

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

**July 28, 2015
DRAFT Minutes**

Present:

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

Absent:

Marcia Wright Yeskoo

DMAS Staff:

Linda Nablo, Chief Deputy Director
Cheryl Roberts, Deputy Director for Programs
Karen E. Kimsey, Deputy Director for Complex Care Services
Seon Rockwell, Sr., Programs Advisor to Deputy Director of
Administration
Anna Healy James, Policy Director, Office of the Governor
Craig Markva, Director, Office of Communications, Legislation
& Administration
Nancy Malczewski, Public Information Officer, Office of
Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of
Communications, Legislation & Administration

Speakers:

Cynthia B. Jones, Director of DMAS
Suzanne Gore, Deputy Director for Administration at DMAS
Abrar Azamuddin, Legal Counsel
Office of the Attorney General
Patrick W. Finnerty, Owner, PWF Consulting
Karen S. Rheuban, MD, BMAS Chair
William A. Hazel, Jr., MD, Secretary of HHR

Guests:

Rick Shinn, VACHA
Steve Ford, VHCA
Chris Whyte, Vectre Corporation
Sara Heisler, VHHA
Jennifer Wicker, VHHA
Heidi Dix, Troutman Sanders Strategies
Chris Nolen, McGuire Woods
Ralston King, Astra Zeneca
Carrie McConnell, Accenture
Stephen Weiss, JCHC
Kenneth McCabe, DPB
Tyler Cox, HDJN
Nicole Pugar, Williams Mullen

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:10 a.m. Dr. Rheuban welcomed Board members and asked members to introduce themselves and others in attendance.

APPROVAL OF MINUTES FROM APRIL 14, 2015 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the April 14, 2015 meeting. Dr. Price made a motion to accept the minutes and Mr. Ewald seconded. The vote was unanimous. **9-yes (Baig, Cook, Ewald, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, and Wynn); 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, provided an update on *A Healthy Virginia* Program as of July 2015, announced the implementation of the Medallion 3.0 Behavioral Health Home (BHH) Regional Pilot Programs effective July 1, and shared proposed initiatives related to the transition of individuals into coordinated models of care referred to as Virginia's Managed Long Term Services and Supports (MLTSS). (See attached handouts.)

Ms. Jones reported that on May 26, the Centers for Medicare & Medicaid Services (CMS) released a notice of proposed rulemaking that represented the first major update to the rules governing Medicaid managed care since 2002. In response, DMAS and the National Association of Medicaid Directors (NAMD) responded to CMS regarding the Medicaid Managed Care Proposed Rules.

Ms. Edwards joined the meeting during this presentation.

ROLES, RESPONSIBILITIES AND DUTIES OF THE BOARD

Abrar Azamuddin, Legal Counsel, Office of the Attorney General, explained the structure of the Board is stated in §32.1-324; however, the general duties and authorities of the Board are delineated in §32.1-325 which Mr. Azamuddin provided at the meeting. He explained that the Bylaws define how the Board practices its duties and responsibilities.

As the BMAS Bylaws state they shall be reviewed in total at least every two years, members agreed to delay review of Bylaws until the next meeting to allow members to review the additional *Code of Virginia* information provided. (See attached handouts.)

Board members shared their thoughts and discussed how future meetings could be structured. Dr. Rheuban asked members to plan for half day meetings in the future and requested that Board members submit agenda items for the September meeting.

Several members expressed confidence in the work presented to the Board by the DMAS Director and staff. Additionally, several members expressed desire to see staff draw more upon the expertise of Board members.

CELEBRATION OF 50 YEARS OF MEDICAID

Ms. Jones gave an overview of the Medicaid history and contributions for the last 50 years based on information provided by the Kaiser Commission on Medicaid and the Uninsured (www.kff.org). She recommended Kaiser as one of the best resources for understanding Medicaid as their information is not written in a bureaucratic way and provides a lot of state comparisons. Ms. Jones provided highlights about changes in the program over the last 50 years – then and now. (See attached handout.)

There was brief discussion regarding the recently convened Provider Assessment Work Group (http://www.dmas.virginia.gov/Content_pgs/pawg.aspx). The next meetings of the work group are scheduled for September 30 and October 28, 2015.

At 11:54 a.m. the Board adjourned for lunch and reconvened at 12:29 p.m.

HHR Presentation

Secretary of Health and Human Resources, William A. Hazel, Jr., MD, provided brief comments to the Board on key challenges in health and human services delivery.

ADULT DENTAL BENEFITS

Patrick W. Finnerty, former DMAS Director and Owner of PWF Consulting, provided important information for discussion on the impact of oral health on general health and explained the current funded dental benefits for adults and children. While Medicaid children's dental benefits are very comprehensive, Medicaid adult dental benefits extremely limited. (See attached handout.)

Dr. Price provided an American Dental Association article entitled, "Visits to US Emergency Departments by 20- to 29-year olds with toothache during 2001-2010". (See attached handout.)

During discussion, members shared their thoughts, suggestions and support for the need to improve access to dental care as a means of achieving better overall health and for increasing the current level of dental coverage and potential coverage enhancements for Virginia Medicaid adults. Ms. Jones explained the topics were intended to promote discussion among the members; however, action was not necessary.

Ms. Hollowell made a motion for the Board to further explore dental benefits. Mr. Cook seconded the motion; however, several members had additional questions and they were not in consensus. Secretary Hazel and Ms. Anna James, Policy Director, provided guidance in the legislative/budget process and timing involved in moving forward with a monetary initiative. Ms. James suggested the Board discuss and then present a list of their priorities for consideration, why priorities were selected, and state the topics the Board would like the Secretary's support for consideration in order to forward to the Governor.

There was consensus that dental is an important issue; however, there was not enough detailed information to make a recommendation at this time. There were several suggested options; however, all resolutions regarding BMAS members providing a specific dental proposal at this time were withdrawn. The Board did request staff to provide additional information regarding other dental benefit enhancement options and asked to revisit the adult dental benefit issue at the September meeting.

After this presentation, there was a break and the meeting reconvened at 2:25 p.m.

CLOSING THE COVERAGE GAP

Ms. Jones explained what some of the other states were doing to close the coverage gap based on information provided by Manatt, Phelps & Phillips, LLP. Ms. Jones explained the questions at the end of the presentation were designed to promote discussion and allow members to express their thoughts and suggestions on the topic of closing the coverage gap in Virginia. (See attached handout.)

The Board decided to discuss Medicaid expansion in the September meeting and generate a letter to the Governor in December before the Governor's budget is released.

After discussion by the Board on the uninsured, more specific information on the uninsured will be provided to the Board.

MEDICAID INNOVATIONS

Ms. Suzanne Gore, Deputy Director for Administration, reviewed components of a new Medicaid waiver initiative called the Delivery System Reform Incentive Payment (DSRIP) waiver. This effort would be targeted at a coordinated delivery of whole person, community-based care with improved health outcomes as a result of enhanced financing for infrastructure and payment reform. Ms. Gore reviewed the questions for consideration to promote discussion at the end of the presentation.

Ms. Gore stated the goal of the DSRIP waiver is to provide financial incentives to achieve higher value care and services for Medicaid enrollees. Staff is planning to submit a concept paper in the

fall and the waiver application to CMS in December. Then, staff will provide a copy to the Board. (See attached handout.)

REGULATORY ACTIVITY SUMMARY

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

OLD BUSINESS

None.

ADJOURNMENT

Dr. Rheuban announced the next meeting will be September 15 at this location and asked members to submit their agenda items. Ms. Jankowski made a motion to adjourn the meeting at 3:50 p.m. and Dr. Price seconded. The vote was unanimous. 10-yes (**Baig, Cook, Edwards, Ewald, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, and Wynn**); 0-no.

A Healthy Virginia Project Implementation Update

Virginia Department of Medical Assistance Services

July 2015

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

A Healthy Virginia Health Care Report

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

Virginia launched the GAP demonstration to provide primary care and behavioral health services for up to 20,000 Virginians who are uninsured, have serious mental illness (SMI), and have incomes at or below 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 (CMS).

- ✓ The GAP demonstration continues to steadily grow in membership. As of June 1, there were 3,248 members enrolled. The program received 946 applications in June, with a total of 8,021 applications received to date.
- ✓ DMAS continues to meet weekly with the contractor to begin discussions on the renewal process for GAP enrollees. Currently, 504 enrollees are currently between 100% and 65% of the federal poverty level (FPL).
- ✓ CMS approved Virginia's request to modify the eligibility threshold from 100% to 60% FPL. Since we anticipate that denials resulting from this change will trigger a call volume surge, DMAS has updated documents and training materials for local screeners to mitigate confusion as much as possible.
- ✓ The GAP team is reviewing applications within the contractual timeframe of eight days, and quality reviews are satisfactory.
- ✓ The program experienced some file exchange issues between contractors that delayed Cover Virginia's receipt of SMI diagnoses. A file has been received from the contractor, Magellan, which includes decisions regarding applicants' behavioral health diagnoses that should have been previously sent. These cases will receive immediate attention for review and processing. Cases that were denied previously due to this issue will be re-opened.

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

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

- ✓ Total children's enrollment through Medicaid/FAMIS increased by 2,273 from May 1 to June 1. This marks an overall net increase of 17,827 children enrolled since September 2014. DMAS is presently halfway to the Governor's enrollment goal. While enrollment may dip slightly over the next two months as it historically has, we expect to see an increase of approximately 25% in applications submitted due to the *Back-to-School* campaign and associated media campaign in September.

		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

- ✓ DMAS continues to work on the annual *Back-to-School* campaign. Staff presented a preview of the campaign at the Children's Health Insurance Program Advisory Committee (CHIPAC) June 4 full committee meeting. Staff also coordinated with Big River Advertising to plan the upcoming FAMIS media campaign, review media markets for *Back-to-School* 2015 and the *Cold and Flu* spring 2016 campaigns, as well as finalize TV, radio, and print materials. The first batch of FAMIS flyers and Free and Reduced School Lunch inserts will be distributed during the week of August 10.
- ✓ Staff continues to provide outreach and materials to engage stakeholder communities. Highlights include: attending the Virginia Western Community College Health Wellness Job Fair and the New River Community College Job Fair; Radford and Richmond Sign Up Now trainings; Children's Health Insurance Program Advisory Committee meeting; 3rd Annual RVA Streets Alive event; and following up on referrals from certified application counselors, school nurses, and other community staff with questions on Cover Virginia and FAMIS.

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 has 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.

- ✓ The first 2016 Open Enrollment communications/messaging workgroup meeting will take place July 22. The focus will be on developing effective messaging around the renewal process, especially for those renewing for the first time. A second meeting will be scheduled for August.

- ✓ A no-cost extension request will be filed with the Center for Consumer Information and Insurance Oversight (CCHIO) at CMS so the existing section 1311 funds can be used into 2016. Contract modifications are in progress for both the Virginia Poverty Law Center (VPLC) and Virginia Community Healthcare Association (VCHA) to incorporate these no-cost extensions. The VCHA contract will be modified to extend in-person assister coverage and VCHA staffing until February 29, 2016. The VPLC contract will be modified to extend Community Health Education Program (CHEP) coverage to January 31, 2016. All contract extensions will be done within the existing budget.

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, coverva.org site has received: more than 355,400 unique visits; 10,700 click-throughs to the federal healthcare.gov site; 13,300 click-throughs to Virginia's *CommonHelp* online application; and 72,200 eligibility screenings.
- ✓ The public notice of proposal to extend the Demonstration Waiver for FAMIS MOMS and FAMIS Select remains on the website, and the second public meeting took place during the CHIPAC meeting on June 4.
- ✓ A page hosting presentations from the 2015 Enrollment Summit was added to the website. Staff is currently working to obtain answers to all remaining questions from the Summit so that they can be added to the website page.
- ✓ Staff continues to negotiate scope reductions for cost savings measures. New contract modifications are drafted and under review to reflect these changes.

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.

- ✓ While Open Enrollment for state employees ended on May 22, Cover Virginia's special processing unit remained in place to handle any additional questions or case actions required on applications which remain pending the 45th day. Cover Virginia continued determining applications received for anyone that cancelled insurance and can be approved for enrollment in FAMIS or FAMIS MOMS effective July 1.
- ✓ Staff is creating a report to summarize the number of children and pregnant women enrolled in the FAMIS and Medicaid programs as a result of this initiative. To date, 902 children of state employees were enrolled in coverage as a result of this special enrollment initiative, with an additional 18 pregnant women also gaining coverage. Additionally, 567 children enrolled in FAMIS while 335 enrolled in Medicaid, and 10 pregnant women enrolled in FAMIS MOMS while 8 enrolled in Medicaid.
- ✓ Proposed regulations were approved by the Office of the Secretary of Health & Human Resources, and are currently at the Governor's Office for review.

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

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

- ✓ Since the March implementation of this effort, a total of 2,175 pregnant women (aged 21 and older) received comprehensive dental service (excluding orthodontia) such as fillings, root canals, cleanings, extractions, etc. through the expanded *Smiles for Children* dental program. To date, DMAS has received 1,564 provider inquiries; 1,622 member inquiries; and paid 2,391 claims for \$614,514. The top services paid are root canal treatment, composite fillings, and surgical removal of erupted tooth.

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

DMAS is collaborating with the Department of Behavioral Health & Developmental Services and the contracted 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.

- ✓ DMAS successfully implemented this effort on July 1. Medallion 3.0 contract language for the pilots was completed and included in the final contracts, and applicable managed care technical manual reporting requirements were also updated.
- ✓ The Medallion 3.0 Behavioral Health Home (BHH) Managed Care Organizations (MCO) regional pilots are designed to deliver integrated health home support for individuals, and represent the culmination of an innovative partnership between the Commonwealth and five contracted MCOs to improve care and access to care for managed care enrollees with SMI.
- ✓ Initial pilot enrollment is 350 adult members across the five MCOs, representing \$9 million in annual claims. MCOs invite qualifying members to participate and inform DMAS on a monthly basis. The program will be assessed throughout the pilot period. Four pilots will coordinate with Magellan for the authorization and payment of community mental health services, utilizing their network, while one pilot will operate without Magellan coordination. Regional pilots are available in Central VA through Coventry Cares and Anthem; in Northern VA through INTotal; in the Tidewater region through Optima; and in the Roanoke/Allegheny region through Virginia Premier.



Health Care Services Division

MCO Behavioral Health Home Pilot Programs

Anthem The first to integrate all services. Case management, care coordination, non-traditional BH services, transition of care, community support service links

Coventry Behavioral home health team, Gold Care prior authorization, community and social support links, health promotion, and transitional planning.

INTotal Member-centered, multidisciplinary care management and psychiatric consultants.

Optima Continuing care strategies, intensive care management and coordination, community support links, community mental health services and transitional care.

VA Premier Focus on preventative health and wellness, transition care, care management including all disciplines. Use of telemedicine and telehealth services.

A Healthy Virginia Medallion 3.0 Behavioral Health Home Regional Pilot Programs



DMAS and DBHDS share the belief that it is important to the medical and behavioral health needs of individuals with serious mental illness to assure the right care in the right place at the right time. The Behavioral Health Home Pilot Initiative supports this belief.

As a part of Governor McAuliffe's—A Healthy Virginia plan, the Department of Medical Assistance Services is excited to announce the implementation of five regional behavioral health home (BHH) pilot programs effective July 1, 2015. The initial BHH pilots will coordinate care for 350 selected members with serious mental illness (SMI) who received \$9M in Medicaid benefits through the Medallion 3.0 Medicaid program in 2014.

Medallion 3.0 BHH Key Points

- ◆ Pilot program structure assures adults with SMI benefit from coordinated behavioral health and medical care
- ◆ Each plan offers a unique care model in different regions of the state with a variety of partners
- ◆ Team-based care coordination driven by providers who consult one another and are dedicated to improving the lives of people suffering with SMI
- ◆ Developed outside the confines of the Affordable Care Act section 2703— State option to establish Health Home care model—allowed structure flexibility and faster implementation
- ◆ Consistent with Commonwealth Coordinated Care (CCC) program - provides coordinated behavioral health and

Regional Pilot Areas

- ◆ Central—Coventry & Anthem
- ◆ Northern VA—INTotal
- ◆ Tidewater—Optima
- ◆ Roanoke/ Alleghany—VA Premier



medical care for dually eligible members

These health homes adopt the “whole person” philosophy of treatment that calls for a team-based approach to health care including primary, acute, behavioral health, and some substance abuse services.

MCO enthusiasm for the health home model of care and improving the lives of people with SMI drove the development and design of the BHH pilots. BHH pilots aim to improve care quality and decrease care costs for the selected individuals enrolled in the pilots. The BHH pilots will be evaluated annually.

Key Quality Measures of Pilot Achievements

- ◆ Successful monthly member contact with BHH Care Team
- ◆ HEDIS Measure: Follow-up Behavioral Health Hospitalization (30 day)
- ◆ Establishing Person-Centered Care Plans
- ◆ Coordinated Care Between Behavioral Health and Medical Providers

General Inquiries

BHHPilot@DMAS.Virginia.Gov

Virginia's Proposed Managed Long Term Services and Supports (MLTSS) Initiatives

Over the next couple of years, the Department of Medical Assistance Services (DMAS) will transition the majority of the remaining Medicaid fee-for-service populations into more coordinated and integrated managed care models.

These populations include individuals with full Medicaid and Medicare benefits (known as dual eligibles) who are not currently enrolled in the [Commonwealth Coordinated Care \(CCC\) Program](#); and, individuals who receive Medicaid and long term services and supports (LTSS) either through an institution or through one of DMAS' six (6) home and community based services (HCBS) waivers. At this time the expansion of Medicaid managed care for individuals enrolled in the Day Support for Persons with Intellectual Disabilities (DS); Intellectual Disabilities (ID); and, Individual and Family Developmental Disabilities Support (DD) Waivers is being considered for their acute and primary care services, only. While DMAS is exploring the feasibility of managed or integrated care models for the ID, DD, and DS Waivers, these individuals will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these Waivers.

DMAS is proposing to transition individuals into coordinated models of care in phases, as described in the table below.

<i>Proposed MLTSS-I: Enroll Individuals Into Mandatory Managed Care Who Are Eligible for the CCC Program but Choose Not to Participate Timeframe: Summer 2016</i>	<i>Proposed MLTSS-II: Enroll Remaining Duals and LTSS Populations into a Mandatory Managed Care Program Timeframe: Mid 2017</i>
<ul style="list-style-type: none"> • Approximately 37,000 CCC-eligible individuals, who have chosen not to participate in CCC, will be transitioned into a mandatory managed care program for their Medicaid services. • In the proposed model, services will include primary and acute, LTSS, and behavioral services coordinated by a CCC health plan (Anthem, Humana and Virginia Premier). • Individuals will continue to have the option to enroll in CCC. • This program will be phased-in regionally. 	<ul style="list-style-type: none"> • Approximately 70,000 eligible individuals, including dual eligibles who are not eligible for CCC and individuals receiving LTSS, will be transitioned into a new managed care program. • Services will include primary and acute, LTSS, and behavioral services coordinated by a health plan. • Individuals enrolled in the ID, DD, and DS Waivers will continue to receive their home and community-based LTSS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these Waivers. • Other carved-out services include dental and school based services • Health plans will be selected through a competitive procurement process. • This program will be phased-in regionally.

These new initiatives are consistent with Virginia General Assembly directives in years 2011 through 2015 to transition fee-for-service individuals into managed care. There are many benefits of utilizing this delivery model. The goal of these new initiatives is to provide a coordinated system of care that focuses on improving quality, access, and efficiency.

For more information about these new programs, visit the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx. For questions, contact DMAS at: VAMLTSS@dmas.virginia.gov.

Comments on Medicaid Managed Care Proposed Rule

Background

On May 26, the Centers for Medicare & Medicaid Services (CMS) released a notice of proposed rulemaking (NPRM) that, once adopted as final regulation, represents the first major update to the rules governing Medicaid managed care since 2002.

The proposed rule, all 653 pages, impacts managed care delivery for both Medicaid and Children's Health Insurance Program (CHIP) and seeks to align the rules governing Medicaid managed care with those of other sources of health insurance coverage such as Medicare Advantage and Qualified Health Plan (public Exchange) as beneficiaries may move across these programs.

The rule also modernizes managed care regulations to update the programs' rules and strengthen the delivery of quality care for beneficiaries.

It would improve beneficiary communications and access, provide new program integrity tools, and support state efforts to deliver higher quality care in a cost-effective way.

The proposed rule also includes several new and significant provisions intended by CMS to address the significant growth in Medicaid managed care enrollment, the accelerating transition to managed care for Medicaid beneficiaries with special health care needs (such as dual eligible members and those with long-term care needs), and the ACA's Medicaid coverage expansion and insurance market reforms.

DMAS has been delivering health care services to Medicaid beneficiaries through a managed care system since 1996. The primary delivery system is our statewide 1915(b) mandatory managed care program known as Medallion 3.0 and covers over 750,000 beneficiaries (including TANF, ABDs and Foster Care) through six health plans, three of which are national plans, and three are regional plans owned by health systems.

Virginia was the third state to implement the dual eligible demonstration project (CCC) that covers almost 30,000 enrollees in five regions across the state with three health plans.

We will be moving towards the development and implementation of Managed Long-Term Supports and Services (MLTSS) within the next two years.

Review Process

The Department's review process was conducted by a team comprised of members from the divisions of Health Care Services, Policy, Provider Reimbursement, Program Operations, Program Integrity, Appeals, and Integrated Care.

CMS hosted webinars on each of the major areas of the regulations that were informative and extremely helpful during our review process.

As a component of our regulatory review process, DMAS actively engaged in discussions with the National Association of Medicaid Directors (NAMd) on every aspect of the proposed regulatory package and fully supports the comments submitted by the organization. We applaud NAMd for their work in outlining the major issues to states, providing a forum to express issues and including input from the states. {Copy of NAMd comments in binder}

We believe that CMS will give credence to the submission by NAMd (of which Cindi Jones is a board member), and as a result, our comments, while they are reflective of specific regulatory issues of concern to the Commonwealth of Virginia, also supplement the comments submitted by NAMd.

We strongly believe that DMAS is in compliance with many of the proposed regulation requirements and with proper resources, can become compliant with some of the other provisions.

DMAS sent to CMS our Virginia comments {in binder} that highlight some of the areas of concern for the Commonwealth. In most cases, they i.) disrupt the program; ii.) are overreaching; or iii.) are unclear.

1. Enrollment choice time period: the 14 day fee-for-service coverage requirement is too prescriptive and states should be allowed flexibility in designing a process that does not hinder expedited enrollment into a health plan;
2. MTLSS disenrollment: states should be allowed to develop clear policies and procedures, including an exceptions process, around member disenrollment in cases where providers exit from an MCO;
3. CMS review of contract and rates: we agree that new health plan contracts and rates require review prior to the effective date, however, we recommend that routine or annual changes bypass the 90 day rule. This 90 day rule also applies to the rate certification process;
4. Quality: states should have the flexibility to develop performance measures and performance improvement projects that are applicable to its populations and programs. States that deliver services predominately through managed care also should have the option of whether to include FFS in the overall quality strategy; and
5. Implementation: DMAS realizes that once the proposed rule is finalized, the effective date will most likely be 60 days after the final notice is published in the Federal Register. DMAS recommends that for many of the provisions outlined in the NPRM, CMS allow states a sufficient amount of time to implement the requirements based on the individual state's legislative and/or contract cycle.

BOARD OF MEDICAL ASSISTANCE SERVICES

BYLAWS

ARTICLE I

Board Structure

1.1 Name - This body shall be known as the State Board of Medical Assistance Services, hereinafter referred to as “the Board.”

1.2 Composition - The Board shall consist of eleven residents of the Commonwealth, five of whom are health care providers and six of whom are not, all to be appointed by the Governor. Any vacancy on the Board, other than by expiration of term, shall be filled by the Governor for the unexpired portion of the term. The Director of the Department of Medical Assistance Services (“the Director”) shall be the executive officer of the Board but shall not be a member thereof.

1.3 Term of Office - Board members shall be appointed for four year terms. No person shall be eligible to serve on the Board for more than two full consecutive terms. Should any Board member be unable to fulfill his/her term on the Board, that member shall provide written notice to the Chairperson of the Board at least 30 days prior to resignation, and shall also provide written notice to the Governor.

1.4 Orientation of New Members - When a new member is appointed to the Board, the Board Chairperson shall assign responsibility for orientation of the new member to one veteran member of the Board. New Board members shall be expected to spend time at the office of the Department of Medical Assistance Services (“the Department”) for program orientation provided by Department staff, and to become familiar with issues requiring Board action.

ARTICLE II

Board Meetings

2.1 Regular Meetings - The Board shall hold regular meetings at least quarterly at such times and places as it shall determine.

2.2 Special Meetings - The Board may meet at such other times and places as it determines to be necessary and appropriate. Special meetings of the Board may be called by the Chairperson of the Board or by any three (3) members of the Board. Reasonable effort must be made by the Chairperson to personally notify each Board member of the meeting.

2.3 Meeting Notice - Each member shall file with the Director the address and/or telephone number at which such notice is to be given.

Written notice of all regular meetings shall be sent to the Board at least ten (10) days in advance of the time and place of the meeting. Notice of all regular meetings shall also be announced in advance by publication in the Virginia Register, and a proposed agenda sent to persons on the public participation list.

2.4 Quorum - Six (6) members of the Board shall constitute a quorum.

2.5 Executive Session - Prior to meeting in an executive session, the Board must vote affirmatively to do so and must announce the purpose of the session. This purpose shall consist of one or more of the purposes for which executive or closed meetings are permitted in accordance with §2.2-3711 of the Code of Virginia, the pertinent portion of the Virginia Freedom of Information Act.

Discussion in the executive session must be limited to the subject or subjects stated in the motion. No final action may be taken in executive session. Upon return to open session, any action taken or motion adopted must be re-stated, voted upon, and placed in the minutes in order to become effective.

2.6 Conduct of Business - The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Board in all cases to which they are applicable, to the extent that they are not inconsistent with the laws of Virginia, these Bylaws, or any special rule which the Board may adopt.

ARTICLE III

Board Authority

3.1 Powers and Duties - The Board shall have the powers and duties as prescribed in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia. (See memorandum of April 13, 2004, from the Office of the Attorney General.)

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided. The Board shall also initiate such cost containment or other measures as are set forth in the Appropriations Act.

The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provision of this chapter.

The Board shall submit biannually a written report to the Governor and the General Assembly.

3.2 Representation of the Board - Individual members of the Board shall represent official positions of the Board only upon action of the Board. When the Board is requested to appear before the General Assembly, legislative committees, study committees, etc., the Board shall be represented by duly designated member(s) who are nominated by the Chairperson and, when practicable, confirmed by the Board.

Individual members of the Board are free to make comments to the media, individual legislators, local boards of health members, legislative committees, etc. Any comments made shall be identified as their personal views and not the position of the Board unless they have been authorized by the Board to express the Board's official position or unless the position they express is a position that has been officially taken by the Board.

3.3 Authority of the Director - The Director shall be vested with the authority of the Board as set forth in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia.

ARTICLE IV

Board Officers

4.1 Term of Office - At the first meeting of the Board after March 1 of each year, the Board shall elect officers from its membership for the coming year. Those elected shall assume their offices at the meeting following their election and shall serve, unless sooner removed, until their successors are elected.

4.2 Type of Officers - The Board shall have a Chairperson and a Vice Chairperson.

4.3 Duties of Officers

4.3.1 The Chairperson of the Board shall preside, when present, at all meetings of the Board; appoint members to committees of the Board; serve as ex-officio member of all committees; act for the Board in executing resolutions of the Board and communicating the actions of the Board to others; call such special meetings as may be deemed necessary; vote as any other member of the Board on any issue; perform other duties which may be delegated by the Board; and delegate to the Vice Chairperson such duties as may be appropriate.

The Chairperson shall work closely with the Director of the Department, or his/her designee, in determining the type of Board meetings, agenda, reports, communications and involvement that will enable Board members to carry out the responsibilities imposed on the Board by Acts of the General Assembly.

4.3.2 The Vice Chairperson shall assume all the powers and duties of the Chairperson in the absence of the Chairperson at any meeting or in the event that the Chairperson is disabled or of a vacancy in the office. The Vice Chairperson shall also perform such other duties as requested by the Board or by the Chairperson.

4.3.3 The Secretary shall be selected by the Board, but shall not be a member of the Board. The Secretary shall assist the Board in carrying out its administrative duties including the maintenance of minutes and records. The Secretary shall be a member of the Director's staff within the Department.

ARTICLE V

Board Committees

5.1 Special Committees - Special Committees may be constituted at any time by action of the full Board or the Chairperson. Such committees shall be formed when necessary for the efficient functioning of the Board. Members of a special committee and its chairperson shall be appointed by the Chairperson from among the membership of the Board. At the time a special committee is created, its mission shall be specifically established by action of the Board or by the Chairperson. In creating such special committees, the Chairperson shall specify the time within which the Committee is to make its report(s) to the Board.

5.2 Advisory Groups - The Board may, from time to time, seek the advice of various advisory groups, committees or individuals other than members of the Board on issues of concern to the Board and may form a group of such individuals for such purpose. Any member of the Board or the Director may request that such advice be sought. Selection of individuals to serve in such capacity shall be made by the Board with the advice of the Director.

Since the Board possesses legal powers which cannot be delegated or surrendered, all recommendations for action by such individual or group must be submitted to the Board for decision.

5.3 Participation in Various Department Workgroups and Committees – In order to facilitate involvement of Board members in key policy issues and activities of the Department, the Chairperson and Director shall identify and recommend, from time-to-time, Department workgroups or committees to which Board members should be appointed as full and active participants. In addition, Board members also may identify and recommend Department workgroups or committees for which they believe Board participation would be appropriate. Such participation in Department workgroups or committees shall not conflict with any pertinent statutory or regulatory requirements that may exist regarding the composition of such workgroups or committees. Members selected to serve on a Department workgroup or committee shall be appointed by the Chairperson from among the membership of the Board.

5.4 Department Committees - In addition to participation in Department workgroups or committees pursuant to Section 5.3, Board members are encouraged to attend meetings of any committee of the Department with stakeholders, including, but not limited to, the Dental Advisory Committee, the Drug Utilization Review Board, the Family Access to Medical Insurance Security (FAMIS) Outreach Oversight Committee, the Managed Care Advisory Committee, the Medicaid Hospital Payment Policy Advisory Council, the Medicaid Physician Advisory Committee, the Medicaid Transportation Advisory Committee, the Pharmacy and Therapeutics Committee, and the Pharmacy Liaison Committee. DMAS staff shall provide information regarding meeting schedules to the Board to facilitate member attendance and involvement.

ARTICLE VI

Board Documents

6.1 Official Papers - All official records of the Board shall be kept on file at the Department and shall be open to inspection. All files shall be maintained for five years. Minutes of Board meetings shall be permanently retained.

ARTICLE VII

Public Participation

7.1 Public Participation - Citizens may attend all Board meetings, except executive sessions as defined by the Freedom of Information Act, and may record the proceedings in writing or by using a recording device. The Board may make and enforce reasonable rules regarding the conduct of persons attending its meetings.

7.2 Presentations to the Board - Opportunities shall be provided for individuals or citizens representing a group or groups to appear on the agenda of a regular meeting of the Board. Requests to appear before the Board should be made in writing 10 days before a scheduled meeting of the Board in order that they may be included on the agenda. The 10 days may be waived by the Board Chairperson. The request must include the subject to be discussed and the name of the speaker. In honoring such requests, the Board will limit presentations to five (5) minutes, unless an extension is granted by the Board Chairperson.

ARTICLE VIII

Revision and Compliance

8.1 Amendments - The Bylaws of the Board may be amended at any regular meeting of the Board by a majority vote, provided that the proposed amendment was submitted in writing at the previous regular meeting of the Board and is included in the notice of the meeting at which a vote is to be taken.

8.2 Review - The Bylaws shall be reviewed in total at least every two years, with a limited annual review for compliance with the Code of Virginia. Revisions shall be made as necessary, and the Bylaws signed and dated to indicate the time of the last review.

8.3 Effective Date - The foregoing Bylaws shall go into effect on the 11th day of June 2013.

Approved:



Chairperson, Board of Medical Assistance Services



Director, Department of Medical Assistance Services

Code of Virginia

§ 32.1-324. Board of Medical Assistance Services.

A. Notwithstanding the provisions of Chapter 1 (§ [32.1-1](#) et seq.), there shall be a State Board of Medical Assistance Services hereinafter referred to as the Board. The Board shall consist of eleven residents of the Commonwealth to be appointed by the Governor as follows: five of whom shall be health care providers and six of whom shall not; of these six, at least two shall be individuals with significant professional experience in the detection, investigation, or prosecution of health care fraud. Any vacancy on the Board, other than by expiration of term, shall be filled by the Governor for the unexpired portion of the term. No person shall be eligible to serve on the Board for more than two full consecutive terms. Appointments shall be made for terms of four years each, except that appointments to fill vacancies shall be made for the unexpired terms. The Board shall meet at such times and places as it shall determine. It shall elect from its members a chairman who shall perform the usual duties of such office. The Board shall submit biennially a written report to the Governor and the General Assembly.

B. The Director shall be the executive officer of the Board but shall not be a member thereof.

C. The Director shall be vested with all the authority of the Board when it is not in session, subject to such rules and regulations as may be prescribed by the Board.

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;
2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;
3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;
4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;
5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;
6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared

by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance, which shall include a requirement that such entities obtain accurate contact information, including the best available address and telephone number, from each applicant for medical assistance, to the extent required by federal law and regulations;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician, physician assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician,

physician assistant, nurse practitioner, or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs;

24. A provision, when authorized by and in compliance with federal law, to establish a public-private long-term care partnership program between the Commonwealth of Virginia and private insurance companies that shall be established through the filing of an amendment to the state plan for medical assistance services by the Department of Medical Assistance Services. The purpose of the program shall be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for such services through encouraging the purchase of private long-term care insurance policies that have been designated as qualified state long-term care insurance partnerships and may be used as the first source of benefits for the participant's long-term care. Components of the program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and applicable federal guidelines; and

25. A provision for the payment of medical assistance for otherwise eligible pregnant women during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.
2. Initiate such cost containment or other measures as are set forth in the appropriation act.
3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.
4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to

implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to 42 C.F.R. Part 1002.

5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of § 32.1-162.13.

6. (Expires January 1, 2020) Provide payments or transfers pursuant to § 457 of the Internal Revenue Code to the deferred compensation plan described in § 51.1-602 on behalf of an individual who is a dentist or an oral and maxillofacial surgeon providing services as an independent contractor pursuant to a Medicaid agreement or contract under this section. Notwithstanding the provisions of § 51.1-600, an "employee" for purposes of Chapter 6 (§ 51.1-600 et seq.) of Title 51.1 shall include an independent contractor as described in this subdivision.

For the purposes of this subsection, "provider" may refer to an individual or an entity.

E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

The Director may consider aggravating and mitigating factors including the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to subsection D, the Director may determine the period of exclusion and may consider aggravating and mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a

provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of health care services under Medicaid and the Family Access to Medical Insurance Security Plan established under § 32.1-351.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

1984, c. 781; 1985, cc. 519, 532, 535, 564; 1986, cc. 393, 455; 1987, cc. 398, 446, 642; 1988, cc. 99, 215, 504, 790; 1989, c. 269; 1990, cc. 395, 793; 1993, cc. 298, 971; 1996, cc. 155, 201, 511, 788, 796, 946; 1997, cc. 671, 683, 730; 1998, cc. 56, 257, 459, 554, 558, 571, 631, 653, 709, 858, 875; 1999, cc. 818, 878, 967, 1005, 1024; 2000, cc. 484, 855, 888; 2001, cc. 334, 534, 663, 859; 2003, cc. 66, 71; 2004, cc. 125, 246, 855; 2006, cc. 396, 425; 2007, cc. 536, 873, 916; 2009, cc. 813, 840; 2010, cc. 305, 785, 790; 2012, cc. 367, 646, 689; 2014, cc. 196, 750.



Department of Medical Assistance Services



Celebration of 50 Years of Medicaid: History and Contributions

Cindi B. Jones, Director
Virginia Department of Medical Assistance Services

July 28, 2015

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

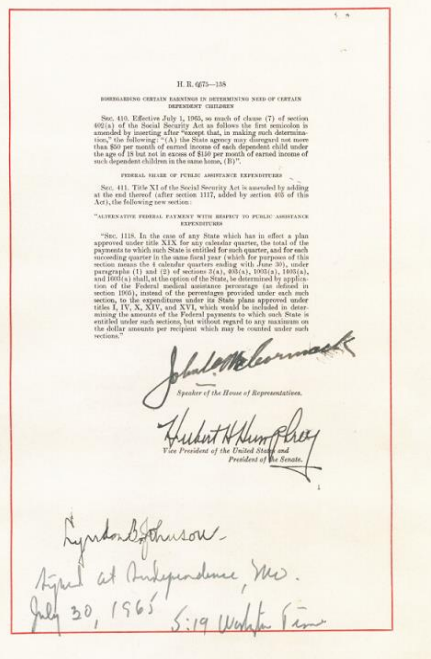
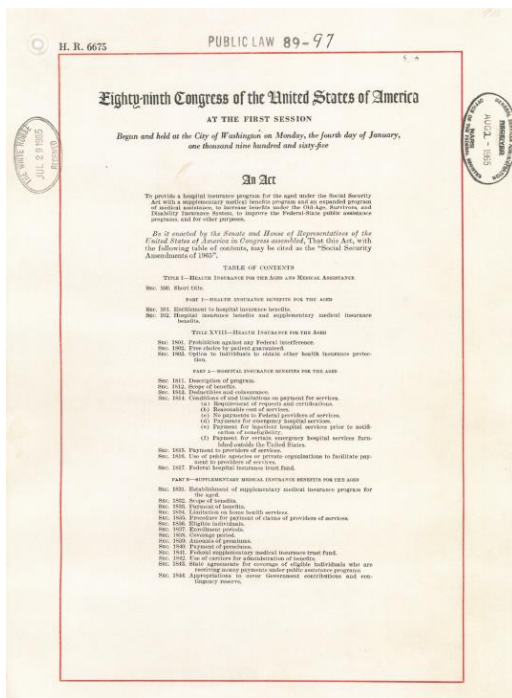
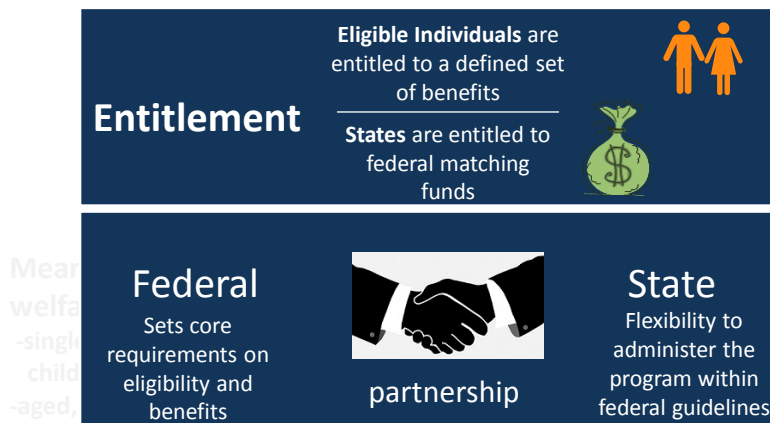


Figure 3

Medicaid's Origins

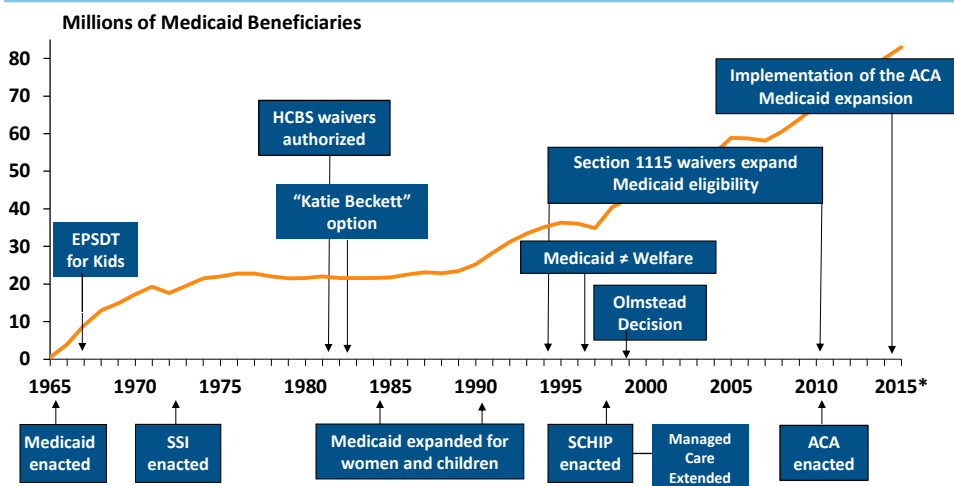
- Enacted in 1965 as title XIX of the Social Security Act
- Means-tested; originally focused on the public assistance population



THE KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 4

But Medicaid has evolved over time to meet changing needs.



NOTE: *Projection based on CBO March 2015 baseline.
 SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2011, as well as March 2015 CBO baseline ever-enrolled counts.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 5

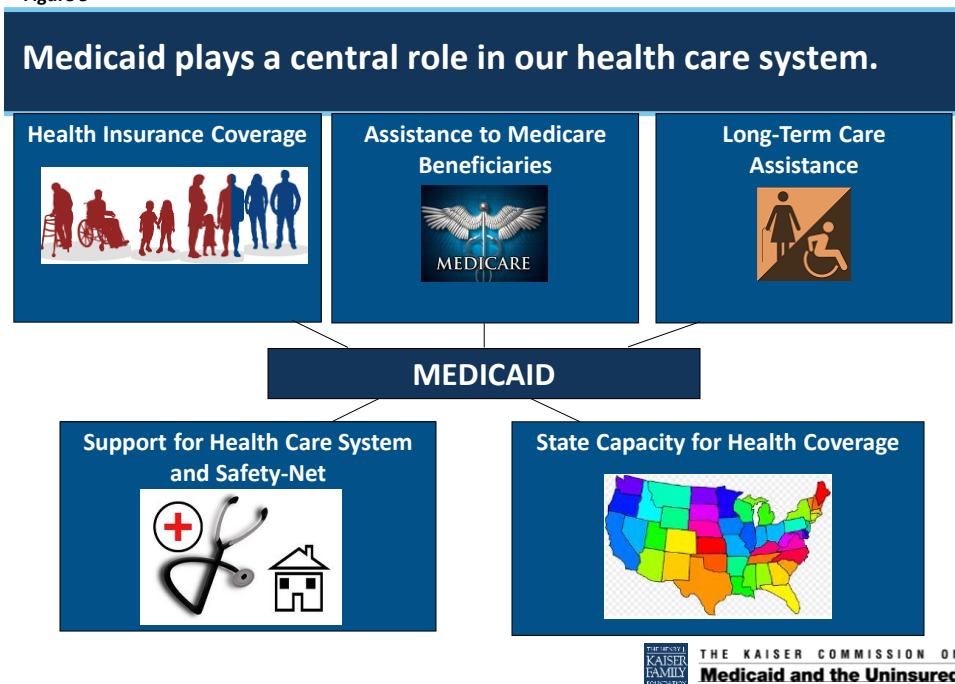
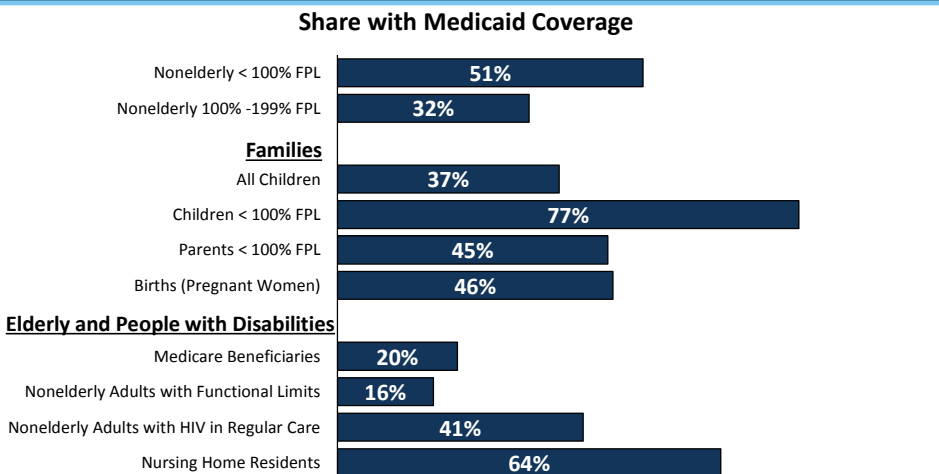


Figure 6

Medicaid covers a large share of certain populations.

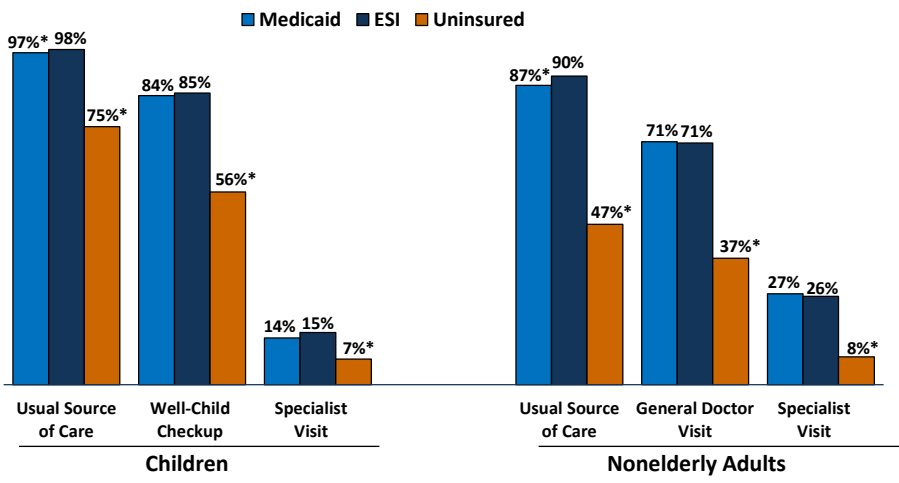


NOTE: FPL means federal poverty level. 100% FPL was \$19,530 for a family of three in 2013.
 SOURCES: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of 2013 CPS/ASEC Supplement; Birth data - Maternal and Child Health Update, National Governors Association, 2012; Medicare data - Medicare Payment Advisory Commission, Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (January 2015), 2010 data; Functional Limitations - KCMU Analysis of 2012 NHIS data; Nonelderly with HIV - 2009 CDC MMP; Nursing Home Residents - 2012 OSCAR data.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 7

Medicaid and private insurance provide similar access to care – the uninsured fare far less well.

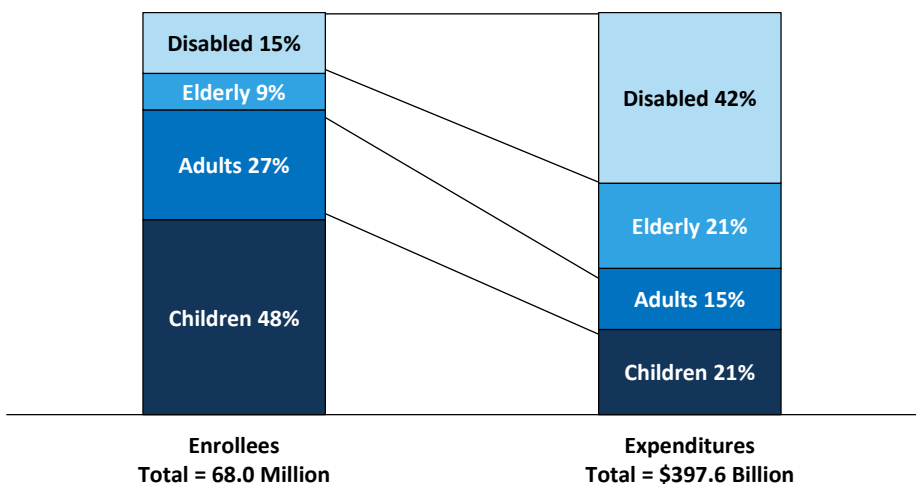


NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. *Difference from ESI is statistically significant (p<.05)
SOURCE: KCMU analysis of 2014 NHIS data.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 8

Medicaid spending is mostly for the elderly and people with disabilities, FY 2011.



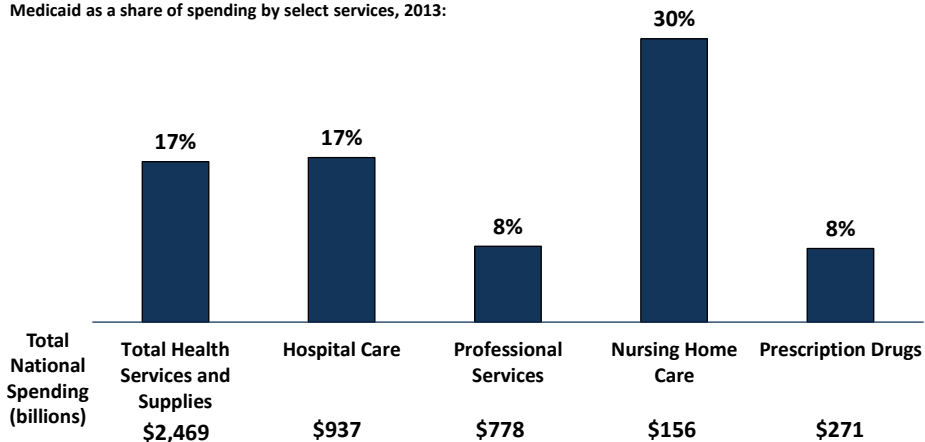
SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Figure 9

Medicaid provides support for providers and services in the health care system.

Medicaid as a share of spending by select services, 2013:



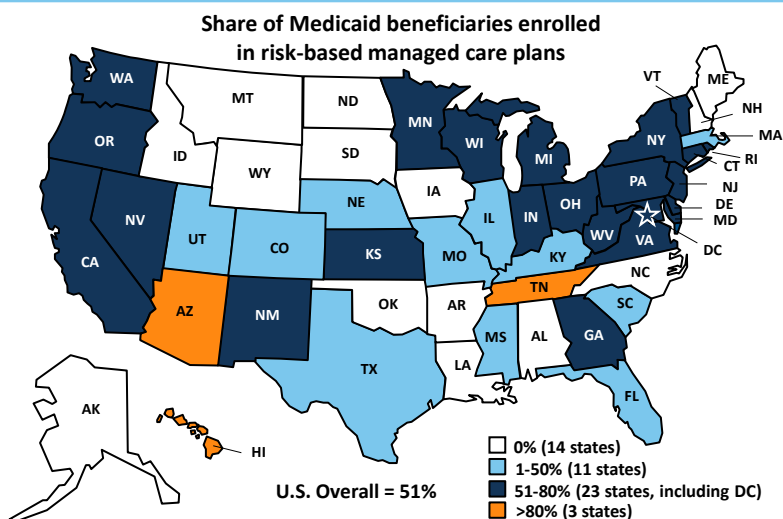
NOTE: Includes neither spending on CHIP nor administrative spending. Definition of nursing facility care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. The nursing facility category includes continuing care retirement communities.

SOURCE: CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditure Accounts, 2015. Data for 2013.



Figure 10

Over half of all Medicaid beneficiaries receive their care in comprehensive risk-based MCOs.

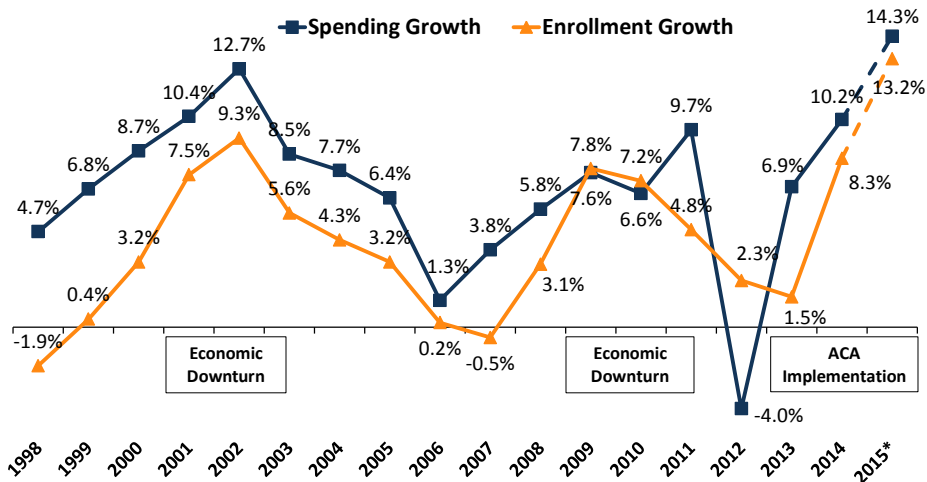


SOURCE: Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2011, CMS, 2012.



Figure 11

Medicaid spending and enrollment are affected by changes in economic conditions and policy.



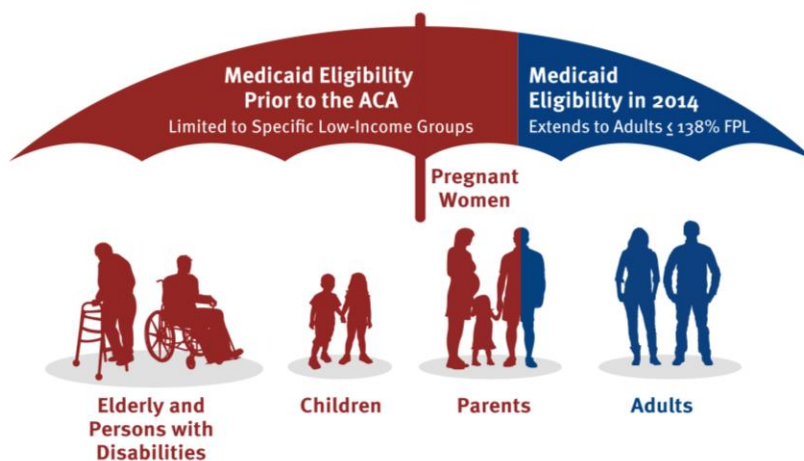
NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015

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Medicaid and the Uninsured

Figure 12

The ACA Medicaid expansion sought to fill gaps in adult coverage.



NOTE: The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = \$16,424 for an individual and \$27,724 for a family of three in 2015.

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Medicaid and the Uninsured

Figure 13

But not all states have expanded Medicaid.

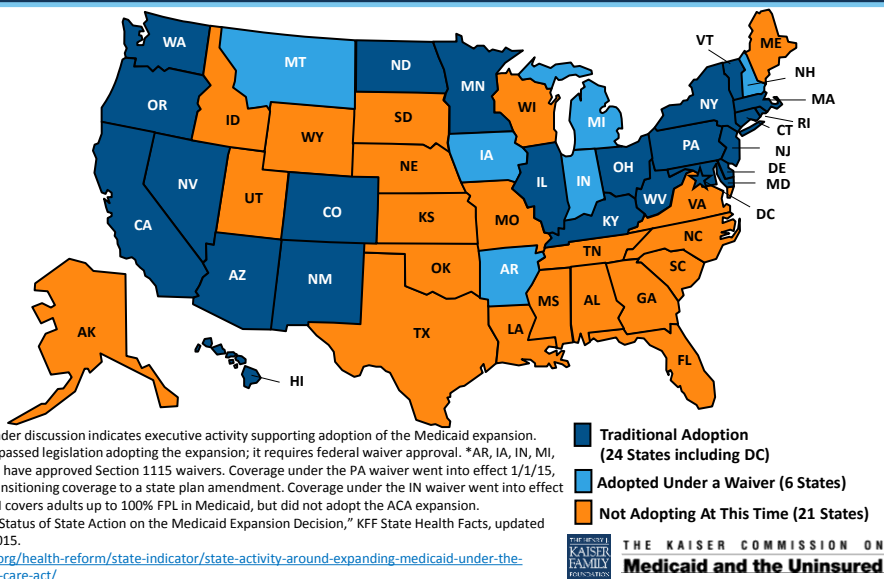
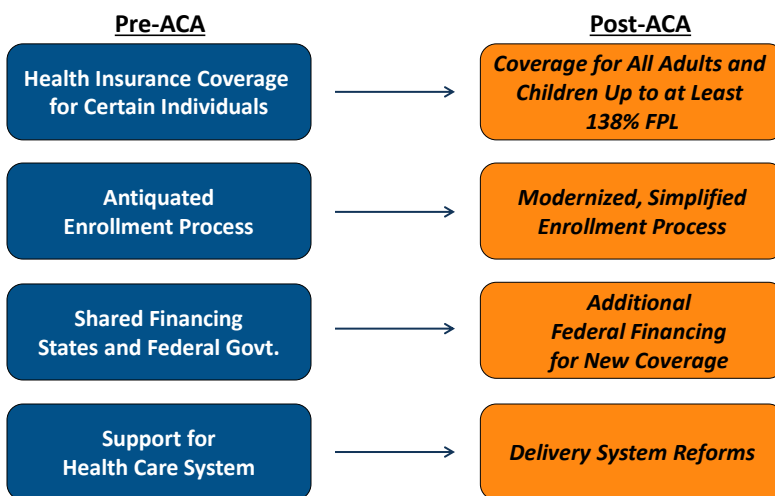







Figure 14





Medicaid at 50: Moving to the future



The Cost of...

	1965	2015
 Gallon of Milk	95¢	\$3.98
 Dozen Eggs	53¢	\$2.19
 Loaf of Bread	23¢	\$2.50
 Gallon of Reg Gas	31¢	\$2.25
 1 st Class Stamp	5¢	\$0.49

The Cost of...

	1965	2015
 New Home	\$21,500	\$165,000
 Median Income	\$6,100	\$54,000
 U.S. Population	194.3 million	320.1 million
 Life Expectancy	70	79



1965

2015



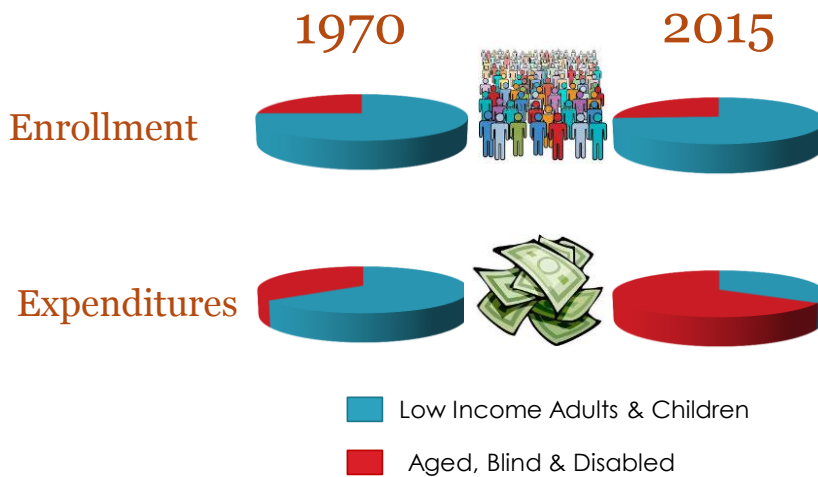
Then



Now



Virginia Medicaid...



Virginia Medicaid...

	1970	2015
Providers	4,500	60,000
Claims Processed	8.8 Mil	22Mil
Average Annual Cost per Recipient	\$306	\$6,500
Recipient Appeals	211	5679

Virginia Medicaid...

	1970	2015
Nursing Facility \$/Day	\$14	\$160
Hospital \$/Day	\$63	\$1,350

*Mobile Hospital
1965*



*Missions Of Mercy (MOM) Project
in Wise, VA - Current Day*



Dental Benefits for Medicaid Adults

Board of Medical Assistance Services

July 28, 2015

A Video Will Be Shown on This Slide

2

Growing Evidence of Oral Health's Impact on General Health

U.S. Surgeon General's Report

- "Oral health is integral to general health; this report provides important reminders that oral health means more than healthy teeth and that *you cannot be healthy without oral health.*"
- "...studies have demonstrated an association between periodontal diseases and diabetes, cardiovascular disease, stroke, and adverse pregnancy outcomes."
- "...there are profound and consequential disparities in the oral health of our citizens. Indeed, what amounts to a ***silent epidemic*** of dental and oral diseases is effecting some population groups."

World Health Organization

- "The interrelationship between oral health and general health *is particularly pronounced among older people.*"
- Poor oral health can increase the risks to general health and, with compromised chewing and eating abilities, affects nutritional intake.
- Insufficient nutrition may ultimately lead to low immune response.
- *Severe periodontal disease is associated with diabetes and HIV infection."*

3

Oral Health for Adults: Some Compelling Statistics

- 42% of non-elderly low-income adults have untreated tooth decay.
- More than one-third of elderly, low-income adults have lost all of their teeth.
- 23% of adults over age 65 have not seen a dentist in the last 5 years
 - *African-American Seniors: 31%*
 - *Mexican-American Seniors: 29%*
- More than 164,000 work hours are lost each year due to dental pain
- The most commonly reported individual health-related service not received because of cost is *dental care.*

Source: Centers for Health Care Strategies, "Dental Coverage and Access for Adults in Medicaid: Opportunities for States," Feb 17, 2015. U.S. Department of Health & Human Services, "Oral Health in America: A Report of the Surgeon General," 2000; Delta Dental Plans Association, "America's Oral Health," April, 2010; National Institute of Dental and Craniofacial Research: "Treatment Needs in Seniors (Age 65 and Over)

4

Access to Publicly Funded Dental Benefits

Children’s Dental Coverage

- Mandated benefit under Medicaid (EPSDT)
- Required benefit under Children’s Health Insurance Program (CHIP)
- Included in *Essential Health Benefits* offered in Health Insurance Marketplaces



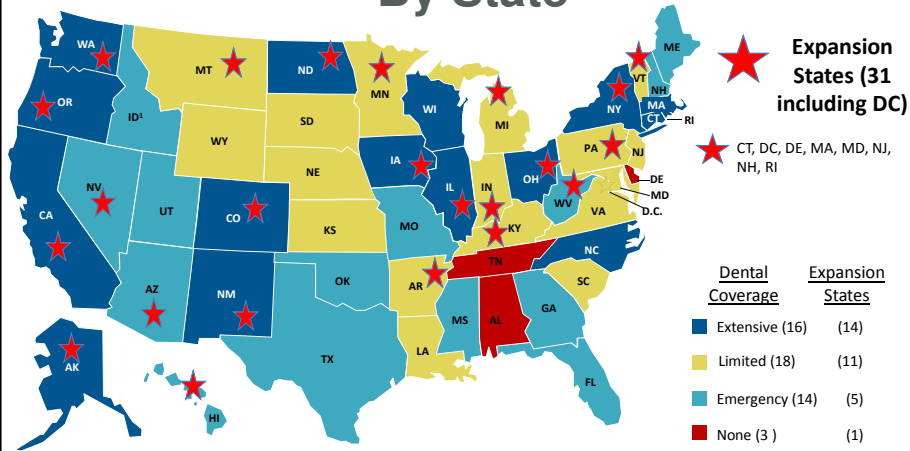
Adult Dental Coverage

- Optional benefit for Medicaid adults
- No Medicare benefit
- Not included in *Essential Health Benefits* offered in Health Insurance Marketplaces



5

Medicaid Adult Dental Coverage By State



1. Idaho provides extensive dental coverage to adults with disabilities and other special health care needs; all other adult members receive emergency only benefits. Virginia provides extensive benefits to pregnant women.

Sources: Kaiser Family Foundation, "Current Status of Medicaid Expansion: State Decisions," July 20, 2015; Vujicic M, Nasseh K. "More than 8 Million Adults Could Gain Dental Benefits through Medicaid Expansion." Health Policy Resources Center Research Brief. American Dental Association. February 2014. Updated by DentaQuest Foundation April 8, 2015.

6

Categories of Medicaid Adult Dental Benefits

Extensive	Limited
A more comprehensive mix of services, including many diagnostic, preventive, and minor and major restorative procedures. It includes benefits that have a per-person annual expenditure cap of at least \$1,000. It includes benefits that cover at least 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature	A limited mix of services, including some diagnostic, preventive, and minor restorative procedures. It includes benefits that have a per-person annual expenditure cap of \$1,000 or less. It includes benefits that cover less than 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature
Emergency	None
Relief of pain and infection. While many services might be available, care may only be delivered under defined emergency situations	No Dental Benefit

7

Emergency Department Visits for Dental Services Continue to Rise

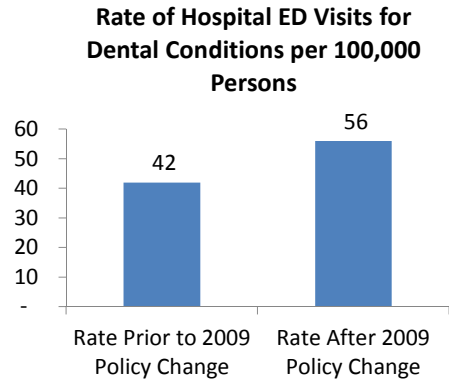
- An American Dental Association (ADA) analysis reports ER dental visits nearly doubled between 2000 and 2010
 - Among adults (21-64), the percentage of ER dental visits paid by Medicaid rose from 27.9% in 2006 to 32.4% in 2012
- In 2012, ED dental visits cost the U.S. health care system \$1.6 billion, with an average cost of \$749 per visit.
- ADA estimates that diverting ER dental visits could save Maryland's Medicaid program \$4 million annually

Sources: Nasseh K, Vujcic M. "Diverting Emergency Department Dental Visits Could Save Maryland's Medicaid Program \$4 million per Year." Health Policy Institute Research Brief. American Dental Association. November, 2014. Wall T, Vujcic M. Emergency Department Use for Dental Conditions Continues to Increase. Health Policy Institute Research Brief. American Dental Association. April 2015. 2015.

8

Cutting Dental Benefits Increases Emergency Department (ED) Use

- Removing a comprehensive dental benefit for California Medicaid adults in 2009 resulted in 1,800 additional ED visits annually
- After adjusting for inflation, the cost of dental ED visits increased by 68% after the policy change.
- California has reinstated most of its Medicaid adult dental benefits



Source: "Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs," Singhal, et. al, Health Affairs; May 2015. 9

Integrating Oral Health & Primary Care Leads to Improved Health and Lower Costs

- Early Oral Care Saves More
 - 2012 Cigna study shows medical savings when periodontal conditions are treated

Average annual savings for those individuals in the study who had proper periodontal treatment

Population	Savings*
Diabetes	\$1,292 or 27.6%
Heart Disease	\$2,183 or 25.4%
Stroke	\$2,831 or 34.7%
ALL CUSTOMERS**	\$1,020 or 27.5%

Prevention produces results

Customers with gum disease receiving appropriate care have:

- 67% lower hospital admission rate
- 54% lower ER rate

Customers receiving proper preventive dental treatment have, on average:

- 12.5% less extractions
- 5.4% less root canals

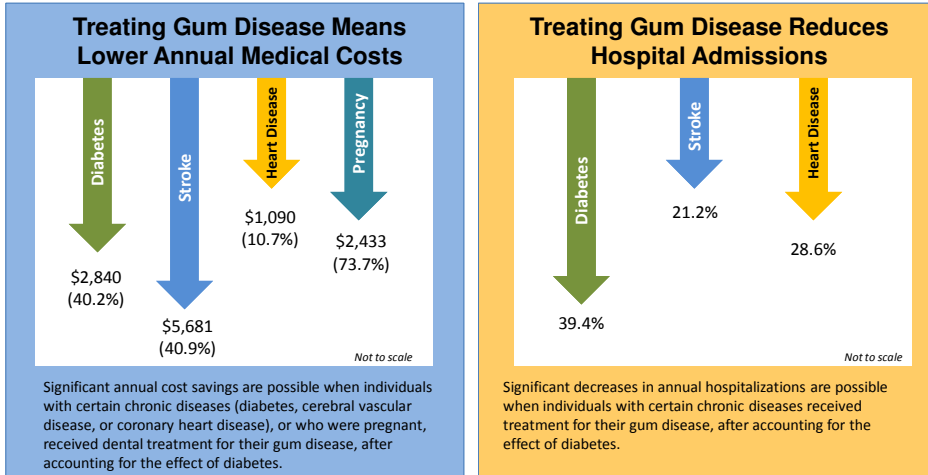
* Not an underwriting decrement

** All customers regardless of condition

Source: Cigna 2013 National Segment Client Forum

10

Integrating Oral Health & Primary Care Leads to Improved Health and Lower Costs



Source: Jeffcoat, M., et. al., "Periodontal Therapy Improves Outcomes in Systemic Conditions." Abstract, American Association of Dental Research; March 21, 2014

11

Cost Estimates to Enhance Dental Benefits for Virginia Medicaid Adults

Benefit Enhancement Options	FY 2015 (GF)	FY 2015 (NGF)	FY 2015 (Total Funds)	FY 2016 (GF)	FY 2016 (NGF)	FY 2016 (Total Funds)
Option 1: Current covered services plus routine preventive services	\$7,563,750	\$7,563,750	\$15,127,500	\$9,530,325	\$9,530,325	\$19,060,650
Option 2: Comprehensive benefits to include routine preventive, restorative and periodontal services	\$30,255,000	\$30,255,000	\$60,510,000	\$63,535,499	\$63,535,499	\$127,070,998

Source: Department of Medical Assistance Services

12

Questions & Board Discussion

- Your thoughts and reactions regarding the importance of oral health and the need to improve access to care as a means of achieving better overall health?

- Your thoughts about the current level of dental coverage for Virginia Medicaid adults and potential coverage enhancements?
 - Level of coverage?
 - All adults or specific adult eligibility groups?



COVER STORY

Visits to US emergency departments by 20- to 29-year-olds with toothache during 2001-2010

Charlotte W. Lewis, MD, MPH; Christy M. McKinney, PhD, MPH; Helen H. Lee, MD, MPH; Molly L. Melbye, DDS, MPH; Tessa C. Rue, MS

The emergency department (ED) is a well-known safety net for those who face barriers to other sources of health care. Reliance on the ED as a dental care safety net, however, is problematic for many reasons. EDs usually are not staffed or equipped to deliver dental care. Most treatment rendered in EDs for toothache is only temporizing,¹⁻³ which means that the symptom is likely to recur in the absence of subsequent professional dental care.⁴ Moreover, because ED visits for dental symptoms are disproportionately made by the uninsured,^{1-3,5-7} the cost of such care is more likely to be shifted to insured patients and absorbed by individual EDs and hospitals,⁴ rather than more widely distributed among dental and public health care systems.

ED toothache visits are usually classified as nonurgent, potentially contributing to ED inefficiency. Yet, advocates point out that the uninsured seek ED care for nonurgent problems not

because they want to, but because they have no other option.⁸ If pain from toothache interferes with ability to sleep, eat, or work, and dental care is not affordable or accessible, then patients will seek care wherever they can get it, including in the ED.

ABSTRACT

Background. Visits to emergency departments (EDs) for dental symptoms are on the rise, yet reliance on EDs for dental care is far from ideal. ED toothache visits represent opportunities to improve access to professional dental care.

Methods. This research focuses on 20- to 29-year-olds, who account for more ED toothache visits than do other age groups. The authors analyzed publicly available ED visit data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) from 2001 through 2010. They assessed trends in ED toothache visit rates compared with back pain and all cause ED visits during the past decade. The authors used NHAMCS data for years 2009 and 2010 to characterize the more recent magnitude, relative frequency, and independent risk factors for ED toothache visits. Statistical analyses accounted for the complex sampling design.

Results. The average annual increase in ED visit rates among 20- to 29-year-olds during 2001-2010 was 6.1% for toothache, 0.3% for back pain, and 0.8% for all causes of ED visits. In 2009 and 2010, 20- to 29-year-olds made an estimated 1.27 million ED visits for toothaches and accounted for 42% of all ED toothache visits. Toothache was the fifth most common reason for any ED visit and third most common for uninsured ED visits by 20- to 29-year-olds. Independent risk factors for ED toothache visits were being uninsured or Medicaid-insured.

Conclusions. Younger adults increasingly rely on EDs for toothaches—likely because of barriers to accessing professional dental care. Expanding dental coverage and access to affordable dental care could increase options for timely dental care and decrease ED use for dental symptoms.

Practical implications. Though additional research is needed to better understand why younger adults disproportionately use the ED for toothaches, findings from this study suggest the importance of maintaining access to a dental home from childhood through adolescence and subsequently into early adulthood.

Key Words. Access to care; emergency services; emergency treatment; toothache.

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<http://dx.doi.org/10.1016/j.adaj.2015.01.013>

This article has an accompanying online continuing education activity available at: <http://jada.ada.org/ce/home>.

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There are few upfront financial barriers to ED care. Unlike dental offices, hospitals must legally provide emergency care to anyone who needs it, regardless of ability to pay.⁹ In addition, tax exempt hospitals (and their EDs) are obligated by the Internal Revenue Service to provide charity care, often in the form of discounted care for low-income patients^{10,11}; such financial assistance may not be as readily available in private dental practices.



Supplemental material
is available online.

In 2012, we reported that ED dental visits had increased between 2001 and 2008, particularly among adults.⁶ Other investigators have documented similar findings.¹²⁻¹⁵ As a next step in our research agenda, we then asked whether certain age groups were disproportionately represented among ED visits for dental symptoms—specifically toothache—and found that 20- to 29-year-olds (“younger adults”) had substantially more ED visits for toothaches than other age groups. Understanding national trends in ED toothache visits and the magnitude and characteristics of more recent ED toothache visits, particularly in this high-utilizer age group, is important because these visits reflect opportunities to improve access to and utilization of professional dental care through patient education, health policy, and expansion of dental public health infrastructure.

METHODS

Research goals. We relied on the National Hospital Ambulatory Medical Care Survey (NHAMCS),¹⁶ a nationally representative sample of United States ED visits, to address 3 research goals as they pertain to 20- to 29-year-olds:

- Compare average annual change in ED visit rates for toothache relative to back pain and all cause ED visits during years 2001 through 2010. We chose back pain as a comparator because, like toothache, it is subjective and often perceived as a nonurgent reason for seeking ED care.¹⁷ We were interested in whether a rise in ED toothache visits was the result of secular increases in ED use overall or for nonurgent reasons. If so, we would expect similar changes in toothache ED visit rates as in all cause ED and back pain visit rates during this period.
- Rank the frequency of ED toothache visits relative to other common reasons for seeking ED care in 2009-2010.
- Characterize patient-, hospital-, and visit-level variables associated with ED toothache visits in 2009-2010. Based on review of the literature regarding racial, income, insurance, and geographic-based disparities in dental care access and oral health,¹⁸⁻²⁴ we hypothesized a priori that an ED toothache visit would be more likely on adjusted multivariable analysis: in nonwhites than whites, when Medicaid or uninsured was listed as payer compared with private insurance, in EDs in non-MSA (rural and micropolitan statistical areas—relative to MSA

(metropolitan statistical area),²⁵ and during business hours compared with after business hours.

Data. NHAMCS is a national probability sample of hospital ED visits conducted annually by the US National Center for Health Statistics (NCHS).¹⁶ The multistaged sample design includes geographic primary sampling units, hospitals within primary sampling units, and patient visits within emergency service areas. Sampled EDs are located in general and short-stay hospitals—exclusive of federal, military, and Veterans Affairs hospitals—in the 50 US states and District of Columbia. Within an ED, visits are systematically selected during a randomly assigned 4-week reporting period. Hospital or US Census Bureau staff complete a patient record form for each sampled visit by reviewing the medical record. Sampled data are extrapolated to population estimates using assigned patient visit weights, which account for probability of visit selection, nonresponse, and ratio of sampled hospitals to all hospitals in the United States.¹⁶

For the first research goal, we used 2001-2010 NHAMCS data and the corresponding year of US Census Bureau population estimate²⁶ to calculate the rate of ED visits in the US population for each of the 10 years. We characterized recent ED toothache visits—the focus of the second and third research goals—using the 2 most recently released years (2009 and 2010) of NHAMCS data, which we combined to improve reliability of our estimates—a strategy recommended by the NCHS.²⁷ To ensure validity of our results, all reported estimates were based on at least 30 unweighted records and relative standard errors less than 30%.

The University of Washington Human Subjects Division considers that research using certain publicly available data sets, including NHAMCS, does not involve “human subjects” as defined by federal regulations. Thus, no institutional review board approval was required (<http://www.washington.edu/research/hds/docs/1125>).

ED visits. From NHAMCS, we selected ED visits made by 20- to 29-year-olds during 2001 through 2010. These were compared with ED toothache visits in other age groups in descriptive analysis.

Measures. Outcomes. The outcomes for this study were derived from the variable “reason for the visit,” which was coded according to a NCHS classification system.²⁸ The primary outcome variable was an ED visit for toothache (reason-for-visit code = 1500.1) as the primary presenting symptom.²⁸ We were interested in the primary presenting symptom rather than discharge

ABBREVIATION KEY. ACA: Affordable Care Act. ED: Emergency department. MEPS: Medical Expenditure Panel Survey. MSA: Metropolitan statistical area. NCHS: National Center for Health Statistics. NHAMCS: National Hospital Ambulatory Medical Care Survey. Non-MSA: Rural and micropolitan statistical area.

diagnoses because our focus was on toothache as a potentially preventable reason for an ED visit. In addition, investigators have noted that primary presenting symptom of toothache is more reliably present in ED records than dental diagnoses, and that assigned dental diagnoses tend to be nonspecific.^{2,29} For comparison with ED toothache visit trends, we extracted ED visits for primary presenting symptoms of back pain (composed of “back pain, ache, soreness, discomfort,” code = 1905.1 and “low back pain, ache, soreness, discomfort,” code = 1910.1). We generated the most frequent primary presenting symptom for ED visits in younger adults to rank these relative to toothache in 2009-2010.

Covariates. For the third research goal, we extracted 3 categories of covariates from 2009 through 2010 NHAMCS: patient-related, hospital-related, and visit-related. Patient-related covariates included patient sex, race (white, black, and other—as imputed or recoded by NHAMCS), and medical payer (private, Medicaid, uninsured, other/unknown). (NHAMCS identifies only medical payer and not dental benefit status.) To aid in interpretation of results, we estimated the degree to which medical insurance status reflected having dental coverage among US 20- to 29-year-olds, by analyzing 2009-2010 Medical Expenditure Panel Survey (MEPS) data (Supplemental Data, available online at the end of this article). We found that being uninsured for medical care was almost always accompanied by lack of dental benefits (99.5% of younger adults who were uninsured for medical were also uninsured for dental care). The converse, however, is not true: only 56% of 20- to 29-year-olds with private medical insurance for the calendar year had dental care coverage for that year. (Patients with private medical insurance making visits to the ED may or may not have dental benefits; thus, we could be underestimating the protective effect of having private dental coverage on ED toothache visits.) Among hospital variables, we included US region where the ED was located (Northeast, South, Midwest, and West), and MSA status of the ED (MSA and non-MSA). The visit-related variable was time and day of visit (during business hours Monday through Friday 8 AM-5 PM versus nights and weekends).

Statistical analysis. We used the survey capabilities in a statistical software program (Stata 12.0) to conduct all analyses. To describe and compare relative trends—our first research goal—we calculated population-based ED visit rates for toothache, back pain, and all causes for each year 2001-2010, by dividing the annual weighted number of ED visits made by 20- to 29-year-olds for toothache, back pain, and all causes in a given year by the estimated annual US Census Bureau’s population of 20- to 29-year-olds in the corresponding year (ED visits per 1,000 US population of 20- to 29-year-olds).²⁶ We then assessed average percentage of annual change in the rates of population-based ED visits during 2001-2010 using weighted linear regression analysis for each of the 3 ED visit types.

For research goal 2, we determined the weighted proportion of each leading reason for the ED visit in 20- to 29-year-olds in 2009-2010. We ranked the top reasons for visit among all payers and then stratified by payer.

For research goal 3, we generated weighted proportions and corresponding 95% confidence intervals (CIs) to describe variables related to patients, hospitals, and visits among 20- to 29-year-olds with and without a primary presenting symptom of toothache. We conducted multivariable logistic regression to test hypotheses, and we generated weighted adjusted odds ratios and 95% CIs. Based on literature review, we specified a priori that the model would include sex, race, payer, hospital region, MSA status, and whether the ED visit occurred during business hours or not. We did not impute any values or take special measures for missing values because these were minimal among our selected covariates.

RESULTS

Relative to 2001, yearly population-based ED visit rates among 20- to 29-year-olds increased at a significantly higher rate for toothaches compared with back pain and all causes (Figure 1): 6.1% (95% CI, 4.2-7.9) for toothache, 0.3% (95% CI, -2.1 to 2.6) for back pain, and 0.8% (95% CI, 0.1-1.4) for all cause ED visits (census and weighted ED-visit estimates for each year are tabulated in the eTable, available online at the end of this article). In 2009-2010, there were an estimated 3.02 million total visits made nationally to EDs for primary presenting symptom of toothache (sample N = 783), and 42% of these were made by 20- to 29-year-olds (sample N = 317). In this age group, 2.8% of ED visits were for toothache—with lower odds for all other age categories (Figure 2). ED toothache visits by younger adults accounted for an estimated 1,271,000 visits nationally during 2009-2010 (95% CI, 1,039,000-1,504,000)—602,000 in 2009 and 669,000 visits in 2010. In 2009-2010, toothache was the fifth most common leading reason for an ED visit among all 20- to 29-year-olds. Toothache was ranked ninth for privately insured visits and fifth for Medicaid-insured visits, but for uninsured ED visits, toothache was the third most common reason for an ED visit in this age group (Table 1).

In multivariable analysis, we found that being uninsured or being Medicaid-insured, relative to privately insured, was independently and positively associated with an ED visit for toothache compared with all other reasons for ED visits among 20- to 29-year-olds in 2009-2010 (Table 2)—confirming 1 out of 4 of our hypotheses. We did not find a statistically significant association with black race (number of sampled visits by nonwhite races was too small to include in the analysis), ED MSA status, or timing of visit on risk of ED toothache visit relative to another reason for an ED visit.

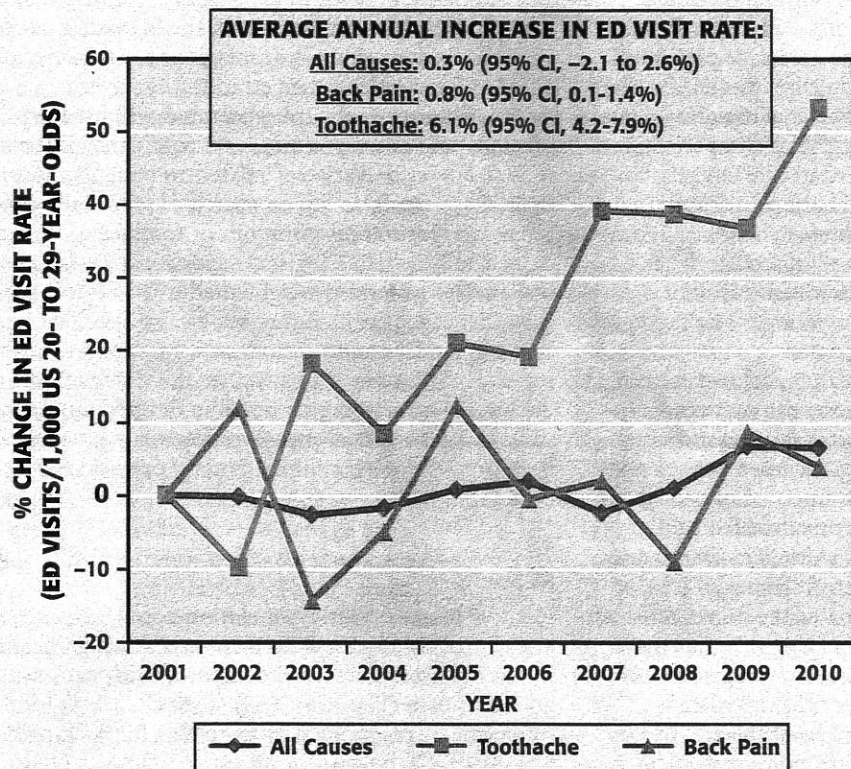


Figure 1. Percentage change in rate of emergency department (ED) visit rates for toothache compared with all causes and back pain among 20- to 29-year-olds from 2001 through 2010. Between 2000 and 2010, ED toothache visits increased at a substantially higher rate than either all causes or back pain ED visits among 20- to 29-year-olds. CI: Confidence interval. Source: Centers for Disease Control and Prevention, National Center for Health Statistics.¹⁶

DISCUSSION

Among 20- to 29-year-olds, ED toothache visits rose, on average, 6.1% each year between 2001 and 2010, far outpacing yearly increases in back pain and all cause ED visits. There are a number of possible explanations for why ED toothache rates grew to such a degree over 10 years, although the relatively stable rates of all cause and ED back pain visits suggest that there are influences besides simple secular shifts that underlie this increase. It is likely that income- and employment-related factors, combined with economic stressors, and decreasing public health resources for adult dental care in this decade, contributed to this trend. During the recent recession (December 2007 through September 2010), higher unemployment rates meant fewer opportunities for employer-based dental benefits and less disposable income to pay for dental care.³⁰ Under these influences, professional dental care visits made by adults declined substantially between 2001 and 2010, and to the greatest degree among poor adults.³¹ With more barriers to professional dental care, dental disease could advance unchecked until it manifests as a toothache or other complication. Toothache is similar to ambulatory care-

sensitive condition (asthma, for example), in that lack of preventive care results in greater morbidity, cost, and societal burden.

Faced with budget shortfalls during the last decade, US states reduced public health funding for safety net dental clinics and eliminated or drastically reduced preventive and restorative dental benefits under adult Medicaid.³³ Unlike the case for children, dental care is an optional state-level benefit for adults insured by Medicaid. Only 7 states maintained comprehensive dental benefits for adult Medicaid beneficiaries for all years between 2002 and 2010.³⁴ There is precedent to support an association between decreased adult

Medicaid dental funding and increased ED dental visits. In 1993, when the state of Maryland eliminated Medicaid reimbursement to dentists for treatment of adults with dental emergencies, the rate of dental visits to EDs by Medicaid recipients rose by 22%—an increase that occurred while ED visits by Medicaid recipients were otherwise decreasing.³⁵ Similarly, after Massachusetts reduced Medicaid adult dental benefits in 2010, dental-related visits at a Boston safety net ED increased 14% by 2012.³⁶

We also found that, in 2009-2010, the largest proportion of ED visits for toothache was made by 20- to 29-year-olds, accounting for 42% of such visits. Similar to our results, Jasek and colleagues²⁹ reported that ED dental visits in New York City during 2009-2011 were highest among 18- to 29-year-olds.

Our research is the first to document that toothache is among the top reasons for younger adults to seek care in EDs. Specifically, toothache was the fifth most common primary presenting symptom in EDs among 20- to 29-year-olds and the third most common for uninsured younger adults.

We posit a variety of reasons why younger adults disproportionately rely on the ED for toothache. Rel-

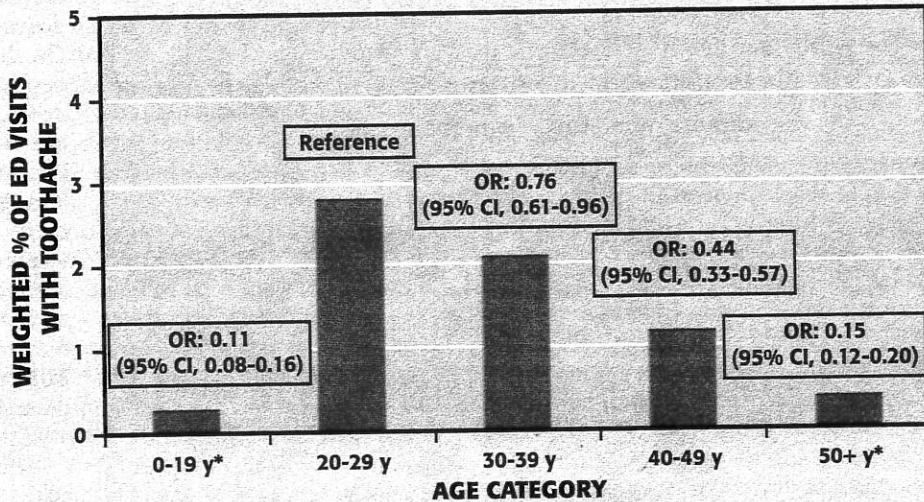


Figure 2. Weighted percentage of emergency department (ED) visits with toothache as leading reason for visit, by age category. Weighted odds ratio (OR) and 95% confidence interval (CI) of ED toothache visit by age category (20- to 29-year-olds are reference category). In 2009 and 2010, 20- to 29-year-olds had statistically significantly higher odds of an ED toothache visit relative to other age groups. *Age categories combined to ensure adequate unweighted sample size. Source: Centers for Disease Control and Prevention, National Center for Health Statistics.¹⁶

adults 30 years and older, younger adults are poorer and less likely to have dental coverage. (In our analyses 2009-2010 MEPS [eFigure, available online at the end of this article], 20- to 29-year-olds had the lowest proportion of all of the age categories with at least 1 dental visit [32.1%] and the second lowest proportion with dental benefits [33.7%] after people 50 years or older. Second only to children, 18.3% of 20- to 29-year-olds are poor—defined as at or below 100% of the federal poverty guidelines or an annual income of less than or

equal to \$10,830 for a single adult in 2010.) Our results indicate that, in this age group, being uninsured or Medicaid-insured were independent risk factors for ED toothache utilization, which supports the precept that financial barriers play a role in younger adults using the ED for toothache. Among 20- to 29-year-olds, being uninsured for medical care is essentially equivalent to being uninsured for dental care (Supplemental Data, available online at the end of this article). Dental benefits under Medicaid are more variable, depending on state of

TABLE 1
Ranking of the most common leading reasons for emergency department visits among 20- to 29-year-olds: all emergency department visits and by payer.*†

ALL VISITS		PRIVATE INSURANCE (28.5%)		UNINSURED (29.0%)		MEDICAID (27.9%)	
Visit Type	Weighted % (95% CI) [‡]	Visit Type	Weighted % (95% CI)	Visit Type	Weighted % (95% CI)	Visit Type	Weighted % (95% CI)
1. Abdominal pain	7.7 (7.0-8.3)	1. Abdominal pain	7.9 (6.6-9.1)	1. Abdominal pain	6.8 (5.9-7.8)	1. Abdominal pain	8.6 (7.2-9.9)
2. Back pain	4.6 (4.2-5.0)	2. Back pain	4.9 (4.1-5.6)	2. Back pain	5.2 (4.3-6.1)	2. Back pain	4.5 (3.3-5.7)
3. Headache	3.6 (3.1-4.1)	3. Chest pain	4.1 (3.0-5.3)	3. Toothache	3.9 (3.1-4.7)	3. Headache	3.7 (2.7-4.6)
4. Chest pain	3.3 (2.8-3.8)	4. Headache	3.1 (2.4-3.9)	4. Throat pain	3.3 (2.3-4.3)	4. Chest pain	3.6 (2.8-4.3)
5. Toothache	2.8 (2.4-3.2)	5. Flank pain	2.0 (1.4-2.7)	5. Headache	3.2 (2.5-3.9)	5. Toothache	3.1 (2.3-3.9)
6. Throat pain	2.5 (2.1-2.9)	6. Fever	1.9 (1.3-2.3)	6. Chest pain	2.6 (1.9-3.3)	6. Throat pain	2.3 (1.7-3.0)
		9. Toothache	1.4 (0.7-2.1)				

* Source: Centers for Disease Control and Prevention, National Center for Health Statistics.¹⁶
† Patients with "other" insurance types not shown.
‡ CI: Confidence interval.

TABLE 2

Select characteristics of emergency department visits by 20- to 29-year-olds for emergency department visits without and with toothache as leading symptom.*†‡

CHARACTERISTIC	ED [§] VISITS FOR 20- TO 29-YEAR-OLDS WITHOUT TOOTHACHE (95% CI [¶])	ED VISITS FOR 20- TO 29-YEAR-OLDS WITH TOOTHACHE (95% CI)	WEIGHTED ADJUSTED ODDS RATIO (95% CI)
Patient			
Sex			
Female	61.2 (60.0-62.4)	59.6 (52.4-66.7)	1.02 (0.75-1.38) Versus male
Race			
White	71.1 (67.3-74.8)	74.0 (67.8-80.2)	Reference
Black	25.0 (21.4-28.7)	24.2 (18.1-30.2)	0.89 (0.64-1.24)
Other	3.8 (2.7-5.1)	Not applicable	Not applicable
Primary payer			
Private	28.9 (27.1-30.8)	14.5 (8.5-20.4)	Reference
Medicaid	26.8 (24.9-28.7)	29.7 (22.5-36.8)	2.21 (1.30-3.77)
Uninsured	28.7 (26.4-31.0)	40.3 (33.8-46.9)	2.83 (1.73-4.64)
Other/unknown	15.6 (13.6-17.6)	15.5 (9.9-21.1)	2.02 (1.04-3.92)
Hospital			
Metropolitan statistical area status of ED			
Nonmetropolitan statistical area	16.9 (7.8-26.0)	20.3 (8.6-31.9)	1.20 (0.82-1.77) Versus metropolitan statistical area
US region of ED			
Northeast	17.8 (15.1-20.5)	18.6 (12.3-24.9)	Reference
Midwest	22.8 (17.4-28.2)	24.7 (16.0-33.4)	0.98 (0.46-1.60)
South	41.4 (36.0-46.8)	39.9 (31.1-48.7)	0.90 (0.58-1.39)
West	17.1 (14.5, 21.3)	16.7 (9.5-23.8)	1.00 (0.60-1.66)
Visit			
Day/time of visit			
During business hours (8 AM-5 PM, Monday-Friday)	37.2 (35.9-38.6)	35.7 (29.3-42.2)	0.96 (0.70-1.31) Versus after business hours
* Weighted percentage, weighted adjusted odds ratio for toothache visit versus another reason for emergency department visit, and 95% confidence intervals.			
† Source: Centers for Disease Control and Prevention, National Center for Health Statistics. ¹⁶			
‡ Unweighted sample size inadequate for valid statistical analysis.			
§ ED: Emergency department.			
¶ CI: Confidence interval.			

residence. To qualify for adult Medicaid benefits during 2009-2010, the period for this study, typically required an income below the federal poverty guideline and eligibility often was restricted to special groups, such as pregnant women, or parents of dependent children.

Regardless of dental coverage, dental care can be costly. Nationally, 42% of dental expenses are paid out of pocket by consumers.³³ Cost-sharing combined with a weak dental care safety net, in which demand outweighs supply,³⁷ may pose insurmountable barriers to dental care for many young Americans,^{18,19} regardless of the value they place on preventive dental care. Although EDs cannot turn away patients with emergency conditions (including pain and infection from toothache) for

become symptomatic—in the form of a toothache—a few years later, just at the point that younger adults have fewer options for dental care because they have “aged out” of more generous pediatric dental coverage and resources. Dental care is a mandated benefit for low-income children on Medicaid under Early and Periodic Screening, Diagnosis, and Treatment³⁹ legislation passed in 1967 and in 2009, the Children’s Health Insurance Program Reauthorization Act.⁴⁰ However, in adulthood, dental care is an optional benefit under Medicaid, with most states substantially restricting eligibility criteria as well as limiting the scope of covered dental services.³³

We did not find an association between time and day of the ED visit and the risk of an ED toothache visit.

inability to pay,⁹ they are inadequately prepared to deliver dental care. On the other hand, dentists and other dental practitioners are uniquely able to provide preventive and restorative dental care needed to prevent toothache, but financial and other barriers may impede access. This is a conundrum deserving additional attention.

The ED toothache visit surge in the third decade of life may also result from missed opportunities for dental care during later adolescence. Only 30% of 16- to 18-year-old Medicaid enrollees received dental care in the previous year compared with 45% of children age 6 to 11 years, and 38% of those aged 12 to 15 years, according a 2008 US Government Accountability Office report.³⁸ Untreated dental decay in later adolescence may

This implies that reasons behind ED toothache visits have less to do with finding a dentist who is open when a toothache occurs. ED MSA status and black race were also not associated with higher risk of ED toothache visits in younger adults. Few studies have addressed ED MSA status as a predictor of ED dental visits. Okunseri and colleagues⁴¹ identified that Wisconsin Medicaid enrollees who lived in dental health professional shortage areas—a more specific variable than MSA—had a higher adjusted risk of an ED dental visit. With regard to race, prior studies have reported conflicting results regarding racial disparities in ED dental visits,^{2,6,13,41,42} but these studies did not generally focus on a specific age group and were often limited to smaller regions.

Certain limitations to this study bear mention. The quality of NHAMCS data may vary because it is abstracted on the hospital level.^{27,43} Some variables in NHAMCS contain missing values, were not recorded, or were imputed. However, the main conclusions drawn in this report were based on variables with few or no missing values. Another limitation to NHAMCS is that data are collected at the visit level, thus, we do not know if individual patients were represented more than once within a 4-week data collection period in an ED. Also inherent to secondary analysis is the limited number of available variables; this leaves some unanswered questions regarding ED visits for toothaches among young adults but generates hypotheses for future research.

CONCLUSIONS

Results of this research suggest the need to reconsider how a dental care delivery and payment model can better meet the oral health needs of adults, particularly in the 20- to 29-year-old range. Toothaches are among the top reasons for younger adults to seek care in EDs, which essentially forces integration of dental care into medical care, albeit in a less than optimal way. The time has come to view dental disease in the same way that we do other preventable medical problems—deserving of equitable funding, accessible care, and monitoring to ensure disparities are being addressed and are diminishing. To that end, ED toothache visits represent a potential quality indicator for system-level barriers to dental care access, or utilization within a region or population.²⁹

Finding solutions to the increasingly common nature of ED toothache visits will be complicated and require short- and long-term considerations. Redirecting ED patients with toothaches to a source of definitive dental care does not address the underlying missed opportunities for preventive and restorative dental care, but it is an essential step to alleviate ongoing reliance on EDs. Strengthening the dental care safety net is also imperative, and ideally, will be facilitated by expanded funding under the Affordable Care Act (ACA) for community health centers beginning in 2014.⁴⁴ Borrowing from the medical insurance provisions under the ACA, maintaining dental coverage from childhood

through younger adulthood, either from one's parents or Medicaid, could provide a bridge to employment-based dental coverage. Likewise, encouraging regular preventive dental care and oral hygiene throughout adolescence may help maintain these practices and a relationship with a dental home into young adulthood as well.

Finally, although expansion of Medicaid under the ACA has increased the number of adults who are eligible for Medicaid, there remains no requirement that states cover dental care for adults enrolled in Medicaid. Furthermore, under the original ACA legislation, oral health care was designated an "essential health benefit" only for children.⁴⁵ It is unclear why dental care would be considered essential during childhood but not adulthood. Dental disease, like other chronic diseases, has its substantive origins in childhood, but caries and periodontal disease continue to occur and advance during adulthood, ultimately affecting more than 90% of adults.⁴⁶ Regular preventive dental care and timely restorative care are important throughout the life span, not just during the first 18 years. ■

SUPPLEMENTAL DATA

Supplemental data related to this article can be found at <http://dx.doi.org/10.1016/j.ada.2015.01.013>.

Dr. Lewis is an associate professor, Department of Pediatrics, Division of General Pediatrics, School of Dentistry, University of Washington, Box 354920, Seattle, WA 98195, e-mail cwlewis@uwashington.edu. Address correspondence to Dr. Lewis.

Dr. McKinney is an assistant professor, Department of Oral Health Sciences, School of Dentistry, University of Washington, Seattle, WA.

Dr. Lee was an assistant professor, Department of Pediatric Anesthesiology and Pain Medicine, Seattle Children's Hospital, Seattle, WA, when this article was written. She now is an assistant professor, Department of Anesthesiology, College of Medicine, University of Illinois at Chicago, Chicago, IL.


Dr. Melbye is an adjunct faculty member, Department of Oral Health Sciences, School of Dentistry, University of Washington, Seattle, WA, and a dentist, Neighborcare Health, Seattle, WA.

Ms. Rue is a research scientist, Department of Biostatistics, University of Washington, Seattle, WA.


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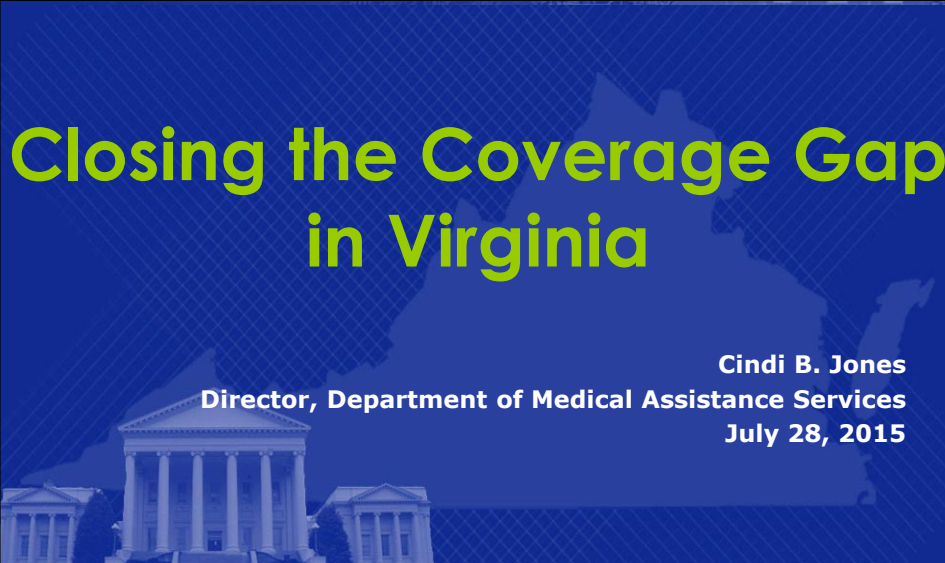


Department of Medical Assistance Services



Closing the Coverage Gap in Virginia

Cindi B. Jones
Director, Department of Medical Assistance Services
July 28, 2015



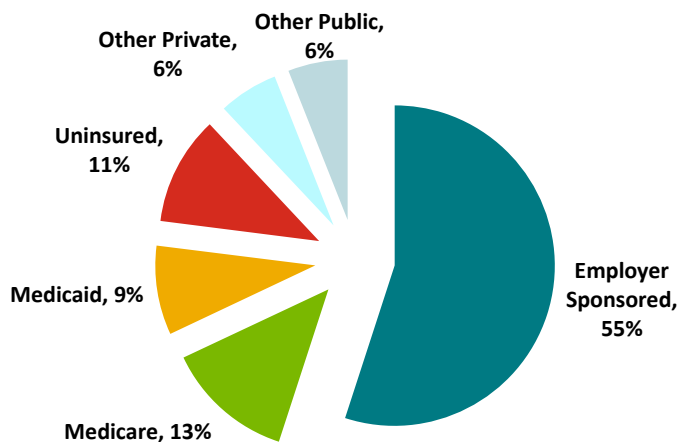
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1

Virginia Medicaid Coverage Landscape



Virginia Coverage Landscape

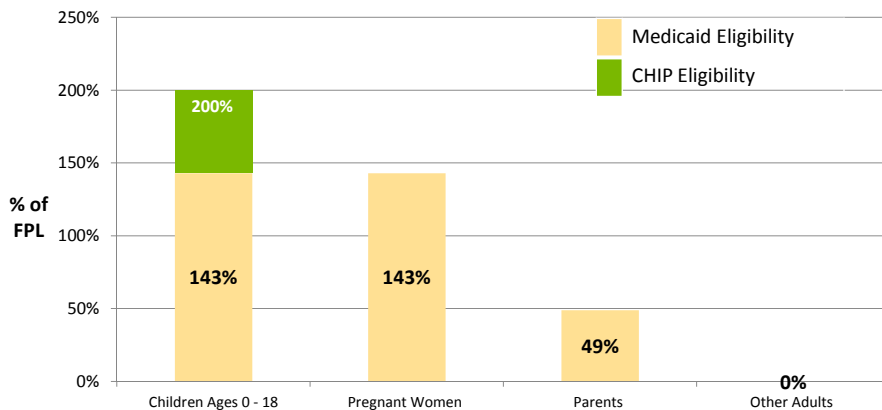


Source: Kaiser Family Foundation State Health Facts, Health Insurance Coverage of the Total Population, Virginia, 2013.

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Current Medicaid & CHIP Eligibility Levels in Virginia

As of April 2015, over 957,600 Virginians were enrolled in Medicaid and CHIP



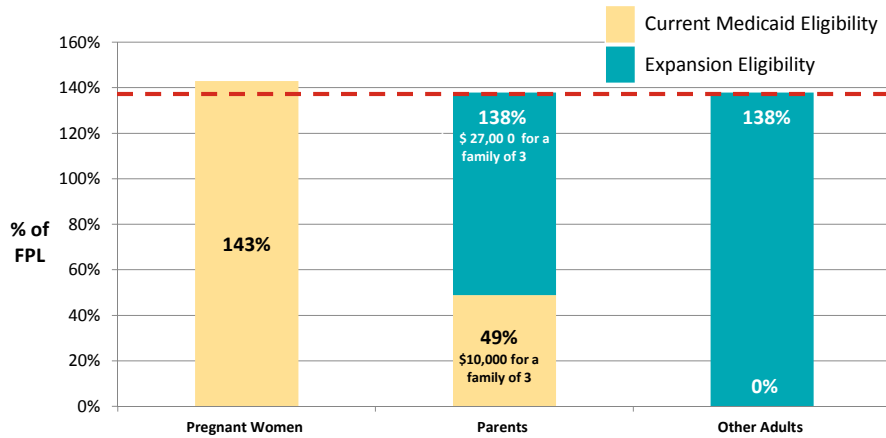
Source: Medicaid.gov, Medicaid and CHIP Eligibility Levels, Virginia.

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Medicaid & CHIP Eligibility Levels Under Expansion

5

Over 400,000 Virginians would become eligible for Medicaid under expansion



Source: Weldon Cooper Center, University of Virginia, *Virginia Medicaid Now and Under Health Reform*, 2010; Medicaid.gov, Medicaid and CHIP Eligibility Levels, Virginia.




New Adult Group in Virginia

Who is in the New Adult Group in Virginia?

7

New Adult Group in Virginia (Ages 19-64)



- Childless adults with incomes below 138% FPL (\$16,243 per year for a single adult)
- Parents with incomes from 49% FPL up to 138% FPL (\$27,724 per year for a family of three and \$33,465 per year for a family of four)

Characteristics of the New Adult Group

- Employed or live in a household with an employed family member but lack access to affordable coverage because income is above current eligibility levels
- Disabled or have a medical condition that prevents them from working and income is above 80% FPL
- Veteran or a spouse of a veteran (In Virginia, ~12,300 new adults are uninsured veterans and ~4,100 new adults are uninsured spouses of veterans)
- Young adults no longer able to be covered on their parents' plans

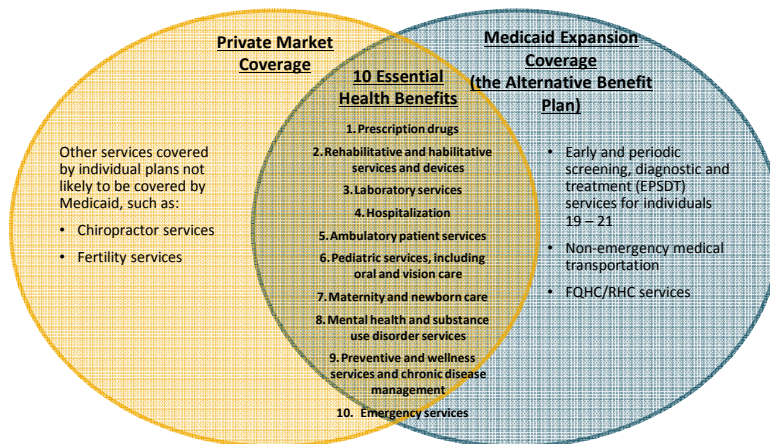
Sources: The Urban Institute, *Uninsured Veterans and Family Members: State and National Estimates of Expanded Medicaid Eligibility Under the ACA*, March 2013. Virginia Department of Social Services, *Aged, Blind or Disabled Individuals with Income Less Than Or Equal To 80% Of The Federal Poverty Level*, January 2015.



New Adults Receive an Alternative Benefit Plan (ABP)

8

States must design their ABP based on a commercial benchmark plan



100% Federal Match for New Adults Continues Through 2016

YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	<i>State Share</i>	<i>Federal Share</i>
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Virginia's Standard Federal Matching Rate
50%

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Coverage Options and Considerations

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Premiums

13

Federal Medicaid law bars premiums for individuals below 150% FPL.

- ❑ CMS has granted waivers permitting states to charge expansion adults premiums up to 2% of household income
- ✗ Eligibility for Medicaid cannot be conditioned on payment of premiums for individuals below 100% FPL

IOWA

Note: Financial hardship exemption available upon request

- **Individual <50% FPL:** No premiums
- **Individuals 50 – 100% FPL:** Premiums of \$5
Consequences of nonpayment: Incur debt to the State
- **Individuals >100 – 138% FPL:** Premiums of \$10
Consequences of nonpayment: Dis-enrolled; may re-enroll with payment of new premium; past unpaid premiums remain a debt to the State

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Premiums (cont'd.)

14

Federal Medicaid law bars premiums for individuals below 150% FPL.

- ❑ CMS has granted waivers permitting states to charge expansion adults premiums up to 2% of household income
- ✗ Eligibility for Medicaid cannot be conditioned on payment of premiums for individuals below 100% FPL

INDIANA

Premiums equal 2% of household income (except individuals ≤5% FPL pay \$1)

- ***Consequences of nonpayment for individuals ≤100% FPL***
 - Receive less generous benefit package
 - Subject to Medicaid cost sharing
- ***Consequences of nonpayment for individuals >100-138% FPL***
 - Dis-enrolled after 60-day grace period and locked out for 6 months
 - May reenroll after 6 months without repayment of unpaid premiums; incur debt to MCO for unpaid premiums

Indiana's premiums are in the form of a contribution to a health savings-like account.

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Cost Sharing

15

States may impose copayments on most Medicaid-covered benefits without a waiver (some populations exempted):

- ❑ States have discretion to charge nominal co-payments for individuals $\leq 100\%$ FPL
- ❑ States may charge higher co-payments for individuals $> 100\%$ FPL

Waiver authority is limited; CMS has granted one state a cost-sharing waiver.

INDIANA

- Indiana has a two-year waiver to test the use of co-payments up to \$25 for new adults for repeated non-emergency use of the ED
 - The first non-emergency visit in a year is subject to an \$8 co-pay (allowed without a waiver)
 - Subsequent non-emergency visits in a year are subject to a \$25 copay
- State must have a control group of 5,000 new adults to evaluate this approach
- Co-payments are waived if the individual calls MCO's 24-hour nurse hotline prior to using the ED

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Health Savings-Like Accounts (HSAs)

16

- Some states are providing Health Savings-like Accounts (HSAs) for newly eligible beneficiaries.
- HSAs are not specifically addressed in federal law; contributions generally would be considered premiums.

ARKANSAS

- "Independence Accounts" for enrollees $> 100\%$ FPL are funded by enrollee contributions and federal funds
 - $> 100 - 129\%$ FPL: \$10/month
 - $> 129 - 133\%$ FPL: \$15/month
- Payment of Independence Account contributions is not a condition of eligibility

INDIANA

- "POWER" accounts are jointly funded by beneficiary premiums and the State
- The State funds the difference between the beneficiary's monthly premiums and the full \$2,500 POWER account value

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Healthy Behavior Incentives

17

Some states are seeking to incent healthy behaviors by forgiving co-pays or premiums for meeting certain health standards. Depending on design, a waiver might be needed.

Examples of “Healthy behaviors” :

- Completion of a health risk assessment
- Completion of a preventive annual health visit
- Participation in a disease management program

MICHIGAN

- Individuals >100 - 133% FPL who complete healthy behaviors:
 - Receive a 50% reduction in required contributions to Health Savings-like Accounts
 - Are eligible for reduced copays
- Individuals ≤100% FPL who complete healthy behaviors:
 - Receive a \$50 gift card
 - Are eligible for reduced copays

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Connecting to Work

18

States may be able to connect newly eligible individuals to work programs.

- CMS does not permit states to condition Medicaid eligibility on work requirements
- CMS may allow states to auto-enroll beneficiaries in work programs

NEW HAMPSHIRE

Unemployed beneficiaries are referred to the Department of Employment Security for employment and career assistance services

PENNSYLVANIA (not implemented)

The State may use State funding to establish incentives for job training and work-related activities

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Benefits and Coverage

18

States are interested in customizing benefits and coverage provisions for new adults.

CMS has:

- Granted limited waivers for non-emergency medical transportation (NEMT) services
- Not granted states' requests to waive the ESPDT requirement for 19- and 20- year olds
- Except in one situation, has not allowed waivers of retroactive coverage until state can show prompt, continuous coverage

IOWA

- Received a one-year waiver, followed by a 7-month extension, of the requirement to provide NEMT pending review of State data on access to care

NEW HAMPSHIRE

- CMS will consider waiver of retroactive coverage pending submission of data showing that State is providing "seamless coverage"

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Delivery Systems

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States Use Different Delivery Models for Expansion 21



Medicaid Managed Care



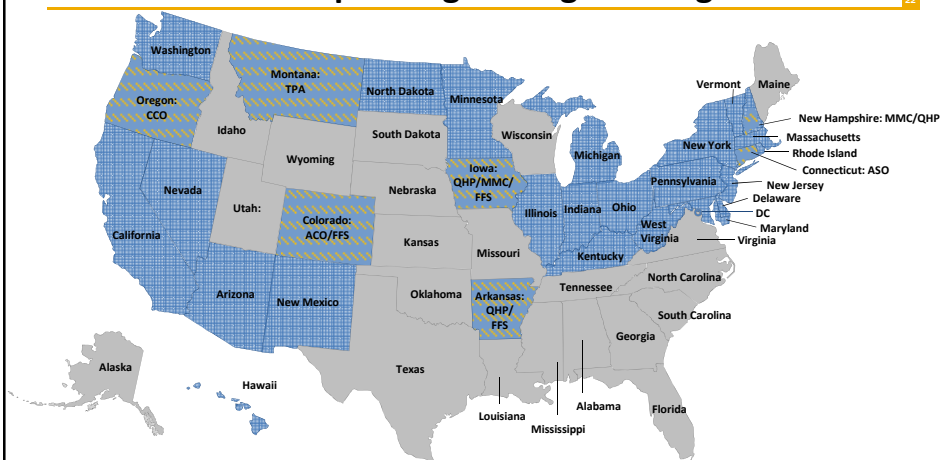
Premium Assistance for Qualified Health Plans (QHPs)



Premium Assistance for Employer-Sponsored Insurance (ESI)

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Most States are Expanding Through Managed Care 22



KEY			
	States expanding through MMC (22 + DC)		States not expanding at this time (21)
	States expanding, <i>not</i> through MMC or partially through MMC (7)		
			QHP – QHP Premium Assistance
			FFS – Fee-for-service Medicaid
			MMC – Medicaid Managed Care
			ACO – Accountable Care Organization
			ASO – Administrative Services Organization
			CCO – Coordinated Care Organization
			TPA – Third Party Administrator

Medicaid expansion decisions as of June 2015. Montana has passed legislation to implement an alternative expansion but has not yet submitted a waiver request to CMS.

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Premium Assistance for Qualified Health Plans (QHPs) 23

- Medicaid pays premiums to enroll newly eligible adults in QHPs
- Medicaid “wraps” benefits missing from the QHP benefit package and pays cost sharing in excess of Medicaid allowable levels
 - May not be mandatory, unless the state receives an 1115 waiver

ARKANSAS

Arkansas is paying premiums to enroll all newly eligible adults who are not medically frail in QHPs.

NEW HAMPSHIRE

Beginning in 2016, New Hampshire will utilize a premium assistance model to enroll newly eligible adults who are not medically frail in QHPs.

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Premium Assistance for Employer-Sponsored Insurance 24

- Medicaid pays employee share of premiums to enable enrollment in ESI if cost effective
- Medicaid “wraps” benefits missing from the ESI benefit package and covers cost sharing above Medicaid limits
- Waiver may be required, for example, if State does not provide benefit or cost sharing wrap or has a different approach to cost effectiveness

IOWA


Iowa offers ESI premium assistance as an option for new adults if cost effective.

NEW HAMPSHIRE





New Hampshire established a mandatory ESI premium assistance program for newly eligible adults if enrollment in ESI is cost effective.

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Sustaining Expansion



Sustaining Expansion 28

-  Savings from New Coverage
-  Provider and Health Plan Financing
-  Delivery System Reform
-  Sunset Provision

"A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage."
CMS Guidance, 12/10/2012



Savings

27

States are using general fund savings and new revenues from provider/plan assessments to finance the State's share of expansion costs in future years when the federal matching rate dips.

In Arkansas and Kentucky, savings and revenue gains are expected to offset costs of the expansion at least through SFY 2021.

ARKANSAS

Arkansas estimated it will save \$118 million related to Medicaid expansion in SFY 2015.

KENTUCKY

Kentucky estimated it will save \$83 million related to Medicaid expansion in SFY 2015.

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Provider and Health Plan Financing

28

States are relying on providers and health plans to help finance the State's share of Medicaid expansion and protect against any unexpected costs.

COLORADO

Colorado will use revenue from a hospital provider fee enacted in 2009 to support state costs associated with Medicaid expansion.

INDIANA

Beginning in 2017, Indiana will use cigarette tax revenues with a recalculated version of its Hospital Assessment Fee enacted in 2011 to support state costs associated with Medicaid expansion.

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Containing Costs Through Delivery System Reform 29

Virginia Medicaid Delivery System Landscape

- Managed care enrollment is mandatory for families and children-related groups and individuals who are aged, blind, or disabled
 - Over 70% of Virginia's Medicaid beneficiaries are enrolled in managed care
 - Seven managed care organizations (MCOs) provide services to Medicaid beneficiaries
- High needs enrollees drive program costs
 - Approximately 65% of Medicaid spending is for individuals with disabilities and seniors, who represent 26% of Medicaid enrollment

Targeted Delivery System Reforms to Contain Costs and Improve Quality

- Imposing value-based purchasing through MCOs, consistent with new provisions proposed by CMS regulations
- Promoting the implementation of new delivery and payment models, such as:
 - Bundled payments
 - Improving care and care coordination, particularly for high need enrollees
 - Enhanced population health management
- Rebalancing Medicaid long-term services and supports (LTSS)

Source: Virginia Department of Medical Assistance Services, *Virginia Medicaid at a Glance*, SFY 2013; Virginia Department of Medical Assistance Services, *2014 Managed Care Annual Report*, 2014

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State Examples of Delivery System Reform 30

TENNESSEE

- To rebalance Medicaid long-term services and supports (LTSS) enrollment and expenditures in favor of home and community-based care, the State integrated a managed LTSS program with its existing managed care delivery system
- MCOs regularly assess Nursing Facility (NF) residents' interest in and potential for transitioning to the community
 - MCO care coordinators develop beneficiary care plans detailing the type and amount of home and community-based services (HCBS) to be provided to ensure the beneficiary's needs are met in the community
 - MCOs are eligible for financial incentives for completed transitions if they meet benchmarks set by the State

MICHIGAN

- Michigan recently issued a new RFP for Medicaid MCOs that places a strong emphasis on population health management and increased use of value-based payment models
- MCOs will be required to promote the use of the PMCH model, identify opportunities to address the social determinants of health, and collaborate with community-based organizations on population health initiatives

ARKANSAS

- Arkansas is implementing the Arkansas Health Care Payment Improvement Initiative, in which public and private payers:
 - Assign individuals to patient-centered medical homes (PCMHs)
 - Assign high-need patients to Health Homes
 - Institute episode-based payments for specified conditions
- All QHP issuers are required to participate in the Initiative's PCMH component
- Since Arkansas is using QHP premium assistance for its expansion, the Initiative is substantially increasing the number of Arkansans with a PCMH, creating opportunities for improved care and practice transformation

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Sunset Provisions

31

Some states are including in their expansion legislation sunset provisions and reauthorization requirements tied to any drop in the federal matching rate relative to current law.

ARKANSAS

- If the federal match rate decreases below statutory levels, Arkansas's expansion would terminate within 120 days
- Arkansas's legislature must reauthorize expansion for it to continue past December 31, 2016

NEW HAMPSHIRE

- If the federal match drops below 100% before December 31, 2016, expansion will sunset
- New Hampshire's legislature must reauthorize expansion for continuation beyond December 31, 2016

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Department of Medical Assistance Services



BMAS Discussion Questions

- What do you see as the benefits of expansion? Which ones would resonate with your peers?
- Do you want to recommend that certain design options or principles be included in any expansion?
- Do you want to send a letter to Governor and/or the General Assembly supporting Medicaid expansion?

32

32



Delivery System Reform Incentive Payment Explanation and Process Update

July 28, 2015

Suzanne Gore, Deputy Director
Virginia Department of
Medical Assistance Services

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

1



Contents

- Overview of SIM
- What is DSRIP?
- What does DSRIP Mean for Virginia?
- Other State's who have an Approved or Pending DSRIP Waiver
- Emerging DSRIP Trends
- Intersection of SIM and DSRIP
- Waiver Development Components
- Governance Waiver Development
- Timeline
- Value Based Purchasing (Why it's important)
- BMAS Discussion Questions

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

2



State Innovation Model (SIM) Grant

Provides **financial and technical support** for the development and testing of state-led, multi-payer **health care payment and service delivery models.**

States could seek a model design (up to \$3M) or model testing (up to \$100M) grant. Preference was given to states that had expanded Medicaid.

Virginia Center for Health Innovation received a \$2.6M Design Grant.



Key Components of SIM

- ✧ **Lieutenant Governor's Roundtable and Core Sets of Population Health and Quality Metrics**
- ✧ **Accountable Care Communities**
- ★ **Delivery System Reform Incentive Payment (DSRIP) Waiver**

In all, the process is looking to focus Virginia's measurement efforts and substantively move the needle on performance.



What is DSRIP?

- Delivery System Reform Incentive Payment (DSRIP) waivers provide financial incentives to achieve delivery system through:
 - Infrastructure Development
 - System Redesign
 - Clinical Outcome Improvements
 - Population-focused improvements
- CMS has approved seven DSRIP programs to date (CA, NM, TX, KS, NJ, MA, NY).
- DSRIPs are NOT grant programs, they are performance based incentive programs.



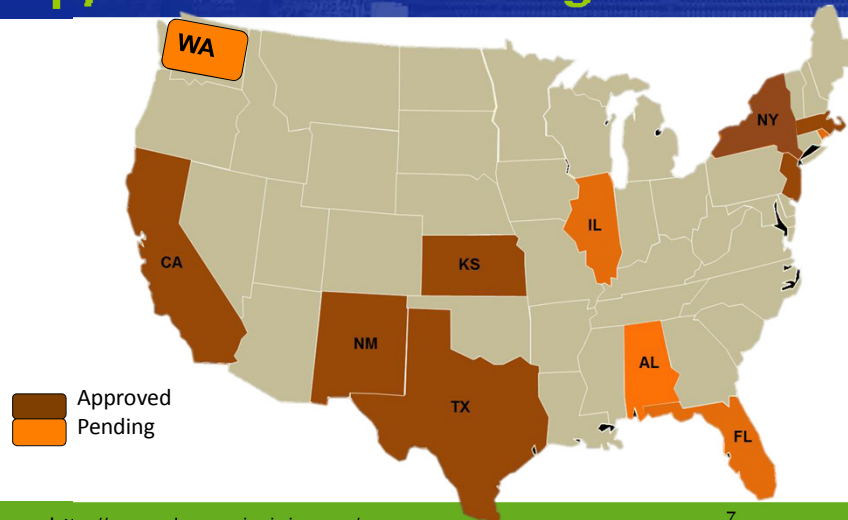
What does DSRIP mean for VA?

Higher value care and services for Virginians

- The ability to measure and quantify improvements in our delivery system.
- Funding for much needed infrastructure to support populations who are in great need in VA, and the providers that provide care to them.
- Significant opportunity for innovation and overall cost savings to both the state and federal government.



Approved and Pending DSRIPs



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

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Emerging DSRIP Trends from CMS

- **Vision**
- **Overarching goal**
 - data to support why this goal is important for their state
- **Focus on behavioral health:**
- **Measurement of outcomes**
 - infrastructure to collect and analyze data to measure the impact of DSRIP on regional outcomes and expenditures (DSRIP can pay for this data infrastructure and data analytics)
- **Sustainability:**
 - CMS expects the program to become self-supporting over time and eliminate the need for continued federal subsidy

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

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Intersection of SIM and DSRIP



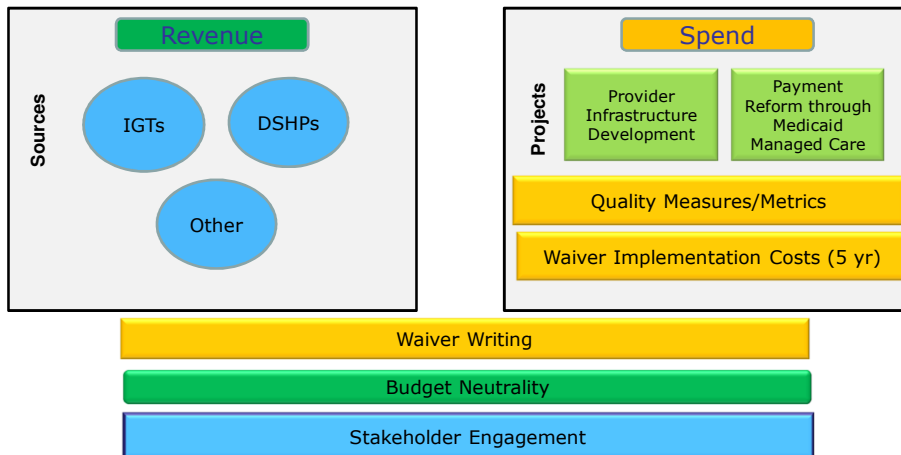
Possible SIM project funding via DSRIP

27 SIM projects from 8 workgroups and three subgroups

- 1) Population Health, Quality, Payment, HIT
- 2) Care Transitions
- 3) Workforce
- 4) Medicaid Innovation
- 5) VBID/Choosing, Wisely
- 6) Telehealth
- 7) Integrated Care (Behavioral Health, Oral Health, Complex Care)



Waiver Development Components





Governance – Waiver Development

Steering Group



Operating Group

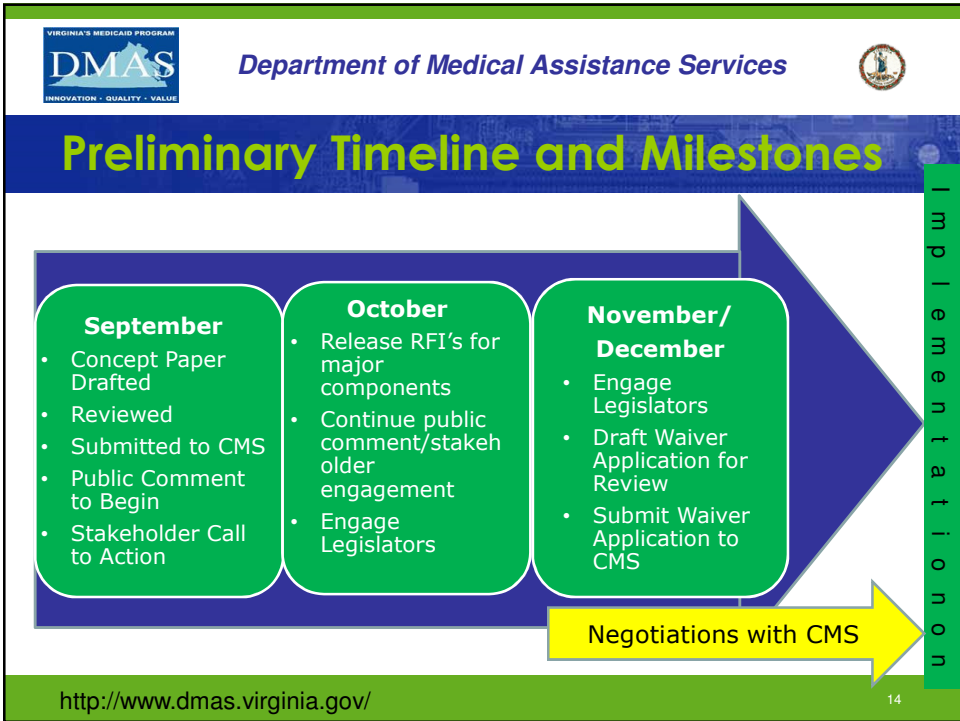
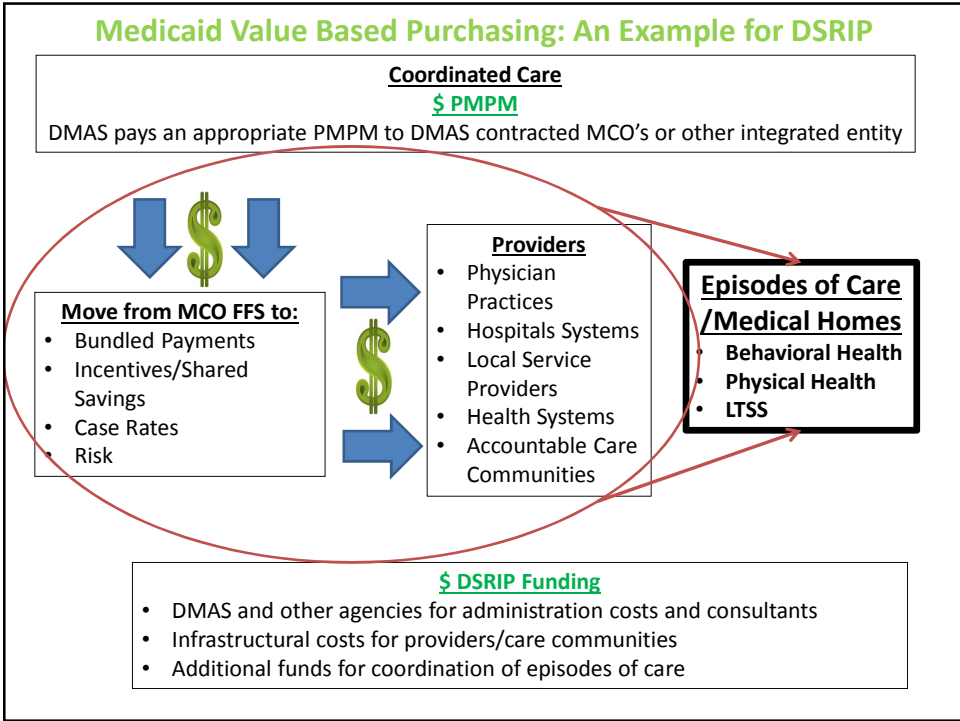
- **Chair:** Secretary Hazel (Chair)
- **Members:** Anna James, Cindi Jones, Debra Ferguson, Marissa Levine, David Brown
- **Responsibilities:** Make major decisions on direction of DSRIP Waiver Program

-
- **Lead:** Suzanne Gore
 - **Participants:** TBD
 - **Responsibilities:** Working level group focused the following activities:
 - review waiver development project progress
 - make working level decisions on DSRIP waiver design
 - escalate major decisions to Steering Group with recommendations



Link the Vision to Goals & Tactics







BMAS Discussion Questions

- What do you see as the benefits of a DSRIP waiver?
- What areas of the health system do you think need the most improvement?
- What are innovations that you see as valuable and needed for consideration as DSRIP projects?



Appendix: Project Charter

Project Objective	Design DSRIP Waiver to achieve the desired vision and goals	Timeframe	Submit Waiver Mid December, 2015
		Project Sponsor	Secretary Hazel
Approach and Deliverables		Anticipated Benefits	
<ul style="list-style-type: none"> ▪ Deliverables: <ul style="list-style-type: none"> ▪ Concept papers to CMS ▪ Complete waiver application and submit to CMS ▪ Approach: <ul style="list-style-type: none"> ▪ Organize with a focus on Revenue and Spend components of the waiver ▪ Design provider infrastructure and payment reform model ▪ Utilize work of SIM as input into the design ▪ Create Concept Paper through feedback from CMS ▪ Complete waiver application ▪ Facilitate interagency collaboration and partnership with the Virginia Center for Health Innovation ▪ Engage stakeholders to receive input into the design and gain buy-in 		<ul style="list-style-type: none"> ▪ Coordinated delivery of whole person, community based care with improved health outcomes as a result of enhanced financing for infrastructure and payment reform through a §1115 Waiver. 	
		Project Stakeholders	
		<ul style="list-style-type: none"> ▪ Constituents/Medicaid beneficiaries, providers, public/private /local delivery systems, local government, Medicaid health plans 	
		Out of Scope	
		This program will not address: poverty, early childhood education, GME, COPN, others?	

Regulatory Activity Summary for July 28, 2015
(* Indicates recent activity)

2015 General Assembly

***(01) Expand Alzheimer's Waiver:** This regulatory action is required by 2015 budget language. This regulation will more broadly define eligible individuals that may be served by the Alzheimer's Assisted Living waiver program. The final exempt regulation is scheduled to be published in the Register on 8/10/15 and will become effective on 9/9/15.

(02) 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 are currently being drafted.

***(03) 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 sent to CMS on May 12, 2015. Once the state plan is approved, DMAS will promulgate VAC changes.

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

(05) 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 reviewed by the Governor.

***(06) 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 NOIRA was submitted to the Department of Planning and Budget (DPB) on 7/7/15.

(07) Standards for Home and Community-Based Settings: This regulatory action will require providers to comply with all of the relevant requirements of 42 CFR 441.530 et seq. with regard to the qualities required for community settings. These text changes are currently being drafted.

***(08) Restore ER Physician Reimbursement; Supplemental Payments Related to Freestanding Children's Hospitals; and Supplemental Clinic Payments to VDH:** 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) is currently being drafted.

(09) Eliminate Hospital Inflation: This action will eliminate inflation for inpatient hospital operating, graduate medical education, disproportionate share hospital, and indirect medical education payments in FY16. A prior public notice was published and a SPA is currently being drafted.

(10) Eliminate Nursing Facility Inflation and & "Hold Harmless" Price-Based Rates: This action will eliminate inflation for nursing facilities in FY16, and will 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 is currently being drafted.

(11) 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 is currently being drafted.

***(12) 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.

***(13) Medicaid and CHIP Eligibility – Same Sex Marriage:** This action changes the Virginia state plan to recognize same-sex couples as spouses for purposes of determining Medicaid eligibility. The CHIP state plan amendment was submitted to CMS on 6/25/15. The Medicaid state plan amendment has been drafted and is circulating through the Agency for review. Once the SPAs are approved, regulatory changes will be drafted.

2014 General Assembly

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

***(02) No Inflation Reimbursement Methodology Changes:** This action affects hospitals, home health agencies, and outpatient rehabilitation providers. Chapter 2 of the *2014 Acts of the Assembly*, Item 301 CCC and IIII directed this change. The SPA was approved by CMS on 6/15/15. Changes to parallel administrative code sections became effective on 4/22/15.

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

***(04) Hospital DSH Reduction:** This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA was approved by CMS on 6/2/15 and a fast track regulatory action is circulating through the Agency for review.

***(05) NF Price Based Reimbursement Methodology:** This action changes the cost-based methodology with the priced based method and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 KKK. The SPA was approved by CMS on 5/4/15. Fast Track changes to parallel administrative code sections are being reviewed by DPB.

***(06) Hospital APR-DRG Methodology Change:** This action changes the APR-DRG grouper for hospital reimbursement and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 VVV. The SPA was approved by CMS on 6/2/15 and changes to parallel administrative code sections are being reviewed by DPB.

***(07) Type One Hospital Partners' Supplemental Payments:** This action provides supplemental payments to Type One hospitals (state-owned teaching hospitals) qualifying partners and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 DDDD. The SPA was approved by CMS on 1/27/2015. The VAC action was submitted to the OAG for review on 5/28/15.

***(08) 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 will incorporate the changes from both emergency regulations, is circulating through the Agency for review.

***(09) HIV Premium Assistance Program:** The agency published a notice of periodic review for this small program and is initiating a rule making action. The changes to be made are: (i) individuals will no longer have to be unable to work; (ii) income considered during the eligibility determination process will be that of only the individual and spouse (rather than family), and; (iii) liquid countable assets is being expanded to include more types beyond the

limited list in the regulations. The agency drafted a Fast Track action for the VAC changes, which are being reviewed by the Governor. No SPA is required.

***(10) GAP FAMIS Coverage of Children of State Employees:** The agency began work developing this FAMIS expansion in early September in response to the Governor's directive. It provides FAMIS coverage for the children of state employees who have low incomes. The emergency regulation became effective 1/1/2015, and the permanent replacement regulation is awaiting the Secretary's review. A companion Title XXI SPA was submitted to CMS.

***(11) GAP Dental Services for Pregnant Women:** The agency began work developing this Medicaid service expansion in early September in response to the Governor's directive. It provides complete, with the exception of orthodontia, dental service coverage to the 45,000 Medicaid-eligible pregnant women. The emergency regulation became effective on 3/1/2015 and the permanent replacement regulation is undergoing review at DPB. CMS approved the SPA on 5/18/15.

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

(13) Mandatory Managed Care (Medallion 3.0) Changes: This emergency regulation action requires individuals who receive personal care services via the Elderly or Disabled with Consumer Direction waiver to obtain their acute care services through managed care. It also shortens the time period for pregnant women to select their managed care organizations and complete the MCO assignment process. This emergency regulation became effective on 1/1/2015 and the permanent replacement regulation was submitted to the OAG on 4/2/15 for certification.

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

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 is being drafted.

(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 is still pending OAG certification. 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 submitted to DPB on 5/11/15.

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

(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 and the NOIRA for the proposed stage is undergoing review by the Governor.

(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 was put on hold, but has been re-activated and the NOIRA is undergoing review by the Governor.

2012 General Assembly

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

(02) 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 of the permanent replacement regulations awaits the Governor's approval.

***(03) 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 is in effect from 1/1/14-12/30/15. The proposed stage regulation awaits the Governor's approval.

2011 General Assembly

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

(02) Client Medical Management (CMM): The Emergency/NOIRA action was designed to assist and educate beneficiaries in appropriately using medical and pharmacy services. Members who use these services excessively or inappropriately, as determined by DMAS, may be assigned to a single physician and/or pharmacy provider. DMAS received an extension of the emergency regulation, which is effective 12/16/13 to 12/15/2015. The fast-track stage is awaiting the Governor's signature.

***(03) 2011 Exceptions to Personal Care Limit:** This action complied with the legislative mandate to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services (which includes supervision time). The final stage documents were sent to the Governor on 5/19/2015.

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 is preparing a response.

2009 General Assembly

(01) Social Security Number Data Match for Citizenship and Identity: This Fast-Track change conforms to CHIPRA of 2009 which offers states a new option to assist Medicaid applicants and recipients in the verification process. Section 211 of CHIPRA gives states the ability to enter into a data match with the Social Security Administration to verify the citizenship and identity of Medicaid applicants and recipients who claim to be United States

citizens. Because provision of a Social Security number is already a condition of eligibility for Medicaid, adoption of this option will remove a barrier to enrollment and will result in a more seamless application process for most Medicaid applicants and recipients. This regulatory package is currently at the Governor's office pending approval.

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.