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

June 13, 2017
Final Minutes

Present:
Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Patricia T. Cook, M.D.
Maureen Hollowell
Peter R. Kongstvedt, M.D.
Vice Chair
McKinley L. Price, D.D.S.
Karen S. Rheuban, M.D.
Chair
Vilma T. Seymour
Kannan Srinivasan

Absent:
Alexis Y. Edwards
Rebecca E. Gwilt, Esq.

DMAS Staff:
Linda Nablo, Chief Deputy Director
Cheryl Roberts, Deputy Director for Programs
Scott Crawford, Deputy Director for Finance
Kate Neuhausen, MD, Chief Medical Officer
Bhaskar Mukherjee, Director of Office of Data Analytics
Beth Ferrara, Digital Content Manager, OCLA
Elizabeth Guggenheim, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration (OCLA)
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
Suzanne Gore, Deputy Director for Administration
Karen Kimsey, Deputy Director for Complex Services

Guests:
W. Scott Johnson, First Choice Consulting, LLC
Sam Garrison, McGuire Woods Consulting
Brittany West, Hunton & Williams
Chris Whyte, VECTRE
Mike Edwards, Kemper Consulting
Amy Hewett, VHCA-VCAL
Rick Shinn, VACHA
Cal Whitehead, CSG
Mark Hickman, CSG
Don Parr, Deloitte
John Mohrmann, Capital Results
Jennifer Wicker, VHHA

ORIENTATION FOR NEW MEMBERS AT 9:00 A.M.

Cynthia B. Jones, Director of DMAS, conducted new member orientation for Dr. Patricia Cook, Vilma Seymour and Kannan Srinivasan which began at 9:05 a.m. Dr. Karen Rheuban attended the orientation along with the Executive Management Team (EMT): Linda Nablo, Suzanne Gore,

Karen Kimsey, Cheryl Roberts, Scott Crawford and Dr. Kate Neuhausen. Introductions were made and Ms. Jones provided an overview of the Virginia Medicaid program (see attached handout) and the Agency Organizational Structure charts (see attached handout). EMT members provided a brief description of their area of responsibility and highlighted the programs for which they were responsible.

CALL TO ORDER

Dr. Karen S. Rheuban called the regular BMAS meeting to order at 10:05 a.m. and thanked Ms. Jones for providing the orientation to the new members. Dr. Rheuban welcomed the members and others in attendance. Then, Dr. Rheuban asked other members to introduce themselves, and introductions continued around the room.

APPROVAL OF MINUTES FROM MAY 9, 2017 MEETING

Dr. Rheuban asked for a motion to approve the Minutes from the May 9, 2017 meeting. Ms. Hollowell made a motion to accept the minutes and Dr. Price seconded. The vote was unanimous-**9-yes (Coleman, M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, provided a brief update on the project status of the key programs the agency is currently focused on: A Healthy Virginia program, Commonwealth Coordinated Care (CCC) Plus, Medallion 4.0, Addiction Recovery and Treatment Services (ARTS), and the Medicaid Enterprise System (MES) Procurement.

AFFORDABLE HEALTH CARE/CHIP/FEDERAL BUDGET UPDATE

Ms. Suzanne Gore, Deputy Director for Administration, provided an analysis of the potential impact of the proposed American Health Care Act (AHCA) on Virginia's Medicaid program based on the federal bill passed by the U.S. House of Representatives on May 4, 2017 (see attached handout).

Then, Ms. Gore gave a status report on the Children's Health Insurance Program (CHIP) (see attached handout). If the federal government does not reauthorize this program, the federal CHIP funding for this program runs out in January 2018.

COMMONWEALTH COORDINATED CARE (CCC) PLUS UPDATE

Ms. Karen Kimsey, Deputy Director for Complex Services, presented an update on the status of the CCC Plus program scheduled to be phased in across six regions of the Commonwealth beginning in Tidewater on August 1, 2017 (see attached handout).

REGULATORY ACTIVITY SUMMARY

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

NEW BUSINESS

After discussion, Dr. Kongstvedt made a motion to draft two letters to be sent to the General Assembly Members and Virginia Delegation. One letter would address the detrimental impact the AHCA would have on Virginia's Medicaid program and the other letter would address the impact of losing CHIP funding. It was suggested that the AHCA letter focus on the facts and Ms. Seymour suggested the letter include a 'personal' story of how these decisions can/will affect an individual. A draft of the letters will be forwarded to Board members for comments and then the Board members agreed to allow the Chair and Vice Chair to make any necessary changes. The final letter will be forwarded to General Assembly Members and the Virginia Delegation. Dr. Price seconded. **9-yes (Coleman, M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

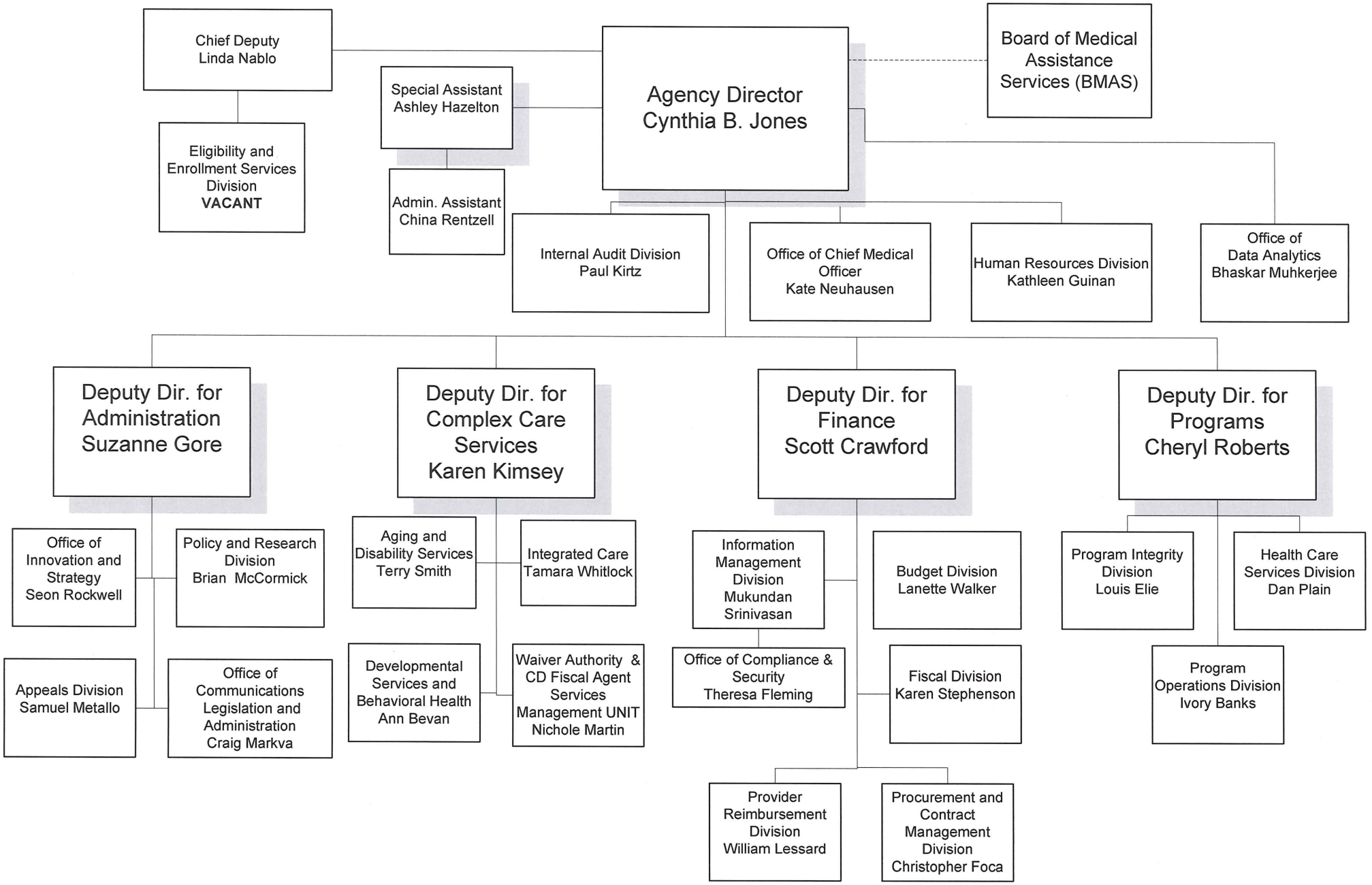
As tentative agendas were developed at the December 13, 2016 BMAS meeting, Dr. Rheuban confirmed the following potential topics for discussion and presentations at the September 12, 2017 meeting: Affordable Care Act Update, Dashboard, and Commonwealth Coordinated Care (CCC) Plus Update. Ms. Jones introduced Bhaskar Mukherjee, Director of Office of Data Analytics, who will provide the briefing for the Dashboard discussion. Dr. Kongstvedt also asked for reports on specialty drugs and the Pharmacy Benefit program by Dr. Neuhausen at the December meeting.

ADJOURNMENT

Dr. Kongstvedt made a motion to adjourn the meeting at 11:50 a.m. Ms. Seymour seconded. The vote was 9-**yes (Coleman, M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

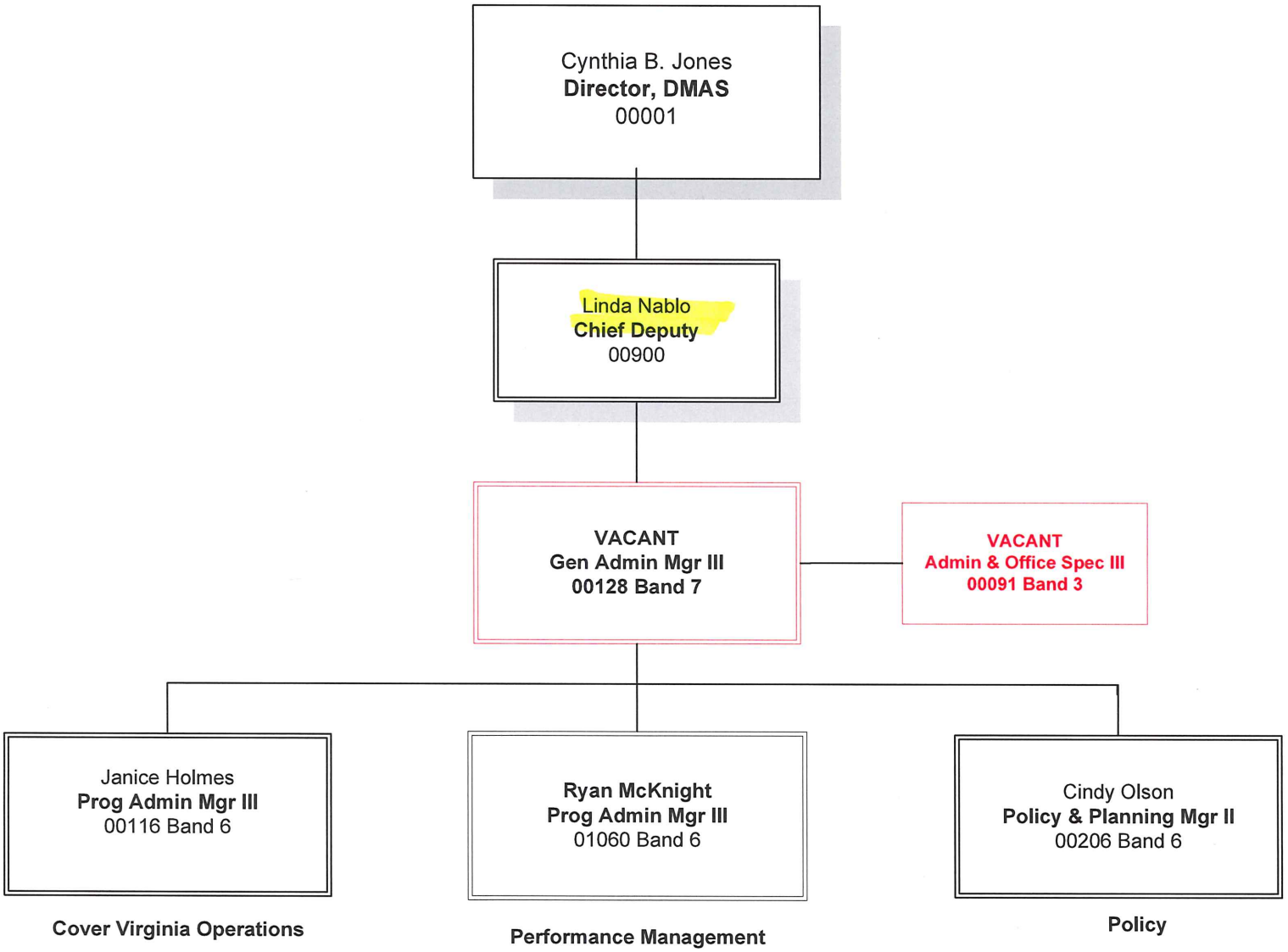
Revised 3-23-17

Department of Medical Assistance Services
Agency Organization Structure



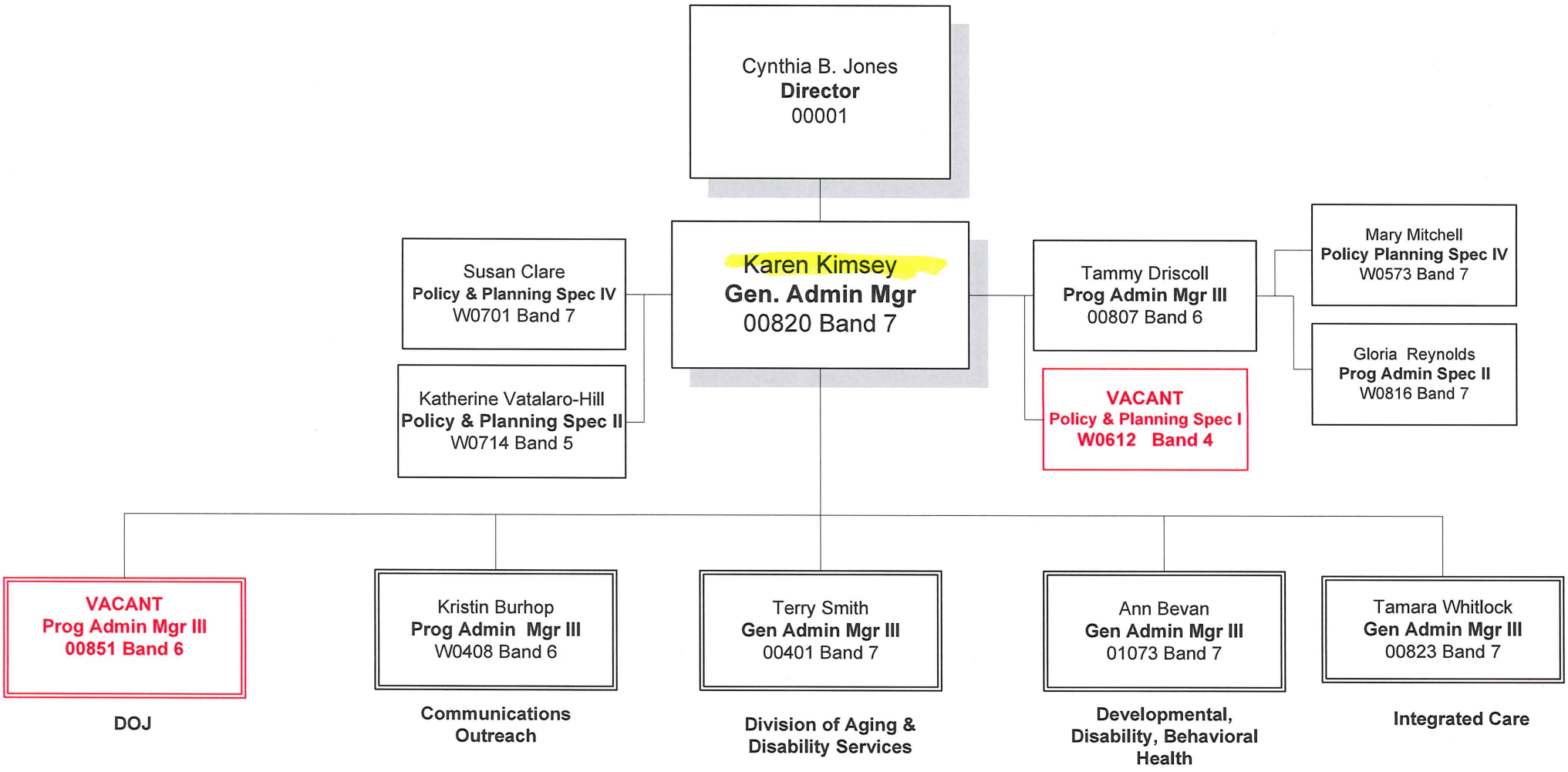
REVISED 6-1-17

Virginia Department Medical Assistance Services
Eligibility and Enrollment Services Division



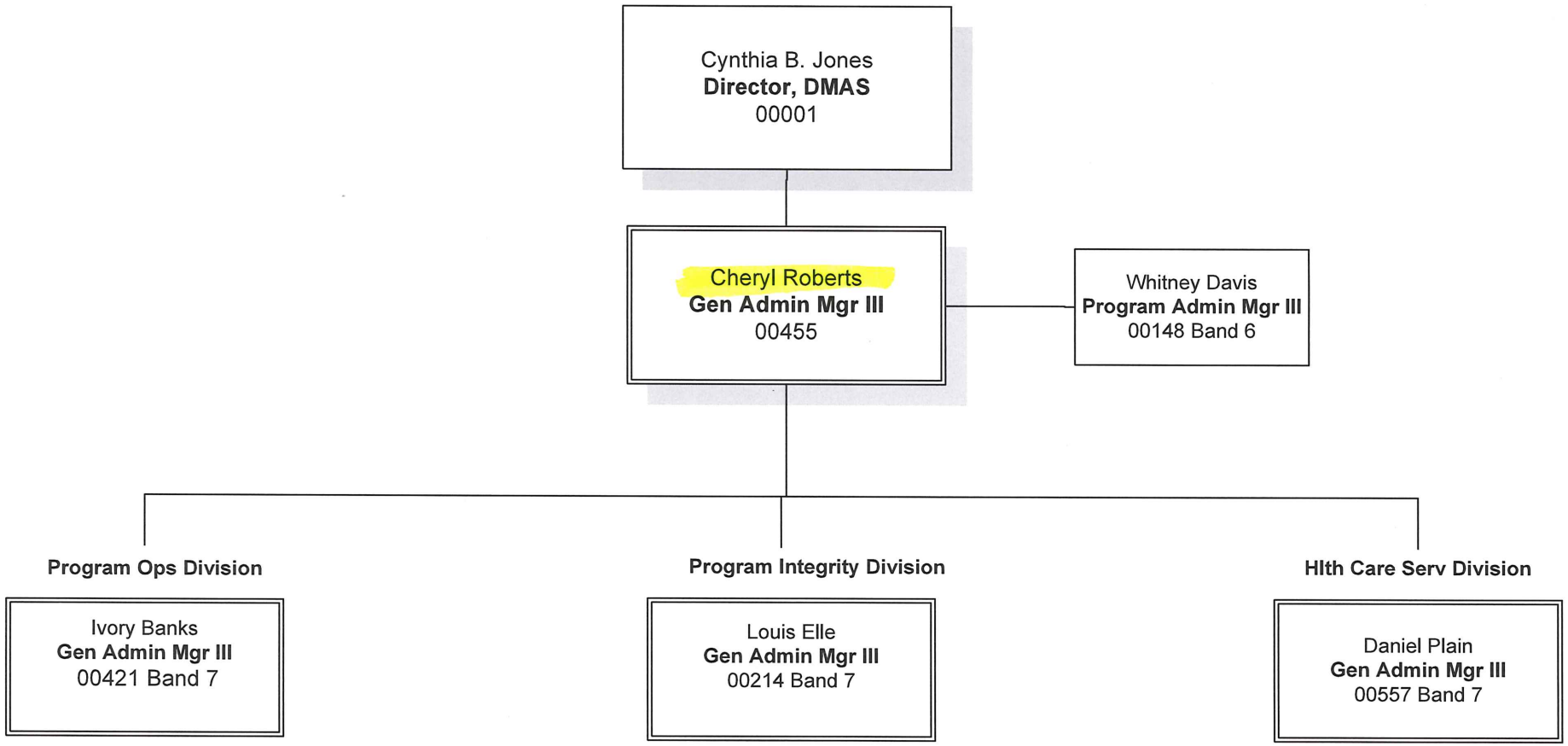
6-1-17

Department of Medical Assistance Services
Deputy Director for Complex Care Services Administration



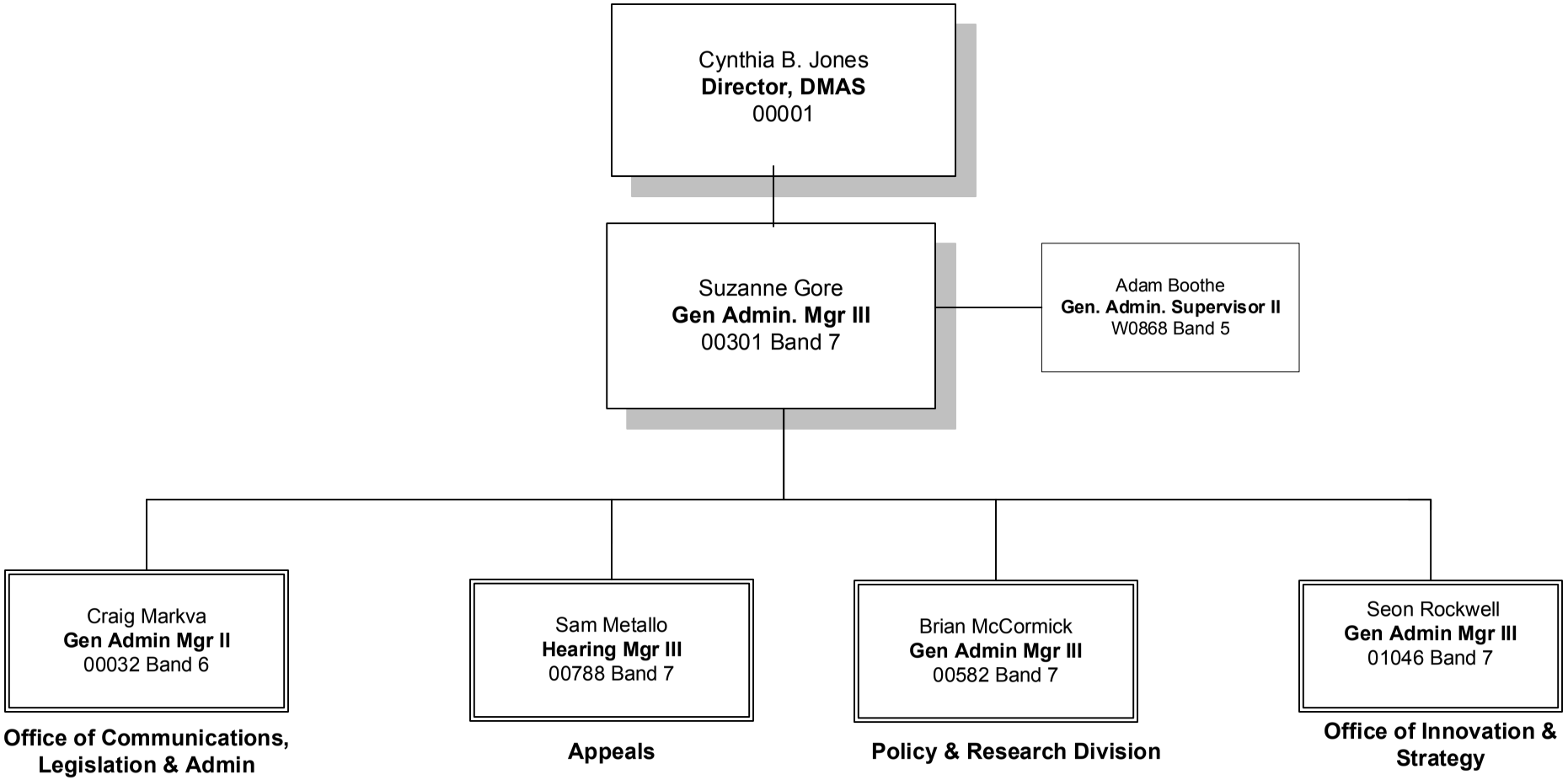
Revised 6-1-17

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Programs



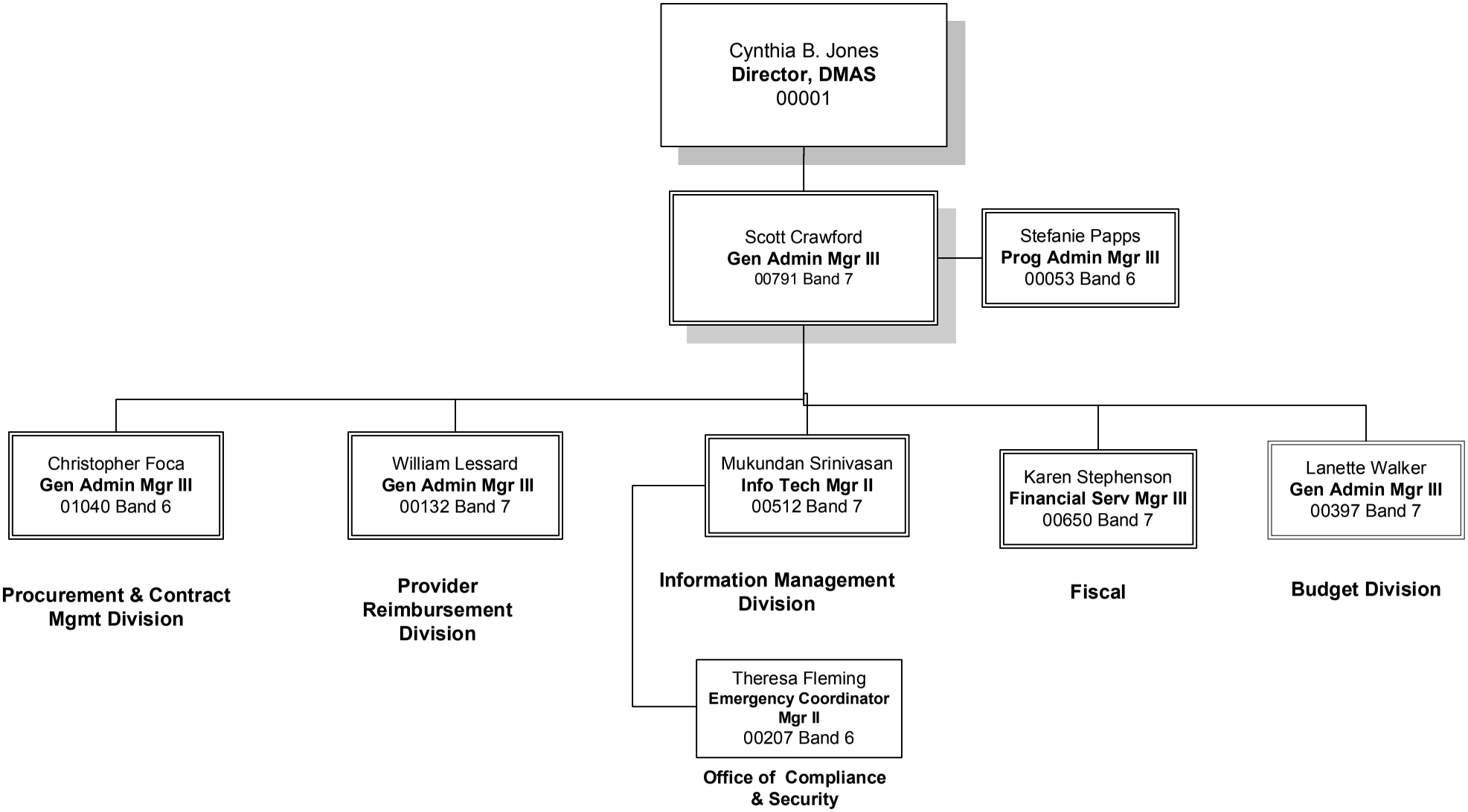
REVISED 6-1-17

Virginia Department Medical Assistance Services
Deputy Director for Administration



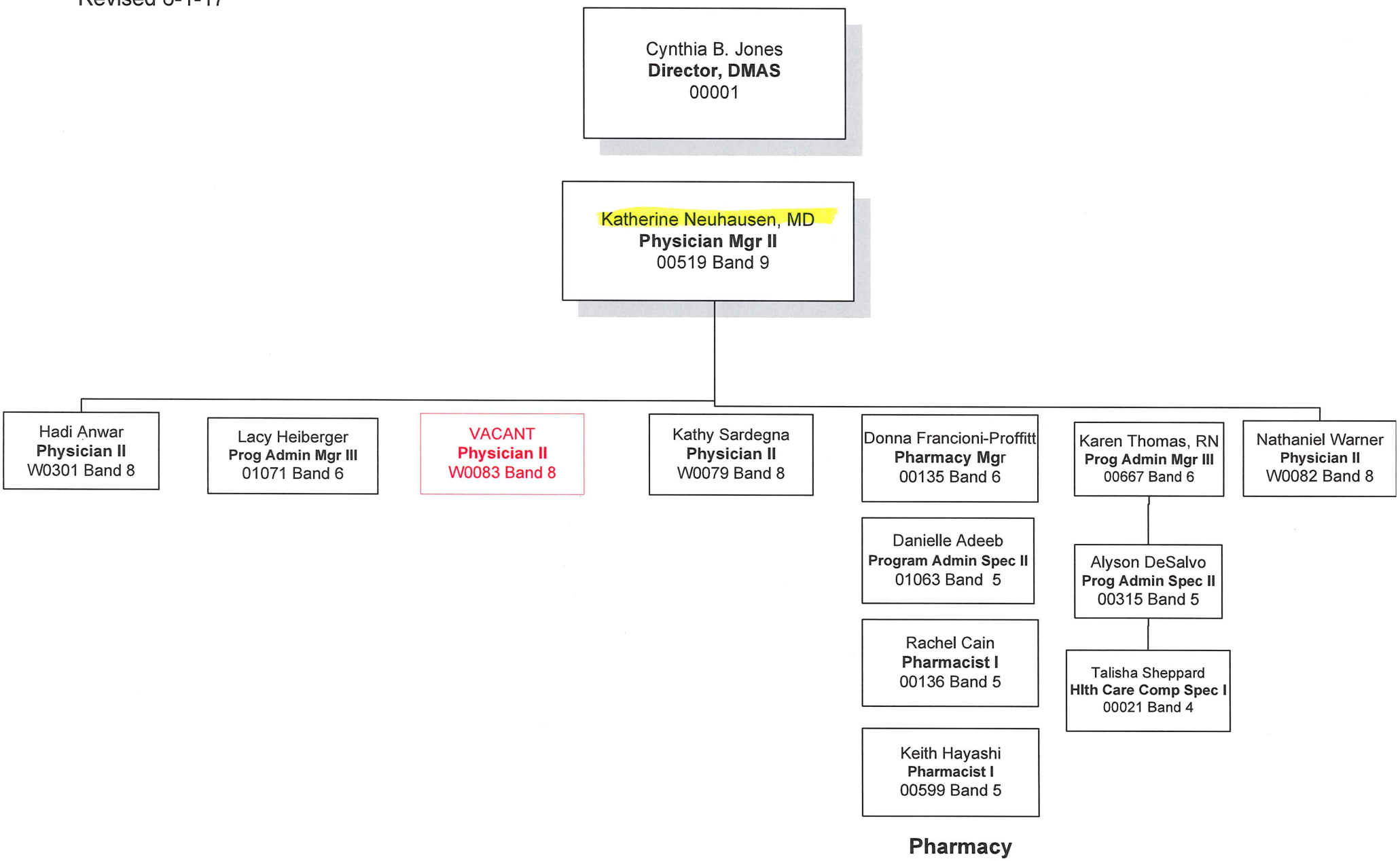
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy Director for Finance

Revised 6-14-17



Virginia Department of Medical Assistance Services
Office of Chief Medical Officer

Revised 6-1-17



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Vice Chair
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Vilma T. Seymour
Kannan Srinivasan

DMAS Staff:
Linda Nablo, Chief Deputy Director
Seon Rockwell, Office of Innovation & Strategy Director
Stephanie Papps, Senior Advisor, Finance
Ashley Harrell, LCSW, Policy and Planning Specialist
Abrar Azamuddin, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Cynthia B. Jones, Director
Suzanne Gore, Deputy Director for Administration
Kate Neuhausen, MD, Chief Medical Officer

Guests:
Tyler Cox, MSV
Kenneth McCabe, DPB
Chris Whyte, VECTRE
Mike Tweedy, Senate Finance Committee
Fred Helm, Kemper Consulting
Jenness Vaccorella, Conduent
Caroline Perrin, MWC
Robert Bohemn, Hunton & Williams

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:07 a.m. and welcomed the new members (Patricia T. Cook, MD, Ms. Vilma T. Seymour and Mr. Kannan Srinivasan) and others in attendance. Then, Dr. Rheuban asked other members to introduce themselves, provide information about themselves, and introductions continued around the room.

APPROVAL OF MINUTES FROM December 13, 2016 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the December 13, 2016 meeting. Dr. Price made a motion to accept the minutes and Dr. Kongstvedt seconded. The vote was 11-**yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

Election of Chairman/Vice Chairman

Dr. Rheuban then turned the meeting over to Ms. Jones for the election process. Ms. Jones noted that the Board bylaws require the election of officers for the Board the first meeting after March 1st of each year and opened the floor to accept nominations for Chair.

Dr. Kongstvedt made a motion to nominate Dr. Rheuban to continue to serve as Chair and Mr. Cook seconded. Hearing no further nominations, the nominations were closed. The vote to elect Dr. Rheuban as Chair was 11-**yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

Ms. Jones opened the floor to accept nominations for Vice Chair. Dr. Price made a motion to nominate Dr. Kongstvedt for Vice Chair. Dr. Rheuban seconded. Hearing no other nomination, the nominations were closed. The vote to elect Dr. Kongstvedt as Vice Chair was 11-**yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

Selection of Secretary

Ms. Jones then opened the floor to accept nominations for Board Secretary. Dr. Rheuban made a motion to accept Mamie White as Board Secretary and Mr. Cook seconded. The vote to elect Ms. White as Board Secretary was 11-**yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

Dr. Kate Neuhausen provided an update on the Addiction and Recovery Treatment Services Benefit implemented statewide on April 1, 2017. This benefit was funded in the 2016 Appropriations Act with bipartisan support from the Governor and General Assembly has expanded access to life-saving addiction treatment for individuals in Virginia. The initial implementation of this program has increased provider participation and been very successful to begin addressing the opioid epidemic in Virginia. For more information on Virginia ARTS benefit, please contact: SUD@dmas.virginia.gov (see attached handout).

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, provided highlights of the Medicaid program and noted the agency is currently focused on five major agency priorities: Commonwealth Coordinated Care (CCC) Plus, Medallion 4.0, Behavioral Health, New Technology Information Systems, and Value Based Payments. Ms. Jones provided a brief update on the American Health Care Act (AHCA) and the potential impacts to Virginia Medicaid (see attached handout).

OVERVIEW OF 2017 GENERAL ASSEMBLY BUDGET/LEGISLATIVE OVERVIEW

Ms. Suzanne Gore, Deputy Director for Administration, provided highlights of some of the 2017 budget actions and legislation which impacted DMAS during the 2017 General Assembly Session (see attached handout).

REGULATORY ACTIVITY SUMMARY

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

OLD BUSINESS

Dr. Rheuban asked for a motion to accept the draft Medicaid expansion letter (attached). After discussion of further modification of the draft letter, Dr. Price made a motion to accept the intent of the letter and that the Board members will allow the Chair and Vice Chair to make any necessary changes and then the final letter will be forwarded to the Governor and members of the General Assembly. Ms. Gwilt seconded. **11-yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

Dr. Rheuban announced the June meeting will begin earlier for new member orientation and all members are welcome to attend. As tentative agendas were developed at the December 13, 2016 BMAS meeting, Dr. Rheuban confirmed the following potential topics for discussion and presentations at the June13, 2017 meeting: Affordable Care Act Update, Innovation Presentation, and Commonwealth Coordinated Care (CCC) Plus Update.

Dr. Rheuban asked for a subcommittee to discuss the elements in the dashboard and asked Dr. Kongstvedt to lead the subcommittee. However, due to Freedom of Information Act (FOIA) requirements, any gathering of as many as three Board members would require a meeting. Board members chose to defer the discussion of the Dashboard until the September meeting. Ms. Jones commented that the agency already has a framework and statistical records available. Ms. Jones suggested providing the information at the September meeting and having a discussion on what the Board members would like to see.

ADJOURNMENT

Dr. Rheuban made a motion to adjourn the meeting at 12:09 p.m. Dr. Kongstvedt seconded. The vote was 11-**yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, Seymour and Srinivasan); and 0-no.**

THE AMERICAN HEALTH CARE ACT

*Virginia Medicaid Impact Analysis**

June 13, 2017

Suzanne Gore, Deputy of Administration

*Based on the bill passed by the House on May 4, 2017

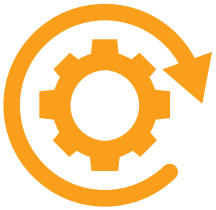
DMAS VISION AND STRATEGY

A Time of Major Change in Health Care

Complex Environment

Growing Costs

Dynamic Policy Debate



New Processes

New Regulations

New Technologies

Individual Impacts

Consistent Themes of Policy Change

- Addressing access to health care
- Controlling health care cost growth
- Shifting responsibility to states and localities

Holding Steady in the Face of Uncertainty

Our mission has not changed…

…but how we meet the mission may be changing…

Success depends on all of us to partner together

DMAS Strategy

Superior Care

Cost Effective

Continuous Improvement

Virginians Covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

Medicaid is the primary payer for **behavioral health** services

Medicaid covers **1 in 3** births in Virginia

33% of children in Virginia are covered by Medicaid & CHIP

2 in 3 nursing facility residents are supported by Medicaid

62% of long-term services and supports spending is in the community

Medicaid plays a critical role in the lives of over 1.3 million Virginians

Strategic Focus: Transitioning to Managed Care

	Medallion 4.0	CCC Plus
	▪ Serving infants, children, pregnant women, care taker adults ▪ 760,000 individuals	▪ Serving older adults and disabled ▪ Includes Medicaid-Medicare eligible ▪ 216,000 individuals
	▪ Births, vaccinations, well visits, sick visits, acute care ▪ Incorporating community mental health	▪ Long-term services and supports in the community and facility-based, acute care ▪ Incorporating community mental health
	▪ New procurement 2017 ▪ Building on two decades of managed care experience	▪ Implementation starts Aug 2017 ▪ Implemented statewide by Jan 2018

Incorporating the best care networks in our state to improve access, increase cost predictability and provide a platform for future innovations

Managed Care as a Platform for Improvement

Compliance Focus

- Emphasize coverage
- Basic metrics
- Meet requirements
- Transactional

Improvement Focus

- Emphasize care
- Integrated metrics
- Drive performance
- Strategic

Innovation Focus

- Emphasize collaboration
- Value based objectives
- Share rewards
- Creative

Virginia is leveraging our managed care experience to build the future

Innovative Programs Serve Virginians in Need

Governor's Access Program

Serving low-income adults with Serious Mental Illness

Addiction Recovery Treatment Services

Combatting the opioid epidemic in Virginia

Dental Coverage

Expanding dental coverage for pregnant women

Behavioral Health Homes

Improving care coordination and access for adults with behavioral health needs

DMAS Strategy

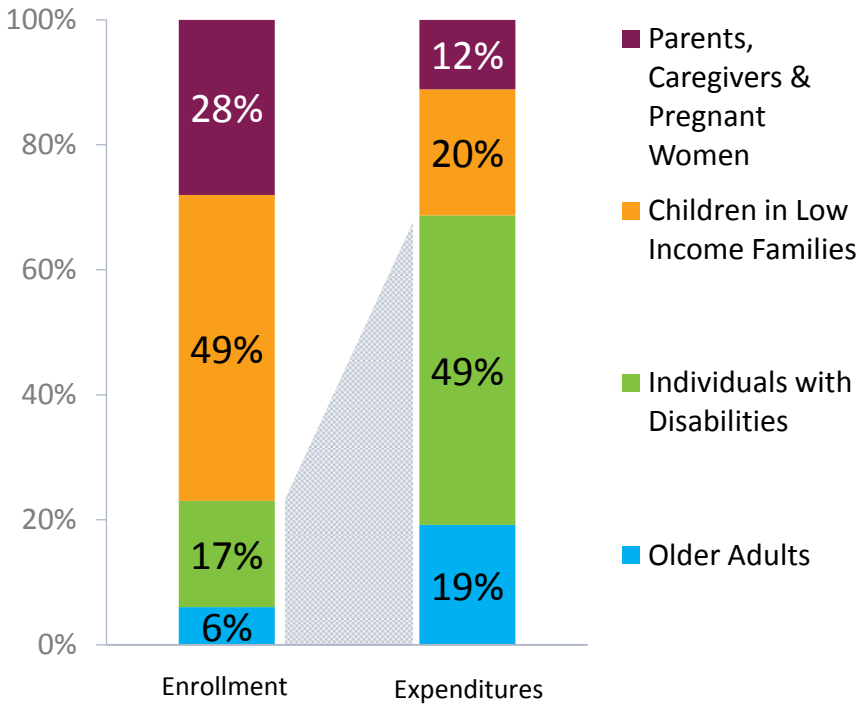
Superior Care

Cost Effective

Continuous Improvement

Virginia Medicaid: Enrollment & Expenditures

Enrollment vs. Expenditure SFY 2016



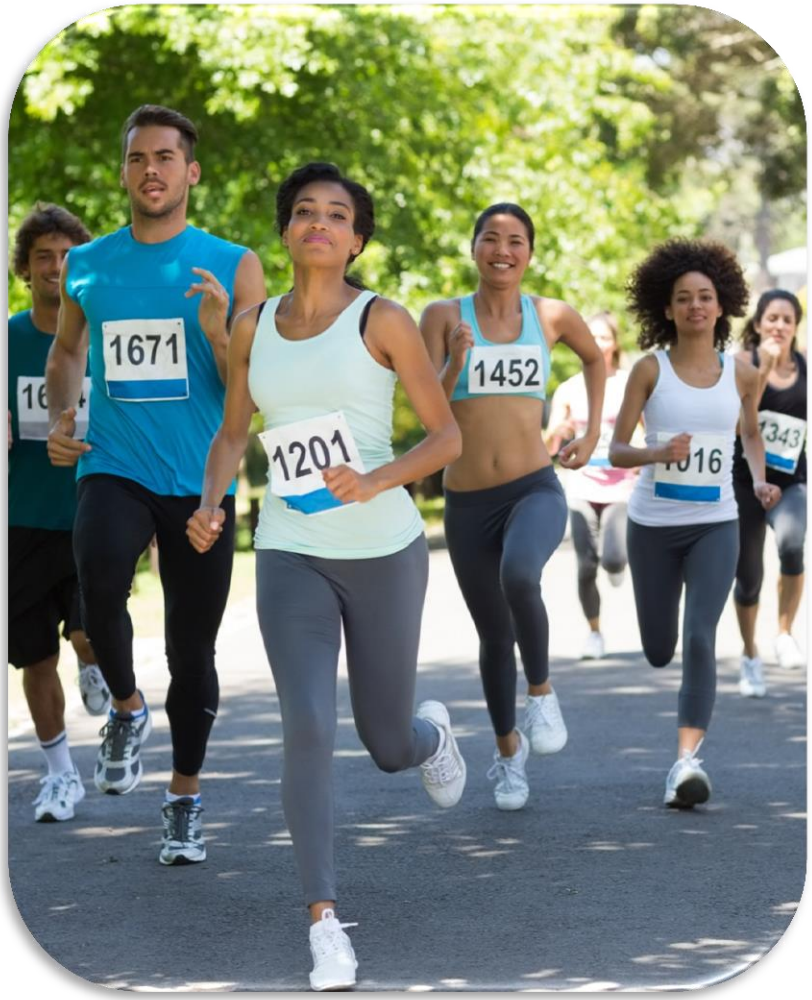
1.3 M Enrolled

$8.41 B Spent

23% of the Medicaid population **Drives** **68%** of total expenditures

Expenditures are disproportionate to the population where services for older adults and individuals with disabilities drive a significant portion of Medicaid costs

Driving Efficiencies on Multiple Fronts



Improving LTC Program Eligibility Screening	Uniform Assessment Instrument
Managing Program Integrity	Enforcement Standards Reporting & Analytics
Evolving Performance Incentives	Incentive Award Report Cards
Decreasing Preventable Utilization	Trend Analysis
Enhanced Financial Review	Profit Cap Policy Revisions Financial Statement Reporting
Modernizing our Infrastructure	Medicaid Enterprise System modernization
Maintaining Low Admin. Cost	DMAS administrative costs remain low

The Medicaid program continues to make changes to realize greater efficiencies

DMAS Strategy

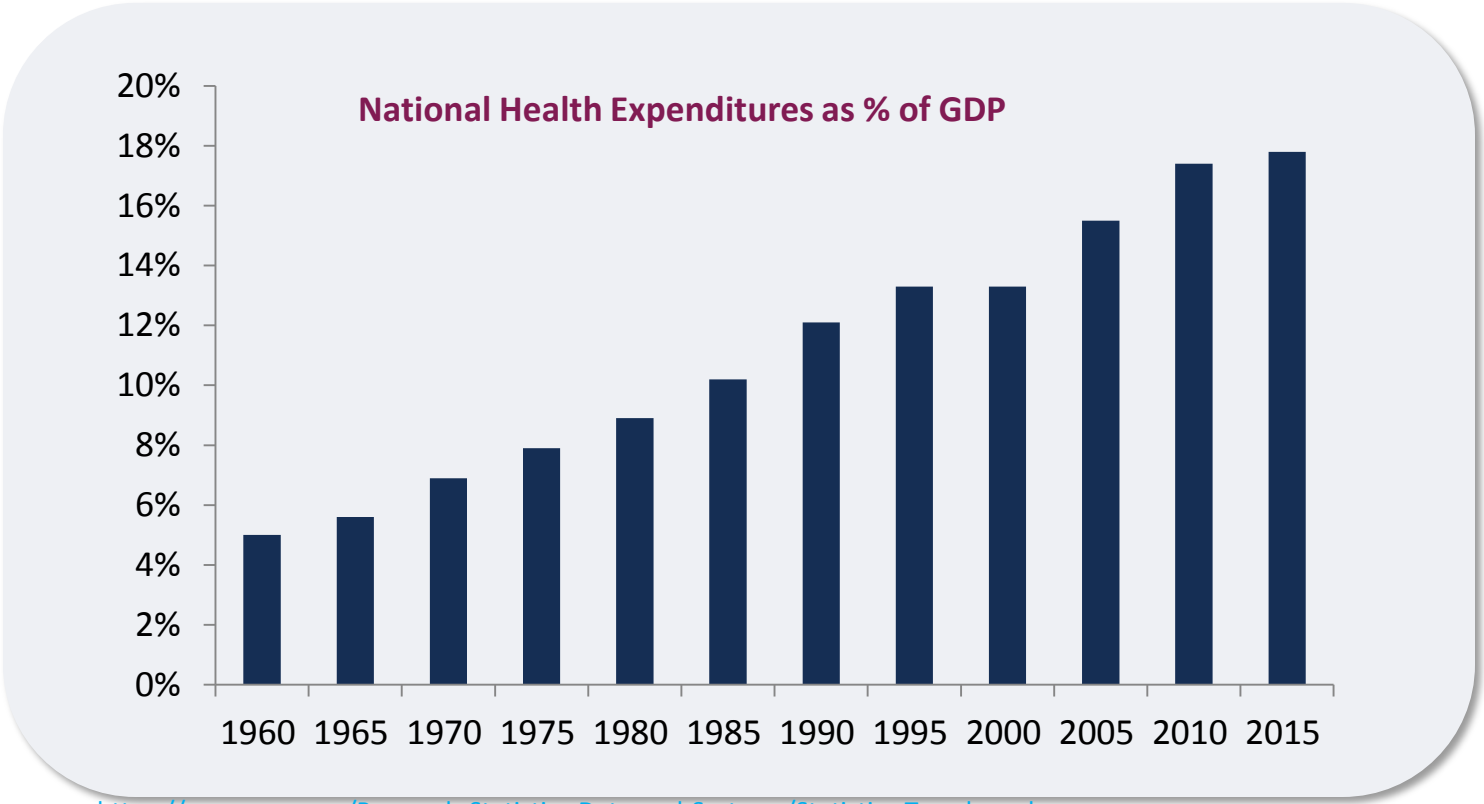
Superior Care

Cost Effective

Continuous Improvement

A Case for Health Care Reform

Addressing heath care cost growth requires an industry-wide solution, not just a focus on Medicaid



Source: NHE summary: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

As health care expenditures continue rising across the country, State Medicaid programs are key contributors to the national delivery system reform conversation


STATE OF THE HEALTH
CARE DEBATE

AHCA Puts Virginians in Harms Way

The proposed American Health Care Act (AHCA) has significant impacts to Virginia

Makes health care less affordable for people who need it most –affecting those who are older, poorer and sicker

Reduces Medicaid funding by $709 million, leaving state lawmakers to either cut services or raise taxes.

Decreases patient protections

Increases risk of destabilizing individual insurance market

The AHCA will pressure states to make difficult decisions that will negatively impact health and quality of life for the sickest and most vulnerable Virginians

Virginia Benefited From the ACA

More Virginians gained health care coverage

- **378,900** Virginians accessed health coverage through the Federal Marketplace
- **1/3 fewer** Virginians without insurance*

*"By The Numbers" The Commonwealth Institute, March 2017

- **Cost Savings**: Medicaid drug rebates, public health funding, and lower uncompensated care costs created savings for the Commonwealth
- **Consumer Protections**: Critical insurance protections guaranteed minimum standards and improved transparency
- **Economic Gains:** Economic activity was generated by new spending for health care services and out-of-pocket costs were reduced for Virginians
- **Workforce**: Health coverage built a labor force that is ready to work

Even without the added benefit of Medicaid expansion, Virginia experienced a tremendous positive impact from the ACA

Medicaid Also Benefited From the ACA

- GAP and ARTS both use ACA authority
- New eligibility system (VACMS)
- Streamlined eligibility for pregnant women and children (MAGI)
- Enhanced CHIP federal match rate
- Dual-eligible demonstration (CCC)
- SIM planning funding
- MMIS funding at 90/10 match rate

Apart from Medicaid Expansion, the ACA provided important gains for Virginia

Fails To Address Cost Drivers of Health Care

Misses a window of opportunity to address health care costs

Cost drivers of health care, like skyrocketing drug costs, should not just be the states' problem

We must address true cost drivers in health care, and not by shifting the problem to states

Addressing true cost drivers in health care requires joint leadership between federal and state governments

The AHCA increases responsibility for care to individuals, providers, plans and states without creating more efficient care that pays for what works

AHCA Provisions: Medicaid Impact

Expansion Rules

- New expansion states that expand after 3/1/2017 only receive regular Federal Match (not enhanced)
- For states who expanded before 3/1/2017, phases out enhanced funding for Medicaid Expansion population starting 12/31/2019

Medicaid Eligibility

- Eliminates presumptive eligibility in most cases
- Eliminates retroactive coverage
- Restricts eligibility for lottery winners
- Repeals ACA mandate to cover "Stair step" children up to 138% FPL in Medicaid (no VA impact)

State Options

- States have option to institute a work requirement for able-bodied adults

Medicaid Funding

- Per-capita caps grow at CPI-M for children & adult categories, CPI-M +1% for aged & disabled categories
- Provides option for block grant funding for children & adult categories with growth at only CPI
- Baseline for per-capita cap determination is 2016
- Reduces federal match funding for expansion states beginning in Jan 1, 2020
- Continues Disproportionate Share Hospital payments
- Provides limited new funding for non-expansion state
- Provides funding to pay for new reporting requirements

AHCA Provisions: Individual and Business Impact

Individuals

- Age-based tax credits instead of income-based
- No individual mandate
- 30% penalty for coverage gaps. Or, state may seek waiver to health status underwrite those with a coverage gap, if state has a high-risk pool.
- Higher out-of-pocket costs from repealing cost-sharing reductions
- Must repay excess tax credits
- Reduces qualifying AGI for medical expense deductions from 10% to 5.8%
- Increases HSA flexibility & max limits
- Repeals 0.9% high-earner Medicare tax
- Repeals net investment tax of 3.8%

The Marketplace

- Max 5:1 premium differential between old & young (up from 3:1), but states may change by waiver
- 10 Essential Health Benefits (EHBs) retained, but states design their own for individual & small group markets through waiver
- Lifetime & annual dollar limits on coverage and cap on out-of-pocket spending preserved, but weakened by option to waive EHBs.
- Actuarial standards removed (gold/silver/bronze)
- Guaranteed issue
- Dependent coverage through age 26

Businesses & Health Care

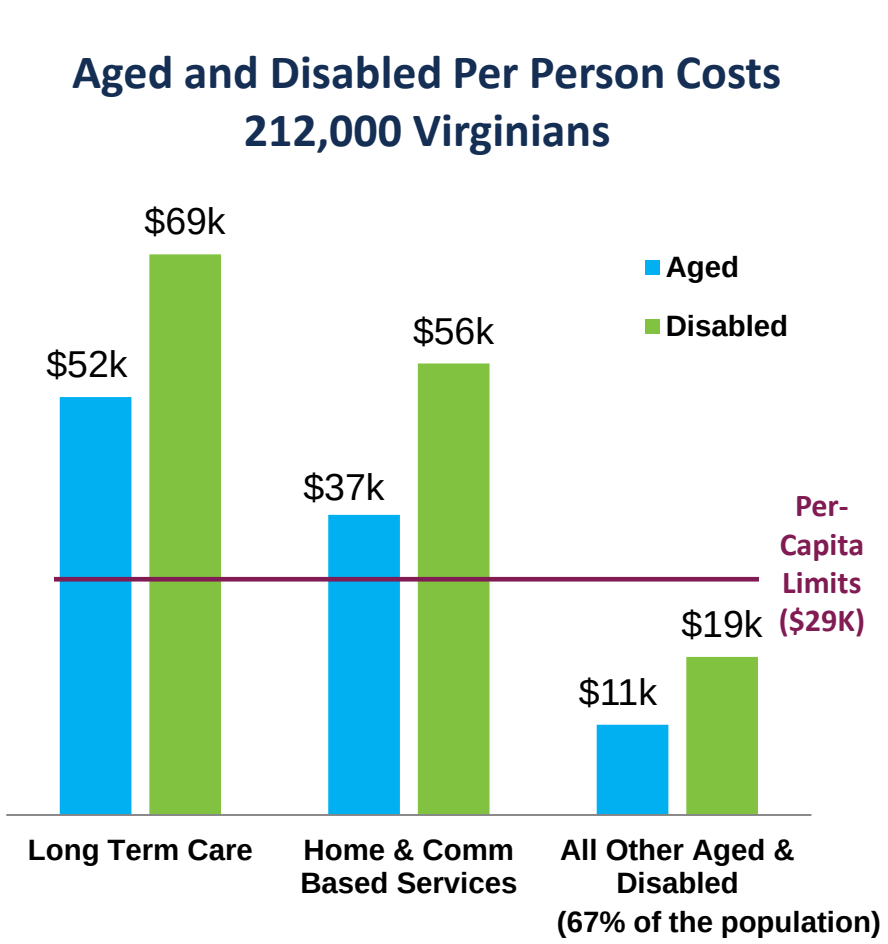
- No employer mandate
- Delays Cadillac Tax (excise tax on high-cost employer-sponsored coverage)
- Reinstates tax deduction for employers who offer Medicare Part D equivalent prescription coverage to their retirees
- Repeals Small Business tax credit
- Repeals 10% tanning bed tax
- Repeals 2.3% medical device tax
- Healthcare executive salaries over $500k are deductible
- Repeals tax on brand pharmaceuticals
- Repeals fee on certain health insurers

State Funding

- **Patient & State Stability Fund:** States may apply for these funds to lower patient costs and stabilize markets (through high-risk pools, reinsurance, and other state initiatives). Virginia allotment requires escalating state match.
- **Supplemental Payment Allotment:** $2 billion for non-expansion states to increase payments to Medicaid providers.
- **Prevention and Public Health Fund:** Repeals funding of core public health programs at end of FY 2018 and rescinds unobligated funds remaining at the end of FY 2018.
- **Reserve Fund:** Allocates $75 to $80 billion to create larger tax subsidies for older Americans in the individual market.

AHCA IMPACT ON VA MEDICAID

Per-Capita Cap Models Result in Funding Shortfalls



Source: Virginia Medicaid 2020 Projected Per Person Expenses (est.)

Per-Capita Cap Model Creates Funding Risks

Aged and Disabled population needs exceed per-capita limits

1st year projected loss for ABD = $22M

7th year projected loss for ABD = $191M

Projected loss over 7 years across all populations = $709M

Population is aging rapidly

Average national growth 2015-2025 **= 8.4%**

Age 65+ growth 2015-2025 **= 35.8%**

Fewer DD Waiver Slots

10,000+ people will wait longer for vital case management, employment supports and living services supports

Note: Projected financial losses are for the aged and disabled groups only

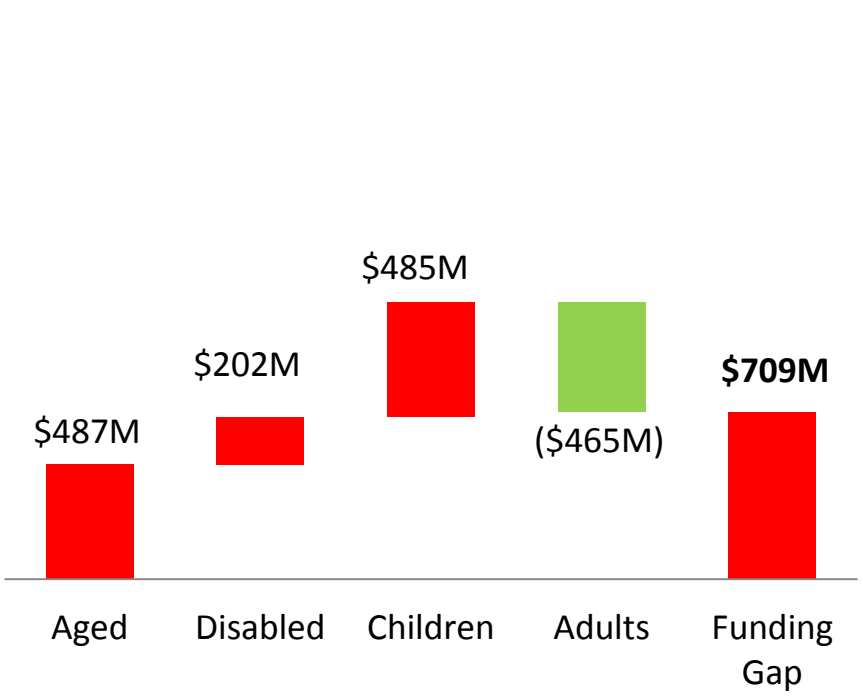
Costs can vary greatly by subgroup. Proposed per-capita cap models using CPI-M are too simplistic to capture differences and create risk of funding shortfalls for states

Funding is very sensitive to variations in CPI-M

Virginia Funding Gap by 2026

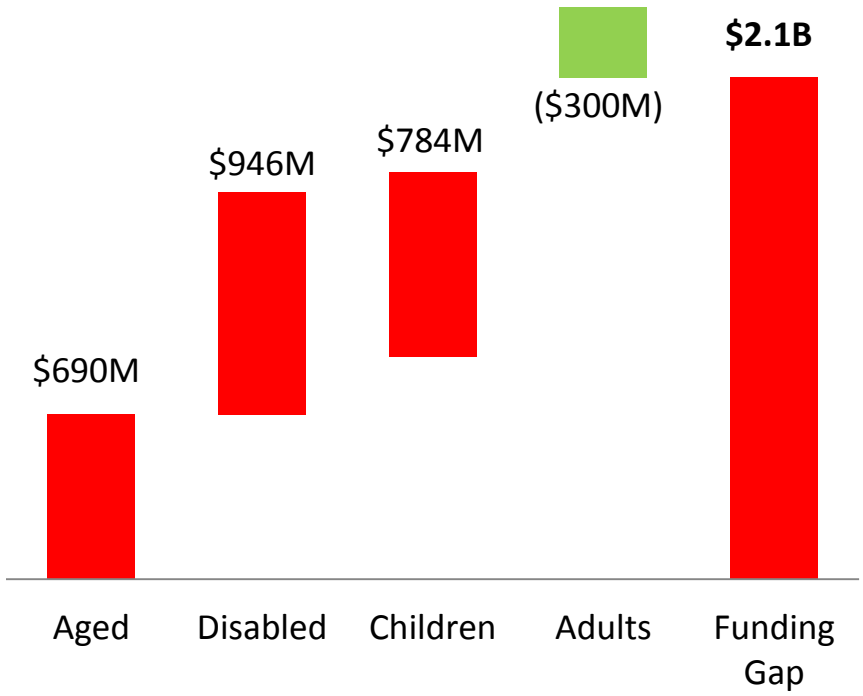
If medical CPI is 3.7%

Higher Rate = More Federal Funding = Smaller Gap



If medical CPI is 3.2%

Lower Rate = Less Federal Funding = Bigger Gap



If CPI is different from the projection, the effects on funding are dramatic…and the state would not know until after the year has concluded

CPI-M Inadequately Represents Medicaid Cost Growth

Neither CPI-M nor CPI-M+1% take into account critical factors that affect the rate of growth in Medicaid costs

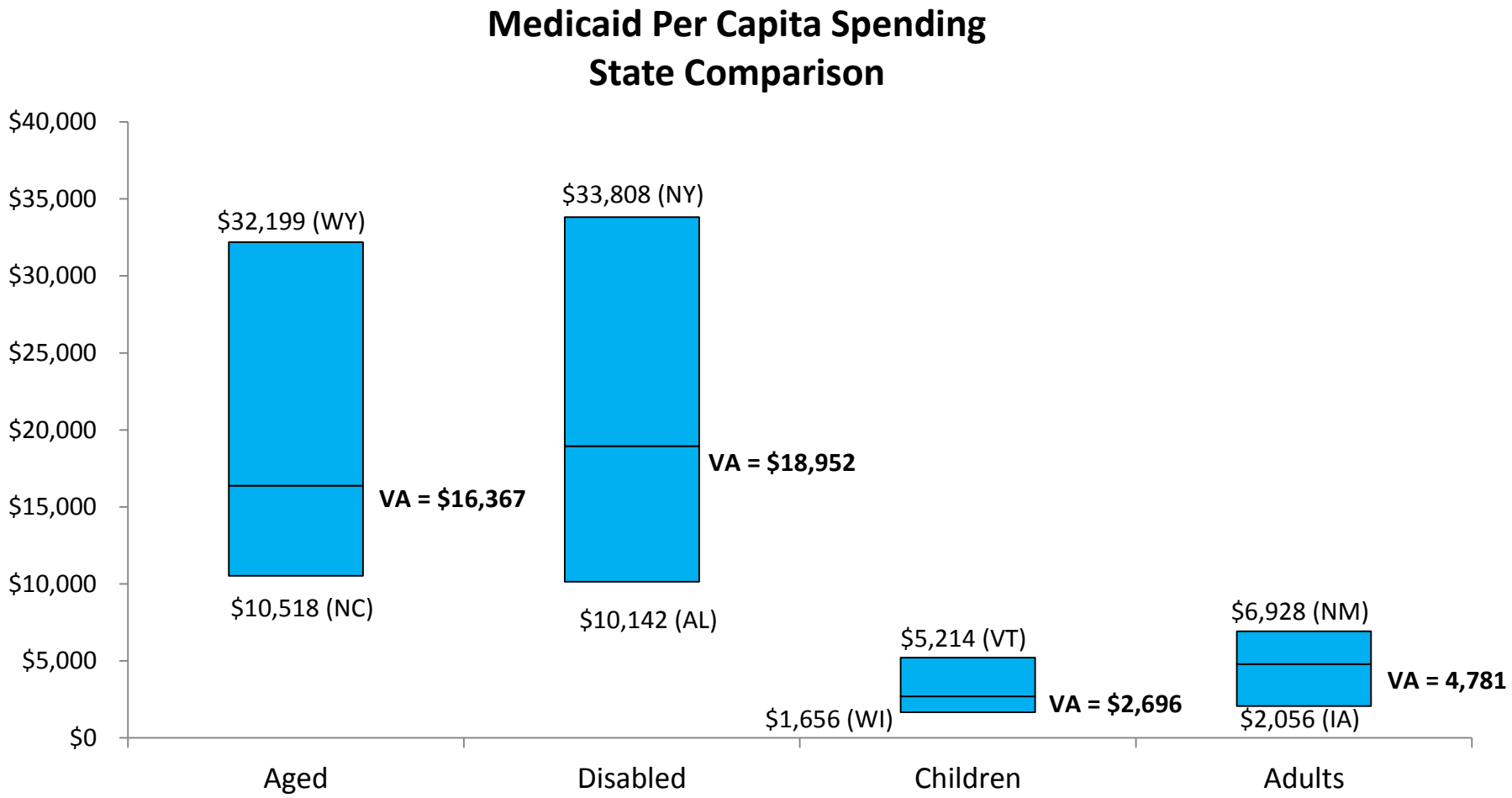
	Price Changes	Quality Changes	Quantity Changes	Medical Services	Behavioral Health Services	Long Term Services and Supports	Total Cost of Care	Rise in Total Cost of Care
Medicaid Expenditures	✓	✓	✓	✓	✓	✓	✓	✓
CPI-M	✓	✗	✗	✓	✗	✗	✗	✗

CPI-M was never intended to reflect total growth in per-capita health care cost. Its use in this context is a misapplication with very serious consequences.

Analysis and Estimates Pose Risks and Opportunities

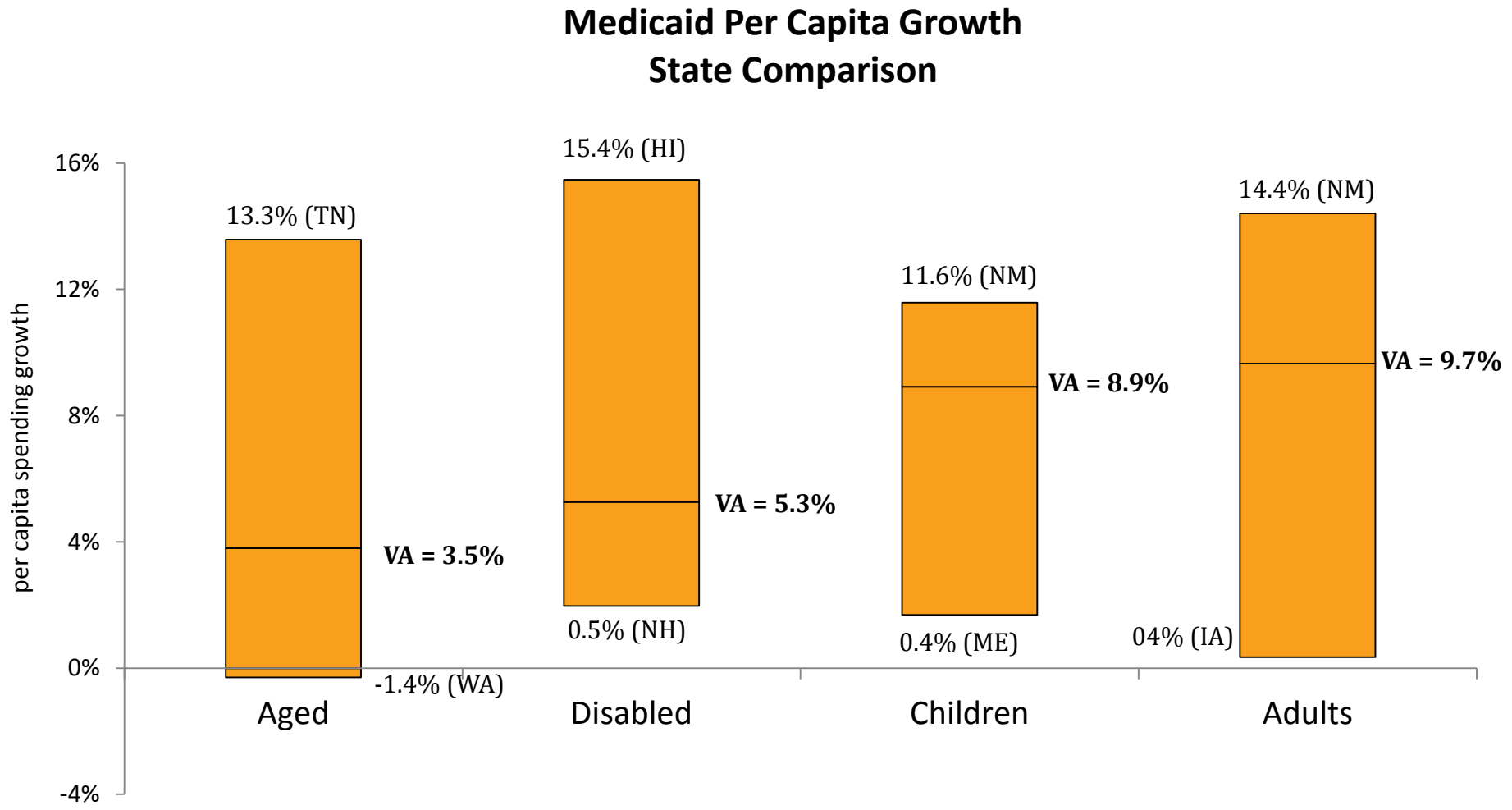
Potential Change	Description	Impact
CPI-M assumption is too optimistic	The 3.7% CPI-M assumption used by the Congressional Budget Office (CBO) is higher than we have seen over the prior 8 years. This means Federal funds projections for Virginia are likely high.	**Risk:** Receive significantly fewer Federal dollars than projected
Enrollment Growth in Aged Population	CPI-M is not reflective of the service bundle for the aging population. By 2025, Virginia is expected to see its senior population – a group with high Medicaid costs – grow by 37%.	**Risk:** An aging baby boomer population who needs more health care support could significantly increase actual Medicaid expenses for this group
Higher Growth in Per Enrollee Costs for Adults	Current Medicaid per enrollee cost for adults reflects a temporary influx of adults attributed to the exchange-related outreach effect with very limited health care services needs.	**Risk:** This effect should normalize over time and there could be a higher than projected per enrollee costs
Quantity of Services for Disabled Population Continues to Grow	Services for the disabled population such as long-term services and supports is not reflected in CPI-M	**Risk:** If there is a greater demand for long-term services and supports in the community, this could increase expenditures above the per-capita cap allotment.
Improvements Through Innovation and Negotiations	Cost reduction initiatives through innovation or negotiation with Managed Care Organizations (MCOs) could drive down costs or contain utilization of services	**Opportunity:** Potential for lower expenses with improvements

Virginia's Per Capita Spending is Conservative



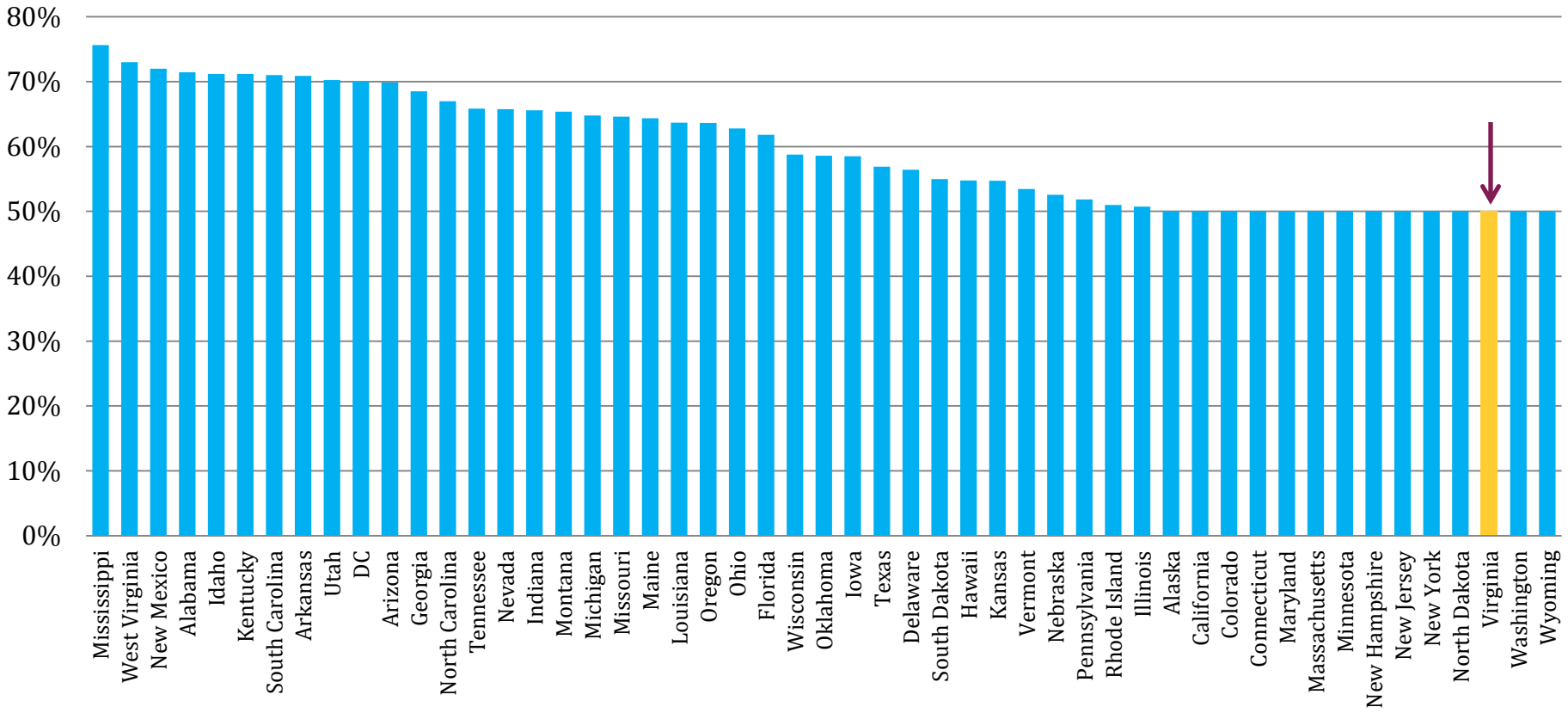
Source: Kaiser Commission estimates based on data from FY 2011 MSIS and CMS-64 reports.

Virginia's Per Capita Historical Spending Growth Has Be Within National Norms



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2000, 2001, 2010, & 2011 MSIS and CMS-64 reports.

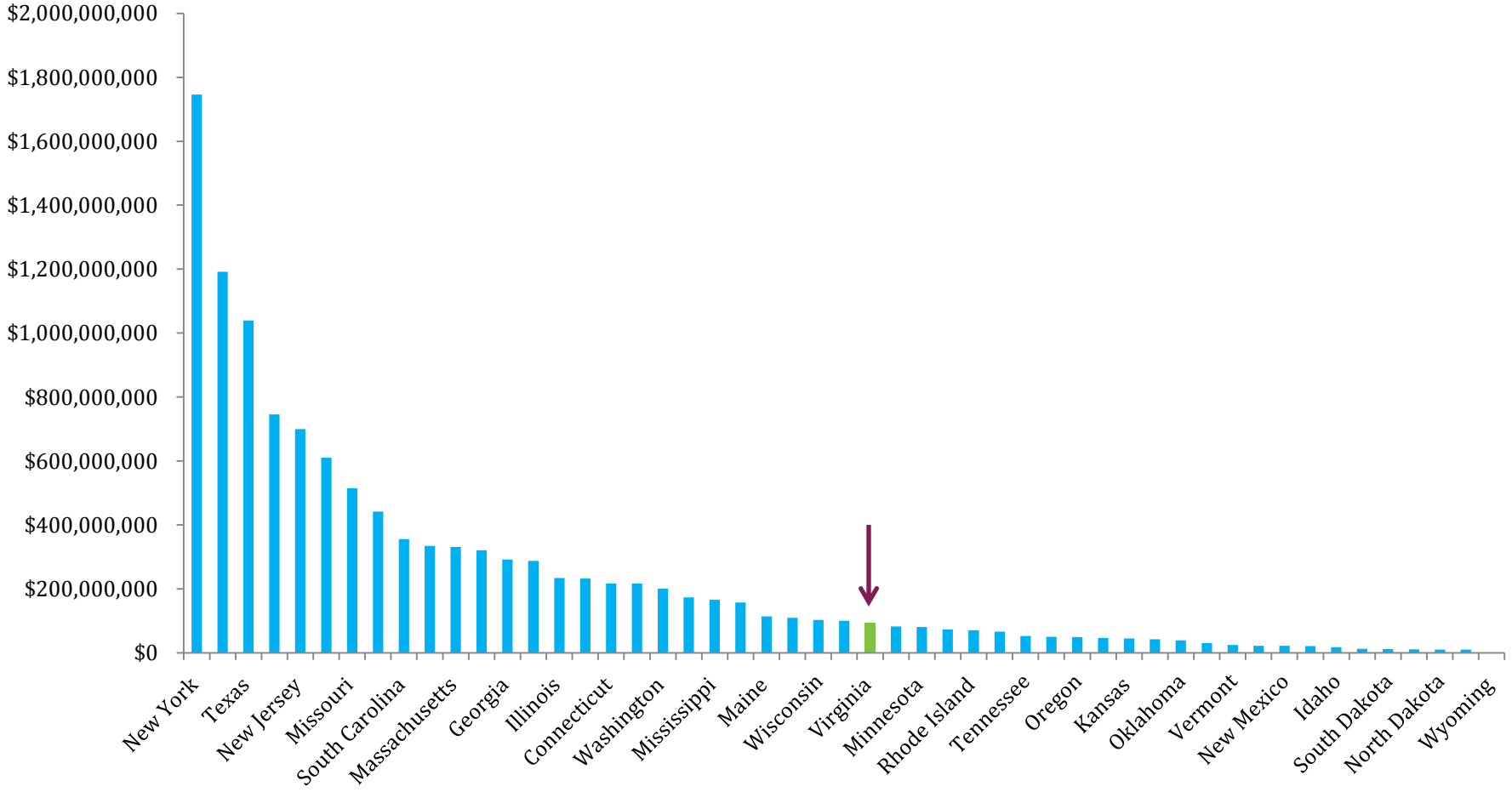
75% of other states receive a higher Medicaid matching rate than Virginia



Sources: Federal Register / Vol. 81, No. 220 / Tuesday, November 15, 2016 / Notices. / p 80079 & 80080 / FY 18 match rate.

Virginia's Medicaid matching rate is 50%, the lowest state matching rate available

Half of states receive a higher DSH allotment than Virginia

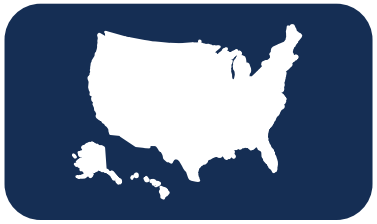


Source: Federal Register, October 26, 2016 (Vol. 81 No. 207), pp. 74439.

Virginia's 2016 DSH allotment was $95.2M

Other Ways Virginia Has Been Conservative

Virginia is conservative by comparison to other states that have taken advantage of opportunities to increase Medicaid funding, such as assessing additional taxes



Virginia	Other States
No Nursing Facility Assessment (Tax)	43 states assess a nursing facility tax
No Hospital Assessment (Tax)	39 states assess a hospital tax
Virginia's Medicaid reimbursement rates are 79% of Medicare rates, which is just slightly above national median. This is conservative without overstretching with risk to care quality and access	National norm is 66% of Medicare rates

Historical conservatism in these areas create additional reasons why Virginia would be disadvantaged under the AHCA as compared with other states

Medicaid Supports Other Programs

Local School Divisions:

- Close to 100 local school divisions rely on Medicaid funding to support special education services (e.g., Occupational, Physical, and Speech Therapy).
- DMAS reimbursement to schools for special education services:
  - Medical Claiming: $29,484,310.32 (FY15)
  - Administrative Claiming: $3,407,152.95 (FY16)
- Therapeutic Day Treatment, a Medicaid service, provides behavioral supports to children during the school day.

Local Departments of Social Services:

- $121 million annually in federal funding goes to the Virginia Department of Social Services for the local departments to determine Medicaid eligibility.

State Information Technology Enhancements leverage 90/10 Medicaid funding:

- VaCMS- the public benefit eligibility system
- Emergency Department Care Coordination system (to be built in 2018)

VA Medicaid also supports other programs and services across the Commonwealth.

Medicaid Coverage Is Not Comparable to Commercial Insurance

Medicaid coverage differs from commercial insurance in critical ways

- **Behavioral health**
  - Medicaid is the largest payer for behavioral health services in Virginia
  - Medicaid covers community mental health services and state psychiatric hospitals not paid for by commercial insurers
  - Behavioral health services are not included in CPI-M
- **Long term services and supports (LTSS)**
  - Medicaid is the largest payer for developmental disability services in Virginia
  - 62% of Medicaid funded LTSS services are provided in the community and 60% of nursing home days are Medicaid-funded
  - LTSS is not included in CPI-M
- **Comprehensive coverage for children**
  - Medicaid's EPSDT program covers all medically necessary care for children.

Medicaid services are critical to the health of Virginians

Virginia Would Incur Implementation Costs

- Technology and infrastructure are needed to comply – uncertainty about enhanced federal match
- Policy, process, and training changes needed to operationalize eligibility changes
- Administrative costs and process changes needed to operationalize new federal funding process
- Uncertainty in Federal Marketplace and infrastructure

2 years of funding for technology changes is inadequate to implement required changes

Virginia is not currently funded to operationalize the proposed changes

Virginia Lawmakers Would Face Tough Choices

Possible Loss in Federal Funds $709 M

Virginia anticipates responsibility for at least $709M above the current federal matching formula between 2020 – 2026 (using 2016 as base year)

To make up for lost federal funding, Virginia lawmakers will have to:

- Increase Medicaid's state appropriation and/or **CUT**:
  - Medical, behavioral health and LTSS services
  - Populations currently eligible for Virginia's Medicaid program, including DD waiver slots
  - Provider and health plan rates

The ACHA increases Virginia Medicaid's financial burden

ACA Repeal Threatens Virginia Programs

Repealing the ACA will eliminate funding and authorization for critical Virginia programs

- **Authorization:** Threat to programs authorized under ACA
  - GAP program
  - ARTS waiver and not calculated in baseline year
- **Repealed funding:** Programs whose funding is repealed under AHCA, such as the Prevention and Public Health Grant programs run by VDH
- **Funding cutbacks:** Limiting funding to states through per-capita caps will force Virginia to make difficult decisions

Threats to Virginia from Per-Capita Cap Funding

Assigning 2016 as baseline year for determining per-capita cap funding will ignore important factors affecting Virginia's current and future Medicaid spending

Not included in Virginia's baseline calculation

- Addiction Recovery Treatment Services (ARTS) benefit
- Provider rate increases (per legislative requirement)
- Governor's Access Plan (GAP) increase of allowable income from 80-100% FPL

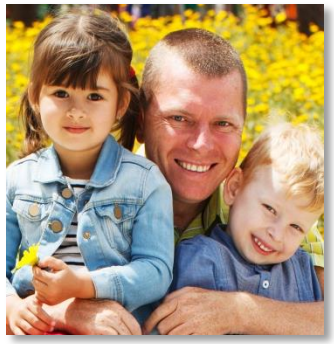
TRUMP BUDGET AND MEDICAID

Federal Budget Cuts on Top of AHCA Cuts

- $627 billion cuts to Medicaid nationally
- Virginia would have immediate shortfall
  - $36.4 million in FY 2018 Caboose Bill
  - $257 million in FY2019/2020 Biennium Budget
  - In 2026 alone, $1.5 billion
- From 2020-2026, AHCA shortfall is $709 million in federal funds; budget adds $5.5 billion during this time frame(cumulative)

Staggering Shortfall Makes Difficult Choices

- Lower/change eligibility income thresholds
- Lower provider rates
- Revise benefit packages, including home and community based programs
- Increasing the acuity levels for Seniors and Individuals with Disabilities to receive long term services and supports
- Raise state taxes or drain from other important state funded programs



AHCA IMPACT ON THE INDIVIDUAL MARKET

Many Virginians Benefit From Tax Credits

More Uninsured

Eliminating subsidies and favoring age-based tax credits makes coverage less affordable. Virginia's uninsured rate will increase.

Higher Out Of Pocket Costs

Rewards those who are younger, richer and healthy. Penalizes those who are older and poorer with greater health care needs

Current Constituents by District as of March 1, 2017

District	Representative	Medicaid Enrollees	Marketplace Enrollees [1]	Est. to Lose coverage[2]
1	R. Wittman	95,903	34,500	23,470
2	S. Taylor	88,851	29,800	21,363
3	B. Scott	179,615	25,000	23,616
4	D. McEachin	105,652	34,200	20,927
5	T. Garrett	146,109	34,900	25,360
6	B. Goodlatte	104,936	30,900	22,526
7	D. Brat	86,168	37,700	27,685
8	D. Beyer	63,043	40,600	29,647
9	M. Griffith	137,239	26,600	19,183
10	B. Comstock	65,959	39,800	29,138
11	G. Connolly	57,096	44,900	32,263
	Total	**1,130,571**	**378,900**	**275,178**

1. Kaiser Family Foundation Interactive Maps: Estimates of Enrollment in ACA Marketplaces and Medicaid Expansion, Feb 2017
2. Health Insurance Resource Center https://www.healthinsurance.org/author/charles-gaba/
3. U.S. Census Bureau American Community Survey Office, 2015

Harming constituents already at greater health risk while benefiting younger, healthier and wealthier Virginians

AHCA Would Destabilize the Individual Market

Incentivizing High-Risk Pools

- **The Patient and State Stability Fund** provides federal funds to lower patient costs & stabilize markets (through funding for high-risk pools, reinsurance, and other state initiatives.)

- **States may seek waivers to rules for underwriting against health status** for those with a break in coverage, if the state has a high-risk pool
  - Higher premiums for pre-existing conditions
  - $8 billion allotted to these states to reduce costs for underwritten individuals is insufficient

Cost-Sharing Reductions (CSRs)

- **CSRs are subsidies the government pays to insurers** for costs incurred from providing required silver tier plans with reduced cost-sharing (i.e., deductibles, coinsurance, copayments, out-of-pocket limits) for low-moderate income enrollees.

- **The max cost-sharing limit is reduced on a sliding scale by increasing the plan's actuarial value** (i.e. the value insurers expect to pay of enrollee's covered costs; ~70% in a silver plan).

- **The AHCA repeals the cost-sharing subsidies →**
  - Higher premiums, insurers exiting the Marketplace, and higher out-of-pocket costs for enrollees

High Premiums Get Even Higher

- **Healthcare will become more expensive as premiums will rise for all consumers**
- **If CSRs are not funded, the cost-shifts from the federal government to consumers**
- **Individuals with pre-existing conditions may be guaranteed coverage, but are not protected from being priced out of the Marketplace with higher premiums based on health status.**
- **High premiums and repeal of the individual mandate will encourage healthy individuals to leave the Marketplace, creating sicker insurance pools and even higher premiums.**

Fewer People Could Afford Coverage Under AHCA

Reductions in premium tax credits under the AHCA would put insurance out of reach for many low-income people AND elimination of cost-sharing subsidies would mean fewer people could afford to use their coverage.

Eliminating cost-sharing reduction payments to insurers will increase premiums for benchmark silver plans:

- The average premium for a benchmark silver plan is estimated to increase by 19%
- Premiums for benchmark silver plans in Virginia are estimated to increase by 17%

Ending subsidies will cost the federal government more money: Insurers will increase premiums to mitigate losses from lost subsidies. This would trigger bigger tax credits for the broader population eligible for help paying their premiums. The larger tax credits would cost the federal government an estimated $2.3 billion above what it would save on the cost reduction subsidies next year (Kaiser)

In 2016, Virginia received an estimated $230 million in cost-sharing subsidies, paid to insurers to reduce out-of-pocket costs for low to moderate income Virginians on silver level plans

More Underinsured Virginians

More Underinsured

By loosening insurance standards and consumer protections, even those insured will face steep out of pocket costs

Confusing the Consumer

Changing health plan standards reduces transparency to consumers, making it harder for consumers to know what they are buying

Constituents will have inadequate coverage for their health needs

Increases Risk to Insurance Market

Changing Rules

- No individual mandate
- Changes in premium differential from 3:1 to 5:1 between old and young

Uncertainty

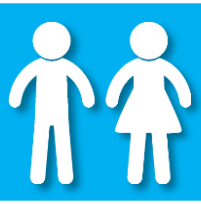
- Uncertain plan prices
- Uncertain individual participation
- Silence on future of Federal Marketplace

New infrastructure is needed to administer the Patient and State Stability Fund (High-Risk Pool)

- **New state obligation**: Virginia must appropriate additional state funds to meet state share requirements and draw down the federal match for the fund, thus putting pressure on General Fund
- **Complex fund administration**: Virginia must provide a significant new investment to establish infrastructure and administer the fund
- **Insufficient existing resources**: Virginia is not currently equipped to influence private market stabilization

Asking state government to support the private insurance market puts Virginia at risk and requires Virginia to build capacity to take on this new role

The AHCA Has Significant Impacts to Virginia

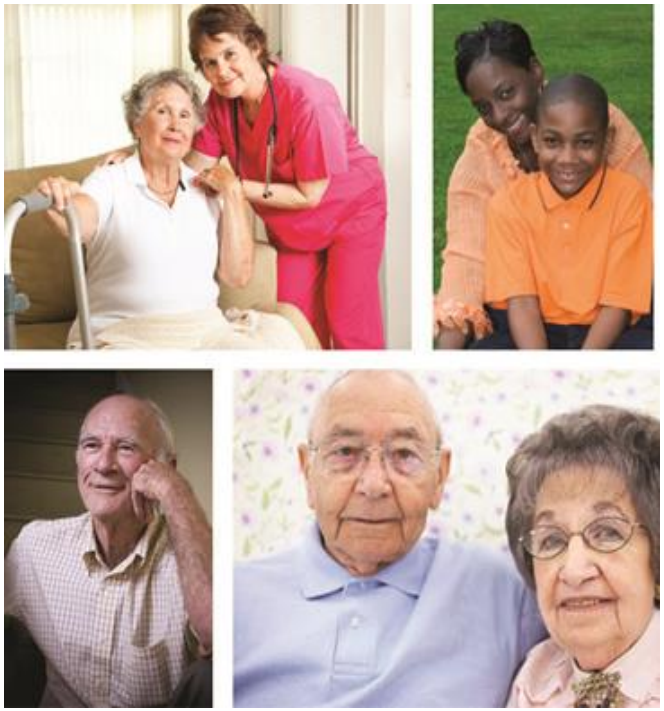


Overall, less affordable for people who need it most – primarily helps younger, healthier, and higher income people

Patient protections decrease with increased out of pocket costs

Shifts risk and costs to states - $709 million expected in federal cuts to Medicaid

Increases risk of destabilizing individual insurance market



CCC PLUS UPDATE TO THE BOARD OF MEDICAL ASSISTANCE SERVICES

Karen E Kimsey

Deputy Director of Complex Care and Services

Agenda

- CCC Update and Transition
- CCC Plus Update and Population Metrics
- CCC Plus Readiness – Network Adequacy
- Streamlining Efforts
- Communication and Outreach

CCC Plus Program Update

- Medicaid managed long term services and supports (MLTSS) program; will serve ~ 216,000 individuals with complex needs
- Participants include individuals ages 65+, adults and children with disabilities; includes duals and individuals receiving LTSS (facility and community based); includes DD Waiver participants for non-waiver services
- Operates through an integrated delivery model that includes medical & behavioral health services and LTSS
- Operates with very few carved-out services (e.g., dental, community mental health *until 1/1/2018*, and DD Waiver services)
- Operates statewide; to be phased in across 6 regions of the Commonwealth beginning in Tidewater on August 1, 2017

Highlights of Accomplishments

- ✓ RFP Development, Award, Rates, and Contracts
- ✓ CMS 1915 (b) Mandatory Managed Care Waiver- *Approved*
- ✓ CMS 1915(c) CCC Plus Waiver (EDCD and Tech)- *Approved*
- ✓ DSNP Contracts In Place for CY 2017
- ✓ CCC Plus Helpline (added CCC Plus to Maximus Contract)
- ✓ CCC Plus Plan/DMAS workgroups (Common Core, Systems, Networks, etc.)
- ✓ Desk and onsite reviews

What's Happening Now?

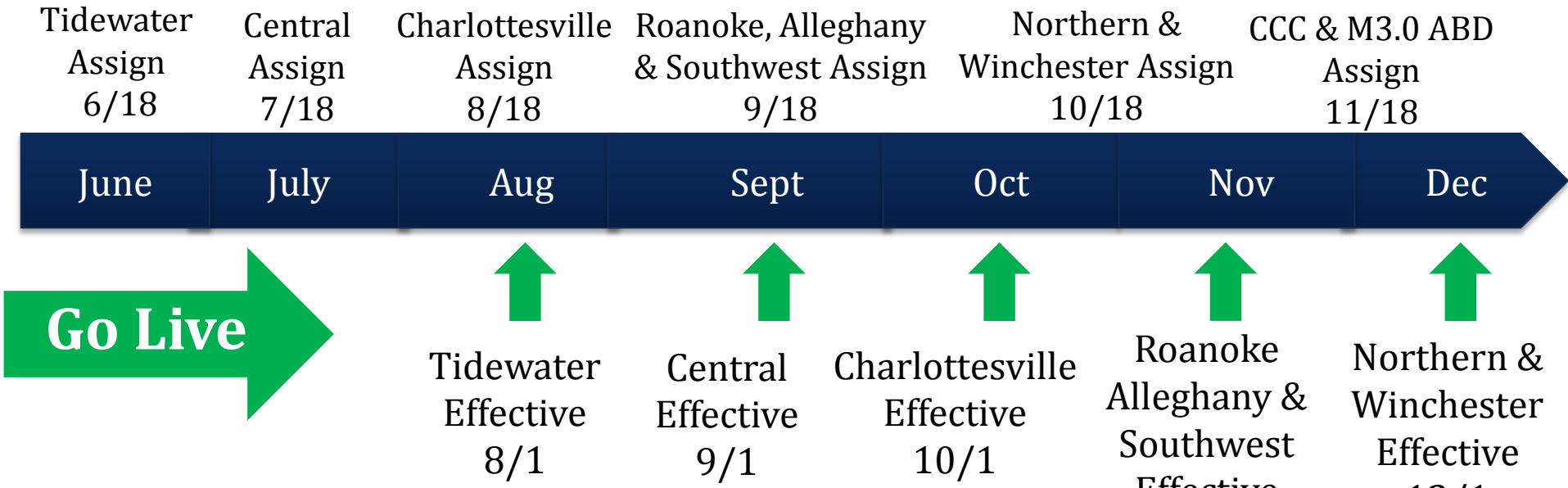
- ✓ Systems Testing (DMAS / Plans)
- ✓ Pediatric HRA Reviews
- ✓ Provider /Health Plan Work Groups
- ✓ Network Adequacy Reviews
- ✓ Review of Several Hundred Member Letters & Other Materials
- ✓ Implementing Member and Provider Town Halls
- ✓ Finalizing Fact Sheets, Brochure, & Comparison Charts
- ✓ Working with CCC Plus Helpline (Maximus)
- ✓ Working with DMAS Mailing Vendor for Member Mailings
- ✓ Finalizing CCC Plus Contract Amendment and Final Rates
- ✓ CCC Plus Program Regs - Virginia Administrative Code *(Managed Care & CCC Plus HCBS Waiver Services)*

CCC Plus Program

Regional Launch

Aug 1, 2017 – Jan 1, 2018

Assignment Begins



Assignment happens on the 18th of each month; CCC Plus enrollment is effective first of the next month following assignment; around 45 days after initial assignment

CCC and ABD effective 1/1/18

CCC Plus Enrollment by Region & Launch Date

Date	Regions	Regional Launch
Aug 1, 2017	Tidewater	20,404
September 1, 2017	Central	23,102
October 1, 2017	Charlottesville/Western	17,133
November 1, 2017	Roanoke/Alleghany	10,974
November 1, 2017	Southwest	12,772
December 1, 2017	Northern/Winchester	26,262
January 2018	CCC Demonstration (Transition plan determined with CMS)	28,785
January 2018	Persons who are Aged, Blind, Disabled (ABD) (Transitioning from Medallion 3.0)	76,607
Total	**All Regions**	**216,039**

Source: VAMMIS Data; totals are based on CCC Plus target population data as of April 2017

Network Adequacy Reviews

- Ongoing network adequacy analysis is a critical part of CCC Plus readiness and implementation
- Goal is to ensure CCC Plus members have choice, sufficient access to care and availability of services
- DMAS is evaluating whether each health plan meets the time and distance access standards set forth by CCC Plus Contract
- As of April, our network adequacy analysis has shown on average across all six CCC Plus health plans, 80% of the localities are meeting both time and distance access standards

CCC Plus Network Adequacy By Region						
Region	Tidewater	Central	Charlottesville	Roanoke	Northern	Southwest
Percentage of Meeting Time and Distance Standards	84%	84%	74%	73%	82%	70%

Stakeholder Work Groups with Health Plans

- Nursing Facility
- Personal Care, Respite and Home Health
- Early Intervention
- Behavioral Health/Community Services Boards
- Hospice
- ARTS
- Fiscal Employer Agent
- Service Facilitation

Examples of Streamlining Efforts

Nursing Facility - all health plans will use DMAS forms for authorization, time frame for authorizations will be 5 days for routine, 72 hours for expedited, use the same revenue codes (190), will create a small work group on claims

Personal Care – all health plans will use DMAS forms for service authorizations and related documentation, use DMAS claims codes

Hospice - health plans will accept the initial DMAS 420 without physician signatures for notification, DMAS 420 with physician signatures for billing, will use DMAS billing codes, will work with the Nursing Facility providers about claims related to pass through payments

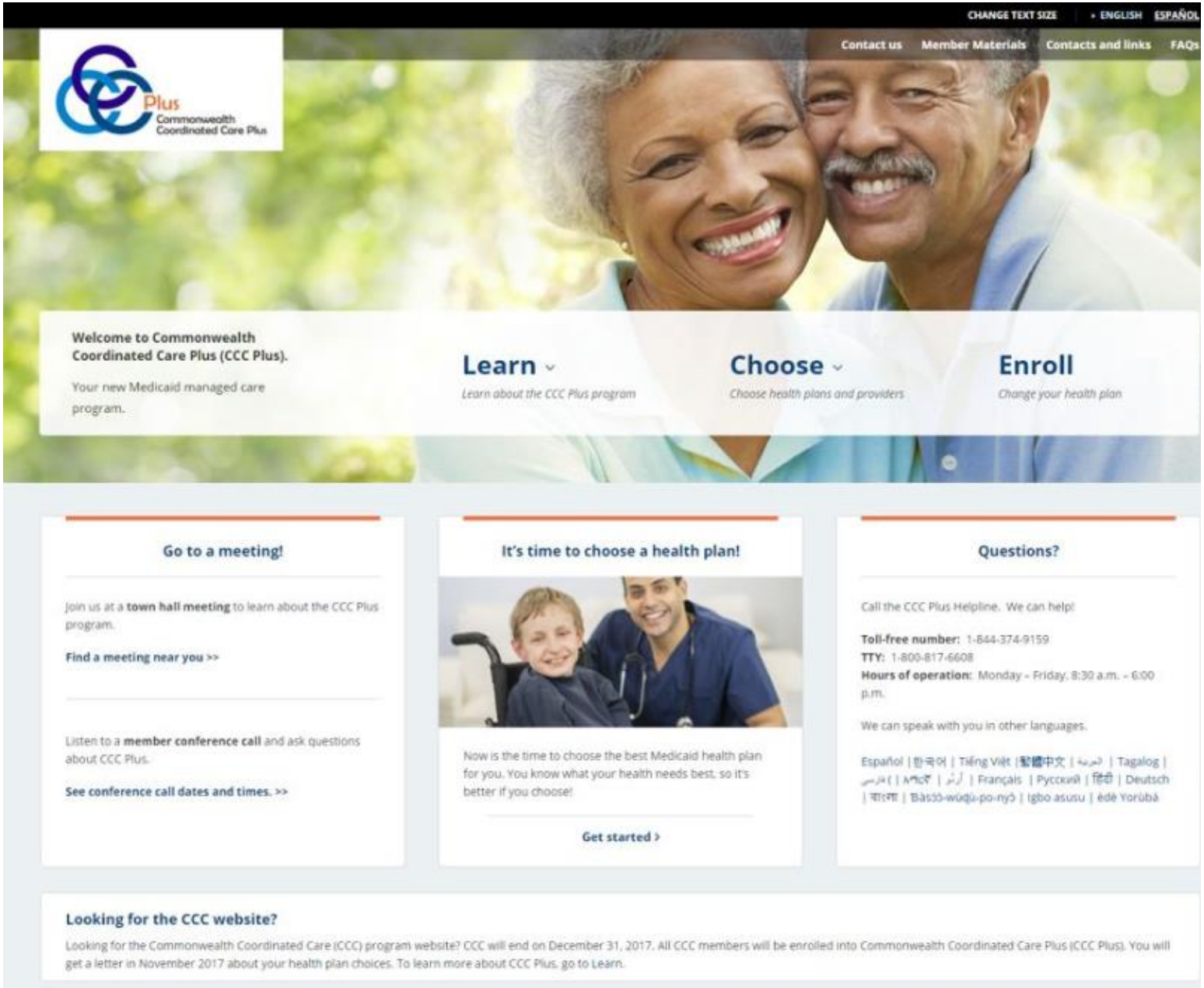
Initial Enrollment Package

Letter

Brochure

Comparison Chart

Town Hall/ Member Call Invitation


CHANGE TEXT SIZE
ENGLISH
ESPAÑOL
Contact us
Member Materials
Contacts and links
FAQs
Plus
Commonwealth Coordinated Care Plus
Welcome to Commonwealth Coordinated Care Plus (CCC Plus).
Your new Medicaid managed care program.
Learn
Learn about the CCC Plus program
Choose
Choose health plans and providers
Enroll
Change your health plan
Go to a meeting!
Join us at a town hall meeting to learn about the CCC Plus program.
Find a meeting near you >>
Listen to a member conference call and ask questions about CCC Plus.
See conference call dates and times. >>
It's time to choose a health plan!
Now is the time to choose the best Medicaid health plan for you. You know what your health needs best, so it's better if you choose!
Get started >
Questions?
Call the CCC Plus Helpline. We can help!
Toll-free number: 1-844-374-9159
TTY: 1-800-817-6608
Hours of operation: Monday - Friday, 8:30 a.m. - 6:00 p.m.
We can speak with you in other languages.
Español | 한국어 | Tiếng Việt | 繁體中文 | العربية | Tagalog | فارسی | አማርኛ | اردو | Français | Русский | हिंदी | Deutsch | বাংলা | Bàsɔ̀ɔ̀-wúqù-po-nyɔ̀ | Igbo asusu | èdè Yorùbá
Looking for the CCC website?
Looking for the Commonwealth Coordinated Care (CCC) program website? CCC will end on December 31, 2017. All CCC members will be enrolled into Commonwealth Coordinated Care Plus (CCC Plus). You will get a letter in November 2017 about your health plan choices. To learn more about CCC Plus, go to Learn.

Virginia has a new Medicaid program!

Commonwealth Coordinated Care Plus (**CCC Plus**) is our new Medicaid managed care program.

In CCC Plus, you get:

- **Medical services**
- **Nursing**
- **Personal care**
- **Behavioral (mental) health services**

All in one health plan!

- ✓ **No** monthly cost for your health plan
- ✓ **No** copays when you see your doctor or specialists

Questions?

Call the CCC Plus Helpline at:

1-844-374-9159

(TTY: 1-800-817-6608)

Monday through Friday
8:30 AM – 6:00 PM

You can share this brochure with a family member or someone who knows your health care needs.

You can also get this information for free in other languages and formats like large print or audio.

Español Tiếng Việt فارسی हिन्दी 한국어 العربية

1-844-374-9159

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

Commonwealth Coordinated Care Plus is a program

Announcing a New Medicaid Program!

Commonwealth Coordinated Care Plu

Plus
Commonwealth
Coordinated Care Plus

Who qualifies for the new CCC Plus program?

If you qualify for Medicaid due to a disability or because you are age 65 or older, you will be enrolled into the new CCC Plus program. If you are enrolled in one of the Developmental Disabilities (DD) Waivers (Community Living, Building Independence or Family and Individual Support), you will be enrolled in CCC Plus for all of your health care needs, but not for your DD waiver services.

How CCC Plus works

- Medicaid works with several health plans to give health care coverage to CCC Plus members across the Commonwealth of Virginia.
- The health plans will team up with local health care agencies, such as doctors' offices, nursing facilities, and personal care agencies to give you care.
- The agencies and providers will be in your health plan "network."
- You will get almost all of your care from "in network" agencies and providers.
- You will have a Primary Care Provider (PCP) to manage your health care and send you to other providers when needed. Your PCP must be in your health plan's network.

Your Care Coordinator

Your health plan will provide a Care Coordinator to work with you and your doctor. Your Care Coordinator can answer your questions about health benefits and help you get the care you need.

Your Medicaid benefits and services

You will get all of the Medicaid benefits and services you get now. We know how important your medical services are to you. With CCC Plus, in some cases, you may even receive added benefits such as, adult dental services, adult eye exams, hearing aids or cell phones. There is also a 24-hour nurse hotline for urgent medical questions.

Your health plan choices

We will enroll you in a health plan. If you want to keep that plan, you do not need to do anything! If you want to change your health plan, you will be able to choose from one of the other health plans in CCC Plus. The plans are listed on the "CCC Plus Comparison Chart." Choose the health plan that has the services, doctors and hospitals that you need.

You can call the CCC Plus Helpline at **1-844-374-9159** (TTY: 1-800-817-6608) or visit the website at **cccplusva.com** to:

- Find out if your doctors and hospitals are "in network" with a health plan
- Choose your plan

Once you choose a plan, you can change health plans:

- In the first **90** days after you become a CCC Plus member
- During open enrollment once a year
- At other times if approved by the Department of Medical Assistance Services

To learn more about changing health plans, call the CCC Plus Helpline or visit the website.

Enrollment Letter

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

<MAIL DATE>

<MEMBER NAME >
<ADDRESS>
<CITY><STATE><ZIP>

Dear <Name>:

Welcome to Commonwealth Coordinated Care Plus (CCC Plus)!
We will soon enroll you in CCC Plus, Virginia Medicaid's new, required managed care program. Medicaid is working with health plans to provide health coverage to CCC Plus members across Virginia. The health plans are also called Managed Care Organizations (MCOs). Here is the health plan we chose for you and the date your coverage starts:

Your CCC Plus Medicaid health plan is < **MCO Name**>. Your coverage will begin **<date>**.
Your Medicaid ID # is <12-Digit Recipient ID #>

Your CCC Plus Medicaid MCO (health plan)
Your health plan will give you all your Medicaid health care, long-term services and supports, and over-the-counter medications (when prescribed by a doctor). You will have a care team that works with you and your providers for primary care, mental health, hospital, nursing facility, and specialty care. Your health plan will also give you the added benefit of a care coordinator.

If you want to keep the Medicaid health plan we chose for you, you do not need to do anything. Your MCO will send you a health plan ID card. It does **not** replace your plastic Medicaid ID card. Keep your Medicaid card. Show both cards when you get care.

If you want to change your health plan
For coverage that begins <**begin date**>, you must change your plan by the 18th of <**month after letter**>.

You have the right to choose a different CCC Plus Medicaid health plan. You must choose one of the health plans that work with CCC Plus. You **cannot** choose to "opt out" of CCC Plus and stay in Medicaid Fee for Service.

You can get this information in Spanish or other formats, such as large print or audio.

ATTENTION: For free interpreter services, call 1-844-374-9159 (TTY: 1-800-817-6608).

Español (Spanish)
ATENCIÓN: Para servicios gratuitos de interprete, llame al 1-844-374-9159 (Número de TTY: 1-800-817-6608).

If you have other insurance in addition to Medicaid, such as Medicare, your other insurance must pay first. Your CCC Plus health plan will work with you and your other insurance company to coordinate your services.

If you are enrolled in one of the Developmental Disabilities waivers (DD), you will be enrolled in CCC Plus for your **non-waiver** services. DMAS will keep paying for your DD waiver services.

The Virginia Department of Medical Assistance Services (DMAS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Virginia Department of Medical Assistance Services pays your health plan a monthly premium for your coverage. If we find that you did not qualify for coverage because information you reported was false or because you did not report a change, you may have to pay us back the premiums. You will have to repay us even if you did not get services during those months.

The information in the comparison chart on the other side of this page is correct to the best of our knowledge. Information may change without notice. For updated information, call 1-844-374-9159 or visit our website at www.cccplusva.com.

Virginia Department of Medical Assistance Services

CCC PLUS 0617-ENG

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

Health Plan Comparison Chart

Commonwealth Coordinated Care Plus (CCC Plus) is a statewide program with 6 participating health plans.

Read this brochure to see the benefits and services covered by all 6 health plans. Use the chart in this packet to compare added benefits not generally covered by Medicaid.

Then choose from the health plans available in your city or county. To ask which plans your doctors and other providers participate in, or to get a list of the health plans for your area, visit **cccplusva.com**. Or call the CCC Plus Helpline at **1-844-374-9159**.

1 Read the letter

We chose a health plan for each person in the CCC Plus program. You have the right to choose a different health plan. You know your health needs best, so it's better if you choose!

2 Choose your health plan

- To keep the health plan we chose for you, you do not need to do anything!
- If you want to choose another plan, read the chart in this packet. Compare the health plans and choose the best one for you.

3 Enroll

There are 2 ways to enroll:

- Online at **www.cccplusva.com**
- Call us at **1-844-374-9159** (TTY: 1-800-817-6608). You can call Monday to Friday, 8:30 a.m. to 6:00 p.m.

All health plans offer these benefits and services:

Basic health benefits

- Addiction and recovery treatment services
- Behavioral (mental) health services, counseling and 24/7 crisis line
- Care coordination services
- Diagnostic services including x-ray, lab and imaging
- Durable medical equipment (DME) and supplies
- Emergency and urgent care
- Family planning services
- Health care for children including checkups, immunizations (shots) and screenings
- Hospital and home health services
- Interpreter and translation services
- Maternity and high-risk pregnancy care
- Medical transportation services
- No co-pays except your patient pay towards long term services and supports and any Medicare Part D drug co-pays
- Physical, occupational and speech therapies and audiology services
- Prescription drugs and over-the-counter medications (when prescribed by doctors)
- Preventive and regular medical care
- Routine eye exams and glasses for children and routine eye exams for adults
- Team approach (interdisciplinary care)
- 24/7 nurse advice line
- Women's health services

Long Term Services and Supports (LTS

All plans cover LTSS if you are on a home and community based waiver or in a nursing facility LTSS can help you live in your own home or other setting of your choice.

- Adult day health care
- Assistive technology
- Environmental modifications
- Personal care
- Personal emergency response system (with or without medication monitoring)
- Private duty nursing services
- Respite care
- Skilled and intermediate (custodial) nursing facility or long stay hospital
- Help for members transitioning to the community from a nursing facility

Other services

Services covered by DMAS or a DMAS contracto

- Community mental health services
- Dental services for children
- Developmental Disabilities waiver services
- School health services including some medica mental health, hearing or rehabilitation therap services as arranged by your child's school

► Abra este panfleto y encontrará esta

► See your member handbook for a full list

► Use the chart in this packet to compare

Click on Tool
PDF.

aetna AETNA BETTER HEALTH® OF VIRGINIA	Anthem. HealthKeepers Plus Offered by HealthKeepers, Inc.	Magellan COMPLETE CARE.	OptimaHealth	UnitedHealthcare Community Plan	VAP
1-855-652-8249 TTY 711 www.aetnabetterhealth.com/virginia	**1-855-323-4687** TTY 711 www.anthem.com/varnedicaid	**1-800-424-4524** TTY 711 www.MCCofVA.com	**1-877-512-3171** or **1-757-552-8360** TTY 711 www.optimahealth.com/communitycare	**1-866-622-7982** TTY 711 www.uhccommunityplan.com	**1-877-719-7358** TTY 711 www.vapremier.com
Added benefits: **Adult dental** • 2 exams and cleanings and 1 set of x-rays each year, plus fillings, extractions, root canal and dentures (up to $525 each year) **Adult hearing** • Exam and 1 hearing aid each year (up to $500 each year) **Adult vision** • Eye exam and $100 for frames, glasses or contacts each year **Phone services** • Free cell phone with 350 minutes each month, data and free unlimited texting **Wellness programs** • Wellness rewards card • Regional wellness center **Other benefits** • No Place Like Home grants for home modifications and rental assistance • Memory alarms and devices • Community health worker to help with housing, food, employment, community resources and more • Diabetic shoes or inserts • Meals delivered to your home after discharge, 2 meals each day for 7 days	**Added benefits:** **Adult dental** • 2 exams and cleanings and 1 set of x-rays each year **Adult hearing** • 1 exam and up to $1,000 for hearing aids and unlimited visits for fitting • 60 hearing aid batteries **Adult vision** • $100 for glasses (lenses and frames) each year **Phone services** • Smartphone with free minutes, data, texts and calls • Mobile app to use on the go **Wellness programs** • Online search tool to find food, jobs and more • Online peer support services **Other benefits** • More than 25,000 providers statewide to choose from • 12 rides to community events, grocery stores, hair salons and more • Healthy Rewards Gift Card program • $50 for assistive devices and $50 for walker and wheelchair accessories • HEPA-grade air purifier	**Added benefits:** **Adult dental** • 2 exams and cleanings and 1 set of x-rays each year (up to $1,500 each year) **Adult vision** • $150 for glasses or contact lenses every two years **Phone services** • Free smartphones for texts and appointment reminders **Wellness programs** • Rewards for healthy behaviors • Help to quit smoking **Other benefits** • Fresh meals delivered to your home after discharge • Environmental and home modifications • Supportive employment services • Online, interactive cognitive behavioral therapy support • Community Connections online directory of community services and organizations **Enhanced short-term services for all members, when needed** • Personal care attendant • Respite care • Caregiver training and support	**Added benefits:** **Adult dental** • 1 exam, cleaning and set of x-rays each year **Adult hearing** • Annual hearing exam • 1 hearing aid for each ear every 36 months **Adult vision** • Annual exam and refraction • Discounts on eye glasses **Phone services** • Free cell phones with 350 minutes and unlimited texting **Wellness programs** • Help to quit smoking • Weight management • Wellness rewards **Other benefits** • Individualized, fully-integrated program with a state-wide network of providers • Assistive devices • Extended respite for caregivers • Diabetic foot care • Memory alarms and devices • Pest control • Meals delivered to your home after discharge from inpatient hospital or nursing facility, 2 meals each day for 7 days	**Added benefits:** **Adult dental** • 2 exams and cleanings and 1 set of x-rays each year **Adult vision** • Eye exam each year and frames and lenses every 2 years if needed **Phone services** • Free smartphone with 350 minutes each month, unlimited texting, and pre-programmed contacts for benefit and NurseLine support **Wellness programs** • Alere Quit For Life program and resources to quit smoking or tobacco use • Weight Watchers: 10 meeting vouchers each year, resources for healthy eating and weight loss **Other benefits** • Baby Blocks prenatal care rewards for attending prenatal and baby's appointments • Health4Me® free mobile app for health tips, reminders and care team secure messaging • Meals delivered to your home after discharge from inpatient hospital or nursing facility, 2 meals each day for 7 days	**Added benefits:** **Adult dental** • Exams, cleanings and x-rays each year **Adult vision** • Eye exams plus up to $100 for lenses or frames **Phone services** • Wellpass program with free smartphone, unlimited texting, and minute and data packages **Wellness programs** • Exercise at YMCA, YWCA and Curves • Smoking cessation services and resources • Healthy Heartbeats prenatal and postpartum wellness program **Other benefits** • Chronic disease management including self-management education classes • Gift card rewards for wellness and preventive activities • Online tools for accessing health plan services • Meals delivered to your home after discharge from hospital or nursing facility for up to 14 days

▶ For a list of **doctors and hospitals** that work with each plan, go to the plan's website or call their toll-free number listed above.

▶ For a list of **basic benefits that all plans offer**, see the brochure in this packet.

CCC PLUS 0617

DMAS
INNOVATION · QUALITY · VALUE

Want to Learn More?

Tidewater Area Commonwealth Coordinated Care Plus Town Hall Meeting

Meeting #1	Meeting #2
Tuesday, July 11th, 2017	Wednesday, July 12th, 2017
2:00-3:30PM	3:00-4:15PM
Denbigh Community Center 15198 Warwick Blvd. Newport News, VA 23606	Endependence Center Inc. 6300 East Virginia Beach Blvd. Norfolk, VA 23502

Who should come?

Medicaid Members, Caregivers, Families and Advocates

- Come learn about the new program called **Commonwealth Coordinated Care Plus (CCC Plus)**
- Have your questions answered by representatives from each of the health plans that you can choose from to provide your Medicaid benefits
- Learn about the unique features and benefits that each plan has to offer
- Learn how to contact your Care Coordinator, and other important health plan information

To request special accessibility or other accommodations, please email ccorluser@dmas.virginia.gov by June27th, 2017
For a full list of the 12 town hall meetings statewide, go to ccorluser.com

CCC Plus Commonwealth Coordinated Care Plus

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION - QUALITY - VALUE

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION - QUALITY - VALUE

CCC Plus Communication

- DMAS conference calls
  - Hospitals & Medical Practices
  - Behavioral Health Providers
  - Nursing Homes
  - Home Health, Personal Care, Services Facilitators, Adult Day Care
- Member calls
- Conference calls to begin in June 2017
  - Calls will be 30 minutes each
  - Health Plans will be on the calls to address questions
    - Care Management, Claims, Authorizations, Contracting, etc.

Want to Learn More?

Commonwealth Coordinated Care Plus Member Phone Calls

Tuesdays: July 11, July 18, July 25, Aug 1
12:00pm – 12:30pm

Dial 1-800-832-0736, press *1095279#
Follow voice prompts
Calls are open to the first 100 callers

Who should call in? Medicaid Members, Caregivers, Families and Advocates

Have your questions answered by Medicaid and CCC Plus health plans representatives.

To request special accessibility or other accommodations, please email:
cccplus@dmas.virginia.gov **by June 27th, 2017**

For a full list of the 2017 Member Calls, go to cccplusva.com

CCC Plus Enrollment

Enrollment Broker: Maximus

Beginning June 19, 2017

- CCC Plus Helpline
- CCC Plus Enrollment website

Thank You!

For More Information . . .

Additional CCC Plus information is available at:

http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Send CCC Plus questions, comments, and suggestions to:

CCCPlus@dmas.virginia.gov

Regulatory Activity Summary June 13, 2017
(* Indicates recent activity)

2017 General Assembly

***(01) Reimbursement for Nursing Facility Evacuation Costs:** In the event of a disaster resulting in an evacuation, nursing facilities seek to relocate individuals to nursing facilities in safer areas. DMAS is submitting this state plan amendment to clarify reimbursement provisions relating to reimbursement to the disaster-struck nursing facility. In November, 2016, CMS announced a final rule entitled "Emergency Preparedness" (42 CFR 483.73) which requires long term care facilities to establish and maintain an emergency preparedness program. The Virginia Department of Health, the Virginia Department of Emergency Management, the Virginia Hospital and Healthcare Association, and the long-term care provider community worked to establish a Long Term Care Mutual Aid Plan and a Memorandum of Understanding (MOU) for all facilities to sign. All nursing facilities in Virginia have signed this MOU, which details their responsibilities in the event of a disaster. Following a draft and internal review which began in March 2017, DMAS submitted the SPA to HHR on 5/30 for review. The action was then submitted to CMS for review on 6/6/17.

***(02) Average Commercial Rate Calculation for Physicians Affiliated with Type One Hospitals:** DMAS is issuing this state plan amendment to update the average commercial rate calculation of supplemental payments for physicians affiliated with Type One Hospitals in Virginia. The state plan includes physician supplemental payments for physician practice plans affiliated with Type One hospitals (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, which has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10. This regulatory action will update the maximum rate to 256% of the Medicare rate effective April 1, 2017, and 258% effective May 1, 2017 based on the most recent information on the average commercial rate (ACR) furnished by the state academic health systems and consistent with appropriate prior public notices. Following a draft and internal review which began in May 2017, DMAS submitted the SPA to HHR on 6/8 for review.

***(03) VIDES Criteria for Care in ICFs/IID:** This fast-track regulatory action implements the same assessment standard to be applied to individuals for admission to an Intermediate Care Facility for Individuals with Intellectual Disability as is being used for admitting such individuals to home and community based Developmental Disability waiver services. Using the same assessment standard for all individuals, regardless of whether they seek institutional care or community care, ensures the uniformity and consistency of evaluation and treatment to protect the health and welfare of these vulnerable citizens. These reg amendments propose to replace the current Level of Functioning survey standards with the new Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) standards for individuals seeking care in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The Commonwealth has recently adopted the VIDES standards for the comparable level of waiver services in communities. By using the VIDES standards for institutional care in this action,

the Commonwealth is restoring the consistency of functional standards for individuals regardless of whether they obtain their care in their communities or in ICF/IID institutions. The reg package has been drafted and is circulating internally for review as of 5/16/17.

***(04) Requirements for LTC Facilities:** This final exempt regulatory action amends DMAS' nursing facility requirements for Medicaid participation so that they are in line with CMS requirements. A series of CMS revisions to CFR Part 483 (Requirements for States and Long Term Care Facilities) necessitates changes to what are now outdated CFR citations in DMAS regulations. As of April 2017, the reg package has been drafted and is circulating for internal review.

***(05) Client Appeals Amendments to Comply with Federal Rules Changes:** This final exempt regulatory action will update DMAS regulations on client appeals to reflect two different federal regulatory changes. The first set of federal rule changes was published in the Federal Register under the title, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." (81 FR 27498, May 6, 2016.) The second set of rule changes was published in the Federal Register under the title "Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP." (81 FR 86382, November 30, 2016.) The regulatory package was drafted, reviewed internally, and submitted to the OAG on 5/18/17.

***(06) State Children's Health Insurance Plan:** This annual SPA is submitted by June 30 each year and reflects changes made to the State Children's Health Insurance Plan program during the previous 12 months. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment. This SPA incorporates the following sections: general background information on the CHIP program, methods of service delivery, eligibility and enrollment, outreach processes, benefit plans (of both fee-for-service and managed care models), quality measures, cost sharing, plan administration, and reporting. Furthermore, the current SPA clarifies the scope of mental health and substance abuse treatment services consistent with implementation in Medicaid, and notes that peer supports for these services will be added July 1, 2017. The SPA was drafted and reviewed internally and submitted to HHR on 6/6. The action was forwarded to CMS on 6/8/17.

***(07) Temporary Adjustments to Enrollment and Redeterminations for Individuals Living or Working in Declared Disaster Areas:** This regulatory action establishes an amendment to VA's state plan. With regard to the Virginia State Children's Health Insurance Program (CHIP), this state plan amemendement (SPA) provides for temporary adjustments to enrollment and redetermination policies for individuals living or working in declared disaster areas at the time of a disaster event. Through this state plan amendment, Virginia can provide families living or working in the Federal Emergency Management Agency (FEMA) or Governor declared disaster areas with additional time to complete the renewal process. This SPA has a retroactive effective date of January 7, 2017. In the event that all or a portion of Virginia is declared a disaster area by the Governor or FEMA, this SPA provides Virginia

with the authority to extend the CHIP renewal period an additional 90 days for families living and/or working in the affected disaster area. The next twelve-month continuous eligibility period will begin the month after the renewal completion date. The package was prepared internally and submitted to HHR on 1/17/2017. The SPA was forwarded to CMS on 1/31/17. CMS approved the SPA on 3/8/17.

***(08) Clarifications for Durable Medical Equipment and Supplies:** This NOIRA regulatory action will serve to update coverage and documentation requirements to better align them with best practices and Centers for Medicare and Medicaid (CMS) guidance, and to eliminate unnecessary elements that create confusion among DME providers. Specifically, these proposed changes include elements around: enteral nutrition, implantable pumps, delivery ticket components, and replacement DME after a natural disaster. It is expected that these changes will clarify coverage of DME and supplies for DME providers and Medicaid beneficiaries, and reduce unnecessary documentation elements for DME providers. Further, the changes will improve coverage by permitting newer and better forms of service delivery that have evolved in recent years and align Virginia's coverage with recent guidance from CMS for enteral nutrition. Following an internal DMAS review, the package was submitted to DPB on 3/13/17. DPB moved the regs to the Governor's Office for review/approval on 3/27/17. The Governor signed the regulatory action on 4/14; and the regs were published on 5/15, with the comment period ending on 6/14/17.

***(09) Peer Support Services and Family Support Partners:** This fast track regulatory action responds to a legislative mandate to implement peer support services to children and adults who have mental health conditions and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. The experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in the delivery of a comprehensive mental health and substance use service delivery system. Peer Support Services shall target individuals 21 years or older with mental health or substance use disorder or co-occurring mental health and substance use disorders. A Peer Support service called Family Support Partners shall be provided to individuals under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their families or caregivers. The reg package was reviewed and prepared internally and submitted to the OAG on 4/21, with additional revisions forwarded on 4/27/17 and 5/ 11/17. Following a conf. call on 5/17, awaiting further direction from the OAG.

***(10) New Qualifying Hospitals:** This state plan amendment will update the list of qualifying hospitals for supplemental payments for private hospital partners of Type One hospitals. Hospital inpatient and outpatient reimbursement is being amended to change supplemental payments for private hospital partners of Type One hospitals by adding new qualifying hospitals. The State Plan supplemental payment provisions currently only apply to Culpeper Hospital. The amendment will add Haymarket and Prince William hospitals, where the University of Virginia has a minority ownership. The package was prepared internally and submitted to HHR on 3/10/2017. The SPA was forwarded to CMS on 3/21/17. DMAS is currently coordinating responses to inquiries sent by CMS.

***(11) SNAP to Determine Medicaid Eligibility:** This state plan amendment (SPA) allows Medicaid eligibility determinations and renewals to be made more quickly and efficiently for individuals who have already submitted applications for the Supplemental Nutrition Assistance Program (SNAP). The changes in this SPA will allow the workers in local Department of Social Services (DSS) offices to complete Medicaid applications and renewals more quickly for individuals who receive benefits through SNAP. The changes will allow DSS workers to obtain information about the individual's gross income from their SNAP documentation, rather than requesting that information from the individual. This change should allow local DSS workers to move more quickly on initial eligibility determinations and will also allow them to have more success with ex parte electronic renewals. The SPA was circulated and reviewed internally, and submitted to HHR on 3/10/2017. The package was forwarded to CMS on 3/21 for review. Following a call with CMS on 4/19, CMS requested that DMAS withdraw the SPA. A withdrawal request was sent on 4/25/17 and the item was withdrawn on 4/25.

***(12) Revision for CMS Conditions of Participation:** This final exempt regulatory action implements two changes: 1) updating a citation to an amended federal regulation related to Conditions of Participation (COPs) for Home Health Agencies (HHAs), and 2) updating regulations to comply with a Virginia Code section relating to exemptions from licensure requirements for HHAs. On January 13, 2017, U.S. Centers for Medicare and Medicaid Services (CMS) issued final regulations to amend the COPs for HHAs. Among the changes, the final rule recodifies 42 CFR 484.36 in the newly created 42 CFR 484.80. The final rule effective date is July 13, 2017. In order to comply with the federal final rule, Virginia regulations need to be amended to update the CFR citation that is referenced for home health aide requirements. Following an internal DMAS review, the package was submitted to the OAG for review on 3/31/17. Per OAG request, revisions were made on 4/26/17. Certified by the OAG and submitted to DPB on 5/9. Project withdrawn from submission based on CMS regulations delay, which had the regs originally taking effect in July 2017, but is now postponed (possibly until January 2018). Project was pulled back and will not be published in the Register, until further notice.

***(13) Home Health Accrediting Organizations:** This fast track regulatory action brings accreditation requirements in line with: 1) the state licensure requirements outlined in §32.1-162.8 of the Code of Virginia; and 2) the CMS list of approved accreditation organizations for Medicare HHAs. Consistency among approved accreditation organizations will clarify and streamline requirements for DMAS providers. This regulation is essential to protect the health, safety, or welfare of citizens in that it provides consistency between the regulations and the Code with regard to the licensure requirements for HHAs. This consistency will help ensure that HHAs are appropriately licensed to provide services to Medicaid members. The regs circulated for internal review and were forwarded to the OAG for review on 4/27/17. DMAS responded to an OAG inquiry on 5/12. The regs were OAG certified on 5/17 and were submitted to DPB on 5/17/17.

(14) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This

regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice.

This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project is currently being processed and reviewed internally.

2016 General Assembly

***(01) Face-to-Face Encounter Requirement for Home Health:** This exempt regulatory action is required by 2016 budget language. Currently, there are no requirements in the DMAS' regulations that require physicians, who are ordering home health services, to have face-to-face encounters with their patients for the purpose of ordering these services. The regulatory changes will necessitate that physicians document the existence of a face-to-face encounter (including through the use of telehealth) with the Medicaid eligible individual prior to ordering home health services. This face-to-face encounter may be conducted by the physician, by a nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with State law, by a certified nurse-midwife as authorized by State law, or by a physician assistant under the supervision of the physician. This new requirement is established as a condition of payment for these services. The regulations were circulated for internal DMAS review, beginning 12/21/16. The project was submitted to the OAG on 2/28/17. Per OAG request, revisions were made on 4/17 and DMAS responded to additional inquiries on 5/11. The regs were submitted to the Registrar on 5/17 (to be published in the Register on 6/12), and will be final on 7/13/17.

***(02) FAMIS Eligibility Changes:** This NOIRA regulatory action was required by 2016 budget language. This regulation will serve to improve access to eligible individuals that may be served by the Family Access to Medical Insurance Security Plan (FAMIS) program. DMAS is currently circulating the corresponding regulations for internal review. This regulatory action was submitted to DPB on 10/27/2016 and forwarded to the Governor's Office on 11/10. The regulations were signed by the Governor on 12/16/16 and published on 1/9/2017, with a public comment period through 2/8/17. Two comments were submitted. DMAS is currently coordinating the regs to proceed to the next regulatory phase.

***(03) Applied Behavioral Analysis:** This action establishes Medicaid coverage for behavior therapy services for children under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which is a mandatory Medicaid-covered service that offers preventive, diagnostic, and treatment health care services to young people from birth through the age of 21 years. The proposed regulations define the behavioral therapy service requirements, medical necessity criteria, provider clinical assessment and intake procedures, service planning and progress measurement requirements, care coordination, clinical supervision, and other standards to assure quality. These regulations have been drafted, subsequently circulated for internal review, and were submitted to the OAG on 8/4. Revised regulatory text was submitted to the OAG on 10/4 and 11/21. Additional revisions were made to the regulatory text and re-submitted to the OAG on 2/22/17. The action was certified and sent to DPB on 3/2/17. The project was submitted HHR and then to the Governor's office on 5/10/17.

***(04) Three Waiver Redesign:** This emergency regulatory action is required by 2016 budget language. The Individual and Family Developmental Disabilities Support Waiver is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver is changing to the Community Living Waiver (CL), and; the Day Support Waiver for Individuals with Mental Retardation is changing to the Building Independence Waiver (BI). This redesign effort, ongoing between DMAS, DBHDS, consultants, and stakeholders for the last two years, combines the target populations of individuals with both intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. The regulatory action was OAG-certified on 8/18/2016 and DPB and the Secretary's Office approved the regulations on 8/22/16. The action was approved by the Governor on 8/24. The action was published in the Register on 9/19, with a public comment period through 10/24. One comment was submitted. A corresponding SPA was drafted and submitted to HHR on 8/24. The SPA was signed by the Sec. and submitted to CMS on 9/15/16. DMAS responded to informal questions on 10/18/16; received additional informal reimbursement questions on 10/28 and 11/2; and sent responses on 11/8/16. DMAS is currently awaiting further CMS input. The proposed stage version of this regulatory action is currently being drafted, and is internally circulating through DMAS for review, as of 4/13/17.

***(05) CCC Plus (MCOs - B Waiver) – formerly known as 'Managed Long Term Care Services and Supports (MLTSS)':** This emergency regulatory action is required by 2016 budget language. The regulation changes will transition the majority of the remaining Medicaid fee-for-service populations into an integrated, managed long-term services and supports (MLTSS) program. DMAS intends to launch an MLTSS program that provides a coordinated system of care that focuses on improving quality, access, and efficiency. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 3/9/2017. DMAS received requests for revisions from the OAG on 3/16, 3/20 and 3/21. Following conference calls on 4/7 and 4/11 and a meeting on 5/1, the action was certified on 5/12 and then submitted to the DPB. The regs were forwarded to HHR on 5/22/17.

***(06) Barrier Crimes Not Permitted:** This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been

convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 2/17/2017. The OAG issued inquiries on 3/21 and a conference call occurred on 4/26 to discuss the regs. DMAS is currently coordinating the responses for the OAG.

(07) Coverage in Approved Supportive Housing: This fast-track regulatory action is required by the 2016 budget language. A SPA was initiated to implement the changes required by House Bill 675, approved March 29, 2016, which stated that DMAS was to provide Medicaid coverage to individuals living in approved supportive housing, and stated that DMAS "shall seek to amend the state plan for medical assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement the necessary changes pursuant to the provisions of this act." The SPA was submitted to the Secretary on 7/22/16 for review and subsequently filed with CMS on 7/26. The SPA was approved 10/17/2016. The corresponding Fast Track regulations were developed and circulated for internal DMAS review and submitted to the OAG for review on 12/7. DMAS responded to an inquiry from OAG on 12/28. The regulatory action was certified and submitted to DPB on 12/29/16. The regs were approved for fast-track action and submitted to DPB on 1/6/2017. The regulations were signed by the Governor on 4/14; and the regs will be published in the Register on 5/15, with a comment period thru 6/14 and finalized on 6/29.

***(08) Low Dose Computed Tomography (LDCT) Lung Cancer Screening:** This emergency regulatory action is required by the 2016 budget language. This regulation will serve to provide coverage of LDCT lung cancer screening as a preventive measure for at-risk beneficiaries. The regulations were drafted and sent to OAG on 10/19/16 and became OAG certified on 11/4/16. The regs were submitted to DPB on 11/7; to HHR on 11/16; to the Governor on 11/20/16; and were signed by the Governor on 12/6. The regs were published in the Register on 12/26, with comment period through 1/25/17. The Proposed Stage regulatory package circulated for internal DMAS review on 2/1/17 and was submitted to the OAG on 3/15 (the corresponding SPA for this regulatory action was approved by CMS on 3/13/17). The OAG approved/certified the regs on 4/6 and they were submitted to DPB on 4/10. DPB submitted the regs to HHR on 5/25. The action was submitted to the Governor's Ofc. for review on 5/29 and the Economic Impact Analysis (EIA) response was posted to the Town Hall on 5/31.

***(09) No Coverage of Overtime Hours for CD Personal Assistance, Respite and Companion Services:** This regulatory action is required by 2016 session of the Virginia General Assembly. This action establishes that DMAS will not reimburse for more than 40 hours per week for consumer-directed personal assistance, respite and companion services for any one provider or working for any one consumer. An attendant may exceed 40 hours of work in a week working for multiple consumers. This limit will not apply to live-in attendants consistent with the U.S. Department of Labor's requirements (Fact Sheet 79B). This change, which will eliminate inconsistencies regarding pay for services in excess of 40 hours, applies to EPSDT-covered attendant services as well as waiver-covered attendant services. The regulations were sent to the OAG on 9/26 and subsequently revised. A submission was sent to DPB on 10/18/16. DPB submitted the action to HHR for review on 11/1; the regs were forwarded to Governor on 11/3; and the Governor signed the regulatory action on 12/6. The item was published in the Register on 12/26, with a 30-day comment period to follow (one comment was generated). As of 5/16/17, this regulatory action is currently in the proposed stage and the package is being drafted.

***(10) 2016 Institutional Provider Reimbursement:** This final exempt regulatory action is required by 2016 budget language. This action will serve to implement mandates in the Virginia budget making specialized care reimbursement fully prospective and modifying the inflation adjustment for hospital inpatient rates to 50% of inflation for FY17. The corresponding SPA (effective 7/1/16) will precede the regulatory changes. The SPA package was drafted and subsequently sent to HHR on 9/13/16. It was signed by HHR and submitted to CMS on 9/23/16. CMS requested additional financial/federal budget related information. Following responses to CMS inquiries on 10/3/16, 2/6/17, and 4/6/17, CMS approved the SPA on 4/25. The corresponding VAC package was drafted and is currently circulating for DMAS review as of 6/1/17.

***(11) 2016 Non-Institutional Provider Reimbursement:** This final exempt regulatory action is required by 2016 budget language. This action will serve to implement mandates in the Virginia budget modifying the inflation adjustment for hospital inpatient rates to 50% of inflation for FY17 and implement a supplemental payment for physicians affiliated with a children's hospital serving Northern Virginia. The corresponding SPA (effective 7/1/16) will precede the regulatory changes. The SPA package was drafted and subsequently sent to HHR on 9/20/16. It was then submitted to CMS on 9/30. CMS requested additional information. Following responses to CMS inquiries on 2/23, 3/23, 4/4, and 4/19/17, CMS approved the SPA on 5/9/17. The corresponding VAC package was drafted and is currently circulating for DMAS review as of 5/24/17.

***(12) Addiction and Recovery Treatment Services:** This fast track regulatory action is required by the 2016 budget language. More Virginians died from drug overdose in 2013 than from automobile accidents. In 2014, 80% of the people who died from drug overdoses (986 people) died from prescription opioid or heroin overdoses. Virginia's 1.1 million Medicaid/FAMIS members are affected disproportionately by this substance use epidemic as demonstrated by DMAS' claims history data showing large numbers of substance abuse diagnoses. As such, the proposed regulatory action implements a comprehensive program of community-based addiction and recovery treatment services in response to the Governor's bipartisan Task Force on Prescription Drug and Heroin Addiction's numerous

recommendations. The regulations were drafted and submitted to the OAG on 11/14/16. They became OAG-certified on 11/30 and were submitted to DPB on 12/1. The regulations became effective on 4/1/17. The corresponding SPA was drafted and reviewed internally and submitted to HHR on 6/6/17.

***(13) Reconsideration of Final Agency Decision:** This emergency regulation made necessary and authorized by action of the 2016 Virginia General Assembly in enacting *Code of Virginia* §2.2-4023.1. That new section provides for establishment of a reconsideration process by which appellants can petition the agency director to reconsider the agency's Final Agency Decision made pursuant to the *Code of Virginia* §2.2-4020. The statute specifically authorizes the agency to promulgate emergency regulations to specify the scope of the reconsideration review. This emergency regulation adopts the process and timeline set forth in the statute and specifies the scope of review. The regulation was drafted and sent to the OAG on 8/4. The regulatory action was certified and sent to DPB on 10/13; forwarded to HHR on 10/23; and submitted to the Governor on 11/20/16. The Governor signed on 12/6/16 and the regs were published in Register on 12/26, with comment period through 1/25/17. The corresponding SPA was drafted and began circulating on 12/1/2016. The SPA was submitted to HHR on 12/9. Following HHR approval, the SPA was submitted to CMS on 12/15 and approved on 1/10/17. The proposed stage regs were sent to the OAG and certified on 2/15/17 and forwarded to the DPB on 2/17. The EIA was posted on 3/28 and DMAS posted a response on 3/29. The regs were forwarded to HHR on 4/3/17; submitted to the Governor on 4/20; and signed by the Gov. on 5/19. The regs are to be published in Register on 6/12/17, which will open a 60-day public comment period.

***(14) Coverage of Mosquito Repellant to Prevent Zika Virus:** This emergency regulatory action is required by the 2016 budget language. This regulation provides Medicaid coverage for mosquito repellants when they are prescribed by an authorized health professional for individuals of childbearing age in order to prevent the transmission of the Zika virus. Covering mosquito repellant could prevent Zika transmission and avert babies being born with microcephaly and other severe brain defects who could eventually need expensive waiver services. The regulation has been submitted to and was approved by DPB on 8/15; approved by the Secretary on 8/15 as well; approved by the Gov. on 8/16; was submitted to the Register on 8/16; and became effective on 8/22/2016. The regulatory action transitioned to the Proposed Stage and was submitted to the OAG on 10/27/16. The regs were sent to DPB on 2/16/17; DMAS participated in a call with DPB on 3/14. The EIA was posted on 3/27 and DMAS posted a response on 3/28. The regs were forwarded to HHR on 3/27; submitted to the Governor on 3/28; and signed by the Gov. on 4/14/17. The regs were published in the Register on 5/15, with a comment period thru 6/14. The regs will become final on 6/29/17.

2015 General Assembly

***(01) Pre-Admission Screening Changes:** This regulatory action is required by 2015 budget language. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services. These regulatory changes were drafted and reviewed internally, and submitted to the OAG. The OAG certified the regulations and they were sent to the DPB on 4/25/16. The regulatory action was submitted to HHR on 5/4 and to

the Governor on 5/17. The regulations were published in the Register on 7/11 and became effective on 9/1/2016. The corresponding SPA was sent to HHR on 8/24, and then submitted to CMS on 9/15/2016. CMS approved the SPA on 11/21/2016. The regulatory action transitioned to the Proposed Stage and was submitted to the OAG on 11/4/2016. DMAS responded to OAG inquiries on 12/6 and 1/25/17 and participated in a conference call with the OAG on 2/16/17. DMAS submitted responses to additional OAG questions. The OAG approved the regs on 4/25, and the action was forwarded to DPB.

***(02) Sterilization Compensation:** This regulation will allow DMAS to seek federal authority to exclude (for purposes of determining Medicaid eligibility) compensation provided to individuals who were involuntarily sterilized pursuant to the Virginia Eugenical Sterilization Act. A state plan amendment containing this change was approved by CMS on July 30, 2015 and an emergency regulation became effective on 11/23/2015. Proposed stage regulations were reviewed internally and, along with the Town Hall background document, were submitted to the Office of the Attorney General (OAG) on 4/5/16. The OAG certified the action on 6/17 and it was submitted to the DPB on 6/21/16. HHR certified the regulations on 8/14 and submitted them to the Governor. The Governor signed the action on 9/23/16 and it was published in the Register on 10/17, with a public comment period through 12/16. DMAS submitted the Final Stage of this regulatory project to DPB on 2/21/17, the item went to HHR on 3/1/17, and also to the Governor on 3/1. The Gov. signed the action on 4/14; the regs were published on 5/15; and are to be finalized on 6/14/17.

***(03) FAMIS MOMS Eligibility for State Employees:** This regulatory action will permit low-income state employees and their dependents to obtain coverage through FAMIS MOMS. The NOIRA for this package is being printed in the Register on 9/7/2015, which will open a 30-day public comment period. The comment period closed on 10/7/2015, and the proposed stage regulations were drafted and reviewed internally. The regs were submitted to the OAG on 1/22/2016 and became OAG-certified on 10/31. The action was submitted to DPB on 12/27; forwarded on to HHR on 2/23/17, and sent to the Governor on 3/28/17. The Gov. signed the regs on 4/26; and they were published on 5/29, with comment period thru 7/28.

***(04) Technology Assisted Waiver Changes:** This regulatory action will change the use of private duty nursing; change the staff experience requirement to include a training program; and remove the reference to exhausting private insurance coverage. The proposed stage was drafted, reviewed internally, and submitted to the OAG on 2/19/2016. The action was submitted to the DPB on 5/9. HHR certified the regulations on 6/23 and sent the package to the Governor's Ofc. for review on 7/8/16. The Governor signed on 10/7 and the regs were published on 10/31, with a public comment period through 12/30/16 (no comments were received). DMAS drafted and internally reviewed the final regs and filed them with DPB on 2/14/17. The action was forwarded to HHR on 3/2/17. DMAS responded to HHR inquiries on 6/5 and is currently awaiting feedback.

***(05) MAGI:** This action implements Modified Adjusted Gross Income (MAGI) thresholds in the Medicaid program and Children's Health Insurance Program (CHIP) in accordance with federally mandated eligibility determination requirements created under the Affordable Care Act. Multiple state plan amendments were submitted to CMS and approved in November and December, 2013. This final exempt regulation copies the state plan changes

into state regulations. The final exempt regulations and Town Hall background document were submitted to the Office of the Attorney General (OAG) on 6/22/15. DMAS reached out to the OAG on 4/18/16 to request a review status update. Additional information was sent to the OAG on 11/21 & 11/22/16. The action was certified on 11/22/16. The project was submitted to DPB on 1/3/17 and forwarded to HHR on 2/16. The action was sent to the Governor on 2/20 and signed on 4/26. The regs were published on 6/12, with a public comment period thru 7/12. The regs will be final on 7/27/17.

***(06) Treatment of Annuities:** This action complies with a federal Deficit Reduction Act, which requires DMAS to treat annuities and income from annuities according to certain rules, for purposes of determining Medicaid eligibility. Regulatory changes were drafted and submitted to the OAG on 9/14/2015. The OAG certified this action on 11/22 and it was submitted to the Register. Based on Registrar feedback, the regs were amended from final exempt status and re-organized as a fast-track action. The regs were re-submitted to the OAG on 12/13. The OAG approved the item on 1/6/17 and it was submitted to DPB on 2/28. Following a conf. call with DPB on 3/30, the regs were submitted to HHR on 4/3/17; and then to the Governor on 4/20. The action was signed by the Gov. on 5/19. The regs were published in the Register on 6/12/17 and will become final on 7/27/17.

***(07) Utilization Review Changes:** DMAS drafted a NOIRA to implement regulatory changes to more accurately reflect current industry standards and trends in the area of utilization review. The regulatory action was submitted to the OAG on 11/2/2015, and comments were received on 11/10. A revised agency background document was sent to the OAG on 11/18. A NOIRA was sent to DPB on 11/30, and the regulatory action was moved to HHR on 12/4. The Governor signed the action on 12/11. The NOIRA was published in the Town Hall Register on 1/11/2016, with the comment period in place through 2/10. Following internal DMAS review, the regulatory action was submitted to the OAG on 6/23/16. Per request, further edits were made and submitted to the OAG on 7/21, 8/4, 10/7, 10/28, and 11/15/16. DMAS made additional edits on 2/21/17. The regs were forwarded to DPB on 3/28 and DMAS responded to follow-up questions from DPB on 4/20. The action was submitted to HHR on 5/12 and is with the Governor's Office for review as of 5/16.

2014 General Assembly

***(01) Hospital DSH Reduction:** This action affects hospitals and was mandated by Chapter 2 of the *2014 Acts of the Assembly*, Item 301 WWW. The SPA was approved by CMS on 6/2/15 and a fast track regulatory action was submitted to the OAG for review on 7/16/15. DMAS received requests for additional information from the OAG and 9/17/2015; 10/5; 10/7; 1/13/2016. The OAG certified the action on 2/29. The submission went to the DPB on 3/9/2016. Following a meeting with DPB on 4/4, DPB certified the regulations and they were submitted to HHR on 4/18. The regulations were forwarded to the Governor's Office on 3/6/17. Following a conf. call with the Gov.'s Ofc. on 3/29, the Gov. signed the action on 4/14. The regs were published on 5/15, with a comment period thru 6/14. The action will be finalized on 6/29/17.

***(02) GAP SMI Demonstration Waiver Program:** The agency began work designing this new non-Medicaid program in early September in response to the Governor's directive. It provides a package of limited benefits to individuals who are 21 to 64 years old, uninsured, and residents of the Commonwealth. Some of the benefits are: physician, clinic, diagnostic outpatient procedures for both medical health conditions and behavioral health conditions related to diagnoses of serious mental illness. CMS approved the program in December, 2014. The emergency regulation action became effective 1/1/2015. The General Assembly proposed changes to this program in the 2015 budget and DMAS drafted a revised emergency regulation to incorporate these changes, which became final on 6/24/15. The proposed stage regulation, which incorporated the changes from both emergency regulations, was submitted to the OAG for review on 11/16/2015. DMAS revised the regulations, updated the Town Hall accordingly, and re-submitted the action to the OAG on 11/20/15. DMAS responded to OAG requests for revisions on 3/8/16 and 4/26. This regulatory action was re-submitted to the OAG on 5/23/16. DMAS submitted further updated info on 7/22 and received OAG revisions on 8/1. DMAS resubmitted info to the OAG on 9/13. The action was subsequently certified and sent to DPB on 9/20/16. Following a meeting with DPB on 10/25, and the submission of follow-up responses, DPB approval was secured on 11/3. HHR approved the action on 11/3; the item was sent to the Governor on 11/3; and the Governor signed the regulatory action on 12/6. It was published on 12/26, with a comment period through 2/24/17. The regulatory project moved to the final stage and following internal DMAS review, it was submitted to the OAG on 5/5. The action was pulled back from OAG review to make amendments on 5/9/17, which are currently underway.

2013 General Assembly

***(01) 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 was certified by the OAG on 11/2/2015 and was signed by the Governor on 11/30/2015. Emergency regulations were published in the Register on 1/11/16, with NOIRA comment period from 1/11thru 2/10. This regulatory action was circulated for internal DMAS review on 2/24/2016. Following internal DMAS revisions, the regulatory action was submitted to the OAG on 5/9/2016. No SPA action is required. DMAS revised the regulations and resubmitted them to the OAG on 9/6. Per request, DMAS made additional OAG edits on 10/25/16. The regulatory action was OAG-certified on 11/1 and submitted to DPB on 12/8. The EIA was posted on 1/29, and DMAS' response was posted 2/1. The regulations were sent to HHR on 1/29/2017 and forwarded to the Governor's Office on 2/12. The Gov. signed the action on 4/14 and it was published in the Register on 5/15, with comment period through 7/14.

***(02) Medicare-Medicaid Alignment Demonstration (FAD)/Commonwealth Coordinated Care (CCC):** This SPA is being implemented by CMS to streamline service delivery, improve health outcomes, and enhance the quality of life for dual eligible individuals and their families. Under the Demonstration's capitated model, DMAS, CMS, and selected managed care organizations (MCOs) have entered into three-way contracts through which the MCOs

receive blended capitated payments for the full continuum of covered Medicare and Medicaid benefits provided to dual eligible individuals, including Medicaid-covered long term services and supports and behavioral health care services. The participating MCOs will cover, at a minimum, all services currently covered by Medicare, Medicaid wrap-around services, nursing facility services, Medicaid-covered behavioral health services, home and community-based long-term services and supports provided under the Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver. Robust care coordination, interdisciplinary care teams, and person-centered care plans are also mandatory services that must be provided through the participating MCOs. Virginia plans to offer the Demonstration from January 1, 2014, through December 31, 2016. This SPA was submitted to CMS 3/28/13 and was approved by CMS 6/12/13. The Emergency regulation took effect 12/10/2014. The proposed stage action of the permanent regulation was submitted to the OAG on 12/21/2015. In response to multiple OAG inquiries, the regulatory action underwent another internal review and subsequent revisions. The revised regulatory action was submitted to the OAG on 7/22/16 and certified on 7/22. The regs were submitted to DPB on 7/25. After a follow-up call with DPB on 9/6/16, the item was sent to HHR on 9/8/16; to the Governor on 9/21; and approved on 10/28. The regs were published in the Register on 11/28, with a comment forum through 1/27/17 (no comments were submitted). The final stage regs were circulated through internal DMAS review on 2/1/17. The final stage package was sent to DPB on 3/21/17 and forwarded to HHR on 4/3. The regs have been under review at the Governor's Ofc. as of 4/20.

2012 General Assembly

(01) 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. 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. Emergency regulations became effective 10/10/13. DMAS received an extension, and the ER will last until 10/19/15. The proposed stage public comment period closed on 10/23/2015 and DMAS submitted final stage documents to the OAG on 2/12/2016. DMAS responded to a 3/22/2016 OAG request for revisions on 4/12/2016 and the OAG certified the regulatory action on 4/25/2016. The action was submitted to DPB on 4/25; to HHR on 5/10/2016; and to the Governor on 5/11/2016. The Gov. signed the regulatory action on 6/3; it was published on 6/27; and became effective on 7/27/16. The corresponding SPA package was drafted and began circulating on 8/8/16. The SPA was submitted to HHR on 8/24 and then on to CMS on 9/6/16. DMAS responded to CMS inquiries on 9/27 and 10/24. DMAS requested a Request for Additional Information (RAI) on 11/3/16. Following internal DMAS review, DMAS submitted RAI responses to CMS on 1/27/17. Additional informal CMS questions were received on 2/6 and responses were forwarded to CMS on 2/7/17 and on 2/28. DMAS is awaiting further feedback.

2011 General Assembly

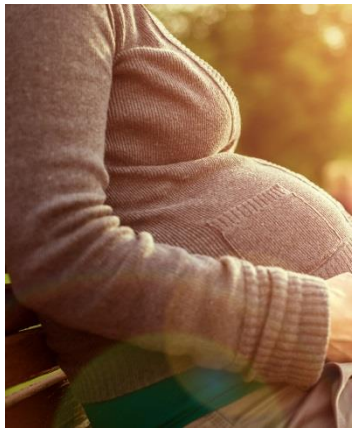
***(01) Inpatient and Outpatient Rehabilitation Update:** This Fast-Track action resulted from internal agency review. DMAS updated its regulations for both inpatient and outpatient rehabilitation services, including services provided in Comprehensive Outpatient Rehabilitation Facilities (CORFs). In addition, several sections of regulations in Chapter 130 were repealed and some of the retained requirements formerly located in that Chapter were moved to Chapters 50 and 60. Outdated, duplicative, and unnecessary regulatory requirements in Chapter 130 were repealed. This regulatory package was published in the Register on 11/16/2015 and became effective on 1/1/2016. A corresponding state plan amendment containing affected parallel regulatory changes was circulated for internal DMAS review on 2/29/2016, prior to OAG submission. The corresponding SPA, SPA 16-001 was circulated for internal DMAS review on 2/29/2016 and subsequently submitted to CMS on 3/23/16. Per request, revisions were made to the SPA and it was re-submitted to CMS on 3/28/16. Additional revisions were made at the request of CMS and revised info was submitted on 4/22/2016. More questions were sent by CMS via email on 5/10/2016. DMAS submitted informal SPA submission responses, in response to their Request for Additional Information (RAI). A conference call with CMS took place on 9/29 to further discuss DMAS' RAI responses. DMAS sent additional info to CMS on 10/13. Resulting inquiries were received from CMS on 11/3. DMAS sent further clarifying content on 12/7. DMAS also sent responses to additional CMS informal questions on 2/27/17. A conference call with CMS was scheduled for 4/4/17 to further discuss the SPA, but that call was rescheduled. Additional information was sent to CMS on 5/9. Another follow-up conference call with CMS is scheduled for 6/15/17.

2010 General Assembly

(01) 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. The final regulations became effective 1/30/2015. A SPA was submitted to CMS on 3/25/15. CMS sent a Request for Additional Information on 6/10/2015 and DMAS submitted responses. During a subsequent conference call with CMS, on 10/20/2015, DMAS took this project off the clock in order to prepare additional changes requested by CMS. DMAS resubmitted SPA changes to CMS on 3/1/2016 and again on 5/5/2016, in response to additional follow-up questions. The SPA was again taken off the clock to coordinate revisions. As of 6/2/17, further internal DMAS coordination and review is underway.

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.

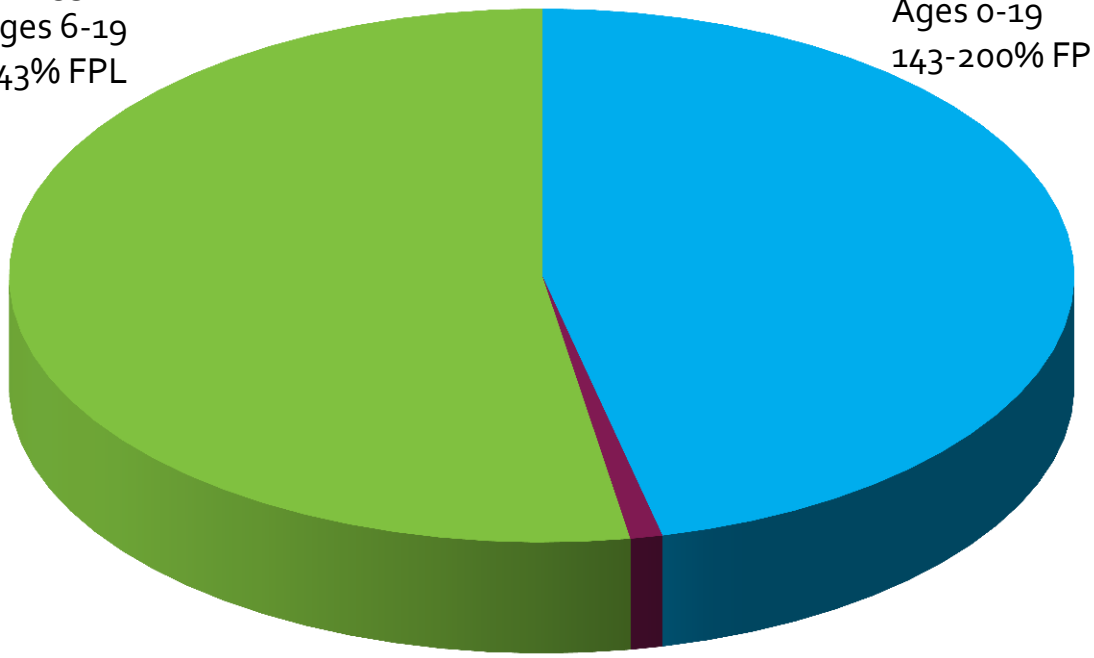




FUTURE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

MAY 24, 2017

Virginia's CHIP Covers 3 Distinct Groups



Note: Represents total enrollment of 116,235 as of May 2017.

Timeline of CHIP

1997

CHIP introduced in the Balanced Budget Act of 1997

2009

Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) amends CHIP

Reauthorizes CHIP for 5 years

2010

PPACA introduces super enhanced FMAP (88%) for CHIP through FFY 2019

Reauthorizes CHIP through FFY 2015

2015

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) reauthorizes CHIP through FFY 2017

Sep 30, 2017

Current CHIP authorization expires

Jan 2018

Virginia runs out of federal CHIP funds

Additional considerations

Maintenance of Effort (MOE) Requirements

- PPACA requires that states maintain the same eligibility levels in place as of 3/23/2010 until 9/30/2019
- Unless this requirement is eliminated, states cannot make any changes to the eligibility levels for CHIP

President's Budget Proposal

- Released on 5/23/2017
- Contains the following proposals:
  - Extends funding for two year (FFY 2018 and FFY 2019, but eliminates 23% super enhanced federal match beginning 10/1/2017
  - Ends MOE requirements
  - Allows states to move children ages 6-19 with household incomes 100-143% FPL to CHIP
  - Eliminates federal matching for enrollees with household incomes above 250% (not applicable to VA)

Potential Scenarios for Congressional Action

	Congressional Action	Impact on Virginia
	▪ Reauthorizes CHIP by 9/30/2017 ▪ Maintains current law with enhanced matching rate (88%)	▪ No impact on current forecast ▪ Super enhanced FMAP (88%) ends in FY 2020 (9/30/2019)
	▪ Reauthorizes CHIP by 9/30/2017 ▪ Amends current law to reduce matching rate to 65%	▪ FY 2018 forecast will need to be amended to increase general funds to account for reduced matching rate
	▪ Takes no action to reauthorize CHIP	▪ Federal funding will run out in January 2018 ▪ State policymakers will need to make a decision by 10/31/2017

Any action, other than reauthorizing CHIP at the enhanced matching rate, will increase Virginia's costs and potentially lead to coverage losses

Scenario 1: Congress reauthorizes and does not adjust matching rate

Federal CHIP funds are authorized at 88% matching rate

		FY 2018	FY 2019
Federal matching rate as of 10/1/2017			
	FAMIS and FAMIS MOMS	88%	88%
	MCHIP	88%	88%
Additional GF costs			
	FAMIS and FAMIS MOMS	$0	$0
	MCHIP	$0	$0
	Administration	$0	$0
Total additional GF costs		**$0**	**$0**

This scenario is current law and already incorporated in the CHIP forecast
Reduction in FMAP to 65% occurs in FY 2020 (9/30/2019)

Scenario 2: Congress reauthorizes and reduces matching rate

Reducing the matching rate will result in additional GF costs in FY18 and FY19

		FY 2018	FY 2019
Federal matching rate as of 10/1/2017			
	FAMIS and FAMIS MOMS	65%	65%
	MCHIP	65%	65%
Additional GF costs			
	FAMIS and FAMIS MOMS	$28.9M	$41.8M
	MCHIP	$24.2M	$35.3
	Administration	$4.5M	$6.0M
Total additional GF costs		**$57.6M**	**$83.1M**

If Congress reduces the matching rate, Virginia will experience significant unplanned expenses in FY 2018 and FY 2019 to maintain current coverage levels

Scenario 3: Congress does not reauthorize

Option 1: End FAMIS when federal CHIP funding runs out in January 2018 – MCHIP continues at Medicaid matching rate (50%)

		FY 2018	FY 2019
Federal matching rate when CHIP funding runs out in January 2018			
	FAMIS and FAMIS MOMS	--	--
	MCHIP	50%	50%
Additional GF costs			
	FAMIS and FAMIS MOMS	($8.4M)	($21.8M)
	MCHIP	$22.2M	$58.3M
	Administration	$3.4M	$7.7M
Total additional GF costs		**$17.3M**	**$44.2M**

- **53,906 children and 1,139 pregnant women would lose coverage on 2/1/2018**
- **DMAS is required to provide at least 10 days advance notice before dropping an enrollee's coverage**

Scenario 3: Congress does not reauthorize

Option 2: Expand Medicaid to cover FAMIS when funding runs out in January 2018

		FY 2018	FY 2019
Federal matching rate when CHIP funding runs out in January 2018			
	FAMIS and FAMIS MOMS	50%	50%
	MCHIP	50%	50%
Additional GF costs			
	FAMIS and FAMIS MOMS	$26.5M	$69.1M
	MCHIP	$22.2M	$58.3M
	Administration	$4.1M	$9.9M
Total additional GF costs		**$52.9M**	**$137.3M**

- **No one would lose coverage**
- **DMAS would need authority to submit a state plan amendment to CMS by 10/31/2017**