

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

**September 13, 2016
Draft Minutes**

Present:

Mirza Baig
Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Alexis Y. Edwards
Maureen Hollowell
Maria Jankowski, Esq.
Peter R. Kongstvedt, MD
McKinley L. Price, DDS
Karen S. Rheuban, MD
Chair

Absent:

Rebecca E. Gwilt, Esq.
Marcia Wright Yeskoo

DMAS Staff:

Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Scott Crawford, Deputy Director for Finance
Karen Kimsey, Deputy Director for Complex Services
Ivory Banks, Program Operations Division Director
Donna Proffitt, Pharmacy Manager
Kathleen Guinan, Human Resources Director
Mukundan Srinivasan, Chief Information Officer
Nancy Malczewski, Public Information Officer, Office of
Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of
Communications, Legislation & Administration

Speakers:

Cynthia B. Jones, Director
Kate Neuhausen, MD, MPH
Abrar Azamuddin, Legal Counsel

Guests:

Jennifer Wicker, VHHA
Tyler Cox, HDJN
Lauren Bates Ronu, MSV
Julie Galloway, MSV
Ross Arrington, MSV
Rick Shinn, VACHA
Kenneth McCabe, DPB
Cecelia Kirkman, SEIU Healthcare
Chris Surrell, VHC
Rebecca Miller, VHC
Hunter Jamerson, Macaulay & Jamerson

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:02 a.m. Dr. Rheuban asked other members to introduce themselves and introductions continued around the room.

APPROVAL OF MINUTES FROM JUNE 14, 2016 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the June 14, 2016 meeting. Dr. Kongstvedt made a motion to accept the minutes and Mr. Cook seconded. The vote was **7-yes (Coleman, Cook, Hollowell, Jankowski, Kongstvedt, Price, and Rheuban); and 0-no.**

Ms. Edwards joined the meeting after the vote.

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, briefly commented on the status of the Requests for Proposals (RFPs) on the Managed Long Term Services and Supports (MLTSS), the Medicaid Enterprise System (MES) and the Medallion 3.0 managed care contract and noted the ID/DD Waiver Redesign was implemented on September 1.

Ms. Jones asked the Deputy Director for Administration, Suzanne Gore, to provide an update on the BMAS Biennial Report due to the General Assembly in October. After Board discussion, it was agreed a draft of the report will be distributed to the Board for review and comment and then a conference call meeting to discuss the report would be established one week after distribution. It was also suggested the Board develop a cover letter which could include information such as the Board's support of Medicaid expansion for review and consideration.

Mr. Baig joined the meeting during this presentation.

INTRODUCTION TO THE OFFICE OF THE CHIEF MEDICAL OFFICER

Ms. Jones introduced and welcomed Dr. Kate Neuhausen. Dr. Neuhausen gave a detailed review of the newly created Office of the Chief Medical Officer and explained the role of the Medical Support Unit (MSU), and the Pharmacy Program. Dr. Neuhausen also gave highlights of several clinical and pharmacy innovations and shared the various DMAS and external committees and workgroups the Office is involved with. (see attached handout).

In light of the public health emergency imposed by the Zika virus and the need to speedily address the likelihood of Zika transmission to Virginia Medicaid and FAMIS enrollees, Dr. Neuhausen explained the recent intervention of DMAS to contact the Governor on behalf of the Board to request the approval to promulgate Emergency regulations to provide necessary coverage to the population most affected by this emergency.

Members were very engaged in discussions of the various pharmacy programs and interested in discussing these issues at a future meeting. Members were also encouraged to attend the upcoming Pharmacy & Therapeutic (P&T) Committee and/or Drug Utilization Review (DUR) Board meetings scheduled in October/November.

PLANNING FOR A BOARD RETREAT/ BACKGROUND: ROLES AND RESPONSIBILITIES OF BMAS

Dr. Rheuban initiated the discussion planning for a Board retreat by asking Legal Counsel, Mr. Azamuddin, to provide a discussion of the role of the Board. Mr. Azamuddin provided a brief discussion of the role of the Board by pointing out specific areas of Section 32.1-325 for the Board to focus on and consider in their deliberations in planning for a retreat. Ms. Jones informed the Board that the Budget Bill was also a large part of the agency direction and a copy of the DMAS section in the budget was included in books for reference.

After members discussed expectations for planning for a retreat and offered suggestions, it was agreed to set a separate date/time for the retreat (in addition to the December meeting) in November.

Ms. Edwards left the meeting during this discussion.

REGULATORY ACTIVITY SUMMARY

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

OLD BUSINESS

None.

ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting at 12:20 p.m. Dr. Kongstvedt made a motion to adjourn the meeting and Mr. Cook seconded. The vote was unanimous. **7-yes (Baig, Coleman, Cook, Hollowell, Jankowski, Kongstvedt, and Rheuban); and 0-no.**



Office of the Chief Medical Officer

Katherine Neuhausen, MD, MPH
Chief Medical Officer
Virginia Department of Medical
Assistance Services



Office of the CMO

- Medical Support Unit (MSU)
- Pharmacy Program
- Clinical and Pharmacy Innovation
- DMAS and External Committees and Workgroups



MSU Staff

- 3 Full Time Staff
 - Karen Thomas, RN – MSU Nurse Manager
 - Alyson DeSalvo, RN – MSU Nurse Supervisor
 - Talisha Sheppard – Medical Support Specialist
- 5 Part Time Medical Consultants
 - Dr. Alexis Aplasca – Triple Boarded Pediatric Psychiatrist/Adult Psychiatrist/Pediatrician
 - Dr. Kathy Sardegna – Double Boarded Pediatric Nephrologist/Pediatrician
 - Dr. Philip Kum-Nji - Pediatrician
 - Dr. Hadi Anwar - Pediatrician
 - Dr. Nate Warner - Internist



MSU: Review Out-of-State Service Requests

- Physician consultants determine:
 - Is the service medically necessary?
 - Can the service be provided in-state?
- If yes: is an in-state provider available to see the member within 4-6 weeks?
- Represent agency for any appeals
- Partner with Program Ops: Transportation Unit, Provider Enrollment, and Payment Processing Unit



MSU: Support ICBH EPSDT Program

- Review all requests for admission to Cumberland Hospital for medical necessity – unstable medical condition must be present to justify inpatient admission
- Review all requests for Feeding Programs
- Review any requests for off label drug use



MSU: Support Program Integrity

- Review Interqual criteria used for Prior Authorization for medical services
- Post audit reviews of coding by physicians



MSU: Support Policy in Coverage Decisions

- New coverage decisions:
 - Cover insect repellent for pregnant women and men and women of childbearing age for Zika Prevention
- Expand current coverage:
 - Advise on evidence-based clinical guidelines for covering CTs for lung cancer screening



MSU: Clinical Coverage Decisions

- Review requests from vendors for DMAS coverage of new FDA-approved services (devices, procedures, imaging, etc.) and drugs
- Medical review of all new CPT and HCPCS codes released by CMS and AMA
- Coverage of services for specific Medicaid populations



Pharmacy Staff

- Donna Francioni-Proffitt, BS Pharmacy
 - Pharmacy Manager
- Rachel Cain, PharmD
 - Clinical specialist
 - Oversees the Drug Utilization Review (DUR) Program
- Keith Hayashi, BS Pharmacy
 - Expertise in drug rebates, 340B program and claims processing



Pharmacy Key Areas

- **Preferred Drug List (PDL) Program**
 - DMAS Pharmacy & Therapeutics Committee
- **Drug Utilization Review (DUR) Program**
 - DUR Board
 - ProDUR Program
 - RetroDUR Program
- **Drug Rebate Program**
 - Rebate collection for FFS & MCOs
 - 340B program (drugs excluded from rebating)



Preferred Drug List (PDL) Program

- Implemented January 2004
- Select drug classes subject to the PDL program
- All clinical decisions regarding the PDL and Criteria used for Service Authorizations are made by DMAS' Pharmacy and Therapeutics (P&T) Committee
- A "preferred" drug is selected based on safety and clinical efficacy first, then on cost effectiveness
- Supplemental rebates are offered on many but not all preferred drugs



Preferred Drug List

All Therapeutic Classes of Drugs

P&T Committee Recommends Drug Classes To Be Subject to PDL & SA

P&T Committee Recommends Drugs Within Each Class That are Clinically Effective and Safe

Preferred Drugs
NO SA Required

Non-Preferred Drugs
Drugs Require SA



Pharmacy & Therapeutics Committee

- Responsible for the development and ongoing administration of PDL and other pharmacy program issues
- Composition
 - 8 physicians
 - 4 pharmacists
- Duties of Committee
 - Receive and review clinical and pricing data related to drug classes
 - Make recommendations to DMAS regarding various aspects of the pharmacy program
 - For the PDL, select those drugs to be deemed “preferred” that are safe, clinically effective and meet pricing standards.
- Meets a least twice a year to review drug classes and recommend policies for appropriate drug use



Drug Utilization Review (DUR) Program

- **Purpose of the DUR**
 - Help ensure the health and safety of patients
- **Prospective DUR Program (ProDUR)**
 - Involves a review of prescription orders and a patient's drug therapy history prior to the prescription being filled.
 - Allows pharmacy claims to be evaluated at the time claims are actually submitted.
- **Retrospective DUR Program (RetroDUR)**
 - Examines history of medication used to identify certain patterns of use.
 - After computer analysis of claims data, expert panel of reviewers evaluate a sampling of records and requests educational intervention letters generated if appropriate.



Drug Rebate Program

- Federal Rebates are collected on all FFS drugs.
- In 2010, ACA expanded federal rebates to drugs for members enrolled in MCOs.
- Supplemental Rebates collected on select preferred FFS drugs on PDL.



Rebate Collections (to date)

- **Federal Rebates**
 - SFY 17: \$14,755,403.53
 - Total: \$601,976,177.86
- **Supplemental Rebates**
 - SYF 17: \$305,896.44
 - Total: \$27,270,798.27
- **MCO Rebates**
 - SFY 17: \$50,118,008.81
 - Total: \$1,222,461,287.09
- **Grand total SFY 17: \$68,699,452.66**
- **Grand total: \$1,855,228,407.10**



Pharmacy Contractors

- **Provider Synergies (aka Magellan)**
 - Pharmacy Services Administrator
 - Supports P&T Committee and PDL
 - Solicits supplemental rebates on behalf of Virginia
 - Drug service authorization (SAs) contractor
 - 24/7 Call Center for SAs
- **Optum (formerly Catamaran)**
 - Rebate vendor
- **Xerox**
 - DMAS' Fiscal Agent – responsible for processing Rx claims
 - Supports DUR Board
 - Call Center support for any claims processing questions/issues



Future Pharmacy Initiatives

- **New Pharmacy Reimbursement Methodology**
 - Planned implementation 12/1/16
 - Based on National Average Acquisition Drug Cost (NADAC) instead of Average Wholesale Price (AWP) + Professional Dispensing Fee
- **“Common Core” Formulary for MLTSS Program**
 - Requires MCOs to include all “preferred drugs” from the DMAS PDL on their formularies
 - MCOs can add additional drugs but cannot be more restrictive than DMAS PDL – cannot require step edits or additional PAs for “preferred drugs”
- **RFP for Pharmacy Benefit Manager (PBM)**
 - All inclusive contract for claims processing, DUR and PDL activities.
 - Go live date summer/early fall 2017
- **MCO Final Rule 438.3(s)**
 - Requires additional oversight of MCO formularies, DUR programs and prior authorization requirements



Clinical and Pharmacy Innovation

- **Addiction and Recovery Treatment Services (ARTS)**
 - Provided clinical input on redesign of SUD delivery system based on national ASAM guidelines and evidence-based best practices including Medication Assisted Treatment (MAT)
- **Long-Acting Reversible Contraception (LARC)**
 - Replicating TennCare model of stocking OB/Gyn practices and Labor & Delivery units with IUDs at no up-front cost
 - Partnering with MCOs to unbundle LARC payment from delivery DRG to support immediate post-partum LARC insertion
 - Partnering with VDH and ACOG in VDH LARC workgroup to educate providers and members on LARC
- **Telemedicine**
 - Supporting Office of Health Innovation and Strategy and Policy to identify promising clinical models for telemedicine



Addiction and Recovery Treatment Services (ARTS)

- **ARTS Pharmacy Benefit Design**
 - Partnered with MCOs and addiction-credentialed providers to design new clinical and payment models for Medication Assisted Treatment for Opioid Use Disorder
- **“Gold-Card” for high quality Office-Based Opioid Treatment Providers**
 - Can bill for peer supports and physician-directed substance abuse care coordination
 - No PAs for buprenorphine
- **Uniform Buprenorphine PA**
 - Help prevent Medicaid from paying for buprenorphine prescribed by pill mill doctors



Implementing CDC Opioid Prescribing Guidelines

- Partnered with MCOs, MSV, VDH, and DHP
- Removing PAs for all non-opioid pain medications (e.g., lidocaine patches, baclofen, diclofenac gel, duloxetine)
- Uniform quantity limits for safe daily doses of all opioid pain relievers.
- Uniform PAs for short-acting and long-acting opioids that require physicians to adhere to the CDC guidelines.
- Educational letters to members on opioids > 90 MME daily and taking opioids with benzodiazepines



DMAS Committees and Workgroups

- **ARTS Workgroup**
 - Co-chair workgroup of providers, MCO CMOs, consumers, and other stakeholders that advises DMAS on ARTS design
- **Medicaid Managed Care Physician Liaison Committee**
 - Convened ED Care Coordination Improvement workgroup to recommend best practices and IT functionalities to support best practices for ED care coordination
- **CMO Workgroup**
 - September: Hepatitis C and SUD and LARC
 - October: Interdisciplinary Chronic Pain Treatment
 - November: Integrated Behavioral Health and Primary Care



External Committees and Workgroups

- **Secretary's Opioid Steering Council**
 - Represent DMAS at council with representatives from health and law enforcement agencies.
- **VDH LARC Workgroup**
 - Supporting VDH by working to decrease payment barriers to increase access to LARC for all women in Virginia.
- **CMS HIV and Hepatitis C Improvement Collaborative**
 - Partnering with VDH to improve HIV and Hepatitis C screening and improve data sharing with DMAS.
- **Physician Monitoring Program Advisory Board**
 - Will represent DMAS because health plan medical directors and pharmacists can access PMP.
- **Board of Medicine Buprenorphine Workgroup**

Addiction and Recovery Treatment Services (ARTS)

Expansion of Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members Effective April 1, 2017

ARTS 101 Informational Sessions for Providers

Attend to learn about Virginia Medicaid's Addiction and Recovery Treatment Services (ARTS) new benefit program transformation!

Virginia Medicaid leaders will provide updates on:

- **Increasing rates up to 400%** for many of the substance use services. Some service rates are higher than commercial plans!
- New **provider requirements** and new payment models.
- Upcoming **provider training opportunities** on treating patients with addiction, Medication Assisted Treatment for opioid addiction, and American Society of Addiction Medicine criteria for the new services.

Upcoming in-person sessions: Click [here](#) to register.

Or visit DMAS online training registration at <http://dmasva.dmas.virginia.gov>.

On the left hand menu click the Upcoming Training Events link.

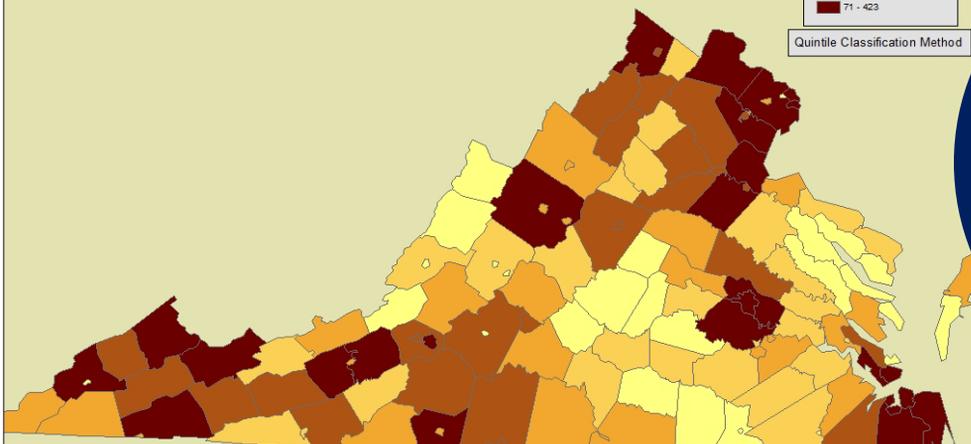
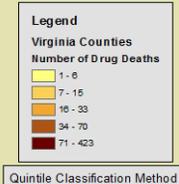
Date	Time	Facility
09/06 Abingdon	Registration: 12:30 p.m. Seminar: 1 p.m. – 3 p.m.	Virginia Highland College Auditorium 100 VHCC Drive, Abingdon, VA 24210
09/07 Roanoke	Registration: 9:30 a.m. Seminar: 10 a.m. - noon	Carilion Roanoke Memorial Hospital 6th Floor Auditorium 1906 Belleview Avenue, Roanoke, VA 24014
09/09 Richmond	Registration: 9:30 a.m. Seminar: 10 a.m. - noon	Deep Run Facility Ball Room 9910 Ridgefield Pkwy, Henrico, VA 23233
09/13 Charlottesville	Registration: 9:30 a.m. Seminar: 10 a.m. - noon	Charlottesville Central Library McIntire Room 201 East Market Street, Charlottesville, VA 22902
09/21 Virginia Beach	Registration: 12:30 p.m. Seminar: 1 p.m.-3:00p.m.	VA Beach Central Library Auditorium 4100 VA Beach Blvd, VA Beach, VA 23452
09/22 Richmond	Registration: 12:30 p.m. Seminar: 1 p.m.-3:00p.m.	Chippenham Hospital, Boshier Auditorium 7101 Jahnke Road, Richmond, VA 23225
09/23 Fairfax	Registration 12:30 p.m. Seminar: 1 p.m. - 3 p.m.	Fairfax Government Center Herrity Building Rooms 106-107 12055 Govt. Center Parkway, Fairfax, VA 22035
09/30 Martinsville	Registration 9:30 a.m. Seminar: 10 a.m. - noon	New College Institute King Building, Room 300 30 Franklin Street, Martinsville, VA 24112

New Site!



The Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit: A Response to the Opioid Epidemic

*Drugs included Benzodiazepines, Cocaine, Heroin, or Prescription Opioids



Fatal Drug Overdose Quarterly Report (Totals 2007 - 2014)
 Sources: Virginia Department of Health - Office of the Chief Medical Examiner
 US Census 2012 Estimates
 Prepared by VCU Office of Health Innovation November 2015



In 2013 more Virginians died from opioid overdose than from car accidents



Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members

All Community-Based SUD Services will be Covered by Managed Care Plans
 A fully integrated Physical and Behavioral Health Continuum of Care

Effective April 1, 2017
 Addiction and Recovery Treatment Services (ARTS)
Peer Recovery Supports effective July 1, 2017



The Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit: A Response to the Opioid Epidemic

Changes to DMAS's Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members

- 1 Expand short-term SUD inpatient detox to all Medicaid /FAMIS members
- 2 Expand short-term SUD residential treatment to all Medicaid members
- 3 Increase rates for existing Medicaid/FAMIS SUD treatment services
- 4 Add Peer Support services for individuals with SUD and/or mental health conditions
- 5 Require SUD Care Coordinators at DMAS contracted Managed Care Plans
- 6 Provide Provider Education, Training, and Recruitment Activities

Implementation Timeline

Phase 1:
January
2017

- Network development and extensive training begins

Phase 2:
April 2017

- Statewide Implementation

Phase 3:
July, 2017

- Peer Support Services Implementation

Supporting the SUD benefit means keeping Virginia families together (#2 cause for VA children entering foster care) and helps adults return to work and contribute to their communities.

BOARD OF MEDICAL ASSISTANCE SERVICES

BYLAWS

ARTICLE I

Board Structure

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

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

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

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

ARTICLE II

Board Meetings

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

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

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

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

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

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

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

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

ARTICLE III

Board Authority

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

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

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

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

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

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

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

ARTICLE IV

Board Officers

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

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

4.3 Duties of Officers

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

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

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

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

ARTICLE V

Board Committees

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

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

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

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

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

ARTICLE VI

Board Documents

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

ARTICLE VII

Public Participation

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

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

ARTICLE VIII

Revision and Compliance

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

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

8.3 Effective Date - The foregoing Bylaws shall go into effect on the 15th day of September 2015.

Approved:



Chairperson, Board of Medical Assistance Services



Director, Department of Medical Assistance Services

§ 32.1-324. Board of Medical Assistance Services

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

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

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

1984, c. 781; 1986, c. 440; 1989, c. 195; 1992, c. 107; 2012, c. 137.

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

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

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

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

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

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

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

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

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

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

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

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

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;
16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;
17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;
18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;
19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;
20. A provision for payment of medical assistance for custom ocular prostheses;
21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician,

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

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

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

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

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

B. In preparing the plan, the Board shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H. The Department of Medical Assistance Services shall:

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

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

2014 General Assembly

***(01) Update Reference to ICD 9:** This Final-exempt action updates references in DMAS' regulations from the International Classification of Diseases (ICD), 9th edition to the 10th edition in compliance with federal requirements. This package was filed with Registrar's office 4/10/14 and became effective 6/5/14. This action was revised and it advances the effective date to 10/1/15. This regulatory package was certified by the Office of the Attorney General (OAG) on 8/28/14 and was filed with the Registrar. It takes effect 10/22/2014. This project will be removed from the next report.

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

***(03) No Inflation Reimbursement Methodology Changes:** This action affects hospitals, home health agencies, and outpatient rehabilitation providers. Chapter 2 of the *2014 Acts of the Assembly*, Item 301 CCC and IIII directed this change. The SPA has been approved internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

***(04) Supplemental Payments for County-Owned NFs:** This action provides supplemental payments to locality-owned nursing facilities who agree to participate. The SPA has been approved internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

***(05) Hospital DSH Reduction:** This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA has been approved internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

***(06) NF Price Based Reimbursement Methodology:** This action changes the cost-based methodology with the priced based method and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 KKK. The SPA has been approved

internally and is awaiting approval by the Secretary's Office prior to submission to CMS by 9/30/14. Changes to parallel administrative code sections are pending.

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

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

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

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

(11) FAMIS Uninsured Waiting Period Elimination: This action eliminated the uninsured waiting period for children applying for Family Access to Medical Insurance Security (FAMIS) as required by the *2014 Acts of Assembly*. New federal regulations required Virginia to reduce its uninsured waiting period from 4 months to 90 days and add new waiting period exceptions. Imposing a waiting period on such a small number of children was determined not to be an effective policy so it has been eliminated to administrative burdens. This action brings Virginia's policy in line with that of 29 other states, including all of Virginia's contiguous neighbors.

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

2013 General Assembly

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

approved with a few still outstanding. Changes to parallel administrative code sections are pending.

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

***(06) Consumer Directed Services Facilitators:** This Emergency/NOIRA complies with the *2012 Acts of the Assembly* Item 307 XXX that directed the DMAS to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home-and-community-based waiver enrollees. This regulatory package has been submitted to the OAG for certification. No SPA action is required.

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

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

(09) Discontinue Coverage of Benzodiazepines-Barbiturates for Dual Eligible Individuals: This Fast-Track regulatory change proposes to eliminate coverage for both benzodiazepines and barbiturates for full benefit dual eligibles (eligible for both Medicare and Medicaid), who may now obtain both these drugs under Medicare Part

D drug coverage. This regulatory package is currently at the Secretary's office pending approval. A SPA of the affected parallel State Plan sections will be required.

(10) Enhanced Ambulatory Patient Group Outpatient Hospital Reimbursement

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

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

This Emergency/NOIRA is the result of the 2012 *Acts of the Assembly*, Chapter 3, Item 307 CCC, which directed DMAS to develop a prospective payment methodology to reimburse institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others. The SPA was drafted and sent to CMS for preliminary review. This regulatory package was filed with the Registrar's office 5/5/14, was published in the Register 6/2/14 and became effective 7/1/14. The Proposed stage is currently being drafted.

(12) Physician Primary Care Rate Increase Update:

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

(13) Supplemental Payments for services Provided by Type One Physicians-ACR Update:

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

to CMS on 3/27/13, CMS issued a request for additional information (RAI). The RAI response was submitted to CMS 3/27/14 and is pending approval.

***(14) Medicare-Medicaid Alignment Demonstration (FAD)/Commonwealth Coordinated Care:** This SPA is being implemented by CMS to streamline service delivery, improve health outcomes, and enhance the quality of life for dual eligible individuals and their families. Under the Demonstration's capitated model, DMAS, CMS, and selected managed care organizations (MCOs) have entered into three-way contracts through which the MCOs receive blended capitated payments for the full continuum of covered Medicare and Medicaid benefits provided to dual eligible individuals, including Medicaid-covered long term services and supports and behavioral health care services. The participating MCOs will cover, at a minimum, all services currently covered by Medicare, Medicaid wrap-around services, nursing facility services, Medicaid-covered behavioral health services, home and community-based long-term services and supports provided under the Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver. Robust care coordination, interdisciplinary care teams, and person-centered care plans are also mandatory services that must be provided through the participating MCOs. Virginia plans to offer the Demonstration from January 1, 2014, through December 31, 2016. This SPA was submitted to CMS 3/28/13 and was approved by CMS 6/12/13. The Emergency regulatory package has been approved internally and by DPB and is now pending Secretary Office approval.

2012 General Assembly

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

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

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

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

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

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

(07) DSH Shortfall Payments/IME and GME Reimbursement Changes for Type One Hospitals:

This SPA increases Medicaid payments for Type One hospitals and physicians consistent with the appropriations to compensate for limits on disproportionate share hospital (DSH) payments to Type One hospitals that the department would otherwise make. In particular, the department has the authority to amend the State Plan to: (i) increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate as demonstrated by UVA and VCU; (ii) change reimbursement for Graduate Medical Education to cover costs for Type One hospitals; (iii) case mix adjust the formula for indirect medical education reimbursement for HMO discharges for Type One hospitals, and; (iv) increase the adjustment factor for Type One hospitals to 1.0. The SPA was approved by CMS 2/5/13. The Fast-Track regulatory package was filed with Registrar's office 4/25/14, published in the Register 5/19/14 and became effective 6/18/14. Project is completed and will be removed from the next report.

2011 General Assembly

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

***(02) Update Medicaid Works Program Income Limit:** This Fast-Track regulatory action implemented the Medicaid buy-in program, MEDICAID WORKS, as authorized by the 2011 General Assembly. House Bill 2384/Chapter 506 directed DMAS to increase the maximum allowable gross earnings for participants in the program to the maximum gross income amount allowed under the Ticket to Work and Work Incentives Improvement Act that does not trigger the collection of mandatory premiums. This amount is calculated to be \$75,000 in gross annual earnings. This regulatory action will also adjust MEDICAID WORKS policy to mitigate the negative impact (loss of Medicaid eligibility) of higher earned income or higher unearned income as a result of participating in this work incentive program. Eligibility policy will be amended to enable a disregard for any increase in the amount of unearned income in the Social Security Disability Insurance (SSDI) payment resulting from employment as a worker with disabilities eligible for assistance under the Ticket to Work and Work Incentives Improvement Act, or as a result of a Cost of Living Adjustment (COLA) adjustment to the SSDI payment. Policy also will be amended to

enable a disregard for any unemployment insurance payments received by an enrollee as a result of loss of employment through no fault of his own. This regulatory package was approved by the Governor's office and filed with the Registrar's office 10/15/13. The comment period ended 12/5/13 and became effective 12/19/13. The SPA was submitted to CMS 12/30/13 and is pending approval.

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

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

(05) Electronic Claim Submission Requirements: This Emergency/NOIRA action complied with the *2011 Acts of the Assembly*, Item 300 H that required DMAS to implement a mandatory electronic claims submission process, including the development of an exclusion process for providers who cannot submit claims electronically. This regulatory package was approved by the Governor 9/3/12 and filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. The Proposed stage regulatory package was approved by the Governor's office and filed with the Registrar's office 10/15/13. The comment period ended 1/16/14. The final stage regulatory package is currently at the Governor's office pending approval.

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

(07) 2011 Exceptions to Personal Care Limit: This Emergency/NOIRA action complied with the legislative mandate to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services (which includes supervision time). This regulatory package was approved by the

Governor on 9/3/12 and was filed with the Registrar's office 9/4/12. The comment period ended 10/24/12. (2011 General Assembly Item 297 CCCCC) The Proposed stage regulatory package is currently at the Governor's office pending approval.

(08) Early Intervention Part C Children Case Management: This Emergency/NOIRA regulatory action supported early intervention services, provided under Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia in accordance with Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) which address developmental problems in young children. These services are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. This Emergency/NOIRA action was approved by the Governor's office 9/12/2012. The SPA was approved by CMS 9/25/2012. This project was changed to a Fast-Track action and is currently at Secretary's office pending approval.

2010 General Assembly

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

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

(03) Inpatient Residential Treatment Psychiatric Services: This State Plan Amendment modifies the reimbursement methodology for inpatient residential psychiatric services provided by residential treatment facilities and freestanding psychiatric facilities. The SPA was submitted to CMS 6/29/10 pending approval. Received a request for additional information (RAI) from CMS 9/30/10. There is currently a matter of litigation pending and DMAS was granted an indefinite extension regarding the RAI response on this issue.

2009 General Assembly

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

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

Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.