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

September 12, 2017
Final Minutes

Present:
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
Kannan Srinivasan

Absent:
Cara L. Coleman, JD, MPH
Alexis Y. Edwards
Rebecca E. Gwilt, Esq.
Vilma T. Seymour

DMAS Staff:
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Abrar Azamuddin, 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
Linda Nablo, Chief Deputy Director
Scott Crawford, Deputy Director for Finance
Kate Neuhausen, MD, Chief Medical Officer
Lacy Heiberger, Senior Policy Advisor
Daniel Plain, Health Care Services Director

Guests:
Jennifer Wicker, VHHA
Jenness Vaccarella, Conduent State Healthcare
Bruce Green, The Pediatric Connection
Beth Bailey, The Pediatric Connection
Patrick W. Finnerty, Myers & Stouffer
Lindsay Womack, Anthem
Steve Ford, VHCA
Tyler Cox, MSV
Mark Hickman, CSG
Ben Peel, VCU
Kenneth McCabe, DPB
Michael Tweedy, SFC
Stephanie Papps, DMAS Staff
Seon Rockwell, DMAS Staff
Matthew Keats, MD, DMAS Staff
Susie Puglisi, DMAS Staff

CALL TO ORDER

Dr. Karen S. Rheuban called the BMAS meeting to order at 10:01 a.m. and 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 June 13, 2017 MEETING

Dr. Rheuban asked for a motion to approve the Minutes from the June 13, 2017 meeting. Dr. Price made a motion to accept the minutes and Mr. Cook seconded. The vote was unanimous-**7-yes (M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, 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: Requests for Proposals (RFPs), Medicaid Expansion, Commonwealth Coordinated Care (CCC) Plus, Behavioral Health, and Addiction Recovery and Treatment Services (ARTS).

FEDERAL ACTIONS AND IMPACT ON VIRGINIA MEDICAID

Mr. Scott Crawford, Deputy Director for Finance, provided a brief summary of a four federal issues that may have an impact on Medicaid: government funding, extending the federal debt ceiling, extending funding for the Children's Health Insurance Program (CHIP), and repeal and replace of the Affordable Care Act (ACA). Congress has until December 8, 2017 to extend the federal debt ceiling and fund the government. Further, federal CHIP funding expires on September 30, 2017. Virginia has enough prior year funds to continue operating the program until January 31, 2018. However, additional federal funding would be needed at that time to continue the program (see attached handout).

CHIP REAUTHORIZATION: VIRGINIA IMPLEMENTATION ISSUES

Ms. Linda Nablo, Chief Deputy Director, presented an update on the status of the CHIP reauthorization and explained the potential impact the decisions made by Congress would have on the program. Currently, funding for this program runs out as of September 30, 2017, if Congress does not reauthorize the program. (see attached handout).

Mr. Cook made a motion to request staff draft another letter to the Governor, Virginia General Assembly Members, and the Virginia Congressional Delegation to encourage the CHIP reauthorization and ask for consideration of the disruptive nature that would be created if CHIP

is not reauthorized. Mr. Srinivasan seconded. The vote was unanimous-**7-yes (M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

UPDATE ON CCC PLUS/MEDALLION 4.0/JLARC RECOMMENDATIONS

Ms. Jones mentioned Governor McAuliffe will be celebrating reaching the Healthy Virginia goal of 35,000 additional children covered by the FAMIS programs. Ms. Jones invited BMAS members to FAMIS event September 21 at the Children's Hospital of Richmond at VCU.

Ms. Jones presented an update on the status of the Commonwealth Coordinated Care (CCC) Plus program, Medallion 4.0, and the Joint Legislative and Audit Review Commission (JLARC) recommendations. (see attached handout).

DMAS DASHBOARD DISCUSSION

Ms. Jones provided introductory remarks to open the discussion of the dashboard.

Mr. Daniel Plain, Health Care Services Director, discussed how a consumer decision support tool is being used to measure Medicaid managed care quality for members comparing managed care organizations. (see attached handout).

Dr. Neuhausen introduced Lacy Heiberger, RN, BSN, MBA, Senior Policy Advisor. Ms. Lacy provided recommendations for building an organizational system to support delivery of quality of care. She emphasized how access to information is critical, and presented recent efforts to develop an agency-wide dashboard (see attached handouts).

After Board discussion, it was agreed the Board Secretary would send an e-mail to all BMAS members to ascertain their interest and availability for a meeting to discuss the Dashboard before the next scheduled meeting of the Board on December 12.

REGULATORY ACTIVITY SUMMARY

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

NEW BUSINESS

ADJOURNMENT

Dr. Cook made a motion to adjourn the meeting at 12:10 p.m. Mr. Cook seconded. The vote was 7-**yes (M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

Meeting of the Board of Medical Assistance Services
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June 13, 2017
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.**





FEDERAL ACTIONS AND IMPACT ON VIRGINIA

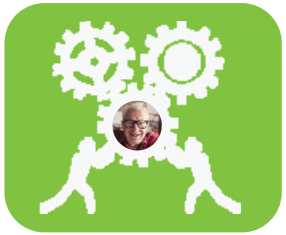
Board of Medical Assistance Services

September 12, 2017

Timeline of Financial Uncertainty

10/1/17	• Federal CHIP funding needed
12/8/17	• Federal debt ceiling estimated deadline
12/8/17	• Federal government shut-down if no action on budget
1/31/18	• CHIP funds exhausted in Virginia, if no action by this date
???	• PPACA Repeal and Replace

Debt Ceiling



What?
Congress must act to extend debt ceiling by December 8, 2017 (per H.R. 601)

What if that doesn't happen?
U.S. Treasury would not be able to borrow any more money to fund the U.S. government's obligations

Federal government would not have enough money to pay all the bills that come in on or after December 8, 2017, potentially including payments to states for Medicaid

Impact on DMAS?
Uncertainty on how the federal government would handle obligations established on or after December 8

Worst case scenario if the federal government defaults - payment of claims submitted after December 1 would be delayed indefinitely

Federal Government Shut-down

What?
Congress must pass a spending bill to continue funding government operations after December 8, 2017

What if that doesn't happen?
Federal government would be shut-down until Congress passes a spending bill

In previous government shut-downs, "essential spending," which includes Medicaid and CHIP funding, continues

Impact on DMAS?
Likely no dollar impact – in previous government shut-downs, the federal government continued to provide Medicaid and CHIP funds throughout the shut-down

During a shutdown, may be difficult to secure approvals or guidance from CMS

CHIP Funding Expiration

What?
Congress must act to provide federal funds allotments for CHIP after September 30, 2017

What if that doesn't happen?
Beginning on October 1, 2017, states may use any funds remaining in the prior year allotments to continue funding CHIP programs (FAMIS and MCHIP).

Once funds are exhausted, CHIP programs that are a Medicaid expansion (MCHIP) will transition to Medicaid funding (50/50 match rather than 88/12). Stand-alone CHIP program (FAMIS) will not have any federal funds available.

Impact on DMAS?
DMAS anticipates that it will exhaust its prior year CHIP allotment on January 31, 2018.

State policymakers will face increased costs for the MCHIP program (~$22M in FY18) and decisions about the future of the FAMIS program.

PPACA Repeal and Replace Efforts

What?

Congress' efforts to repeal and replace the Affordable Care Act (ACA) stalled when the Senate failed to pass a bill in July

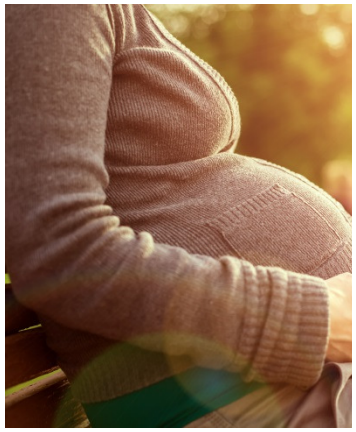
Repeal and replace legislation included proposals to change Medicaid funding to a per capita cap – fundamentally changing the way Medicaid has been funded for 50 years.

Impact on DMAS?

Uncertain – DMAS estimated that proposals had an impact ranging from a loss of $709M over 7 years to a loss of $1.4B over 7 years, depending on the details of the proposal

Future?

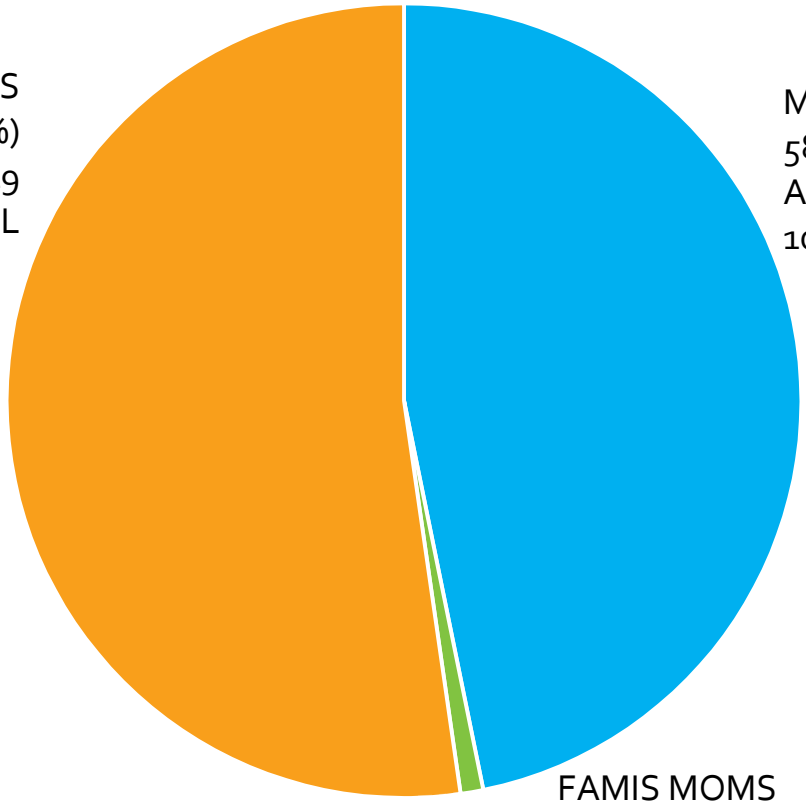
Extremely uncertain – Congress may begin new negotiations on repeal and replace, but uncertain when those negotiations would resume, what would be included in legislation, and whether caps on Medicaid spending would be resurrected.



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

SEPTEMBER 11, 2017

Virginia's CHIP Covers 3 Distinct Groups



Note: Represents total enrollment of 124,402 as of September 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

Funds CHIP for 5 years

2010

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

Funds CHIP through FFY 2015

2015

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

Sep 30, 2017

Current CHIP funding expires

Jan 2018

Virginia runs out of federal CHIP funds

Additional consideration

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
- If federal CHIP funding is not provided, does not apply to FAMIS recipients
  - BUT, would still apply to MCHIP recipients who would revert to a 50/50 match

Potential Scenarios for Congressional Action

	Congressional Action	Impact on Virginia
	▪ Funds 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)
	▪ Funds 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 fund 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 funding CHIP at the enhanced matching rate, will increase Virginia's costs and potentially lead to coverage losses

Scenario 1: Congress funds CHIP and does not adjust matching rate

Federal CHIP funds are provided 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 funds CHIP but reduces the 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	$35.3M
	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 fund CHIP

End FAMIS and extend 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**

Scenario 3: Congress does not fund CHIP

DMAS would need to engage in <u>extensive transition planning</u> to end FAMIS and extend Medicaid, including:

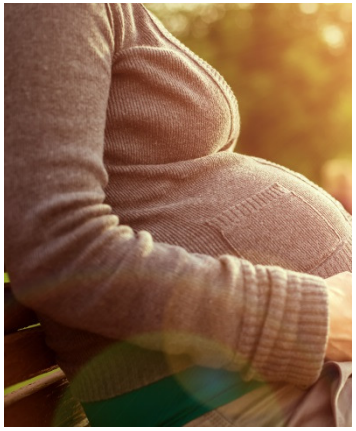
- Notification to families (65,000+)
- Notification to providers
- Training of Eligibility Workers, Call Centers, Application Assistors, etc.
- System changes (Eligibility rules and MMIS)
- Contract changes (MCOs, prior authorization, audits, etc.)
- Federal authority changes (CHIP State Plan termination, Medicaid state plan amendment, 1915(b) waiver amendment),
- State authority changes (General Assembly to repeal FAMIS & expand Medicaid, state regulation modifications)
- Plus much more

How Long Can We Wait?

- Virginia will run out of federal funds sometime in March, 2018
- We pay managed care plans retroactively for the previous month's coverage – so there will be insufficient funds in March to pay for February
- FAMIS shuts down at end of January
- Notices to families should be sent December 1st.
- Training and system/contract changes developed before notices
- Tasks must start in October

- **Congress may extend for 3 months; 1 – 2 year extension with current or lower federal match; reauthorize for 5 years at current or phased down funding.**





BMAS UPDATE: CCC+, MEDALLION 4.0, JLARC

September 12, 2017

The DMAS Mission

Superior Care

Cost Effective

Continuous Improvement

Strategic Transition to Managed Care

Two managed care programs

	CCC Plus	Medallion 4.0
	▪ Serving older adults and disabled ▪ Includes Medicaid-Medicare eligible ▪ 216,000 individuals	▪ Serving infants, children, pregnant women, parents ▪ 760,000 individuals
	▪ Long-term services and supports in the community and facility-based, acute care, pharmacy ▪ Incorporating community mental health	▪ Births, vaccinations, well visits, sick visits, acute care, pharmacy ▪ Incorporating community mental health
	▪ Implementation started Aug 2017 ▪ Implement statewide by Jan 2018	▪ New procurement 2017 ▪ Building on two decades of managed care experience ▪ Implement statewide 2018
	▪ Approximately $30B over 5 years	▪ Estimated $10B - $15B over 5 years

Managed Care Alignment

CCC Plus and Medallion 4.0 managed care programs are aligned in many ways

- Regions
- Services (where possible)
- Integrated behavioral health models
- Common core formulary
- Care management
- Provider and member engagement
- Innovation in managed care practices including VBP
- Quality, data and outcomes
- Strong compliance and reporting
- Streamlined processes and shared services

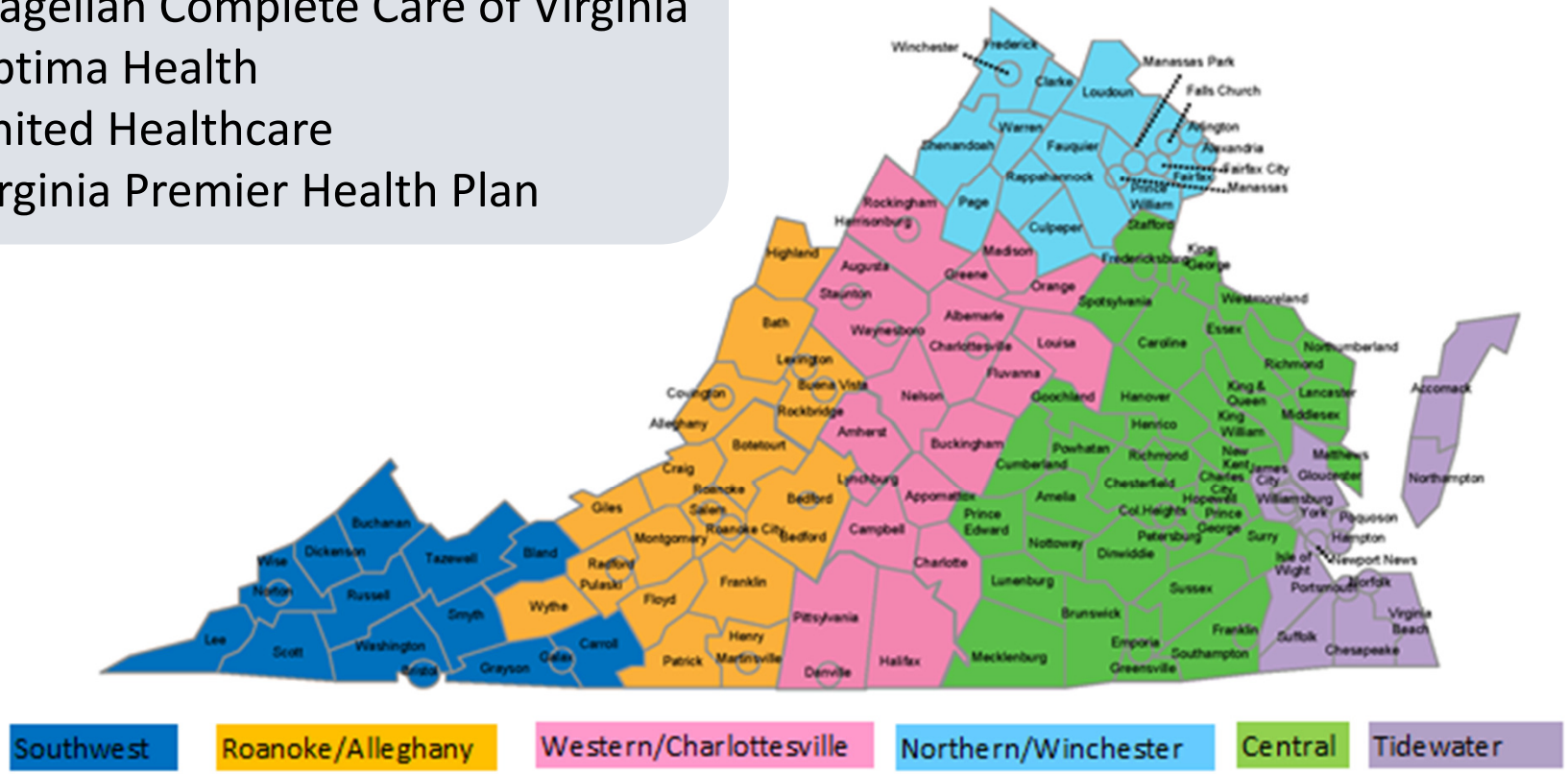
CCC PLUS OVERVIEW

Commonwealth Coordinated Care Plus (CCC Plus)

- New statewide Medicaid managed care program beginning August 2017 for over 216,000 individuals
- Participation is required for qualifying populations
- Integrated delivery model that includes medical services, behavioral health services and long term services and supports (LTSS)
- Care coordination and person centered care with an interdisciplinary team approach

Six Health Plans Contracted Statewide

- Aetna Better Health of Virginia
- Anthem HealthKeepers Plus
- Magellan Complete Care of Virginia
- Optima Health
- United Healthcare
- Virginia Premier Health Plan



A list of CCC Plus regions by locality is available at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

CCC Plus Regional Launch

CCC Plus has a phased in approach

August 2017 – January 2018

August	September	October	November	December	January
Tidewater	Central	Charlottesville	Roanoke Alleghany & Southwest	Northern & Winchester	CCC and remaining ABD
Effective 8/1/17	Effective 9/1/17	Effective 10/1/17	Effective 11/1/17	Effective 12/1/17	Effective 1/1/18

MEDALLION 4.0 OVERVIEW

Medallion 4.0

- Medallion 4.0 will cover 760,000 Virginians
- Medicaid enrollees have a choice of 3 or more plans in each of the six regions
- New carved-in populations and services:
  - Early Intervention Services
  - Third Party Liability (TPL)
  - Community Mental Health and Rehabilitation Services (CMHRS)

Optional Services in the Medallion 4.0 RFP

Medallion 4.0 presents optional carved-out services, such as:

- School-based services
- Dental Care
- Plan First

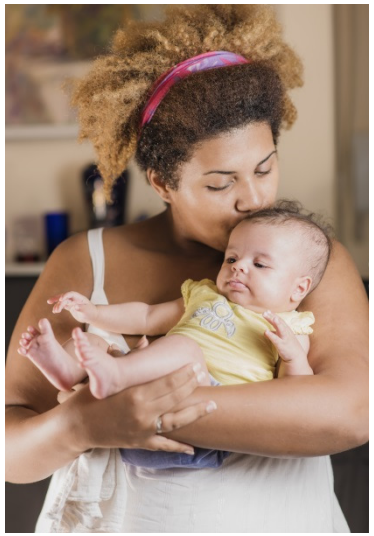
DMAS will not consider optional services before 2019

Medallion 4.0 Timeline

Medallion 4.0 has a phased in approach

2017–2018

August 2018	September 2018	October 2018	November 2018	December 2018
Tidewater Region	Central Region	Northern / Winchester	Charlottesville/ Western Region	Roanoke / Alleghany / Southwest Region
Effective 8/1/18	Effective 9/1/18	Effective 10/1/18	Effective 11/1/18	Effective 12/1/18



IMPLEMENTING JLARC RECOMMENDATIONS

JLARC Project Functional Categories

Projects fit into one of more of the following categories:

Uniform Assessment Instrument (UAI)	Recommended efforts to improve UAI reliability for children; UAI training and screening; ensure timely screening; and strengthen oversight of UAI process
Rates	Adjust rates to: account for expected savings; allow negative historical trends to carry forward; rebase administrative rates for enrollment changes and deduct unallowable administrative expenses from rate setting
Financial Oversight	Strengthen oversight by requiring: detailed MCO financial and utilization reporting; control of related party spending; excessive related party spending is not included in capitation; and underwriting gain returns above three percent
Programs	Administer compliance review and sanctions, report on MCO performance and incentivize MCO performance improvement. Additionally, strengthen oversight of behavioral health and LTSS service delivery
Trend Impact	Monitor MCO spending and utilization trends and analyze what is driving those trends. To include: identifying inefficiencies and adjusting rates accordingly, and monitoring MCO utilization control methods and evaluating their impact
Policy	Submit for CMS review, a proposal requiring cost-sharing based on family income for LTSS eligible individuals eligible through the optional 300 percent of SSI

12 FTES and $3,046,792 appropriated to DMAS over the next two years

JLARC Project Implementation Work to Date

- ✓ Issued and reviewed responses from MCO Trend Analysis RFI
- ✓ Organized projects across different areas of DMAS
- ✓ Began process of hiring contractors and staff, including a Chief Health Economist, to complete JLARC projects

VIRGINIA MEDICAID MANAGED CARE QUALITY

CONSUMER DECISION SUPPORT TOOL 2016-2017

Comparing Virginia Medicaid Managed Care Organizations

Choosing a managed care organization (MCO) that works best for you and your family is important. This tool is designed to help eligible members choose a Medicaid MCO. This tool shows how well the different MCOs provide care and services in various performance areas. The ratings for each area summarize how the MCO performs on a number of related standards.

Key

Above Virginia Medicaid MCO Average ★★★

Virginia Medicaid MCO Average ★★

Below Virginia Medicaid MCO Average ★

MCO	Accreditation Level	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna*	Accredited	★★	★★	★	★★	★★
Anthem	Commendable	★★	★★	★★★	★	★★
INTotal	Accredited	★★	★★	★★★	★	★
Kaiser Permanente	Accredited	★★	★★	★★	★★★	★★★
Optima	Commendable	★★	★★	★	★★	★★★
VA Premier	Accredited	★★	★★	★★	★★★	★★

**formerly CoventryCares*

What is Measured in Each Performance Area?

Doctors' Communication
- Doctors explain things well to members
- Doctors involve members in decisions about their care

Getting Care
- Members get the care they need, when they need it

Keeping Kids Healthy
- Children get regular checkups and important shots that help protect them against serious illness

Living With Illness
- Members with asthma, diabetes, high blood pressure, and depression get the care they need by getting tests, checkups, and the right medicine

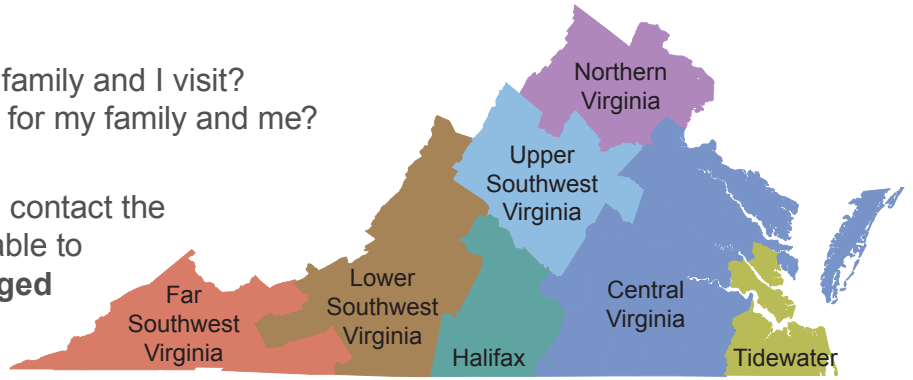
Taking Care of Women
- Women get tests for breast and cervical cancer to help find these diseases early
- Moms get care before and after their baby is born to help keep mom and baby healthy

Choosing a Medicaid Managed Care Organization

Your health care is important, and choosing the MCO that best meets your needs is also important. Here are some questions to ask yourself before you pick an MCO:

- How well did each MCO perform in each performance area in this tool?
- Which MCO has all or most of the doctors, providers, and hospitals that my family and I visit?
- Which MCO has doctors with office hours and locations that are convenient for my family and me?
- Which MCO offers extra services that I want to use?

You may have other questions or concerns that are important to you. You can contact the MCOs using the information below. They can tell you which doctors are available to you and what extra services they offer. You can also call the **Medicaid Managed Care HelpLine** at 1-800-643-2273. HelpLine staff can answer your questions and help you decide which MCO is best for you and your family.



MCO	Contact Information	Available in the Following Regions
Aetna Better Health of Virginia (Aetna)*	1-800-279-1878 www.aetnabetterhealth.com/virginia	Central Virginia, Far Southwest Virginia, Halifax, Lower Southwest Virginia
Anthem HealthKeepers Plus (Anthem)	1-800-901-0020 www.anthem.com/vamedicaid	Available in all regions.
INTotal Health (INTotal)	1-855-323-5588 www.intotalhealth.org	Far Southwest Virginia, Lower Southwest Virginia, Northern Virginia, Upper Southwest Virginia
Kaiser Permanente	1-855-249-5025 virginia-medicaid.kaiserpermanente.org	Northern Virginia
Optima Family Care (Optima)	1-800-881-2166 www.optimahealth.com/familycare	Available in all regions.
Virginia Premier Health Plan (VA Premier)	1-800-727-7536 www.vapremier.com	Available in all regions.

**formerly CoventryCares*

Information as of November 2016

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION · QUALITY · VALUE

For More Information:

Visit the Virginia Department of Medical Assistance Services online at: www.dmas.virginia.gov and Virginia's Medicaid Managed Care online at: www.virginiamanagedcare.com.

About This Tool

The 2016 Virginia MCO Consumer Decision Support Tool utilizes results from HEDIS and CAHPS. Calendar year 2015 data were used to derive 2016 reporting year rates. This report was compiled by Health Services Advisory Group, Inc. (HSAG) in collaboration with the Department of Medical Assistance Services (DMAS).

About the Accreditation Levels

Accreditation levels as of November 2016 are based on compliance with the National Committee for Quality Assurance's (NCQA's) rigorous requirements and the MCOs performance on Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures. The highest level of accreditation an MCO can receive is Excellent, followed by Commendable, and then Accredited. For more information regarding accreditation levels as of November 2016, visit: http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels.

The 2017 Data Book is now available on the DMAS web site at:
2017 Virginia Medicaid and CHIP Data Book xls | pdf

This book is responsive in part to language in Chapter 836 - Item 310 K (p. 330) which states:

K.*1.* It is the intent of the General Assembly that the Department of Medical Assistance Services provide more data regarding Medicaid and other programs operated by the department on their public website. The department shall create a central website that consolidates data and statistical information to make the information more readily available to the general public. At a minimum the information included on such website shall include monthly enrollment data, expenditures by service, and other relevant data.

2. No later than June 30, 2018, the department shall make Medicaid and other agency data stored in the agency's data warehouse available ***through the department's website*** *that includes, at a minimum, interactive tools for the user to select, display, manipulate and export requested data.*

BUILDING A "SYSTEM" FOR QUALITY

PRESENTED TO THE BOARD OF MEDICAL ASSISTANCE SERVICES
SEPTEMBER 12, 2017

LACY HEIBERGER, RN, BSN, MBA
SENIOR POLICY ADVISOR TO THE CMO

DMAS Strategy

Superior Care

Cost Effective

Continuous Improvement

Opportunities

- A chance to build on existing strengths
  - Collaborative relationship with MCOs
  - Procurement of both major programs
  - CMS Mega Regs require an update of quality strategy…and have expert assistance (HSAG)
  - Medicaid Enterprise System build
  - Increasing appetite for alternative payments
  - JLARC mandates

Quality Improvement Efforts

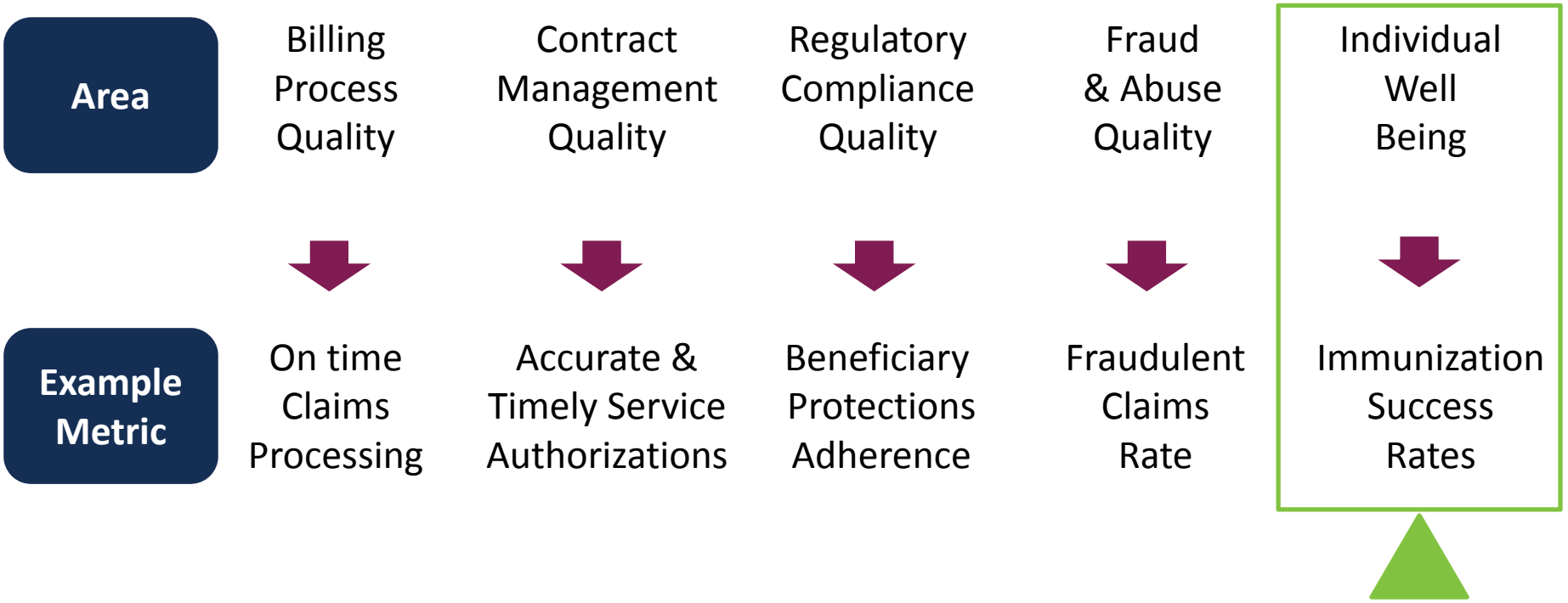
We have a long history of quality improvement efforts

National Committee for Quality Assurance (NCQA)	All MCOs must obtain and maintain NCQA accreditation HEDIS measures CAHPS surveys
Performance Incentive Awards (PIA)	+/- financial penalties base on MCO performance 3 administrative measures / 3 clinical measures
Consumer Decision Support Tool	MCO "Score Cards" for high priority performance areas and publically available in 2017
Performance Monitoring	High priority HEDIS measures w/ performance expectations CAPHS collection to track patient satisfaction
Medallion Care Partnerships	MCO VBP projects targeted at high priority populations MCOs must initiate at least one CSP
Rapid Cycle Performance Improvement Program (PIP)	MCO groups dispatched to target discrete performance issues Currently targets improved performance for diabetic patients

Medallion 3.0 introduced new requirements to promote MCO performance measurement.

Focusing the strategy on health

Quality can apply to many areas



Individual well being is paramount

What is Quality?

"A direct correlation between the level of improved health services and the desired health outcomes of individuals and populations."
- Institute of Medicine

Quality Assurance (QA):

Administrative and procedural activities implemented in a quality system so that requirements and goals will be fulfilled

Quality Improvement (QI):

Systematic and continuous actions that lead to a measurable improvement in health care services and the health status of targeted patient groups.

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

Managed Care as a Platform for Improvement

Identify Needs

Meet Needs

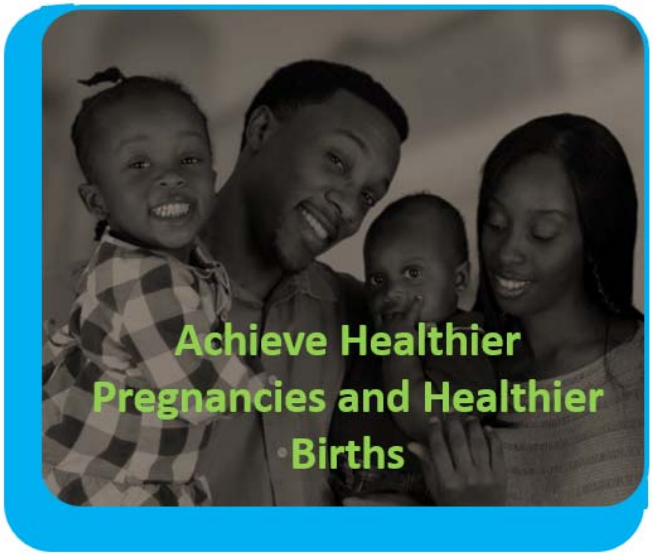
Change Outcomes

Virginia is leveraging our managed care experience to build the future

"Every system is designed to get exactly the results it gets."

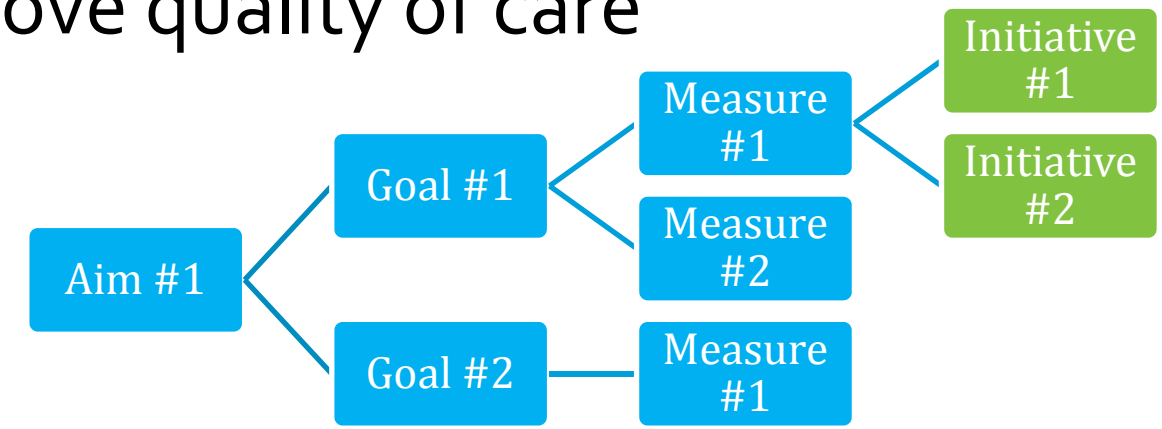
- W. Edwards Deming

Health Aims for DMAS Quality



Dashboards

- Segmented measures by area of impact:
  - Clinical Effectiveness
  - Cost
  - Utilization
  - Access
- Link measures to initiatives intended to improve quality of care



Next Steps

- Established a Quality Steering Committee
- Aligned CCC Plus and Medallion 4 measures with agency-wide priorities
- HSAG Quality Strategy draft revisions, for public comment Oct 1, 2017
- Positions in progress: Director of Health Economics and Business Intelligence, 2 Data Scientists

Questions?

Thank you!

DRAFT

DMAS Quality Dashboard

version: September 5, 2017

Health Aims	Goals (Aligned with Virginia Plan for Wellbeing)	Measurements	Clinical Quality Measures	Access Measures	Utilization Measures	Cost Measures *(Under development)*
Build a wellness-focused, Integrated System of Care	Strengthen access to primary care network *(4.1)*	**HEDIS: Adults' Access to primary care (preventative/ambulatory Health Services)**		**M/C**		
		HEDIS: Childrens' and adolescents' access to primary care		**M/C**		
	Decrease inappropriate utilization and total cost of care	**All-cause PQI admission rate**			**M/C**	
		CMS/NQF #1768: Plan all-cause readmissions			**M/C**	
		HEDIS: Ambulatory care - emergency department visits			**M/C**	
		Total Cost of Care				*M/C*
	Emphasize member experience of care	**CAHPS/NQF #0006: Member Rating of Health Plan**	**M/C**			
	Integration of behavioral, oral and physical health *(4.1)*	**CMS/HEDIS/NQF #0004: Initiation and engagement of Alcohol and Other Drug Dependence treatment (2 rates)**		**M/C**		
		CMS/NQF #1664: SUB-3 Alcohol and Other Drug Use Disorder Treatment provided or offered at Discharge and SUB-3a Alcohol and Other Drug use disorder treatment at Discharge	M/C			
		HEDIS: Use of first-line psychosocial care for children and adolescents on antipsychotics	M/C			
		HEDIS/NQF #0576: Follow-up after hospitalization for mental illness, 7-day follow-up		**M/C**		
		CMS/NQF #2605: Follow-up after discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence		M/C		
		CMS: Fourteen day readmission rate among Medicaid beneficiaries for inpatient treatment for SUDs and 180-day readmission rate for residential treatment for SUDs *(CMS defining technical specifications)*			M/C	
		NQF #2599: Alcohol Screening and Follow-up for People with Serious Mental Illness		M/C		
	Encourage appropriate management of prescription medications	Use of High-risk Medications in the Elderly	C			
		HEDIS: Antidepressant Medication Management - effective acute phase treatment, effective continuation phase treatment	M/C			
		PQA: Use of opioids at high dosage in persons without cancer	**M/C**			
		PQA: Concurrent Use of Opioids and Benzodiazepenes	M/C			
		NQF #3175: Continuity of Pharmacotherapy for Opioid Use Disorder	**M/C**			
	Cancers are prevented or diagnosed at the earliest stage possible (3.4)	HEDIS/NQF #2372: Breast Cancer Screening	M/C			
		NQF #0034: Colorectal screening	M/C			
		HEDIS/NQF #0032: Cervical Cancer screening	M/C			

*Measures in BOLD are agency-wide priorities

*DMAS will select a subset of these measures for Medallion 4.0 and CCC Plus plans quality withhold/performance incentive payments

C = CCC Plus Program

M = Medallion 4.0 Program

M/C = Both Programs

DRAFT

DMAS Quality Dashboard

version: September 5, 2017

Health Aims	Goals (Aligned with Virginia Plan for Wellbeing)	Measurements	Clinical Quality Measures	Access Measures	Utilization Measures	Cost Measures *(Under development)*
Focus on Screening and Prevention	Prevention of nicotine dependency (3.2)	AMA-PCPI/NQF #0027: Tobacco use - screening and cessation	M/C			
	Virginians protected against vaccine-preventable diseases (3.3)	**HEDIS: Childhood immunization status (combo 3)**	**M**			
		HEDIS: Pnuemococcal vaccination status for Older Adults	M/C			
		HEDIS: Flu vaccinations	M/C			
	Support consistency of recommended pediatric screenings	CMS/HEDIS: Annual preventative dental visits		M		
		HEDIS: Well child visits, 1st 15 months of life		M		
		HEDIS: Well child visits in 3rd, 4th, 5th, 6th years of life		M		
		HEDIS: Adolescent well-care visits (12-21 years)		M		
		OHSU: Developmental Screening in the First 3 years of life	M			
Achieve Healthier Pregnancies and Healthier Births	Virginians plan their pregnancies (2.1)	NQF 2902/OPA: Contraceptive care - postpartum women ages 15-44	M			
		HEDIS: Post-partum Care Visit		M		
	Improved Pre-term birth rate	Early elective deliveries rate	M			
		HEDIS: Timeliness of prenatal care		**M**		
		HEDIS: Frequency of Ongoing prenatal care		M		
		CMS/CDC/PQI: Percent of live births <2,500 grams	**M**			
Maximize Wellbeing Across the Lifespan	Effective management of chronic respiratory disease	HEDIS: Asthma Medication Ratio, 50%	M/C			
		PQI 14 + PQI 15 combo: Asthma admission rate (ages 2-17 and younger adults)			M	
		CMS/PQI 05/NQF #0275: COPD and Asthma in older adults Admission rate (2 measures)			C	
	Comprehensive management of Diabetes	**HEDIS: Comprehensive Diabetes Care - HbA1c poor control (>9.0%)**	**M/C**			
		PQI 01/NQF #0272: PQI Diabetes Short-term complication Admission Rate			M/C	
	Effective management of cardiovascular disease	**HEDIS/NQF #0018: Controlling high blood pressure**	**M/C**			
		CMS/PQI 8/NQF #0277: Heart Failure Admission Rate			M/C	
	Ensure quality of life for members with intensive healthcare needs	JLARC: Nursing facility diversion - # and % of new members meeting nursing facility level of care criteria who opt for Home & Community Based Services (HCBS) over institutional placement			C	

*Measures in BOLD are agency-wide priorities

*DMAS will select a subset of these measures for Medallion 4.0 and CCC Plus plans quality withhold/performance incentive payments

C = CCC Plus Program

M = Medallion 4.0 Program

M/C = Both Programs

DRAFT

DMAS Quality Dashboard

version: September 5, 2017

Health Aims	Goals (Aligned with Virginia Plan for Wellbeing)	Measurements	Clinical Quality Measures	Access Measures	Utilization Measures	Cost Measures *(Under development)*
		Quality of Life and member satisfaction survey CMS specific	C			
		JLARC: Transition of existing members between Community Well, LTSS and Nursing Facility Services and successful retention in lower care settings			C	
		JLARC: Nursing Facility Residents Hospitalization and readmission Rate			C	
		Fall Risk Management: intervention/managing fall risk	C			
	Provide support for End of Life	% enrollees with advanced directives	C			

*Measures in BOLD are agency-wide priorities

*DMAS will select a subset of these measures for Medallion 4.0 and CCC Plus plans quality withhold/performance incentive payments

C = CCC Plus Program

M = Medallion 4.0 Program

M/C = Both Programs

Regulatory Activity Summary September 12, 2017
(* Indicates recent activity)

2017 General Assembly

***(01) 2017 Institutional Provider Reimbursement and 2017 Non-Institutional Provider Reimbursement:** These final exempt regulatory actions are required by the *2017 Acts of Assembly*. These actions will allow DMAS to make supplemental payments to certain hospitals for a specified number of primary care residencies with the stipulation that the hospital maintains residency slots and required documentation annually to verify that required criteria is met. Preference for the residency slots shall be given to those in underserved areas. DMAS shall adopt criteria for primary care, high need specialties, and underserved areas developed by the Virginia Health Workforce Authority. Additional language has been added to clarify that effective July 1, 2017, IME payments will continue to be limited for freestanding children's hospital with greater than 50 percent utilization to not exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject, excluding third party reimbursement for Medicaid eligible patients. The corresponding SPA packages (which implement mandates in the Virginia 2017 Acts of Assembly pertaining to payment methodology and inflation in state fiscal year 2018) are being processed concurrently with the regulatory changes. The regs were drafted and submitted to the OAG for review on 8/2/1. DMAS responded to OAG inquiries on 9/7. The Institutional Provider Reimbursement SPA package was drafted and forwarded to HHR on 9/5/17. The Non-Institutional Provider Reimbursement SPA package is currently being drafted internally.

***(02) Outpatient Mental Health Service Limit Review:** This state plan amendment removes the 26-visit limit from outpatient psychiatric services in conformance to changes in federal law and state regulation. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and federal regulations (42 CFR Part 438, Subpart K (438.900 et seq.) and 42 CFR Part 440, Subpart C (440.395) require that Medicaid cover mental health and substance use disorder benefits to the same degree and in the same manner as medical/surgical benefits; that is, the financial requirements and treatment limitations must be the same. Medicaid is not permitted to impose financial limitations (such as a lifetime dollar benefit limit) nor service limits (such as a specified number of covered visits) for mental health and substance abuse treatment services that it does not also impose on medical/surgical services. In the past, DMAS limited its coverage of outpatient psychiatric visits to 26 visits in a year without prior authorization being required. Subsequent outpatient psychiatric services required prior authorization and were also limited to 26 visits per annum. This service limit was adopted in 1981 (State Plan Amendment 81-05). This update removes the 26-visit limit from outpatient psychiatric services from the State Plan in accordance with the mental health parity provisions. Following internal DMAS review, the SPA was sent to HHR on 7/19/17 and subsequently to CMS 7/25/17. DMAS is currently fielding multiple rounds of questions from CMS.

***(03) Reimbursement of Community Mental Health Services, Dental Interpretive Services, PDN, AT, PAS:** This state plan amendment serves to add text to the state plan regarding reimbursement practices that currently are in place relating to reimbursement of community mental health services, private duty nursing, assistive technology, and personal assistance services, and to reflect the inclusion of updated dental procedure codes in the agency fee schedule. The SPA was drafted internally; submitted to HHR on 7/17; and forwarded to CMS on 7/25/17. DMAS is currently fielding questions from CMS, with the most recent round of responses sent to CMS on 9/1/17.

***(04) Supplemental Drug Rebates and Managed Care Organizations:** This state plan amendment enables DMAS to collect supplemental rebates for Medicaid member utilization through MCOs. The Department has the authority to seek supplemental rebates from pharmaceutical manufacturers. Currently, DMAS only collects supplemental rebates for fee-for-service claims. This update to the State Plan will allow the Department the option to also collect supplemental payments for Medicaid member utilization through MCOs. The state supplemental rebates from managed care organizations for Medicaid member utilization will occur in the same manner in which fee-for-service supplemental rebates are collected. The contract will exist between the manufacturer and the State and will remain separate from federal rebates in compliance with federal law §§ 1927(a)(1) and 1927(a)(4) of the *Social Security Act* (Act). The SPA package was reviewed internally and submitted to HHR on 7/12/17, and after approval, forwarded to CMS on 7/20/17.

***(05) CHKD Hospital Inflation:** This fast-track regulatory action serves to exclude Children's Hospital of the King's Daughters (CHKD) from the elimination of the inflation adjustment by allowing an exception of 100% of inflation for the CHKD. This regulation is essential to protect the health, safety or welfare of citizens as it will improve access to pediatric specialty services for beneficiaries in Virginia. The methodology for hospital reimbursement includes an annual inflation adjustment. Previously, in state fiscal year 2017, the inflation adjustment was 50% of the adjustment and in state fiscal year 2018, the inflation adjustment was eliminated. The regs have been drafted and are currently circulating for review.

***(06) Reduction of Inpatient Cost Sharing to Comply with Federal Regulation:** This final exempt regulatory action decreases the cost sharing amount charged per inpatient hospitalization from $100 to $75 in order to comply with federal rules at 42 CFR 447.52(b)(2). Under current DMAS regulations, DMAS requires members to share the cost of inpatient hospitalization by paying $100 toward the cost of their care. As of July 1, 2017, this cost must be changed to $75 for DMAS to remain in compliance with federal rules. The regs and state plan amendment have been drafted internally and are currently circulating for review.

***(07) 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 and approved on 7/14/17. The corresponding regulatory changes are currently circulating for internal DMAS review.

***(08) 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. The SPA was then submitted to CMS on 6/22 for review. DMAS responded to CMS inquiries on 8/15/17 and split the SPA into two sections per CMS request. CMS approved the SPAs on 8/31.

(09) 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.

***(10) 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. Beginning April 2017, the reg package was drafted and circulated for internal review. The regs were submitted to the OAG on 6/22. DMAS responded to OAG inquiries on 6/28 and 8/9/17. The regs were OAG certified on 8/14, submitted to DPB on 8/15, and submitted to the Registrar on 8/16. The regs were published in the Register on 9/4, with an effective date of 10/19/17.

***(11) 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. Submitted response to OAG inquiries on 6/26 and 8/3. Awaiting OAG response.

(12) 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.

***(13) 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. The proposed stage regs were drafted on 6/16 and are currently circulated for internal review.

***(14) 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 with the OAG, DMAS submitted revisions to the regs on 5/22, 5/24, 5/31, and 6/6. The regs were certified by the OAG on 6/13; forwarded to DPB on 6/19/17; and submitted to HHR on 7/28. The regs were submitted to the Governor on 8/1.

***(15) 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, and following responses to inquiries, the SPA was approved on 6/15/17.

***(16) 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 was withdrawn from submission based on CMS regulations delay, which had the regs originally taking effect in July 2017, but is now postponed until January 2018. CMS issued an amended effective date on 7/10. The regs were submitted to the Registrar on 7/10; and published in the Register on 8/7/17. The final exempt effective date is Jan. 13, 2018. The corresponding SPA package is currently circulating internally for review.

***(17) 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. Following a conf. call with DPB on 6/16, the regs were submitted to HHR on 6/23, and to Governor on 7/5/16. The Governor approved the action on 8/4, with an effective date of 10/19/2017. A notification of a final reg available for review was sent to Town Hall users on 9/5. The corresponding SPA package has been drafted and is currently circulating internally for review.

(18) 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; published in the Register on 6/12; and were final on 7/13/17. The corresponding SPA was drafted on 6/19; submitted to HHR on 7/5; and forwarded to CMS on 8/11. Following a conference call with CMS on 8/28, revisions were submitted and the SPA was approved on 9/1/17.

(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. The regs were signed by the Governor on 6/30 and submitted to the Registrar. The regs were published on 7/24, with a 60-day comment period.

***(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 and published in the Register on 9/19/16, with a public comment period through 10/24 (1 comment submitted). The Proposed Stage regs were drafted on 12/2016 and following internal DMAS review, submitted to the OAG on 7/31, and re-submitted on 9/7/17.

***(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 and on to the Governor on 5/29. The Gov. signed the action on 6/16/17, with an effective date between 6/16 and 12/15/2018. The regs were published in the Register on 7/10, with a comment period through 8/9 (three comments were submitted). DMAS is currently drafting the next stage of the regulatory review.

(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) 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. The action was signed by Governor on 6/30 and submitted to the Registrar. The regs were published on 7/24, with a 60-day comment period.

***(08) 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). This regulatory action is currently in the proposed stage and the package was drafted internally on 5/16. The regs were submitted to the OAG on 8/16/17 for review.

***(09) 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 were published in the Register on 6/12/17, which opened a 60-day public comment period. The final stage regs were drafted and submitted to DPB on 9/6.

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. The action was submitted to HHR on 6/14; to the Governor on 7/5; and the Gov. signed the action on 8/4. The regs were published in the Register on 9/4, which will open a 60-day comment period.

***(02) 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 a

comment period thru 7/28. The Final Stage phase was initiated and the regs were submitted to DPB on 9/7/17.

***(03) 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 the regs were forwarded to the Governor on 6/6/17, and were signed on 7/12. The regs were published on 8/7 and were finalized on 9/6/17.

***(04) 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 became final on 7/27/17. The corresponding SPA was drafted on 6/8/17 and sent to HHR on 7/13/17. The SPA was submitted to CMS on 7/20 and was approved on 9/7/17.

***(05) 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 sent to the Governor's Office for review on 5/16. The action was signed by the Governor on 6/30 and submitted to the Register. The regs were published on 7/24, with an open 60-day public comment period.

2014 General Assembly

***(01) 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 and was re-submitted to the OAG on 6/15.

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. One comment was generated and a summary of the public comment was sent back to the commenter. Final stage reg coordination is underway internally.

*(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 were signed by the Governor on 6/16; were published in the Register on 7/10; and were finalized on 8/10.

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 was conducted with CMS on 6/15/17. As of 8/30, DMAS is currently working on SPA revisions prior to re-submitting draft to CMS.

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. Beginning 6/2/17, further internal DMAS coordination commenced. The SPA was sent to HHR on 8/9/17 and forwarded to CMS on 8/24/17. CMS submitted informal questions on 8/31 and responses were forwarded to CMS on 9/6/17.

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.