BPRO Subcommittee Meeting

Work Requirement Update:

Work requirement is one of three sections of COMPASS (Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency) which is submitted to CMS as a proposal as part of the Section 1115 Waiver; we already have The Virginia Governor’s Access Plan (GAP) and Additional and Recovery Treatment Services (ARTS) Delivery System Transformation waiver, and Virginia is seeking to extend the waiver by 5 years to implement COMPASS.

An 1115 waiver is a way to for states to pilot or experiment with new way to deliver health care services to their Medicaid and CHIP populations.

The waiver consists of three sections:

* TEEOP (Training, Education, Employment, and Opportunity Program, otherwise known as the work requirement)
* Health and Wellness Program (Premiums, Rewards for Health and Wellness accounts)
* Housing and Employment Supports (for high need enrollees)

The 30 day public comment period was 09/20/18-10/20/18; the proposal was submitted to CMS for approval. That is the latest update and to keep track you can go to the DMAS site and under New Initiatives click on the 1115 Waiver link for more information.

ABD Renewal Form:

No updates at this time with the new form; DMAS has a workgroup that will work on this however with expansion it is not as high on the priority list.

Duplicate cases, best practices:

We are asking that agencies do not try to merge cases at this time; VDSS and DES are going to begin meeting to speak about how to best merge the cases. However, we do understand that these cases may come up for a renewal, or a change may be reported. If you are merging cases, the best practices are:

* Maintain the case with the most history. Even though most client data is shared, you will want to keep the case open with the longest period of eligibility.
* Remember that when you close one case, it will send transactions to close the individuals in MMIS. You will have to complete a case change/closure action and perform an override to force the transaction over to MMIS to reinstate. Steps are in VaCMS under Retro Cancel Reinstate (QRG under MA > Data Collection).
* You should be ready to close and open the cases on the same day. Also be sure to research up front to make sure if one of the cases is multi program it isn’t due for renewal/IR.
* Client shared data will be on both cases so there shouldn’t be a need to update information. You may need to update Program Request based on who is receiving coverage on each case.

Other Expansion Updates:

As of 02/08/2019, 237,895 have been enrolled

FFM D processes are in the QRG under VaCMS Help; there should be a slowing in new FFM applications now that open enrollment has ended, however some individuals may meet a special enrollment period and could be considered for Marketplace and/or Medicaid/FAMIS coverage.

Other MA Updates:

* Pending applications:

Delay indicators; make sure you are updating all delay indicators to ensure overdue applications are accounted for. For disability determinations sending the DDS referral only shows the delay in one area; all delays should be indicated on the Program Request page. For 10 day PG/BCCPTA if you don’t have information you should update with client delay; for Emergency Medicaid Certification delays or outstanding tickets update with agency delay. Other delays should be indicated with the specific delay type, and the cases should have notices sent and the case should be documented with the reason for delay.

Also on any applications that had a previous DDS decision pending, go back and see if they are expansion now to decrease your overdue applications; per policy if they are eligible for Plan First you are to enroll until the DDS decision comes back, and now that we have Expansion some individuals may be eligible for Expansion and their applications can be approved. You will have to change the MA Verification for Disability to Not Verified and then when the DDS information comes back you can update the screen and run RCR.

* Income limit updates:

Income limit updates were posted in a broadcast on 02/01/19; some changes were made and an updated broadcast was posted 02/14/19. We’ve had some questions on how the amounts are calculated as the monthly and annual limits do not seem to match. For most covered groups, DMAS receives the annual income, divides by twelve, and then rounds up to the next dollar amount. This is calculated differently for MN and LIFC covered groups. Also remember that 109% is used in VaCMS for AC assignment.

The broadcast for the income limit changes also stated that agencies needed to go back and review cases where individuals were determined over income during the timeframe between when the income limits were effective (01/11/2019) and when they were put in VaCMS (01/31/2019). Regional consultants were sent the report to distribute to LDSS for processing. If the case was original processed by CoverVA, then CoverVA will be re-evaluating those cases.

* MMIS Reports:

Data Warehouse moved reports from by MMIS caseworker to LDAP about 7 weeks ago. There were some concerns that some agencies needed to maintain pulling reports by MMIS caseworker. Another broadcast was posted 02/05/2019 to state that the reports are able to be accessed again by MMIS caseworker and by LDAP.

If there is no VaCMS worker listed there is a blank line at the end of the search box when looking up reports by worker. You will be able to click that blank line to bring up cases that don’t have a VaCMS worker listed. Also you will notice that if you use the reports with the LDAP you may find cases in MMIS that may not belong to your FIPS; this is a great way to look quickly and see if they need to be reassigned to another locality or reassigned to the correct worker if the case does belong in that FIPS. If you have questions about the reports or their formats, please contact Ellis Erickson and/or Jeff Price (their information is listed in the broadcast).