ms. Nablo presented opening remarks about the evolution of the eligibility process over the last few years. In an effort to improve the overall eligibility system in Virginia, DMAS and the Department of Social Services (DSS) developed a new VaCMS Eligibility and Enrollment System.

Ms. Rebecca Mendoza, Division Director for Maternal and Child Health, provided an overview of the efforts to expand the Cover Virginia Call Center. (see handout attached)

Dr. Boatwright shared comments by several legislators related to the Affordable Care Act (ACA) and Medicaid expansion.

2015 GENERAL ASSEMBLY SESSION

Ms. Gore explained the agency legislative process and role during the session. As the agency does not promote legislation, Ms. Gore explained how DMAS staff will inform the Board with weekly updates on major legislation affecting Medicaid during the 2015 General Assembly Session which convenes on January 14, 2015. (see handouts attached)

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. Mr. Ewald made a motion to adjourn the meeting and Ms. Hollowell seconded. The vote was unanimous. **9-yes (Boatwright, Collins-Robinson, Ewald, Hollowell, Kongstvedt, Price, Rheuban, Wynn, and Yeskoo); 0-no.**

Beth Bortz

Beth Bortz is the President and CEO of the Virginia Center for Health Innovation (VCHI), a nonprofit established in January 2012 to accelerate the adoption of value-driven models of wellness and health care in Virginia.



Prior to joining VCHI, she served for nine years as the Executive Director of the Medical Society of Virginia (MSV) Foundation, where she developed and led programs in health care quality improvement, medication assistance, public health awareness, and physician leadership. Ms. Bortz also served as Senior Program Officer and Deputy Director of the Virginia Health Care Foundation for seven years and as a Senior Associate Legislative Analyst for the Virginia General Assembly's Joint Legislative Audit and Review Commission for three years.

Ms. Bortz currently serves on the Board of Directors of Virginia Health Information and Connor's Heroes, and on the Virginia Chamber of Commerce's Healthcare Committee. She is a 2007 graduate of LEAD Virginia and served as its Alumni Chair. She was a founding board member of Rx Partnership, serving as Board Chair from 2006-2008. She has received several awards and recognition for her work, including:

- *Virginia Leader of the Year 2014* from Lead Virginia
- *Influential Women of Virginia Award* from Virginia Lawyer's Media;
- *Medallion Award for Community Partnership* from Mutual of America;
- *Stettinius Award for Nonprofit Leadership* from the Community Foundation representing Greater Richmond; and
- *Style Weekly's Top 40 Under 40*.

Ms. Bortz earned her undergraduate degree in Economics and Government and her Masters in Public Policy from the College of William and Mary.

A transplanted southerner, Beth and her husband David are avid Philadelphia sports fans, and active PTA volunteers. She has two daughters, Devon and Katy.

VIRGINIA HEALTH INNOVATION plan

Virginia's State Innovation Model (SIM) Design Strategy

Beth A. Bortz
April 14, 2015





About

Mission:

To work in partnership with multiple stakeholders to **accelerate the adoption of value-driven models** of wellness and health care throughout Virginia.

Founded in 2012

- ✓ Public-private
- ✓ Multi-stakeholder
- ✓ Nonprofit
- ✓ Convener



Who We Are

BOARD

Advisory Board Company
Carilion Clinic
Community Memorial Healthcenter
Dominion
Kaiser Permanente
HCA Virginia
Health Diagnostic Laboratory
MeadWestvaco
Medical Society of Virginia
PhRMA
Virginia Association of Health Plans
Virginia Chamber of Commerce
Virginia Health Care Foundation
Virginia Hospital and Healthcare Association

STAFF

Beth Bortz
President & CEO

Ashley Edwards
Chief Innovation Officer

Elizabeth Brady
Logistics Coordinator

Molly Huffstetler
Innovation Waiver Manager

Brenden Rivenbark
Integrated Care Manager

Suzannah Stora
Sustainability Director

About SIM

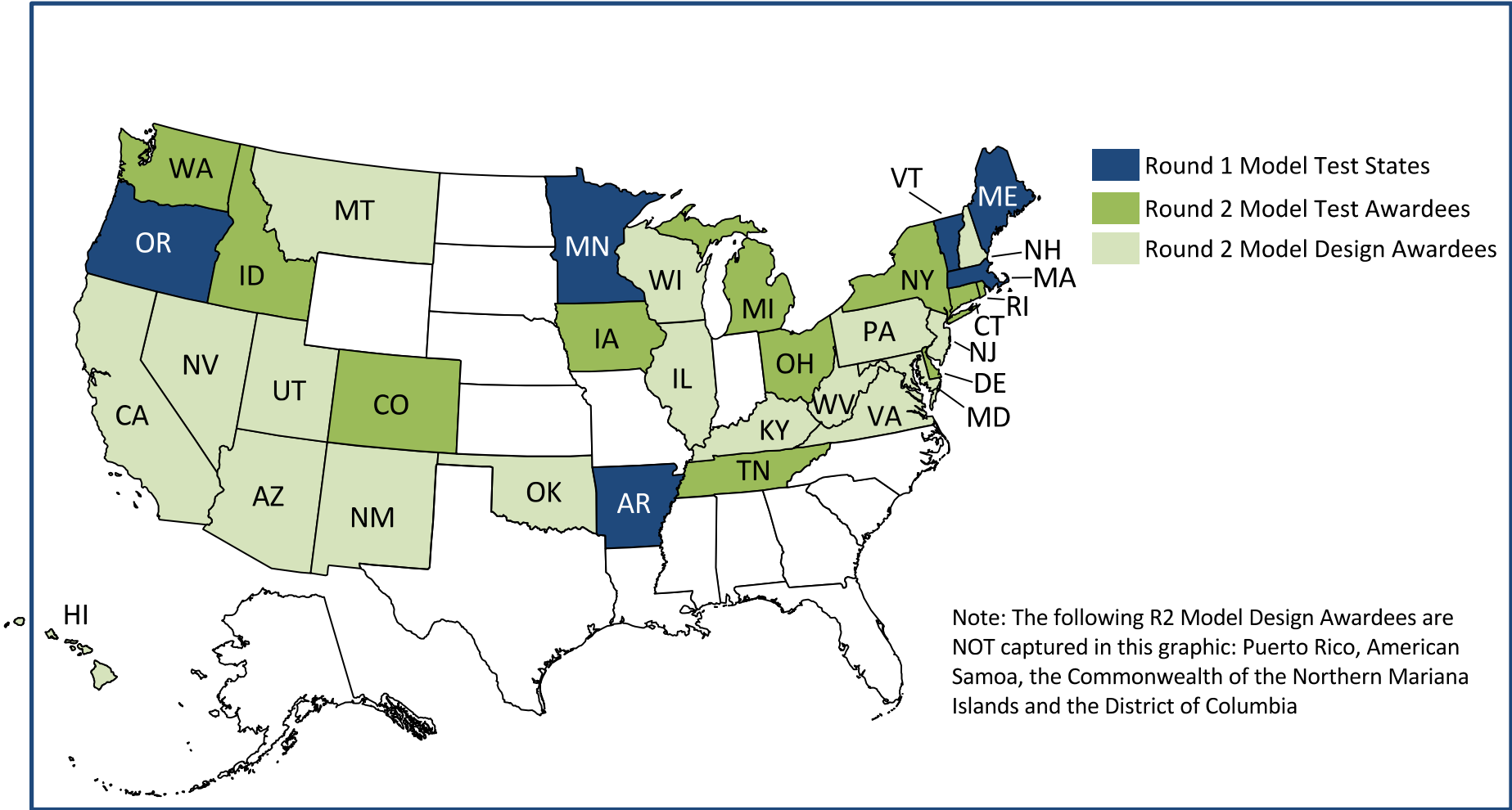
Provides **financial and technical support** to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will:

- ✓ Improve health system performance,
- ✓ Increase quality of care, and
- ✓ Decrease costs for Medicare, Medicaid and CHIP beneficiaries—and for all residents of participating states.

In December, CMS announced **32 winners** of the Round 2 awards.

- ✧ These join the six states that received four year Model Testing awards in 2013, bringing the total number of engaged states or territories to thirty-eight.
- ✧ CMS estimates these grants will collectively cover 61% of the U.S. population.

SIM States



Virginia's Plan

Will engage multiple stakeholders in a statewide effort to achieve the **Triple Aim** of improving the patient experience and population health while **reducing costs** for all Virginians.

VHIP action strategies will benefit all Virginians, with special emphasis on:

- **Regional** health promotion and prevention
- Effective treatment for populations with **chronic conditions**
- **Integration** of primary care and behavioral health for populations with multiple diagnoses.



ACCOUNTABLE
CARE
COMMUNITIES

Core SIM Strategy

Public and private stakeholders work collaboratively to advance the Triple Aim for their region's population.

CASE STUDY: Akron

“The ACC is focused on **improving the health of the community** and **incentivizing the health system** to reward **improved health while delivering cost effective care**. Success is measured by factors such as the improved health of the whole community, cost effectiveness and cost savings in the healthcare system, improved patient experience for those using the healthcare system, job creation in Akron, and more.”

“The ACC leverages the resources and expertise of a wide range of organizations, including the major health systems and healthcare providers, local public health district, employers, the Chamber of Commerce, universities, housing groups, public parks and city planners, transportation groups, economic developers and planners, a range of faith-based organizations and many others.”

Janine E. Janosky, Ph.D., Vice President, Head, Center for Community Health Improvement, Austen BioInnovation Institute in Akron



ACCOUNTABLE
CARE
COMMUNITIES

Development Strategy

April – December 2015

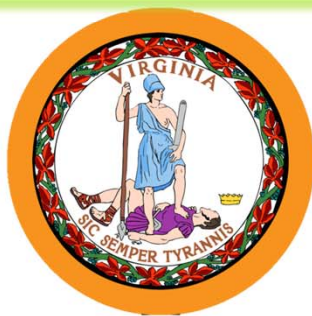
- Select 5 regions to serve as pilot Accountable Care Communities (ACC) and hold ACC development meetings with community leadership to finalize coordinating structures.
- Review each region's performance on core population health and quality improvement measures to target priorities.
- Review emerging pilots from Virginia's SIM portfolio (Primary Care Transformation, Care Transitions, Integrated Care, Telemedicine and Remote Patient Monitoring) and consider community adoption.
- Begin development of Regional Transformation Plans for each of the ACC regions.

ACC Supports and Tools

Quality, Payment, Workforce, and Infrastructure Alignment



Population Health, Quality, Payment & HIT



Medicaid Innovation



Workforce Enrichment

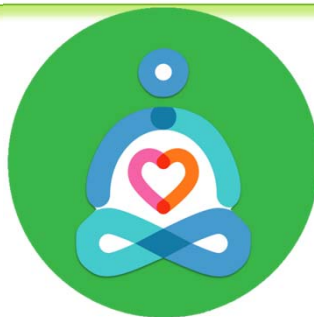


VBID & Choosing Wisely

To support and expand delivery system transformation levers that improve population health.



Care Transitions



Integrated Care



Primary Care Transformation

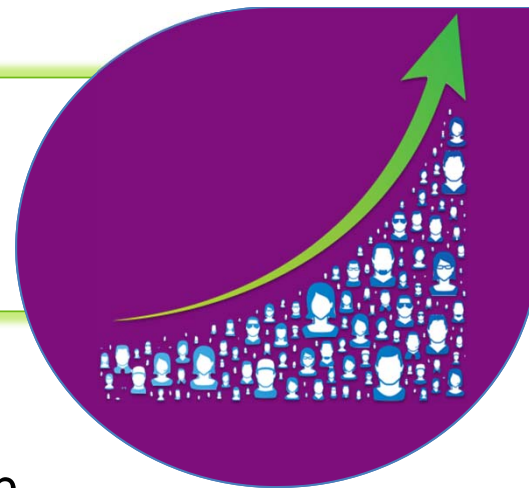


Telehealth & Remote Monitoring



Quality, Payment, Workforce, and Infrastructure Alignment:

Population Health



Lead Partners: Virginia Department of Health,
Community Health Solutions, Virginia Health Information,
George Mason University

Core Activities:

- Development of Population Health Information Portal (PHIP)
- Identify data sources for PHIP
- Develop ***Plan to Improve Population Health***



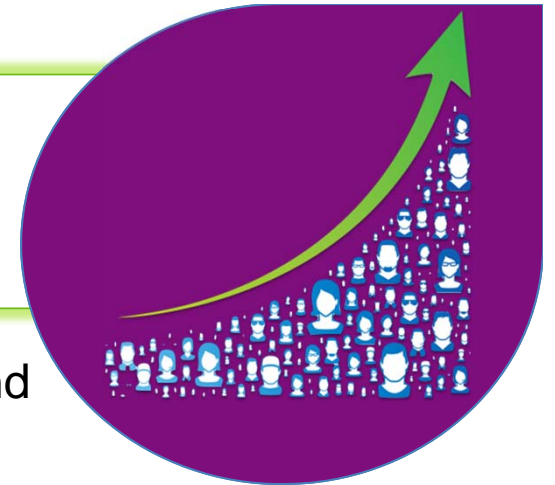
Quality, Payment, Workforce, and Infrastructure Alignment:

Quality, Payment Reform, & HIT

Lead Partners: Office of the Lt. Governor; Virginia's Health and Human Resources State Agencies; Community Health Solutions, Virginia Health Information, ConnectVirginia HIE; Virginia Association of Health Plans and members; Medical Society of Virginia; Virginia Academy of Family Physicians; American College of Physicians, VA; George Mason University

Core Activities:

- Lt. Governor convenes monthly meetings to discuss and finalize a plan to **align statewide quality, health, and cost related performance measures** across all payers in Virginia.
- Develop **HIT Plan** for the Commonwealth of Virginia that includes a health information exchange strategy that ACCs can use to accomplish local health information exchange in Model Testing.



Quality, Payment, Workforce, and Infrastructure Alignment:

Workforce Enrichment

Lead Partners: Virginia Commonwealth University, Institute for Public Health Innovation



Core Activities:

- Expand use of **Community Health Workers**, define scope of practice, and recommend credentialing.
- Develop and pilot online **Learning Transformation** course for health professions.
- Develop **care coordination** and **community health educator** certificate programs.
- Explore **funding** mechanism for CHW with private insurers and DMAS.



Quality, Payment, Workforce, and Infrastructure Alignment:

VBID & Choosing Wisely®

Lead Partners: Virginia Department of Human Resource Management, Center for Value Based Insurance Design, Milliman; Medical Society of Virginia, Virginia Health Information



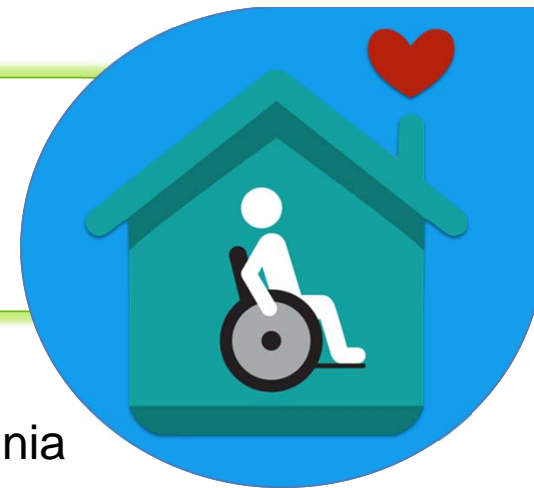
Core Activities:

- Use Milliman's **Waste Calculator** application on Virginia's state employee health plan data and on the APCD data
- Design an educational campaign to be piloted with state employees around the targeted **Choosing Wisely** test and procedures
- Recommend changes to **COVA's benefit design** so that it incentivizes consumers to be engaged in and responsible for their own care
- Continue to improve the Commonwealth of Virginia's (COVA) **Diabetes Management Pilot Program**



Care Transitions

Key Partners: Eastern Virginia Care Transitions Partnership, Virginia Department of Aging and Rehabilitative Services, Virginia Health Quality Center, Virginia Hospital and Healthcare Association, Virginia Association of Area Agencies on Aging



Core Activities:

- Finalize 3 year plan for statewide **expansion of the Coleman Care Transitions Initiative**, which includes a sustainability plan compendium including current success of EVCTP project in contracting with MCOs, ACOs and other payers and with targets for **securing on-going funding for all AAA/hospital partnerships**. It should also include a preliminary assessment of EVCTP pilot enhancements.



Integrated Care

Key Partners: Virginia Commonwealth University; Virginia Association of Community Service Boards, Virginia Oral Health Coalition, Virginia Community Healthcare Association; Virginia Department of Medical Assistance Services, Virginia Department of Behavioral Health and Developmental Services, and the Virginia Hospital and Healthcare Association

Core Activities:

- **Behavioral Health, Oral, and Complex Care** Working groups develop project portfolio for ACCs and DSRIP consideration
- Finalize **metrics and data and economic analysis** plans for each of the proposed models



Delivery System Transformation Levers

Primary Care Transformation*

Key Partners: Virginia Commonwealth University, Virginia Association of Family Physicians, American College of Physicians, VA Chapter, Virginia Community Healthcare Association, Virginia Health Quality Center

Core Activities:

- Develop a package of capacity building supports to help primary care providers transform their practices for population health management based on principles of the Chronic Care Model, the Patient Centered Medical Home, health information exchange, and clinical-community partnership.



*This initiative is not funded by SIM. Funding for this initiative is pending.



Telehealth & Remote Monitoring

Key Partners: University of Virginia Center for Telehealth; Virginia Telehealth Network; Virginia Community Healthcare Association; Virginia Department of Health; George Mason University



Core Activities:

- Work with the regional ACCs and FQHCs on the selection for **high risk OB** and **chronic disease remote patient monitoring** pilot expansions
- Prepare **financial analysis** of potential **cost savings** of expansions.
- Develop a proposed **bundled payment model**



Quality, Payment, Workforce, and Infrastructure Alignment:

Medicaid Innovation

Lead Partners: Virginia Department of Medical Assistance Services, Virginia hospitals, community service boards, federally qualified health centers, free clinics, dental providers, and primary care and psychiatry practices affiliated with academic medical centers.



Core Activities:

- Explore **Delivery System Reform Incentive Program Waiver** for Virginia to support providers in transforming their delivery models and thereby improving access, quality and efficiency in Virginia's healthcare delivery system:
 - *Convene DSRIP work group and stakeholder meetings*
 - *Develop DSRIP concept paper for CMS if appropriate*
 - *Perform actuarial analysis on financial projection for DMAS*
 - *Identify sources of funds for non-federal share*



DMAS Representation on SIM Workgroups

Cindi Jones

*Governor's Office Leadership Team
Quality, Payment Reform, HIT and Population Health
DSRIP Innovation Waiver
Data Need Workgroup*

Scott Crawford

DSRIP Innovation Waiver

Suzanne Gore

*Complex Care
DSRIP Innovation Waiver
Data Needs Workgroup*

Vivian Horn

Workforce Enrichment/ Community Health Worker Advisory Council

Karen Kimsey

Complex Care

Bill Lessard

DSRIP Innovation Waiver

Bhashkar Mukherjee

Data Need Workgroup

Linda Nablo

DSRIP Innovation Waiver

Bryan Tomlinson

Oral Health and Primary Care

Tina Weatherford

Oral Health and Primary Care



Overview of 2015 General Assembly Budget Actions

Presentation to the
Board of Medical Assistance Services

April 14, 2015





Budget Amendment Funding - DMAS

	FY2015		FY2016	
	General Funds	Total Funds	General Funds	Total Funds
Base Appropriation	\$4,042	\$8,974	\$4,155	\$9,217
Utilization & Inflation Forecasts	(\$192.1)	(\$339.5)	(\$53.5)	(\$195.5)
Budget Amendments	(\$3.5)	(\$1.1)	(\$4.0)	\$12.5
Chapter 665	\$3,846	\$8,633	\$4,098	\$9,036
Net Change	(\$196.2)	(\$341.0)	(\$57.5)	(\$181.0)

*Appropriation and amendments reflect all DMAS programs, in millions



Utilization & Inflation Forecasts

- Updated Medicaid & CHIP Forecasts resulted in surplus of \$246 million GF over the biennium
 - Lower than expected FY15 MCO rate increases
 - Lower than expected woodwork effect from the Federal Exchange
 - Lower than projected hospital supplemental payments
 - Higher than projected savings from Reform Efforts targeting Behavioral Health services
 - Delay in the reinstatement of the FAMIS MOMS program



Budget Amendments

- Modifications to the Governor's Healthy Virginia Initiatives (\$3.4M)
 - Modified Governor's Access Program eligibility level from 100% to 60% FPL; provided funding for all potential enrollees
 - Eliminated funding associated with the Behavioral Health Homes through MCOs initiative

- Provided Funding for On-Going Operational Costs of CoverVA Central Processing Unit - \$3.2M GF
 - Implementation costs were paid for using approved funds carried over from FY 2014

- Authorized and Funded (through OSHHR) an Analysis of a Provider Assessment Options and a Workgroup on the COPN Process



Budget Amendments

- Eliminate ER Fee Reduction for Non-Emergency Claims - \$2.2M GF
 - Funding and language to offset savings from pending and reducing payment for claims from emergency room physicians who treat Medicaid recipients determined to be more appropriation for an outpatient setting

- Funding for Physician Supplemental payments for CHKD - \$1.4M GF
 - Helps address critical workforce development needs as Hampton Roads only teaching hospital for pediatrics

- Funding and language to hold harmless any nursing facility which was negatively impacted by the conversion from a cost-based to a price-based reimbursement methodology - \$0.2M GF



Budget Amendments

- Increase Rates for Agency and Consumer-Directed Attendant Care Services by 2% - \$3.5M GF
- Remove Overtime Funding Consumer-Directed Attendants – (\$14M GF)
- Increase ID/DD Waiver Provider Rates eff. July 1, 2015 - \$8.2M GF
 - 2 percent for congregate residential services (except sponsored placement),
 - 5.5 percent for in-home residential services,
 - 2 percent for day support services and prevocational services,
 - 10 percent for therapeutic consultation services,
 - 15.7 percent for skilled nursing services in the Intellectual Disability and IFDDS waivers and six percent for EPSDT nursing to be equal to the private duty nursing rates in the Technology Assisted Waiver



Budget Amendments

- Adjust Medicaid Funding for Piedmont and Catawba Geriatric Hospitals - \$4.9M GF
 - Reflects change in enrollment from hospitals to nursing homes for the purposes of Medicaid reimbursement to comply with federal requirements
 - This change reflects the savings from lower Medicaid reimbursement, mainly due to the loss of eligibility for disproportionate share hospital (DSH) funding

- Funding and Language to Implement an electronic and improved Pre-Admission Screening process and a Contract for Screenings for Children in Need of Long-Term Care Services - \$0.2M GF



Budget Amendments

- Implemented Administrative Savings Actions Initiated in October 2014 through the Governor's FY15 Savings Plan (\$5.9M GF)
 - Electronic notification of most Medicaid communications
 - Eliminating \$100,000 GF in funding for the VA Health Center for Innovation in FY15
 - Converting in-house Fiscal Agent contractor positions and contractors supporting eHHR efforts to state employees (19.0 positions)
 - Reductions in contractor payments

- Administrative Initiatives
 - Provided 9.0 new MEL for implementation of new initiatives, additional financial analysis and reporting, and increased third-party liability recovery activities
 - Funding for upgrade of Agency's Oracle System
 - Funding and 4.0 new MEL for MMIS reprocurement efforts



General Assembly Update – Regular Session Actions

Board of Medical Assistance Services

April 14, 2015



Relevant Bills

- **HB 2372 (Sickles): Electronic Asset Verification System (AVS)**
- **Requirement: Requires DMAS to establish an electronic Asset Verification System for Medicaid Long Term Care eligibility**
- **Final version allows for voluntary cooperation of financial institutions.**
 - **Fiscal Impact: Savings of \$159,000 to \$174,000 annually.**
 - **Status: **PASSED & SIGNED****



Relevant Bills (continued)

- **HB 1942 (Habeeb) / SB 1262 (Newman): Health Plan Drug Prior Authorization Standards**
 - **Requirement:** Requires Virginia health plans, including Medicaid contracted MCOs, to follow drug prior authorization standards and processes that comply with the National Council for Prescription Drug Program's SCRIPT standards.
 - **Fiscal Impact:** No fiscal impact as MCOs already follow these standards.
 - **Status:** **PASSED & SIGNED**



Relevant Bills (continued)

- **HB 1747 (O'Bannon) Mental Health Parity and Addiction Equity Act of 2008**
 - **Requirement:** Broadens the definition of mental health and substance abuse services that are required to be provided by Virginia commercial health plans. Does not apply to Medicaid or its MCOs.
 - **Fiscal Impact:** No fiscal impact.
 - **Status:** **PASSED & SIGNED**



Relevant Bills (continued)

- **SB 1114 (Barker) Temporary detention for testing, observation, and treatment :**
 - **Requirement:** Allows a court/magistrate to issue a 24-hour temporary detention order for medical testing, observation, and treatment for a person who is also under an emergency custody order for mental illness, with notification to the local CSB. Allows increased diagnostic services to persons who present with complicated medical and behavioral conditions (DBHDS Lead Bill).
 - **Fiscal Impact:** Potential impact based upon added 24-hour service provisions; difficult to assess.
 - **Status:** **PASSED & SIGNED**



Relevant Bills (continued)

- **SB 928 (Edwards): Administrative Process: Default for non-appearance**
 - **Requirement:** Provides for the entry of a default order against a party required at an administrative hearing who fails to appear. Does not apply to DMAS hearings.
 - **Fiscal Impact:** No fiscal impact.
 - **Status:** **PASSED & SIGNED**



Questions or Discussion?

**Department of Medical Assistance Services
 BMAS Legislative Status Report – February 27, 2015**

NUMBER AND PATRON	DESCRIPTION	WEB LINK TO SUMMARY	GOVERNOR'S POSITION TO DATE
HB1747 O'Bannon	<p>Health insurance; mental health parity. Conforms certain requirements regarding coverage for mental health and substance use disorders to provisions of the federal Mental Health Parity and Addiction Equity Act. The measure requires that group and individual health insurance coverage shall provide mental health and substance use disorder benefits. Such benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, even where those requirements would not otherwise apply directly. The measure requires any health insurer whose policy, contract or plan provides coverage for mental health and substance use disorder benefits to provide to the Bureau of Insurance information regarding the rates at which claims for mental health and substance use disorder benefits are denied under each policy, contract, or plan it provides. The Bureau shall make annual reports available to the public. The reports shall provide the means to compare the rates at which each insurer, for each of its policies, contracts, and plans, has denied claims for mental health and substance use disorder benefits.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB1747</p> <p style="text-align: center;">BILL PASSED</p>	<p>GOVERNOR SUPPORTS</p>
HB1830 Plum	<p>State plan for medical assistance; eligibility. Requires the Board of Medical Assistance Services to include in the state plan for medical assistance provision for the payment of medical assistance on behalf of individuals described in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) who are under 65 years of age and not otherwise eligible for medical assistance and whose household income does not exceed 133 percent of the federal poverty level for a family of that size. The bill provides that such provision shall expire on December 31 of any year in which the federal medical assistance percentage for such individuals falls below the percentages set forth in 42 C.F.R. § 433.10(c)(6).</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB1830</p> <p>Subcommittee recommends laying on table</p>	<p>GOVERNOR SUPPORTS</p>

**Department of Medical Assistance Services
 BMAS Legislative Status Report – February 27, 2015**

NUMBER AND PATRON	DESCRIPTION	WEB LINK TO SUMMARY	GOVERNOR'S POSITION TO DATE
HB1942 Habeeb	<p>Health insurance; prior authorization for drug benefits. Requires health insurance provider contracts under which a carrier has the right or obligation to require prior authorization for a drug benefit contain specific provisions that, among other things, (i) accept universal prior authorization forms; (ii) permit the electronic submission of prior authorization requests using certain electronic submission formats; (iii) address when prior authorization may be required for chronic disease management drug benefits and mental health drug benefits; (iv) require that prior authorization approved by another carrier be honored for the initial 90 days of an insured's prescription drug benefit coverage upon the carrier's receipt from the prescriber of a record demonstrating the previous carrier's prior authorization approval; (v) address when prior authorization requests are deemed to be approved; (vi) require that, if a prior authorization request is approved by the carrier, the prior authorization approval be valid for not less than one year; (vii) limit when prior authorization may be required for generic drug benefits; (viii) require that a tracking number be assigned by the carrier to all prior authorization requests and that the tracking number be provided electronically to the prescriber upon the carrier's receipt of the prior authorization request; and (ix) require that the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier be centrally located on the carrier's website and that such postings be updated by the carrier within seven days of approved changes. These requirements do not apply when the carrier has evidence of fraud, waste, or abuse by the insured or the prescriber. The measure also requires certain entities to develop, and annually update, universal prior authorization forms and to provide the forms to the State Corporation Commission. The State Corporation Commission is required to make the universal prior authorization forms available on or before January 1, 2016, and to make revised universal prior authorization forms available annually thereafter.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB1942</p> <p style="text-align: center;">BILL PASSED</p>	<p style="text-align: center;">NO POSITION</p>
HB2194 Yost	<p>Immunizations; meningococcal vaccine. Adds certain doses of the meningococcal vaccine to the minimum immunization requirements set forth in the State Board of Health Regulations for the Immunization of School Children.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB2194</p> <p>Subcommittee recommends laying on table by voice vote</p>	<p style="text-align: center;">NONE SPECIFIED</p>
HB2251 Preston	<p>Appeals of adverse initial determinations of overpayment; attorney fees. Provides that in cases in which the Department of Medical Assistance Services makes an initial determination that an overpayment has been made to a provider and the provider substantially prevails on the merits of an appeal of that decision, the provider shall be entitled to attorney fees. Currently, the law requires that the provider substantially prevail on the merits of the appeal and demonstrate that the Department's position was not substantially justified. The bill also provides that a provider will be deemed to have substantially prevailed and shall be eligible to recover attorney fees if the amount the provider is reimbursed following the appeal is equal to at least 80 percent of the original payment received.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB2251</p> <p>Subcommittee recommends laying on table by voice vote</p>	<p style="text-align: center;">NONE SPECIFIED</p>

**Department of Medical Assistance Services
 BMAS Legislative Status Report – February 27, 2015**

NUMBER AND PATRON	DESCRIPTION	WEB LINK TO SUMMARY	GOVERNOR'S POSITION TO DATE
HB2258 Head	<p>Preadmission screening for nursing facility services. Eliminates a requirement that physicians serving as members of screening teams for community-based long-term care services as defined in the state plan for medical assistance be an employee of the Department of Health or the local department of social services; eliminates the requirement that the Department of Medical Assistance Services (the Department) contract with an acute care hospital for institutional screenings for long-term care services as defined in the state plan for medical assistance, so that the Department may but is not required to contract with acute care hospitals for such screenings; and allows the Department to contract with one or more vendors to receive, conduct, track, and monitor requests for all community-based and institutional long-term care screenings. The bill also requires the Board of Medical Assistance Services to promulgate regulations to implement the bill's provisions within 280 days and allows the Board to implement changes necessary to implement the bill's provisions upon its passage and prior to the promulgation of regulations.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB2258</p> <p>Subcommittee recommends laying on table by voice vote</p>	<p>NONE SPECIFIED</p>
HB2372 Sickles	<p>Medical assistance; asset verification; financial institutions to provide certain medical records. Requires the Department of Medical Assistance Services to establish an electronic financial record matching program for the purpose of verifying the assets of applicants for and recipients of medical assistance for (i) individuals applying for or receiving medical assistance as aged, blind or disabled and (ii) individuals for whom an assets test is required to determine the applicant's or recipient's eligibility for medical assistance. The bill requires financial institutions in the Commonwealth to provide to the Department financial records of applicants for or recipients of medical assistance and other individuals whose assets are required to be considered in determining whether the applicant or recipient is eligible for medical assistance. The bill provides that the Department shall reimburse financial institutions in an amount equal to their actual costs in complying with the requirements of the bill.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HB2372</p> <p>BILL PASSED</p>	<p>NONE SPECIFIED</p>
SB713 Stanley	<p>Patient-Centered Medical Home Advisory Council. Establishes the Patient-Centered Medical Home Advisory Council (Council) as an advisory council in the executive branch. The bill requires the Council to advise and make recommendations to the Department of Medical Assistance Services on reforms to the Commonwealth's program of medical assistance that would increase the quality of care while containing costs through a patient-centered medical home system. The bill defines a patient-centered medical home as a team approach to providing health care that (i) originates in a primary care setting; (ii) fosters a partnership among the patient, the personal provider and other health care professionals, and, where appropriate, the patient's family; (iii) utilizes the partnership to access all medical and nonmedical health-related services needed by the patient to achieve maximum health potential; and (iv) maintains a centralized, comprehensive record of all health-related services to promote continuity of care.</p>	<p>http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SB713</p> <p>Subcommittee recommends laying on table by voice vote</p>	<p>GOVERNOR OPPOSES</p>

**Department of Medical Assistance Services
 BMAS Legislative Status Report – February 27, 2015**

NUMBER AND PATRON	DESCRIPTION	WEB LINK TO SUMMARY	GOVERNOR'S POSITION TO DATE
SB928 Edwards	Virginia Administrative Process Act; default by nonappearing party. Establishes a mechanism to more efficiently dispose of contested matters under the Virginia Administrative Process Act where the defendant in an administrative proceeding fails to appear at a hearing without a valid excuse. Currently, unless an agency's enabling statute provides differently, there is no provision for allowing an agency to enter a default order in a case in which the defendant fails to appear at a hearing. This bill is a recommendation of the Virginia Code Commission.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SB928 BILL PASSED	GOVERNOR SUPPORTS
SB1083 Vogel	Immunizations; meningococcal vaccine. Adds certain doses of the meningococcal vaccine to the minimum immunization requirements set forth in the State Board of Health Regulations for the Immunization of School Children.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SB1083 Subcommittee recommends laying on table by voice vote	NONE SPECIFIED
SB1114 Barker	Temporary detention for testing, observation, and treatment of person who is the subject of an emergency custody order. Provides that a court or magistrate may issue a temporary detention order for medical testing, observation, and treatment for a person who is also the subject of an emergency custody order for evaluation and treatment of mental illness. Upon completion of any required testing, observation, or treatment, the hospital emergency room or other appropriate facility in which the person is temporarily detained shall notify the community services board responsible for performing an evaluation to determine whether the person meets the criteria for temporary detention for treatment of mental illness, and a designee of the community services board shall complete the evaluation as soon as is practicable but prior to the expiration of the order for temporary detention for testing, observation, or treatment.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SB1114 BILL PASSED	NONE SPECIFIED
SB1262 Newman	Health insurance plans and programs; preauthorization for drug benefits. Requires certain health insurance contracts under which an insurance carrier or its intermediary has the right or obligation to require preauthorization for a drug benefit to include provisions governing the preauthorization process. Required provisions address (i) use of a common preauthorization form to be developed by the State Corporation Commission, (ii) the electronic submission of preauthorization requests, (iii) waiving preauthorization requirements for chronic disease management drug benefits and for mental health drug benefits, (iv) requests for supplementation of a preauthorization or waiver request, (v) preauthorization restrictions for generic drug benefits, and (vi) posting of certain information. These provisions are also applicable to Medicaid fee-for-service and Medicaid managed care health plans and the state employee health insurance program.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SB1262 BILL PASSED	2/4 NO POSITION 1/29 GOVERNOR OPPOSES

**Department of Medical Assistance Services
 BMAS Legislative Status Report – February 27, 2015**

NUMBER AND PATRON	DESCRIPTION	WEB LINK TO SUMMARY	GOVERNOR'S POSITION TO DATE
SB1282 Edwards	Administrative Process Act; disciplinary proceedings. Amends the disciplinary process under the Administrative Process Act by (i) establishing a process for the disqualification of presiding officers and hearing officers, (ii) prohibiting ex parte communications, and (iii) establishing a process for discovery relating to formal hearings.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SB1282 Subcommittee recommends laying on table	NONE SPECIFIED
HJ637 Landes	Study; JLARC; Commonwealth's Medicaid program; report. Directs the Joint Legislative Audit and Review Commission (JLARC) to study the Commonwealth's Medicaid program. In conducting its study, JLARC shall (i) analyze the impact of major cost drivers on the growth of Medicaid program expenditures; (ii) identify highest-cost Medicaid recipients and services and assess whether opportunities exist to improve the cost-effectiveness of health care delivery; (iii) examine the efficiency of the administration of the Commonwealth's Medicaid program, including financial processes and controls and the recovery of third-party payments, and review the implementation status of recommendations made in 2011 JLARC report on improper payments and other reports related to improving efficiency and cost-effectiveness; (iv) identify evidence-based practices and strategies that have been successfully adopted in other states and that could be used in the Commonwealth to provide cost-effective care, strengthen patient outcomes, and maximize the efficiency and integrity of internal processes; and (v) review other relevant issues and make recommendations as appropriate. JLARC shall complete its work by November 30, 2016.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=HJ637 Conference report agreed to	NONE SPECIFIED
SJ268 Hanger	Study; JLARC; pathways for determining eligibility for Medicaid-funded long-term care; report. Directs the Joint Legislative Audit and Review Commission to study pathways for determining eligibility for Medicaid-funded long-term care. In conducting its study, JLARC shall review (i) the Commonwealth's long-term care preadmission screening process, including the process by which individuals access such screenings, the timeliness of such screenings, support for individual choice upon meeting long-term care criteria, and assurance that the assessment teams are neutral and have no financial or legal ties to discharge locations and (ii) state and federal long-term care financial eligibility laws, including the use of annuities to protect assets, transfer of assets, lien and estate recovery, assessing a child as a family of one for eligibility purposes, and the effects of the new Modified Adjusted Gross Income eligibility standards and access to nursing home care services. The Joint Legislative Audit and Review Commission shall complete its meetings by November 30, 2016.	http://lis.virginia.gov/cgi-bin/legp604.exe?ses=151&typ=bil&val=SJ268 Conference report agreed to	NONE SPECIFIED



Department of Medical Assistance Services



Governor McAuliffe's A Healthy Virginia Plan

Spring 2015 Updates

*Cindi B. Jones, Director
April 14, 2015*

Governor's *A Healthy Virginia Plan*: Ten Steps

<p>Step 1: The Governor's Access Plan (GAP) for Medical and Behavioral Health Services</p>	<p>Reaching Virginia's Uninsured with Serious Mental Illness (Goal: 20,000+ adults covered)</p>	<p>Launched on 1/12/15 As of 3/24/15: 1,395 enrollees from 118 localities</p>
<p>Step 2: Covering our Children</p>	<p>Reaching More Children through Medicaid and FAMIS (Goal: 35,000 children)</p>	<p>14,000 additional children covered since 9/1/2014</p>
<p>Step 3: Supporting Enrollment in the Federal Marketplace</p>	<p>Reaching More Virginians during Open Enrollment (Goal: 160,000 individuals)</p>	<p>385,154 enrolled - Of these, 207,983 were NEW enrollees (Goal Exceeded!)</p>
<p>Step 4: Informing Virginians of their Health Care Options</p>	<p>Reaching more Virginians through CoverVA.org</p>	<p>273,500 unique visits and over 50,000 eligibility self-screenings (Since 11/15/14)</p>

Governor's *A Healthy Virginia Plan*: Ten Steps

Step 5:
Making Dependent Coverage
Affordable for Lower-Income
State Employees

Reaching More Children
through FAMIS
(Goal: 5,000 children)

LIVE 1/1/15 for full-time state
workers with uninsured
children

IN DEVELOPMENT for full-time
state workers with children
currently covered under the
state employee plan (open
enrollment in May for 7/1/15)

Step 6:
Providing Comprehensive Dental
Coverage to Pregnant Women in
Medicaid and FAMIS

Improving Access to
Oral Health Care
(Goal: 45,000 women)

Launched on 3/1/15

Expecting March utilization
soon!

Step 7:
Creating Behavioral Health
Homes

Strengthening Virginia's
Behavioral Health
System through
Innovation

On track for a 7/1/15
implementation through the
Medallion 3.0 managed care
organizations

Governor's *A Healthy Virginia Plan*: Ten Steps

(DMAS is not the lead on these steps)

Step 8

Prioritizing the Health of Virginia's
Veterans - Accelerating Veterans'
Access to Care

Step 9

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

Step 10

Reducing Prescription Drug
and Heroin Abuse - Stemming a Devastating Proliferation
of Substance Abuse

In June 2014, Governor McAuliffe requested recommendations from Secretary Hazel on how to improve health care in Virginia. Secretary Hazel responded with *A Healthy Virginia*, a plan that offers previously unavailable services and utilizes available but underutilized sources of coverage. The seven components of this plan that DMAS implements are discussed below.



1. The Governor's Access Plan (GAP) for Medical & Behavioral Health Services for Individuals with Serious Mental Illness

Virginia launched the GAP program to provide primary care and behavioral health services for up to 20,000 Virginians who are uninsured, have serious mental illness (SMI), and have incomes at or below 100% of the Federal Poverty Level in the hopes of improving access to care, physical and behavioral health outcomes, and bridging the coverage gap for those with serious mental illness via 1115 Waiver authority granted by CMS.

- ✓ As of March 24, there were 1,395 individuals enrolled in the GAP demonstration from 118 unique localities across the Commonwealth. To date, the greatest saturation of enrollment has been in Norfolk and Virginia Beach. Membership in the demonstration currently ranges evenly between age groups. Further, 86% of claims are for pharmacy, 6% are for practitioner/doctor visits, 6% are for laboratory, and 2% are general outpatient claims.
- ✓ Increasing enrollment in the GAP demonstration continues to reinforce the dire need individuals with serious mental illness (SMI) experienced in accessing appropriate mental/physical health supports. Another significant success is the developing trend of receiving appropriate and complete applications, as this is a significant factor in timely/accurate eligibility determinations and allowing qualifying individuals to quickly enroll and gain much needed access to care.
- ✓ To date, the GAP call center has received 5,473 calls, taking 1,783 telephonic applications and 2,352 online applications for a total of 4,135 applications received. Also, 65% of SMI screenings received have been previously known to the system, indicating that the program is utilizing existing connections/networks to identify potentially eligible individuals.
- ✓ The 2015 General Assembly's budget language now signed by the Governor to reduce eligibility from 100% to 60% of the federal poverty level will impact 141 current members. These individuals will lose their coverage upon their one year renewal if their financial situation remains the same. DMAS is working diligently to implement these changes and posted a public notice on its website on April 1.
- ✓ Stakeholder outreach and engagement continues to be a focus. DMAS held a series of well-attended town hall meetings in Richmond, Tidewater, Roanoke, Abingdon, and Fairfax. These allowed staff the opportunity to meet with providers and individuals interested in the program, answer questions, and explain program eligibility and access.

2. Covering Our Children (Reaching More Children through Medicaid and FAMIS)

Although Virginia covers approximately 580,000 children each month in FAMIS/Medicaid, 100,000 more children who are eligible for these programs remain uninsured. Virginia will launch an aggressive outreach campaign to reach the parents of eligible but unenrolled children.

- ✓ The Virginia Health Care Foundation (VHCF) contract was signed. DMAS met with their staff, OSHHR, and the Virginia Department of Social Services (DSS) to discuss project planning, including the May 21 Eligibility & Enrollment Summit. An agenda has been drafted, with Secretary Hazel as the keynote speaker and a CMS representative also scheduled to speak. An electronic save-the-date will be distributed.
- ✓ Big River also signed their contract. DMAS and their staff agreed that the first media buy should coincide with the annual *Back-to-School* campaign. This year's campaign includes sending flyers to every school in the state and establishing a special partnership with Arlington Public Schools to ensure maximum flyer coverage.
- ✓ The community outreach coordinators continued their efforts among local health departments and departments of social services, community health centers, public schools/libraries, etc. Highlights included: all marketing and outreach staff participating in the VHCF Project Connect Grantee meeting; staffing a FAMIS table at the Virginia Commonwealth University Wellness Block Party, distributing over 200 flyers and 300 giveaways, and personally speaking with over 200 mostly lower-income individuals; and hosting a Cover Virginia informational event for New River Valley agencies.
- ✓ DMAS continues to revamp its outreach materials, including: providing 22,000 kindergarten registration flyers to the Department of Education for statewide distribution; 2,500 FAMIS flyers for ongoing distribution by all Richmond city libraries; and ordering 7,000 chip clips as FAMIS promotional giveaways.

Enrollment of Children				
2014	Medicaid (XIX)	FAMIS (XXI)	Total	Change
September 1	463,254	112,481	575,735	—
October 1	467,755	112,108	579,863	4,128
November 1	472,337	111,085	583,422	3,559
December 1	470,119	109,627	579,746	-3,676
January 1	469,599	108,724	578,323	-1,423
February 1	474,765	109,045	583,810	5,487
March 1	476,568	108,287	584,855	1,045
April 1	482,409	107,500	589,909	5,504

3. Supporting Enrollment in the Federal Marketplace (Reaching More Virginians during Open Enrollment)

Virginia was awarded a \$4.3 million federal grant to begin building a state-based health insurance marketplace. While Virginia decided not to move forward with plans for its own marketplace, we obtained permission from CMS to use the funds for outreach and enrollment activities supporting the Federal Marketplace.

- ✓ Virginia enrollment stands at 385,154, including 207,983 new enrollees, and exceeds the Healthy Virginia goal of 160,000 new enrollees by nearly 30%. The tax time special enrollment period for those who paid a penalty for not having coverage in 2014 and do not have 2015 coverage began on March 15. This population has until April 30 to enroll in a 2015 plan.
- ✓ DMAS prepared first drafts of open enrollment reports and continues to develop a suite of reports/tools to analyze performance and project future goals. Staff began preliminary work in developing the 2016 open enrollment goal.
- ✓ We are exploring the feasibility of extending Virginia Community Healthcare Association contracts and subcontracts until January 2016. This will keep 108 full-time in-person assisters on staff through September 30, and 80 on staff through January 31, 2016 to provide thorough coverage during 2016 open enrollment.
- ✓ Staff attended the Virginia Community Healthcare Association's Enrollment Assisters Summit. The event drew over 170 navigators, certified application counselors, in-person assisters, and community health education program representatives.

4. Informing Virginians of their Health Care Options (Reaching More Virginians through Cover Virginia)

Cover Virginia is a source of information for uninsured Virginians seeking access to coverage that offers basic information on the FAMIS and Medicaid programs, as well as new health insurance options available through the Affordable Care Act. DMAS enhanced the Cover Virginia website prior to open enrollment to make it easier for Virginians to connect with the programs and services for which they qualify.

- ✓ Since the November 15 re-launch, the coverva.org website has received: more than 273,500 unique visits; 8,300 click-throughs to the federal healthcare.gov site; 9,200 click-throughs to Virginia's CommonHelp online application; and 50,500 eligibility inquiries via the site's self-screening tool. Average daily visits decreased from approximately 2,600 a day for December and January to about 1,700 a day in February. However, this volume is still significantly higher than 2014's average daily visits of roughly 600 prior to open enrollment.

5. Affordable Dependent Coverage for Lower-income State Employees (Reaching More Children via FAMIS)

Prior to the Affordable Care Act, federal law prohibited dependents of public employees from enrolling in the state's children's health insurance program (FAMIS). Virginia now has federal approval to enroll children of eligible state employees in FAMIS, improving their access to affordable, quality, comprehensive health care.

- ✓ DMAS created a flyer in coordination with the Department of Human Resource Management to advise state employees about open enrollment options. After receiving an expensive printing quote for printing the flyer, staff obtained a new quote from a small, women, and minority (SWAM) vendor that resulted in a \$10,000 administrative cost savings. 106,000 flyers are currently printing at the SWAM vendor to be received on April 3.
- ✓ The emergency regulations public comment period ended on March 25 with no comments received, and the permanent regulations package is in process. The contract modification to create a special state employee expedited processing unit at the Cover Virginia central processing unit awaits CMS review and approval and remains on track to open on April 20.

6. Comprehensive Dental Coverage for Pregnant Women (Improving Access to Oral Health Care)

Since a pregnant woman's oral health is linked to delivery and her baby's health, lack of comprehensive dental care may allow undiagnosed/untreated dental issues to put unborn babies at risk. DMAS is therefore implement comprehensive dental coverage for pregnant women enrolled in Medicaid and FAMIS MOMS.

- ✓ Dental services for Pregnant Women went live on March 1 with no problems. The Virginia Woman's Center (a large women's healthcare chain in Virginia) included an article on this in their provider newsletter. DentaQuest staff continues to receive inquiries from providers and members related to eligibility, benefits, and finding a provider.
- ✓ Staff from the National Academy of State Health Policy met with DMAS on March 13 to discuss strategies used in preparing to launch this new dental coverage for pregnant women enrolled in Medicaid and FAMIS MOMS.

7. Behavioral Health Homes (Strengthening Virginia's Behavioral Health System through Innovation)

DMAS is collaborating with the Department of Behavioral Health & Developmental Services and the contracted health plans to establish health homes that coordinate care for adults and children enrolled in Medicaid with a diagnosed serious mental illness or emotional disturbance.

- ✓ This effort remains in progress towards July 1 implementation. The Medicaid managed care organizations (MCOs), DMAS staff, and mental health audit contractors attended a webinar hosted by Magellan that detailed non-traditional behavioral health services, information sharing, prior authorization processes, and future trainings. DMAS continues to draft contract language for the pilots and to look at other states' program models for examples of reporting metrics.



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Cindi B. Jones, Director

Virginia Department of Medical Assistance Services

Board of Medical Assistance

April 14, 2015

CCC Overview:

Implemented March 1, 2014

- CCC is an **integrated care initiative** for individuals who are currently served by both Medicare and Medicaid
- **Eligibility Requirements** : 21 and over, Full Dual, Live in Demo area, includes EDCD and Nursing Facility
- Program is designed to **align the delivery and financing of care** (primary, preventive, behavioral health, and long-term services & supports) through care coordination, interdisciplinary care teams, and person-centered care plans **through Managed Care**



Care Coordination

- Unique to CCC
- Designated MMP Care Coordinator
- Care Coordinator works with beneficiary and providers to coordinate supports and services
- Care Coordinator assembles ICT
- Care Coordinator can be a resource to providers for authorizations and arranging care transitions



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Overview of CCC Benefits

Beneficiaries

- ✓ One health plan to coordinate all benefits
- ✓ One Insurance Card
- ✓ One number to call 24/7
- ✓ Designated Care Coordinator
- ✓ Streamlined Appeals
- ✓ Expanded benefits

Virginia benefits through shared Medicare Savings!

Providers

- ✓ Streamlined financing of Medicare and Medicaid services
- ✓ One card for all services
- ✓ Eliminate cost-shifting
- ✓ Eliminate duplicative services
- ✓ Care Coordination can address member medical and social needs across the care continuum, not just in provider's setting



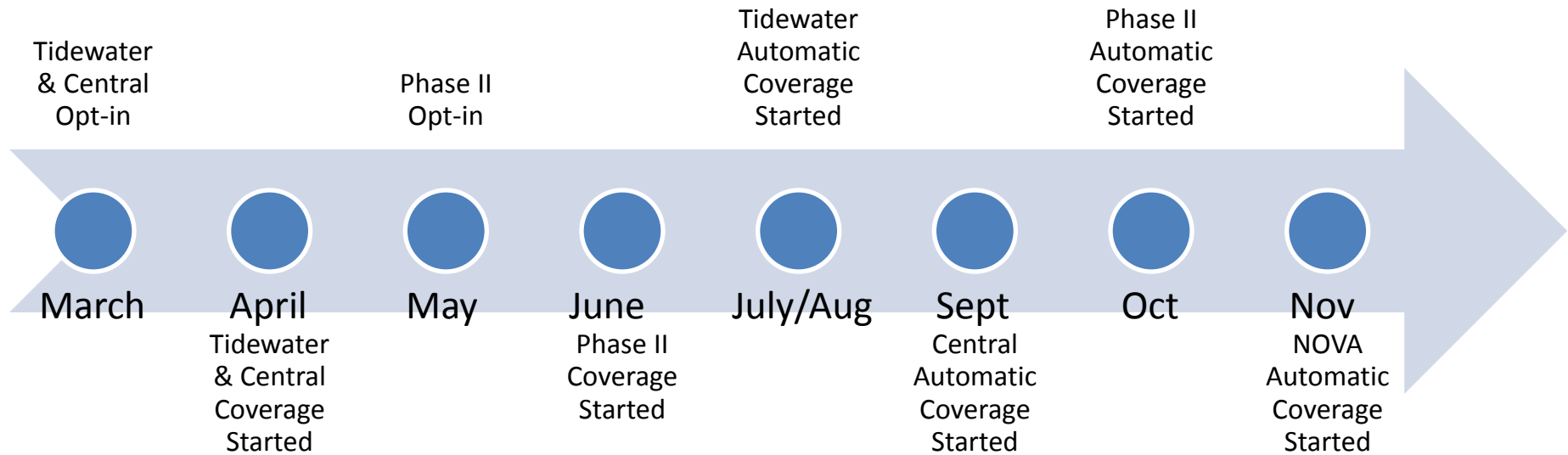
Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Benefits for Virginia

- Eliminates cost shifting
- Achieves cost savings
- Slows the rate of Medicaid cost growth for Virginia
- Reduces duplicative or unnecessary services
- Streamlines administrative burden
- Single set of quality reporting measures, appeals and auditing
- Promotes and measures improvements in quality of life and health outcomes

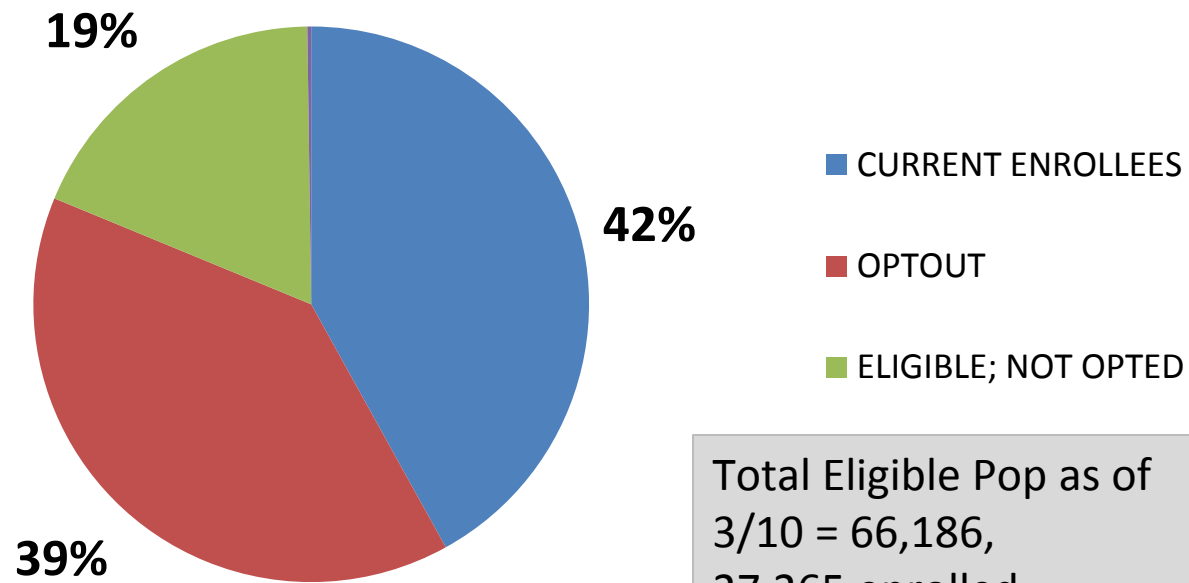


2014 Enrollment Timeline



Virginia Dual Demonstration Enrollment

CURRENT ENROLLMENT STATUS OF TOTAL ELIGIBLE POPULATION



CURRENT ENROLLEES = All Active and Automatic Enrollments as of 3/10/15; **OPTOUT** = All potential enrollees that elected to not participate as of 3/10/15; **ELIGIBLE; NOT OPTED** = Potential enrollees that have not decided as of 3/10/15



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Virginia Dual Demonstration Enrollment

CCC Optins By Plan and Opt out- March 14 , 2015

MMP Provider	MMP NAME	Optins		
		Active	Passive	Total
173024859	VaPremier	890	5423	6313
173025666	HealthKeepers	2481	8629	11110
173030070	Humana	1504	8556	10060
Total Optins		4875	22608	27483
Total Opt outs				26164

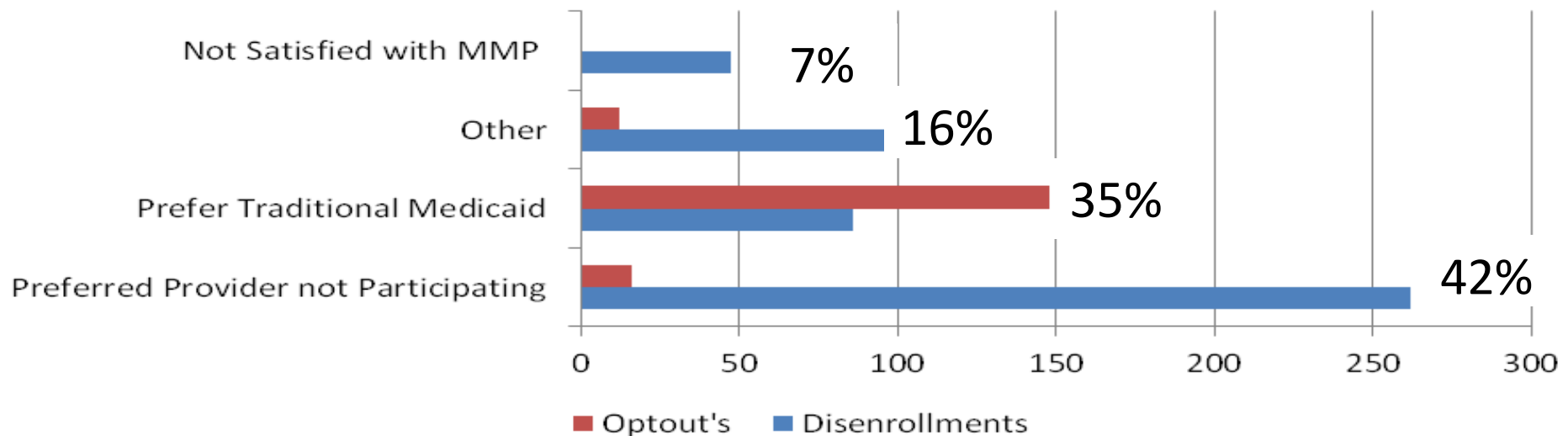
*This figure includes passive assignment future effective dates for November 1 – January 1, 2015

**Approximately 10,469 enrollees were not be passively enrolled due to single-MMP approved FIPS

Virginia Dual Demonstration Enrollment

Disenrollment and Optout's Reasons

02/02 - 02/27

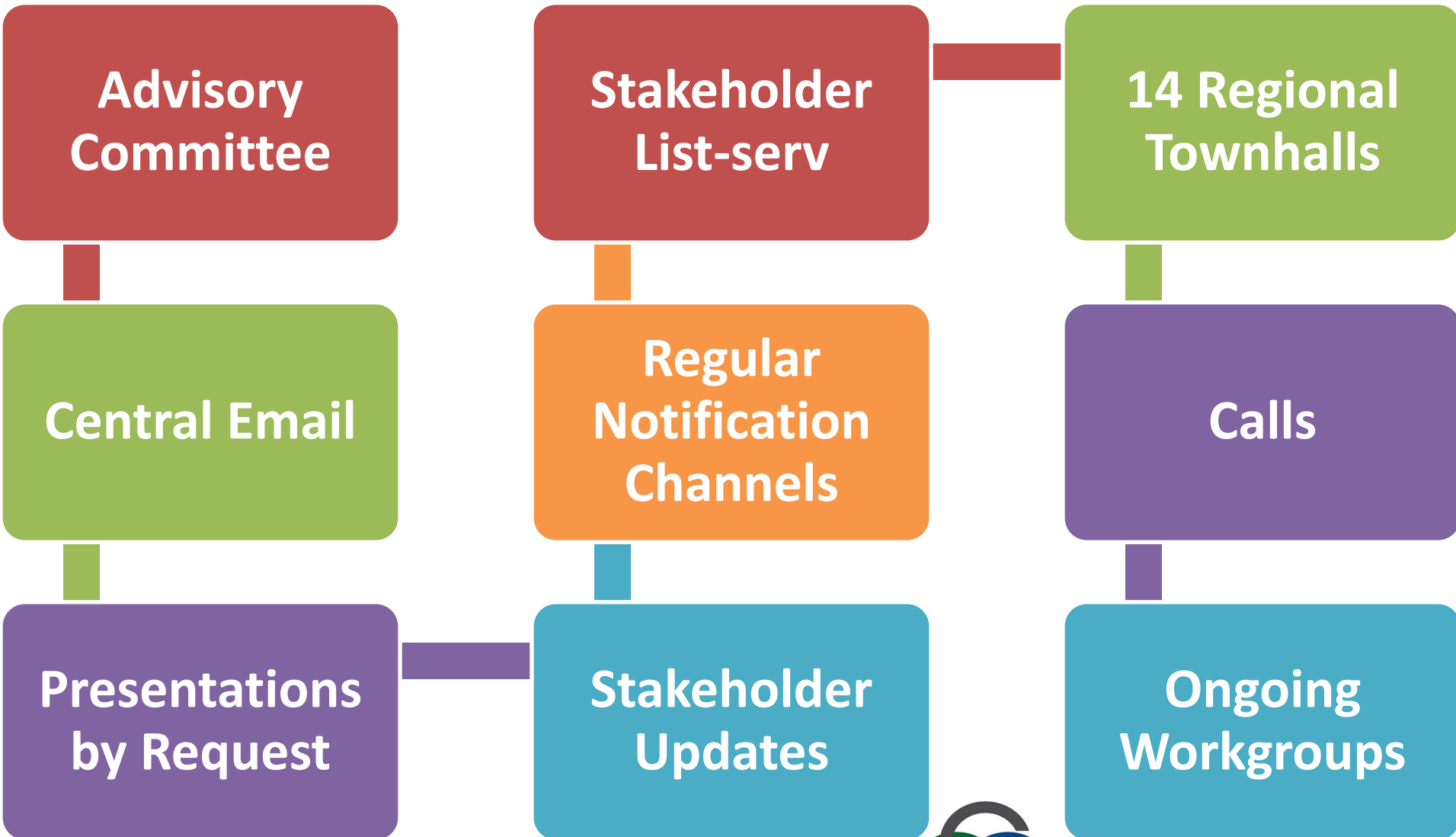


Other = No reason given; Don't like change; Don't like CCC benefits; Pharmacy benefit not included; Co-pay too high; Too Complicated. Each is less than 5% of total Disenrollment's and Optout's

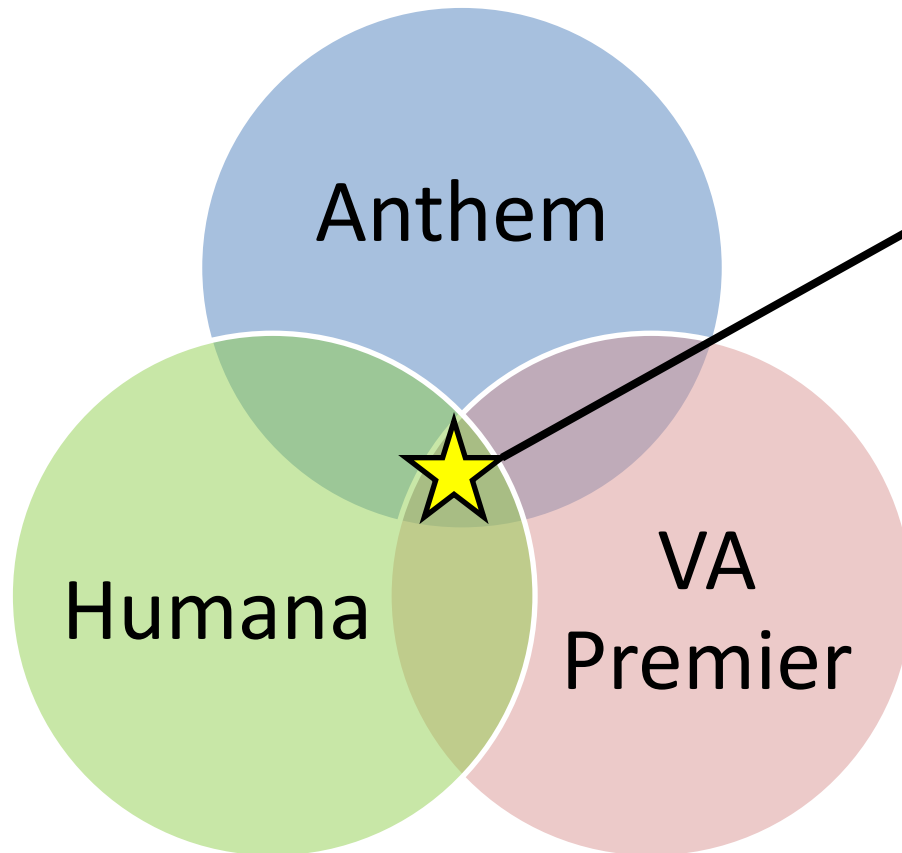


Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Multi-faceted Stakeholder Engagement



VA's Highly Collaborative Approach



Collaborating on:

- Outreach and Education
 - Town halls
 - Provider Calls
- Provider Behavioral Health Forms
- Required Provider Training
 - cultural competency



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Member Satisfaction

A Dually Eligible Beneficiary: “...reading through [the] benefits...[I liked] eyeglasses and my teeth...dental work...[CCC] benefits me **[more] than plain Medicare and Medicaid** and that’s why I’m with [the MMP].”

One enrollee reports positive care coordination outcomes demonstrated by **significant reduction in hospital visits**. In the 90 days prior to enrollment she went to the **ER 10 times** and had **4 overnight admissions**. In the five months after enrollment she has **only 2 ER visits and 1 overnight hospital day!**



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Stakeholders Report Early Success

- Access to extra benefits like dental, vision, and wellness services
- Early intervention keeping Virginians at home
- Improving transitions between care settings
- Caring for social, emotional, and medical needs together

Program Challenges & Opportunities

Provider Network Adequacy

- Provider network standards have not been achieved in some localities
- Claims payments were delayed in some cases
- Network development is ongoing and CMS/DMAS are working with the MMPs to address

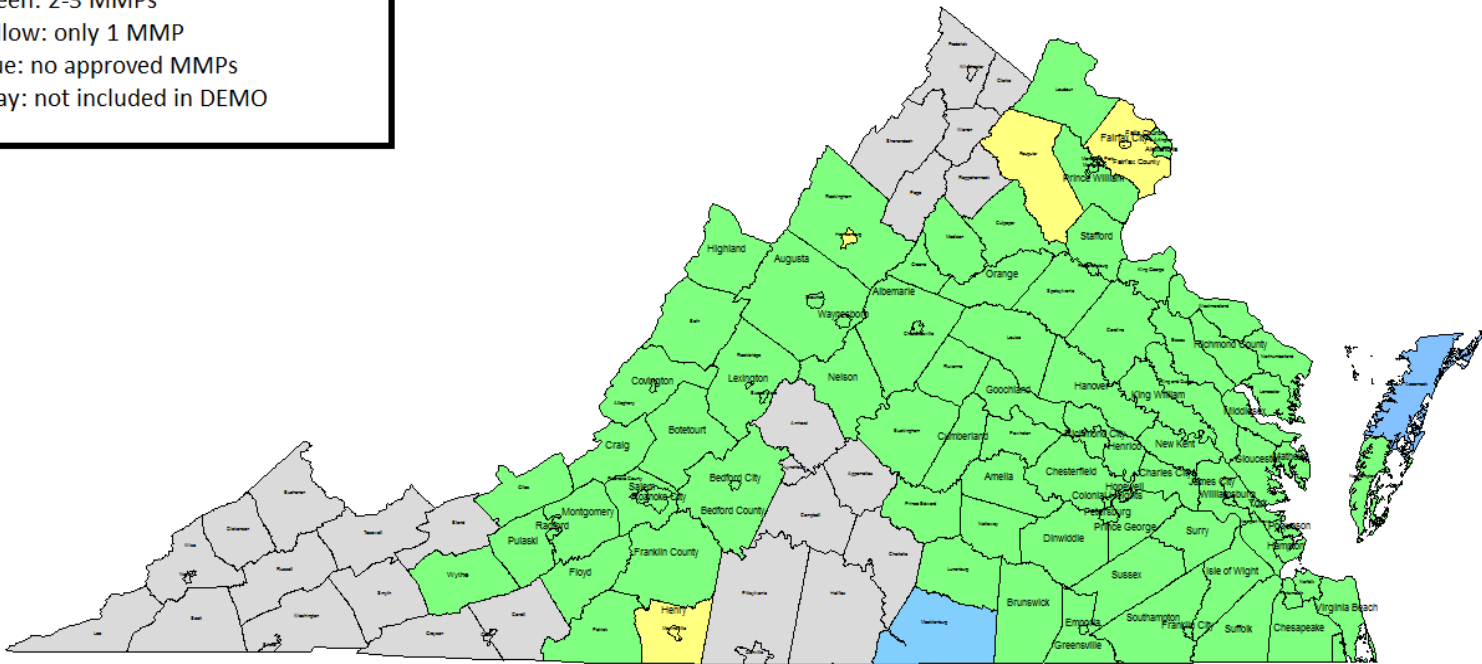
Protecting Beneficiary Choice

- Some providers encouraged duals to opt-out of CCC during initial stages
- DMAS works to address issue through educational meetings, newsletters, conference calls, and Medicaid memo



Potential Challenges & Opportunities

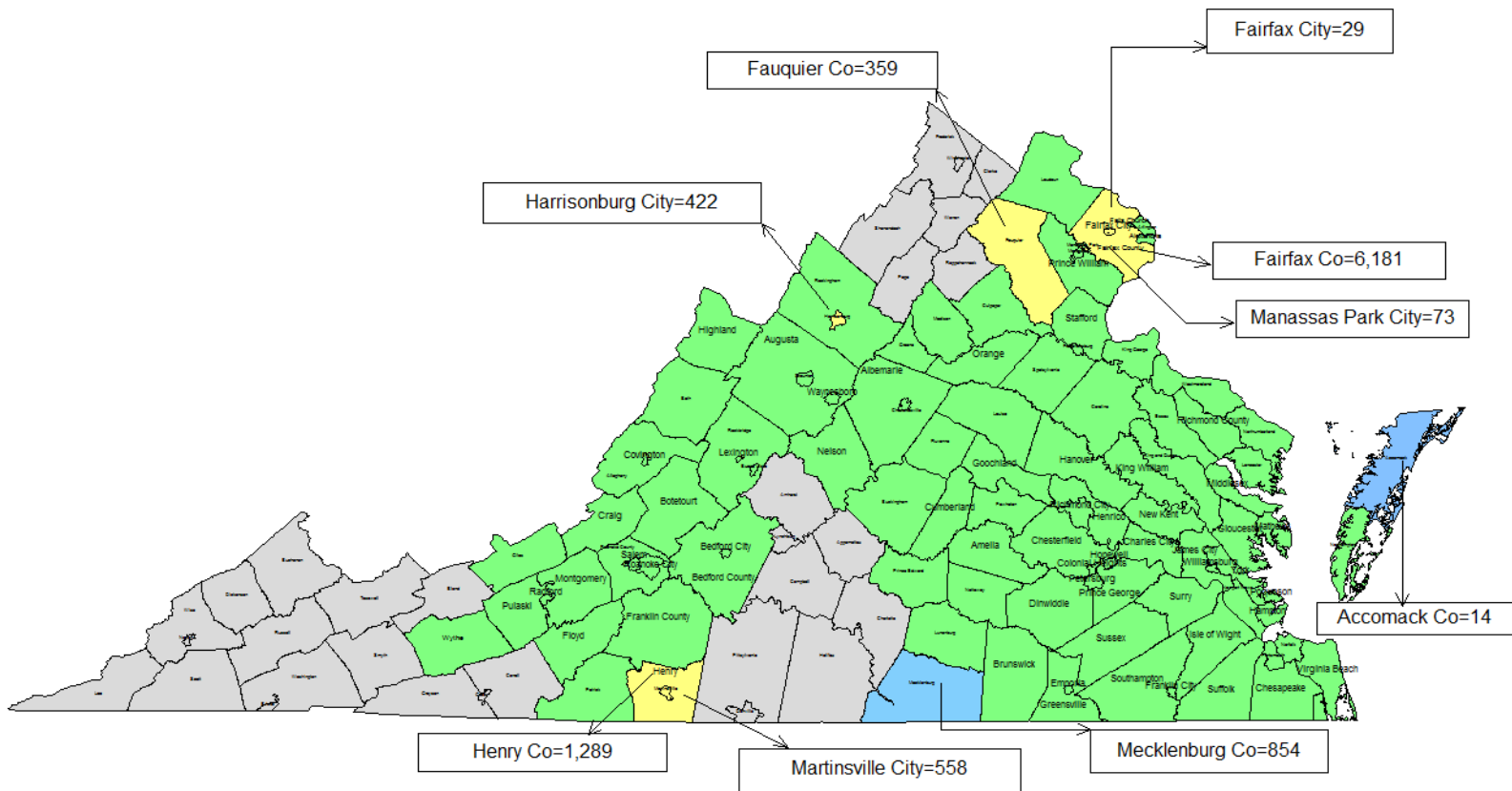
Green: 2-3 MMPs
Yellow: only 1 MMP
Blue: no approved MMPs
Gray: not included in DEMO



Green=Passive, Yellow=Non Passive, Blue=No MMP, Grey=Non Participating

Single MMP Population Count

CCC Potential Members



Green=Passive, Yellow=Non Passive, Blue=No MMP, Grey=Non Participating

■ Single MMP Population Count

Challenges Create Opportunities

- Claims/Provider Reimbursement
 - Each MMP has had individual issues with their claims processes and platforms.
 - Working through provider associations to identify all issues, track issues, and rebuild trust with provider community
- Care Coordination challenges
 - Training information not trickling down to ground level staff
- Contract Monitoring
 - Depth and breadth of the contract
 - New contract monitoring tools to develop

State Successes

- New Enrollment Dashboard producing positive stakeholder feedback
- HRA Completions currently at 92% (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAIEnrollmentHRAJan2015.pdf>)
- Receiving increased provider feedback/communication and positive provider stories
- CMS approval for Annual Letter to beneficiaries

PPL Member Satisfaction Survey: Total Strongly Agree or Agree

	2014
I am satisfied with receiving services through the MMP	99%
My MMP case manager provided the right amount of assistance with the enrollment and hiring processes.	94%

Best Practices

- VA is the first state to move forward with rolling enrollment
- Quality Learning Collaborative
 - Virginia's unique partnership between DMAS, health plans, members, providers and other key stakeholders
 - Collaborative allows for Quality updates and focus areas for discussion
- Qualitative Program Analysis through Focus Groups and Observations
- Posting Evaluation and Quality Updates to web as they become available.



What Is Complete & Where Are We Going?

2013

- MOU & Competitive process for MMP selection

Summer-Fall 2013

- Multiple-step readiness reviews
- Ensure adequate provider networks

December 2013-March 2014

- Contracts signed
- Extensive systems testing

March 2014-December 2014

- Phased in Enrollment
- Outreach & Education
- Contract Monitoring
- Program Evaluation

January 2015 Forward

- Beneficiaries continue with rolling automatic assignment
- Ongoing Education
- Contract Monitoring
- Increased Program Evaluation
- Quality Metrics



Looking Ahead

- Outreach to those who previously opted out
- Changes in intelligent assignment to include Medicare data (PCP)
- Examining options for inclusion of more dually eligible population into CCC program
- Examining options for managed care for other remaining vulnerable populations
 - Will seek public input to the development of the RFP

**DMAS Office Of
Coordinated Care**

CCC@dmas.virginia.gov



Regulatory Activity Summary for April 14, 2015
(* Indicates recent activity)

2015 General Assembly

***(01) Expand Alzheimer's Waiver:** This regulatory action is required by 2015 budget language that awaits the Governor's signature. This regulation will more broadly define eligible individuals that may be served by the Alzheimer's Assisted Living waiver program.

***(02) Pre-Admission Screening Changes:** This regulatory action is required by 2015 budget language that awaits the Governor's signature. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services.

***(03) Sterilization Compensation:** This regulatory action is required by 2015 budget language that awaits the Governor's signature. 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.

***(04) PERS Changes:** This regulatory action will implement updates to the Personal Emergency Response System sections in multiple waiver regulations.

***(05) Levels A-B-C Psychiatric Services:** This regulatory action will make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency.

2014 General Assembly

(01) Discontinue Coverage for Barbiturates for Duals: This State Plan Amendment (SPA), effective January 1, 2014, enacts Section 2502 of the Affordable Care Act which amended section 1927(d)(2) of the *Social Security Act*. It excluded from Title XIX coverage for all conditions for barbiturates, by removing barbiturates and agents when used to promote smoking cessation from the list of drugs a state Medicaid program may exclude from coverage or otherwise restrict. The SPA was submitted to CMS 3/24/14 and CMS approved on 4/23/14. The Fast-Track regulatory package is currently at Governor's office pending approval.

***(02) No Inflation Reimbursement Methodology Changes:** This action affects hospitals, home health agencies, and outpatient rehabilitation providers. Chapter 2 of the *2014 Acts of the Assembly*, Item 301 CCC and IIII directed this change. The SPA was approved by the Secretary's Office on 9/23/14 and was submitted to CMS on 9/26/14. CMS sent a request for

additional information, and DMAS responded on 3/16/2015. SPA now pending approval by CMS and changes to parallel administrative code sections are pending.

***(03) Supplemental Payments for County-Owned NFs:** This action provides supplemental payments to locality-owned nursing facilities who agree to participate. The SPA was approved by the Secretary's Office on 9/23/14 and submitted to CMS on 9/24/14. CMS approved the SPA on 12/5/2014 and changes to parallel administrative code sections are pending.

***(04) 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 the Secretary's Office on 9/23/14 and submitted to CMS on 9/29/14. CMS sent a request for additional information, and DMAS responded on 3/9/2015. SPA now pending approval by CMS and changes to parallel administrative code sections are pending.

***(05) NF Price Based Reimbursement Methodology:** This action changes the cost-based methodology with the priced based method and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 KKK. The SPA was approved by the Secretary's Office on 9/23/14 and submitted to CMS on 9/29/14. CMS sent a request for additional information, and DMAS responded on 3/9/2015. SPA now pending approval by CMS and Fast Track changes to parallel administrative code sections are pending.

***(06) Hospital APR-DRG Methodology Change:** This action changes the APR-DRG grouper for hospital reimbursement and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 VVV. The SPA was developed and submitted to CMS on 12/15/14. The SPA now pending approval by CMS and changes to parallel administrative code sections are pending.

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

***(08) Primary Care Rate Increase Vaccine Administration:** This action adds to the State Plan rate increases for the administration of vaccines. The SPA was approved by CMS on 5/27/14 and changes to parallel administrative code sections are pending drafting.

***(09) Type One Hospital Partners' Supplemental Payments:** This action provides supplemental payments to Type One hospitals (state-owned teaching hospitals) qualifying partners and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 DDDD. The SPA was submitted to CMS which submitted a request for additional information. DMAS responded on 1/23/15, and CMS approved the SPA on 1/27/2015. The VAC action is pending being drafted.

***(10) 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 language. Once this language is finalized, DMAS may need to promulgate a revised emergency regulation.

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

***(12) GAP FAMIS Coverage of Children of State Employees:** The agency began work developing this FAMIS expansion in early September in response to the Governor's directive. It provides FAMIS coverage for the children of state employees who have low incomes. The emergency regulation became effective 1/1/2015, and DMAS has begun drafting the permanent replacement regulation. A companion Title XXI SPA will be required.

***(13) GAP Dental Services for Pregnant Women:** The agency began work developing this Medicaid service expansion in early September in response to the Governor's directive. It provides complete, with the exception of orthodontia, dental service coverage to the 45,000 Medicaid-eligible pregnant women. The emergency regulation became effective on 3/1/2015. DMAS filed companion Title XIX SPA with CMS on 2/24/15. CMS submitted an informal request for information on 3/6/2015.

***(14) MEDICAID WORKS:** This action is tied to item (02) in the 2011 General Assembly section below. As a result of CMS approval of the agency's SPA for the 2011 action, the agency must modify the VAC to maintain the parallel contents between the Plan and VAC. A Fast Track action has been drafted and is awaiting approval by the Secretary.

***(15) Mandatory Managed Care (Medallion 3.0) Changes:** This emergency regulation action requires individuals who receive personal care services via the Elderly or Disabled with Consumer Direction waiver to obtain their acute care services through managed care. It also shortens the time period for pregnant women to select their managed care organizations and complete the MCO assignment process. This emergency regulation became effective on 1/1/2015 and DMAS is drafting the permanent replacement regulation.

***(16) DOC Signature Authority for Medicaid Applications:** This Fast Track action proposes to grant authority to the director of the Department of Corrections, or his designee, to sign applications for medical assistance for those inmates who are unable or unwilling to sign their own application. This action only enables Medicaid to reimburse for inpatient hospital services received by inmates who leave the prison campus for care. This action is responsive to a mandate: Chapter 2 of the *2014 Acts of the Assembly*, Item 384 J(2). VAC-only change is awaiting approval by the Secretary.

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

2013 General Assembly

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

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

(03) 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 is still pending OAG certification. No SPA action is required.

***(04) Exceptional Rate for ID Waiver Individuals:** This Emergency/NOIRA will enable providers of congregate residential support services, currently covered in the Individual with Intellectual Disabilities Waiver (ID waiver), to render, in a more fiscally sound manner, services to individuals who have complex medical and behavioral care needs. Such individuals, who have long been institutionalized in the Commonwealth's training centers, are being moved into community settings over the next several years in response to the settlement of the lawsuit brought against the Commonwealth by the Department of Justice. These affected individuals have exceptional medical and behavioral support needs. For providers to render services for such individuals, it is requiring substantially more staff time and skills than for individuals who have not been institutionalized for extended periods of their lives. This regulatory action has been approved by the Governor and was submitted to the Registrar for publication on 11/13/14. The waiver change was approved by CMS on 4/23/2014. An emergency regulation is effective until May 1, 2016. The permanent regulation is being drafted and reviewed internally prior to OAG submission for certification.

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

(06) Discontinue Coverage of Benzodiazepines-Barbiturates for Dual Eligible Individuals: This Fast-Track regulatory change proposes to eliminate coverage for both benzodiazepines and barbiturates for full benefit dual eligibles (eligible for both Medicare and Medicaid), who may now obtain both these drugs under Medicare Part D drug coverage. This regulatory package is currently at the Governor's office pending approval. A SPA of the affected parallel State Plan sections will be required.

***(07) 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 (14-12) was submitted to CMS on 9/24/14. CMS has returned informal questions about the SPA that DMAS responded to on 3/5/2015. This regulatory package was filed with the Registrar's office 5/5/14, was published in the Register 6/2/14 and became effective 7/1/14. The proposed stage is being drafted to address CMS' informal SPA questions as well as the issues of this change.

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

***(09) Supplemental Payments for services provided by Type One Physicians-ACR Update:** This SPA revises the maximum reimbursement to 190% of the Medicare rate for Type One physicians, based on updated information on the average commercial rate furnished

by the providers which are affected by this change (state academic health systems). In response to the SPA that was submitted to CMS on 3/27/13, CMS issued a request for additional information (RAI). The RAI response was submitted to CMS 3/27/14 and was approved 1/26/2015. The parallel VAC change is pending certification by the OAG.

***(10) 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 and the NOIRA for the proposed stage is undergoing internal review.

***(11) 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) September 22, 2011. This action was put on hold, but has been re-activated and the NOIRA is undergoing internal review as of 3/11/2015.

2012 General Assembly

(01) EPSDT Behavioral Therapy Services: The NOIRA action promoted an improved quality of Medicaid-covered behavioral therapy services provided to children and adolescents who may have autism spectrum disorders and similar developmental disorders. The proposed changes will differentiate Medicaid's coverage of behavioral therapy services, including applied behavior analysis, from coverage of community mental health and other developmental services and establish provider qualifications and clear criteria for Medicaid payment. This regulatory package was approved by DPB 11/27/12 and submitted to the Registrar's office 12/12/12 for publication in the *Virginia Register* 1/14/13 and the comment period ended 2/13/13. The proposed stage regulation has been certified by the OAG, approved by DPB, the Secretary's Office, and is pending approval by the Governor's Office.

***(02) Supplemental Payments for Institutional/Non-Institutional Providers:** This Fast-Track action modifies or establishes supplemental payments for 1) physicians affiliated with Type One hospitals and state-funded medical schools, 2) hospitals and nursing homes affiliated with Type One hospitals and Type One hospitals. This regulation also modifies indirect medical education (IME), and graduate medical education (GME) reimbursement for Type One hospitals. This regulatory package became effective on 2/13/2015. SPA was approved by CMS 6/24/2013.

***(03) Mental Health Skill-Building Services:** The Emergency/NOIRA complied with the *2012 Acts of the Assembly*, Chapter 3, Item 307 LL that directed programmatic changes to Community Mental Health services to consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. Pursuant to the *2012 Acts of Assembly*, Chapter 3, Item 307 RR (f) directed DMAS to implement a mandatory care coordination model for Behavioral Health. The goals of Item 307 RR (e) include the achievement of cost savings and simplification of the administration of Community Mental Health Services. Item 307 RR (f) authorizes DMAS to promulgate Emergency regulations for this mandatory model. This regulatory package was approved by the Governor and submitted to the Registrar's Office 10/10/13. The comment period ended 12/11/13. DPB is preparing an economic impact analysis for the proposed stage.

***(04) Timely Claims Filing:** This Fast-Track action creates a 13-month deadline in which Medicaid providers may resubmit denied claims for reconsideration by DMAS. There is currently no set deadline in DMAS regulations for such reconsiderations, which has the effect on both DMAS and providers of dealing with open accounts for sometimes years at a time. This action brings closure to providers and the Agency by setting a generous 13-month resubmission policy. The regulation became effective 2/15/15.

(05) Appeals Regulations Update: This Emergency/NOIRA regulatory action complied with the legislative mandate (Item 307, III of the *2012 Acts of Assembly*) and addressed recent case law and administrative decisions. These actions have created the need to clarify existing appeals processes and codify emerging processes made urgent by court and administrative case decisions and the increasing volume of appeals generated by provider audits and other utilization review mandates. The SPA was approved by CMS 12/12/12. This regulatory package was approved by the Governor's office 10/30/13 and filed with the Registrar's office 11/1/13. The comment period ended 1/1/14. The Emergency regulation expires on 6/30/15. The proposed stage regulation has been approved internally and is currently pending OAG certification.

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

allowed is the average commercial rate. The SPA was approved by CMS 6/29/12. An update to the percentage is being made and another SPA is currently being drafted. Changes to parallel administrative code sections are pending.

2011 General Assembly

***(01) Collaboration Agreement Hospitals:** These SPAs create supplemental payments for qualifying private hospitals. Qualifying hospitals must have signed a Low Income and Needy Care Patient Collaboration Agreement with a state or local government entity for purposes of providing health care services to low income and needy patients. Supplemental payments would be calculated as the difference between charges and regular payments. Supplemental payments to Disproportionate Share Hospitals (DSH), however, cannot exceed a separate limit that applies to them and total payments to all hospitals cannot exceed the UPL. These SPAs were submitted to CMS 12/20/11. The agency received requests for additional information and responses were submitted to CMS on 5/30/12 and 6/4/12. Additional questions were received from CMS. RAI responses submitted to CMS 11/28/12. DMAS is awaiting response from CMS. There were multiple SPAs (4) involved with this action and CMS approved 2 of the SPAs on 8/2/13 and 8/13/13. SPAs 11-018 and 11-019 are being reviewed internally as of 3/12/15 prior to resubmission to CMS.

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

***(03) Client Medical Management (CMM):** The Emergency/NOIRA action was designed to assist and educate beneficiaries in appropriately using medical and pharmacy services. Members, who use these services excessively or inappropriately, as determined by the DMAS may be assigned to a single physician and/or pharmacy provider. This regulatory action was approved by the Governor's office 12/16/13 to be effective 12/16/13 and expires 6/15/2015. The fast-track stage is awaiting the Governor's signature.

***(04) 2011 Exceptions to Personal Care Limit:** This Emergency/NOIRA action complied with the legislative mandate to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services (which includes supervision time). This regulatory package was approved by the Governor on 9/3/12 and was filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. (2011 General Assembly Item 297 CCCCC) The proposed stage regulatory package was approved by the Governor's Office on 11/18/14, filed with the Registrar on 11/18/14 and was published in the Register on 12/15/14. The final stage documents are going through internal review as of February, 2015.

***(05) Early Intervention Part C Children Case Management:** This Emergency/NOIRA regulatory action supported early intervention services, provided under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) which address developmental problems in young children. These services are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. This Emergency/NOIRA action was approved by the Governor's office 9/12/2012. The SPA was approved by CMS 9/25/2012. This regulation became effective on 2/13/15.

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. This regulatory package was filed with Registrar's office 7/1/10. The State Plan Amendment was submitted to CMS on 9/28/10 and was approved 6/1/11. A new Emergency regulation was drafted based on the 2011 Appropriations Act to replace the previous one. Secretary's office approved 7/12/11. Governor approved 7/18/11 and became effective on 7/18/11. NOIRA comment period ended 9/14/11. The proposed stage package was approved by DPB 9/6/12 and approved by the Secretary 9/24/12. This proposed stage package was approved by the Governor's office on 1/14/13. The comment period ended 4/12/13. (Item YY of the 2010 Appropriations Act) The final regulations became effective 1/30/2015. The SPA is undergoing internal review and will be submitted to CMS by 3/31/2015.

2009 General Assembly

(01) Social Security Number Data Match for Citizenship and Identity: This Fast-Track change conforms to CHIPRA of 2009 which offers states a new option to assist Medicaid applicants and recipients in the verification process. Section 211 of CHIPRA gives states the ability to enter into a data match with the Social Security Administration to verify the citizenship and identity of Medicaid applicants and recipients who claim to be United States citizens. Because provision of a Social Security number is already a condition of eligibility for Medicaid, adoption of this option will remove a barrier to enrollment and will result in a more seamless application process for most Medicaid applicants and recipients. This regulatory package is currently at the Governor's office pending approval.

***(02) Elderly and Disabled Waiver 2009 Changes:** This initial Notice of Intended Regulatory Action (NOIRA) updates the Elderly or Disabled with Consumer Direction Waiver (EDCD) to accommodate changes in the industry and to provide greater clarity in these regulations. The NOIRA stage regulatory action was filed with the Registrar's office 10/2/09 and the comment period ended 11/25/09. The Proposed regulatory stage was

approved by the Attorney General's office 12/6/10. DPB approved package 3/31/11. The Governor approved this package on 9/11/12 and it was filed with the Registrar's office 9/11/12. The public comment period ended 12/7/12. The final stage regulation became effective on 2/12/15.

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.