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

June 11, 2013

Minutes

Present:
Joseph W. Boatwright, III, M.D.
Vice Chair
Michelle Collins-Robinson
Brian H. Ewald
Kay C. Horney
Maria Jankowski
Karen S. Rheuban, M.D.
Chair
J. Mott Robertson, Jr., M.D.
Marcia Wright Yeskoo
Erica L. Wynn, M.D.

Absent:
Ashley L. Taylor, Jr.
One vacant position

DMAS Staff:
Cheryl J. Roberts, Deputy Director for Operations
Jennifer Gobble, Legal Counsel
Suzanne Gore, Senior Executive Advisor
Curt Diemer, Program Administration Specialist
Craig Markva, Director, Office of Communications, Legislation & Administration
Nancy Malczewski, Public Information Officer
Mamie White, Public Relations Specialist and Board Liaison

Speakers:
Cynthia B. Jones, Director
Scott Crawford, Deputy Director for Finance
Steven E. Ford, Deputy Director for Administration
Karen E. Kimsey, Deputy Director for Complex Care and Services

Guests:
Scott Johnson, Esq., First Choice Consulting
Rick Shinn, Va. Community Healthcare Association
Anne Kerr, Troutman Sanders
Linda L. Redmond, VA Board for People with Disabilities
Richard Grossman, Vectre Corporation
R. J. Gilson, Xerox
Blair Swanson, Medical Society of Virginia
Rick Meidlidger, Johnson & Johnson
Ralston King, Whitehead Consulting
Lindsay Walton, Macaulay & Burtch
Hunter Jamerson, Macaulay & Burtch
Aimee Perron Seibert, VA College of Emergency Physicians/VA Chapter of Pediatrics

Call to Order

Dr. Karen S. Rheuban, Chair of the Board, called the meeting to order at 10:04 a.m. and recognized newly appointed members Marcia Wright Yeskoo, Maria Jankowski, and Dr. Erica L. Wynn, potential appointee pending paperwork.

Approval of Minutes from April 9, 2013 Meeting

Dr. Rheuban asked that the Board review and approve the Minutes from the April 9, 2013 meeting. Dr. Rheuban made a motion to accept the minutes and Dr. Robertson seconded. The vote was: **8-yes (Boatwright, Collins-Robinson, Ewald, Horney, Jankowski, Rheuban, Robertson, and Yeskoo); 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Jones shared information and highlights of Medicaid reform discussion scheduled at several upcoming important meetings of the Virginia Health Reform Initiative (VHRI) Advisory Council, House Appropriations Committee, and the Medicaid Innovation and Reform Commission (MIRC).

Ms. Jones announced that the Behavioral Health Services Administrator (BHSA) contract was awarded to Magellan Health Services and implementation will occur on December 1, 2013. Also, Virginia was approved to implement the Medicare-Medicaid Enrollee (dual eligible) Financial Alignment Demonstration and finalized the Memorandum of Understanding with the Centers for Medicare and Medicaid Services (CMS) on May 21, 2013. This initiative will begin January 1, 2014.

In response to a VHRI recommendation that Medicaid increase use of electronic claims and remittance submission, both areas have realized steady growth each month since implementation and currently have a rate of 95% and 98% respectively.

During discussion of pending Medicaid claims for emergency room physicians, Dr. Robertson provided detailed background information and explanation of this process. After discussion by the Board, Dr. Robertson offered and made a motion that the Board accept the proposal (below) and forward a letter of support to the Secretary of Health and Human Resources.

> In recognition of the valuable medical care and other services provided to Medicaid and all other patients by physicians in Emergency Departments, The Board of the Department of Medical Assistance Services supports the termination of the current DMAS policy of pending Medicaid claims codes 99283 for emergency department visits. The Board instructs the Director to work with the Secretary of Health and Human Resources to include the necessary budgetary language in the Department budget requests for the 2014 budget, and any other regulatory steps necessary to effect this process.

During the previous proceedings, the Board received confirmation of the appointment of Dr. Wynn from the Office of the Secretary of the Commonwealth. Dr. Rheuban asked Dr. Wynn to be seated at the table for the vote. Ms. Horney seconded the motion. The vote was: **9-yes (Boatwright, Collins-Robinson, Ewald, Horney, Jankowski, Rheuban, Robertson, Wynn and Yeskoo); 0-no.**

UPDATE ON MEDICAID REFORM

Ms. Jones provided an overview of the Medicaid reform Health and Human Resources (HHR)-Department of Medical Assistance Services (DMAS) project matrix (attached).

REPORT ON DUAL DEMONSTRATION PROJECT

Karen E. Kimsey, Deputy Director for Complex Care and Services, provided an update on the Dual Eligible Demonstration also referred to as Commonwealth Coordinated Care. The goal of this initiative is to provide Virginians high quality health care and supports coordinating the Medicare and Medicaid benefits into a single person-centered program. This program is vital to Virginia's Medicaid reform efforts and will be rigorously evaluated during the demonstration period beginning January 1, 2014.

REPORT ON PRIMARY CARE RATE INCREASE

Scott Crawford, Deputy Director for Finance, provided an update on the Medicaid physician primary care rate increase. Physicians qualify for this rate increase by "attesting" to their specialty, with specialty established based on board certification or the percent (60%) of practice devoted to primary care. Mr. Crawford reported that eligible physicians would receive supplemental payments for the first two quarters of the year in July. After that, payments will be quarterly. DMAS is awaiting federal approval for rates before eligible managed care providers can begin receiving the supplemental payments.

NEWBORN ENROLLMENT

Steven E. Ford, Deputy Director for Administration, reviewed current status of newborn enrollment pilot and explained the process in place. There have not been any gaps in coverage, educational issues are being addressed, and the process is being evaluated for quality assurance checks. The statewide implementation is contingent on the proper functionality of the new enrollment system being developed and merging this "abbreviated" newborn enrollment process.

OLD BUSINESS

None.

Regulatory Activity Summary

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

New Business

None.

Adjournment

Dr. Rheuban thanked Dr. Harris and Ms. Klear for their service to the Board during their tenure and adjourned the meeting at 12:05 p.m.

This document is to inform stakeholders of the Virginia Health Reform Initiative regarding plans of the Department of Medical Assistance Services (DMAS) to strategically implement Medicaid Reform budget language as passed by the 2013 General Assembly and subsequently signed by the Governor. Additionally, this document serves as a tool to solicit stakeholder written public comment and support for implementation strategies. Instructions for written public comment can be found at the end of the document. Please note: this document is not intended to solicit comments for the Medicaid Innovation and Reform Commission.

Phase 1: Advancing Reforms in Progress

Title	Budget Language	Resource Information	Targeted Completion Date
1. Dual Eligible Demonstration Pilot	(i) implementation of a Medicare-Medicaid Enrollee (dual eligible) Financial Alignment demonstration as evidenced by a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (CMS), signing of a three-way contract with CMS and participating plans, and approval of the necessary amendments to the State Plan for Medical Assistance and any waivers thereof	Medicare-Medicaid Financial Alignment Demonstration: Medicare-Medicaid enrollees ("Dual Eligibles") have among the most complex health care needs of any Medicaid or Medicare members, including chronic conditions, behavioral health needs, and disabling conditions. These enrollees expend 41% of the Medicaid budget. The Commonwealth is developing a coordinated program that will include all Medicare (Parts A, B and D) and Medicaid services, including long-term care services (nursing facility and Elderly and Disabled with Consumer Direction waiver services) and behavioral health services, through managed care organizations (MCOs). Goals include providing person-centered, seamless care across the full spectrum of Medicare and Medicaid Services. For further information regarding the Duals demonstration, please visit: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx	January 2014
2. Enhanced Program Integrity	(ii) enhanced program integrity and fraud prevention efforts to include at a minimum: recovery audit contracting (RAC); data mining; service authorization; enhanced coordination with the Medicaid Fraud Control Unit (MFCU); and Payment Error Rate Measure (PERM);	DMAS undertakes significant effort to ensure the integrity of the Virginia Medicaid program. Following are summaries of the integrity efforts outlined in the budget language and additional select examples of current DMAS program integrity efforts. ***Recovery Audit Contract (RAC)*** – DMAS contracts with HMS on a contingency fee basis to review processed claims for overpayments and fraud waste and abuse for all services. The RAC is federally required and reimbursed based on recovered overpayments.	Ongoing

		Fraud, Waste, and Abuse Contract – DMAS contracts with HMS to analyze data on submitted claims in order to identify opportunities for prepayment and post-payment program integrity activities. ***Service Authorization***- DMAS requires providers to obtain prior authorization of the medical necessity of certain services (referred to as Service Authorization) before a claim can be paid through MMIS. DMAS contracts with Keystone Peer Review Organization (KePRO,) which provides telephone and internet access for providers to request authorization of services. KePRO medical staff review the information submitted by providers and determine if the service is medically necessary under DMAS policy. ***Medicaid Fraud Control Unit (MFCU)-*** DMAS refers providers to the Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General, Department of Health Professions and other state licensing agencies if a review indicates waste, suspected fraud or abuse. MFCU determines if the case warrants further investigation as fraud. MFCU conducts investigations and gathers evidence to establish the existence of provider fraud. MFCU works in collaboration with DMAS staff during the investigation as subject matter experts and owners of the original audit. ***Payment Error Rate Measurement (PERM) Review-*** The federal government conducts the PERM review every three years in each state to measure improper payments in state Medicaid programs. The findings of the PERM project are used to determine how Virginia compares on a national level in the area of payment accuracy. Select Additional Integrity Efforts Include: ***MMIS Claims Processing Edits***- DMAS subjects claims to rigorous prepayment scrutiny through its automated claims processing and review system called the Medicaid Management Information System (MMIS). Currently there are over 1,550 edits in the Virginia MMIS- these are rules that must be passed before claims are adjudicated for payment. These edits reject things like duplicate claims or claims for services or service levels that are not authorized under Medicaid policy.	

		Managed Care Collaboration - The majority of Medicaid recipients are covered through contracts with managed care organizations (MCOs) who receive a monthly rate for each enrollee, and are responsible for paying providers directly for the medical services incurred by those individuals. Each MCO is required to have policies and procedures in place to prevent, detect and investigate allegations of fraud, waste and abuse. In 2012, DMAS implemented an annual audit of each MCO's compliance with the program integrity requirements under the MCO contract. ***Provider and Recipient Audits***- DMAS reviews provider service claims, medical documentation, medical reports and service-authorizations (if applicable); to identify potentially fraudulent, abusive or incorrect billing practices. DMAS staff and contractors review all provider types to include physicians, waiver services, mental health services, durable medical equipment and laboratories. DMAS also audits recipients where allegations of fraud, waste, or abuse are reported.	
3. Foster Care	(iii) inclusion of children enrolled in foster care in managed care;	DMAS will be completing its transition of 12,000 children in Virginia's foster care and adoption assistance programs from Medicaid Fee For Service into DMAS contracted MCOs. MCO enrollment will improve the coordination of care for this vulnerable population ensuring timely access to behavioral health services, preventive medical treatment, and ongoing health care. For further information regarding this transition, please visit: http://www.dmas.virginia.gov/Content_pgs/ialtc-plt.aspx	Fall 2013/Winter 2014
4. eHHR	(iv) implementation of a new eligibility and enrollment information system for Medicaid and other social services	The Health and Human Resources Secretariat is spearheading a cross agency effort to simplify administrative processes and create citizen-centric service access. Know as "eHHR," this effort seeks to achieve the following goals: • Modernize Eligibility and Enrollment for Medicaid and other social services; create a self-service environment to improve service quality and reduce costs • Create a business framework where new functions can easily be added • Leverage existing information technology systems that work well • Recognize that social service policy	Fall 2013

		• Enable paperwork reduction through automation • Fight fraud and abuse with modern citizen identification tools For Further Information on new Medicaid financial eligibility requirements (referred to as "MAGI"), please visit: http://aspe.hhs.gov/health/reports/2013/MAGIConversions/rb.pdf For access to Virginia's new eligibility website, known as the Commonhelp Portal, please visit: https://commonhelp.virginia.gov	
5. Veterans	(v) improved access to Veterans services through creation of the Veterans Benefit Enhancement Program; and	DMAS, Virginia Department of Veterans Services, and Virginia Department of Social Services are working together to identify protocol and procedures to ensure qualifying Veterans and their family members have access to needed services. The 2012 budget language created this opportunity for the Veterans Benefit Enhancement Program. ***Promote Access to Federal Veterans Benefits for Medicaid Recipients.*** *Adds $130,979 GF in FY 2013 and $141,521 GF in FY 2014 and an equal amount of federal Medicaid matching funds for three new positions to work in cooperation with the Department of Veterans Services to expand access to comprehensive federally-funded benefit services for Medicaid recipients who are also veterans of the military.*	Ongoing
6. Behavioral Health	(vi) expedite the tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services.	In an effort to strengthen the integrity of DMAS' behavioral health program and ensure access to quality behavioral health providers, DMAS is hiring a contractor to oversee the community behavioral health provider network, authorize services that are not currently being provided through Medicaid MCOs, and reimburse providers for services delivered. For information regarding the proposed Behavioral Health Services Administrator, please visit: RFP: http://dmasva.dmas.virginia.gov/Content_atchs/rfp/rfp2011_bh_admin.pdf Addendum 1: http://dmasva.dmas.virginia.gov/Content_atchs/rfp/rfp2011_bh_adn1.pdf Addendum 2: http://dmasva.dmas.virginia.gov/Content_atchs/rfp/rfp2011_bh_adn2.pdf	Fall 2013

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

Virginia provides Medicaid to individuals through two delivery models: a managed care model that utilizes contracted managed care organizations (MCOs) and a fee-for-service (FFS) model, where service providers are reimbursed directly by DMAS. Managed care is now statewide and provides services to 70% of the Medicaid population. Phase 2 addresses both reforms for the current service delivery models as well as reforms for future changes for payment and service delivery models.

DMAS has laid the groundwork for reforms of the existing MCOs in its upcoming July 1, 2013, Medallion II (managed care) Contract. The new contract has several improvements:

- Reformatted to clarify requirements and improve monitoring;
- Provided a new technical manual to improve reporting, automation, encounter data, and scoring;
- Initiated a new quality incentive program;
- Initiated a new Medallion Care System Partnership which focuses on new payment and delivery models;
- Instituted All Payer's Claims Data Base (ACPD) requirements;
- Improved program integrity collaborative incentives;
- Improved maternity care requirements;
- Improved chronic disease management for the aged, blind, and disabled; and
- Improved wellness programs.

In addition, the MCOs have formed workgroups to focus on potential improvements to EPSDT, emergency room usage, personal responsibility, co-pays, administration simplifications, and wellness incentive programs.

Title	Budget Language	Resource Information	Targeted Completion Date
7. Commercial-Like Benefit Package	(i) the services and benefits provided are the types of services and benefits provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care; with the exception of non-traditional behavioral health and substance use disorder services; (ii) reasonable limitations on non-essential benefits such as non-emergency transportation are implemented	DMAS is looking to align medical benefits offered through the Medicaid program with those provided in the commercial marketplace. This should facilitate a less disruptive transition for an individual moving from the Medicaid program into private health coverage; including coverage offered through the federally facilitated (exchange) marketplace. DMAS is planning to offer commercial-like medical services for adults in the managed care program and fee for service. The concept would be to have one commercial like benefit plan for adults in Medicaid and add wrap around services as needed for certain populations (such as long term care and behavioral health services) For further information on essential health benefits to be included within the Medicaid Benchmark Package, please visit: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf To view the link to full Notice of Proposed Rule Making (NPRM) (Includes Medicaid Benchmark), please visit: https://www.federalregister.gov/articles/2013/01/22/2013-00659/medicaid-childrens-health-insurance-	July 2014

		programs-and-exchanges-essential-health-benefits-in-alternative Letter to Governors from Secretary Sebelius: http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Downloads/Markell-and-Fallin-Letter.pdf State Medicaid Director Letter – Essential Health Benefits in the Medicaid Alternative Benefit Plans http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf	
8. Cost Sharing and Wellness	(iii) patient responsibility is required including reasonable cost sharing and active patient participation in health and wellness activities to improve health and control costs.	DMAS recognizes that beneficiary engagement strategies must be designed in a way that will not deter an individual from seeking primary and preventive care. However, DMAS views this as an opportunity to guide beneficiaries to the appropriate care setting and become engaged in their overall healthcare. As mentioned in the introduction, DMAS and the MCOs are working together on innovations in cost sharing and wellness. Existing Cost Sharing Authority via the Social Security Act: http://www.ssa.gov/OP_Home/ssact/title19/1916.htm To view the link to full Notice of Proposed Rule Making (NPRM) (includes information on Medicaid Premiums and Cost Sharing) please visit: https://www.federalregister.gov/articles/2013/01/22/2013-00659/medicaid-childrens-health-insurance-programs-and-exchanges-essential-health-benefits-in-alternative#p-101	July 2014
9. Coordinate Behavioral Health Services	Any coordination of non-traditional behavioral health services covered under contract with qualified health plans or through other means shall adhere to the principles outlined in paragraph RR. e.	Please see #6, Behavioral Health. Upon implementation of the BHSA, DMAS-contracted MCOs will work with the BHSA to coordinate behavioral health and medical services. For further information regarding the budget language referenced (RR.e.) Please review the 2012-2014 Biennium Budget: http://lis.virginia.gov/cgi-bin/legp604.exe?131+bud+21-307	Will coincide with BHSA Implementation (see #6): Fall 2013
10. Limited Provider Networks and Medical Homes	(i) limited high-performing provider networks and medical/health homes;	Within the parameters of the traditional Medicaid MCO arrangement, the federal government allows a lot of flexibility for provider, payment and service delivery models. However, if DMAS wants to create different payment and delivery models	DMAS' contracted MCOs already operate a variety of medical homes now. Beginning July

		outside of an MCO arrangement, DMAS must seek waiver of certain authorities (such as individual choice) from the federal government. DMAS is developing a concept paper to share with CMS which outlines parameters to test pilots (see #16 below), including limited providers and medical homes outside of the existing MCO contracts. The benefit to creating an agreement with the federal government that allows for limited provider networks would afford Virginia's MCO's, health systems, and health care providers to create innovative models of comprehensive care specific to a region, chronic condition, or co-occurring medical situations that span across physical and mental health. While the actual number of providers may be reduced with a limited network, qualifying beneficiaries could receive higher quality coordinated care through a limited network arrangement. Patient Centered Medical Homes have five core principles: 1) Comprehensive Care 2) Patient Centered 3) Coordinated Care 4) Accessible Services 5) Quality and Safety For further information on Patient Centered Medical Homes, please visit: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483	2013, DMAS MCOs will continue to operate and/or develop medical homes. The new contract requires more data and reporting related to these models.
11. Quality Payment Incentives	(ii) financial incentives for high quality outcomes and alternative payment methods,	Quality care is a core tenet of the Medicaid program. Virginia Medicaid MCOs must all attain National Committee on Quality Assurance (NCQA) accreditation, and are reviewed based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. Incorporating incentives and conversely, withholds for lower performance, will continue to encourage accountability within the Medicaid provider and MCO communities. As mentioned in the introduction, DMAS and the MCOs are already working together on a quality payment incentive plan. In addition, DMAS and MCOs will coordinate these efforts with the work of the Virginia Center for Health Innovation (VCHI). For further information on VCHI, please visit: http://www.vahealthinnovation.org/	July 2013

12. Data Improvements	(iii) improvements to encounter data submission, reporting, and oversight;	Across the nation and in both public and private healthcare arrangements, capturing provider and payment data is an ongoing conversation. Having access to this data allows for the ability to identify trends and better understand the complexities of the population served within the program. This component of reform language pertains to ensuring that the department receives timely and accurate information regarding beneficiaries from contracted health plans. Health plans are currently working with the department to identify strategies for implementation. As mentioned in the introduction, DMAS and the MCOs are working together on data improvements and reporting.	July 2013
13. Standard Administrative Processes for Providers	(iv) standardization of administrative and other processes for providers; and	DMAS plans to use input from the Medicaid Physician and Managed Care liaison committee to identify administrative obstacles and develop solutions to ensure quality, cost effective, patient care. For more information regarding the Medicaid Physician and Managed Care Liaison Committee, please visit: http://leg2.state.va.us/WebData/13amend.nsf/e36ae9ff57e29a228525689e00349980/068fb0dba3c3f0f685257b1b004cb2b2?OpenDocument	TBD
14. Health Information Exchange	(v) support of the health information exchange.	The purpose of a Health Information Exchange is to foster and sustain trust, collaboration and information-sharing among consumers, providers and purchasers of healthcare services in the Commonwealth of Virginia. Having access cumulative data from both the private pay and public sector health programs will lead to measureable improvement in outcomes and cost-effective delivery of health care services. For more information on Virginia's Health Information Exchange please visit: http://www.vahimss.org/documents/VDHStatewideHIEHIMSS.pdf	TBD
15. Agency Administrative Simplification	include administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act	In order to receive federal funding for the Medicaid program, DMAS enters into contract with the federal government through the Virginia Medicaid State Plan or specialized Waivers (e.g. 1915(c) for home and community based services, 1915 (b) for managed care, etc.). Varying authorities make the administration of the Medicaid program extremely complex. DMAS is developing a concept paper to share with the federal government to develop ways	TBD

		to maintain accountability while streamlining administration and legal authority for the program. In most areas of the Medicaid program Virginia pays 50% of the Medicaid budget and the federal government pays 50%.Virginia is seeking flexibility in program administration to reflect equal decision making power.	
16. Parameters to Test Pilots	Outline agreed upon parameters and metrics to provide maximum flexibility and expedited ability to develop and implement pilot programs to test innovative models that (i) leverage innovations and variations in regional delivery systems; (ii) link payment and reimbursement to quality and cost containment outcomes; or (iii) encourage innovations that improve service quality and yield cost savings to the Commonwealth.	The administration of the Medicaid program is far from nimble and leaves little to no room for pilot or demonstration projects to be implemented in an expedited fashion. The idea within this component of reform is to identify, along with CMS, agreed upon parameters that all pilot and demonstration projects must meet. This would facilitate a quick review and within a few months, as opposed to 12-18 months, these innovations could be underway. Staff is currently developing a concept paper and in conversations with CMS regarding authority options for developing parameters to quickly approve and begin pilot models.	TBD

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

Title	Budget Language	Resource Information	Targeted Completion Date
17. Long-Term Care Coordinated Care	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	DMAS is developing a concept paper and having conversations with CMS on ways to transition the long term care population and services into managed care, which includes administrative simplification. This transition will likely include three different groups and will be completed over several years in order to ensure the quality and continuity of services for this vulnerable population. 1) Dual Eligible Demonstration Pilot in five regions of the state (described in Phase I above). 2) After the Dual Demonstration, expand this program statewide, pursuant to federal approval. 3) Medicaid only (non duals) population with long term care services (institutional settings and all home and community based care waiver programs)	Provided to the General Assembly October 2013

	designing and implementing such reforms.		
Forecast			
Title	**Budget Language**	**Resource Information**	**Targeted Completion Date**
18. Forecast	(i) develop a five-year consensus forecast of expenditures and savings associated with the Virginia Medicaid/FAMIS reform efforts by November 15 of each year in conjunction with the Department of Planning and Budget, and with input from the House Appropriations and Senate Finance Committees, and	In an attempt to capture DMAS expenditures and savings associated with reform efforts, a five year consensus forecast will be developed. DMAS' budget staff along with Department of Planning and Budget as well as House Appropriations and Senate Finance Committee staff will work to inform these efforts. This process does not replace the biannual budget process that the department has historically used for actual budgetary purposes	Due annually on November 15
Stakeholder Engagement			
Title	**Budget Language**	**Resource Information**	**Targeted Completion Date**
19. Stakeholder Involvement	(ii) engage stakeholder involvement in meeting annual targets for quality and cost-effectiveness."	DMAS routinely involves and communicates with all types of stakeholders as it develops new programs or policies. Many of the reforms listed in this document have their own stakeholder engagement processes and will continue. The Virginia Health Reform Initiative Advisory Council also will hold up to three public meetings in 2013 to discuss the Medicaid reform efforts. Written public comment will be solicited by stakeholders throughout the process. The Medicaid Innovation and Reform Commission meetings are another opportunity for stakeholders to provide input to the suggested reforms. The three phases of Medicaid reform efforts are far reaching and impact all stakeholders affiliated with the program. In an effort to ensure ongoing engagement and support, the department is seeking to solicit additional ideas regarding how all stakeholders (individuals and their families, providers, health plans, health systems, etc.) should remain engaged in Medicaid reforms for the long-term.	Ongoing

Public Comment Instructions

Public comments regarding the Medicaid Reform project matrix MUST BE submitted no later than 5:00 pm on Tuesday, June 4th. Comments must be submitted to vhri@governor.virginia.gov in order to be considered by the Virginia Health Reform Initiative Advisory Council for their June 12, 2013, meeting. Comments received after 5:00 pm on that date will have no guarantee of inclusion into the compiled comments for Advisory Council consideration.

In order for the comments to be compiled quickly and in a logical fashion for dissemination to advisory council members, please:

- indicate the section title and corresponding number at the beginning of each comment
- if submitting comments for multiple titles, submit the comments on separate pages
- if possible, submit public comments via a Microsoft word document as it is easier to manipulate and compile (pdf documents will be included, the preference however is a word document).

An example can be found on the next page.

As always, public comment regarding the activities of the Virginia Health Reform Initiative can be submitted anytime to vhri@governor.virginia.gov; however, for inclusion for the June 12th meeting they must be received by the date and time indicated above.