

DMAS UPDATE FOR SENATE FINANCE COMMITTEE

SEPTEMBER 20, 2018

JENNIFER LEE, MD

DIRECTOR,
DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES



Agenda (Continued)

☐ Medicaid Expansion Overview

☐ Implementation Status Updates

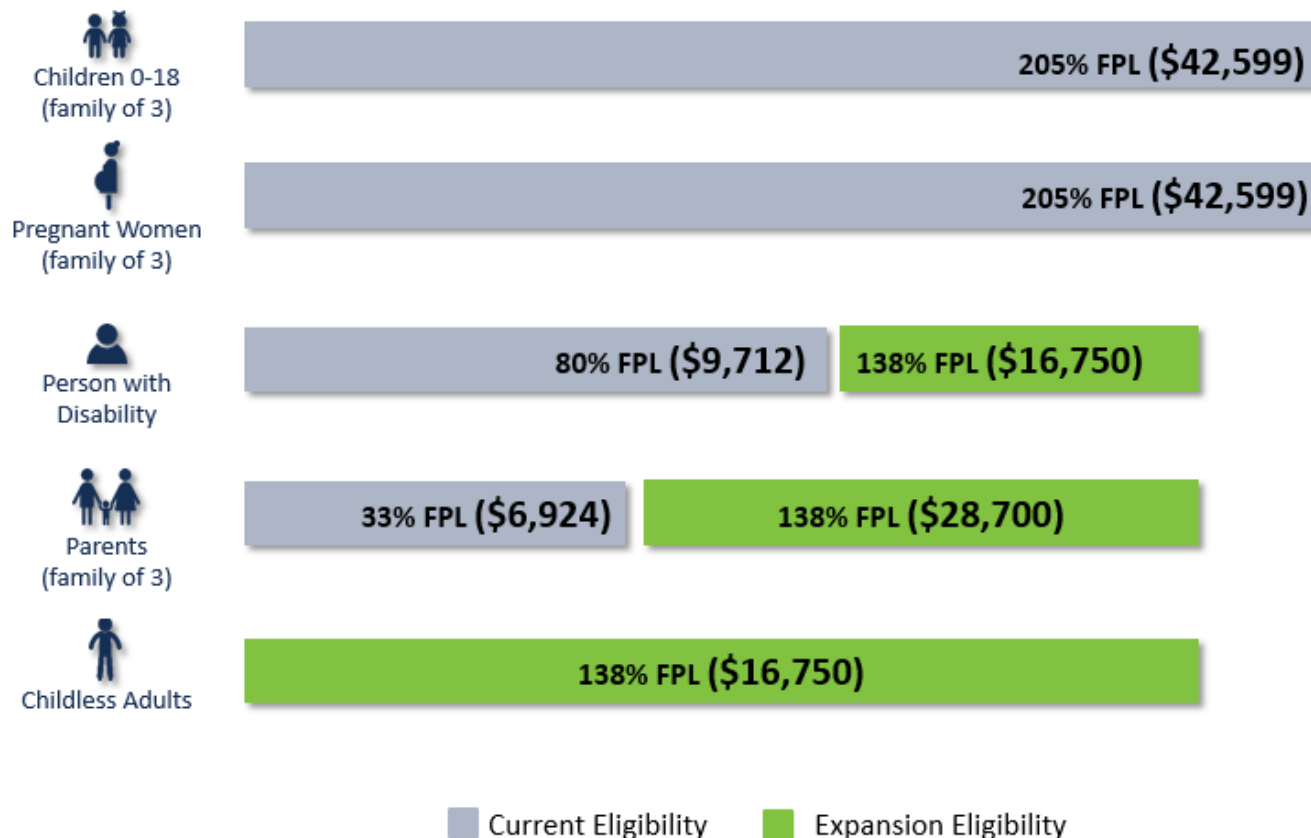
- ☐ Policy and Authorities
- ☐ Section 1115 Waiver
- ☐ Delivery System
- ☐ Eligibility and Enrollment
- ☐ Provider Assessments
- ☐ Outreach and Communications
- ☐ Reporting and Evaluation

☐ Disallowance and Deferrals

Who Qualifies for Virginia Medicaid Under Expansion?

Medicaid expansion will provide quality, low-cost coverage to ~ 400,000 Virginians

- Adults ages 19 – 64, not Medicare eligible
- Income from 0% to 138% Federal Poverty Level



Overview of Medicaid Expansion Requirements

The 2018 Appropriations Act directs DMAS to implement new coverage for adults and transform coverage

State Plan Amendments, contracts, or other policy changes

Implement new coverage for adults with incomes up to 138% FPL and implement early reforms for newly eligible individuals

§ 1115 Demonstration Waiver

Implement required reforms that transform the Medicaid program for certain individuals

DMAS is working in parallel and will submit a § 1115 Waiver while awaiting CMS approval of State Plan Amendments

Future Medicaid Reforms (Under § 1115 Waiver)

Required Medicaid reforms for populations earning 100-138% FPL will promote healthy behaviors and foster personal responsibility

Healthy Behavior Incentives



- Health and Wellness Accounts comprised of participant contributions and state funds to be used to fund premiums, cover out-of-pocket expenses for the deductible, and the ability to roll over funds into succeeding years if not fully used
- Cost-sharing to promote healthy behaviors (e.g. avoidance of tobacco use)
- Cost-sharing reductions for compliance with healthy behaviors

Personal Responsibility



- Monthly premiums, copayments, and deductibles
- Cost-sharing to encourage accountability for service utilization (e.g. appropriate ED use)
- Waiting period prior to re-enrollment if premium not paid

Future Medicaid Reforms (Under § 1115 Waiver)

The Training, Enrollment, Education, Employment and Opportunity Program (TEEOP) will increase the health and well-being of able-bodied adults through community engagement

Gradually Increasing Participation



- Participation in community engagement activities increases gradually to at least 80 hours per month

Community Engagement Activities



- Employment
- Job Skills Training
- Education
- Volunteering
- Job Search Activities
- Caregiving

Certain Populations Are Exempt



- Medically Complex
- Children < Age 18
- Individuals > Age 65
- Primary Caregivers with a Dependent Child < Age 18
- Others

Future Medicaid Reforms (Under § 1115 Waiver)

The Supportive Employment and Housing Benefit will help high-risk Medicaid beneficiaries obtain and maintain employment and stable housing

High-Risk Medicaid Beneficiaries



Targeting high-risk beneficiaries:

- With mental illness, substance use disorder, or other complex, chronic conditions
- Who need intensive, ongoing support to obtain and maintain employment and stable housing

Supportive Employment Services



**Possible services could include:*

- Vocational/job-related discovery or assessment;
- Person-centered employment planning;
- Job placement or development;
- Other services

Supportive Housing Services



**Possible services could include:*

- Screening and housing assessment;
- Developing an individual housing support plan;
- Other services

Provider Assessments: Overview

Coverage Assessment



- Same as included in Governor's Introduced Budget
- **Covers the full cost of Medicaid expansion**
- Expected to be approximately 0.5% in FY19 and 1.4% in FY20

Payment Rate Assessment



- New assessment in Adopted Budget
- **Covers the state cost of increasing hospital reimbursement rates to approximately average cost**

**Two
assessments
have many
of the same
features**

- Assessed on most private acute hospitals – excluded hospitals include public, freestanding psychiatric, rehabilitation, children's, long-stay, long-term acute, and critical access
- DMAS responsible for assessing and calculating assessment
- Assessments to be a percentage of net patient revenue
- Total of the two assessments cannot exceed 6% of net patient revenue (Federal requirement)
- CMS must approve that assessments are sufficiently "broad-based"

Medicaid Expansion Savings

FY19-FY20 total GF savings estimated at \$355.0M

	FY 2019 GF Costs/(Savings)	FY 2020 GF Costs/(Savings)
DMAS Savings (including indigent care, GAP, TDOs, etc...) Newly covered populations receive an enhanced federal matching rate	(\$72.1M)	(\$214.6M)
Corrections Savings Federal reimbursement available for inpatient hospital services delivered to incarcerated individuals	(\$10.8M)	(\$26.9M)
CSBs Savings Federal reimbursement available for substance abuse and mental health services	(\$10.4M)	(\$25.0M)
Total GF Savings	*(\$91.9M)	*(\$263.1M)
<div> <div>Total GF Savings FY19 –FY20</div> <div>(\$355.0M)</div> </div>		

* Note: DSS costs were subtracted from FY19 and FY20 savings to determine total GF Savings for FY19 and FY20

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Status Update: Policy and Authorities

DMAS is working to ensure all State Plan Amendments (SPAs) and waivers are submitted to CMS in a timely fashion to seek proper authority for the Medicaid expansion

Submitted SPAs and Waivers

- Federal Medical Assistance Percentage (FMAP) SPA
- Health Insurance Premium Payment (HIPP) SPA
- FFS Supplemental Payment SPA (Outpatient)
- Alternative Benefit Plan (ABP) SPA
- Adult Expansion Eligibility SPA
- Hospital Presumptive Eligibility SPA
- SNAP SPA and 1902(e)(14) letter
- Determination SPA
- Changes to Medicaid Application SPA
- FFS Supplemental Payment SPA (Inpatient)
- 1915(b) waiver amendments
- 1915(c) waiver amendments

Approved SPAs and Waivers

- ✓ Federal Medical Assistance Percentage (FMAP) SPA
- ✓ Health Insurance Premium Payment (HIPP) SPA
- ✓ FFS Supplemental Payment SPA (Outpatient)
- ✓ Provider Assessment (P1/P2)

Status Update: Section 1115 Waiver

DMAS is working on the Section 1115 Demonstration Waiver to seek authority from CMS for the TEEOP program and other reforms, as outlined in the 2018 Appropriations Act.

- DMAS moving forward with timeline as outlined in Appropriations Act
 - Will submit the Section 1115 Demonstration Waiver Application to CMS for approval no later than 150 days from passage of HB 5001 (no later than November 4th)
- Negotiations have started: Biweekly regular calls scheduled with CMS
- 30-day public comment period will open soon
 - Event details for upcoming Public Hearings will be available on the DMAS website

At the conclusion of the public comment period, DMAS will begin compiling and responding to comments as part of the Section 1115 Waiver Application

Status Update:

Delivery System Will Use Current Managed Care Plans

Coverage will be provided for 96% of Medicaid enrollees through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

Medicaid Delivery Systems

Commonwealth Coordinated Care Plus (CCC Plus) will serve populations who are *medically complex* (individuals with a complex behavioral or medical condition and functional impairment)

Medallion 4.0 will serve populations other than those who are medically complex

Fee for Service will serve populations until they are enrolled in an MCO and the populations and services that are excluded from managed care

6 Health Plans Contracted Statewide

1. Aetna Better Health of Virginia
2. Anthem HealthKeepers Plus
3. Magellan Complete Care of Virginia
4. Optima Health
5. United Healthcare
6. Virginia Premier Health Plan



Southwest Roanoke/Alleghany Western/Charlottesville Northern/Winchester Central Tidewater

What Services are Covered?

New enrollees will receive coverage for all Medicaid covered services including evidence-based, preventive services

- Doctor, hospital and emergency services, including primary and specialty care
- Prescription drugs
- Laboratory and X-ray services
- Maternity and newborn care
- Home health services
- Behavioral health services, including addiction & recovery treatment services (ARTS)
- Rehabilitative services, including physical, occupational and speech therapies
- Family planning services
- Medical equipment and supplies
- Preventive and wellness services, including annual wellness exams, immunizations, smoking cessation and nutritional counseling
- And more

Status Update: Eligibility & Enrollment

Enrollment Pathways

The new adult population will enroll in coverage through a variety of enrollment pathways, including streamlined enrollment processes



**Transition to Full
Benefit Medicaid**
Limited Benefit Programs

GAP (Governor's Access Plan) Adults 21 to 64 years of age with Severe Mental Illness (SMI)
Plan First Family planning services ≤ 138% FPL



**Express
Application**

SNAP beneficiaries Supplemental Nutrition Assistance Program formerly known as Food Stamps
Parents of Child(ren) enrolled in Medicaid



**Transition to
Virginia Medicaid**

Individuals currently enrolled in a qualified health plan (QHP) from the Federally-facilitated Exchange (FFE), also known as the Marketplace or Healthcare.gov



**General
Public**

Newly eligible adults not captured in Streamlined Enrollment groups



**Priority
Populations**

Uninsured individuals served through other systems of care

Status Update: Eligibility & Enrollment

Enrollment Pathways

DMAS will prepare these populations by providing important information related to streamlined enrollment and ways to apply for the new adult coverage



Transition to Full Benefit Medicaid Limited Benefit Programs

GAP: Receive letter notifying that GAP will end in 2019. Receive letter notifying that member will transition to full Medicaid 1/1/19.
Plan First Receive letter notifying of transition to full Medicaid 1/1/19.



Express Application

SNAP beneficiaries & Parents of Child(ren) enrolled in Medicaid: Both populations receive letter inviting beneficiary to apply through the express application included in the letter.



Transition to Virginia Medicaid

Individuals currently enrolled in a QHP from FFE: Receive letter from healthcare.gov with notice to update FFE account. Receive a follow-up letter from Virginia to inform them about changes in VA Medicaid rules.



General Public

Newly eligible adults not captured in Streamlined Enrollment groups: May begin applying for the new adult coverage in fall 2018 through Cover VA Call Center, LDSS, Common Help website, or healthcare.gov.



Priority Populations

Uninsured individuals served through other systems of care: Many will be captured through planned streamlined enrollment efforts, but DMAS is coordinating with these groups through targeted efforts

Status Update: Outreach and Communications

New DMAS Website

Virginia.gov Agencies | Governor

Select Language | Search Virginia.Gov

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

Department of Medical Assistance Services

Google Custom Search

New Adult Eligibility!

About Medicaid

Eligibility Guidance

FAMIS

Managed Care Benefits

Programs & Services

Long Term Care

For Providers

DMAS administers the Medicaid program in Virginia, providing access to health care for the most vulnerable.

Virginia Governor
Ralph S. Northam

Agency Director
Dr. Jennifer Lee



Status Update: Outreach and Communications

Sign up on the Cover Virginia Website to Receive Updates!

The screenshot shows the Cover Virginia website interface. At the top, the logo features a stylized group of people in various colors (red, green, blue, yellow) under a blue arc, with the text "COVER VIRGINIA" and "Connecting Virginians to Affordable Health Insurance" below it. To the right of the logo is the phone number "1-855-242-8282". Further right are social media icons for Facebook, Twitter, and YouTube, and a link to "Important Tax Information | Partners | Resources".

A navigation bar contains the following links: "Programs", "Apply", "Already Enrolled", "Marketplace", "Need Help?", "Health Plans", and "News".

A green banner in the center reads: "Coming Soon: New Health Coverage for Adults". Below this, it says: "Beginning January 1, 2019, more adults living in Virginia will have access to quality low cost health coverage. Eligibility is based on income of three making".

A white modal box is centered on the screen. It contains the Cover Virginia logo and the text: "Stay Connected. Sign up here to receive the latest news and updates from Cover Virginia." Below this text is a form with a text input field labeled "Email Address" and a blue button labeled "SUBSCRIBE". At the bottom of the modal are two links: "No Thanks" and "Remind Me Later".

On the left side of the page, under the heading "Welcome to Cover Virginia", there is a paragraph: "On this website you can learn about Virginia's Medicaid and FAMIS programs for children, pregnant women and adults. You can also get information about health insurance options available through the Family Marketplace. You can apply online or search for someone who can assist you with your application." Below this is another paragraph: "To begin, use the screening tool on the Eligibility page to get connected to the right health care coverage for you and your family."

On the right side, a box with a dark blue border contains the text: "The rules have changed. Check out new quality low cost health coverage options coming soon for adults."

At the bottom of the page, there is a large section titled "Health Insurance Marketplace". Below this title are three icons with corresponding labels: a checkmark icon for "Eligibility", a pencil icon for "Apply", and a refresh icon for "Renew".

Status Update: Outreach and Communications

Strategic Communications Plan

A comprehensive strategic communications plan drives stakeholder engagement

KEY STAKEHOLDER ENGAGEMENT ACTIVITIES

**Cover VA Countdown:
100 Days to Coverage**



Preparing advocate groups through an interactive strategy session led by national communications experts

**Provider Events, including
“Medicaid Expansion:
What Providers Need to
Know”**



Engage with providers through a series of provider outreach events in regions across Virginia

**State Agency Workshops,
Live Webinars, and Fall
Advertising Campaign**



Supporting intensive, continuing outreach to state agencies, newly eligible adults, and other stakeholders

Visit www.coverva.org to access advocate resources, information on provider outreach events, a recorded webinar, and more!

Status Update: Outreach and Communications

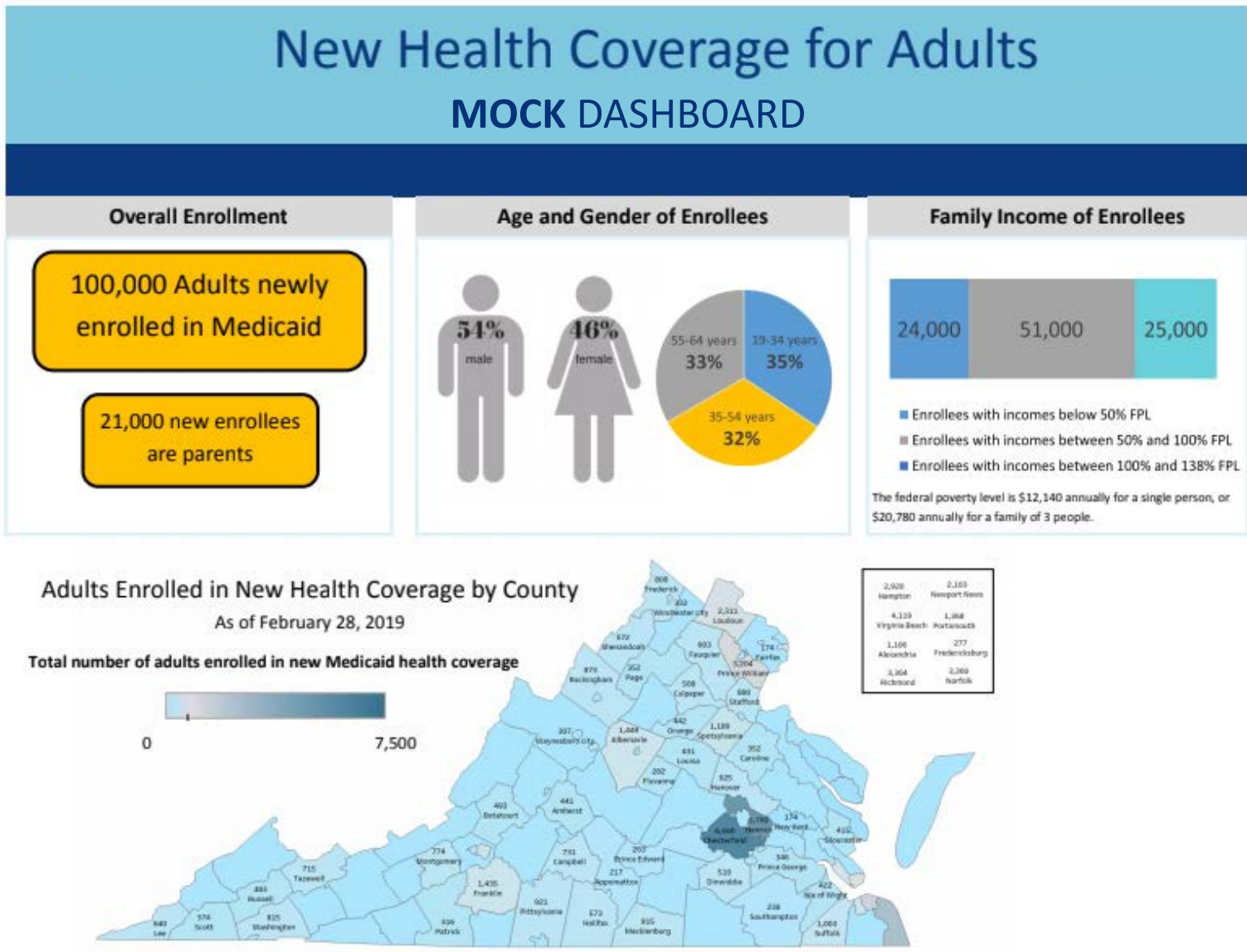
“Medicaid Expansion: What Providers Need to Know”

September 26	<u>Richmond (HCA Chippenham Hospital)</u>
October 2	<u>Norfolk/Hampton Roads (Sentara Norfolk General Hospital)</u>
October 9	<u>Winchester (Valley Health Winchester Medical Center)</u>
October 11	<u>Tri-Cities (Southside College of Health Sciences)</u>
October 15	<u>South Hill (VCU Community Memorial Hospital)</u>
October 17	<u>Lynchburg (Centra Lynchburg General Hospital)</u>
October 18	<u>Roanoke (Virginia Tech Carilion School of Medicine)</u>
October 22	<u>Charlottesville (University of Virginia Medical Center)</u>
October 25	<u>Abingdon (Ballad Health Johnston Memorial Hospital)</u>
October 29	<u>Fairfax (Inova Center for Personalized Health)</u>
November 1	<u>Richmond (Bon Secours St. Mary's Hospital)</u>

Visit <http://www.coverva.org/providerMedEx/> for event details and to register to attend (required)

Status Update: Reporting and Evaluation

MOCK Dashboard (Early 2019)




Status Update: Reporting and Evaluation

Example of Cost-Savings Report in Montana

Montana Medicaid Expansion Has Saved the State More than \$36 Million Through SFY 2017

17

State Savings from Medicaid Expansion (millions)								
	Total	Moving some Medicaid populations to enhanced federal match				Replacing some State spending with federal match		
		Waiver	Pregnant women	Medically needy	Breast & cervical cancer	Mental health services	SUD treatment	Inmate care
Total	\$36.5	\$9.8	\$5.0	\$4.0	\$1.0	\$3.1	\$3.0	\$10.5
SFY 2016	\$11.3	\$2.8	\$0.7	\$1.9	\$0.2	\$1.3	\$1.5	\$2.9
SFY 2017	\$25.2	\$7.0	\$4.3	\$2.1	\$0.8	\$1.8	\$1.5	\$7.7
State Costs for Medicaid Expansion*								
Total	\$29.4 million in state spending (remaining \$706.0 million funded by federal government)							
SFY 2016	\$5.0 million in state spending (remaining \$153.6 million funded by federal government)							
SFY 2017	\$24.5 million in state spending (remaining \$552.4 million funded by federal government)							
<p>Note: Sum of components may not equal total due to rounding.</p> <p>* Excludes premium revenues, which are shared with the federal government at existing federal matching rates. Includes benefit and administrative spending.</p>								
						 manatt		

Montana expanded Medicaid effective January 1, 2016 and reported on cost savings by early 2018.

Implementation Status Update: Reporting and Evaluation

Program Integrity – Current Operations

DMAS currently operates a robust program integrity (PI) program, which currently includes targeted data driven eligibility audits and quality reviews

PI GOALS



Ensure accuracy of systems and processes granting eligibility and enrolling new members



Ensure that the correct federal match is claimed

CURRENT PI ACTIVITIES

- Worked with VDSS and a contractor to develop a proposed eligibility performance management plan in the past year
- Participating in the federal Payment Error Rate Measurement (PERM)/MEQC project
- Enhanced the focus on program integrity in managed care contracts
- Contracting with McKinsey to independently verify and validate VaCMS and MMIS systems

Implementation Status Update: Reporting and Evaluation

Program Integrity - Medicaid Expansion Audit Plan

DMAS will implement enhanced program integrity (PI) strategies to ensure appropriate enrollment of eligible individuals in the new adult coverage group.

DESIGN

- Nationally recognized eligibility audit vendor (Myers & Stauffer) already contracted with DMAS to design and assist with implementing the Medicaid Audit Plan
- Review a sample of all eligibility cases (including approvals and denials) from submission through all stages of processing from all entities performing this function, including the Federal Facilitated Exchange (Marketplace)
- Check proper application of policies/procedures (e.g. for the collection and verification of data, case documentation, timely processing, eligibility decision, issuance of notices, etc.)
- Correct errors, notify the entity making the error, and report the types and frequency of errors to use for training, system enhancements or corrective action

Implementation Status Update: Reporting and Evaluation

Program Integrity - Medicaid Expansion Audit Plan

DMAS will implement enhanced program integrity (PI) strategies to ensure appropriate enrollment of eligible individuals in the new adult coverage group.

METHODOLOGY

- Audit will consist of a desk-level review
 - Check all necessary automated systems to ensure the process was followed correctly for eligibility determination
 - If errors are identified, a second level of independent review conducted by a supervisor will verify it is an actual error

TIMELINE

- Audits will begin in early 2019 for the new adult population that will begin coverage January 1, 2019
- A sample of applications will be selected from all applications received since the first date of the application period for new adult coverage

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☐ Disallowance and Deferrals

Piedmont Geriatric Hospital and Catawba Hospital Background

- Piedmont and Catawba are state-owned hospitals operated by DBHDS
 - Piedmont serves 130 patients and is located in Nottoway County – 2017 DMAS spend at Piedmont = \$17.4 million (total funds)
 - Catawba serves 111 patients and is located in Roanoke County – 2017 DMAS spend at Catawba = \$8.4 million (total funds)
- They focus on inpatient treatment for geriatric mental illnesses
- Most patients are Medicaid-eligible, and many are dually eligible for Medicare
- Facilities primarily furnish long-term psychiatric services, they often provide acute care services when their patients fall physically ill
- Piedmont and Catawba are Institutes of Mental Disease (IMD) for Medicaid Purposes
 - The Social Security Act lists two types of inpatient mental health services that Medicaid may reimburse for:

For member 65 and older - **Institute of Mental Disease (IMD)**: A term used exclusively in the Medicaid program, a facility with 16 or more beds which provides diagnosis, treatment and care of persons with mental diseases...does not require survey as a psychiatric hospital

For member under 21 – **Psychiatric Hospital**: Used in Medicaid and Medicare statute, a facility that primarily provides psychiatric services for the diagnosis and treatment of mental illness...requires survey as a psychiatric hospital

Piedmont Geriatric Hospital and Catawba Hospital

OIG Audit Findings and Licensure Status

OIG issued a final report in July 2014, with the following findings:

- Facilities were not properly certified as psychiatric hospitals because they did not demonstrate compliance with special Conditions of Participation (CoP)
- State should refund federal share of payments to facilities made during the audit period
- Ensure that psychiatric hospitals receiving Medicaid reimbursement meet the special CoP

Licensure Status

- Both facilities were compliant with acute care hospital CoP through Joint Commission accreditation
- Both facilities complied with an extensive set of state requirements governing state-owned behavioral health hospitals
- These extensive state requirements are substantially similar to the special CoP applicable to psychiatric hospitals
 - Even though IMDs are not subject to the same requirements at psychiatric hospitals, both Piedmont and Catawba satisfied these same requirements that are similar to the special CoP

Why must the facilities qualify as IMDs? If they do not qualify as IMDs, because of the nature of the services they provide, Medicaid cannot reimburse them. Most of the facilities' reimbursement comes from Medicaid.

Piedmont Geriatric Hospital and Catawba Hospital

Potential Liability

- DMAS has continued to pay the facilities since 12/31/2010
- Total potential liability
 - ❑ Disallowance = \$57.9M
 - ❑ Payments made since 12/31/2010 = \$78.9M
 - ❑ Total Potential Liability = \$136.8M*
 - If DSH payments are included, total potential liability = \$185.4M*
- DMAS is continuing to pay the facilities at this time – DMAS pays the facilities approximately \$2.2 million per month (total funds)/\$1.1 million per month (federal funds)
- DMAS will continue to pursue a reconsideration, followed by an appeal if necessary. If successful, this could eliminate any liability.

*Note: This represents the federal portion of payments made to the facilities. DMAS will need to use 100% General Funds to repay this amount to the federal government.

OIG Audit and CMS Interest in Cost Allocation

Cost allocation is the methodology used to distribute administrative costs to benefiting programs. Any agency claiming federal funds for administrative costs is required to have a cost allocation plan (CAP) that describes the methodology.



Spring 2017

OIG initiated an audit of cost allocation



Spring 2017

CMS financial reviewers took an interest in cost allocation



October 2017

CMS financial reviewers issue first cost allocation deferral for \$25M

DMAS disagrees with this finding



June 2018

OIG issues their final report which recommends Virginia return \$7.7M.

DMAS disagrees with this finding – OIG misinterpreted the cost allocation plan

OIG and CMS findings are both related to cost allocation, but the alleged problems they found are slightly different

CMS Actions on Cost Allocation Plan (CAP) and DMAS Actions to Resolve Cost Allocation Issues

CMS Actions on Cost Allocation Plan (CAP)

- CMS financial reviewers issued deferral for \$25.7M in Oct. 2017 related to cost allocation
 - DMAS was forced to return the funds to federal government in August 2018
- CMS financial reviewers contend that DMAS did not include appropriate methodologies in its cost allocation plan - DMAS again disagreed with the finding
 - CMS issued 7 additional deferrals between January and June 2018 for the same reason
- Even though DMAS disagreed with the finding, DMAS began working with CMS in Oct. 2017 to rectify the cost allocation issues
- In July 2018, CMS accepted the changes that DMAS had made to its cost allocation plan and released all deferrals it had issued except for the first \$25.7M deferral from Oct. 2017
 - CMS has indicated that this deferral will eventually become a disallowance, meaning that the funds will be permanently kept by the federal government

DMAS Actions to Resolve Cost Allocation Issues

- DMAS engaged outside expertise, through Public Consulting Group, to review all cost allocation methodologies and work done at DMAS to make recommendations to improve cost allocation
- DMAS is in the process of engaging outside expertise, through Myers and Stauffer LC, to review all federal expenditure reporting functions at DMAS. They will make recommendations to improve these functions, as well as update internal standard operating procedures and train staff.

Regular Updates

Visit the Cover VA Website at www.coverva.org
or call 1-855-242-8282
for information and regular updates



Coming Soon: New Health Coverage for Adults

Beginning January 1, 2019, more adults living in Virginia will have access to quality, low-cost health coverage.

Get more information at coverva.org



APPENDIX

Federal Claiming



Medicaid eligible services are delivered to Medicaid eligible members



DMAS pays the provider for the services using a mix of state and federal funds – DMAS draws federal funds weekly to make payments



DMAS files a federal expenditure report with CMS quarterly



CMS reviews federal expenditure report on a quarterly basis – CMS finalizes the grant on an annual basis (meaning any outstanding issues must be resolved)

If CMS believes an expense was not allowable, they can issue a disallowance or deferral, which removes federal funding for the questioned expense.

DMAS has some experience with disallowances, particularly related to a DSH spending at UVA and VCU in 2006-2011.

DMAS has limited experience with deferrals.

Disallowances and Deferrals

The federal government can retain and demand the return of federal funds when they believe that spending was not allowable



Disallowance

An action the Federal Government can take to demand the State return federal funds that were spent anytime in the past...once issued, states can appeal and retain funds while appeal is in progress



Deferral

An action the Federal Government can take to stop the payment of federal funds for expenditures in recent quarters...once issued, states may attempt to resolve but must pay funds when the annual grant finalizes if not resolved

Unless deferrals are resolved, they eventually become disallowances and the state would then have appeal rights

Piedmont and Catawba OIG Audit

Timeline of Events

March 2014	<ul style="list-style-type: none">• OIG issues draft report
April 2014	<ul style="list-style-type: none">• DMAS responds indicating its disagreement with the findings• DMAS and DBHDS request that facilities be surveyed for special CoPs• CMS blocks the facilities from being surveyed
October 2014	<ul style="list-style-type: none">• CMS advises that they blocked the survey because the facilities cannot be acute care for Medicare and long-term care for Medicaid
December 2014	<ul style="list-style-type: none">• DBHDS meets with CMS to explore options for the facilities
January 2015	<ul style="list-style-type: none">• DBHDS conducts meeting with Money Committee staff regarding facilities
September 2016	<ul style="list-style-type: none">• DMAS and DBHDS conduct conference call with CMS on issues
September 2017	<ul style="list-style-type: none">• CMS provides letter with answers to questions from September 2016 call
June 2018	<ul style="list-style-type: none">• DMAS receives disallowance letter
August 2018	<ul style="list-style-type: none">• DMAS files reconsideration request with CMS

Throughout this timeframe, DMAS and DBHDS were keeping DPB and Money Committee staff aware of the status of the Piedmont and Catawba issue