

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

**December 9, 2014  
DRAFT Minutes**

**Present:**

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

**Absent:**

Mirza Baig  
Maria Jankowski

**DMAS Staff:**

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

**Speakers:**

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

**Guests:**

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

**CALL TO ORDER**

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

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

### **APPROVAL OF MINUTES FROM SEPTEMBER 9, 2014 MEETING**

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

### **DIRECTOR'S REPORT**

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

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

Ms. Nablo briefly discussed several updates and programmatic changes:

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

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

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

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

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

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

### **UPDATE ON MEDICAID FORECAST**

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

### **ELIGIBILITY AND ENROLLMENT TRANSFORMATION**

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

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

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

### **2015 GENERAL ASSEMBLY SESSION**

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

### **REGULATORY ACTIVITY SUMMARY**

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

### **OLD BUSINESS**

None.

### **ADJOURNMENT**

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

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

Step 1	<b>The Governor's Access Plan for Medical and Behavioral Health Services - Reaching Virginia's Uninsured with Serious Mental Illness (20,000 adults)</b>
Step 2	<b>Covering our Children - Reaching More Children through Medicaid and FAMIS (35,000 children)</b>
Step 3	<b>Supporting Enrollment in the Federal Marketplace - Reaching More Virginians during Open Enrollment (160,000 individuals)</b>
Step 4	<b>Informing Virginians of their Health Care Options - Reaching more Virginians through Cover Virginia</b>
Step 5	<b>Making Dependent Coverage Affordable for Lower-Income State Employees - Reaching More Children through FAMIS (5,000 children)</b>

<b>Step 6</b>	<b>Providing Comprehensive Dental Coverage to Pregnant Women in Medicaid and FAMIS - Improving Access to Oral Health Care (45,000 women)</b>
Step 7	<b>Prioritizing the Health of Virginia's Veterans - Accelerating Veterans' Access to Care</b>
Step 8	<b>Winning a State Innovation Model Grant - Seizing Opportunity to Transform Health Care Delivery</b>
Step 9	<b>Creating Behavioral Health Homes - Strengthening Virginia's Behavioral Health System through Innovation (13,000 individuals)</b>
Step 10	<b>Reducing Prescription Drug and Heroin Abuse - Stemming a Devastating Proliferation of Substance Abuse</b>



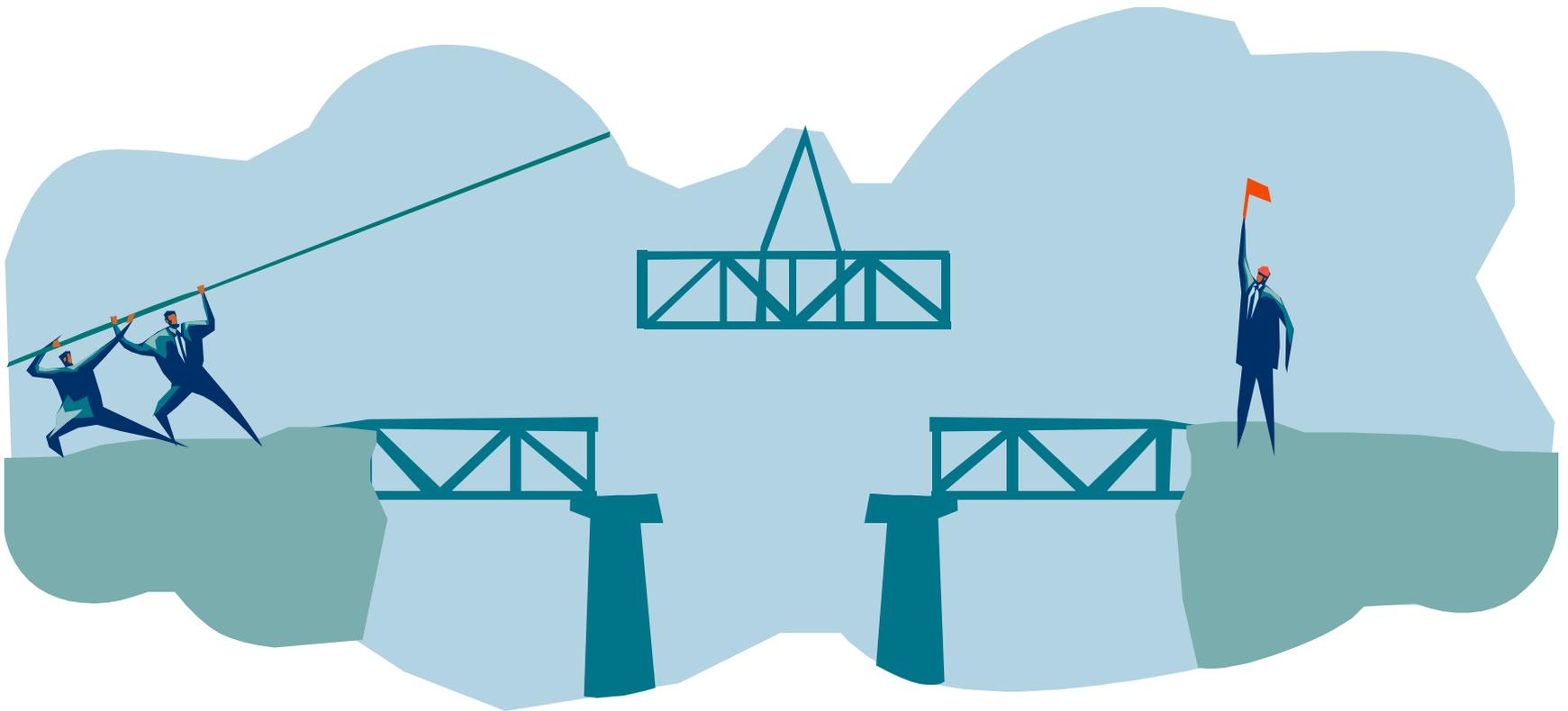
# GOVERNOR'S ACCESS PLAN FOR THE SERIOUSLY MENTALLY ILL (GAP)

Karen Kimsey, Deputy Director of Complex Care and Services  
Virginia Department of Medical Assistance Services  
Board of Medical Assistance Meeting

December 9, 2014



# The Mental Health Coverage GAP in VA



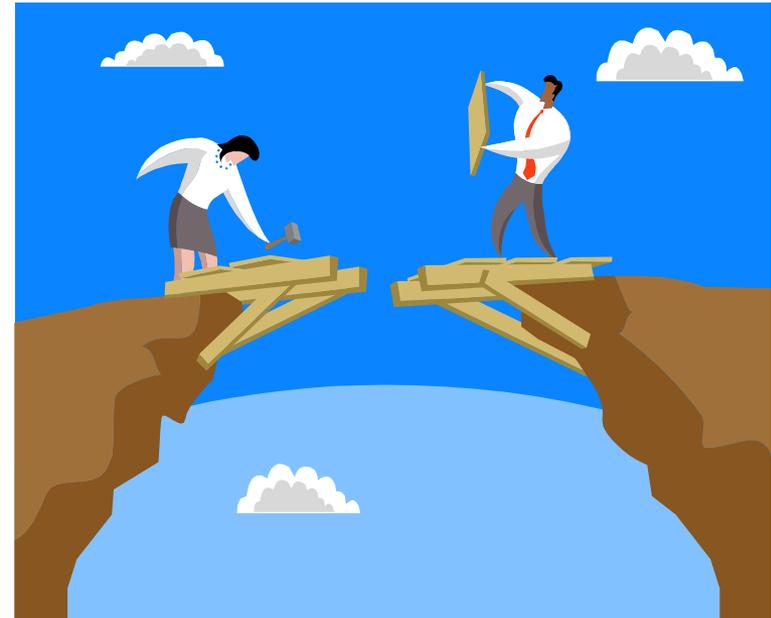


# The Mental Health Coverage GAP in VA

- National Statistics show that in the past year, nearly 20% of adults experience some form of behavioral health condition and 4.1% of Americans experience a Serious Mental Illness (SMI). Among low-income, uninsured populations, these figures are significantly higher.
- More than 50,000 of the 300,000 Virginians with SMI are uninsured.
- Individuals with SMI have an increased risk for co-morbid medical conditions such as diabetes, heart disease, and obesity. Nearly 50% of individuals with SMI have a co-occurring substance use disorder.
- SMI has systemic effects on social issues: homelessness, disability, substance abuse, crime, etc.

# The Mental Health Coverage GAP in VA

- SMI and co-occurring disorders and conditions are **HIGHLY** treatable.
- We believe that establishing a benefit plan that targets individuals with SMI will enable them to access behavioral and primary health services in order to help them recover, live, work, parent, learn, and participate in their communities.





**Bridging the Mental Health  
Coverage Gap in Virginia**

# The Governor's Access Plan

The Governor's Access Plan (GAP) for the seriously mentally ill is step 1 of a 10 point action plan toward *A Healthy Virginia*.

If approved by CMS, the GAP §1115 Demonstration Waiver will provide a targeted benefit package for approximately 20,000 uninsured, low income Virginians who have a serious mental illness.

The GAP will provide basic medical and targeted behavioral health care services through an integrated and coordinated delivery model to qualifying individuals with SMI.

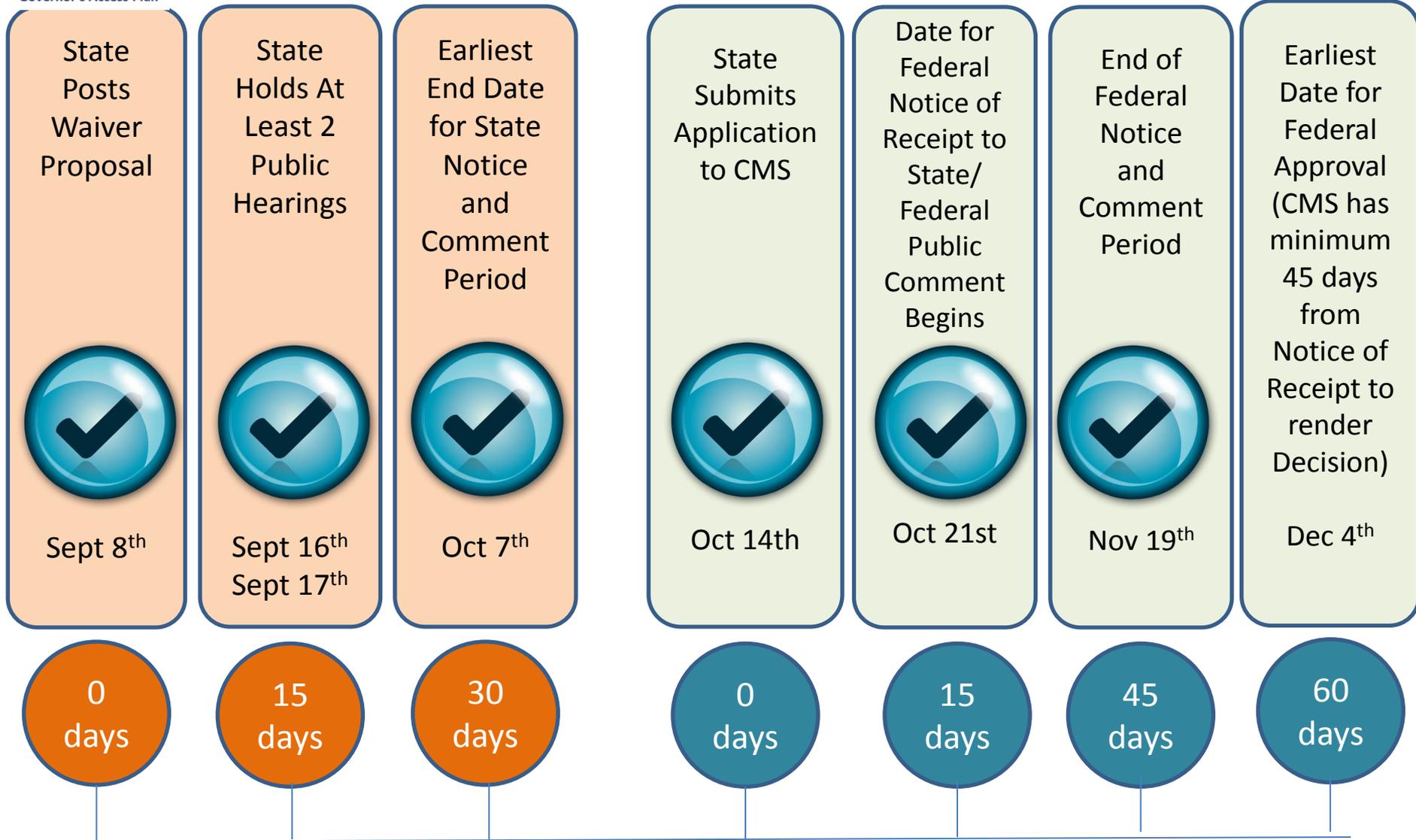
The GAP program will launch in early January of 2015.

# GAP Demonstration Goals

## Three key goals of the GAP Demonstration include:

1. To improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs;
2. To improve health and behavioral health outcomes of demonstration participants; and,
3. To serve as a bridge to closing the insurance coverage gap for uninsured Virginians.

# §1115 Waiver Application Timeline



# GAP Delivery System

GAP will leverage the DMAS established infrastructure to administer the GAP program

- Medical and pharmacy services will utilize the existing Medicaid fee-for-service provider networks and will follow existing Medicaid coverage rules and reimbursement policies.
- Some medical services require service authorization which will continue to be performed by KePRO, the current DMAS service authorization contractor.
- Behavioral health, network management, service authorizations, and claims will continue to be managed by Magellan of Virginia, DMAS' Behavioral Health Services Administrator (BHSA).

# GAP Eligibility Requirements

In order to be eligible, individuals must meet ALL of the requirements outlined below, which are reviewed and verified by Cover Virginia:

- Adult age 21 through 64 years old;
- U. S. Citizen or lawfully residing immigrant;
- Not eligible for any existing entitlement program including: Medicaid, Medicare, or TriCare;
- Resident of Virginia;
- Household income that is below 100% of the Federal Poverty Level (FPL);
- Uninsured;
- Not residing in a long term care facility, mental health facility, or penal institution; and
- Screened and meet the criteria for GAP SMI.

# GAP Eligibility Process

GAP eligibility is a two step process:

1. Financial/non-financial determination; and
2. GAP SMI determination.

Individuals may start at either step to enter the GAP Program.

# Cover Virginia

"Cover Virginia" manages GAP applications and determines program eligibility:

- Receives online and telephonic applications for the GAP Program;
- Provides a toll free customer service line;
- Determines eligibility;
- Sends member handbook; and
- Handles individuals' appeal of eligibility related adverse actions.

# GAP SMI Screening

- GAP SMI screening may be conducted by:
  - Community Services Boards (CSBs)
  - Federally Qualified Health Centers(FQHCs)
  - Inpatient Psychiatric Hospitals
  - General Hospitals with an Inpatient Psychiatric Unit
- GAP SMI screenings are submitted to Magellan for final approval through a secure on-line web entry portal.
- Applicants do not need to wait for the financial/non-financial information to be reviewed prior to being referred for the GAP SMI Screening.

# GAP SMI Screening

- GAP SMI is determined via the use of the GAP Serious Mental Illness Screening Tool
- The screening tool addresses 5 areas:
  - Age
  - Diagnosis
  - Duration of Illness
  - Level of Disability, and
  - Whether due to mental illness the individual requires assistance to consistently access and utilize needed medical and/or behavioral health services/supports.

# GAP Eligibility (Annual Review)

- Individuals meeting the eligibility requirements are enrolled for a period of 12 continuous months except in the following cases; the individual:
  - reaches their 65<sup>th</sup> birthday
  - Moves out of the Commonwealth of VA
  - Is Deceased, or
  - Becomes enrolled in Medicare or Medicaid.
- After 12 months the financial/non-financial eligibility will be reviewed by Cover VA. Individuals will not need a new GAP SMI Screening for the re-review.



# GAP Benefits

***Integrating care coordination, primary care, specialty care, pharmacy and behavioral health services***

## **Outpatient Medical**

- Primary & Specialty Care
- Laboratory
- Pharmacy
- Diagnostic Services
  - Physician's office
  - Outpatient hospital coverage is limited to diagnostic ultrasound, diagnostic radiology (including MRI and CAT), and EKG including stress
- Diabetic Supplies

## **Outpatient Behavioral Health**

- GAP Case Management
- Psychiatric Evaluation, Management & Treatment
- Crisis Intervention & Stabilization
- Psychosocial Rehab
- Peer Supports
- Outpatient Psych & Substance Abuse (SA) Treatment Services
- SA Intensive Outpatient (IOP)
- Methadone & Opioid Treatment



# GAP Services Through Magellan

Services provided through Magellan include:

- **Care Coordination**, includes identification of the individual's behavioral health, medical and social/community support needs to efficiently achieve the individual outcomes in the most cost-effective manner.
- **Crisis Line** available 24/7 and staffed by licensed mental health professionals.
- **Peer Supports** including a state wide warm telephone line and limited, local, voluntary, in-person supports.



# Preferred Pathway Providers

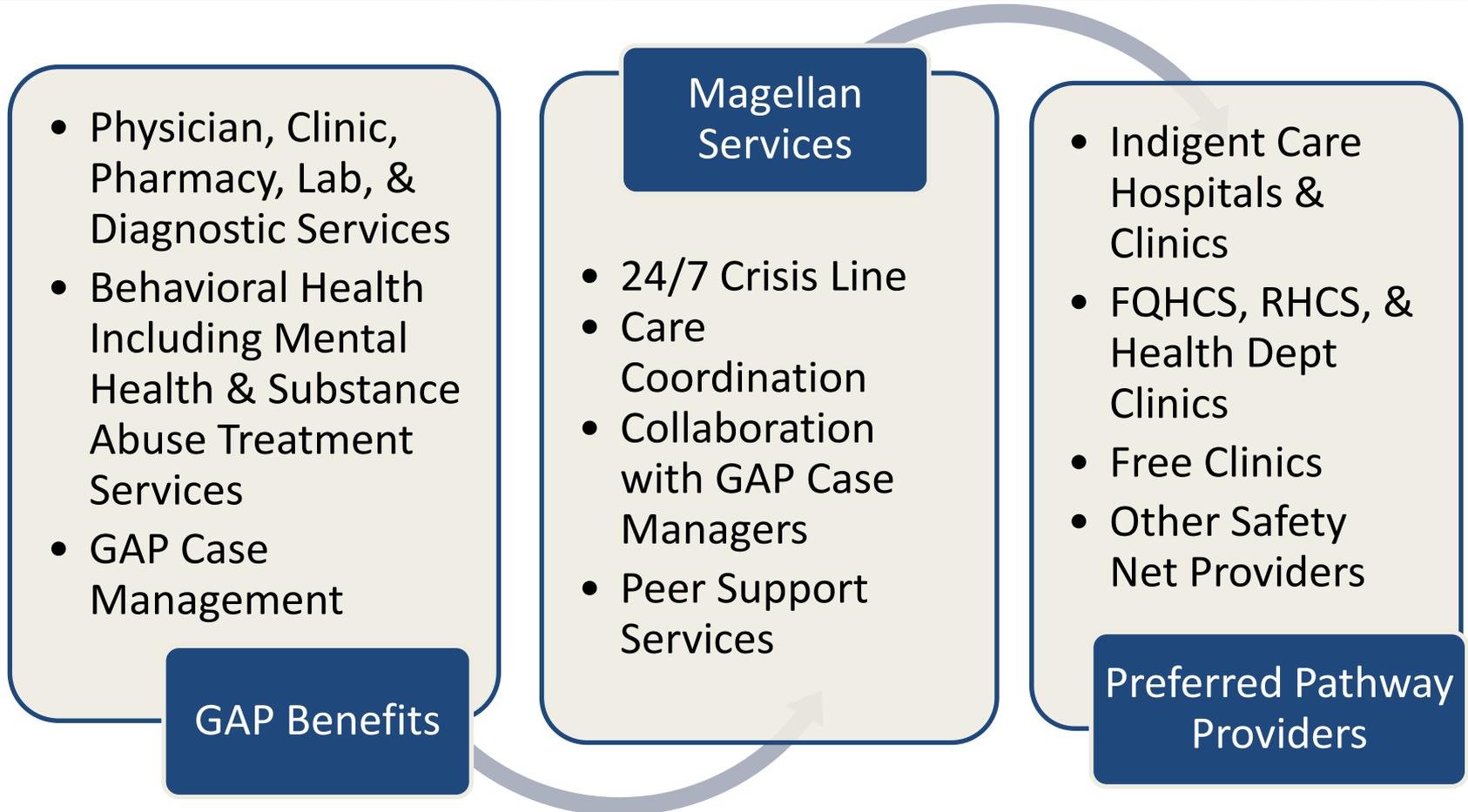
Non-covered medical services will be coordinated through an alternative preferred service pathway using existing indigent care providers.

DMAS and Magellan are working in collaboration with external stakeholders and partners to compile regional lists of preferred indigent care pathway providers to assist GAP beneficiaries in locating non-covered services at a reduced or free rate.

A complete list of covered and non-covered GAP services is available on the DMAS website at [http://www.dmas.virginia.gov/Content\\_pgs/GAP.aspx](http://www.dmas.virginia.gov/Content_pgs/GAP.aspx)



# GAP Integrated Service Delivery



# GAP Trainings & Town Hall Meetings

- Information regarding upcoming trainings and town hall meetings will be posted to the DMAS and Magellan of Virginia websites.
- Recorded web-based presentations will also be posted to both websites. Additional web-based trainings will be announced once the effective dates are finalized.

# GAP Educational Material

The DMAS GAP web-page currently has educational material such as:

- Frequently asked questions
- Fact Sheet,
- Examples of eligible individuals, and
- Information for stakeholders.

[http://www.dmas.virginia.gov/Content\\_pgs/GAP.aspx](http://www.dmas.virginia.gov/Content_pgs/GAP.aspx)



# GAP Web Resources

Virginia DMAS website at:  
[www.dmas.virginia.gov](http://www.dmas.virginia.gov)



Magellan website at:  
<http://www.magellanofvirginia.com/>

Questions pertaining to the GAP demonstration may be e-mailed to  
[BridgetheGAP@dmas.virginia.gov](mailto:BridgetheGAP@dmas.virginia.gov)

# Cover Virginia Operations Overview



**COVER VIRGINIA**

Connecting Virginians to Affordable Health Insurance

**BMAS Board Meeting  
December 9, 2014**

# Cover Virginia Call Center

- **Contract with Xerox signed on June 24, 2013**
- **New call center to serve MAGI population went live on October 1, 2013**
  - **Two sites: Primary site in Richmond & secondary overflow site in Florida**
  - **Accepts telephonic application w/telephonic signatures**
  - **Included new Cover Virginia website for applicants and enrollees**



# Expanding the Scope of Cover Virginia

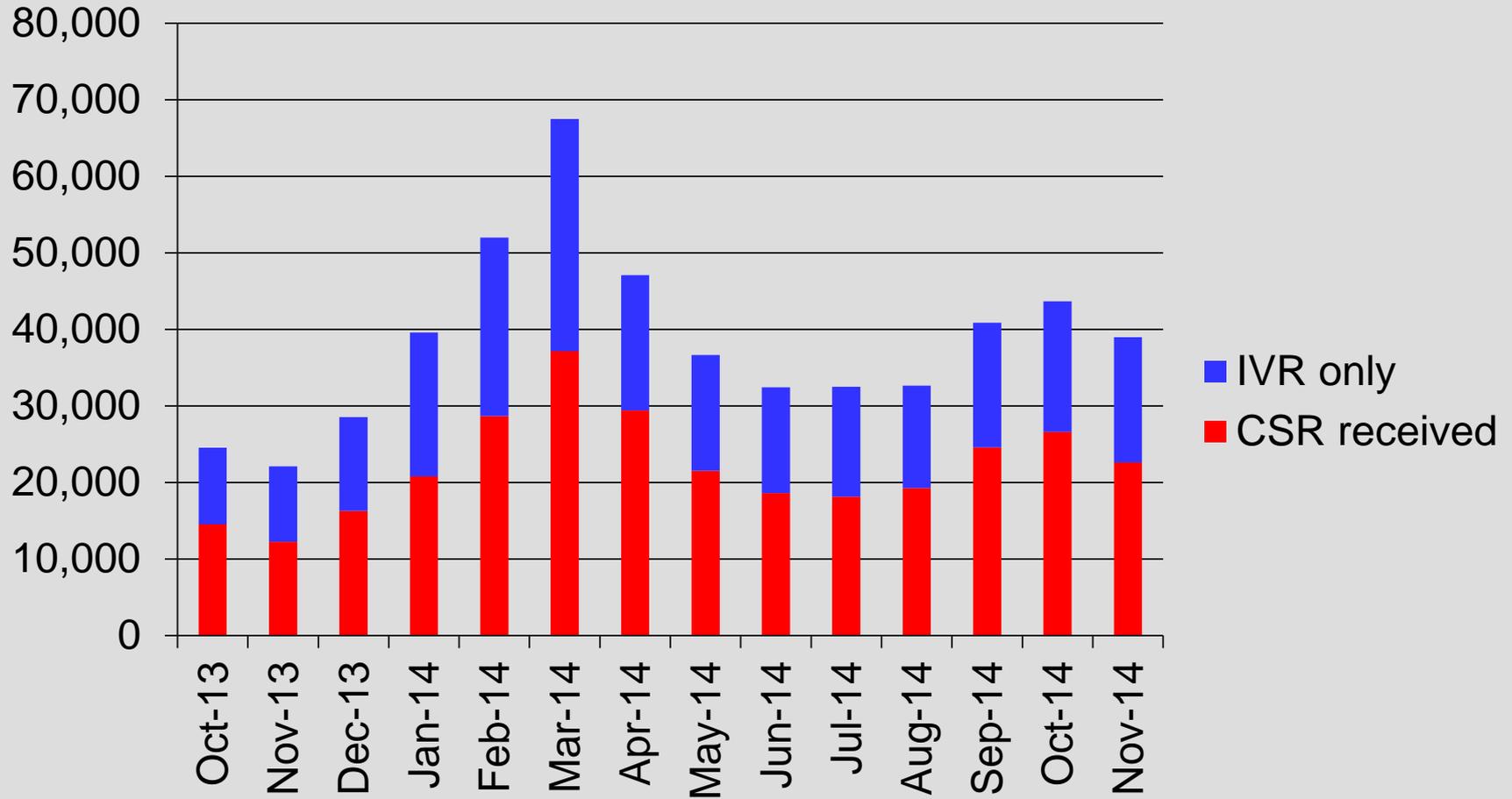


# Cover Virginia Call Center Enhancements

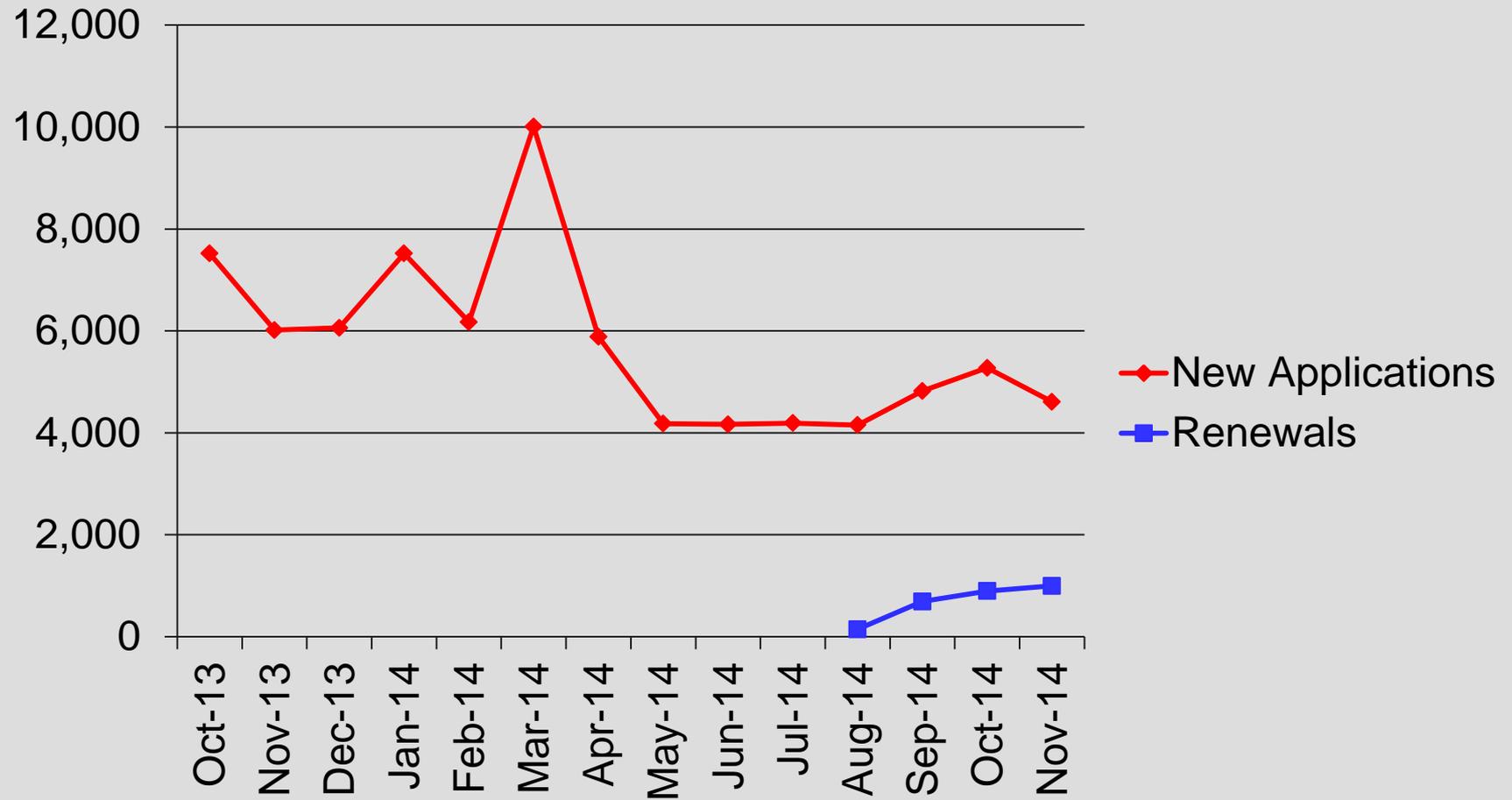
- **New VaCMS Eligibility and Enrollment System Modules - August 25, 2014**
  - **Telephonic renewals**
  - **Reporting changes via the call center**
  - **Automated determinations (*self-directed*)**



# Cover Virginia Call Center



# Telephonic Applications



# Cover Virginia FFM Backlog Project

- Launched August 18, 2014
- FFM Backlog applications from 10/1/13 – 6/30/14 (approximately 47,000)
- 98 eligibility related staff added
- Expanded office space at current call center site
- Project 99% complete as of 12/2/14



# Cover Virginia Central Processing Unit (CPU)

**Coming November – December 2014**

- **Eligibility determination of new telephonic, online, & FFM applications**
- **Multi-benefit applications received via CommonHelp will go to local agency for processing**
- **After determination, cases will be transferred to LDSS for ongoing case maintenance and renewal processing**

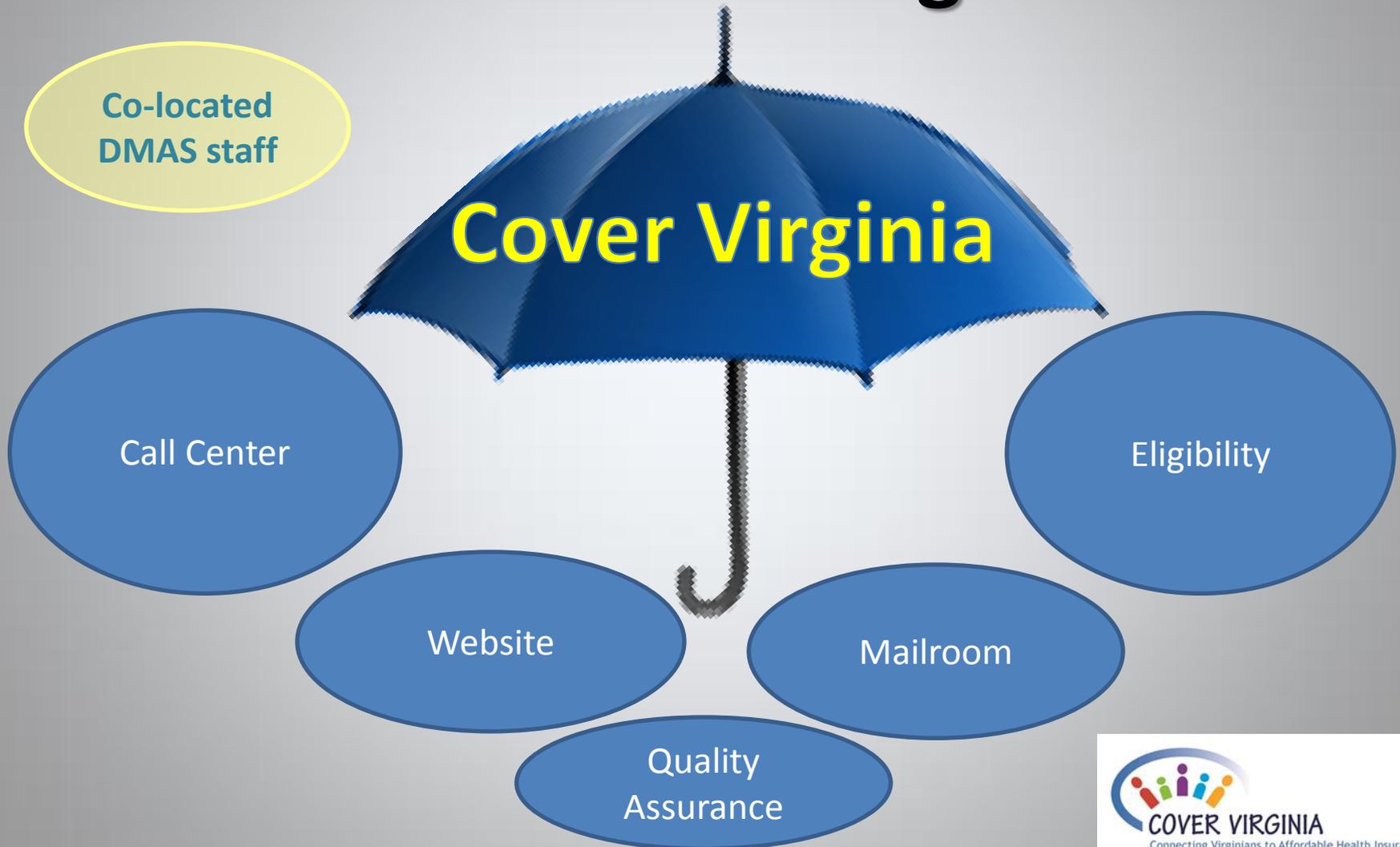


# Cover Virginia Central Processing Unit (CPU)

- Staffing with over 200 eligibility related employees including management
- New secure location for application processing in Richmond – Spring 2015
- Scope of services include: Eligibility, Mailroom, and QA – review of applications within 8 business days
- DMAS Oversight and Contract Monitoring



# Cover Virginia Central Processing Unit



# Cover Virginia

## Governor's Healthy Virginia

- **Eligibility & Enrollment services to support the Governor's Access Program (GAP) for individuals who have a serious mental illness effective January 12, 2015**
  - **New toll-free number**
  - **Telephonic application & provider assisted on-line application**
  - **Dedicated GAP unit**
- **Coverva.org redesign to support Federal Health Insurance Marketplace open enrollment campaign**



# Cover Virginia Website Enhancements

- **Since website relaunch on November 15<sup>th</sup>**
  - **Over 31,000 unique visits**
  - **Over 1,000 click-throughs to healthcare.gov**
  - **Over 4,000 click-throughs to Virginia's CommonHelp online application**
  - **Approximately 7,500 eligibility screenings**



# Cover Virginia Social Media

- **New Cover Virginia Facebook page at [www.facebook.com/coverva](http://www.facebook.com/coverva)**

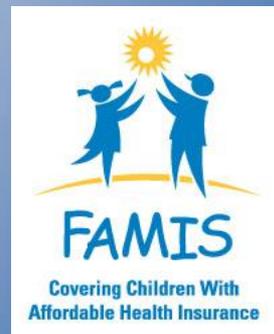


- **New Cover Virginia Twitter account - @coverva**



# **New FAMIS Marketing & Outreach**

- **New children's coverage marketing campaign – Coming Spring 2015**
- **Expanded outreach activities through new DMAS staff – now**
- **Expanded contract with Virginia Health Care Foundation for Project Connect and SignUpNow activities – early 2015**



# Questions?





# Update on Medicaid Forecast and Budget Issues

Presentation to the:  
Board of Medical Assistance Services

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December 9, 2014

# Forecasting Process

- Section 32.1-323.1 of the *Code of Virginia* mandates:

“By November 15 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit an estimate of Medicaid expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and to the Senate Committees on Finance and Education and Health, and to the Joint Legislative Audit and Review Commission.”
- Each year, DMAS and DPB prepare independent forecasts using monthly level expenditure and utilization data
- The forecasts are comprised of over 100 different models that project utilization and cost per unit for each benefit category
- Manual adjustments are made to the forecast to reflect implementation of new programs, one-time payments, or other series not best projected with statistical models

# Forecasting Process

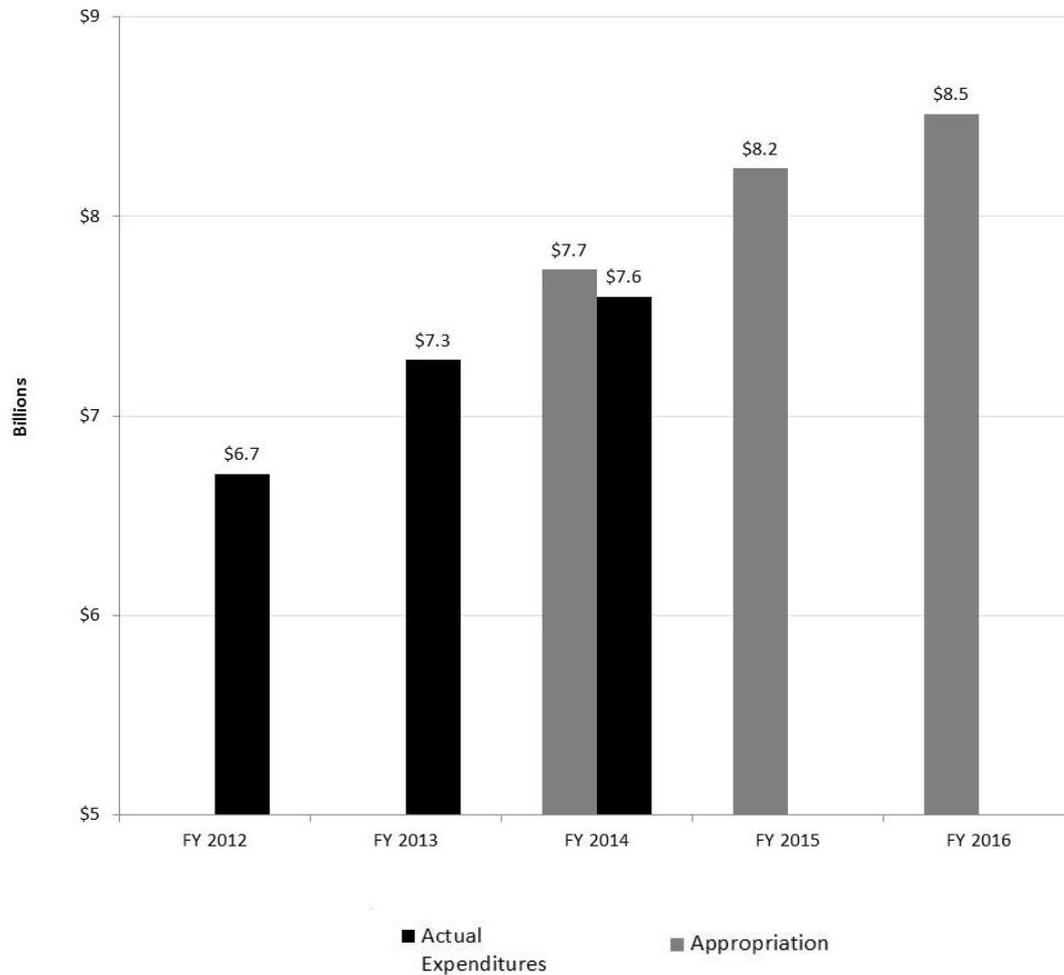
- Forecast projects spending in current and subsequent two years
- Forecast reflects:
  - Application of existing state laws and regulations  
(A Healthy Virginia is considered existing state regulation by virtue of emergency action)
  - Application of existing federal laws and regulations
  - Changes in enrollment, utilization, inflation and acuity mix
- The two agencies meet to compare and evaluate the individual forecasts and an official “Consensus” forecast is adopted
- Due November 15 to Governor and General Assembly
  - October 15th Preliminary Forecast provided to Executive Branch

# Funding Surplus/(Need) based on Official Consensus Medicaid Forecast

		Appropriation (\$millions)	Consensus Forecast (\$millions)	Surplus/(Need) (\$millions)
<b>FY 2015</b>	<b>Total Medicaid</b>	<b>\$8,239</b>	<b>\$7,942</b>	<b>\$296.8</b>
	State Funds	\$4,155	\$4,028	\$127.8
	Federal Funds	\$4,084	\$3,915	\$169.0
<b>FY 2016</b>	<b>Total Medicaid</b>	<b>\$8,510</b>	<b>\$8,360</b>	<b>\$150.1</b>
	State Funds	\$4,334	\$4,267	\$66.5
	Federal Funds	\$4,176	\$4,093	\$83.5
<b>FY15-FY16 Biennium</b>				<b>\$194.4 GF</b>

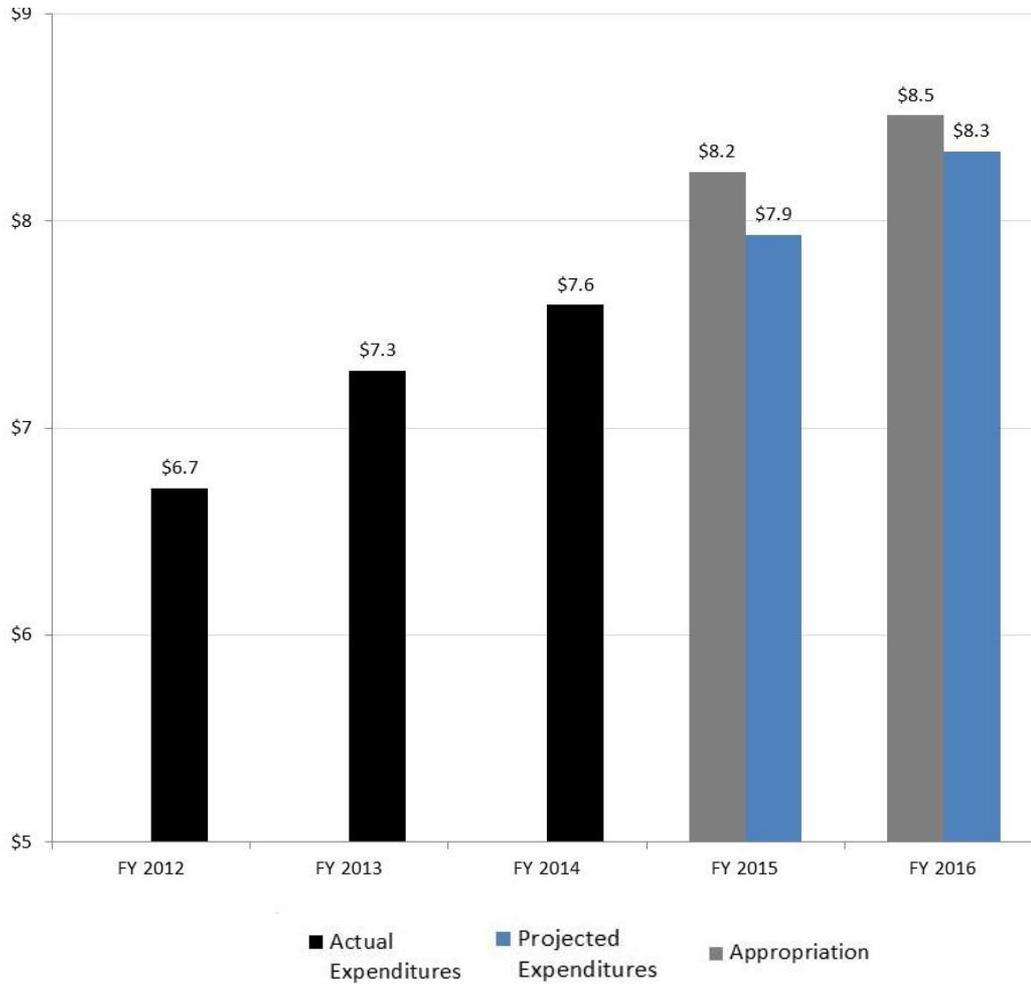
Figures may not add due to rounding

# Medicaid Funding: FY14



- Final FY14 expenditures were \$137m lower than funding
  - \$46m more in pharmacy rebates (FFS & MCO) collected than projected
  - Approximately \$75 million less in indigent care payments to state teaching hospitals made than assumed in forecast due to hitting federal DSH limits
  - Dental expenditures were significantly less than projected this year related to reductions in children's enrollment
- 2014 Appropriation Act funded 6.6% growth in FY15 and 3.3% in FY16
- Due to lower FY14 expenditures, current funding allows for 8.5% growth in FY15

# Medicaid Funding: FY15 – FY16



➤ Updated Forecast projects lower spending in FY15

## Factors decreasing expenditures

- Lower than expected FY15 MCO rate increases
- Lower than projected hospital supplemental payments for FY15
- Lower than expected woodwork effect from the Federal Exchange
- Higher than projected savings from Reform Efforts targeting Behavioral Health services
- Projected savings from Reform Efforts targeting acute care for LTC recipients

## ... outweigh factors increasing expenditures

- Lower than expected CCC savings
- Expenditures associated with Healthy Virginia initiatives

# Major Expenditure Decreases

- Lower than expected FY15 MCO rate increases

## 2013 Forecast

Assumed 3-4% rate increases for FY15  
Assumed 4% rate increases for FY16

## 2014 Forecast

Actual rate increases were 0.3-0.5% in FY15  
Assume 3-3.6% rate increases for FY16

- Lower than projected hospital supplemental payments

## 2013 Forecast

Assumed \$582m for FY15  
Assumed \$606m for FY16

## 2014 Forecast

Assume \$457m for FY15  
Assume \$492m for FY16

- FY 2013 settlement – last year assumed DMAS would owe hospital; preliminary closing indicates hospitals owe DMAS
- Hitting up against current year federal DSH allotments – **we are accruing an obligation to VCU/UVA for indigent care costs and in FY17 or FY18 we will not have access to enough federal funds to pay**

# Major Expenditure Decreases

- Lower than expected woodwork effect from the Federal Exchange

## 2013 Forecast

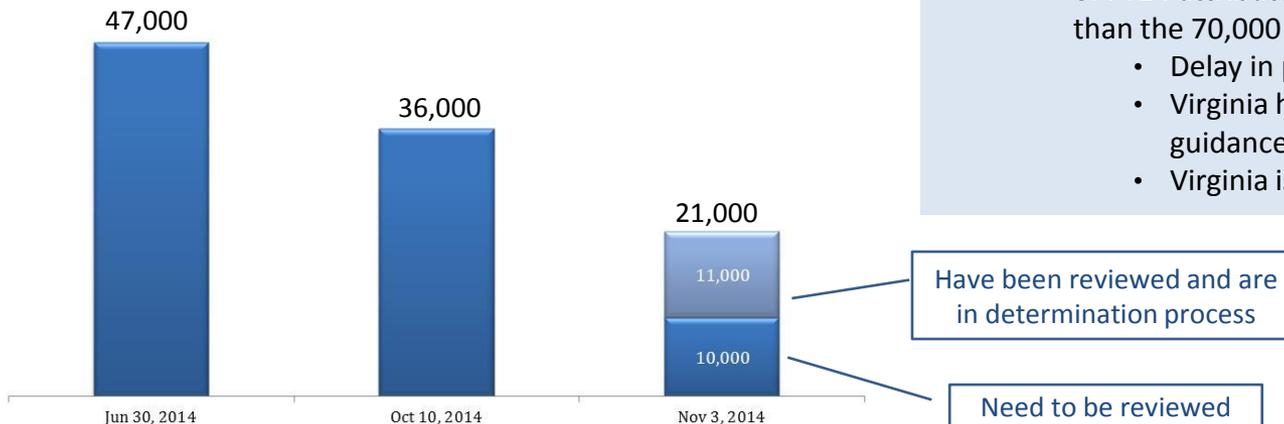
Assumed \$19m for FY14  
Assumed \$111m for FY15  
Assumed \$118m for FY16

## 2014 Forecast

Estimate actual costs of only \$2m in FY14  
Assume \$12m for FY15  
Assume \$13m for FY16

- Approximately 40% of FFM applications are approved for Medicaid; however, almost 2/3 of new enrollees are enrolled in Plan First not full Medicaid
- Approximately 15,000 new enrollees added by end of FY14 attributed to woodwork, Significantly lower than the 70,000 expected. Due to:
  - Delay in processing transferred applications
  - Virginia had no active outreach or process guidance for citizens
  - Virginia is not a Medicaid Expansion state

## FFM Backlog Project Progress



# Major Expenditure Decreases

- Higher than projected savings from Reform Efforts targeting Behavioral Health services

## 2013 Forecast

Assumed (\$21m) for FY14

Assumed (\$55m) for FY15

Assumed (\$59m) for FY16

## 2014 Forecast

Estimate actual savings of (\$32m) in FY14

Assume (\$135m) for FY15

Assume (\$176m) for FY16

- Projected savings from Reform Efforts targeting acute care for LTC recipients

## 2013 Forecast

## 2014 Forecast

Assume (\$1.6m) for FY15

Assume (\$3.2m) for FY16

# Major Expenditure Increases

- Lower than expected CCC savings

## 2013 Forecast

Assumed (\$1.4m) for FY14  
 Assumed (\$28.7m) for FY15  
 Assumed (\$14.7m) for FY16

## 2014 Forecast

Program went live “opt-in” March 2014  
 Assume (\$5.3m) for FY15  
 Assume (\$18.2m) for FY16

- Actual savings per person are in line with estimates
- External factors resulted in delayed implementation and lower enrollments

- Funding for Healthy Virginia initiatives

	SFY15		SFY16	
	Total Funds	GF	Total Funds	GF
GAP Program	\$27,000,000	\$13,000,000	\$ 157,000,000	\$77,000,000
Medicaid Impact of CHIP Outreach	\$2,100,000	\$1,050,000	\$22,800,000	\$11,400,000
Dental Coverage for Pregnant Women	\$550,000	\$275,000	\$3,200,000	\$1,600,000
Behavioral Health Homes	\$0	\$0	\$17,100,000	\$8,550,000

# Summary: Major Increases/Decreases

## 2014 Preliminary Medicaid Forecast

	FY 2015	
	Total Funds	GF
Changes in MCO Rate Assumptions	(\$67,000,000)	(\$33,500,000)
Reduced Woodwork Estimates	(\$99,000,000)	(\$49,500,000)
Reduced Supplemental Payments	(\$120,000,000)	(\$60,000,000)
Increased MHSS Savings	(\$80,000,000)	(\$40,000,000)

Change in CCC/Duals Savings	\$23,400,000	\$11,700,000
GAP Program	\$27,000,000	\$12,926,048
Medicaid Impact of CHIP Outreach	\$2,100,000	\$1,050,000
Dental Coverage for Pregnant Women	\$546,168	\$273,084
Behavioral Health Homes	\$0	\$0
<b>Subtotal: Major Decreases/Increases</b>	<b>(\$312,953,832)</b>	<b>(\$157,050,868)</b>

<b>Projected Surplus</b>	<b>(\$305,708,972)</b>	<b>(\$132,460,398)</b>
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Other Forecast Changes	\$7,244,860	\$24,590,470
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	FY 2016	
	Total Funds	GF
	(\$75,000,000)	(\$37,500,000)
	(\$77,000,000)	(\$38,500,000)
	(\$114,000,000)	(\$57,000,000)
	(\$117,000,000)	(\$58,500,000)

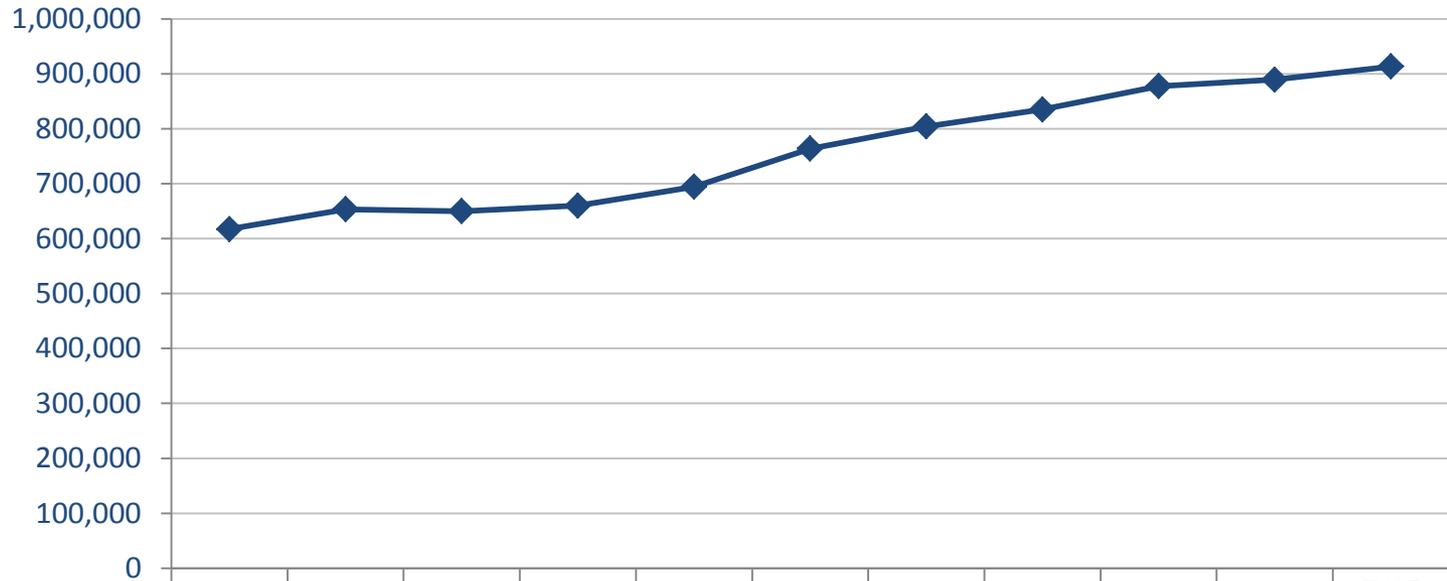
	(\$3,500,000)	(\$1,750,000)
	\$157,000,000	\$76,898,145
	\$22,800,000	\$11,400,000
	\$3,234,522	\$1,617,261
	\$17,100,000	\$8,550,000
	(\$186,365,478)	(\$94,784,594)

	(\$172,856,044)	(\$76,146,982)
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	\$13,509,434	\$18,637,612
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# Other Forecast Changes

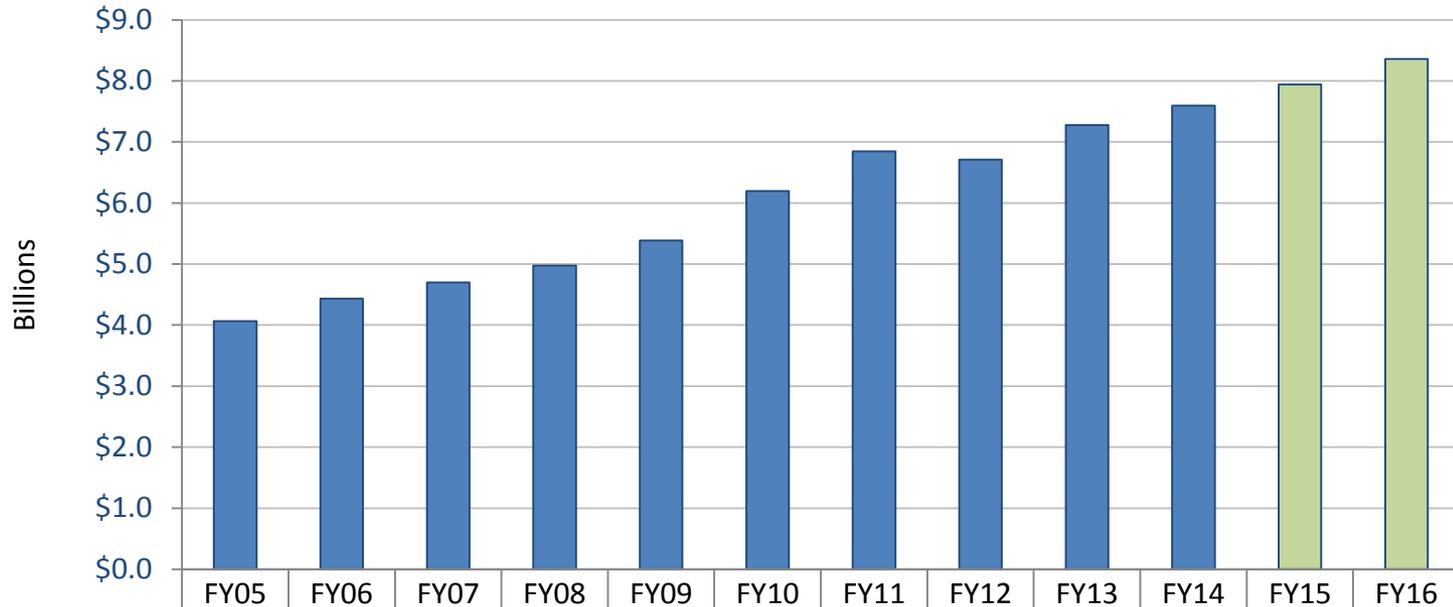
Medicaid Enrollment



	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15 YTD
Monthly Enrollment	617,372	653,377	649,903	659,969	694,276	763,745	804,186	834,876	877,395	889,262	913,341
Annual Growth	9%	6%	-1%	2%	5%	10%	5%	4%	5%	1%	3%

- Enrollment is still growing but has slowed from the growth rates observed from 2009-2013.
- Enrollment has grown 48% FY2005 – FY2015 (October)

# Medicaid Expenditures



■ Medicaid Expenditures	4.1	4.4	4.7	5.0	5.4	6.2	6.8	6.7	7.3	7.6	7.9	8.4
Annual Growth	14%	9%	6%	6%	8%	15%	10%	-2%	8%	4%	5%	5%

- Expenditures and growth rates in FY09-12 reflect cash payment processing changes intended to generate one-time savings (FY09 delay of last weekly remittance cycle) or capture additional federal funds (FY11 payment of 13 MCO capitation payments)

# Budget Cuts

- Governor McAuliffe announced his FY 2015 Savings Plan (pursuant to Item 471.10 of HB 5010) on September 20, 2014
- Included reductions of \$2.5 million GF for DMAS, to be achieved by:
  - Requiring electronic notification of most Medicaid communications
  - Converting in-house fiscal agent contractors to agency staff
  - Capturing savings from eHHR program
  - Eliminating funding for the Virginia Center for Health Innovation
  - Eliminating funding for additional community mental health audits
  - Reducing contractor costs
- FY 2016 reductions will not be announced until release of the Governor's Introduced Budget but DMAS reductions could be up to \$3.5 million GF
- Targeted reductions to the medical program are also possible



**Questions?**

# Board of Medical Assistance Services



## Legislative Process 2015

Suzanne S. Gore  
Deputy Director, Administration

December 9, 2014

# Background

- During the General Assembly Session, DMAS provides expertise and analysis to the Administration and provides technical assistance to the General Assembly Members/Staff on matters impacting programs administered by the department
  - Analysis to the Administration is considered Confidential Governor's Working Papers that DMAS is not authorized to share outside of the designated Administration staff
- It is important to understand that DMAS does not take a position on any bill before the General Assembly, but does communicate the Administration's position, to the extent there is one, on relevant legislation as authorized by the Administration
  - The limited DMAS staff identified to testify before committees are not authorized to express personal opinions, but only relevant facts or analysis based on their professional expertise in regard to the policy decision(s) at hand

# BMAS & The General Assembly

- In the past, the Board expressed concern with being unaware of some legislation affecting the Board, the agency, and the programs we administer
- In response to this concern, the department has developed an approach to provide the Board with weekly updates on major legislation affecting the program
- These updates will contain:
  - Bill # / Chief Patron
  - Bill Summary
  - Link to the Legislative Information System (LIS) for that Bill
    - Provides a copy of the bill, the current status and history, and any public documents – like a fiscal impact statement
  - The Administration's position on the bill to the extent there is a position to report

# Legislative Information System

- The Legislative Information System provides updated information on all matters before the General Assembly
- Through the LIS, you can get information on individual bills and you can view dockets/agendas in order to know when a bill is supposed to be heard by a committee
- <http://lis.virginia.gov/>
- Be sure to use the 2015 Session!!

Regulatory Activity Summary for December 9, 2014  
(\* Indicates recent activity)

**2014 General Assembly**

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

**\*(02) No Inflation Reimbursement Methodology Changes:** This action affects hospitals, home health agencies, and outpatient rehabilitation providers. Chapter 2 of the *2014 Acts of the Assembly*, Item 301 CCC and IIII directed this change. The SPA was approved by the Secretary's Office on 9/23/14 and was submitted to CMS on 9/26/14. SPA now pending approval by CMS and changes to parallel administrative code sections are pending.

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

**\*(04) Hospital DSH Reduction:** This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA was approved by the Secretary's Office on 9/23/14 and submitted to CMS on 9/29/14. SPA now pending approval by CMS and changes to parallel administrative code sections are pending.

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

**\*(06) Hospital APR-DRG Methodology Change:** This action changes the APR-DRG grouper for hospital reimbursement and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 VVV. The SPA is being developed now and will soon be submitted to the Secretary's Office for submission to CMS by 12/30/14. Changes to parallel administrative code sections are pending.

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

**\*(08) Primary Care Rate Increase Vaccine Administration:** This action adds to the State Plan rate increases for the administration of vaccines. The SPA has been submitted to CMS and is pending approval. The regulatory action is pending drafting.

**\*(09) Type One Hospital Partners' Supplemental Payments:** This action provides supplemental payments to Type One hospitals (state-owned teaching hospitals) qualifying partners and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 DDDD. The SPA has been submitted to CMS and is pending approval. The VAC action is pending being drafted.

**\*(11) Discontinue Coverage of Barbiturates for Dual Eligible Individuals:** This action was required by federal law and the agency's Fast Track action has been adopted internally and is pending approval by the Secretary's Office. A SPA will be required for the affected parallel State Plan sections.

**\*(12) 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. The emergency regulation action has been completed, certified by the OAG and is now pending review/approval by DPB. An effective date of 1/1/15 is targeted. This is a new demonstration waiver program; CMS approval is pending.

**\*(13) 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 is drafting a Fast Track action for the VAC changes; no SPA is required.

**\*(14) 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 action has been completed and is pending OAG certification. A companion Title XXI SPA will be required.

**\*(15) 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 action has been completed and is pending OAG certification. A companion Title XIX SPA will be required.

**\*(15) 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 approved by the agency and is pending OAG certification.

**\*(16) 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 action has been certified by the OAG and it has been submitted to DPB.

**\*(17) DOC Signature Authority for Medicaid Applications:** This Fast Track action proposes to grant authority to the director of the Department of Corrections, or his designee, to sign applications for medical assistance for those inmates who are unable or unwilling to sign their own application. This action only enables Medicaid to reimburse for inpatient hospital services received by inmates who leave the prison campus for care. This action is responsive to a mandate: Chapter 2 of the *2014 Acts of the Assembly*, Item 384 J(2). VAC-only change is in internal agency review and approval prior to OAG submission.

**\*(18) 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 pending OAG review and certification.

## **2013 General Assembly**

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

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

**\*(06) 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.

**\*(07) Exceptional Rate for ID Waiver Individuals:** This Emergency/NOIRA will enable providers of congregate residential support services, currently covered in the Individual with Intellectual Disabilities Waiver (ID waiver), to render, in a more fiscally sound manner, services to individuals who have complex medical and behavioral care needs. Such individuals, who have long been institutionalized in the Commonwealth's training centers, are being moved into community settings over the next several years in response to the settlement of the lawsuit brought against the Commonwealth by the Department of Justice. These affected individuals have exceptional medical and behavioral support needs. For providers to render services for such individuals, it is requiring substantially more staff time and skills than for individuals who have not been institutionalized for extended periods of their lives. This regulatory action has been approved by the Governor and was submitted to the Registrar for publication on 11/13/14. The waiver change was approved by CMS on 4/23/2014. The parallel VAC change is being drafted and reviewed internally prior to OAG submission for certification.

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

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

**(10) Enhanced Ambulatory Patient Group Outpatient Hospital Reimbursement**

**Methodology:** This Emergency/NOIRA action implements a prospective payment methodology for outpatient hospital services. The current cost-based methodology is out-of-date, inefficient and costly. DMAS is proposing to implement the EAPG methodology that is a more efficient and predictable reimbursement methodology for DMAS to pay hospitals that furnish services to Medicaid recipients in an outpatient hospital setting. This regulatory package was approved by the Governor's office 10/28/13, filed with the Registrar's office 11/6/13 and became effective 1/1/14. The Proposed stage package has been approved by the Secretary's Office and is now pending approval of the Governor's Office. SPA was approved by CMS 5/15/2014.

**\*(11) Changes to Institutions for Mental Disease (IMD) Reimbursement:**

This Emergency/NOIRA is the result of the 2012 *Acts of the Assembly*, Chapter 3, Item 307 CCC, which directed DMAS to develop a prospective payment methodology to reimburse institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others. The SPA (14-12) was submitted to CMS on 9/24/14. CMS has returned informal questions about the SPA that must be addressed. This regulatory package was filed with the Registrar's office 5/5/14, was published in the Register 6/2/14 and became effective 7/1/14. The proposed stage is being drafted to address CMS' informal SPA questions as well as the issues of this change.

**(12) Physician Primary Care Rate Increase Update:**

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

**(13) Supplemental Payments for services provided by Type One Physicians-**

**ACR Update:** This SPA revises the maximum reimbursement to 190% of the Medicare rate for Type One physicians, based on updated information on the average commercial rate furnished by the providers which are affected by this change (state academic health systems). In response to the SPA that was submitted

to CMS on 3/27/13, CMS issued a request for additional information (RAI). The RAI response was submitted to CMS 3/27/14 and is pending approval. CMS approved the SPA. The parallel VAC change is pending the Governor's approval.

**(14) 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 has been approved by the Secretary's Office and is pending the Governor's Office approval.

## **2012 General Assembly**

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

**(02) Supplemental Payments for Institutional/Non-Institutional Providers:** This Fast-Track action modifies or establishes supplemental payments for 1) physicians affiliated with Type One hospitals and state-funded medical schools, 2) hospitals and nursing homes affiliated with Type One hospitals and Type One hospitals. This regulation also modifies indirect medical education (IME), and graduate medical education (GME) reimbursement for Type One hospitals. This regulatory package was approved by DPB on 6/5/2014, the Secretary's Office and is now pending the Governor's Office approval. SPA was approved by CMS 6/24/2013.

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

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

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

**(06) Physician Medicare Percentage Payments for Type I Hospitals:** This SPA revises the maximum reimbursement from 143% to 220% of the Medicare rate for Type One physicians, based on updated information on the average commercial rate furnished by the providers which are affected by this change (state academic health systems). A Type One physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10. These payments are calculated as the difference between the maximum payment allowed and regular payments. CMS has determined that the maximum allowed is the average commercial rate. The SPA was approved by CMS 6/29/12. An update to the percentage is being made and another SPA is currently being drafted. Changes to parallel administrative code sections are pending.

## **2011 General Assembly**

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

**\*(02) Update Medicaid Works Program Income Limit:** This Fast-Track regulatory action implemented the Medicaid buy-in program, MEDICAID WORKS, as authorized by the 2011 General Assembly. House Bill 2384/Chapter 506 directed DMAS to increase the maximum allowable gross earnings for participants in the program to the maximum gross income amount allowed under the Ticket to Work and Work Incentives Improvement Act that does not trigger the collection of mandatory premiums. This amount is calculated to be \$75,000 in gross annual earnings. This regulatory action will also adjust MEDICAID WORKS policy to mitigate the negative impact (loss of Medicaid eligibility) of higher earned income or higher unearned income as a result of participating in this work incentive program. Eligibility policy will be amended to enable a disregard for any increase in the amount of unearned income in the Social Security Disability Insurance (SSDI) payment resulting from employment as a worker with disabilities eligible for assistance under the Ticket to Work and Work Incentives Improvement Act, or as a result of a Cost of Living Adjustment (COLA) adjustment to the SSDI payment. Policy also will be amended to enable a disregard for any unemployment insurance payments received by an enrollee as a result of loss of employment through no fault of his own. This regulatory package was approved by the Governor's office and filed with the Registrar's office 10/15/13. The comment period ended 12/5/13 and became effective 12/19/13. The SPA was submitted to CMS 12/30/13 and was approved 9/19/14.

**(03) 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.

**\*(04) Client Medical Management (CMM):** The Emergency/NOIRA action was designed to assist and educate beneficiaries in appropriately using medical and pharmacy services. Members, who use these services excessively or inappropriately, as determined by the DMAS may be assigned to a single physician and/or pharmacy provider. This regulatory action was approved by the Governor's office 12/16/13 to be effective 12/16/13 and expires 6/15/2015. The fast-track stage has been internally approved, certified by the OAG and is now under review by DPB.

**(05) Electronic Claim Submission Requirements:** This Emergency/NOIRA action complied with the *2011 Acts of the Assembly*, Item 300 H that required DMAS to implement a mandatory electronic claims submission process, including the development of an exclusion process for providers who cannot submit claims electronically. This regulatory package was approved by the Governor 9/3/12 and filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. The Proposed stage regulatory package was approved by the Governor's office and filed with the Registrar's office 10/15/13. The comment period ended 1/16/14. The final stage regulatory package was approved by the Governor's Office on 9/8/14, submitted to the Registrar on 9/8/14, published in the *Register* 10/6/14 and became effective 11/6/14. This action is completed and will be removed from the next report.

**(06) Signature Requirement for Medical Records:** This Emergency/NOIRA action complied with the *2011 Acts of the Assembly*, Item 297.TTTT requiring DMAS to specify that the documentation requirements for the signing and dating of medical records, both paper and electronic, by health care providers be a mandatory condition of Medicaid reimbursement. This regulatory package was approved by the Attorney General's office 3/21/12 and approved by DPB on 4/3/12. This package was approved by the Governor's office 10/30/13. Per project manager we will wait 60 days in order to get the appropriate notice out to providers.

**(07) 2011 Exceptions to Personal Care Limit:** This Emergency/NOIRA action complied with the legislative mandate to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services (which includes supervision time). This regulatory package was approved by the Governor on 9/3/12 and was filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. (2011 General Assembly Item 297 CCCCC) The proposed stage regulatory package was approved by the Governor's Office on 11/18/14, filed with the Registrar on 11/18/14 and is due to be published in the *Register* on 12/15/14.

**(08) Early Intervention Part C Children Case Management:** This Emergency/NOIRA regulatory action supported early intervention services, provided under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) which address developmental problems in young children. These services are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development,

or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. This Emergency/NOIRA action was approved by the Governor's office 9/12/2012. The SPA was approved by CMS 9/25/2012. This project was changed to a Fast-Track action and is currently at Governor's Office pending approval.

## **2010 General Assembly**

**(01) Durable Medical Equipment (DME) Services Update:** This Emergency/NOIRA complies with 2010 Appropriations Act to modify reimbursement for Durable Medical Equipment (DME), and modify the limit on incontinence supplies prior to requiring prior authorization. This regulatory package was approved by the Governor 6/30/10 and filed with the Registrar's office 7/1/10, became effective 7/1/10 and the NOIRA comment period ended 9/1/10. (Item 297 UUU and Item 297 WWW of the 2010 Appropriations Act). The Final regulation stage was approved by the Governor on 4/27/12 and became effective on 7/1/12. The SPA was submitted to CMS 8/20/12 pending approval. Informal comments were received from CMS 10/15/12 and the responses were forwarded to CMS. A second round of questions was received from CMS and the responses are currently being drafted.

**(02) Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications:** This Emergency/NOIRA action complied with the 2010 Appropriations Act that required DMAS to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. This regulatory package was filed with Registrar's office 7/1/10. The State Plan Amendment was submitted to CMS on 9/28/10 and was approved 6/1/11. A new Emergency regulation was drafted based on the 2011 Appropriations Act to replace the previous one. Secretary's office approved 7/12/11. Governor approved 7/18/11 and became effective on 7/18/11. NOIRA comment period ended 9/14/11. The proposed stage package was approved by DPB 9/6/12 and approved by the Secretary 9/24/12. This proposed stage package was approved by the Governor's office on 1/14/13. The comment period ended 4/12/13. (Item YY of the 2010 Appropriations Act) The final regulations stage was internally approved, certified by the OAG on 6/19/2014, approved by the Secretary's Office 9/24/14, and is now pending approval by the Governor's Office.

## **2009 General Assembly**

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

application process for most Medicaid applicants and recipients. This regulatory package is currently at the Governor's office pending approval.

**\*(02) Elderly and Disabled Waiver 2009 Changes:** This initial Notice of Intended Regulatory Action (NOIRA) updates the Elderly or Disabled with Consumer Direction Waiver (EDCD) to accommodate changes in the industry and to provide greater clarity in these regulations. The NOIRA stage regulatory action was filed with the Registrar's office 10/2/09 and the comment period ended 11/25/09. The Proposed regulatory stage was approved by the Attorney General's office 12/6/10. DPB approved package 3/31/11. The Governor approved this package on 9/11/12 and it was filed with the Registrar's office 9/11/12. The public comment period ended 12/7/12. The final stage 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.*