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

June 14, 2016
DRAFT Minutes

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

Absent:
Alexis Y. Edwards

DMAS Staff:
Linda Nablo, Chief Deputy Director
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Ivory Banks, Program Operations Division Director
Seta Vandegrift, Budget Division Director
Charlotte Arbogast, LTC Staff
Abrar Azamuddin, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Cynthia B. Jones, Director
Scott Crawford, Deputy Director for Finance
Terry Smith, Division Director, Long-Term Care

Guests:
Kenneth McCabe, DPB
Steve Ford, VHCA
Cecelia Kirkman, SEIU Healthcare
Chris Law, Xerox
Richard Grossman, VECTRE
Lindsay Walton, Macaulay & Jamerson
Stephanie Lynch, VAHP

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:05 a.m. Dr. Rheuban asked other members to introduce themselves and introductions continued around the room. Dr. Rheuban encouraged members to continue to submit potential topics of interest for discussion at future Board meetings.

APPROVAL OF MINUTES FROM APRIL 19, 2016 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the April 19, 2016 meeting. Ms. Jankowski made a motion to accept the minutes and Dr. Kongstvedt seconded. The vote was **10-yes (Baig, Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, and Yeskoo); and 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, provided an update on the agency's top five priorities, Managed Long Term Services and Supports (MLTSS), Medallion 3.0 managed care contract, Delivery System Reform Incentive Program (DSRIP), Substance Use Disorders (SUD) services and waiver, and the Medicaid Enterprise System (MES), and their current status. The Department of Behavioral Health and Developmental Services (DBHDS) ID/DD Waiver Redesign is also another priority for DMAS and is set to be implemented on July 1.

Ms. Gwilt suggested discussion of capacity issues and training for providers as it relates to the upcoming Substance Use Disorders (SUD) services waiver at the next BMAS meeting scheduled for September 13.

Mr. Baig suggested a discussion of value based purchasing and what DMAS has learned from other states at the next BMAS meeting.

PROCUREMENT AND CONTRACT MANAGEMENT

Mr. Scott Crawford, Deputy Director for Finance, briefly discussed a recent report entitled "Development and Management of State Contracts in Virginia" published by the Joint Legislative Audit and Review Commission (JLARC) which noted, "…some agencies--like DMAS—are ensuring that contract administrators receive proper guidance on enforcing contract provisions." The JLARC report can be accessed at this link: http://jlarc.virginia.gov/reports.asp.

Mr. Crawford explained DMAS expenditures, types of contracts, and Virginia's procurement policy. (see attached handout).

CONSUMER DIRECTED SERVICES IN HOME AND COMMUNITY BASED WAIVER PROGRAMS

Ms. Terry Smith, Long-Term Care Division Director, provided an overview of the consumer directed (CD) services in home and community based waiver programs. CD personal assistance services help individuals with their activities of daily living (ADLs), such as dressing, bathing, toileting, eating, and assistance with self-administration of medication. This service is available

in the EDCD, ID, and DD Waivers and in the EPSDT program. Individuals may choose CD, agency directed or from both models. (see attached handout)

Ms. Yeskoo left during this presentation.

REGULATORY ACTIVITY SUMMARY

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

OLD BUSINESS

None.

NEW BUSINESS

In response to discussion at past meetings, agenda topics are being focused on discussing a topic in-depth rather than highlights of several topics during a meeting. During discussion of agenda planning, several members expressed desire to be more helpful. Mr. Cook made a motion that the Board plan a retreat to discuss the roles of the Board and how members can be more helpful. It was decided a workgroup consisting of Dr. Rheuban, Mr. Baig and Mr. Cook would plan the retreat/meeting. The workgroup would propose when, where and what agenda topics would be included for discussion at the potential retreat/meeting. Mr. Baig seconded. The vote was **9-yes (Baig, Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Price, and Rheuban); and 0-no.**

ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting at 12:07 p.m. Ms. Jankowski made a motion to adjourn the meeting and Dr. Price seconded. The vote was unanimous. 9-**yes (Baig, Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Price, and Rheuban); and 0-no.**

Immediately following the Board meeting, members of the Board attended an orientation training open to the public in the Board Room. Board members, DMAS staff and others attending included: Maureen Hollowell, Karen Rheuban, MD, Cara L. Coleman, JD, MPH, Michael H. Cook, Esq., Rebecca E. Gwilt, Esq., Cynthia B. Jones, Director, Linda Nablo, Chief Deputy Director, Ivory Banks, Program Operations Division Director, and Kenneth McCabe, DPB. (handouts attached)

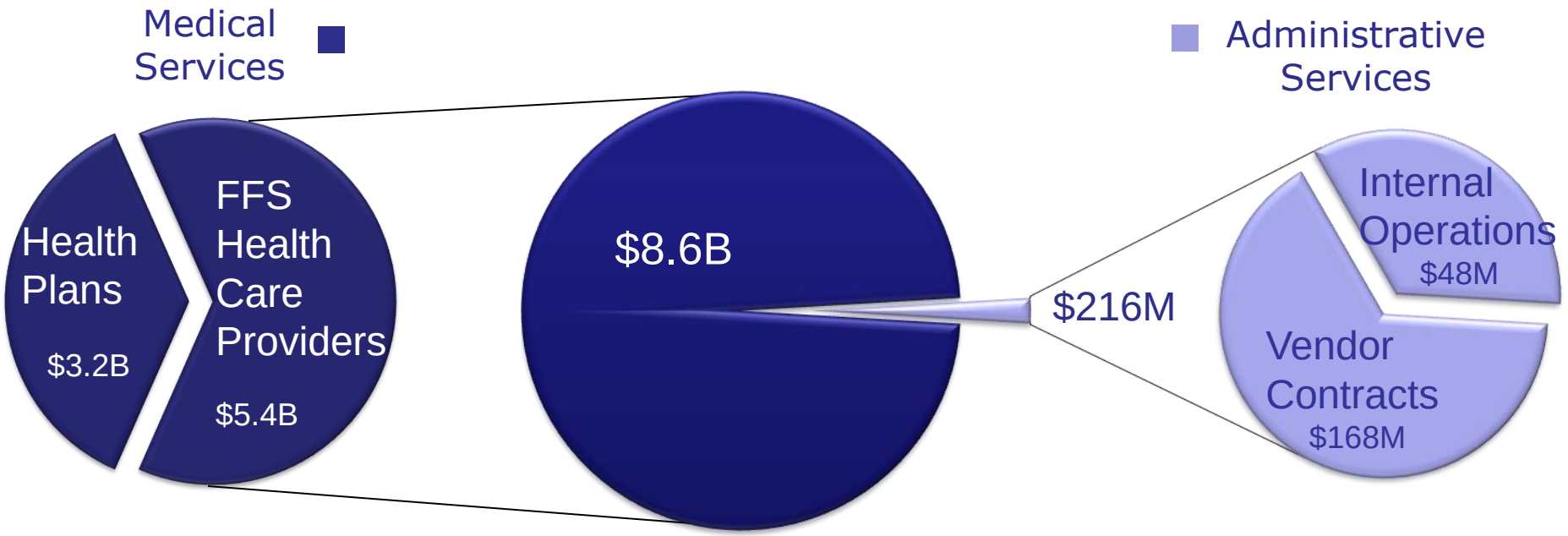
Department of Medical Assistance Services

Management of Contracts at DMAS

Presentation to the
Board of Medical Assistance Services

June 14, 2016

DMAS Expenditures – SFY2015 $8.8B

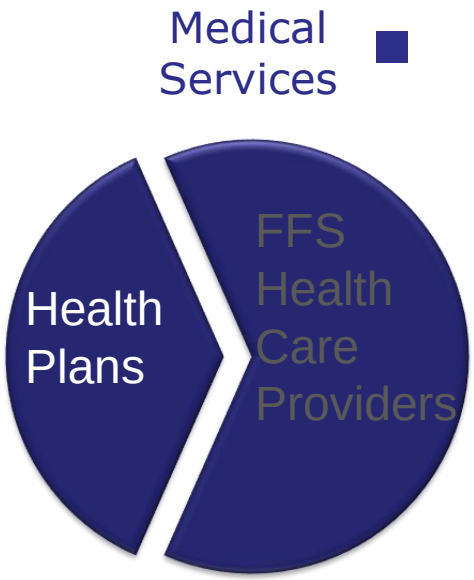


Types of Contracts: Medical Services

FFS Health Care Providers: Provider Agreements

- Short and simple contract document
- No procurement process, no bidding, no negotiation
- Terms and payments are based on federal and state laws and regulations; must be accepted by all who "enroll" to be providers
- State must enroll "any willing provider"
- Enrollment process, not contract execution

Types of Contracts: Medical Services



Health Plans: Health Plan Contract

- Involves a procurement process
- Usually no bidding or negotiation of price
- Contract rates set by DMAS using actuarial principles, some policy decisions controlled by DMAS but within established federal rate setting guidelines

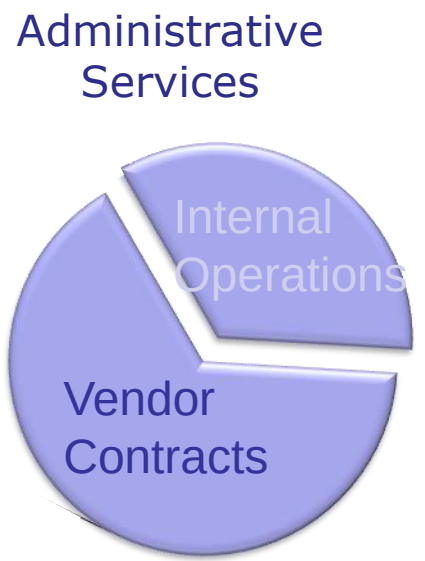
Types of Contracts: Admin Services

Vendor Contracts

- Professional Services
  - Accounting, actuarial, legal services, etc.

    "Professional services" means all work performed by an independent contractor within the scope of the practice of accounting, actuarial services, architecture, land surveying, landscape architecture, law, dentistry, medicine, optometry, pharmacy, professional engineering, and the services of an economist procured by the State Corporation Commission.

- Non-Professional Services
  - All services not within the scope of practice of the above professions



Types of Contracts: Admin Services

Vendor Contracts

- Professional Services
  - RFP procurement is used
  - Selection based primarily on technical evaluation
  - Price negotiation occurs as last step
  - Legal services – DMAS' counsel is OAG or counsel procured by OAG

- Non-Professional Services
  - Competitive procurement with selection through scoring on defined criteria with price as one criterion
  - IT services
    - "In-scope" – purchased through VITA contract
    - "Out-of-scope" – purchased under VITA guidelines, large contracts subject to VITA project management

DMAS Vendor Contracts

	SFY15 Total	SFY15 GF
Service Authorization, QA and ASO Services	$49.7M	$18.6M
Rate Setting, Financial Review, Auditing Services	$23.2M	$ 8.7M
Enrollment & Outreach	$49.3M	$11.0M
Claims Processing and Information Systems	$45.6M	$11.0M
TOTAL VENDOR CONTRACTS	$167.8M	$49.3M

Virginia Procurement Policy

Department of General Services, Division of Purchasing & Supply (DGS/DPS) is the state's centralized purchasing agency for non-technology goods and services

- DMAS, and other state agencies, receive their delegated procurement authority from DGS/DPS
- Agency must follow state law, regulations and guidance documents
  - Agency Procurement and Surplus Property Manual (APSPM)
  - Virginia Public Procurement Act Section 2.2-4300 et seq.
  - VITA IT Procurement Manual
  - Commonwealth Accounting Policies and Procedures Manual
- DGS/DPS certifications available to procurement personnel include
  - Virginia Contracting Associate (VCA)
  - Virginia Contracting Officer (VCO)
  - Virginia Contracting Master (VCM)

Virginia Procurement Policy

The Virginia Information Technology Agency (VITA) is the state's centralized purchasing agency for information technology goods and services

- DMAS, and other state agencies, receive their delegated procurement authority for IT goods and services from VITA
- Agency must follow state law, regulations and guidance documents
  - Agency Procurement and Surplus Property Manual (APSPM)
  - Virginia Public Procurement Act Section 2.2-4300 et seq.
  - VITA IT Procurement Policy Manual: BUY IT

DMAS Contract Management

- Unit with staff of 8 within Budget & Contract Management Division
- Creating a new stand-alone division to focus solely on contracts
- Every contract has a “contract administrator” in the end-user division who has operational contract management responsibilities

Contract Management Activities

Administrative activities associated with contract management include:

- Request for proposal
- Proposal evaluation
- Negotiation and award of contract
- Contract implementation
- Measurement of work completed
- Computation and processing of payments
- Monitoring contract expenditures and contract value
- Monitoring contract relationship and addressing related problems
- Incorporating necessary changes or modifications in the contract
- Ensuring both parties meet or exceed each other's expectations,
- Actively interacting with the contractor to achieve the contract's objective(s),
- Ensuring compliance with state procurement and contracting rules

Audits/Reviews of DMAS Contracting

- State
  - Department of General Services, Division of Purchasing & Supply
  - Auditor of Public Accounts
  - Joint Legislative Audit and Review Commission
  - Office of the State Inspector General
- Federal
  - Centers for Medicare and Medicaid Services
  - Office of the Inspector General, Health and Human Services

Consumer Direction: A Model Making a Difference

Terry Smith, Director

Division of Long-Term Care

June 14, 2016

Virginia's Medicaid Program Key Facts

1 Million +

Virginians covered by Medicaid/CHIP

1 in 8

Virginians rely on Medicaid

2 in 3

Residents in nursing facilities supported by Medicaid - Primary payer for LTSS

50%

Medicaid beneficiaries are children

58%

Long-Term Services & Supports spending is in the community

1 in 3

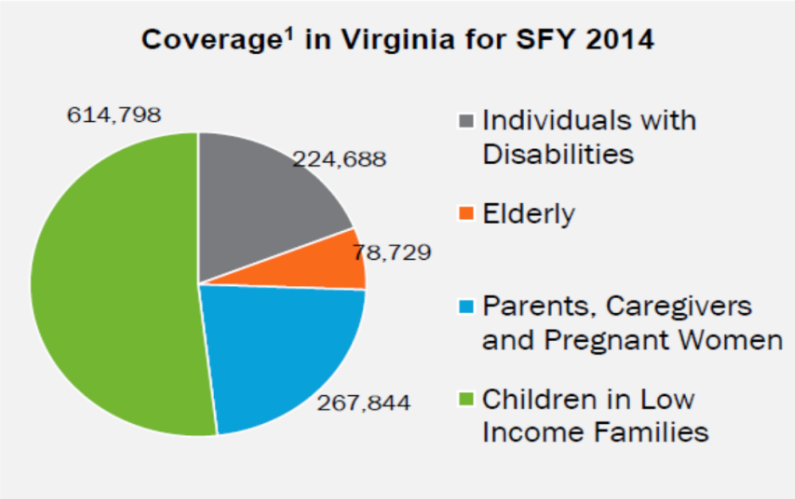
Births covered in Virginia

Behavioral Health

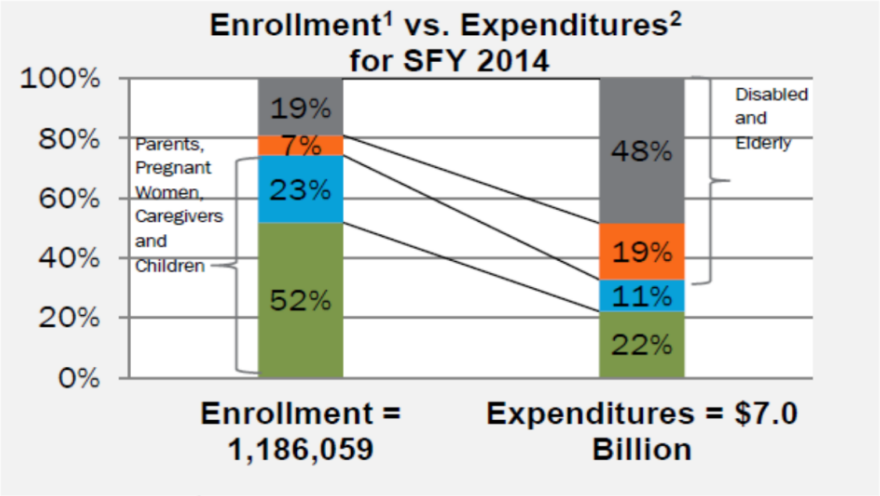
Medicaid is primary payer for services

Overview: Virginia Medicaid

Virginia's Medicaid population breakdown and expenditures



Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.



[1] Coverage and enrollment numbers show the total annual unduplicated enrollments for Virginia's Title XIX program
[2] Expenditures represent claims expenditures for Virginia's Title XIX program

Medicaid expenditures are disproportionate to covered populations. Seniors and individuals with disabilities make up over 25% of the total population, yet almost 70% of expenditures are attributed to this group.

Personal Care: Two Models

Agency Services	Agency care is provided to individuals who require personal services, companion services and respite services and choose this model of care. The agency is the employer of the staff member. Approximately 500 providers.
CD Services	Consumer directed care is provided to individuals who require personal services, companion services and respite services and choose this model of care. The Medicaid individual is the employer of the attendant that they hire. 21,000 consumers and 23,000 attendants
Agency and CD	A Medicaid individual may choose to have services from both models of care, receiving some services from an agency and some from an attendant.

Consumer Direction: Defined

Common Names

Participant Direction	Consumer Direction or CD

Waiver individual or the individual's employer of record (EOR), as appropriate, are responsible for hiring, training, supervising, and firing of the person or persons who actually render the services that are reimbursed by DMAS.

Abbreviated/modified definitions from 12VAC30-120

Consumer Direction: Key Players

- "Employer of record" or "EOR"
  - The person who performs the functions of the employer. The EOR may be the individual enrolled in the waiver, a family member, caregiver, or another person.
- "Fiscal/employer agent" or "F/EA"
  - A state agency or other entity as determined by DMAS to meet the requirements of 42 CFR 441.484 and the Virginia Public Procurement Act.
- "Individual"
  - The person receiving waiver services.
- "Personal care attendant" or "attendant"
  - A person who provides personal care or respite services that are directed by an individual, family member/caregiver, or EOR.
- "Services facilitator" or "SF"
  - The provider who is responsible for the development and monitoring of the CD services plans of care, employee management training and ongoing review activities as required by DMAS.

Abbreviated/modified definitions from 12VAC30-120

Consumer Direction: How It All Fits

Basics

- Individuals as the EOR (or through an EOR) hire and fire their own attendants
- Attendants may be friends or family members
- Individuals may have a combination of CD and agency-directed services
- Individuals must have a back-up plan

Waivers

- Intellectual Disability (ID) Waiver
- Individual and Family Developmental Disabilities Support (DD) Waiver
- Elderly or Disabled with Consumer Direction (EDCD) Waiver
- The Early, Periodic, Screening Diagnosis and Treatment (EPSDT)
- Children's Mental Health (CMH) program

Available Services

- Personal Care
- Respite Care
- Companion Care
- Not included: 1) Nursing Services; or 2) Services provided to others in the house

Consumer Direction: PPL Responsibilities

DMAS contract with PPL: Started in 2006, awarded again in 2012

As the F/EA, PPL performs the following activities:

- Conducts criminal background checks on potential attendants
- Processes hiring paperwork for attendants
- Receives, verifies and processes attendant time sheets
- Maintains attendant payroll records
- Processes all required state and federal tax forms and payments on behalf of the employer and the attendant

Consumer Direction: How It Unfolds

Individual or representative selects CD services and selects a SF

The EOR is identified and the SF helps develop a plan of care and train the EOR on responsibilities

The EOR works with the SF to get service authorization and start the hiring process for an attendant ; PPL manages the hiring paperwork

The attendant is approved and begins providing services to the individual

PPL continues to provide payroll-related supports to the EOR and the SF provides ongoing support to the individual and EOR as needed

Consumer Direction: Advantages

Consistency	• Home care agencies sometimes experience worker shortages and high staff turnover
Flexibility	• Services can be tailored to meet participants' individual needs, including the potential for more evening and weekend coverage
Empowerment	• Individuals make decisions regarding their own care, including their needs and preferences and control over and choice with employment decisions
Trust	• Individuals select attendants, who often have prior relationships with the individual and established trust

Consumer Direction: The Research

- A 2000 study found that individuals in the CD model reported more positive outcomes than those in the agency model, with statistically significant differences in the areas of individual **safety**, **unmet needs**, and services **satisfaction**. In addition, "a family member present as a paid provider was also associated with more positive reported outcomes" (Benjamin, Matthias & Franke, 2000).
- A 2003 study found that, for both elderly and nonelderly adults, individuals participating in consumer direction were "more satisfied with the **timing** and **reliability** of their care, **less likely to feel neglected or rudely treated** by paid caregivers, and **more satisfied** with the way paid caregivers performed their tasks." Further, CD "reduced some unmet needs and greatly enhanced quality of life" (Foster et al., 2003).
- A 2006 study found that, "**family caregivers** of CD participants reported **greater well-being** compared to family caregivers of those receiving agency-directed services." Moreover, **caregivers were less likely to "report high levels of physical, financial, and emotional strain**" and they "**worried less** about insufficient care" (Foster et al., 2006).

Consumer Direction: When It's Not Appropriate

An individual may be found NOT to be eligible for CD services if:

No EOR:

It is determined that he or she cannot be the EOR, and no one else is able to assume this role

Too Much Risk:

The individual wants CD services, but health and safety cannot be assured

Needs Don't Fit:

The individual has medication or skilled nursing needs or medical/behavioral conditions that cannot be met through CD services

Consumer Direction: National History

1970s

- Idea of choice and control in personal assistance services starts

1990s

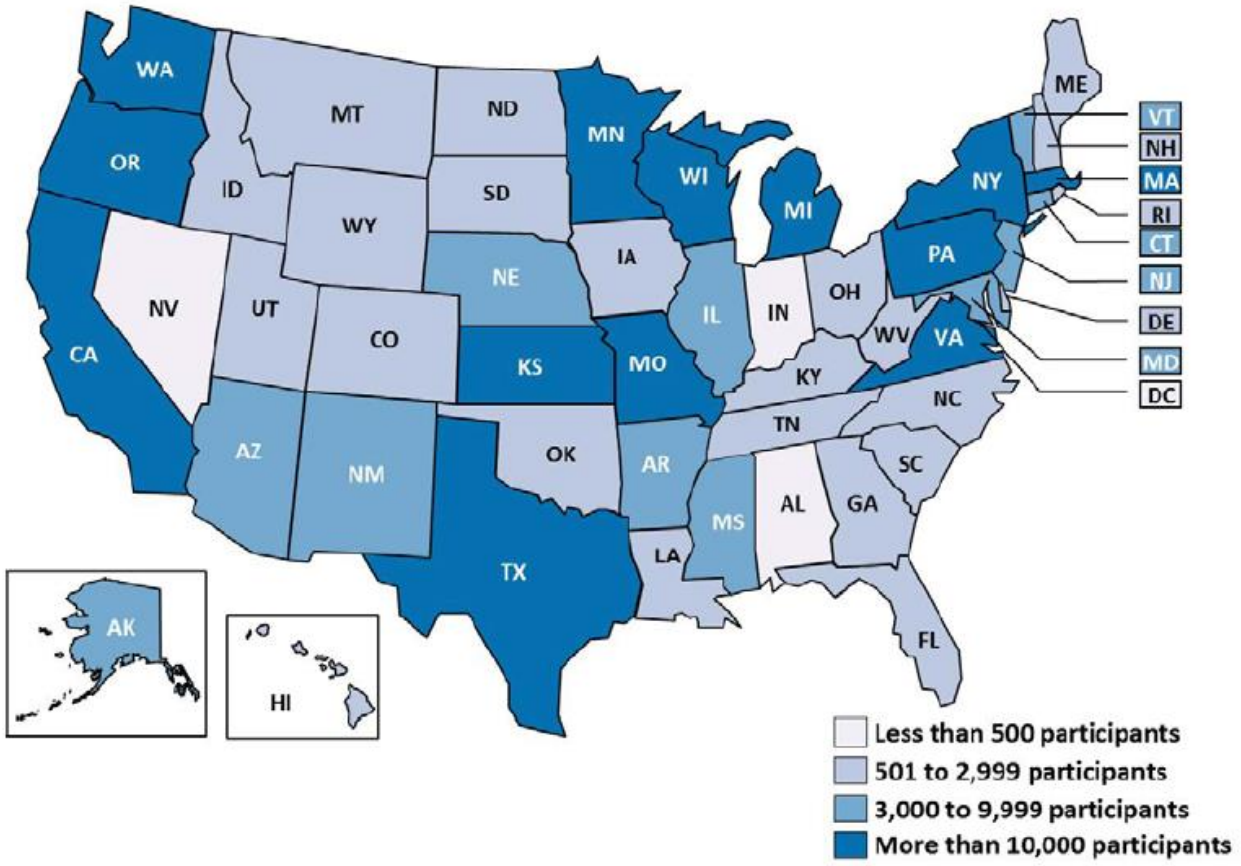
- Health Care Reform Act of 1993
- HHS and RWJF fund 3 demonstrations focused on self-direction and individualized budgets managed by waiver individuals
- Results: Fewer unmet needs, health outcomes were as good or better than those receiving agency-directed services

2000s

- 2002: CMS releases Independence Plus waiver application to streamline approval for waiver programs offering self-direction
- 2004-2005: CMS revised the §1915(c) HCBS waiver application to include self-direction options
- 2005 Deficit Reduction Act allowed for more flexibility in self-direction; initiatives did not need 1115 demonstration authority

Participant Direction/CD Enrollment by State

Figure 1: *Participant Direction Enrollment by State*[3]

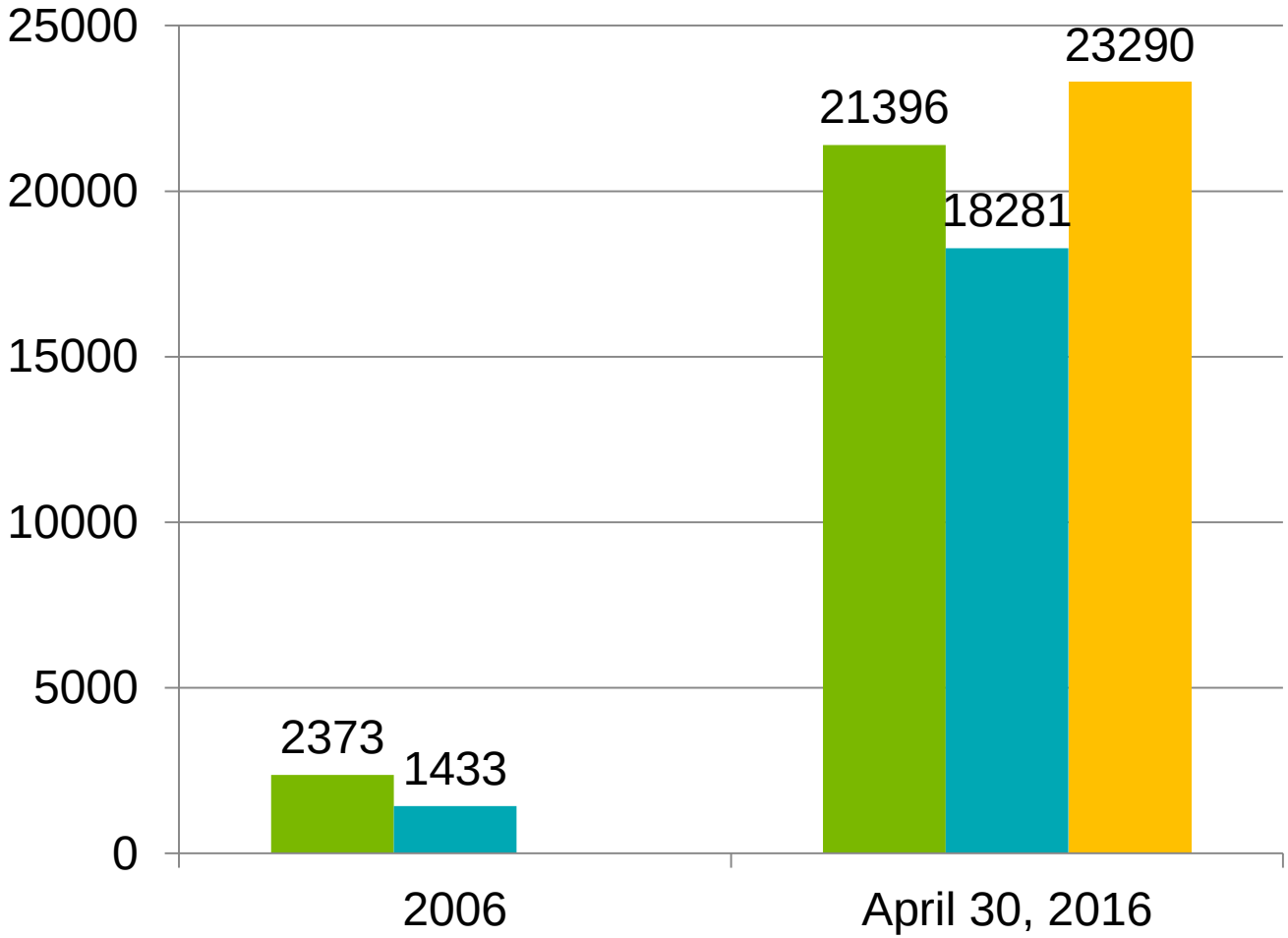


Facts and Figures: 2013 National Survey on Participant Direction
Boston College, National Resource Center for Participant-Directed Services

Consumer Direction: Virginia Medicaid History

- Elderly or Disabled with Consumer Direction (EDCD) Waiver
  - Waiver started February 1, 2005 and includes CD Personal Care and CD Respite Care
  - Formed by combining the two waivers: 1) Elderly and Disabled (E&D) Waiver, which began in 1982; and 2) the Consumer-Directed Personal Attendant Services (CD-PAS) Waiver, which began in July 1997. Both were discontinued on January 31, 2005.
- Intellectual Disability (ID) Waiver
  - Formerly known as the MR Waiver
  - Waiver started in January 1991
  - October 2001: CD Personal Care, CD Respite Care, and CD Companion Care were added
- Individual and Family Developmental Disabilities Support (DD) Waiver
  - Waiver started in July 1, 2000 and includes CD PAS, CD Respite Care, and CD Companion Care

Consumer Direction: Growth in Virginia Medicaid CD Services



800% increase in enrolled consumers

1175% increase in active consumers

*Attendant figures not available for 2006

Source: Public Partnerships, LLC Monthly Report Card Data 2006-2016

Consumer Direction: Program Management and Monitoring

Aspects of Monitoring

PPL Fraud and Abuse Compliance Plan	DMAS: LTC Annual Level of Care Reviews	DMAS: LTC Quality Management Reviews	DMAS: Division of Program Integrity	Virginia Office of the Attorney General: Medicaid Fraud Control Unit (MFCU)

Consumer Direction: The Future

Expect Continued Growth

- Individuals Selecting CD
- Attendants Participating in CD

Increased Use of Technology

- Monitoring Care and Attendants
- Streamlined Processing
- Integration of “Smart Home” elements

One Solution to Workforce Capacity Challenges

- Current workforce shortages in traditional LTC settings/providers
- CD offers expanded opportunities for employment and service delivery

References

- Benjamin, A.E., Matthias, R. Franke, T. (2000). *Comparing CD and agency models for providing supportive services at home*. Los Angeles, CA: Hospital Research and Educational Trust.
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- Foster, L., Brown, R., Phillips, B. & Carlson, B.L.(2006). Easing the burden of caregiving: The impact of consumer direction on primary informal caregivers in Arkansas. *The Gerontologist*, 45(4), 474-486.
- The National Resource Center for Participant-Directed Services. Retrieved from: https://www.caregiver.org/national-resource-center-participant-directed-services.

Regulatory Activity Summary June 14, 2016
(* Indicates recent activity)

2016 General Assembly

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

***(02) FAMIS Eligibility Changes:** This regulatory action was required by 2016 budget language. This regulation will serve to improve access to eligible individuals that may be served by the Family Access to Medical Insurance Security Plan (FAMIS) program. These regulatory changes are currently being drafted.

***(03) FAMIS Behavioral Therapy:** The General Assembly has required that the current coverage gap between FAMIS and Medicaid be closed and a more uniform approach to treatment be implemented. As such, this fast-track regulatory action is designed to add coverage of behavioral therapy services, including applied behavior analysis, to FAMIS recipients and to, accordingly, update DMAS' FAMIS regulations. These changes will enable DMAS to ensure services are provided to qualified recipients. These regulatory changes are currently being drafted.

***(04) Applied Behavioral Analysis:** This action establishes Medicaid coverage for behavior therapy services for children under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which is a mandatory Medicaid-covered service that offers preventive, diagnostic, and treatment health care services to young people from birth through the age of 21 years. The proposed regulations define the behavioral therapy service requirements, medical necessity criteria, provider clinical assessment and intake procedures, service planning and progress measurement requirements, care coordination, clinical supervision, and other standards to assure quality. These regulations have been drafted and are currently circulating for internal review, prior to submission to the OAG.

(05) Three Waiver Redesign: This emergency regulatory action is required by 2016 budget language. The Individual and Family Developmental Disabilities Support Waiver is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver is changing to the Community Living Waiver (CL), and; the Day Support Waiver for

Individuals with Mental Retardation is changing to the Building Independence Waiver (BI). This redesign effort, ongoing between DMAS, DBHDS, consultants, and stakeholders for the last two years, combines the target populations of individuals with both intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. The regulation has been drafted and is circulating internally for review prior to submission to the Office of the Attorney General (OAG).

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

2015 General Assembly

***(01) Pre-Admission Screening Changes:** This regulatory action is required by 2015 budget language. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services. These regulatory changes were drafted and reviewed internally, and submitted to the OAG. The OAG certified the regulations and they were sent to the DPB on 4/25/16.

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

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

(04) Technology Assisted Waiver Changes: This regulatory action will change the use of private duty nursing; change the staff experience requirement to include a training program; and remove the reference to exhausting private insurance coverage. The proposed stage was drafted, reviewed internally, and submitted to the OAG on 2/19/2016.

***(05) Non-Institutional Provider Reimbursement Changes:** This regulatory action combines three separate items required by 2015 budget language. First, this regulatory action will eliminate the requirement for pending, reviewing, and reducing fees for emergency room

claims. Second, it will increase supplemental payments for physicians affiliated with freestanding children's hospitals with more than 50 percent Virginia Medicaid inpatient utilization effective July 1, 2015. Third, it will establish supplemental payment for state clinics operated by the Virginia Department of Health (VDH) effective July 1, 2015. A prior public notice was published and a state plan amendment (SPA) was submitted to CMS on August 31, 2015. CMS sent informal questions about the SPA, and DMAS provided responses on 10/23/2015. DMAS received a request for additional information from CMS and provided responses on 2/19/2016. CMS approved the SPA on 2/24/16. DMAS is currently circulating the corresponding regulations for internal review.

***(06) Institutional Provider Reimbursement Changes**: This action will eliminate inflation for inpatient hospital operating, graduate medical education, disproportionate share hospital, and indirect medical education payments in FY16. It will also implement the "hold harmless provision" for nursing facilities that meet the bed capacity and occupancy requirements, reimbursing with the price-based operating rate rather than the transition operating rate for those facilities. A prior public notice was published and a SPA was submitted to CMS on 9/15/2015. CMS sent informal questions about the SPA, and DMAS provided responses on 11/16/2015. CMS approved the SPA on 12/16/15. The fast-track stage package was drafted, reviewed internally, and submitted to the OAG on 4/21/2016.

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

***(08) MAGI:** This action implements Modified Adjusted Gross Income (MAGI) thresholds in the Medicaid program and Children's Health Insurance Program (CHIP) in accordance with federally mandated eligibility determination requirements created under the Affordable Care Act. Multiple state plan amendments were submitted to CMS and approved in November and December, 2013. This final exempt regulation copies the state plan changes into state regulations. The final exempt regulations and Town Hall background document were submitted to the Office of the Attorney General (OAG) on 6/22/15. DMAS reached out to the OAG on 4/18/16 to request a review status update.

(09) Treatment of Annuities: This action complies with a federal Deficit Reduction Act, which requires DMAS to treat annuities and income from annuities according to certain rules, for purposes of determining Medicaid eligibility. Regulatory changes were drafted and submitted to the OAG on 9/14/2015. As of 1/27/2016, this regulation is under OAG review.

***(10) Hospital Presumptive Eligibility:** In 2014, DMAS submitted a SPA to CMS to permit certain hospitals to make presumptive eligibility determinations for individuals seeking to be treated at those hospitals. The SPA was approved on July 28, 2015, and DMAS drafted related regulatory changes. These were submitted to the OAG on 10/29/2015. DMAS responded to multiple rounds of inquiries on 11/17/2015; 12/15; 12/17; and 2/29/2016. The

OAG certified the action on 3/4/2016, and the package was submitted to the DPB on 3/7/2016. Following a meeting with DPB on 4/4, DPB certified the regulations on 4/21 and submitted them to HHR.

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

***(12) Utilization Review Changes:** DMAS drafted a NOIRA to implement regulatory changes to more accurately reflect current industry standards and trends in the area of utilization review. The regulatory action was submitted to the OAG on 11/2/2015, and comments were received on 11/10. A revised ABD was sent to the OAG on 11/18. A NOIRA was sent to DPB on 11/30, and the regulatory action was moved to HHR on 12/4. The Governor signed the action on 12/11. The NOIRA was published in the Town Hall Register on 1/11/2016, with the comment period in place through 2/10. As of 4/27/2016, the proposed stage regulatory text is undergoing internal DMAS review.

***(13) Recovery Audit Contractor:** DMAS drafted a State Plan Amendment to reflect that Virginia will not have a Recovery Audit Contractor (RAC) in place for a limited time while that contract is re-procured. DMAS entered into negotiations with the prior RAC but the negotiations were unsuccessful, and the contractor eventually determined that it would not renew the contract for the option year. The SPA was sent to HHR on 11/25/2015, and subsequently submitted to CMS on 12/4. DMAS received a request for additional information from CMS on 1/20/2016 and provided responses on 1/26. The SPA was approved by CMS on 2/29/16. The project has been completed and was closed out on 3/14/2016.

2014 General Assembly

(01) Supplemental Payments for County-Owned NFs: This action provides supplemental payments to locality-owned nursing facilities who agree to participate. The SPA was approved by CMS on 12/5/2014, with pending changes to parallel administrative code sections. The OAG certified the regulatory action and submitted it to DPB on 4/28/2015. On 6/7/2015, DPB submitted the action to the Secretary and it is currently still under review.

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

(03) GAP SMI Demonstration Waiver Program: The agency began work designing this new non-Medicaid program in early September in response to the Governor's directive. It provides a package of limited benefits to individuals who are 21 to 64 years old, uninsured, and residents of the Commonwealth. Some of the benefits are: physician, clinic, diagnostic outpatient procedures for both medical health conditions and behavioral health conditions related to diagnoses of serious mental illness. CMS approved the program in December, 2014. The emergency regulation action became effective 1/1/2015. The General Assembly proposed changes to this program in the 2015 budget and DMAS drafted a revised emergency regulation to incorporate these changes, which became final on 6/24/15. The proposed stage regulation, which incorporated the changes from both emergency regulations, was submitted to the OAG for review on 11/16/2015. DMAS revised the regulations, updated the Town Hall accordingly, and re-submitted the action to the OAG on 11/20/15. DMAS responded to OAG requests for revisions on 3/8/16 and 4/26. As of 4/27, this regulatory action is currently circulating through internal DMAS review, prior to re-submission to the OAG.

***(04) GAP FAMIS Coverage of Children of State Employees**: The agency began work developing this FAMIS expansion in early September in response to the Governor's directive. It provides FAMIS coverage for the children of state employees who have low incomes. The emergency regulation became effective 1/1/2015. The permanent, proposed stage regulation was published in the Register on 11/30/2015 with a public comment period through 1/29/2016. The regulatory action was submitted to DPB and HHR on 2/19/2016. On 4/6, the regulatory action was submitted to the Governor and was signed on 4/28. The action will become effective on 6/29/2016.

***(05) GAP Dental Services for Pregnant Women**: The agency began work developing this Medicaid service expansion in early September 2014 in response to the Governor's directive. It provides complete, with the exception of orthodontia, dental service coverage to the 45,000 Medicaid-eligible pregnant women. The emergency regulation became effective on 3/1/2015 and CMS approved the SPA on 5/18/2015. The permanent replacement regulation was signed by the Governor on 11/13/2015. It was published in the Register on 12/14/2015 and a comment period was in effect through 2/12/2016. The final stage reg package/VAC changes were circulated for internal DMAS review on 2/26/2016 was submitted to DPB on 3/17. DMAS responded to an inquiry on 3/29/2016, and DPB subsequently approved the regulatory action. The action was submitted to HHR on 3/30/2016 and sent to the Governor on 4/5/2016.

***(06) Mandatory Managed Care (Medallion 3.0) Changes**: This emergency regulation action requires individuals who receive personal care services via the Elderly or Disabled with Consumer Direction waiver to obtain their acute care services through managed care. It also shortens the time period for pregnant women to select their managed care organizations and complete the MCO assignment process. This emergency regulation became effective on 1/1/2015. The permanent replacement regulation was signed by the Governor on 11/13/2015. It was published in the Register on 12/14/2015 with a comment period that was in effect through 2/12/2016. No substantive changes were made between the proposed and final stages, and the final stage reg package was submitted to DPB on 3/16/2016. DMAS responded to an inquiry on 3/29/2016, and DPB subsequently approved

the regulatory action. The action was submitted to HHR on 3/30/2016 and sent to the Governor on 4/5/2016.

2013 General Assembly

***(01) Targeted Case Management for Baby Care, MH, ID, and DD:** This SPA incorporates the reimbursement methodology for targeted case management for high risk pregnant women and infants up to age 2, for seriously mentally ill adults, emotional disturbed children or for youth at risk of serious emotional disturbance, for individuals with intellectual disability and for individuals with developmental disability. The SPA package was approved by CMS 12/19/13. The final-exempt VAC package was submitted to the OAG on 11/12/2015. DMAS received a request for additional information from the OAG and provided responses on 2/23/2016. The regulatory action was certified on 2/25/2016 and submitted to DPB. The action moved to HHR on 3/24/16 and was subsequently sent to the Governor on 5/11/2016.

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

***(03) Exceptional Rate for ID Waiver Individuals:** This Emergency/NOIRA enables providers of congregate residential support services, currently covered in the Individual with Intellectual Disabilities Waiver (ID waiver), to render, in a more fiscally sound manner, services to individuals who have complex medical and behavioral care needs. Some of these individuals have long been institutionalized in the Commonwealth's training centers, and are being moved into community settings over the next several years in response to the settlement of the lawsuit brought against the Commonwealth by the Department of Justice. For providers to render services for such individuals, it is requiring substantially more staff time and skills. This regulatory action has been approved by the Governor and was submitted to the Registrar for publication on 11/13/14. The waiver change was approved by CMS on 4/23/2014. An emergency regulation is effective until 5/1/16. The proposed stage regulation was published in the Register on 11/16/2015 with a public comment period through 1/15/2016. Following internal DMAS review, the final stage action was submitted to the OAG on 3/14/2016. DPB received the regulatory action on 3/22/2016 and it was subsequently approved. The action was submitted to HHR on 4/5/2016 and sent to the Governor on 4/6/2016. The Governor signed the action on 4/28/2016 and it will become effective 6/29/16.

***(04) Cost Report Submission; Credit Balance Reporting**: This Fast-Track modifies the Nursing Facility (NF) reimbursement methodology in two areas: (i) makes a technical correction to an incorporation by reference included in NF cost reporting requirements, and; (ii) updates NF credit balance reporting requirements to reflect more current Medicaid

policies. This regulation was published in the Virginia Register on 11/16/2015 and became effective on 1/1/2016. A SPA of affected parallel State Plan sections was drafted and submitted to CMS on 12/4/15. CMS approved the SPA on 2/25/2016 and the project was closed out on 3/24/2016.

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

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

***(07) Repeal Family Planning Waiver Regulations:** The Family Planning program is a benefit to qualified low income families by providing them with the means for obtaining medical family planning services to avoid unintended pregnancies and increase the spacing between births to help promote healthier mothers and infants. The purpose of this amended regulation is to implement the change of the program from a demonstration waiver to the state plan option to be in compliance with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2011. This action had been placed hold, but has since been re-activated and the proposed stage was submitted to the OAG on 9/14/2015. The action was certified by OAG on 12/11/2015; submitted to DPB; and subsequently sent to HHR on 1/28/2016. The regulatory action was sent to the Governor on 4/5/2016.

2012 General Assembly

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

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

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2011 General Assembly

***(01) Inpatient and Outpatient Rehabilitation Update:** This Fast-Track action resulted from internal agency review. DMAS updated its regulations for both inpatient and outpatient rehabilitation services, including services provided in Comprehensive Outpatient Rehabilitation Facilities (CORFs). In addition, several sections of regulations in Chapter 130 were repealed and some of the retained requirements formerly located in that Chapter were moved to Chapters 50 and 60. Outdated, duplicative, and unnecessary regulatory requirements in Chapter 130 were repealed. This regulatory package was published in the Register on 11/16/2015 and became effective on 1/1/2016. A corresponding state plan amendment containing affected parallel regulatory changes was circulated for internal DMAS review on 2/29/2016, prior to OAG submission. The corresponding SPA, SPA 16-001 was circulated for internal DMAS review on 2/29/2016 and subsequently submitted to CMS on 3/23/16. Per request, revisions were made to the SPA and it was re-submitted to CMS on 3/28/16. Additional revisions were made at the request of CMS and revised info was submitted on 4/22/2016. More questions were sent by CMS via email on 5/10/2016. DMAS is currently in the process of revising the SPA.

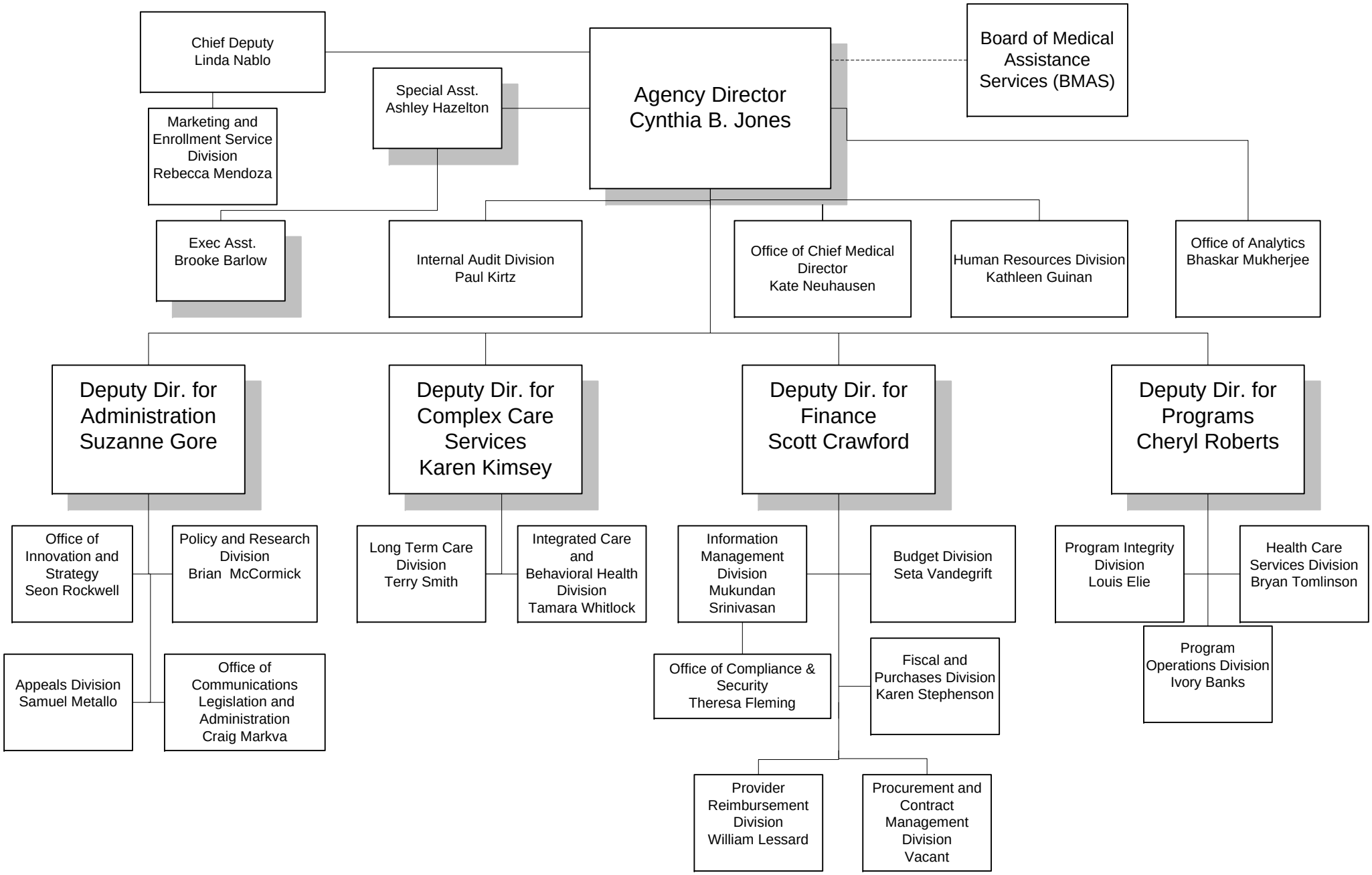
2010 General Assembly

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

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.

6/1/16

Department of Medical Assistance Services
Agency Organization Structure



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2016 Virginia Medicaid at a Glance

Introduction

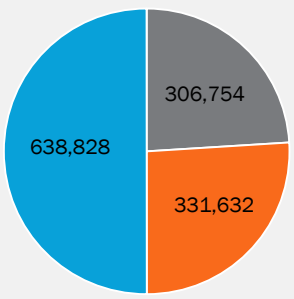
Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act that provides health and long-term care coverage for 1.3 million Virginians. In Virginia, Medicaid is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government. Virginia's federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is generally 50%, meaning Virginia receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Who is covered by Medicaid?

Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.

All states must follow general federal Medicaid guidelines regarding who is covered, but states set their own income and asset eligibility criteria. Virginia's eligibility criteria are among the strictest in the nation.

Coverage[1] in Virginia for SFY 2014



- Elderly & Individuals with Disabilities
- Parents, Caregivers and Pregnant Women
- Children in Low Income Families

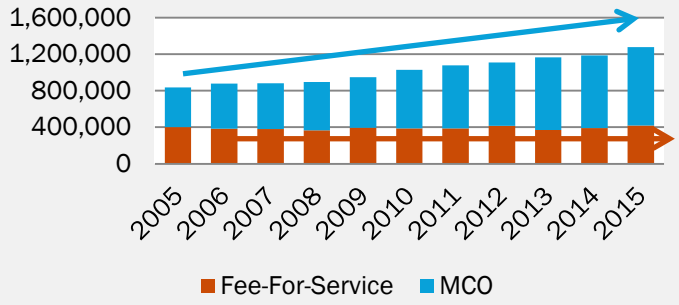
How is Care Delivered through Virginia Medicaid?

DMAS provides Medicaid to individuals through two delivery models: commercial managed care organizations (MCOs) and Fee for Service (direct reimbursement to service providers). Virginia has been increasing its use of the MCO program because of the value it provides to enrollees and to the Commonwealth. As of December 2015, just over 68% of Medicaid enrollees are in managed care.

MCOs in Virginia

Optima Health Family Care; CoventryCares of Virginia; Kaiser Permanente; Anthem HealthKeepers Plus Offered by HealthKeepers, Inc.; INTotal Health; Humana; VA Premier Health Plan, Inc.

MCO vs. Fee-For-Service Enrollment

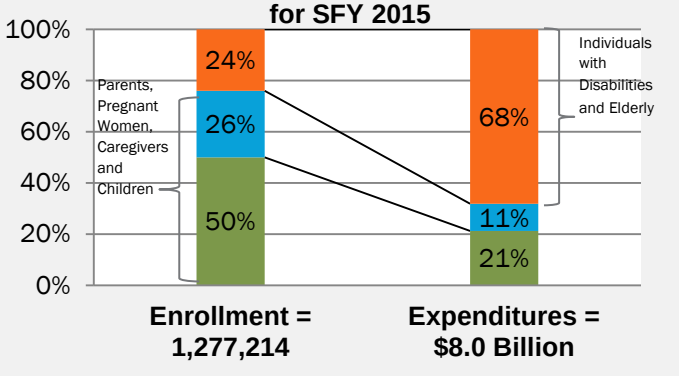


Virginia has focused on quality while expanding managed care. Virginia was one of the first states to require its MCOs to be accredited by the National Committee for Quality Assurance (NCQA). Accreditation is widely recognized as a commitment toward continuous quality improvement and requires MCOs to pass a rigorous, comprehensive review and report annually on performance. The benefits of accreditation impact more than half a million Virginians.

Medicaid Expenditures and Enrollees

Similar to other states, Medicaid spending in Virginia is heavily weighted towards seniors and individuals with disabilities due to their intensive needs and use of more costly acute and long-term care services.

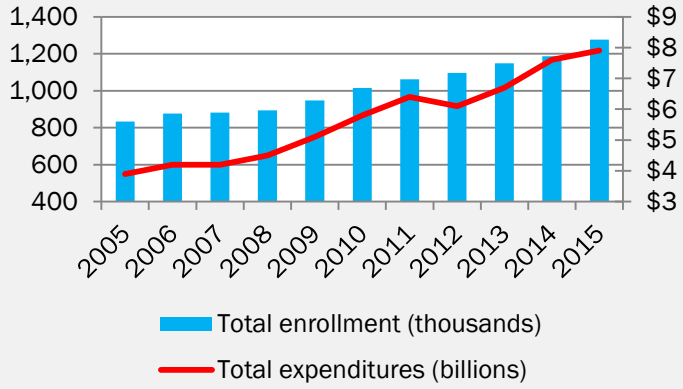
Enrollment[1] vs. Expenditures[2] for SFY 2015



[1]Coverage and enrollment numbers show the total annual unduplicated enrollments for Virginia's Title XIX program
[2] Expenditures represent claims expenditures for Virginia's Title XIX program

Virginia's Medicaid spending per capita is consistently lower than the majority of other states. While enrollment has increased, spending growth has changed at a rate similar to other states. Although increases in enrollment have been the primary driver of spending increases, other factors affecting expenditures for Medicaid in Virginia include: economic changes such as health care cost inflation, advances in health care technology, and program changes directed by federal and state law. Virginia Medicaid administration is efficient; despite rising expenditures, only 2.5% of total FY 2015 DMAS expenditures were allocated toward administrative expenses.

Enrollment[1] and Expenditures[2]



Enrollment in the Virginia Medicaid program continues to increase in all eligibility categories except for the elderly. Children's enrollment numbers are increasing the fastest.

What Services Are Covered Under Medicaid?

The Virginia Medicaid program covers medical services, nursing facility services, and behavioral health services. Virginia Medicaid enrollees may also receive coverage through home and community-based "waivers." Waivers provide community-based long-term care services as an alternative to institutionalization.

Additionally, DMAS is implementing requirements of the Patient Protection and Affordable Care Act (PPACA). For more information about Medicaid Reform and the PPACA in Virginia, please visit: **http://www.dmas.virginia.gov/Content_pgs/va-ppaca.aspx**

Waiver programs available to Medicaid beneficiaries include:

- Alzheimer's
- Day Support for Persons with Intellectual Disabilities
- Elderly or Disabled with Consumer-Direction
- Intellectual Disabilities
- Technology Assisted
- Individual and Family Developmental Disabilities Support

Please visit **www.dmas.virginia.gov** for more information about the services available through Virginia's Medicaid program.

Reforming the Virginia Medicaid Program

DMAS continues to improve the Medicaid program in Virginia. A number of current and future initiatives are underway to address current and future challenges including:

- Implementing a multi-year Medicare and Medicaid enrollee (dual eligible) financial alignment demonstration
- Enhancing the quality of care and oversight for behavioral health
- Moving forward with Managed Long Term Services and Supports (MLTSS) to improve the coordination of service delivery for all enrollees, including individuals receiving long term care services and supports

[1]Coverage and enrollment numbers show the total annual unduplicated enrollments for Virginia's Title XIX program
[2] Expenditures represent claims expenditures for Virginia's Title XIX program

A Healthy Virginia Project Implementation Update — May 2016
Virginia Department of Medical Assistance Services

In June 2014, Governor McAuliffe requested recommendations from Secretary of Health and Human Resources, Dr. Bill 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.

A Healthy Virginia
Health Care Report

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

Virginia launched the GAP demonstration to provide primary care and behavioral health services for Virginians who are uninsured, have serious mental illness, and have incomes at or below 60% 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 SMI via §1115 Waiver authority granted by the Centers for Medicare & Medicaid Services.

- ✓ Total enrollment increased to 6,722 at the end of April, with 44 enrollees between 61-95% of the federal poverty level (FPL). DMAS is monitoring the renewal process and cancellation numbers closely, as members can still re-enroll during a 90-day grace period from their cancellation date if they were administratively cancelled for non-response. The GAP Unit at the *Cover Virginia* central processing unit (CPU) received 813 applications in April, with a total of 15,127 applications received since the program's inception.
- ✓ The GAP Annual Eligibility Renewal process continues, on a monthly basis, to perform the required annual review of eligibility for continued coverage of GAP members. 3,289 GAP members have been approved for ongoing GAP coverage through early 2017 since the beginning of the renewal process. Another 101 members have been approved and enrolled in full benefit Medicaid coverage. A total of 1,014 GAP members have been cancelled from the program since January 31. However, 220 of these cancellations fall within the 90-day grace period, and the individual could still provide additional documentation to complete the renewal for re-enrollment. For the renewal cycle ending April 30, 67% of the GAP enrollees were able to have their renewal approved via the Ex Parte process, with an overall 79% renewal approval rate for this renewal cycle.
- ✓ A presentation to the Attorney General's conference on local and regional jail re-entry is scheduled for May, and a statewide town hall tour is planned for May/June. GAP staff presented at the Virginia Association of Reimbursement Officers conference on program progress and noted eligibility renewal training that had been recorded and posted to Magellan's website. DMAS staff is pursuing collaboration with the Homeless Coordinating Councils as another avenue for outreach.
- ✓ The waiver application amendment to increase the financial eligibility criteria to 80% FPL was submitted to CMS and, thus far, has generated positive discussion. DMAS hopes to hear the final CMS decision by the end of May.

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

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

- ✓ Total children's enrollment through Medicaid/FAMIS increased by 2,257 from April 1 to May 1, and overall enrollment has increased by 15,814 children since September 2014. This equates to 45% of the Governor's Healthy Virginia goal of enrolling 35,000 more children by the end of 2016.
- ✓ The spring television, radio, and on-line digital campaign began on March 28. Traffic to the FAMIS page on the coverva.org website increased from approximately 7,300 visits in March to over 21,600 visits in April. Another indicator that the campaign is working is that during the month there was an 18% increase in new telephonic applications submitted through the *Cover Virginia* call center, as compared to April 2015. Also, the 30-second television ad and the four 15-second video ads have won a Bronze Telly award and a Silver Healthcare Advertising award.
- ✓ DMAS sponsorship of an on-air weekly radio interview on 1380 AM Radio Podor (Spanish radio) continues through July. This has been an excellent means of outreach to the Spanish speaking community. The sponsorship includes three 60-second advertising spots during the interview, as well as two 30-second spots each weekday during regular programming.

Enrollment of Children

	Month	Medicaid (XIX)	FAMIS (XXI)	Total	Monthly Change	9/14 Net Change
2014	September 1	463,254	112,481	575,735	—	—
	October 1	467,755	112,108	579,863	4,128	4,128
	November 1	472,337	111,085	583,422	3,559	7,687
	December 1	470,119	109,627	579,746	-3,676	4,011
2015	January 1	469,599	108,724	578,323	-1,423	2,588
	February 1	474,765	109,045	583,810	5,487	8,075
	March 1	476,568	108,287	584,855	1,045	9,120
	April 1	482,409	107,500	589,909	5,504	14,174
	May 1	485,517	105,772	591,289	1,380	15,554
	June 1	487,820	105,742	593,562	2,273	17,827
	July 1	486,525	106,602	593,127	-435	17,392
	August 1	483,612	106,443	590,055	-3,072	14,320
	September 1	484,108	106,847	590,955	900	15,220
	October 1	482,488	106,635	589,123	-1,832	13,388
	November 1	481,343	106,325	587,668	-1,455	11,933
	December 1	477,468	105,712	583,180	-4,488	7,445
2016	January 1	476,688	106,047	582,735	-445	7,000
	February 1	476,978	106,335	583,313	578	7,578
	March 1	478,447	107,145	585,592	2,279	9,857
	April 1	480,896	108,396	589,292	3,700	13,557
	May 1	482,071	109,478	591,549	2,257	15,814

- ✓ The 2016 *Children's Enrollment Summit* took place on April 11. The summit was organized by the Virginia Health Care Foundation, DMAS, the Department of Social Services, OSHHR, and other stakeholders. The keynote speaker was Diane Rowland, Chair of the Medicaid and CHIP Payment and Access Commission (MACPAC) and Executive Vice President of the Kaiser Family Foundation. There was a pre-conference session on the use of *CommonHelp*, and the two main summit sessions focused on the renewal process and on reaching Latino

families with a higher rate of un-insurance. Almost 300 individuals attended, and evaluation comments were extremely positive. The Summit ended with Secretary Hazel challenging all participants to help enroll an additional 2,000 children per month through the end of the year.

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

Virginia was awarded a $4.3 million federal grant for state exchange development activities that it repurposed to support outreach and education efforts related to the Federal Marketplace, as well as a $9.3 million grant for in-person assisters for improved consumer assistance efforts during open enrollment.

✓ 2016 Open Enrollment succeeded in enrolling 216,255 additional Virginians for a total of 421,897 enrolled. This marks Virginia's highest enrollment ever. As the contract with the Virginia Community Healthcare Association for the in-person assister program ended on February 29, the last day for DMAS contracted staff dedicated to this effort was March 31.

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 in order to make it easier for Virginians to connect with the programs and services for which they qualify.

✓ Since the November 2014 re-launch, the www.coverva.org website has received: more than 777,100 unique visits; 18,500 click-throughs to the federal www.healthcare.gov site; 29,700 click-throughs to Virginia's *CommonHelp* online application; and 159,400 eligibility self-screenings. Overall visits to the website during April totaled 46,077.

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.

✓ Phase I of this effort was complete as of July 31, 2015. As a result, 902 children of state employees and 18 pregnant women gaining health coverage. Phase II of this project for state employees of the University of Virginia and Virginia Commonwealth University was completed in December 2015. Eight children and one pregnant adult were enrolled in FAMIS and Medicaid as a result. While the policy continues to allow state employees to enroll their children in FAMIS, no special handling or expedited determination processes are in place this year.

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 therefore implemented comprehensive dental coverage for pregnant women enrolled in Medicaid and FAMIS MOMS.

✓ As of May 16, 7,176 pregnant women have received oral health care services. Inquiries continue to increase, with member inquiries totaling 6,088 and provider inquiries totaling over 4,634. Outreach efforts continue, with 144 Pregnant Women/Infant kits and 100 *Smiles for Children* brochures distributed to pediatrics practices in Newport News and Gloucester. Work with managed care plans continues, including a discussion with Aetna regarding the benefit and use of the dental health and pregnancy kits.

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

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

Active April 2016 Enrollment	
MMP	**Members**
Aetna	18
Anthem	31
INTotal	58
Optima	32
Virginia Premier	67
TOTAL:	**206**

✓ The five participating Medicaid managed care plans are in the tenth month of the behavioral health home regional pilots. To date, the pilots serve more than 200 Medallion 3.0 members. Over the past three months, the plans reported that approximately 56% of members received care or case management from the care team or the dedicated care manager. As is usual for the SMI population, care and medication compliance have been barriers. In an effort to increase member participation in the pilot programs, considerable outreach efforts to educate and coordination care continue to be top priorities. Pilots programs are focused on member hospitalizations for both behavioral and medical admissions. Across the pilots, the plans had a total of 14 hospitalizations in which 100% of members received a follow-up care team or case management visit within seven days of discharge. During the first business quarter, 19 care teams requested non-traditional behavioral health services, and 100% of requests were approved and services were provided. Individual member success stories include: training family members to administer medication, helping members find housing resources, assisting members in obtaining eyeglasses, overcoming obstacles in locating difficult-to-find members, and establishing medical homes for members.

Enrollments as of April 29, 2016		
MMP	**Members**	**CSB Partners**
Anthem/Healthkeepers	172	20
Virginia Premier	29	3
Beacon/Humana	23	2
TOTAL:	**224**	**NA**

✓ The Commonwealth Coordinated Care (CCC) behavioral health home pilots continue to work on integrated care efforts. All three Medicare-Medicaid Plans (MMPs) report efforts to improve communication and collaboration with community service boards and medical/acute care providers. There are currently 20 community service boards partnering with the CCC health plans on this effort. Magellan and the plans report no issues regarding care coordination or collaboration regarding the pilots. DMAS and the managed care plans are developing a uniform bi-monthly reporting format with specific elements. While reporting has been timely and informative to date, all agree that a template will focus the reporting and better demonstrate program progress.

DMAS Critical Issues – At a Glance

Delivery System Reform Incentive Payment (DSRIP) Program

What Is DSRIP?

- **5-year innovation waiver program with CMS to transform the state's Medicaid delivery system**
- **Provides financial incentives to Medicaid providers to achieve delivery system transformation**

Virginia's DSRIP Vision

- **"Think Big, Start Focused, Scale Fast" – Leverage the DSRIP opportunity to achieve lasting improvements across the care continuum for broader Medicaid population**
- **Start focused on the needs of Medicaid members with complex needs**
- **Achieve sustainable transformation through new provider partnerships that work in concert with MCOs. These partnerships will leverage DSRIP funding to increase capacity for clinical integration, data sharing, and catalyze the transition to value-based payments**

DSRIP Innovations

- Achieves Medicaid delivery system transformation through infrastructure development, system redesign, and clinical outcome improvements
- Supports provider readiness for value based payment
- Accelerates transition of how care is delivered and paid for in Virginia's Medicaid delivery system

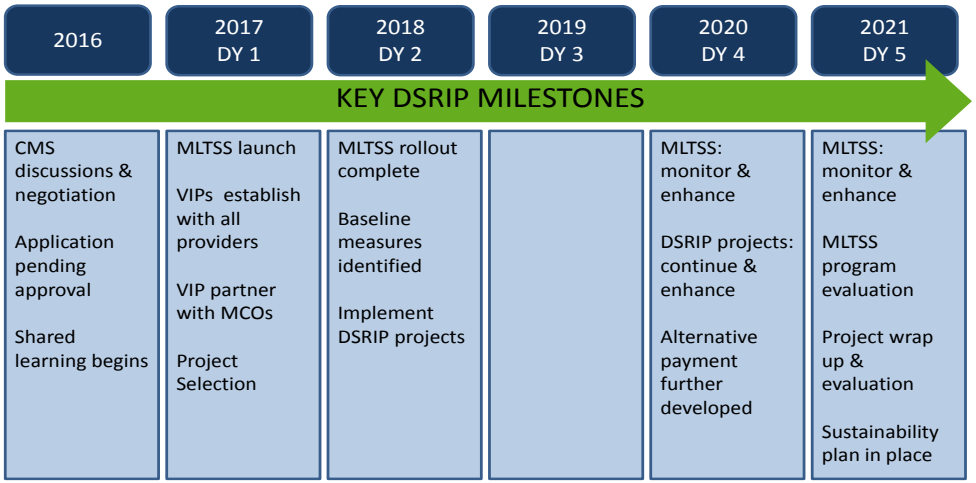
DSRIP Outcomes

- Strengthen community capacity for Medicaid members with disabilities and behavioral health needs
- Integrate clinical and social data infrastructure to optimally serve Medicaid members
- Pay providers based on achievement of quality outcomes – not just utilization
- Improve health outcomes by expanding infrastructure for existing services and addressing social determinants of health

DSRIP Benefits for Virginia

- Improve enrollee health – provider partnerships are a robust vehicle for individualized member care planning
- Improve enrollee experience –integrated clinical and social data coupled with care coordination will assist Medicaid members to navigate the health care landscape and ensure full access to available services
- Bend the cost curve – Support for providers transitioning to alternative payment models

Timeline



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DMAS Critical Issues – At a Glance

DMAS Medallion 3.0 Managed Care Transformation

Background Information

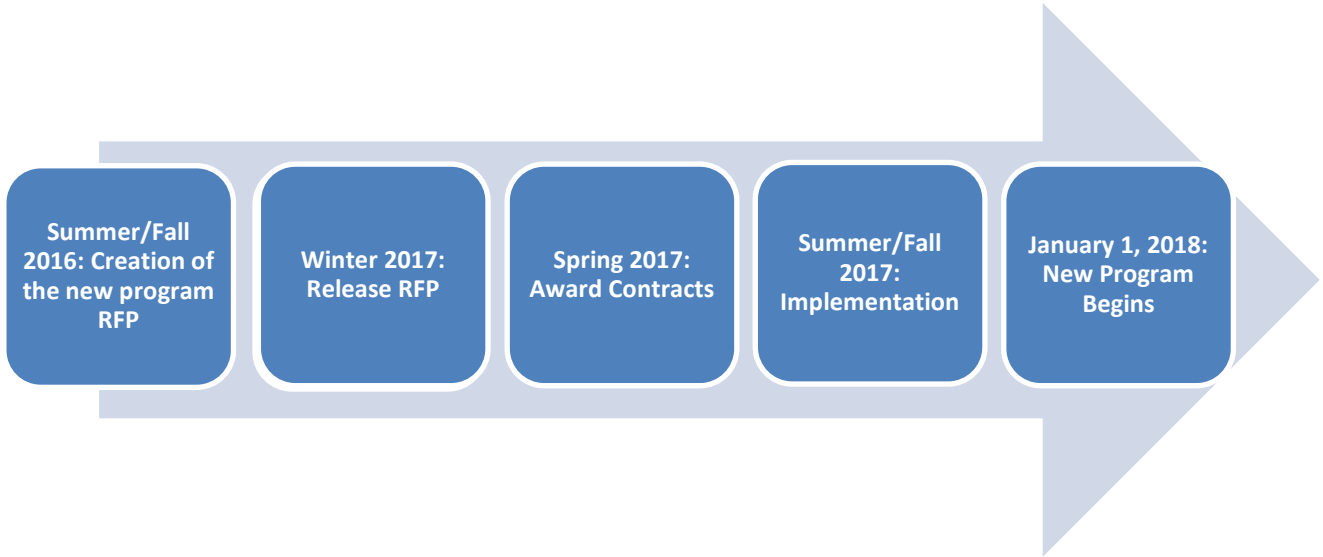
- **Started in 1996, the Medallion 3.0 program has provided high quality, cost effective health care through its state-wide managed care delivery system to 750,000 pregnant women, mothers and children, including acute care for Home & Community Based Care waiver members.**

- **As part of DMAS' transition to move all members to managed care and in conjunction with the transformation of MLTSS, Virginia will procure Medallion 3.0 effective January 1, 2018.**

The New Medallion Program Will Include:

- A transformed population - ABD and waiver members will be transitioned to the new MLTSS program on January 1, 2018
- Compliance with the final CMS managed care regulation
- Coordinated medical and behavioral health care - Non-traditional behavioral health care services and medical services will be provided through the same MCO
- Value-based payment requirement – Managed Care Organization performance will be recognized based on ability to transform provider payment through innovation while improving coordination of all aspects of care and improvement of quality

The New Medallion Program Will Have a Dedicated Focus on serving Pregnant Women, Children and Parents



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DMAS Critical Issues – At a Glance

Medicaid Enterprise System (MES)

Background Information

- **State Self-Assessments in 2007 and 2010 resulted in the MITA 3.0 Roadmap**
- **DMAS will replace the current MMIS with a modular Medicaid Enterprise System (MES) by 2020**

Benefits of MES

- **Modernize how Virginia provides services to its citizens and align with Federal initiatives and opportunities**
- **More user-friendly experience for citizens accessing government services**
- **More accurate data, less work redundancy, and increased protection against fraud and abuse**

Changes to the Current MMIS - July 2015 to June 2018

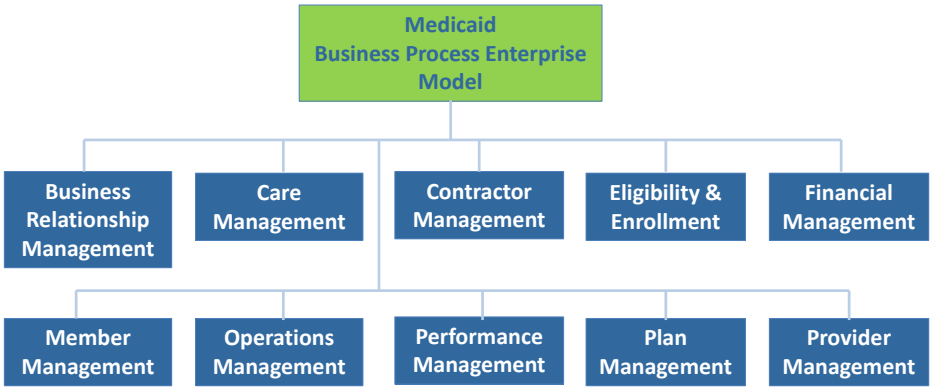
- Implement Enterprise Technical Infrastructure and Member Eligibility & Enrollment Modernization projects
- Transition to ICD-10 diagnosis and procedure codes
- Implement the CMS-mandated Transformed Medicaid Statistical Information Systems
- Implement a waiver management system and a contract management system
- Begin using the National Health Plan Identifier
- Transition to Managed Long Term Care Supports and Services (MLTSS) via Phases I and II
- Migrate all of DMAS/XEROX SAS functionality to VITA-hosted solution
- Create Business Process Models that document DMAS's business process
- Upgrade Oracle Financials from version 11.1 to 12.2
- Implement Case and Document Management System for Appeals Division
- Establish a single secured medium to exchange intrastate data

Additions to the Replacement MMIS - projected July 2018

- Procure a stand-alone Financial Management solution
- Procure a Pharmacy Benefit Management Solution (PBMS) as part of the MES
- Establish enhanced encounter processing and auxiliary applications
- Procure a provider portal and a member portal as part of the MES Core Systems Solution
- Procure an enterprise data warehouse solution as part of MES

Enhancements to the fully implemented MES - July 2018 to June 2020

- Create a platform that allows for state and federal data exchanges
- Increase Federal data sharing as prescribed in higher MITA business process
- Collect and use clinical data



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DMAS Critical Issues – At a Glance

Managed Long Term Supports and Services (MLTSS)

Benefits of MLTSS

- **Improved quality, access, and efficiency**
- **High-touch, person-centered care**
- **Builds on the foundation of the Commonwealth Coordinated Care (CCC) program – one of the first in the country to blend care and financing for Medicare-Medicaid enrollees.**

Date	Region
July 2017	Tidewater
September 2017	Central
October 2017	Charlottesville/ Western
November 2017	Roanoke/Alleghany/ Southwest
December 2017	Northern/Winchester
January 2018	CCC Enrolled
January 2018	Aged, Blind, and Disabled

What is MLTSS?

- New Medicaid managed care program that will serve ~212,000 individuals with complex care needs
- Focus on care coordination
- Employs an integrated delivery model across the full continuum of care
- Includes medical, behavioral health, and long-term services and supports (LTSS)
- Intellectual and Developmental Disability Waiver services will not be provided through the MLTSS program at this time

Eligible Enrollees

- Full-benefit dual eligible (i.e., receiving both Medicare and Medicaid)
- Receiving LTSS through a home and community-based services (HCBS) waiver
- Receiving LTSS through an institutional setting
- Other Aged, Blind, and Disabled Medicaid enrollees

Additional Information

- DMAS issued a Request for Proposals on April 29, 2016, to competitively select health plans – at least two per region. Responses are due to DMAS on June 30.
- Regional phase-in beginning in July 2017
- All awarded managed care plans will be required to operate a Dual Eligible Special Needs Plan (D-SNP) within two years of contract award
- Contract will include targets for value-based payments and alternative payment models
- DMAS will consider proposals from “specialty plans” to provide focused care to members with a specific condition or diagnosis

Procurement Schedule	
Mandatory Preproposal Conference	May 10, 2016
Proposals Due	June 30, 2016
Preliminary Selections, Negotiation Begins	August 19, 2016
Notice of Intent to Award	December 9, 2016
Phased Implementation	July 2017 – January 2018

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DMAS Critical Issues – At a Glance

Substance Use Disorder Services (SUD)

Key Statistics for Virginia

- **Of the 986 deaths from drug overdoses in Virginia in 2014, 80% involved prescription opioids or heroin.**
- **More Virginians die each year from drug overdoses than motor vehicle accidents.**
- **Opioid prescriptions cost Medicaid $26 million annually.**
- **$28 million spent on ER and inpatient hospital treatment for Medicaid members with substance use disorders per year.**
- **#2 cause for children entering foster care.**

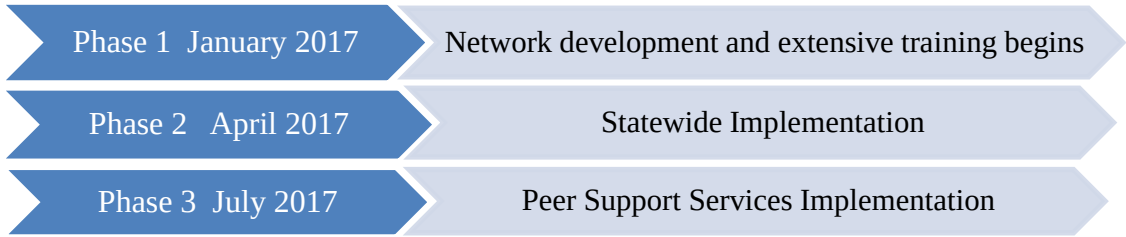
With Support from the General Assembly, Virginia Medicaid will Enhance Treatment Options for Medicaid Recipients By:

- Creating a fully integrated Physical & Behavioral Health Continuum of Care through Managed Care plans; Magellan will continue to cover non-traditional SUD services through Fee-For-Service.
- Supporting current Medicaid members by:
  1. Expanding short-term SUD inpatient detox to all Medicaid members
  2. Expanding short-term SUD residential treatment to all Medicaid members
  3. Increasing rates for existing Medicaid/FAMIS SUD treatment services
  4. Adding Peer Support Services for individuals receiving SUD benefit
  5. Requiring SUD Care Coordination at Medicaid health plans
  6. Providing Provider Education, Training and Recruitment Activities

The SUD Program Development Process:

- March 17 – May 26: Core Workgroup, consisting of MCOs and Magellan, public and private stakeholders is actively designing the SUD benefit management structure within an integrated care environment.
- March 17 – April 21: This SUD model will feature Standardized Clinical Operations and medical necessity criteria. All MCOs and Magellan have collaborated to produce a standardized reimbursement model and standard operational structures.
- September, 2015 – August, 2016: DMAS is pursuing a CMS Demonstration and will expand bed capacity in residential treatment and services and enhance network development efforts.
- May, 2016 – April, 2017: Extensive training activity is being planned to align service delivery and network capacity with the American Society of Addictions Medicine (ASAM) Program Model.

Proposed Implementation Timeline:



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Medicaid 101

Board of Medical Assistance Services

Virginia Department of Medical Assistance Services

June 14, 2016

What is Medicaid?

- It is not Medicare – which is a mainly a federal program for those over 65 or disabled
- Medicaid is a shared state/federal program to provide health insurance for **certain** low-income groups. Virginia implemented in 1969.
  - For Virginia, 50% state funding matched by 50% federal funding
- Federal oversight provided by the Centers for Medicare and Medicaid Services (CMS)
- State programs are based on a CMS approved "State Plan" or "Waivers"
- DMAS is designated as the "single-state agency" to administer the program in Virginia

Other DMAS Programs

- **FAMIS** – Virginia's CHIP (Children's Health Insurance Program).
  - Consists of an expansion of Medicaid for children 6 – 18 with family income 100% - 133% FPL and a separate program for children 0 – 18 with income 133% - 200% FPL.
  - June 1, 2016 enrollment in both parts of FAMIS is 110,295
  - CHIP and Medicaid coverage for children is marketed under the brand name FAMIS and FAMIS Plus.
- **FAMIS Moms** – coverage for pregnant women with income from 133 – 200% FPL. Current enrollment is 1,093
- **Plan First** – Virginia's family planning program for adults who do to qualify for full benefit Medicaid and income up to 200% FPL; Enrollment is 106,786.
  - Limited coverage for men & women – family planning services only.
- **GAP** – Targeted coverage for those with serious mental illness and income below 80% FPL (as of July 1).
  - Benefits limited to certain medical, behavioral health and prescription drugs.
  - Current enrollment is 7,269.
- **Other programs**: HIPP, Buy-In, etc.

Virginia's Medicaid Program Key Facts

1 Million +

Virginians covered by Medicaid/CHIP

1 in 8

Virginians rely on Medicaid

2 in 3

Residents in nursing facilities supported by Medicaid - Primary payer for LTSS

50%

Medicaid beneficiaries are children

58%

Long-Term Services & Supports spending is in the community

1 in 3

Births covered in Virginia

Behavioral Health

Medicaid is primary payer for services

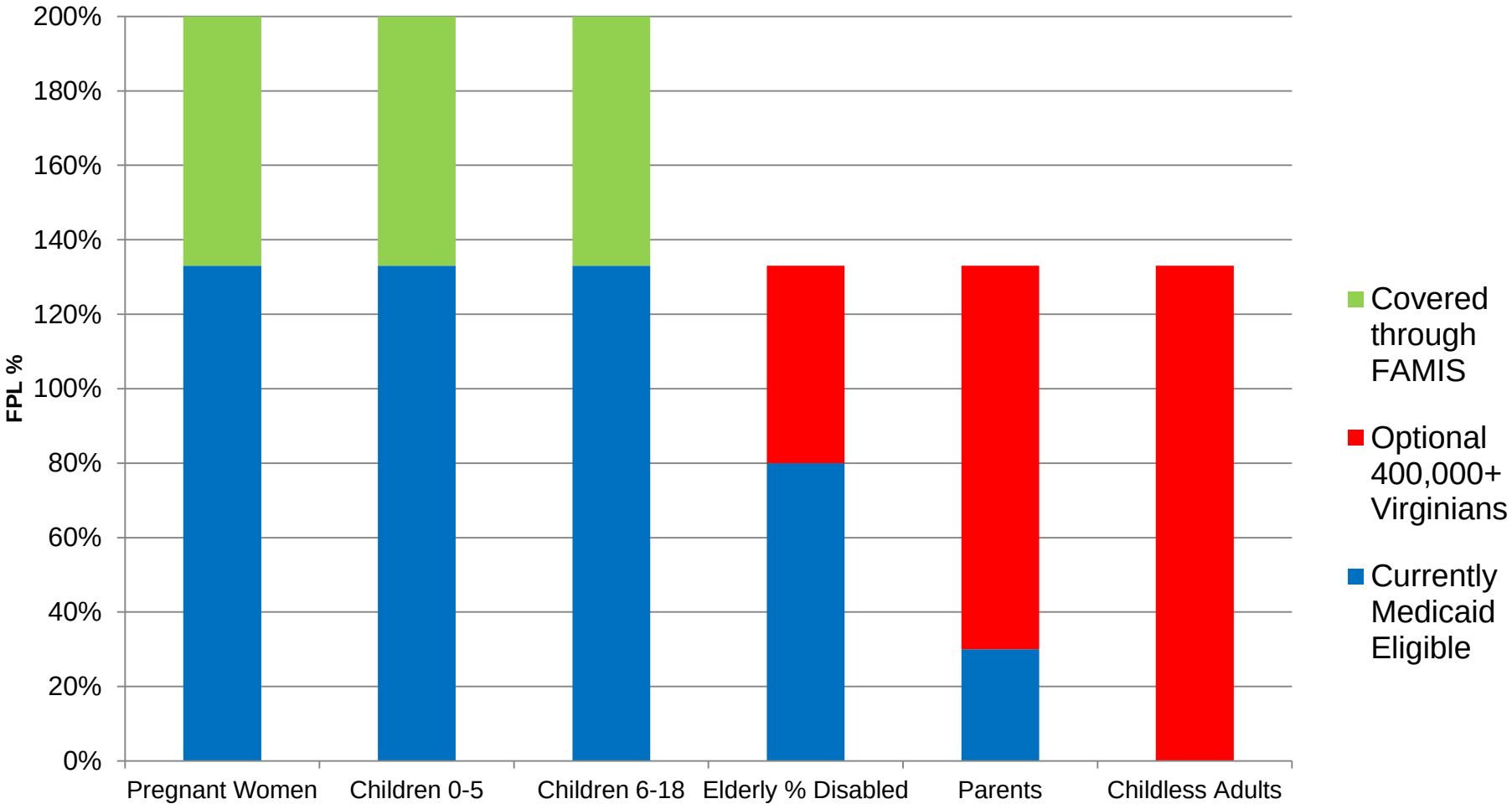
Who is Eligible for Medicaid?

- Eligibility is EXTRAORDINARILY complex!

- Currently, to qualify for Medicaid, individuals must:
  - Meet financial eligibility requirements; AND
  - Fall into a "covered group" such as:
    - Aged, blind, and disabled;
    - Pregnant;
    - Child; or
    - Caretaker parents of children
  - Coverage for long term services and supports requires additional program criteria

- Currently, Virginia Medicaid does not provide medical assistance for all people with limited incomes and resources.

Current vs. Optional Eligibility



States that choose to expand Medicaid, must expand coverage to 133% FPL for all.

Who is Eligible

Four Primary Groups are Eligible for Virginia Medicaid/FAMIS

Group	Financial Requirements	Non-Financial	Asset Limits
Children	*133% of Poverty 200% for FAMIS	Citizenship/Immigration status & Residency	None
Pregnant Women	*133% of Poverty 200% for FAMIS	Citizenship/Immigration status & Residency	None
Aged, Blind or Disabled	**80% of Poverty or 300% of SSI for Long-Term Care**	Citizenship/Immigration status & Residency	$2,000 Individual / $3,000 Married
Low-Income Parents	24-48% of Poverty	Citizenship/Immigration status & Residency	None

2016 Federal Poverty Limits

Family Size	80%	100%	133%	200%
1	$9,504	$11,880	$15,801	$23,760
4	$19,440	$24,300	$32,319	$48,600

* Actual income limits somewhat higher

** Supplemental Security Income (SSI) is $766 per month for an individual

What is a Home and Community-Based Waiver?

- Allows exceptions to normal Medicaid rules, for example, to cap enrollment (which is why we have waiting lists) or limit services to a certain region of a state.

- Virginia has six home and community-based waivers (known as 1915c waivers) to prevent individuals from entering institutional settings:
  - Nursing facility alternative:
    - Elderly or Disabled
    - Alzheimer's Assisted Living
  - Intermediate Care Facility alternative:
    - Intellectual Disability (ID)
    - Individual and Family Developmental Disabilities and Support (DD)
    - Day Support (provides limited services to individuals on ID waiting list)
  - Hospital alternative:
    - Technology Assisted

Summary of Virginia Medicaid Home and Community – Based Waivers

May 2016 Waiver Enrollment = 46,479

	Elderly and Disabled	Intellectual Disability	Developmental Disability	Technology Assisted	Day Support	Alzheimer's
Approved Slots	No cap	10,717	1,053	513	300	200
Current Enrollment	34,445	10,478	951	275	269	61
Wait List	-	8,362	2,340	-	-	-
Average Cost	$17,614	$68,194	$31,290	$81,690	$13,957	$11,457
FY 2015 Expenditures	$612.1 million	$693.8 million	$28.6 million	$29.7 million	$3.8 million	$0.8 million
Primary Services	Personal Care, Respite Care	Congregate Residential, In-Home Residential Support	Personal Care, In-Home Residential Support	Private Duty Nursing	Day Support	Assisted Living

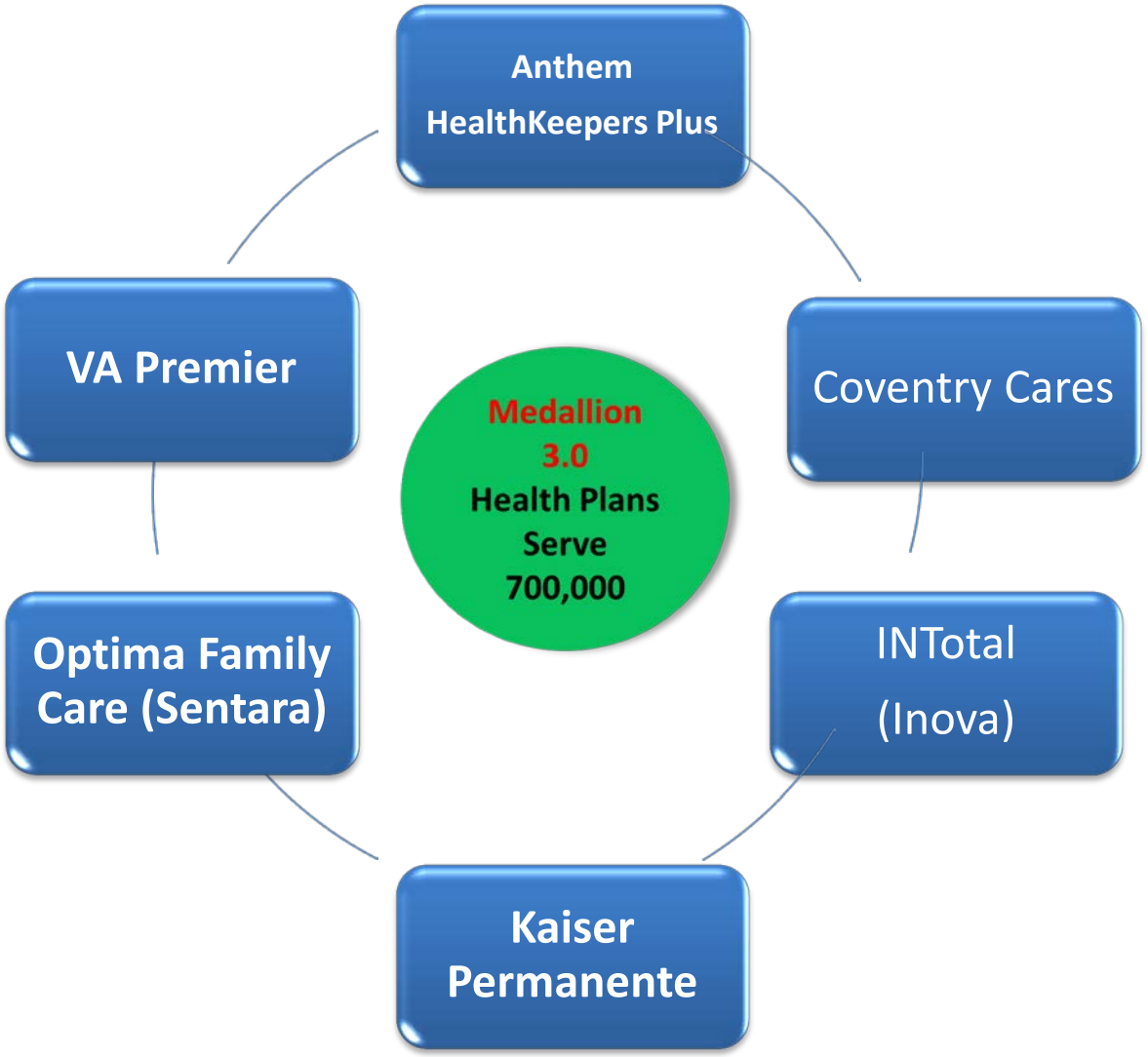
Other Virginia Medicaid Waivers

- Medallion 3.0, a 1915b managed care waiver, allows us to make participation mandatory if there are two or more participating health plans
- Governor's Access Plan or GAP, a 1115 demonstration waiver, allows us to provide a limited but targeted group of medical and behavioral health services to individuals with serious mental illness. Plan to amend this waiver for substance use services.
- In January 2016, DMAS submitted a new 1115 waiver on Managed Long Term Services and Supports (MLTSS) and Delivery System Reform Incentive Payment (DSRIP)

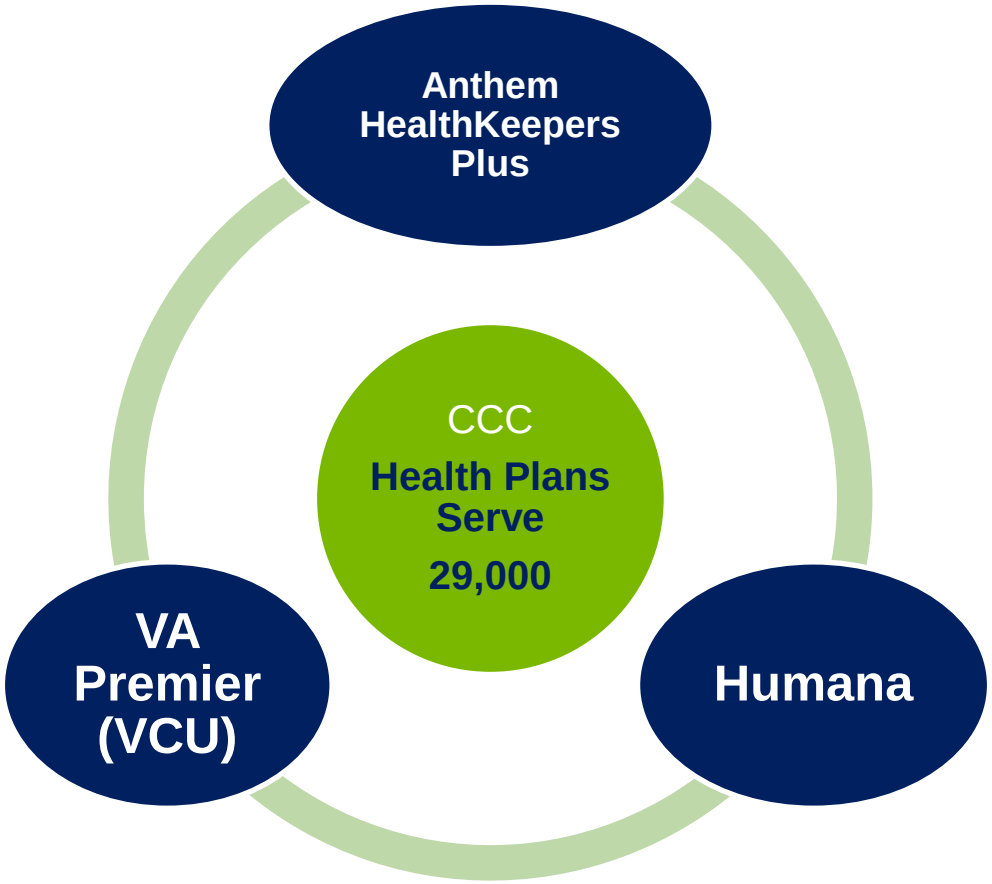
How Care is Delivered: Medicaid Service Delivery System:

- As of November 2015, **75%** of Medicaid enrollees are enrolled in managed care through Medallion 3.0, Commonwealth Coordinated Care (Duals), or PACE.
- Since 1969, when Virginia implemented Medicaid, the state has had a traditional fee-for-service system in which the state receives and pays the claims to providers.
- In 1996, Virginia initiated the managed care model.
- By 2012, Medicaid managed care was available in every locality and for a majority of the populations.
- In 2013, the program became known as Medallion 3.0, to reflect more focus on quality and value-based purchasing.
- Managed Long Term Services and Supports will move additional populations into Managed Care; nearly 100% of full benefit Medicaid will then be in managed care.

Medallion 3.0 Health Plans

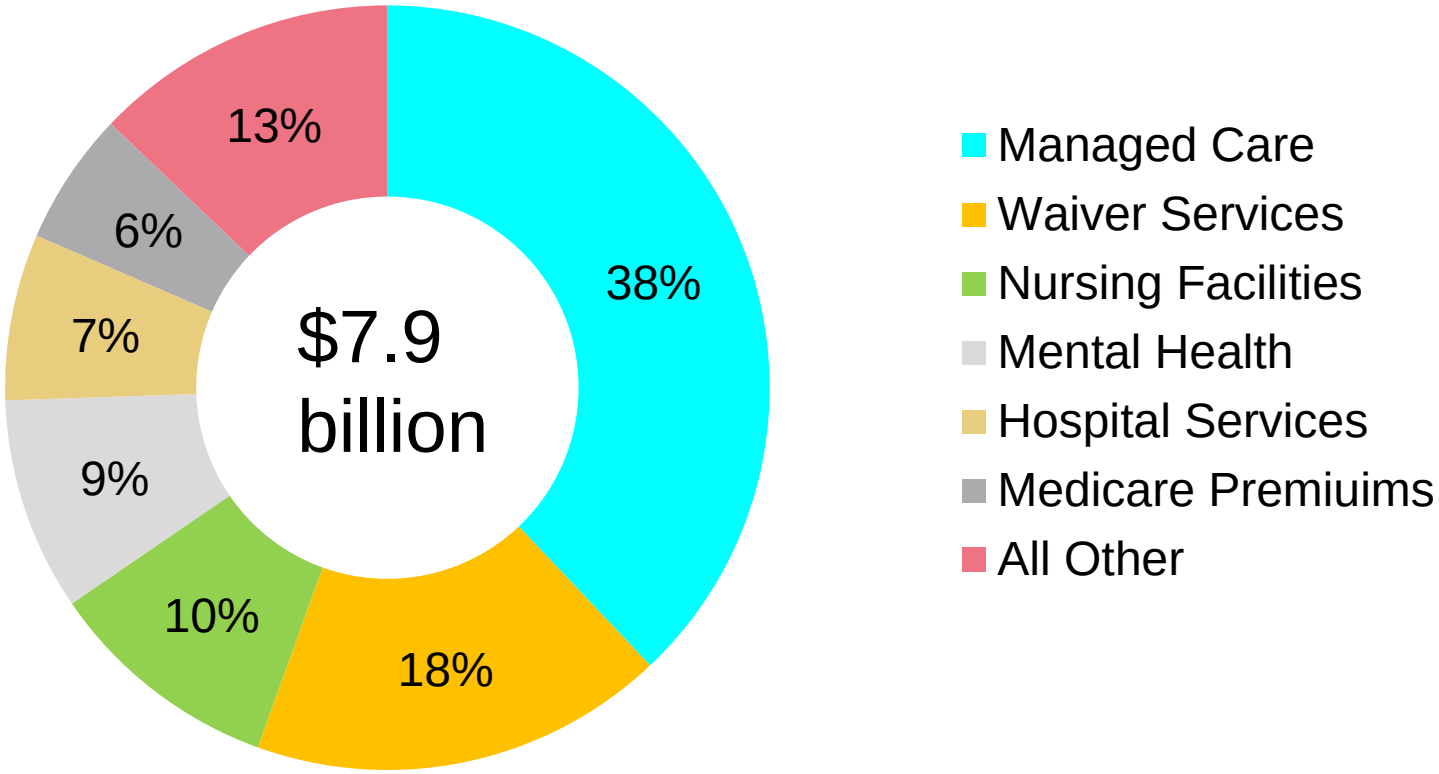


Commonwealth Coordinated Care (CCC) Health Plans



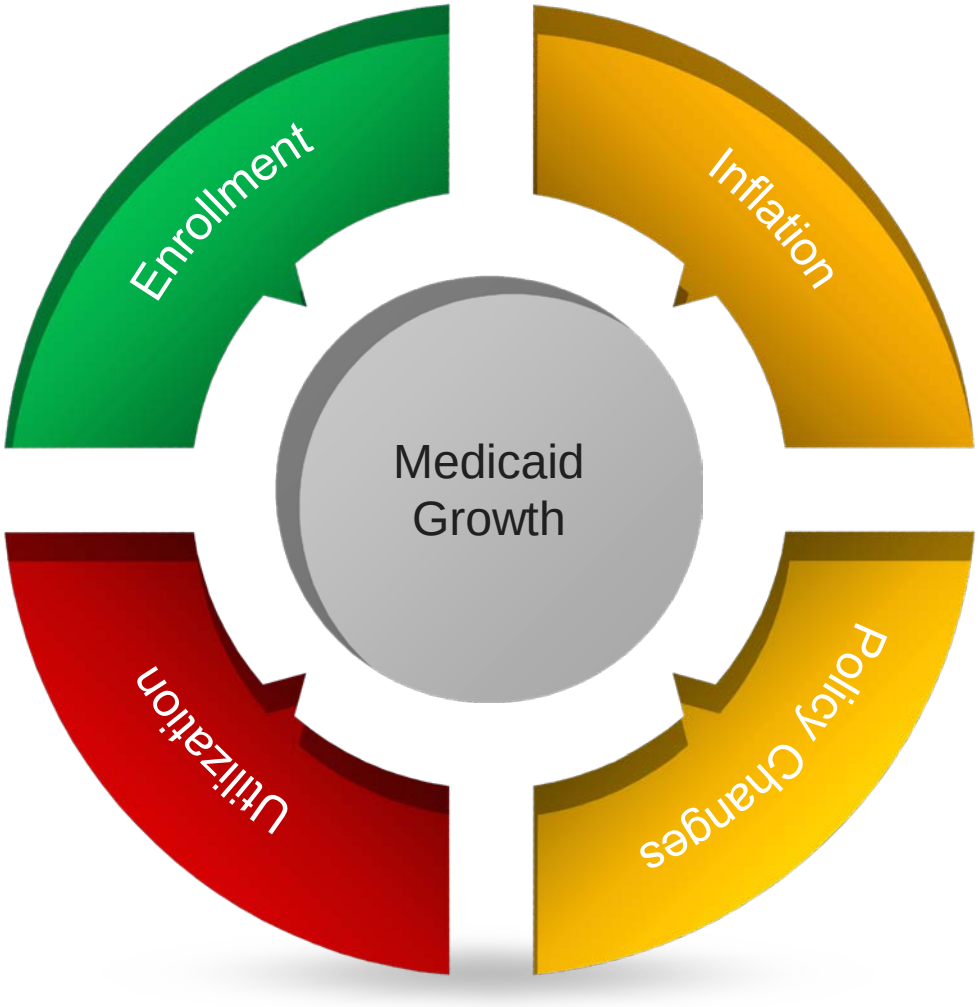
Virginia Medicaid Spending by Service

FY 2015 Expenditures (Total Funds)*



** Does not include payments to state facilities operated by the Department of Behavioral Health and Developmental Services.*

What drives costs in Medicaid?



Enrollment

Primary driver of higher costs.

Inflation

Impact of medical inflation.

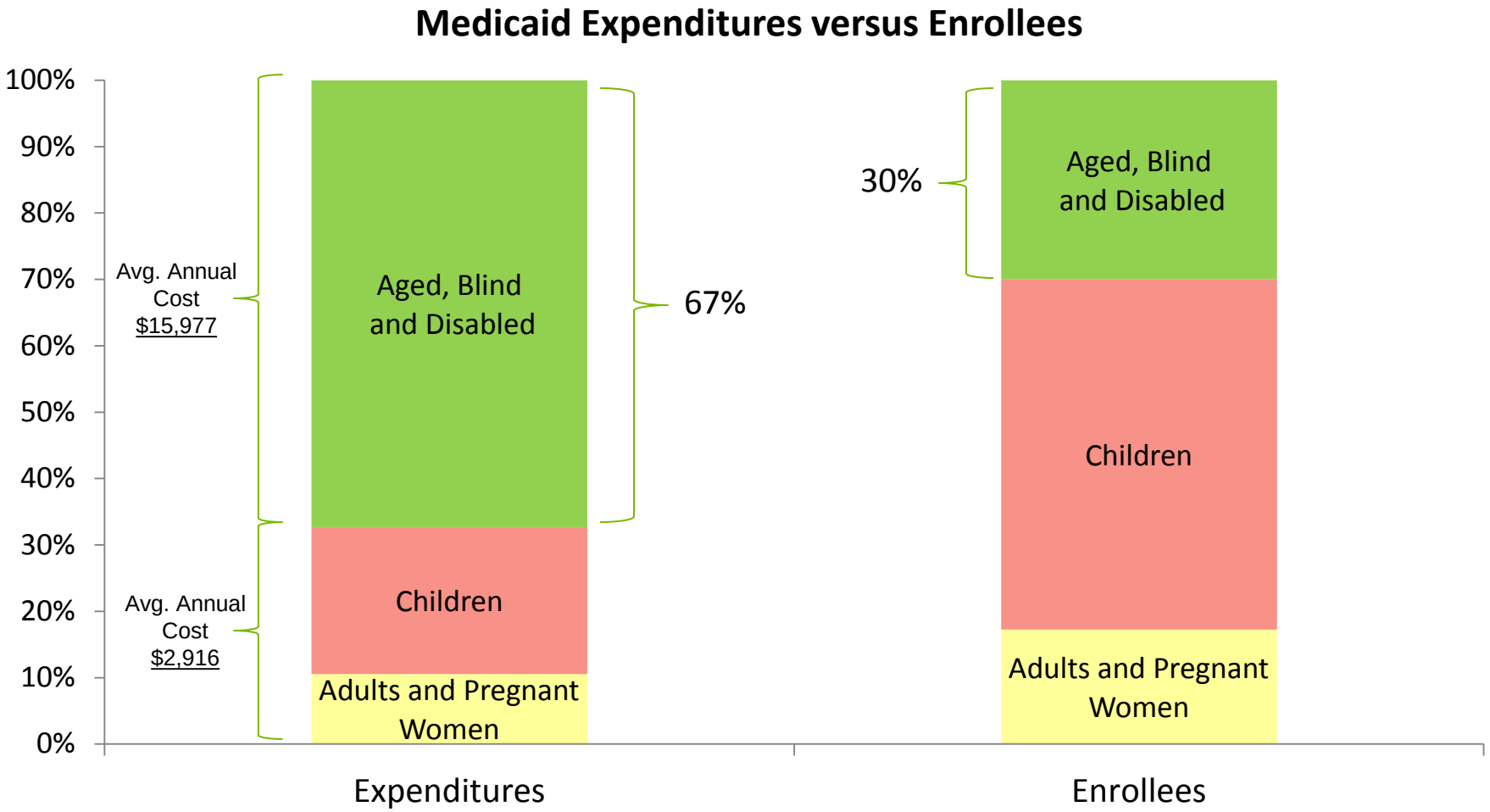
Policy Changes

Provider rates, benefit changes, additional waiver slots, etc.

Utilization

Higher use of services.

Aged, Blind and Disabled are the Most Costly Recipients



Note: Based on FY 2014 data.

Forecasting Process

- Mandated by Section 32.1-323.1 of the *Code of Virginia*
- Each year, DMAS and DPB prepare independent forecasts using monthly level expenditure and utilization data - Projects spending in current and subsequent two years.
- The forecasts are comprised of over 100 different models that project utilization and cost per unit for each benefit category.
- New - DMAS & DPB convene by October 15th with staff from House Appropriations & Senate Finance Committees to review current trends and the assumptions used in the Medicaid forecast prior to finalization.
- Manual adjustments are made to reflect new programs, one-time payments, or other known changes.
- Change - Due November 1st to Governor and General Assembly.
- Change - DMAS submits monthly reports comparing actual expenditures to the forecast.

3 reports published (2015)

1st – State Spending – 2015 Update

2nd – Eligibility Determination in Virginia's Medicaid Program

3rd – Medicaid Non-Emergency Medical Transportation

Currently underway - Areas to be examined include:

- Managed care - Long-term care services
- High-cost recipients
- Growing population of disabled recipients
- Community-based behavioral health services

Medicaid is Always Reforming: Major Reforms Since 2000

❑**2001:** *FAMIS* Program Implemented. In 2001, less than 300,000 children; today more than 550,000 covered by Medicaid and FAMIS.

❑**2002:** Since this year, added 4,800 slots to ID waiver, 775 slots to DD waiver. To date, over 50% of long-term care services being delivered in the community, as opposed to institutionalization

❑ **2004:** Preferred Drug List and other reforms for FFS. More than $950 million in supplemental rebates since 2010.

❑**2005:** *FAMIS MOMs* implemented

Medicaid is Always Reforming: Major Reforms Since 2000

❑**2005:** *Smiles For Children* dental program implemented; significant increase in provider participation; children receiving dental care doubled.

❑**2008:** Program Integrity efforts on community mental health services increased. Created internal Office of Behavioral Health. Behavioral Health Services Administrator (Magellan) in 2013.

❑**2012:** Drug rebates related to ACA; over $569 million for drugs dispensed by MCOs; $198 million in this year.

❑**2012:** Statewide expansion of Managed Care; 700,000 enrollees.

Updates to Additional Reforms

Budget language passed by the 2013 General Assembly established a series of reforms to Medicaid as well as the Medicaid Innovation and Reform Commission.

Reformed Accomplished

Phase 1: Advancing Reforms in Progress

Phase 2: Implementing Innovations in Service Delivery, Administration, and Beneficiary Engagement

Phase 3: Moving forward with Coordination of Long-Term Services and Supports

Virginia Medicaid Reform Goals

Coordinated Service Delivery	•DMAS provides a health system where services are coordinated, innovation is rewarded, costs are predictable, and provider compensation is based on the quality of the care.
Efficient Administration	•DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes.
Beneficiary Engagement	•Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

Phase 1 Reforms

Budget Language: In the first phase of reform, the Department of Medical Assistance Services shall continue currently authorized reforms of the Virginia Medicaid/FAMIS service delivery model that shall, at a minimum, include:

- Commonwealth Coordinated Care
- Enhanced Program Integrity
- Children in Foster Care Enrolled in Managed Care
- eHHR

Phase 2 Reforms

Budget Language: In the second phase of reform, the Department of Medical Assistance Services shall implement value-based purchasing reforms for all recipients subject to a Modified Adjusted Gross Income (MAGI) methodology for program eligibility and any other recipient categories not excluded from the Medallion II managed care program. Such reforms shall, at minimum, include the following:

- Commercial-like Benefits
- Cost sharing and Wellness
- Coordinated Behavioral Health
- Limited Provider Networks/Medical Homes
- Quality Payment Incentives
- Parameters to Test Innovation Pilots

Phase 3 Reforms

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

- ID/DD Waiver Redesign
- EDCD Waiver Enrollees in Managed Care for Medical
- MLTSS
- Coordinated Care for All Waiver Recipients

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

Step 1	**The Governor's Access - Reaching Virginia's Uninsured with Serious Mental Illness (7,269 adults enrolled)**
Step 2	**Covering our Children - Reaching More Children through Medicaid and FAMIS (15,800 more children enrolled)**
Step 3	**Supporting Open Enrollment in the Federal Marketplace - Reaching More Virginians (more than 200,000 new individuals enrolled)**
Step 4	**Informing Virginians of their Health Care Options - Reaching more Virginians through Cover Virginia (more than 700,000 visits to website)**
Step 5	**Making Dependent Coverage Affordable for Lower-Income State Employees - through FAMIS (908 children)**

Step 6	**Providing Comprehensive Dental Coverage to Pregnant Women in Medicaid and FAMIS - Improving Access to Oral Health Care (6,500+ women)**
Step 7	**Prioritizing the Health of Virginia's Veterans - Accelerating Veterans' Access to Care**
Step 8	**Winning a State Innovation Model Grant - Seizing Opportunity to Transform Health Care Delivery (DSRIP waiver)**
Step 9	**Creating Behavioral Health Homes - Strengthening Virginia's Behavioral Health System through Innovation (200 members, 5 health plans)**
Step 10	**Reducing Prescription Drug and Heroin Abuse - Stemming a Devastating Proliferation of Substance Abuse (Substance Use Disorder service package)**

Agency Program Priorities: 2016-2017

1. **Managed Long Term Services and Support (MLTSS)**
2. **Medallion 3.0**
3. **Delivery System Reform Incentive Payment (DSRIP)**
4. **Substance Use Disorder (SUD)**
5. **Medicaid Enterprise System RFPs (5)**

Update on Medicaid Projects: MLTSS, DSRIP and SUD

Presentation to:

House Appropriations Committee

Subcommittee on Health and Human Resources

Cindi B. Jones, Director

Virginia Department of Medical Assistance Services

May 16, 2016

Agenda

- ❑ Introduction
- ❑ Managed Long Term Services and Supports (MLTSS)
- ❑ Delivery System Reform Incentive Payment (DSRIP)
- ❑ Substance Use Disorders (SUD) Program Changes

Virginia's Medicaid Program Key Facts

1 Million +

Virginians covered by Medicaid/CHIP

1 in 8

Virginians rely on Medicaid

2 in 3

Residents in nursing facilities supported by Medicaid - Primary payer for LTSS

50%

Medicaid beneficiaries are children

58%

Long-Term Services & Supports spending is in the community

1 in 3

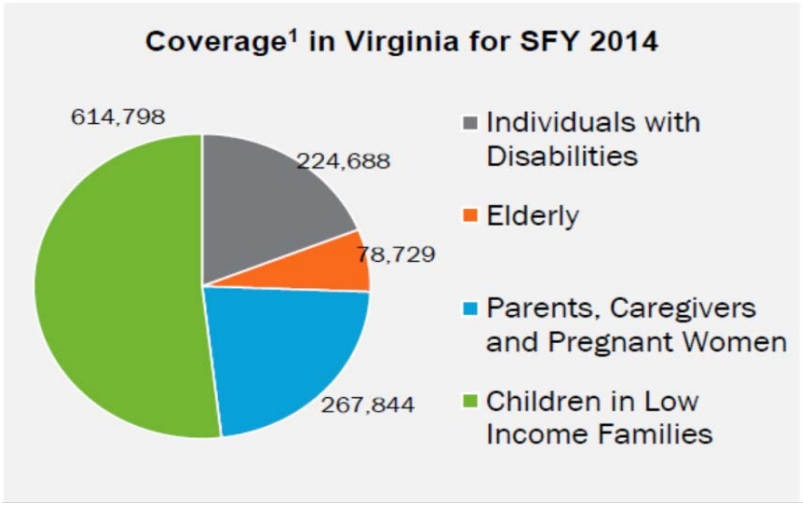
Births covered in Virginia

Behavioral Health

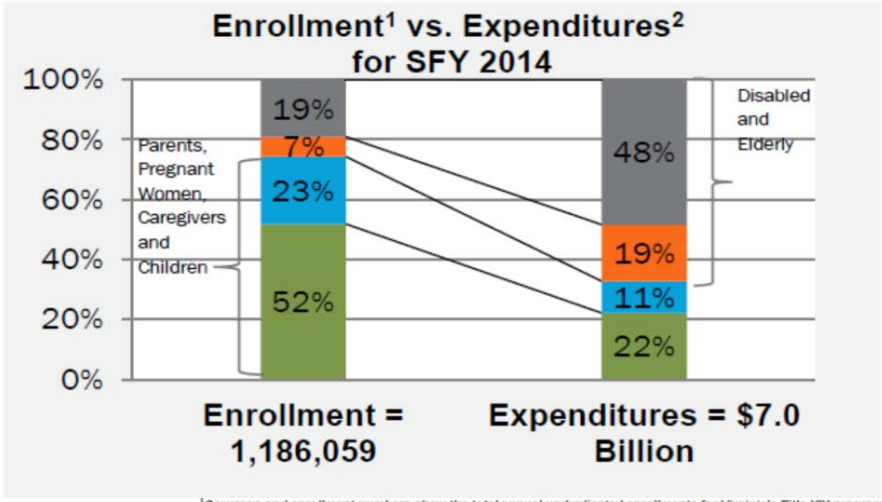
Medicaid is primary payer for services

Overview: Virginia Medicaid

Virginia's Medicaid population breakdown and expenditures



Medicaid coverage is primarily available to Virginians who are children in low-income families, pregnant women, elderly, individuals with disabilities and parents meeting specific income thresholds.



[1] Coverage and enrollment numbers show the total annual unduplicated enrollments for Virginia's Title XIX program
[2] Expenditures represent claims expenditures for Virginia's Title XIX program

Medicaid expenditures are disproportionate to covered populations. Seniors and individuals with disabilities make up over 25% of the total population, yet almost 70% of expenditures are attributed to this group.

Managed Care

Management of Medicaid population has been an ongoing and evolving process over the last 20 years

Population focused – improving care and costs for broader population groups

- ✓ Managed Care (full-risk):
  - Pregnant Women & Children (1996)
  - ABD (1996)
  - ALTC (2007)
  - PACE (2006)
  - Statewide Coverage (2012)
- ✓ Waivers – HCBS (1980's)
- ✓ Magellan – BHSA (2013)
- ✓ CCC Demo (2014)

Innovation efforts and additional programs – improve care for complex population

- ❑ Pilots (BH homes in MCOs, 2014 and 2015), also in CCC
- ❑ MLTSS
- ❑ DSRIP
- ❑ GAP and SUD
- ❑ ID/DD System Redesign
- ❑ Brain Injury Population Programs

Major delivery system reform

- ❑ VIPs through DSRIP – Provider partnerships focused on super-utilizers/high-risk beneficiaries
- ❑ Provider-led Care Management – high-touch, person-centered care
- ❑ Moving from population-based to needs-based service delivery model
- ❑ Full-risk managed care and shared-risk with providers

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MLTSS – Top Five Things to Know

1. MLTSS is a Legislative Mandate and an administrative priority.
2. MLTSS will ensure a comprehensive care coordination strategy that will help control costs.
3. MLTSS has a strong person-centered, fully integrated delivery model.
4. MLTSS will be statewide.
5. MLTSS implementation will be phased-in, beginning in 2017.

MLTSS – Legislative Mandate

Consistent with the Virginia General Assembly and Medicaid reform initiatives, DMAS is moving forward with transitioning individuals from fee-for-service delivery models into managed care

General Assembly Directives beginning 2011 through 2015

Continue to transition fee-for-service populations into managed care

Phase 3 of Medicaid Reform Initiatives

Move forward with managed long term services and supports (MLTSS) initiatives

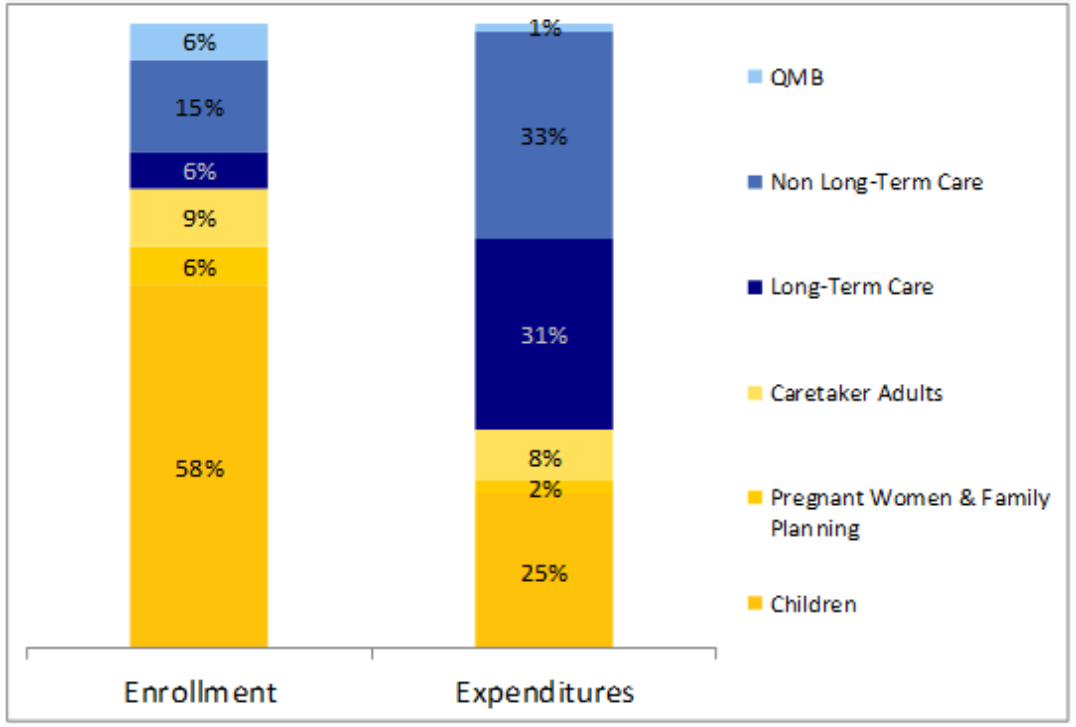
Value of Managed Care

Timely access to appropriate, high-quality care; comprehensive care coordination; and budget predictability

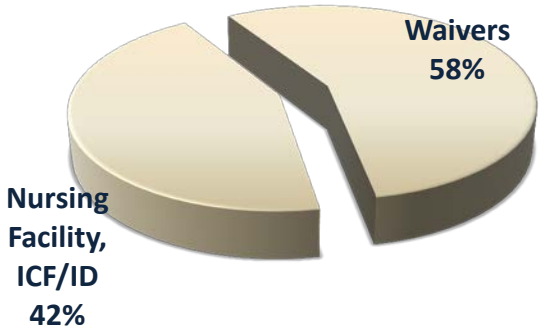
Benefit of MLTSS

The current fee-for-service system lacks comprehensive care coordination, the flexibility to provide innovative benefit plans & value-based payment strategies, and budget predictability

Medicaid Enrollment v. Expenditures

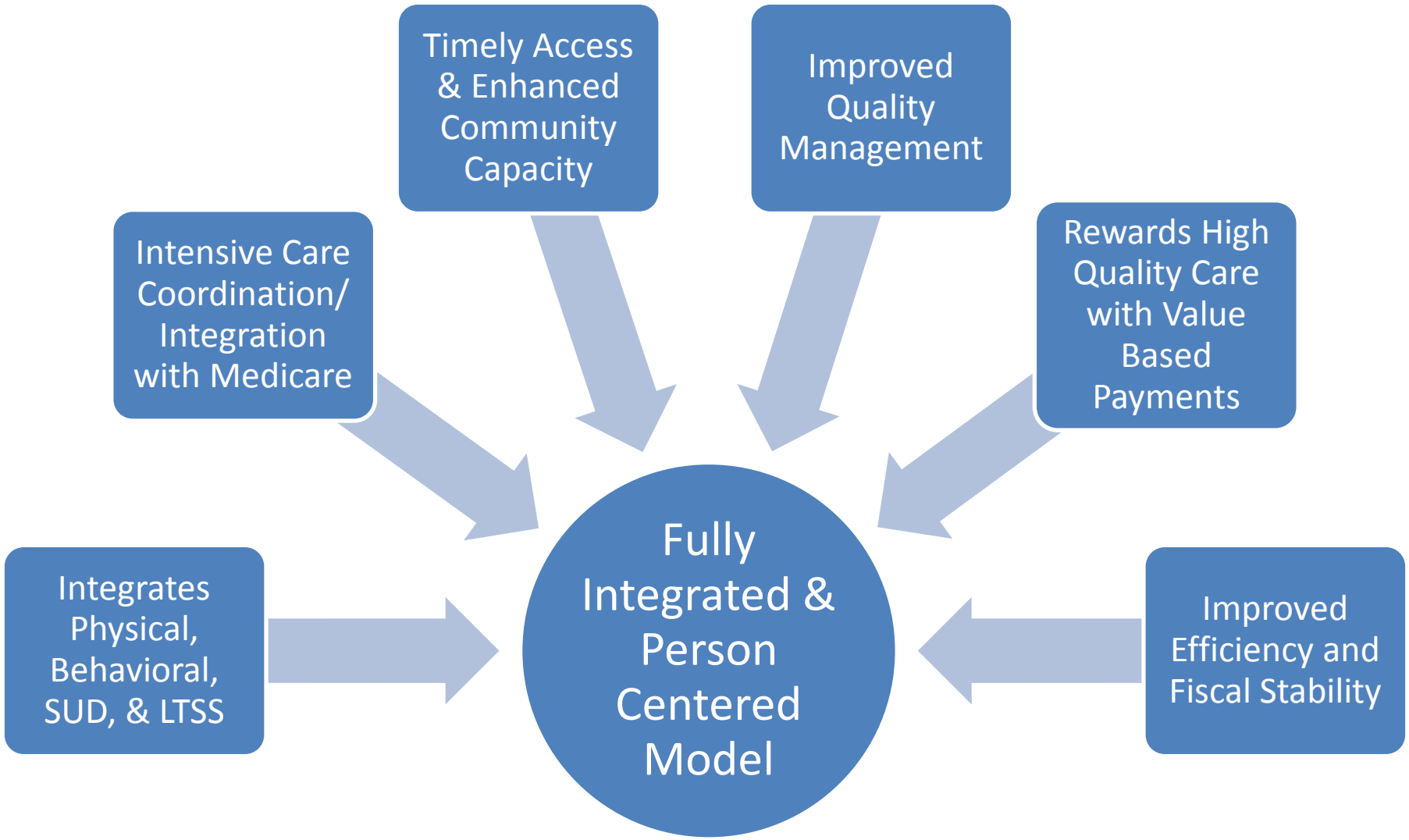


Long-Term Care Expenditures



Current LTSS spending trends are unsustainable

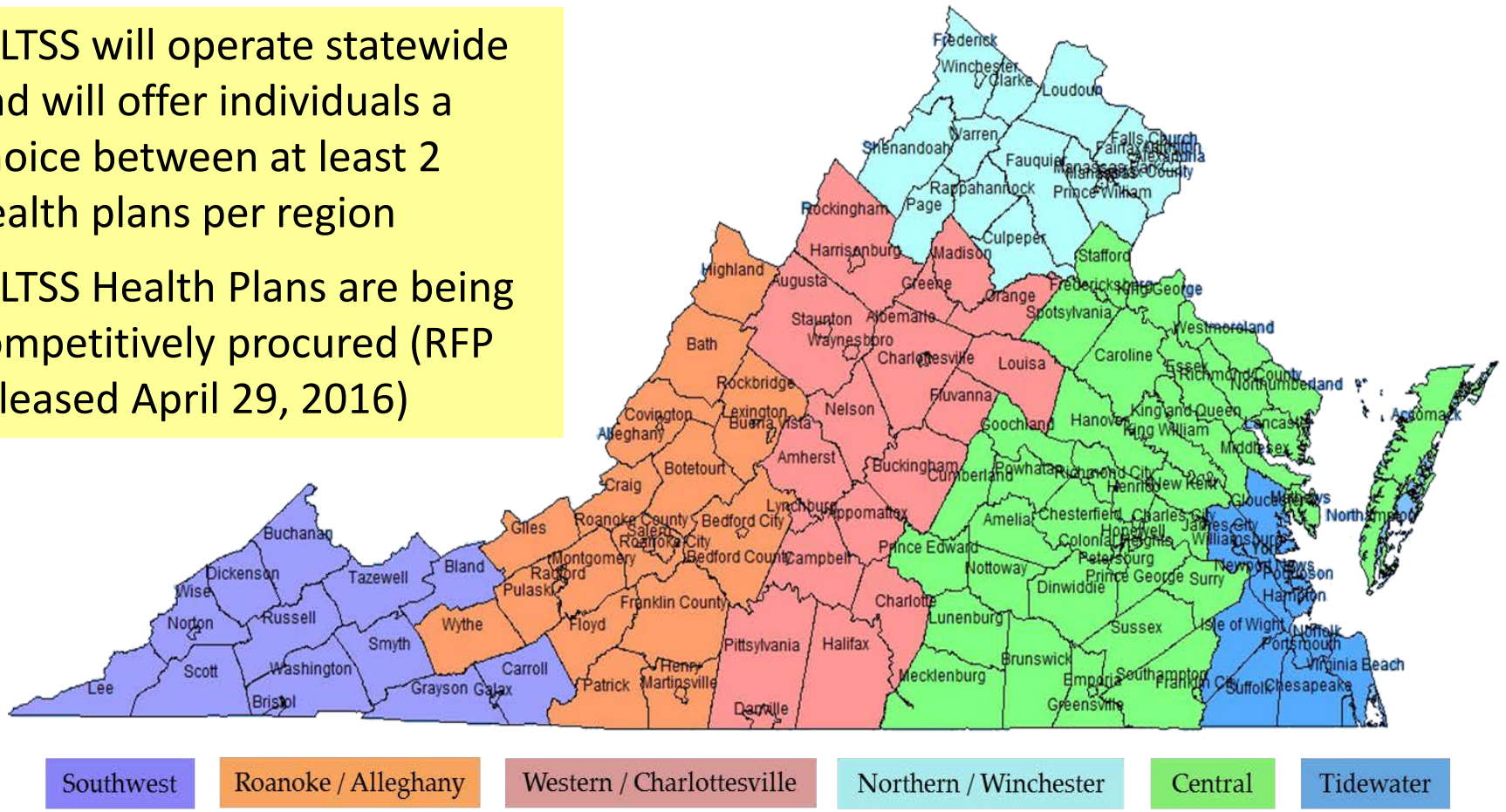
MLTSS Person Centered Delivery Model



MLTSS Regional Map

Virginia Medicaid's Regional Map for Managed Long-Term Services and Supports (MLTSS)

- MLTSS will operate statewide and will offer individuals a choice between at least 2 health plans per region
- MLTSS Health Plans are being competitively procured (RFP released April 29, 2016)



MLTSS Proposed Program Launch

Date	Region	Totals	
		At Time of Regional Launch	With CCC& ABD
7/1/2017	Tidewater	17,395	42,910
9/1/2017	Central	23,573	54,275
10/1/2017	Charlottesville/Western	16,481	29,614
11/1/2017	Roanoke/Alleghany/Southwest	23,665	47,291
12/1/2017	Northern/Winchester	25,099	37,964
1/1/2018	CCC Enrolled	29,510	*included above*
1/1/2018	Aged, Blind, and Disabled (from Medallion 3.0	76,331	*included above*
Total	**All Regions**	**212,054**	**212,054**

**Source – VAMMIS Data; approximate totals based upon MLTSS targeted population as of March 2016*

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DSRIP – Top Five Things to Know

1. Virginia's Medicaid population is aging with more disabilities and complex needs.

2. Health care is provided in silos and cannot meet the complex needs of the Medicaid population.

3. Health outcomes are not improving while health care spending is increasing, and as a result the Medicaid cost trajectory is not sustainable.

4. DSRIP presents the opportunity to fundamentally shift how care is delivered for the whole person and align payment incentives through culture and process changes.

5. Value will improve and be sustained with shared accountability across providers and payers, resulting in better Medicaid health outcomes and decrease in the growth of Medicaid spending.

Driving Medicaid Transformation

Virginia's Medicaid Program continues to evolve and transform. Delivery System Reform Incentive Payment (DSRIP) Program presents the opportunity to continue Medicaid reforms to achieve **quality, better outcomes, and efficiency**.

The Medicaid Delivery System is...

..how providers, payers, health care settings, and community resources work together to deliver health care and support services to meet the needs of the Medicaid population.

Delivery System Reform

DSRIP is a one-time investment where all Terms & Conditions with CMS are clearly outlined before Virginia moves forward.

What is DSRIP?

DSRIP programs provide the opportunity to invest in delivery system reform across the entire health care landscape.

DSRIP programs cannot pay for...

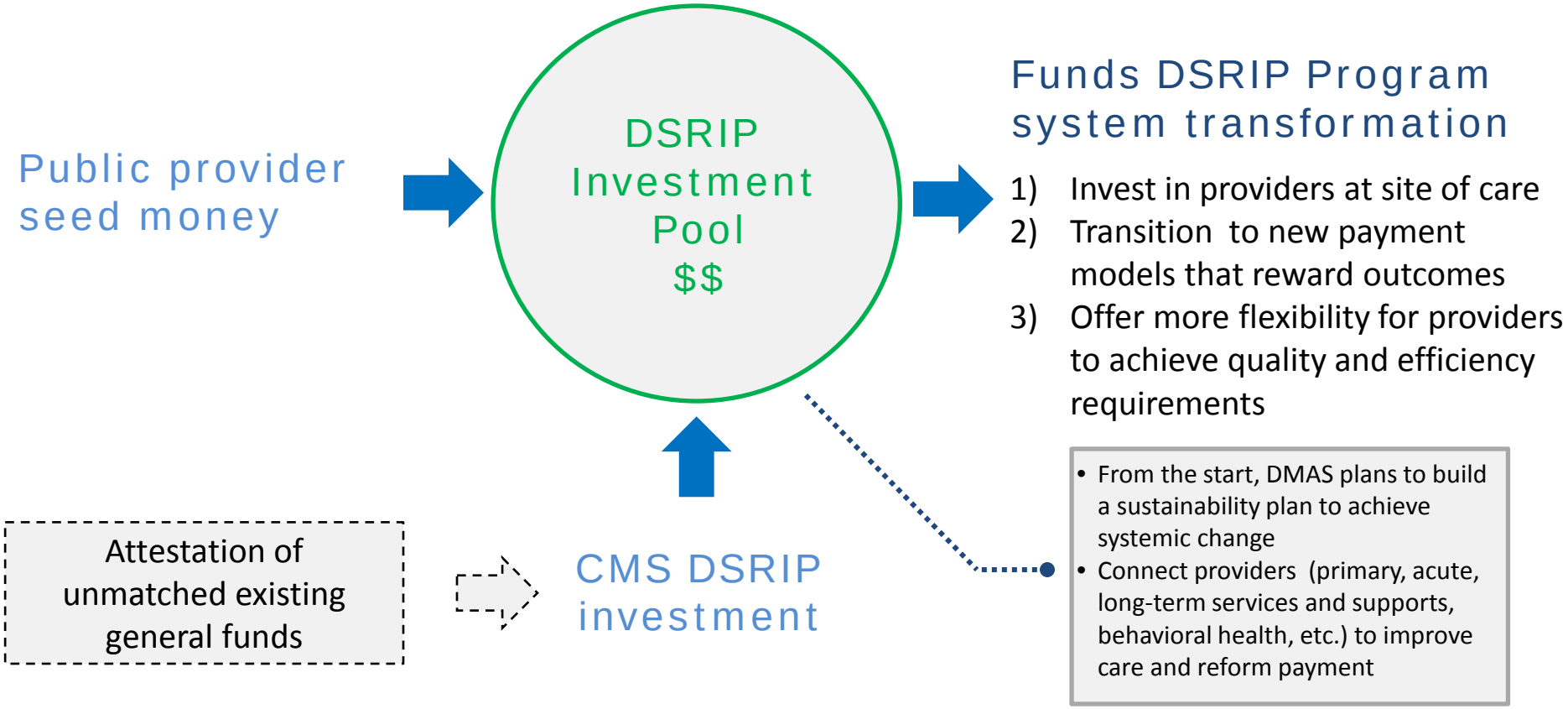
- ...new Medicaid services
- ...new populations
- ...bricks and mortar

...and must be strictly focused on **infrastructure development** for the **current** Medicaid population.

DMAS will invest in Medicaid provider infrastructure and process improvements in order for providers, payers, health plans, and the Department to succeed in the shift toward a new model of care and Medicaid payment models.

DSRIP Financing

DSRIP seed money fuels an investment pool that supports delivery system reform and provider readiness for value-based payments.



DSRIP Initiatives

The DSRIP investment starts with the formation of new provider partnerships to implement initiatives.

Form Provider Partnerships (about 10 partnerships in Virginia)

Example Projects:

- Formalize partnership across all different public and private provider types (medical, behavioral health, long-term services and supports, and others)

Implement Initiatives to Improve Care Delivery

Example Projects:

- Integrate behavioral and medical health services with bi-directional coordination to breakdown silos and increase capacity
- Integrate social determinants of health into medical care
- Implement strong transitions between care settings
- Create real time data sharing across all provider partners to enable clinical action
- Implement emergency department information system

Transition to Value-Based Payments

Example Projects:

- Implement alternative payment models to reward outcomes

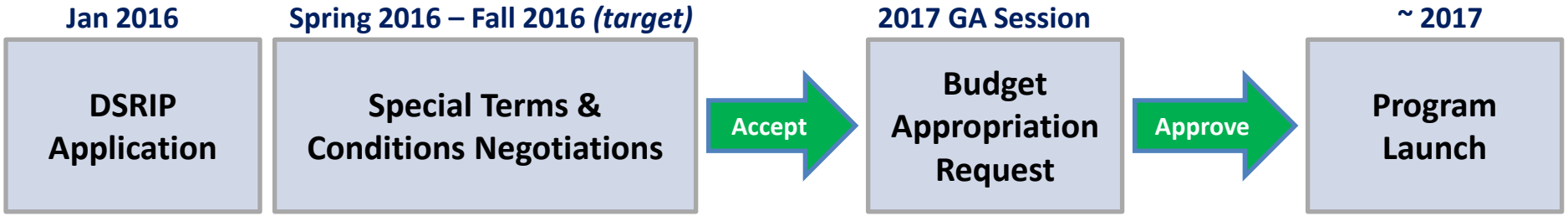
DSRIP Critical Success Factors

Virginia's proposed DSRIP Program "thinks big, starts focused, and scales fast."

Critical Success Factor	Virginia's Approach
CMS supports Virginia's concept for a transformed Medicaid delivery system	Innovative proposal with delivery system and payment reform within 5 year period
Stakeholders are supportive and willing to engage in the transformation	Formed stakeholder working groups and holding multiple public meetings to engage and build support
Time is of the essence	Responsive to CMS to stay on target for approval by Fall 2016
Strong budget neutrality and financing approach	Proposed sound budget neutrality approach to protect Virginia's investment

Next Steps and Timeline

Negotiations with CMS will occur throughout 2016 and the earliest the program could start is in 2017. DMAS is in the preliminary stages of developing a potential budget for this program.



- Submitted application to CMS

- Negotiation on scope of innovation and demonstration
- DMAS stakeholder engagement to define details
- Negotiation of program details (administration, expectations, milestones, financing, and reporting/evaluation)
- Length varies

How can we best keep you involved?

- Launch first year of five year program
- Request for Application from Provider Partnerships
- Strong alignment with Managed Care and sustainability plan

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SUD – Top Five Things to Know

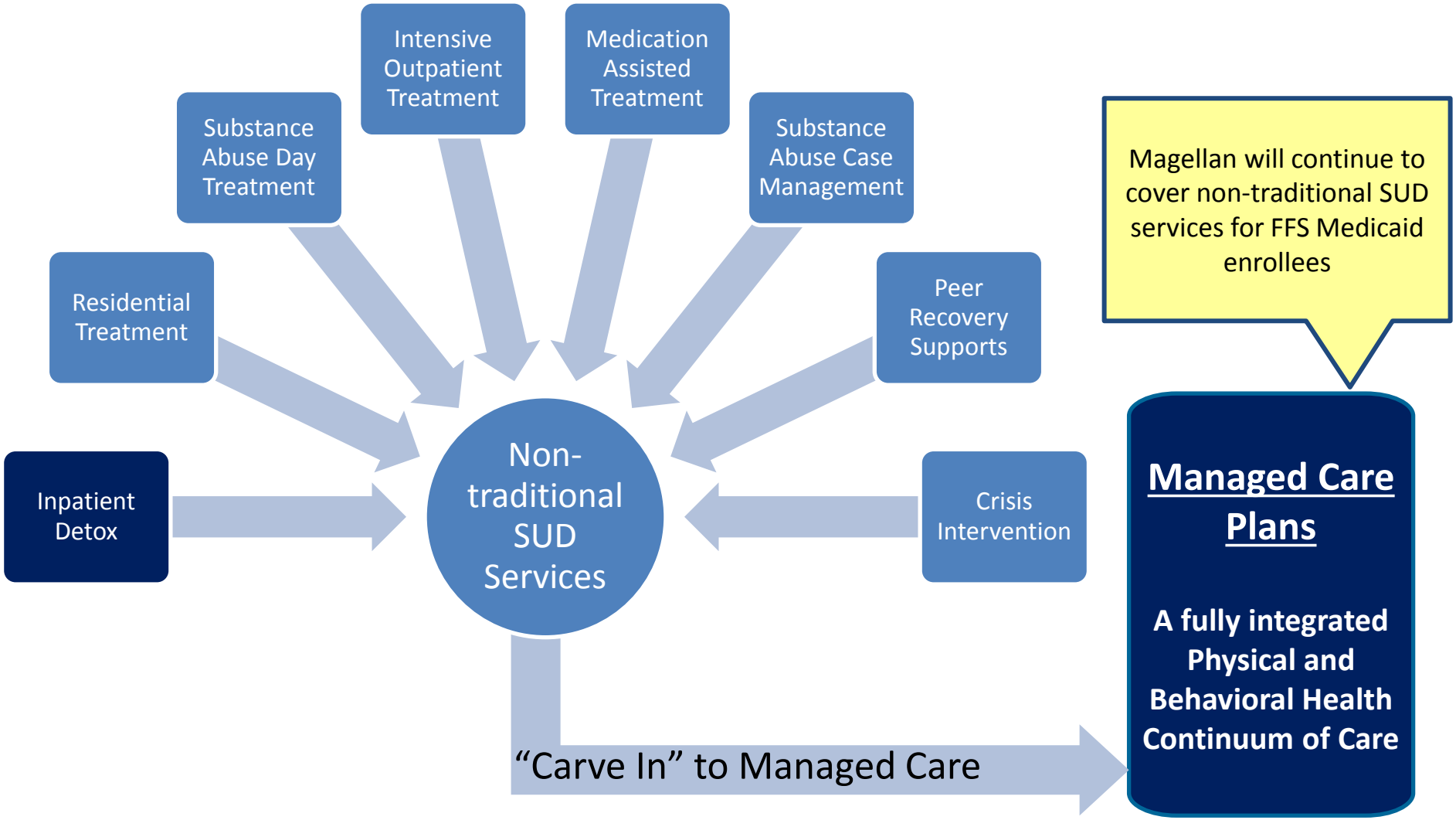
1. SUD changes will increase access to addiction treatment.
2. The current Medicaid SUD delivery system will be reformed.
3. There are many SUD activities currently underway.
4. Intensive provider education, recruitment and training will occur.
5. SUD service implementation will occur in April 2017.

Increasing Access to Addiction Treatment

Six approved SUD service enhancements for current Medicaid members

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

Reforming the Current Medicaid SUD Delivery System



Current Activities

Workgroup

- Define benefit & service limits
- Determine payment structure

Criteria

- Align ASAM criteria with licensing
- Standardize operating procedures among MCOs & Magellan

Training & Outreach

- ASAM Criteria Training
- Medication Assisted Treatment Training

1115 Waiver

- Increase Residential Bed Capacity
- Application for Waiver to CMS in May

Intensive Provider Education, Recruitment, and Training

Medication Assisted Treatment (MAT) Training Curriculum	• Partner with VDH and MAT experts to develop comprehensive **in-person and online training curricula**
Conduct Trainings	• Training around the State for physicians, pharmacies, counselors, hospitals and any other provider of services • Family, advocacy sessions to educate about service array
Ongoing Support	• Statewide **Virginia MAT Support Network** for new providers • **Regional champions (mentors)** • Regular case conferences where new MAT providers can bring challenging patient cases and receive advice.

SUD Implementation Timeline