

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

**May 9, 2017
Final Minutes**

Present:

Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Patricia T. Cook, M.D.
Alexis Y. Edwards
Rebecca E. Gwilt, Esq.
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

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
Jeness 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 June 13, 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.

**Meeting/Retreat of the Board of Medical Assistance Services
600 East Broad Street, Conference Room 7A/B
Richmond, Virginia**

**December 13, 2016
Minutes**

Present:

Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Rebecca E. Gwilt, Esq.
Maureen Hollowell
Maria Jankowski, Esq.
Peter R. Kongstvedt, MD
Vice Chair
McKinley L. Price, DDS
Karen S. Rheuban, MD
Chair
Marcia Wright Yeskoo

Absent:

Mirza Baig
Alexis Y. Edwards

DMAS Staff:

Linda Nablo, Chief Deputy Director
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Karen Kimsey, Deputy Director for Complex Services
Ivory Banks, Program Operations Division Director
Dan Plain, Director of Health Care Services
Terry Smith, Director of Long-Term Care
Kathleen Guinan, Human Resources Director
Mukundan Srinivasan, Chief Information Officer
Abrar Azamuddin, Legal Counsel
Craig Markva, Director, 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
Scott Crawford, Deputy Director for Finance
Seon Rockwell, Director of Office of Innovation and Strategy
Bhaskar Mukherjee, Director of Office of Data Analytics
William H. Leighty, Retreat Facilitator

Guests:

Nicole Pugar, Williams Mullen
Ross Grogg, Kemper Consulting
Doug Davis, Xerox
Richard Grossman, Vectre
Mike Tweedy, Senate Finance Staff
Steve Ford, VHCA
Lindsay Walton, Macaulay & Jamerson, PC
Fred Helm, Kemper Consulting
Tyler Cox, HDJN
Rick Shinn, VACHA
Cecelia Kirkman, SEIU Healthcare

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 9:07 a.m. and welcomed everyone in attendance. Dr. Rheuban asked other members to introduce themselves and introductions continued around the room. Dr. Rheuban announced the proposed quarterly meeting dates for 2017: April 11, June 13, September 12 and December 12.

APPROVAL OF MINUTES FROM SEPTEMBER 13, 2016 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the September 13, 2016 meeting. Dr. Kongstvedt made a motion to accept the minutes and Mr. Cook seconded. The vote was **8-yes (Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Rheuban, and Yeskoo); and 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, briefly provided brief updates on the current status of several key projects including Addiction and Recovery Treatment Services (ARTS), the Commonwealth Coordinated Care Plus (CCC Plus) Program, Medallion 4.0 Medicaid Managed Care Program, and active RFPs. Information regarding these projects is available on the DMAS website. (See handouts attached.)

REPORT ON JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION FINDINGS

Ms. Jones provided highlights of the JLARC's report entitled, "*Summary: Managing Spending in Virginia's Medicaid Program*" attached. Based on this report, staff will be prioritizing and continuing to implement the JLARC recommendations. (See handout attached.)

UPDATE ON MEDICAID FORECAST

Scott Crawford, Deputy Director for Finance, explained the forecasting process and provided an update on the Medicaid forecast which included spending in current period ending June 30, 2016 and subsequent two years. Governor McAuliffe announced his budget Savings Plan for 2017 on October 13, 2016 and the 2018 reductions will be announced with the release of the Governor's Budget on December 16, 2016. (See handout attached.)

Dr. Price joined the meeting during this discussion.

REGULATORY ACTIVITY SUMMARY

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

OLD/NEW BUSINESS

None.

PUBLIC COMMENT

Cecilia Kirkman, SEIU Healthcare, provided comments to the Board regarding Medicaid expenditures for Level C residential treatment facilities and Medicaid's eligibility policy for Level C residential treatment and requested the Board consider this topic in their 2017 discussions.

RECESS

Dr. Rheuban asked for a motion to recess the meeting at 10:17 a.m. Dr. Kongstvedt made a motion to recess the meeting and Ms. Gwilt seconded. The vote was unanimous. **9-yes (Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Price, Rheuban, and Yeskoo); and 0-no.**

BMAS RETREAT

At 10:32 a.m., the Board resumed the meeting. Ms. Jones discussed the agenda for the retreat portion of the meeting and introduced the Director of the Office of Innovation and Strategy, Seon Rockwell.

OVERVIEW OF THE OFFICE OF INNOVATION AND STRATEGY (I&S)

Seon Rockwell, Director, provided an overview of the newly created Office of Innovation and Strategy (I&S) which was organized to provide collaborative thought leadership to catalyze and sustain continuous innovation of Virginia's Medicaid delivery system and to lead multiple facets of Medicaid health innovation to support DMAS' continued national presence as a recognized leader in the delivery of high quality, comprehensive health and support services. (See handout attached.)

OVERVIEW OF THE OFFICE OF DATA ANALYTICS (ODA)

In 2014, the General Assembly mandated the Department of Medical Assistance Services create a data analytics division. Mr. Bhaskar Mukherjee, ODA Director, explained the history of the development of the Office of Data Analytics from 2014 to the present, including its mission and strategy. The Office of Data Analytics provides a structured analytics environment that assures data integrity, data consistency, well documented research, and repeatability. The basic functions of the Division involve supporting infrastructure like the data warehouse and SAS analytics platform so that analyses can be presented in a format that is informative, accurate, and supportive of Agency decision making.

The ODA has implemented a fully functional data governance program in order to support the implementation of a data warehouse. The vision of this program is to guide the management of data as an Agency-wide asset, which is standardized, integrated, and used to enhance analyses and encourage data driven decision making. Currently, there is an active Request for Proposal to develop the data warehouse which is scheduled to be implemented in 2017. (See handout attached.)

LUNCH BREAK

After lunch break, the meeting resumed at 12:17 p.m. Ms. Jones introduced William H. Leighty, Retreat Facilitator.

ROLES OF THE BOARD

Mr. Leighty made opening comments and noted he was able to contact all but two Board members prior to the meeting to get their ideas about how they view their role as a BMAS member. From his conversations, he concluded there was a strong consensus that the Board members wanted to be helpful to the Department, had a desire to help others, and supported DMAS staff as a whole. Mr. Leighty explained his interpretation of the statutory authority of the role of the Board and there was discussion on the various ways Board members contribute and support staff in continuing to maintain Virginia's status as a national leader in the delivery of health care services to the citizens in the Commonwealth.

INFORMATION IDEAS FOR BMAS DASHBOARD

Mr. Leighty asked for suggestions and discussed what types of information BMAS members could be made available on a dashboard. At this time, the dashboard is being developed and will be included in discussions in 2017.

AGENDA TOPICS FOR 2017

The following topics were suggested for 2017 BMAS meetings:

POTENTIAL APRIL 2017 TOPICS

- Affordable Care Act (ACA) Update
- Director's Report
- Addiction and Recovery Treatment Services (ARTS)
- Dashboard Discussion
- Legislative Overview
- Mental Health Parity and Addiction Act of 2008
- Listening @ Town Hall
- Request For Proposals (RFP)

POTENTIAL JUNE 2017 TOPICS

- ACA Update
- Innovation
- Patient Centered Care (PCC) & Other Innovations
- Consumer Directed Services
- Appeals
- RFPs

POTENTIAL SEPTEMBER 2017 TOPICS

- ACA Update
- Small, Women and Minority Business (SWAM)
- Managed Care Plans
- Roll out Dashboard?

POTENTIAL DECEMBER 2017 TOPICS

- ACA Update
- Office of the Attorney General Fraud Program Update
- Medicaid's Relationship with the Department of Juvenile Justice
- Transition in State Government

ADJOURNMENT

Dr. Rheuban asked for a motion to adjourn the meeting at 2:39 p.m. Dr. Kongstvedt made a motion to recess the meeting and Ms. Gwilt seconded. The vote was unanimous. **8-yes (Coleman, Cook, Gwilt, Hollowell, Jankowski, Kongstvedt, Rheuban, and Yeskoo); and 0-no.**

2017 GA Session – DMAS Lead and Comment Bills

BILL	TITLE	ACTION
Action Required		
HB 2304 (Orrock)	JLARC Recommendations; including UAI training	<p>Managed Care: This bill directs DMAS to implement a number of recommendations included in the December 2017 JLARC report on Medicaid spending.</p> <p>Requires a number of contract changes including that DMAS is to impose additional data and information submission requirements on the MCOs, as well as to implement a number of spending and utilization control measures in conjunction with MCOs.</p> <p>LTSS: DMAS is to require all individuals who administer preadmission screenings for LTSS to receive training and be certified in the use of the Uniform Assessment Instrument.</p> <p>DMAS is also to develop a program for this training and certification, develop guidelines for a standardized preadmission screening process, and strengthen oversight of it to ensure that problems are identified and addressed promptly.</p>
HB 1944 (Peace)	DMAS/DBHDS regulations of licensed providers	Establishes requirements related to stakeholders notices and public comment opportunity when DMAS or DBHDS posts to the Town Hall, proposes a provider manual change, or proposes a change to licensure guidance documents.
HB 2183 (Yost)	Medicaid eligibility for incarcerated individuals	<p>Workgroup: DMAS is to convene a work group to identify and develop processes for streamlining the Medicaid and FAMIS application and enrollment processes for incarcerated individuals.</p> <p>Goal is for applicable services to be available to individuals immediately upon release. The workgroup is to report its findings and recommendations by November 30, 2017.</p>
HB 2417 (Landes)	Fraud prevention, prepayment analytics	DMAS is to establish a program that uses prepayment analytics to mitigate the risk of improper payments to FFS providers who commit fraud, abuse, or errors.
HB 2209 (O'Bannon)	ED Care Coordination	Establishes the Emergency Department Care Coordination Program in the Department of Health to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration between physicians, other health care providers, and other clinical and care management personnel for patients receiving services in hospital emergency departments.

2017 GA Session – DMAS Lead and Comment Bills

BILL	TITLE	ACTION
Opioids		
HB 1885 (Hugo) SB 1232 (Dunnavant)	Opioids; limit on amount prescribed, extends sunset provision.	Requires a prescriber registered with the Rx Monitoring Program (PMP) to request info about a patient prior to prescribing an opioid prescription of 7 days or more – unless it is following an invasive surgical procedure – then a PMP check is required for a prescription of 14 days or more.
HB 2163 (Pillion) SB 1178 (Chafin)	Prescription of buprenorphine without naloxone; limitation.	Prescriptions for products containing buprenorphine without naloxone are to be issued only (i) for patients who are pregnant, (ii) when converting a patient from methadone to buprenorphine containing naloxone for a period not to exceed seven days, or (iii) as permitted by regulations of the Board of Medicine or the Board of Nursing. Includes the Board of Veterinary Medicine.
SB 1484 (Hanger)	Prescription Monitoring Program.	Info in the possession of the PMP disclosed by the DHP Director about a specific recipient who is a Medicaid managed care beneficiary to a physician or pharmacist employed by the Medicaid MCO may be disclosed to the physician’s or pharmacist’s clinical designee who holds a multistate licensure and is employed by the Medicaid MCO.

2017 GA Session – DMAS Lead and Comment Bills

Watch		
HB 1426 (Garrett) SB 1221 (Barker) BH/Prog. Ops. - Watch/Participate?	Emergency custody or involuntary admission process; alternative transportation model	DBHDS and Criminal Justice Services are to develop (in conjunction with relevant stakeholders) a comprehensive model for using alternative transportation providers for individuals involved in the emergency custody or involuntary admission process (vs. transportation by law enforcement).
HB 1750 (O'Bannon) CMO - looks like no changes needed	Dispensing of naloxone; patient- specific order not required.	Pursuant to a standing order issued by the Commissioner of Health, a pharmacist may dispense naloxone for overdose reversal in the absence of a prescription.
HB 2156 (Rasoul) LTC – Admin/ IT Change?	Licensure of facilities operated by agencies of the Commonwealth.	Provides for licensure of child welfare agencies operated by state agencies.

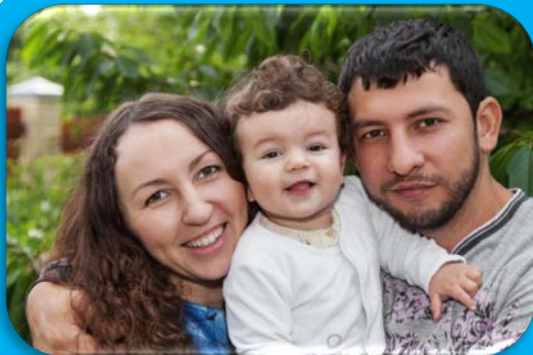


DIRECTOR'S UPDATE

BOARD OF MEDICAL ASSISTANCE SERVICES
MAY 9, 2017

Cindi B. Jones, Director
Department of Medical Assistance Services

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



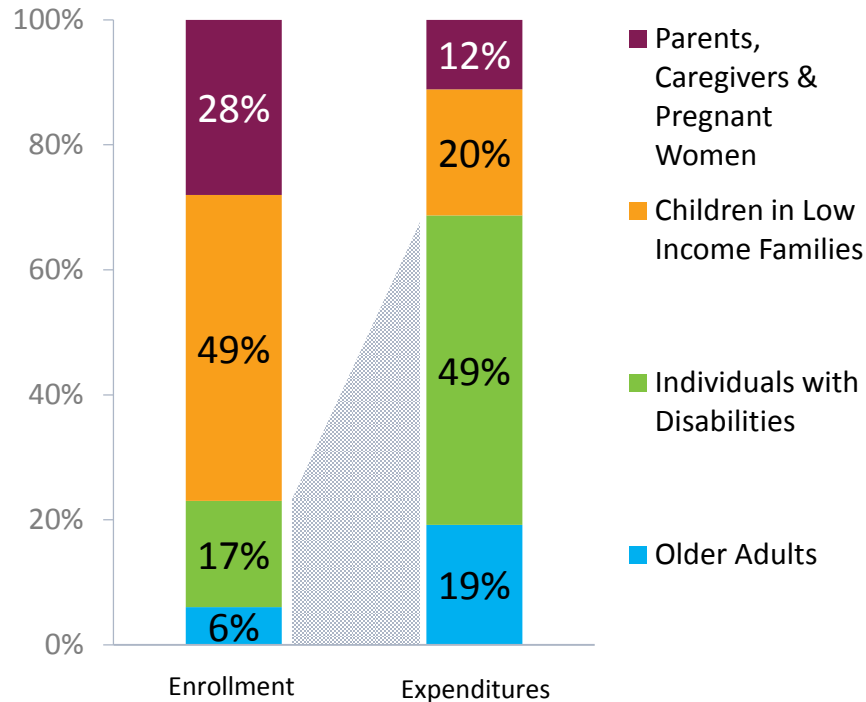
2 in 3 nursing facility residents are supported by Medicaid

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

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

Virginia Gained Under 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

The American Health Care Act

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



Shifts risk and costs to states



Decreases patient protections with increased out of pocket costs



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

Fails To Address Cost Drivers of Health Care



Continues to miss the 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 Impacts Virginia Medicaid

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

State Options

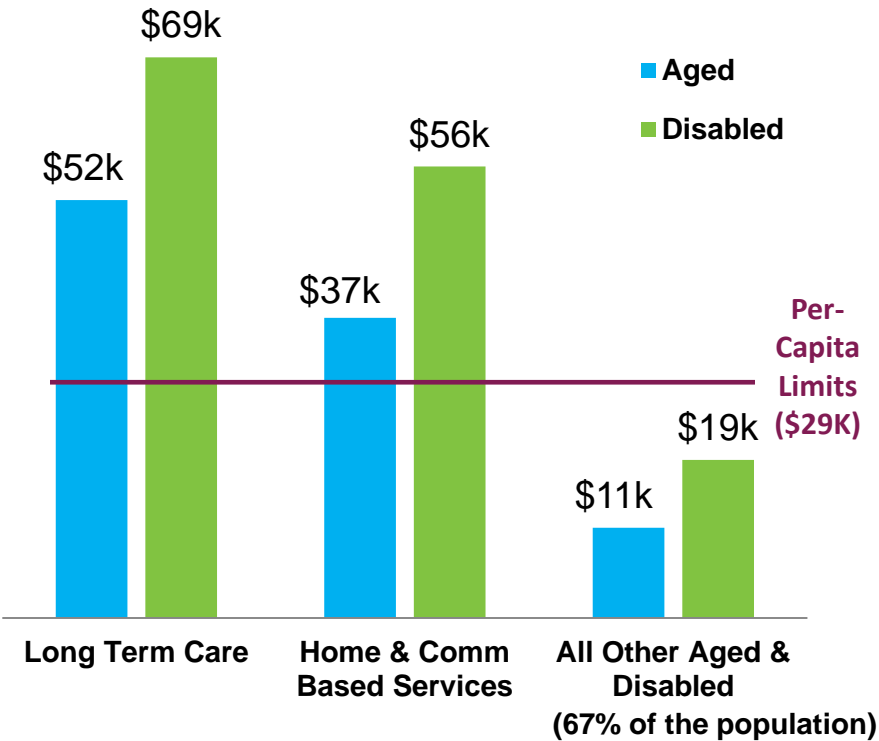
- States have option to institute a work requirement for able-bodied adults

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

Per-Capita Cap Models Result in Funding Shortfalls

Aged and Disabled Per Person Costs 212,000 Virginians



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

Per-Capita Cap Model Creates Funding Risks

Needs exceed per-capita limits

1st year projected loss = \$22M

7th year projected loss = \$191M

Projected loss over 7 years = \$689M

Population is aging rapidly

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

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

Fewer DD Waiver Slots

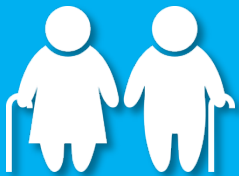
10,000+ people will wait longer for vital case management, employment supports and living services supports

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.

Per-Capita Caps are Bad for States

Per-capita cap allotments put disproportionate pressure on state budgets and force states to make difficult decisions



Unable to meet the needs of a growing population of older adults with increasing needs



Decreased funding over time makes it more difficult to pay for existing high-cost services or add new services



Pressure on state budgets will force difficult decisions



Timing of true-up makes it more complex to manage to annual budgets

Reconciling cap payment with actual spend is complicated and creates uncertainty for Virginia's lawmakers and the Medicaid Program

Per-Capita Cap Budget is Unpredictable



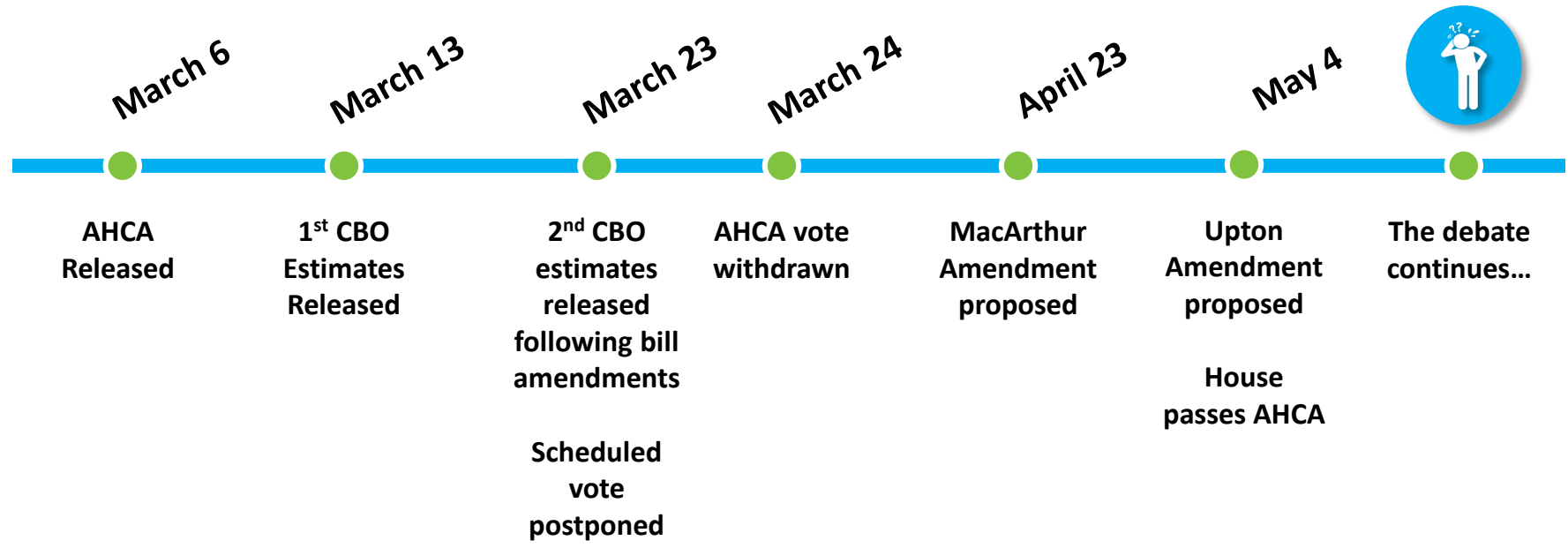
Budget Uncertainty

The method of determining payment to states based on CPI-M and CPI-M+1% requires states to spend before the budget is determined

Per-Capita Cap reconciliation limits budget predictability for states

Current State of the Debate

The AHCA reawakened a vigorous national debate

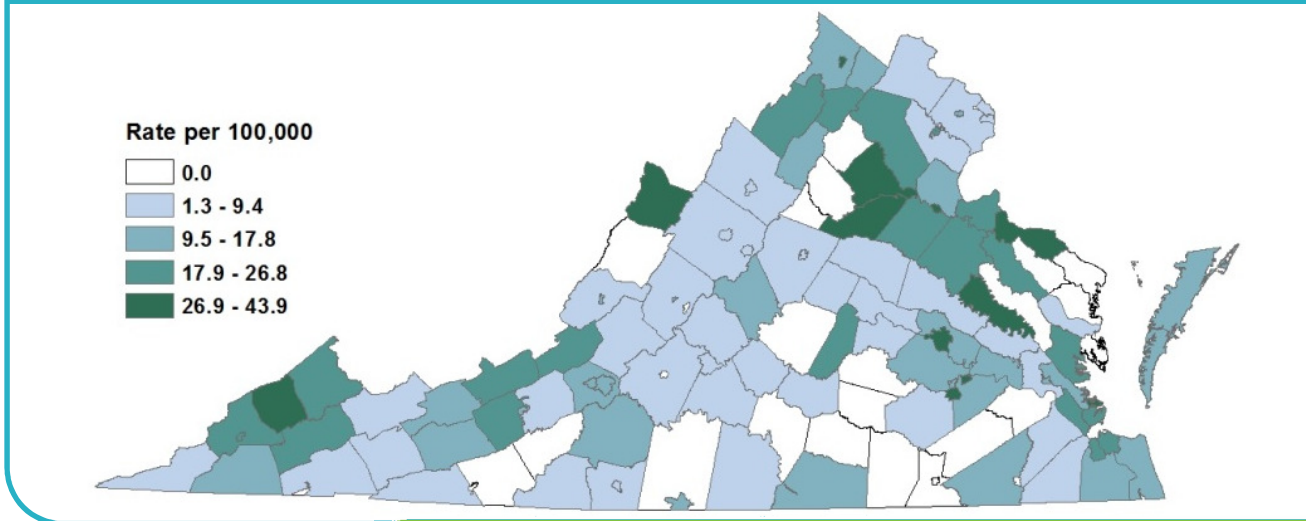




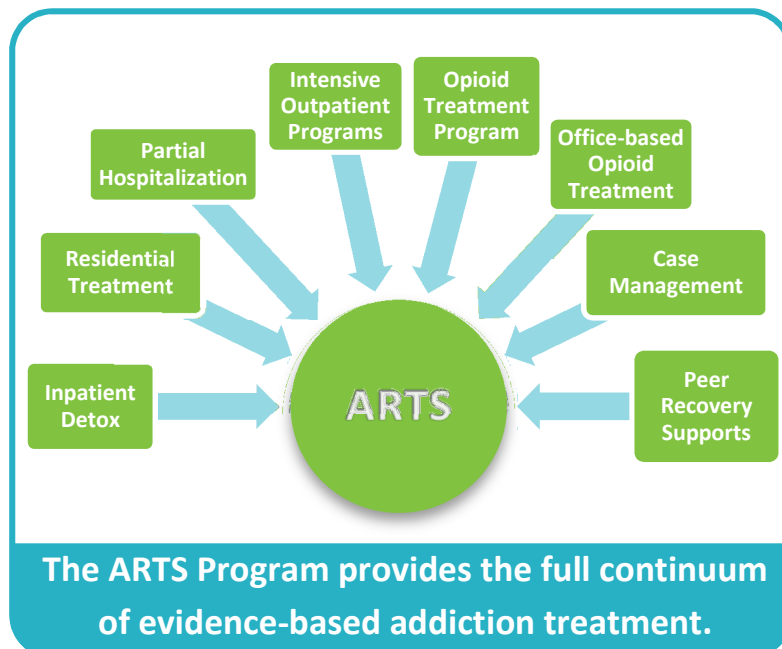
Addiction and Recovery Treatment Services (ARTS) Program Update May 2017

- An estimated 1,079 Virginians died from opioid overdoses in 2016.
- Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose.
- The Medicaid ARTS benefit was funded in the 2016 Appropriations Act with **bipartisan support** from the Governor and General Assembly to expand access to life-saving addiction treatment.

Rate of Fatal Opioid Overdose (Fentanyl, Heroin, and/or RX) per 100,000



Medicaid has decreased the number of opioid pills prescribed to Fee-for-Service members by 56% since July 2016.



- The ARTS benefit will provide the full continuum of evidence-based addiction treatment to any of the 1.1 million Medicaid and FAMIS members who need treatment.
- The ARTS program “carves in” the community-based addiction treatment services into Managed Care Organizations (MCOs) to promote full integration of physical health, traditional mental health, and addiction treatment services.
- The ARTS waiver approved by CMS allows DMAS to draw down new federal matching funds for residential treatment facilities with > 16 beds, significantly increasing treatment capacity.

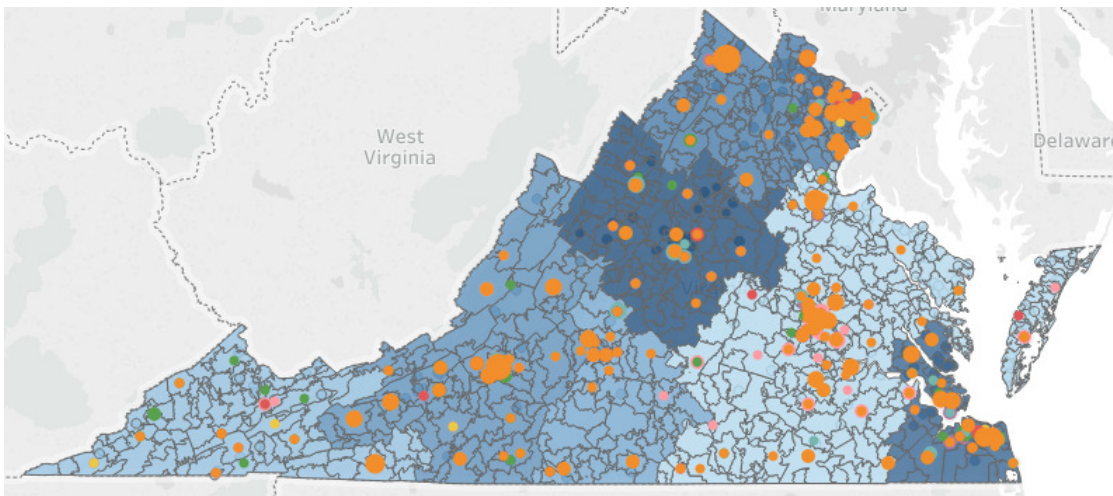
- Increased Medicaid rates under ARTS catalyzed a dramatic increase in addiction treatment providers.
- These providers will serve all Virginians with addiction, not just Medicaid members.

Preliminary Increases in Medicaid Addiction Provider Network

Addiction Provider Type	# of Providers <i>before</i> ARTS	# of Providers <i>after</i> ARTS	% Increase in Providers
Inpatient Detox	Unknown	86	NEW
Residential Treatment	4	71	↑ 1675%
Partial Hospitalization	0	14	NEW
Intensive Outpatient	49	70	↑ 43%
Opioid Treatment Program	6	22	↑ 267%
Office-Based Opioid Treatment (OBOT) Provider	0	31	NEW

The ARTS Program went live statewide on April 1, 2017.

Post-ARTS Medicaid Addiction Provider Network in the Commonwealth



For more information, please visit: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx

To ask questions or to let us know you would like to join a stakeholder distribution list, please email us at SUD@dmas.virginia.gov.



Regulatory Activity Summary May 9, 2017
(* Indicates recent activity)

2017 General Assembly

***(01) 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 amendment (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.

***(02) 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 will be published on 5/15, with the comment period ending on 6/14/17.

***(03) 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.

***(04) 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.

***(05) 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.

***(06) 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.

***(07) 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.

***(08) 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. The regs are currently being reviewed.

***(02) FAMIS Eligibility Changes:** This 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.

***(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. DMAS is awaiting a response.

***(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 been drafted, as of 12/2016.

***(05) 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 and 3/20, and is currently coordinating responses.

***(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.

***(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 OAG approved/certified the regs on 4/6 and they were submitted to DPB on 4/10. The corresponding SPA for this regulatory action was approved by CMS on 3/13/17.

***(09) No Coverage of Overtime Hours for CD Personal Assistance, Respite and Companion Services:** This final exempt 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 on hold, prior to coordinating the proposed stage review process.

***(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. CMS has requested additional information. DMAS is currently drafting and responding to multiple rounds of CMS inquiries.

***(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 has requested additional information. DMAS is currently drafting and responding to multiple rounds of CMS inquiries.

***(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. They became OAG-certified on 11/30 and were submitted to DPB on 12/1. DMAS is awaiting a response.

***(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 proposed stage regs were sent to the OAG and certified on 2/15/17 and forwarded to the DPB on 2/17. 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.

***(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, and is awaiting further response.

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 is currently coordinating responses to additional OAG questions.

***(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 is currently being reviewed by the Governor's Ofc., as of 3/1/17.

***(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 and was forwarded on to HHR on 2/23/17.

***(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.

***(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 is with the Governor, as of 2/20/17.

***(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.

***(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 and the regulations remain under review with the OAG.

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.

***(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 has moved to the final stage and is currently circulating through DMAS review.

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 1/11 thru 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. EIA posted 1/29, response posted 2/1. The regulations were sent to HHR on 1/29/2017 and forwarded to the Governor's Office on 2/12.

***(02) Changes to Institutions for Mental Disease (IMD) Reimbursement:** This Emergency/NOIRA is the result of the *2012 Acts of the Assembly*, Chapter 3, Item 307 CCC, which directed DMAS to develop a prospective payment methodology to reimburse institutions of mental disease (residential treatment centers and freestanding psychiatric hospitals) for services furnished by the facility and by others. The SPA was approved on 6/2/15. This Emergency regulation became effective 7/1/14. The permanent replacement regulation was certified by the OAG and sent to DBP on 5/17/2016 and then on to HHR on 7/8/16. The Gov. signed the regulatory action on 8/19; it will be published in the Register on 9/19/16; and the public comment period will extend through 11/19/16. The project transitioned to the Final Stage phase and the regulations; were submitted to submitted to DPB on 12/1/16; and submitted to HHR on 12/8/16. The regs were forwarded to the Governor on 12/9 and were approved on 1/13/2017.

***(03) 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.

***(04) Repeal Family Planning Waiver Regulations:** The Family Planning program is a benefit to qualified low income families by providing them with the means for obtaining medical family planning services to avoid unintended pregnancies and increase the spacing between births to help promote healthier mothers and infants. The purpose of this amended regulation is to implement the change of the program from a demonstration waiver to the state plan option to be in compliance with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2011. This action had been placed hold, but has since been re-activated and the proposed stage was submitted to the OAG on 9/14/2015. The action was certified by OAG on 12/11/2015; submitted to DPB; and subsequently sent to HHR on 1/28/2016. The regulatory action was sent to the Governor on 4/5/2016 and signed on 6/3. The regulatory action was published in the Register on 6/27, with a public comment period that extended through 8/26, with no comments received. The project transitioned to the Final Stage phase, and following internal DMAS review, the regulations were submitted to DPB on 10/27/2016; to HHR on 11/4/16; and forwarded to the Governor's Ofc. on 11/20/16. Governor approval was received on 12/30 and the regulations were published in the Register on 1/23/17, with a final adoption effective date of 2/22/17. The project has been closed out.

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.

***(02) Appeals Regulations Update:** This Emergency/NOIRA regulatory action complied with the legislative mandate (Item 307, III of the *2012 Acts of Assembly*) and addressed recent case law and administrative decisions. These actions have created the need to clarify existing appeals processes and codify emerging processes made urgent by court and administrative case decisions and the increasing volume of appeals generated by provider audits and other utilization review mandates. The SPA was approved by CMS 12/12/12. DMAS received an extension of the emergency regulation, and it was in effect from 1/1/14-12/30/15. The Governor signed the proposed stage regulation and a public comment period opened on 11/2/2015. The final stage regulation was drafted and sent to the OAG on 4/4/2016. DMAS responded to OAG inquiries on 4/20. The OAG approved this regulatory action on 4/28/2016 and it was submitted to DPB on 4/28/2016. The regulation was submitted to HHR on 6/2 and moved to the Governor's Office on 6/3. The regulations were published in Register on 7/11 and became effective on 8/10/2016.

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 is scheduled for 4/4/17 to further discuss the SPA.

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. SPA was again taken off the clock to coordinate revisions, which are currently 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.

May 9, 2017

The Honorable Terence R. McAuliffe
Governor
Commonwealth of Virginia
Post Office Box 1475
Richmond, Virginia 23218

Dear Governor McAuliffe:

On behalf of the Board of Medical Assistance Services, I am writing to reaffirm our position on Medicaid Expansion under the Affordable Care Act (ACA). The case for expanding Medicaid in the Commonwealth is reiterated below, yet one factor must be called out first and foremost: Medicaid Expansion is a moral imperative we cannot continue to ignore.

Expanding Medicaid in the Commonwealth under the ACA at this time would provide basic health care coverage for 400,000 of our fellow Virginians who have none. Failure to act puts Virginian men, women and children needlessly at risk, forsaking the most vulnerable among us. This moral imperative is amplified by the fact that expansion poses essentially little or no cost to the Commonwealth. Simply stated, Medicaid Expansion has become the pass/fail moral test of our time.

Providing 400,000 Virginians with health care coverage would dramatically improve not only the health of our state and our workforce, but also our economy. Since Virginia first declined to expand Medicaid, the Commonwealth has lost over \$10.4 billion and we continue to give up \$6.6 million in federal funding each day we do not expand Medicaid. In addition, the Commonwealth is completely shouldering the financial and resource burden of Virginia's mental health and opioid crises, when we could be accessing federal dollars to support these efforts and do a much better job of serving Virginians and saving lives. Additionally, providers have indicated they may be willing to cover the State's ten percent share of Medicaid Expansion cost. Such support could allow Virginia to expand Medicaid without additional financial burden to the Commonwealth.

Equally important, expanding Medicaid would not only provide financial stability to our hospitals, doctors, nurses, and other providers, but also bring 75,000 new jobs for Virginians.

The recent national health care reform debate revealed several important lessons for our Commonwealth. Chief, and perhaps most fiscally urgent among these lessons is the fact that non-expansion states, like Virginia, would be worse off than expansion states under block grants and/or per-capita cap allotment programs should either of those come to pass. Either arrangement would result in putting Virginia at a substantial financial disadvantage as a non-expansion state with a low Medicaid baseline compared to the baselines of expansion states.

The Kansas legislature recently voted to expand coverage, and other non-expansion states are also now re-examining Medicaid Expansion, including our neighbor, North Carolina. Our Commonwealth will find it substantially more difficult to compete when neighboring states are drawing down billions of dollars in federal funding, some of which is coming from Virginia taxpayers. This puts Virginia's economy, and the very health of the Commonwealth, at risk.

The Honorable Terence R. McAuliffe
May 9, 2017
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With so much to gain, we applaud your declaration that everything is still on the table for negotiation, in light of the recent debate and events at the federal level. The Centers for Medicare and Medicaid Services (CMS) is supporting more state flexibility than ever before, opening the door for Virginia's Joint Subcommittee to focus on program flexibility as needed. Medicaid Expansion deserves robust consideration and exploration, and we urge our General Assembly to join you in this critical conversation. Not only do we regain the fiscal benefit expansion brings, but we embrace the moral imperative to act.

Sincerely,

Karen S. Rheuban, M.D.
Chair, Board of Medical Assistance Services

Pc: All Members of Virginia's General Assembly