2013-15 Biennial Plan

State Executive Council

GOAL 1

SUPPORT IMPLEMENTATION OF A UNIFIED SYSTEM OF CARE THAT ENSURES EQUAL ACCESS TO QUALITY SERVICES FOR AT RISK YOUTH IN THE COMMONWEALTH.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 1: Strategies

- Align policies governing use of funds (Pool Funds, Medicaid, PSSF, VJCCCA, MH Initiative)
- Ensure dollars protected for "non-mandated" youth are utilized for the target population.
- Address gaps in services through regional efforts.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 1: Strategies

- Address inadvertent fiscal incentives that encourage residential placement.
- Support cross-secretariat collaboration re. children's services.
- Support increased reporting regarding cross-agency initiatives for children's services.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 1: Strategies

- Implement assessment of local program performance relative to identified benchmarks and target training/technical assistance to lower performing programs.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 2

SUPPORT INFORMED DECISION MAKING THROUGH UTILIZATION OF DATA TO IMPROVE CHILD AND FAMILY OUTCOMES AND PRIVATE PERFORMANCE IN THE PROVISION OF SERVICES TO CHILDREN AND FAMILIES.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 2: Strategies

- Enhance collection, analysis, and utilization of individual client data.
- Improve availability of meaningful data.
- Implement training for users to sustain data systems.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 2: Strategies

- Standardize terminology and definitions, e.g., service names, data elements.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 3

IMPROVE THE OPERATIONAL EFFECTIVENESS OF CSA ADMINISTRATION.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 3: Strategies

- Support a comprehensive internal audit program.
- Maximize engagement of FAPT and CPMT stakeholder representatives in training and team participation.
- Improve usability of CSA manual.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 3: Strategies

- Enhance fiscal and data reporting requirements.
- Implement robust training plan.
- Build/enhance systemic culture of collaboration across state and local agencies.

Office of Comprehensive Services
Empowering communities to serve youth

GOAL 3: Strategies

- Enhance collaboration between SLAT and SEC through annual joint meeting.

Office of Comprehensive Services
Empowering communities to serve youth

VIRGINIA LEAGUE OF SOCIAL SERVICES EXECUTIVES
Legislative Committee
Legislative and Public Policy Issues

Positions taken on Proposed Legislation to Date

November 7, 2013

VLSSE Legislative Agenda for the 2014 Virginia General Assembly Session

CONTENTS

Section 1. Local Social Services Departments

ITEM	DESCRIPTION	VLSSE POSTION	VLSSE COMMITTEE
Administrative Funding **(Seek a Patron)**	Funding for Eligibility Determination, Allocation of CHIPS funding to Local Social Service Agencies In Assuming FAMIS Program Operations	VLSSE Initiative Support	Administration
Eligibility Determination **(Seek a Patron)**	It is anticipated that sixty-three (63) new Benefit Program Specialists and six (6) supervisors will be needed to perform the program volume. Recognizing that the program is phased in through FY14 and then full time beginning in FY15, then adjusting the 6.3% annual increase for FY16, the increased cost of operations	VLSSE Initiative Support	Administration
Chore & Companion Services **(Seek a Patron)**	Reinstate state funding for adult chore and companion services and other purchased adult protective services that was reduced in 2010,	VLSSE Initiative Support	Chore & Companion Services

VLSSE Legislative Agenda for the 2013 Virginia General Assembly Session

Section 2. Allied Issue Items

CSA Issue	VLSSE Statement	VLSSE Position	VLSSE Committee
Require CSA policies to align with the policy of the core agencies **(Seek a Patron)**	Amend current CSA law to require OCS to conduct an analysis of any impediments to existing core agency policies as part of the development of any new policy.	VLSSE Initiative Support	CSA
Place the state Office of Comprehensive Services Under the Administrative Processes Act **(VACo will take the lead)**	This consistency with other regulatory and policy making entities would enhance stakeholder's preparedness and ability to provide input in a structured and meaningful way.	VLSSE Initiative Support	CSA
Establish a Process Concerning the Denial of Funds **(Seek a Patron)**	An amendment to VA code section 2.2-2628 that provides for reasonable efforts by the state to give localities an opportunity to improve practice following audit findings, and that denial of funds be implemented in a rational, progressive fashion similar to that proposed for IV-E funding and other state and federal funding sources.	VLSSE Initiative Support	CSA
Creation of a New Funding Stream for Prevention/Diversion **(Seek a Patron)**	Establish a three year prevention/diversion pilot program that incorporates a robust evaluation component.	VLSSE Initiative Support	CSA

Section 3. VDSS Legislative Items the 2013 Virginia General Assembly Session

Issue	VDSS Statement	VLSSE Position	VLSSE Committee
Presumptive Eligibility	Places on VDMAS the responsibility to provide records a presumptive eligibility records	SPPORT	Financial Services
Appeals for Independent Living (IL)	Provides for a non-IV-E case to appeal. Provides parity with IV-E case.	SUPPORT	
Release of CPS Information	In the event that the local department does not release the information to the appellant, it shall notify the appellant in writing at the time of the appellant's request for an appeal. If 180 days elapse from the date of the appellant's request without the filing of any criminal charge involving the same conduct and the same victim, the local department shall then provide the appellant with all information used in making the determination.	**PENDING**	Child Welfare
Child Day Care Background Checks	Proposal for background and fingerprint check for child day care providers. No draft legislation at this time.	**SUPPORT , w/ Funding**	Child Care
Social Work Title Medicaid Preadmission-Screening 32.1-330 Preadmission screening required.	Provides for "other DMAS-designated assessor. Deletes the term social worker from the Code of Virginia and inserts 1. Workers in the field of adult protection services 2. Family services specialist 3. Other appropriately qualified worker	**SUPPORT**	Personnel Adult Services Administrative
Social Work Title Board to establish employee entrance and performance standards (63.2-219)	Amendments are needed with regard to the occupational title for social workers employed in the Department of Social Services and 120 local departments of social services, to replace the title 'social worker' with 'family services specialist.' This term was sanctioned by the League of	**Monitor**	Personnel

Issue	VDSS Statement	VLSSE Position	VLSSE Committee
	Social Services Executives and the State Board of Social Services.		
Social Work Title Determination of appropriate home. (63.2-1225)	The current statute restricts who can counsel prospective adoptive parents to a 'social worker.' Amendment is needed to provide flexibility in who can perform this function.	**Monitor**	Personnel
Social Work Title When birth parents recommend adoptive parents. (63.2-1226**)**	The current statute restricts who can counsel birth parents to 'social worker.' Amendment is needed to provide flexibility in who can perform this function.	**Monitor**	Personnel
Social Work Title Home study; meeting required; exception**.** (63.2-1231)	The current statute restricts who must meet with birth and prospective adoptive parents to a 'social worker.' Amendment is needed to provide flexibility in who can perform this function. **(Concern with VA DMAS amendment to the VDSS proposed legislation that adds a provision to permit contacting out the UAI)**	**Monitor**	Personnel
Social Work Title Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report. (63.1-150-9)	The current statute identifies as a mandated reporter of child abuse or neglect a 'social worker.' Amendment is needed to add 'family services specialist.'	**Monitor**	Personnel
FOSTER CARE Department of Juvenile Justice Legal Custody of Children committed to state Department of Juvenile Justice	Proposal by DJJ: Legal Custody of Children In Foster Care committed to the state Department of Juvenile Justice Legislative.	**OPPOSE**	Child & Family
FOSTER CARE – EDUCATON Just Children, Legal Aid Justice Center	Proposal to provide a safe and positive environment for public schools. Legislative.	**SUPPORT**	Legislative
GENERAL RELIEF Disposal of Bodies Posed by the Office of the Chief Medical Examiner **(Support VACo & VML in seeking a Patron, if a budget**	Over the last few years the Office of the Chief Medical Examiner has introduced legislation having to do with the disposition of dead bodies. It seems that when they try to	**Monitor, concerns: Funding, work load, liability**	Administrative

Issue	VDSS Statement	VLSSE Position	VLSSE Committee
amendment is needed)	"solve" an issue, it raises other issues, and it's become kind of a three ring circus with reps from the sheriffs, police departments, funeral directors, health department, OAG, the hospital association and us.		

For additional information contact

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VIRGINIA LEAGUE OF SOCIAL SERVICES EXECUTIVES
Legislative Committee
Legislative and Public Policy Issues

VLSSE Legislative Agenda for the Virginia General Assembly 2014 Session

Adopted by the VLSSE Membership

November 7, 2013

SUPPORT

Comprehensive Services Act for At-Risk Children & Families

Proposal 1. Require CSA policies to align with the policy of the core agencies

Proposed Legislation

Amend current CSA law to require OCS to conduct an analysis of any impediments to existing core agency policies as part of the development of any new policy. Such new policies should be tested against pre-existing policies of CSA (such as the CSA State Executive Council (SEC) policy on Family Engagement) as well as any related, or affected, policies of the core agencies. Such amendments would be mostly about nuance and emphasis, as there is nothing in the code that precludes OCS from adopting this as a practice today. The law would need to be amended in two places as identified below:

2 2.2-2649. Office of Comprehensive Services for At-Risk Youth and Families established; powers and duties.

A. The Office of Comprehensive Services for At-Risk Youth and Families is hereby established to serve as the administrative entity of the Council and to ensure that the decisions of the council are implemented. The director shall be hired by and subject to the direction and supervision of the Council pursuant to § 2.2-2648.

B. The director of the Office of Comprehensive Services for At-Risk Youth and Families shall:

1. Develop and recommend to the state executive council, programs and fiscal policies that promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels. ***Such policies shall be analyzed and aligned for consistency with other federal and state laws and policies governing the performance of those agency's duties prior to submission to the state executive council, and a report describing the impact on such other related policies shall be included.***

2. Develop and recommend to the Council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

AND

2.2-2648. State Executive Council for Comprehensive Services for At-Risk Youth and Families; membership; meetings; powers and duties……

C. The Council shall be chaired by the Secretary of Health and Human Resources or a designated deputy who shall be responsible for convening the council. The Council shall meet, at a minimum, quarterly, to oversee the administration of this article and make such decisions as may be necessary to carry out its purposes. Legislative members shall receive compensation as provided in § 30-19.12 and nonlegislative citizen members shall receive compensation for their services as provided in §§ 2.2-2813 and 2.2-2825.

D. The Council shall have the following powers and duties:

1. Hire and supervise a director of the Office of Comprehensive Services for At-Risk Youth and Families;

2. Appoint the members of the state and local advisory team in accordance with the requirements of § 2.2-5201;

3. Provide for the establishment of interagency programmatic and fiscal policies developed by the Office of Comprehensive Services for At-Risk Youth and Families, which support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.), through the promulgation of regulations by the participating state boards or by administrative action, as appropriate; ***notwithstanding any authority granted by this clause, the Council shall not consider or adopt policies that would inhibit executive branch agencies from complying with any other federal or state mandate in the performance of their duties***

4. Provide for a public participation process for programmatic and fiscal guidelines and dispute resolution procedures developed for administrative actions that support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.). The public participation process shall include, at a minimum, 60 days of public comment and the distribution of these guidelines and procedures to all interested parties;

Proposal 2. Place the state Office of Comprehensive Services Under the Administrative Processes Act

Proposed Legislation

The Virginia League of Social Services Executives requests legislation that would add the state Office of Comprehensive Services Act and the CSA State Executive Council under the state Administrative Process Action (APA). This consistency with other regulatory and policy making entities would enhance stakeholder's preparedness and ability to provide input in a structured and meaningful way.

Proposal 3. Establish a Process Concerning the Denial of Funds

Virginia League of Social Services Executives requests an amendment to VA code section 2.2-2628 that provides for reasonable efforts by the state to give localities an opportunity to improve practice following audit findings, and that denial of funds be implemented in a rational, progressive fashion similar to that proposed for IV-E funding and other state and federal funding sources. An example of such amendment follows:

2.2-2628 State Executive Council for Comprehensive Services for At-Risk Youth and Families; membership; meetings; powers and duties

D. The Council shall have the following powers and duties:…….

> Subdivision 20. Deny state funding to a locality, in accordance with subdivision 19, where the CPMT fails to provide services that comply with the Comprehensive Services Act (§ 2.2-5200 et seq.), any other state law or policy, or any federal law pertaining to the provision of any service funded in accordance with § 2.2-5211; **Add:** ***Except in the cases of apparent fraud, or intentional mismanagement, such denial of funds shall only be implemented following a process of corrective action and technical assistance. Further, the Council shall develop such procedures in collaboration with relevant stakeholders in order to be consistent with denial of funds procedures used for similar state and federal child serving programs administered by participating state agencies.***

Proposal 4. Creation of a New Funding Stream for Prevention/Diversion

Request for Legislative Budget Amendment

Establish a three year prevention/diversion pilot program that incorporates a robust evaluation component. VDSS could seek a few interested partners from among a sample of urban/ rural, large/small agencies. Program design and evaluation methodologies would be developed in the fourth quarter of FY14.

Eligibility Determination

Request for Legislative Budget Amendment

Social Services Funding for Eligibility Determination, Allocation of CHIPS funding to Local Social Service Agencies In Assuming FAMIS Program Operations

It is anticipated that sixty-three (63) new Benefit Program Specialists and six (6) supervisors will be needed to perform the program volume. Recognizing that the program is phased in through FY14 and then full time beginning in FY15, then adjusting the 6.3% annual increase for FY16, the increased cost of operations is as follows:

Fiscal Year	Total Cost	Federal Funds	State General Funds	Local Funds
First Year FY14	$2,700,000	$1,336,500	$ 945,000	$418,500
Second Year FY15	$5,100,000	$2,524,500	$1,785,000	$790,500
Third Year FY16	$5,300,000	$2,623,500	$1,855,000	$821,500

Chore & Companion Services

Request for Legislative Budget Amendment

Reinstate state funding for chore and companion services of $2.0 million a fiscal year.

This amendment restores funding for adult chore and companion services and other purchased adult protective services that was reduced in Chapter 874 of the 2010 Virginia Acts of Assembly. These programs will experience a reduction of $2.0 million from the general fund in fiscal year 2012. Without these additional funds Adult Protective Services (APS) can investigate complaints but has no funds to provide services. Chore and companion services are used to provide protective services at home to prevent or address abuse, neglect or exploitation, and keep elderly and disabled individuals in their homes. Previous cuts have coincided with significant increases in APS reports (17,140 last year, nearly a 10 percent increase over the previous year). Without home-based services, elderly and disabled individuals will be forced into institutional care at a much higher cost to the Commonwealth. Other purchased services are for emergency protective services including services to meet emergency needs for victims who have to escape dangerous situations.

Fiscal Year	Total Cost	State General Funds	Non-Federal Funds, FFP
First Year FY14	$2,000,000	$1,600,000	$ 400,000
Second Year FY15	$2,000,000	$1,600,000	$ 400,000
Third Year FY16	$2,000,000	$1,600,000	$ 400,000

OPPOSE

Foster Care

The Department of Juvenile Justice (DJJ) is considering proposing legislation to address the custodial status of committed juveniles by amending the Code of Virginia to clarify that commitment to DJJ transfers physical custody and legal custody remains with the parent, guardian, custodian, agency, or institution in whom it was vested immediately prior to commitment.

For additional information contact

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Magellan: Virginia's Behavioral Health Services Administrator

VCOPPA
November 14, 2013

MAGELLAN
BEHAVIORAL HEALTH

Introductions

- Sandra Brown, Manager Behavioral Health Services, DMAS
- Elizabeth E Smith, RN, Program Analyst, DMAS
- Kristin Burhop, Integrated Care Program Advisor, DMAS
- Jim Forrester, Ed.D., Director System of Care
- Ajah Mills, Field Network Director
- Brian Smock, M.A. National Director Behavioral Health Network Services

VAProviderQuestions@MagellanHealth.com

MAGELLAN BEHAVIORAL HEALTH

Overview

- BHSA Introduction
- Implementation update
- Governance board
- Frequently Asked Questions
- Panel Questions and Answers

MAGELLAN BEHAVIORAL HEALTH

Behavioral Health Services Administrator Introduction

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How did we get here?

- **Initially started as a Program Integrity Initiative**
- **Realization that services were fragmented and not coordinated, especially for children who are in managed care for acute and primary services**
- **General Assembly Directive that DMAS Improve/Coordinate Care in 2011-2013 GA Sessions**

MAGELLAN BEHAVIORAL HEALTH

Purpose

- To improve access to quality behavioral health services and the value of behavioral health services purchased by the Commonwealth.
- Magellan will administer a comprehensive care coordination model which is expected to reduce unnecessary expenditures (including work with Medicaid MCOs and CCC Program Plans)
- Promotion of more efficient utilization of services
- Development and monitoring of progress towards outcome-based quality measures

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BH Services Covered by Magellan

	FFS	Medallion II	CCC Program
Inpatient	x		
Outpatient	x		
CMHRS	x	X –carved out	
MH/SA Case Mgmt.	x	X-carved out	X-carved out

Implementation update

MAGELLAN BEHAVIORAL HEALTH

Implementation Update

- Provider Handbook will be published next week - check www.MagellanofVirginia.com
- Overall we are at 90% project completion- as of 11/11/13
- Virginia network team fully staffed, trained and in place
- Member services on board as of November 4th
- Clinical staff on board with Clinical Director in place
- EDI/Claims Webinar (182 providers called in) 11/5/13. Recorded version of webinar posted to MagellanofVirginia.com.

VAProviderQuestions@MagellanHealth.com

MAGELLAN BEHAVIORAL HEALTH

Implementation Update

Upcoming Clinical webinars are as follows:

- Inpatient Psychiatric Services, Thursday, November 14, 2013, 4:00 to 5:00 p.m. Eastern time
- Non-traditional Outpatient Services/Level A, B, and C Residential, Monday, November 18, 2013, 10:00 to 11:00 a.m., Eastern time -these are critical trainings and will go through completion of online service authorization request (SAR) forms
- Traditional Outpatient Services, Wednesday, November 20, 2013, 4:00 to 5:00 p.m., Eastern time
- Mental Health Skill-building Services Webinar – week of November 18, date and time TBA

MAGELLAN BEHAVIORAL HEALTH

Population & Services to be Managed and Coordinated

- Magellan will manage the full spectrum of **behavioral health services** for:
  - Medicaid and FAMIS members, including members who participate in Medicaid home and community-based waiver programs, such as the Intellectual Disabilities Waiver, Elderly and Disabled with Consumer Direction Waiver, and Individual and Family Developmental Disabilities Support Waiver.
  - Members who are not currently enrolled in one of the DMAS managed care organization (MCO) contracts.
  - The subset of community mental health and rehabilitation services that are excluded from the DMAS MCO contracts.
- Magellan will NOT manage traditional behavioral health inpatient and outpatient services (such as psychotherapy) for members in DMAS managed care organization (MCO) contracts.

MAGELLAN BEHAVIORAL HEALTH

Service and Other Limits

- Based on Virginia Administrative Code, CMHRS Manual, EPSDT Manual, and Psychiatric Services Manual
- Most services have annual limits; no changes to these limits
- VICAP required for Intensive In-Home Services, Therapeutic Day Treatment, and Mental Health Skill-building Services.
- Service Limit Summary Grid to be posted : www.MagellanofVirginia.com in November as quick reference guide – no changes are being made to these limits

MAGELLAN BEHAVIORAL HEALTH

Community Governance Board: Assuring the Voice & Participation of Members & Stakeholders

- Designed to promote transparency, accountability, and collaboration
- Creation of a Governance Board to include the voice and participation of all stakeholders and assure that the implementation and operation of the program is responsive to local needs
- Stakeholder representation on the Board includes members, persons in recovery, parents or custodians of children and adolescents, CSBs, private community providers, advocates, and health plan/community health representatives
- **Magellan's shared governance structure is inclusive.**

Community Representation	Magellan Representation
CSB or CSB Association Representative	Project Director
Private Community Provider or Association Representative	Provider Relations Director
Adult Service Member Representative	Medical Director
Parent or Custodian Representative of a Child or Adolescent Member	QM/UM Director
Advocate for Mental Health	Director of Recovery and Resiliency
Advocate for Substance Abuse Services	Member Services Director
Health Plan /Community Health Representative	MCO Liaison

Claims FAQ's

What is the process for claims denials and voids?	Claim denials will be sent on the provider paper EOB or the electronic remittance, whichever the provider receives. Electronic submissions are the preferred method for claims submission, payment and remittance advice. Magellan doesn't void claims unless a stop-payment is done on a Magellan check. If there is a need for a change to a claim, the claim should be sent as a corrected claim and the original claim will be adjusted, not voided. Corrected claims can be submitted electronically by selecting the appropriate "corrected claim field." Please note: Only claims that were originally paid and have changes should be sent as corrected. An originally denied claim should just be submitted as a new claim, even if there are changes. For paper submissions, please write "corrected claim" on the bill. Highlighting the changes will ensure Magellan understands the changes being made.
What is the timely filing limit if we have a corrected claim?	Timely filing is 365 days, for all claims.
I have a "pay to" account set up through CAQH. Can you obtain my payment information from that account?	At this time, Magellan is not able to obtain CAQH payment information. Information on our EFT/ACH process can be found on www.MagellanHealth.com/provider under the "Getting Paid" section.

MAGELLAN BEHAVIORAL HEALTH

Claims FAQ's

How are claims processed for dual-eligibles?	Claims for dual-eligibles should be submitted to Medicare for reimbursement. The claims will be sent to DMAS for processing for the Medicaid portion. Magellan will not receive the dual-eligible claims for services covered by Medicare. For non-traditional CMHRS claims for FFS dual eligible's will come to Magellan
Will the rates be different through Magellan?	No. The rates will remain the same, as will the codes that you currently bill.
In our previous provider enrollment forms, we had a section for the EFT/ACH (direct deposit) information. I noticed it isn't requested in the Magellan provider enrollment forms. How is this information shared with Magellan?	You can sign up for EFT (electronic funds transfer) on the secure section of the Magellan provider website. Your login information for the secure site is sent with your "Welcome" letter, along with your executed contract.
Where can I find a list of codes and rates for billing to Magellan?	The rates and codes are the same that are in place today. Magellan also will post DMAS rates on MagellanofVirginia.com in November 2013.

MAGELLAN BEHAVIORAL HEALTH

Clinical/Covered Services: Frequently Asked Questions

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Clinical/Covered Services FAQ's

What if consumers have questions or issues with medication or other treatments?	You may speak with a Magellan physician advisor or care manager and or your treating provider.
What is Magellan's referral process for difficult cases (kids)?	Providers are still responsible for transitioning case, help with d/c planning, etc. Magellan will work with providers and members to help identify the best match. Magellan will be able to assist in finding network providers, and provide case consultation when needed.
Will you cover services for children in foster care?	Magellan will manage Treatment Foster Care Case Management services. Magellan will not manage Treatment Foster Care services, however. If the child is covered within the Medicaid fee-for-service program, Magellan would also manage their array of behavioral health benefits.
Is teletherapy allowed as a covered service?	There are specific codes allowed for teletherapy, as outlined in the Virginia Medicaid provider manual from DMAS.
Is Magellan responsible for step-down services? Who do I contact?	For the fee-for-service Medicaid population, Magellan will be responsible for all behavioral health services. For members enrolled in managed care organizations (MCOs), Magellan will be responsible for step-down to non-traditional services, but not for traditional outpatient services. Contact the Magellan of Virginia customer service line, after December 1st.

MAGELLAN BEHAVIORAL HEALTH

Authorizations: Frequently Asked Questions

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Authorizations: FAQ's

What is the turnaround time for preauthorization?	Magellan's goal is to make an authorization decision as soon as possible. Established maximum limits are currently: • 3 hours if someone is at an ER and requesting inpatient admission; • 1 business day if already admitted to inpatient; and • 3 business days for all other services.
What happens if Medicaid eligibility gets established retroactively, after Dec. 1, but the dates of service are before Dec. 1?	Any service authorized after Dec. 1, 2013, even retroactively, would be handled through Magellan.
What if we submit a request prior to Dec. 1, for dates of service that extend beyond Dec. 1? From whom do we obtain authorization?	If you submit a request prior to Dec. 1, 2013, for dates of service that begin or extend beyond Dec. 1, to December 7, then send the request to KePRO. They will authorize in their regular manner. Magellan will honor KePRO's authorizations. Magellan will begin taking authorizations on Dec. 1.

MAGELLAN BEHAVIORAL HEALTH

Authorizations: FAQ's

How will you handle authorizations that came from the KePRO system where the authorization was made to the physician?	All existing KePRO authorizations will be transferred to Magellan, as they were originally made.
What is the primary method for notifying providers of authorizations?	On the Magellan website, feedback will be given immediately, if authorized through our "Request Higher Level of Care" system for inpatient admissions. If the provider talks with a care manager to receive the inpatient authorization, the provider will receive verbal confirmation of authorization. For all service requests, the authorization also will be available for viewing on the secure section of the provider website.
If an authorization is pended, what is the turnaround time for notification? How will providers be notified?	If a service authorization request is incomplete, Magellan will call or fax the provider (regardless of whether the request was sent by mail, fax or submitted online). The provider has one business day to complete the request. Magellan then has one business day to review and respond to the request. If the provider does not complete the request within one business day, Magellan will Administratively Deny the request. At that point, the provider will need to resubmit the request.

MAGELLAN BEHAVIORAL HEALTH

Credentialing: Frequently Asked Questions

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Credentialing: FAQ's

What if our organization provides only in-home service and the home is where the individual receives services? Do you want the organizational address?	Yes, you would list your organizational address that is registered with your agency license for all licensed locations.
Are the staff requirements for Magellan any different from what DBHDS requires?	Magellan's requirements mirror what DBHDS and DMAS requires.
I did not receive a credentialing application. How do I get one sent to me/my organization?	You may call a Magellan network representative at 1-800-424-4536, or send an email to: VAProviderQuestions@MagellanHealth.com.

MAGELLAN BEHAVIORAL HEALTH

Credentialing: FAQ's

My organization is not accredited by any of the accrediting bodies mentioned in the application. Will my organization still be allowed to participate?	Accreditation is recommended, but not required for participation with Magellan. If you are licensed and in good standing with DBHDS, Magellan will accept the license (which indicates your organization has been site visited by DBHDS and meets requirements) in lieu of an accreditation.
Do I need to complete an application for my school-based locations?	Yes, each active service location that provides behavioral health services will need to be reported to Magellan in order to be credentialed.
Is the staff roster for all staff or for licensed staff only? What about QMHP or paraprofessional?	The organizational roster staff form will need to include all licensed professional staff providing behavioral health services. Your QMHP and paraprofessional staff do not need to be reported.

MAGELLAN BEHAVIORAL HEALTH

Credentialing: FAQ's

My organization only provides community based/in-home services. Do we need to have professional liability insurance?	All providers are required to have a minimum of $1 million per occurrence and $1 million aggregate coverage for both General and Professional Liability. DMAS has confirmed this is the minimum allowed.
Will Magellan require client visits to meet physician directed requirements or can we credential providers independently and use the psychiatric services model?	The DMAS rules and regulations for delivery of services remain the same. DMAS will continue to require client visits to meet physician directed requirements.

MAGELLAN BEHAVIORAL HEALTH

Training: Frequently Asked Questions

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BEHAVIORAL HEALTH

Training: FAQ's

Will you host any more in-person training sessions for providers?	Magellan will host several webinars for providers between now and Dec. 1 on key topics such as EDI Claims billing and how to request service authorizations. The webinar for requesting Inpatient Psychiatric services will be from 4-5 pm on November 14; the webinar for requesting non-traditional services including Level A, B, and C Residential will be from 10-11am on November 18; and the webinar for requesting traditional outpatient (mental health and substance use) will be from 4-5 pm on November 20. After Dec. 1, our network team will determine when additional in-person training sessions are needed.
I missed the training forums/webinars. Will they be repeated?	You can find recorded versions of past webinars, as well as any slides/handouts from our provider forums, on the MagellanofVirginia.com website.

Questions

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Department of Medical Assistance Services

Virginia Coalition of Private Provider Associations

Kristin Burhop and Elizabeth Smith

November 14, 2013

Overview

- Introducing Commonwealth Coordinated Care (CCC)
- Behavioral Health Homes
- Enrollment
- Timelines

Commonwealth Coordinated Care

- Beginning early 2014, Virginia is rolling out a new initiative called *Commonwealth Coordinated Care* or CCC.
- Provides high-quality, person-centered care for Medicare-Medicaid enrollees that is focused on their needs and preferences
- Blends Medicare and Medicaid services and financing to streamline care and eliminate cost shifting

Commonwealth Coordinated Care

- Creates a single program to coordinate delivery of primary, preventative, acute, behavioral, and long term services and supports
- Promotes the use of home and community based behavioral and long term services and supports
- Supports improved transitions between acute and long term facilities

Commonwealth Coordinated Care

- CCC is a voluntary program for individuals who are full benefit Medicaid and Medicare (entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits).
- Individuals may proactively sign up or be automatically enrolled.
- When an individual is enrolled in CCC, he/she will no longer have traditional Medicare or Medicaid fee-for-service.
- Instead, the individual will have one plan, with one ID card, and one number to call for assistance.

Commonwealth Coordinated Care

- DMAS is currently in negotiations with three health plans who are proposing to provide services and supports under CCC:
  - Healthkeepers
  - Humana
  - Virginia Premier

Commonwealth Coordinated Care

- CCC provides all the same benefits currently available under Medicaid and Medicare
- CCC also provides case management services for all beneficiaries
- Behavioral health homes will also be an option
- There may be additional services such as telehealth and dental coverage
- More specific information on services and supports available under CCC will be available next month.

Who is eligible for CCC?

- Full benefit Medicare-Medicaid Enrollees (entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits)
- Participants in the Elderly or Disabled with Consumer Direction Waiver
- Residents of nursing facilities
- Age 21 and Over
- Live in designated regions (Northern VA, Tidewater, Richmond/Central, Charlottesville, and Roanoke)

Who is eligible for CCC?

Approximately 78,600 Medicare-Medicaid Enrollees

Region	Nursing Facility	EDCD Wavier	Community Non-waiver	Total
Central VA	4,430	3,762	16,135	24,327
Northern VA	1,935	1,766	12,952	16,653
Tidewater	3,031	2,492	12,575	18,098
Charlottesville	1,477	842	4,427	6,747
Roanoke	2,833	1,355	8,583	12,771
Total	**13,706**	**10,217**	**54,672**	**78,596**

Who is *not* eligible for CCC?

- Individuals not eligible include those in:
  - ID, DD, Day Support, Alzheimer's, Technology Assisted HCBS Waivers
  - MH/ID facilities
  - ICF/IDs
  - PACE (although they can opt in)
  - Long Stay Hospitals
  - Money Follows the Person (MFP) program
  - Hospice

Behavioral Health Homes

- One of the unique features of the CCC is the opportunity for health plans to develop behavioral health homes.
- Behavioral health homes are a team-based services delivery model that provides comprehensive and continuous care to patients, including care management, with the goal of maximizing health outcomes.
- Behavioral and physical health services are provided to individuals in one system of care.

Behavioral Health Homes

- DMAS estimates there are over 17,000 dual eligible individuals with SMI in Virginia.
- This figure represents a population of individuals with comprehensive health and behavioral health care needs that historically have been underserved.

Behavioral Health Homes

- Health Plans are working in partnership with Virginia's Community Services Boards (CSBs) in the development of these health homes.
- The behavioral health homes will serve as a comprehensive behavioral health management program that integrates physical and behavioral health services and that has the staff and resources to improve health care delivery, including the ability to rapidly respond to acute episodes for individuals with severe mental illnesses.

Behavioral Health Homes

- The CSBs will use person-centered planning to work with the individual in assessing overall needs, goals, and preferences for services and choices of service providers.
- Together, the health plan, CSB and individual, will design a service plan that will meet the individual's life and health goals while coordinating care for healthy and productive community living.

Behavioral Health Homes

- Individuals with high behavioral health needs benefit from this health home choice:
  - The Targeted Case Management provided by the CSBs will assure outreach, linkage to services that support well-being, monitoring for stability and wellness, and making adjustments in levels of service needs.
  - This Targeted Case Management assists with an individual's medical health condition with routine care.
  - The health plan care coordinator can ensure that follow-up and support services are coordinated outside of the behavioral health home.

Behavioral Health Homes

- Expected outcomes for the health homes are:
  - Reduced use of the ER for routine care
  - Regular use of preventive strategies
  - Reduced hospitalizations and re-admissions
  - Coordinated prescribing and medication management
  - Crisis prevention and avoidance

Behavioral Health

- For CCC, health plans are required to have an adequate network of behavioral health and substance abuse providers to meet the needs of the dual eligible population, including their community mental health rehabilitative service needs.

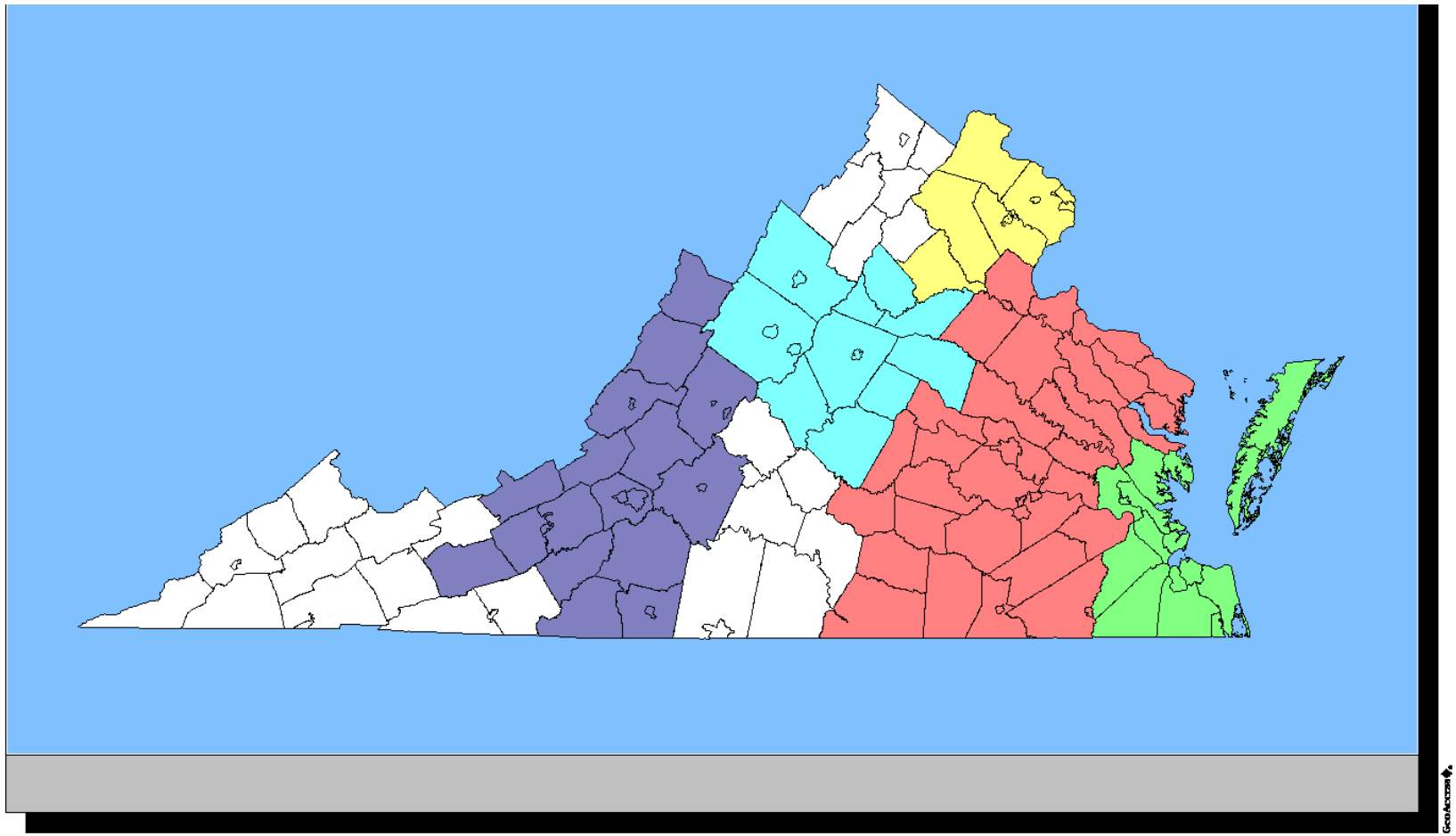
Behavioral Health

- Examples of the types of providers in the health plan network include but are not limited to the following:
  - Psychiatrists
  - Clinical psychologists
  - Licensed clinical social workers
  - Outpatient substance abuse treatment providers
  - Residential substance abuse treatment providers for pregnant women

Enrollment

- Enrollment in CCC will be in five regions of the Commonwealth:
  - Central Virginia/Richmond
  - Tidewater
  - Northern Virginia
  - Roanoke area
  - Charlottesville area

Virginia's Service Regions



Enrollment

- Enrollment will also be in two phases:
  - The first phase is called “voluntary enrollment” where an individual proactively enrolls in the program
  - The second phase is called “passive enrollment” (also known as automatic enrollment) where the individual is automatically enrolled into the CCC program. Individuals will be automatically enrolled after considering the individual’s previous enrollment with the health plans, or the health plan network that includes their current adult day health provider or nursing facility (if applicable).

Enrollment

Most importantly, if an individual is unhappy with the health plan chosen for them, he/she may request reassignment to another health plan or opt out of the program and return to traditional Medicare and Medicaid.

Commonwealth Coordinated Care
Enrollment Timeline

- Central Virginia/Richmond and Tidewater areas:
  - Early 2014: Voluntary enrollment begins
  - March 2014: Coverage begins
  - May 2014: Automatic enrollment begins
  - July 2014: Coverage for those automatically enrolled begins

- Northern Virginia, Roanoke, Charlottesville areas:
  - May 2014: Voluntary enrollment begins
  - June 2014: Coverage begins
  - August 2014: Automatic enrollment begins
  - October 2014: Coverage for those automatically enrolled begins

Timeline

for

Central Virginia/Richmond and Tidewater areas

- Early 2014: first letters are mailed to eligible individuals.
- March 2014: For those signed up with CCC, coverage begins.
- May 2014: Automatic enrollment begins.
- July 2014: For those automatically enrolled in CCC, coverage begins.

Timeline

for

Northern Virginia, Roanoke, Charlottesville areas

- May 2014: First letters are mailed out to eligible individuals
- June 2014: for those signed up for CCC, coverage begins.
- August 2014: Automatic enrollment begins.
- October 2014: Coverage for those automatically enrolled begins.

Contact Information

Office of Coordinated Care
Virginia Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, VA 23219
CCC@dmas.virginia.gov

Cuts in Funding for the CSA Budget
Since 2009

- Since October 2009, Governors Kaine and McDonnell, along with the General Assembly, have reduced funding to the Comprehensive Services Act as follows:
  - October 2009 (Emergency Budget Action): **$31.6 million** reduced for FY 2010, based on estimated lower utilization of residential treatment services;
  - 2010 General Assembly: **$31.6 million** reduction for FY 2011 AND **$31.6 million** reduction for FY 2012, based on anticipated decline in program growth;

Cuts in Funding for the CSA Budget
Since 2009 – continued

- FY 2011 Year End: **$32.4 million** unallocated balance was captured and re-allocated to other non-children's services areas;
- FY 2012 (Caboose Budget): **$24.8 million** reduction based on "anticipated use of the program by localities;"
- 2012-2014 Governor's Proposed Budget: Over biennium, **$22.4 million** reduction in base budget, **$10.8 million** reduction in elimination of special education wrap-around services as a "mandated" service.

Cuts in Funding for the CSA Budget
Since 2009 – continued

- 2012-2014 Budget Conference Report: Additional **$17.7 million** reduction over biennium to "reflect lower caseload growth" with **$4.5 million** *restored* for special education wrap-around services.
- 2013 Session: Additional **$51.5 million** reduction over the remainder of the biennium in anticipation of lower caseloads and reduction of "fraud, waste and abuse."

- Total Reduction in CSA Spending from October 2009 through end of FY 2014: **$254.4 million**

Cuts in Funding for the CSA Budget
Since 2009 – continued

- Total Re-allocation of CSA Budget from October 2009 through end of FY 2014 to Other CSA Services: **$4.5 million** (to partially restore special education wrap-around services to mandated category)
- Total Net Reduction in CSA Spending (real and proposed) from October 2009 through end of FY 2014: **$249.9 million**
- There are many other critical unmet needs in children's services. However, since 2009, ***nearly $250 million of CSA funds have been redirected away from children's services*** into other areas of the budget or as part of other various budget savings strategies.

Critical Budget Issues Facing the 2014 General Assembly

Presentation to Virginia Coalition of Private Provider Associations (VCOPPA)

Joe Flores, Senate Finance Committee

Thursday, November 14, 2013

Overview of Presentation

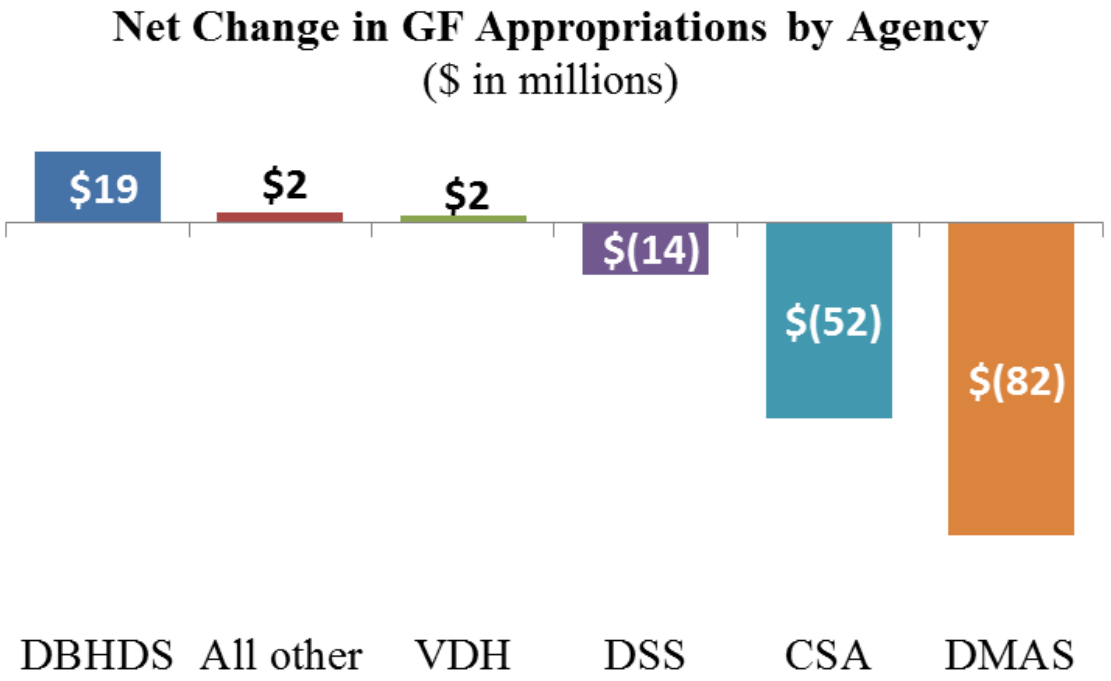
- What does Virginia's revenue picture look like?
- What are the spending pressures?
- What are the major issues in HHR?
  - Medicaid Reform and Expansion
  - Department of Justice Settlement Agreement
- What else?

What Does Virginia's Revenue Picture Look Like? Sluggish

- Even though Virginia's revenue picture continues to improve, the general fund revenue forecast will likely be conservative reflecting various headwinds.
- Uncertainties surrounding the federal budget stalemate continue to cloud the economic horizon leading to:
  - Layoffs by federal contractors;
  - Reductions in federal grant funding; and
  - Waning business and consumer confidence.
- What other federal budget and policy issues are out there?
  - The federal shutdown is estimated to have had a multi-billion dollar impact on the national economy.
  - The sequester is likely here to stay.
  - Implementation of the Affordable Care Act has been bumpy.
- Revenue growth will be modest.

How did HHR Agencies Fare in 2013?

- HHR was not a priority area for new spending during the 2013 Session, additional funding met immediate needs.
  - Net general fund reductions in HHR reflected additional revenues or declining caseloads.



Where Were General Fund Resources Added in HHR Last Session?

- Recession-induced budget reductions have led to growing waiting lists for services across HHR agencies.
  - Modest investments were made to mental health services.

Sample of HHR Budget Priorities During 2013 Session	
Behavioral Health & Developmental Services	Reduce waiting lists for Part C services
	Implement DOJ agreement
	Expand DAP funding
	Expand access to mental health care
Department for Aging & Rehabilitative Services	Reduce waiting list for Vocational Rehabilitation and brain injury services
Department of Medical Assistance Services	Add ID and DD waiver slots
	Restore eligibility for SSI recipients/LTC services

What are the current spending pressures? Medicaid, VRS and SOQ

- Three programs areas are expected to put pressure on the resources available for other spending – Medicaid, the Virginia Retirement System and Standards of Quality.
- Medicaid spending is projected to slow as enrollment growth has fallen from recession-level highs.
  - Projected growth in Medicaid may require the addition of $750 million from the general fund over the biennium to account for utilization and inflation for health and long-term care services.
- Pension liabilities for the Virginia Retirement System are expected to exceed $313 million GF for the biennium.
- Funding the SOQ is expected to cost $350 million GF.

What are spending pressures in HHR?

- Additional resources will be needed to implement the Department of Justice Settlement Agreement.
  - Over 525 new intellectual disability (ID) waiver slots must be added during the biennium.
  - Additional resources will likely be needed to ensure the successful transition of training center residents into the community.
- Adoption Assistance subsidy payments continue to grow as children are adopted from foster care.
- The impact of federal funding cuts is hitting numerous state agencies.
  - Each reduction will be considered independently.

Major Policy Issues in HHR? Medicaid Reform and Expansion

- Budget conferees agreed that reforms should be put in place before expanding Medicaid.
  - Major differences centered around **a)** how extensive the reforms would be, **b)** what populations the reforms applied to, and **c)** when expansion could occur.

- The Senate-approved language that would have triggered the expansion of coverage upon federal approval of specific reforms related to services, benefits, and cost-sharing for the expansion population.

- The House-approved language required a more comprehensive list of reforms to the services, benefits, delivery systems, and administrative process for current enrollees and the expansion population before deciding whether to expand coverage.

- The Senate agreed to the House's comprehensive approach with the caveat that coverage would be expanded if the conditions for reform were met.

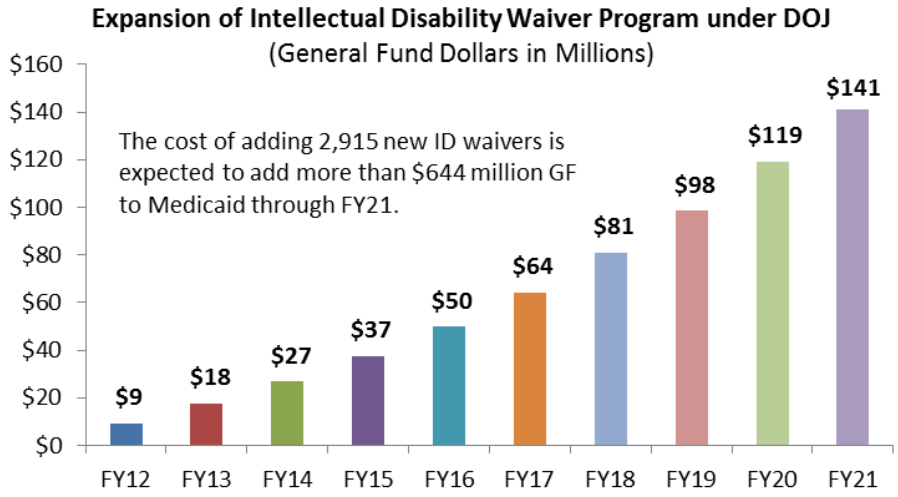
Medicaid Innovation and Reform Commissions (MIRC)

- The 2013 General Assembly charged the MIRC with overseeing the implementation of reforms related to the Medicaid program.
- Four meetings have been convened to date, including a session to solicit public comments.
  - The MIRC heard testimony about Virginia's Medicaid program, recent trends in caseload and cost, reform efforts implemented in Virginia as well as other states, and the cost of expanding coverage in Virginia.
- The Commission has not taken a vote on the question of whether reforms have been satisfactorily implemented.
- The 2013 General Assembly spent considerable amounts of time and energy discussing the question of Medicaid reform and expansion.
  - The 2014 General Assembly will likely resume the conversation.

Department of Justice Settlement Agreement

- The Commonwealth made a historic commitment to expand community-based care for individuals with intellectual and developmental disabilities when it agreed to a settlement with the Department of Justice.

- However, there was very little discussion about reforming Medicaid-funded, home- and community-based waiver services before committing to add 2,915 new slots through FY 2021.
  - Without reforms, these new slots will put added pressure on Medicaid spending in future years.



What's Next?

- Over the next few weeks, the McAuliffe Administration will appoint key staff and begin to lay out its agenda.
  - Lobbyists and advocates will need to quickly convey their message to new actors within the Administration.
- But don't forget about the old actors!
- Governor McDonnell will present the 2014-16 biennial budget on Monday, December 16th.
  - The incoming Governor will propose amendments to that budget along with changes proposed by the members of the House and Senate.
- Membership in the House did not change significantly but key Committee assignments will.
- The final make-up of the Senate has yet to be decided.
  - At least two special elections will need to be held to replace Senate seats that become vacant.
- Divided government will be the rule for the next four years.

Conclusion

- General fund resources have stabilized but are not likely to grow significantly in the short-term.
- Modest investments were made to HHR programs during the 2013 Session, primarily to address waiting list for services and small service expansions.
- Obligations for three programs – Medicaid, VRS and SOQ – will likely consume most of the available resources in the next biennial budget.
- Whether to expand Medicaid (or not) and implementation of the DOJ Settlement agreement will once again dominate budget discussions in HHR.
- The new Governor will confront a sizeable House Republican majority and equally divided Senate in the next few years.

An Analysis of Trends in the 2013 Virginia House of Delegates Elections

After digging a little deeper into the 2013 Election results (courtesy of VPAP and the State Board of Elections), some interesting numbers emerged in the House of Delegates races. Obviously, the first visible result is that Republicans lost two incumbents, but picked up the open Joe Johnson (D) seat and the open Lacey Putney (I) seat, keeping their numbers at 67 in the House; and that Democrats had a net gain of +1 (defeating 2 R incumbents, losing the Johnson seat unopposed), bringing their numbers to 33 in the House.

However, what was interesting were the results in the House races that were contested by a candidate of the opposite party or an independent candidate:

- On the D side, of the remaining 31 D pre-election held seats, *only 15 of those were contested*. In those 15 contests, only in one race did the D candidate receive *less than 60% of the vote* (and that was 57%).

- On the R side, in addition to the two incumbents who were defeated, of the remaining 65 R pre-election held seats, *37 of those were contested*. In those 37 contests, 8 victorious R's held their seats with *less than 53% of the vote*. If the threshold is moved to 55% or less of the vote (the upper levels of competitiveness), that number increases to 13. Conversely, there were 14 R's in contested races who won 60% or more of the vote, *the same number as D's in similar circumstances as noted above*. If the race for Putney's open seat is added, that number increases to 15.

So what are the takeaways from this?

1. Democrats obviously are now situated in *very heavily concentrated and seemingly uncompetitive districts* (other than the two new seats they just picked up). Only 15 of their seats were contested, with 16 being uncontested, and only *one contested D received less than 60% of the vote*. Therefore, at this point it seems that D's are at their core minimum strength and really *do not have to play defense* with any of the seats they have (other than the two new seats).

2. On the other hand, Republicans are probably at their maximum possible strength and as a result have more territory to defend, *including 13 seats that could be considered at least loosely competitive* (winning with 55% or less of the vote) based on the 2013 results. But still, of their now currently elected 67 seats, 29 were uncontested on Election Day, while 38 seats (including the Putney pickup) were contested.

Here's another way to look at it, based on the 2013 results:

Democrats (33 total)

- 16 were elected uncontested
- 15 were elected uncompetitively (greater than 55%)
- 2 were elected competitively (both new seats)

Republicans (67 total)

- 29 were elected uncontested
- 25 were elected uncompetitively (greater than 55%)
- 13 were elected competitively (less than 55%)

While each election is its own separate event and caution should be taken not to carry over too much of a trend from one to another, in looking at these numbers, it would appear that *Democrats have 31 "safe" seats* (either uncontested or uncompetitive in 2013), while *Republicans have 54 "safe" seats*. In the middle are 15 seats that are potentially "in play" every two years, currently held by 2 Democrats and 13 Republicans. Again, the Republicans have more ground to defend, and can possibly expect to lose some of these seats in the next few elections (especially in northern Virginia), but even if **ALL** 15 of these seats were in the D column, *Republicans would still control the House 54-46*.

Analysis of Results in Contested House of Delegates Seats by Party

(Sources: Virginia Public Access Project, Virginia State Board of Elections)

Contested Seats Held by Democrats Before the 2013 Elections

	Dem	GOP	Oth
HD35: **Keam*** /Luse	66.0%	34.0%	-
HD37: **Bulova*** /Winter	61.1%	38.9%	-
HD38: **Kory*** /Leslie	75.2%	0.0%	24.8%
*HD41: **Filler-Corn*** /Burgos/DeCarlo*	*57.0%*	*39.4%*	*3.6%*
HD43: **Sickles*** /Parker	74.4%	0.0%	25.6%
HD44: **Surovell*** /Glean	71.7%	0.0%	28.3%
HD45: **Krupicka*** /Engle	74.5%	0.0%	25.5%
HD47: **Hope*** /Delhomme	77.6%	0.0%	22.4%
HD49: **Lopez*** /Modglin	78.8%	0.0%	21.2%
HD53: **Simon**/Tidwell/Tellez	66.8%	29.0%	4.2%
HD69: **Carr*** /Barnett	87.4%	0.0%	12.6%
HD71: **McClellan*** /Fitch	88.1%	11.9%	-
HD75: **Tyler*** /Peschke	62.5%	37.5%	-
HD95: **BaCote*** /Bloom	76.7%	23.3%	-
HD100: **Lewis*** /Smith	71.2%	0.0%	28.8%

Contested Seats Held by Republicans Before the 2013 Elections

	Dem	GOP	Oth	
HD02: Dudenhefer*/**Futrell**	50.7%	49.3%	-	
HD03: **Morefield***/O'Quinn	29.7%	70.3%	-	
HD06: **Campbell**/McGrady/Hall	36.6%	57.1%	6.3%	
HD07: **Rush***/Abraham	34.9%	65.1%	-	
HD10: **Minchew***/Johnson	43.1%	56.9%	-	
*HD12: **Yost***/Harder*	*47.5%*	*52.5%*	-	*+892*
*HD13: **Marshall***/Qarni*	*48.6%*	*51.4%*	-	*+498*
HD14: **Marshall***/Miller/Martin	38.0%	58.7%	3.2%	
HD16: **Adams**/Jones	36.8%	63.2%	-	
HD17: **Head***/Cathcart	37.9%	62.1%	-	
HD18: **Webert***/Harris	36.6%	63.4%	-	
HD21: **Villanueva***/Hippen	45.4%	54.6%	-	
HD22: **Byron***/Cyphert	33.8%	66.2%	-	
HD23: **Garrett***/Parrish	0.0%	77.1%	22.9%	
HD29: **Berg**/Yates	0.0%	65.5%	34.5%	
HD30: **Scott***/Dippert	36.6%	63.4%	-	
*HD31: **Lingamfelter***/McPike*	*49.5%*	*50.5%*	-	*+234*
*HD32: **Greason***/Miller*	*48.6%*	*51.4%*	-	*+634*
HD33: **LaRock**/Daniel/Hagerty	42.9%	53.7%	3.4%	
*HD34: **Comstock***/Murphy*	*49.3%*	*50.7%*	-	*+431*
HD40: **Hugo***/Foltz	39.9%	60.1%	-	
HD42: **Albo***/Deitsch	40.1%	59.9%	-	
HD50: **Miller***/Cabellos	45.0%	55.0%	-	
HD51: **Anderson***/Heddleston	46.4%	53.6%	-	
HD55: **Fowler**/Radler/Sullivan	37.5%	56.9%	5.6%	
HD60: **Edmunds***/Hendricks	35.7%	64.3%	-	
HD65: **Ware***/Quarles	32.2%	67.8%	-	
HD67: **LeMunyon***/Nguyen	45.4%	54.6%	-	
HD68: **Loupassi***/Grogan	0.0%	62.6%	37.1%	
HD78: **Leftwich**/Bryant/Foster	39.1%	57.2%	3.7%	
HD82: **DeSteph**/Fleming	40.1%	59.9%	-	
HD84: **Davis**/McKenzie	42.6%	57.4%	-	
HD85: **Taylor**/Dale	43.6%	56.4%	-	
*HD86: **Rust***/Boysko*	*49.9%*	*50.1%*	-	*+56*
*HD87: **Ramadan***/Bell*	*49.3%*	*50.3%*	-	*+195*
HD88: **Cole***/O'Halloran	38.5%	61.5%	-	
HD93: Watson*/**Mason**	52.2%	47.8%	-	
*HD94: **Yancey***/Farinholt*	*48.7%*	*51.3%*	-	*+537*
HD98: **Hodges***/Putt	0.0%	76.0%	24.0%	

2013 Virginia Elections Post Mortem

Analysis of Statewide and House of Delegates Results

2013 Statewide Elections

Governor of Virginia

47.7%

45.2%

2013 Statewide Elections

Lieutenant Governor of Virginia

55.1%

44.5%

2013 Statewide Elections

Attorney General of Virginia

49.89%

+164**

49.88%

2013 House of Delegates Elections

House of Delegates:

- **Prior to Election:**
  - **67 Republicans**
  - **32 Democrats**
  - **1 Independent**

- **2013 House Election Results:**
  - **67 Republicans**
    - **2 Incumbents Defeated**
    - **Pick Up 1 D Open Seat, 1 Independent Open Seat**
  - **33 Democrats (+1)**
    - **All Incumbents Re-Elected** *(with at least 57%)*
    - **Defeat 2 R Incumbents**

Senate of Virginia

Elected Every 4 Years – Next Regular Election 2015

Current Party Control:

- *Prior to Election:*
  - **Republicans - 20 (Lieutenant Governor Bolling is tie-breaker)**
  - **Democrats - 20**

- *Impact of 2013 Statewide Election Results:*
  - **Special Election to Replace Senator Northam (D)**
    - **Swing District**
    - **D selection 11/16 (3 candidates), R selection 11/21 (2 candidates)**
  - **Special Election to Replace Senator Herring (D) or Senator Obenshain (R)**
    - **Herring Swing District / Obenshain Safe R District**
    - **Limbo Until AG Results Final**

2013 House of Delegates Elections

Changing Demographics of Virginia General Assembly

House of Delegates:

- 67/100 elected since 2005 (>8 years experience)
- 14/100 retirements/defeats since end of 2013 Session
- 5 Committee chairs will change
  - Appropriations
  - Finance
  - Education
  - Transportation
  - Agriculture
- 4 out of top 6 in seniority retired
- 24% of the House's years of experience leaving

Senate of Virginia:

- 23/40 elected since 2003 (>10 years experience)

Initial Analysis of 2013 Virginia Statewide and House of Delegates Elections

Below is an initial analysis of the results of the Virginia Statewide and House of Delegates elections held on November 5th. Democratic candidates took the top two statewide offices, while the Attorney General's race is too close to call and almost certainly headed to a recount, the results of which may not be known until December. In addition, there follows a brief discussion of how these results may impact policy decisions that will be heard during the 2014 Virginia General Assembly.

Governor of Virginia:

With all precincts now reporting, Democrat Terry McAuliffe has been elected Governor over Republican Attorney General (and Tea Party favorite) Ken Cuccinelli by a narrow margin of 47.7% to 45.3%. Independent Robert Sarvis, an unknown private businessman, also received 6.5% of the vote, an indication of the voters' dissatisfaction with the major party candidates. Sarvis ran as a Libertarian, but it was felt that his supporters pulled support equally from the two main candidates and his presence in the race did not change the outcome.

Although it was thought that McAuliffe enjoyed a comfortable lead in the polls in the weeks leading up until Election Day, and he was outspending Cuccinelli by record margins, the Republican was able to close the gap substantially by election day. Early analysis seems to point to the shift in Cuccinelli's strategy in the final weeks to make the race a referendum on Obamacare and remind voters that he was the first state Attorney General to file suit against it after it was passed. It was an effective strategy and had the race lasted another week, he may have been able to close the gap completely and won the election. Turnout was also a factor that worked in Cuccinelli's favor, as only 39% of Virginia's voters participated, down from the 62% who came out last November in the Presidential elections.

Governor-Elect McAuliffe will be faced with the immediate challenge of trying to govern while dealing with a state legislature controlled overwhelmingly in the House by a very conservative Republican majority of 67-33. The Senate was split 20-20 prior to the election, but the outcomes in the Lieutenant Governor's and Attorney General's races will create vacancies in the Senate that will necessitate special elections that could swing the balance of power to the Republicans in that body.

Lieutenant Governor of Virginia

In a race that was never really in doubt from the moment the Republicans chose their controversial nominee, Democratic State Senator Ralph Northam comfortably defeated his Republican opponent, Bishop E. W. Jackson, by a margin of 55.1% to 44.5%. Lieutenant Governor-Elect Northam is a doctor from the Eastern Shore of Virginia and is considered moderate to conservative on most issues. While he will have the potential to now break the 20-20 tie in the Senate in favor of the Democrats, which could lead to new Democratic committee chairs, his State Senate seat is considered a swing district that is not guaranteed to remain in the Democratic column. So Northam could conceivably preside over a Republican controlled Senate (21-19, or 22-18, depending on the results of the AG's race). This development also has major policy implications for the incoming McAuliffe Administration, already facing a Republican roadblock in the House of Delegates.

Attorney General of Virginia

By the end of the evening on Election Day, the race for Attorney General was the only one still very much in doubt. As of 5:00 p.m. on Thursday, November 7, with all precincts reporting in, Republican State Senator Mark Obenshain of Harrisonburg is holding a razor slim 681 vote lead over Democratic State Senator Mark Herring of Leesburg, or a margin of 49.90% to 49.87%. However, these numbers continue to fluctuate, as local voting registrars recheck their totals and correct transcription errors. This race will most certainly head for a recount; however that action cannot happen until after the State Board of Elections certifies the election results on November 25. After that, the candidate behind may formally request the recount. Eight years ago, current Governor Bob McDonnell was declared the winner in the Attorney General's race by 323 votes, six weeks after the election was held.

In the closing weeks of this campaign, Republican donors poured huge amounts of cash into Obenshain's campaign in an effort to salvage one of the three statewide offices. During that time, Obenshain outraised Cuccinelli at the top of the Republican ticket by a 10-1 ratio, an unheard of development in Virginia politics. Whichever candidate eventually wins, their election will open up another Senate seat – Obenshain currently holds a reliably Republican seat, while Herring's district is considered a toss-up. So theoretically, should Herring win the AG's race, the Democrats could wind up sweeping the three statewide races, but lose two Senate seats and potential control of that body. If Obenshain wins this race, he will immediately become the front-runner for the 2017 Republican nomination for Governor (presumable lined up against Lieutenant Governor Northam on the Democratic side).

House of Delegates Races

All 100 seats in the House of Delegates were up for election on Tuesday, although only 55 of those were contested at all, either by a candidate of the opposite party or an independent. As mentioned earlier, the Republicans will maintain an overwhelming 67-33 majority in that body. In the actual results, Democrats lost no incumbents (but did lose one open seat), while the Republicans did lose two incumbents (but picked up one D open seat and an open seat previously held by an Independent).

Conclusions

One issue sure to be impacted by yesterday's results is the fate of Medicaid expansion in Virginia. At the end of the 2013 General Assembly, a trigger mechanism was agreed to which would have allowed expansion to take place should certain Medicaid reform measures be put in place. These triggers were to be certified by a commission of ten legislators, five from the Senate and five from the House (with a majority of three from each body needed to vote affirmatively). Although the state Medicaid agency feels that these triggers have now been met, there is serious doubt that three House members on the reform commission will agree.

Had Cuccinelli won, Medicaid expansion would be dead in Virginia for the foreseeable future, as he spent a great deal of effort as Attorney General trying to have the commission's authority declared unconstitutional. With McAuliffe's victory, expansion at least still has a pulse, but it should be considered on life-support for right now. After yesterday's results and Cuccinelli's ability to nearly pull off a last minute upset, Republicans have discovered a very effective political tool in exploiting the troubled rollout of the ACA.

Until these problems are fixed at least in the public's mind, there is no way the House members of the reform commission will certify that reform triggers have been met. If Democrats maintain the 20-20 split in the Senate, they will probably be able to get expansion back into their version of the state budget and try to prevail in conference with the House at the end of the Session in March. But if the ACA difficulties have not be addressed sufficiently by then, or if the Republicans pick up a Senate seat in the special elections leading up to the 2014 Session, it will be unlikely to see the expansion enacted in the near future.

It is too early to tell if McAuliffe's election is likely a positive development for our interests in Virginia. He is at his core a businessman and a dealmaker, so in that sense he has an appreciation for the needs of business. He has also been clear in his support of mental and behavioral health issues and campaigned in support of the expansion of Medicaid. In terms of appointments to his Administration, he has expressed the desire to operate in a bi-partisan manner. There is certainly the possibility that he will retain current Secretary of Health and Human Resources Bill Hazel in his Administration (while Cuccinelli most certainly would not have); if not, another name mentioned prominently in the early stages of speculation for that position is former State Health Commissioner Karen Remley, who resigned that position earlier this year in protest over AG Cuccinelli's role in forcing through the stricter regulations for abortion clinics.

In the next few weeks, we will be working with the Governor-Elect's transition team to make sure our interests are protected and to make sure we have access as needed. In the meantime, please do not hesitate to contact me if you have questions then.