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

June 26, 2018
DRAFT Minutes

Present:
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
Karen S. Rheuban, M.D.
Chair
Kannan Srinivasan

Absent:
Cara L. Coleman, JD, MPH
McKinley L. Price, D.D.S.
Vilma T. Seymour

DMAS Staff:
Kate Neuhausen, MD, Chief Medical Officer
Tammy Whitlock, Deputy Director for Complex Care & Services
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:
Jennifer S. Lee, M.D., Director
Karen Kimsey, Chief Deputy Director
Cheryl Roberts, Deputy Director for Programs
Scott Crawford, Deputy Director for Finance
Brian McCormick, Acting Deputy Director for Administration
Mukundan Srinivasan, Information Management Division Director
Gregory Lewis, DMAS IM Staff
Joanna Fowler, DMAS Senior Policy Assistant

Guests:
Tyler Cox, MSV
Kenneth McCabe, DPB
Chris Whyte, VECTRE
Kassie Schloth, McGuire Woods Consulting
Chris Nolen, McGuire Woods Consulting
Steve Ford, VHCA
Don Parr, Deloitte
Karen Shablin, FEI Systems
Charles Smith, MSLC
Robert Bohannon, HAK
Julie Calloway, MSV
Brittany West, HAK
Cameron Webb, UVA
Katie O'Connor, Virginia Mercury
Ben Paul, VCU
D. Frenach Staushter, UVA

CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:00 a.m., and other members introduced themselves and introductions continued around the room. Dr. Rheuban noted Dr. Kongstvedt's reappointment to serve another term by Governor Northam. Dr. Rheuban stated how thrilled she was that Medicaid expansion passed and thanked the past and current leadership for their involvement in helping to advance this.

APPROVAL OF MINUTES FROM April 10, 2018 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the April 10, 2018 meeting. Dr. Kongstvedt made a motion to accept the minutes and Mr. Cook seconded. The vote was 7-**yes (M. Cook, P. Cook, Gwilt, Hollowell, Kongstvedt, Rheuban, and Srinivasan); and 0-no.**

Dr. Rheuban noted the entrance of Board Member Alexis Edwards.

DIRECTOR'S REPORT—Medicaid Expansion

As DMAS Director Dr. Lee was participating in another speaking engagement, Chief Deputy Karen Kimsey provided the Medicaid Expansion update and announced the appointment of Tammy Whitlock as the Deputy Director for Complex Care Services.

Ms. Kimsey reported that beginning January 1, 2019, approximately 400,000 more Virginia adults will have access to quality, low-cost health care coverage. The rules have changed. Virginians who may have applied for Medicaid in the past and have been denied may be eligible now. Ms. Kimsey discussed who qualifies for Medicaid and who will under Medicaid expansion, what services will be covered, and the current delivery models—Commonwealth Coordinated Care Plus, Medallion 4.0 and Fee-for-Service. Further, she shared information and findings obtained via the Robert Wood Johnson Foundation and GMMB on who are the Virginia uninsured adults. Ms. Kimsey provided details on the process of applying for a Section 1115 Demonstration Waiver while submitting the State Plan Amendments to CMS as Virginia moves toward implementing new health coverage for Virginia adults. (see attached handout).

BUDGET UPDATE

Scott Crawford, Deputy Director for Finance, provided highlights of the substitute budget adopted by the House of Delegates and Senate on May 30 and signed by the Governor on June 7. The adopted budget includes Medicaid Expansion, as well as two new provider assessments on most private acute care hospitals. (see attached handout).

Dr. Rheuban recognized the arrival of Dr. Lee.

MEDALLION 4.0 UPDATE

Cheryl Roberts, Deputy Director for Programs and Operations, explained the upcoming transition to the Medallion 4.0 program. Medallion 4.0 is scheduled to be regionally implemented beginning August 2018 and will focus on member-centric care for pregnant women, infants, children, parents/caregivers, and expansion adults. Medallion 4.0 will serve as the platform, along with CCC Plus, for access to health care for Medicaid expansion adults. (see attached handout).

BMAS PORTAL

Mukundan Srinivasan, Director of Information Management, explained a new Board application software (NASDAQ Boardvantage) members will be able to access at future meetings followed by viewing a demonstration video under consideration for procurement. Once software is purchased, training will be set up for Board members. Dr. Rheuban expressed appreciation for introducing this new application software.

WEBSITE DEMO

Craig Markva, Division Director for the Office of Communications, Legislation and Administration, gave an overview of the new DMAS website scheduled to launch officially on July 2 and provided a demonstration. Board Member Kongstvedt suggested limited use of acronyms on the new website.

DMAS AGENCY SCORECARD

To determine how effective DMAS is as an agency in providing superior health care to the Medicaid members of the Commonwealth of Virginia, and to understand some areas where DMAS can be more efficient, Joanna Fowler, DMAS Senior Policy Assistant, and Board Member Kannan Srivivasan explained a performance measurement project Dr. Lee initiated across all DMAS divisions. All division heads were asked to present on how they measure success as a division. Then, divisions were asked to select three metrics from their division-level reports that are important to the Agency's success to be included on the weekly Round Robin Report. This report is reviewed at weekly Management Team meetings to celebrate successes, problem solve and work through key dependencies. Once this Round Robin Report is finalized with metrics from all divisions (anticipated mid-July), it will be utilized to develop an Agency Scorecard. Ivory Banks, Director of Program Operations, is also on the team supporting this work along with Ms. Fowler and Mr. Srivivasan. (see attached handout).

MEMBER ADVISORY COUNCIL

Brian McCormick, Acting Deputy Director for Administration, provided highlights of a proposal to organize a Medicaid Member Advisory Committee (MAC) to enhance our member engagement at the systems and policymaking level. The MAC would be entirely comprised of Medicaid enrollees who would offer DMAS insight into their experience with Medicaid. Board members were supportive of the proposal and offered suggestions to ensure the council is reflective of the diverse Medicaid population by including representation from: the LGBT community, caregivers, individuals with experience accessing substance use services, and those for whom English is not their first language. Board Member Ms. Gwilt volunteered to support this effort. (see attached handout).

SOCIAL DETERMINANTS OF HEALTH

Brian McCormick, Acting Deputy Director for Administration, provided a report on the Social Determinants of Health (SDOH). His presentation included a discussion of the six key domains of SDOH - Economic Stability, Physical Environment, Education, Food, Community Context and Health Care. The report highlighted the fact that the impact of clinical care on an individual's total health is only about 20%, and that in order to more fully address the total health care needs of Virginians more data sharing and coordination in both the public and private sectors is needed. (see attached handout).

REGULATORY ACTIVITY SUMMARY

Board Member Maureen Hollowell suggested a discussion of the regulations at a future meeting. The Regulatory Activity Summary is included in the Members' books to review at their convenience (see attached).

OLD/NEW BUSINESS

Mr. Cook asked for information regarding the invitation to participate in the volunteer efforts for the Remote Area Medical (RAM) Clinic being held in Wise on July 20-22, 2018. The RAM event creates access to medical examinations, dental care and vision correction for uninsured people, drawing national attention to healthcare issues in southwest Virginia.

Dr. Lee introduced and welcomed Ellen Montz, Ph.D., Chief Health Economist. Dr. Montz will be directing the Health Economics and Economic Policy Division and the Office of Data Analytics.

ADJOURNMENT

Ms. Hollowell made a motion to adjourn the meeting at 12:14 p.m. Dr. Cook seconded. The vote was 8-**yes (M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Rheuban, and Srinivasan); and 0-no.**

New Health Coverage for Virginia Adults

Board of Medical Assistance Services (BMAS)
June 26, 2018

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Jennifer Lee, MD
Director,
Department of Medical Assistance Services

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Agenda

- Medicaid Expansion
- DMAS Mission and Values
- Agency Scorecard

Overview of New Health Coverage for Adults

- Beginning January 1, 2019
- Approximately 400,000 more Virginia adults will enroll in quality, low-cost health coverage
- People working in retail, construction, childcare, landscaping, food service or other jobs that do not offer health insurance may be eligible for this low-cost health insurance in Virginia
- The rules have changed. Virginians who may have applied for Medicaid in the past and have been denied may be eligible now.

Who Qualifies for Virginia Medicaid?

Not all low-income Virginians are eligible

Children 0-18
(family of 3)

205% FPL ($42,599)

Pregnant Women
(family of 3)

205% FPL ($42,599)

Person With
Disability

80% FPL ($9,712)

Parents
(Family of 3)

33% FPL ($6,924)

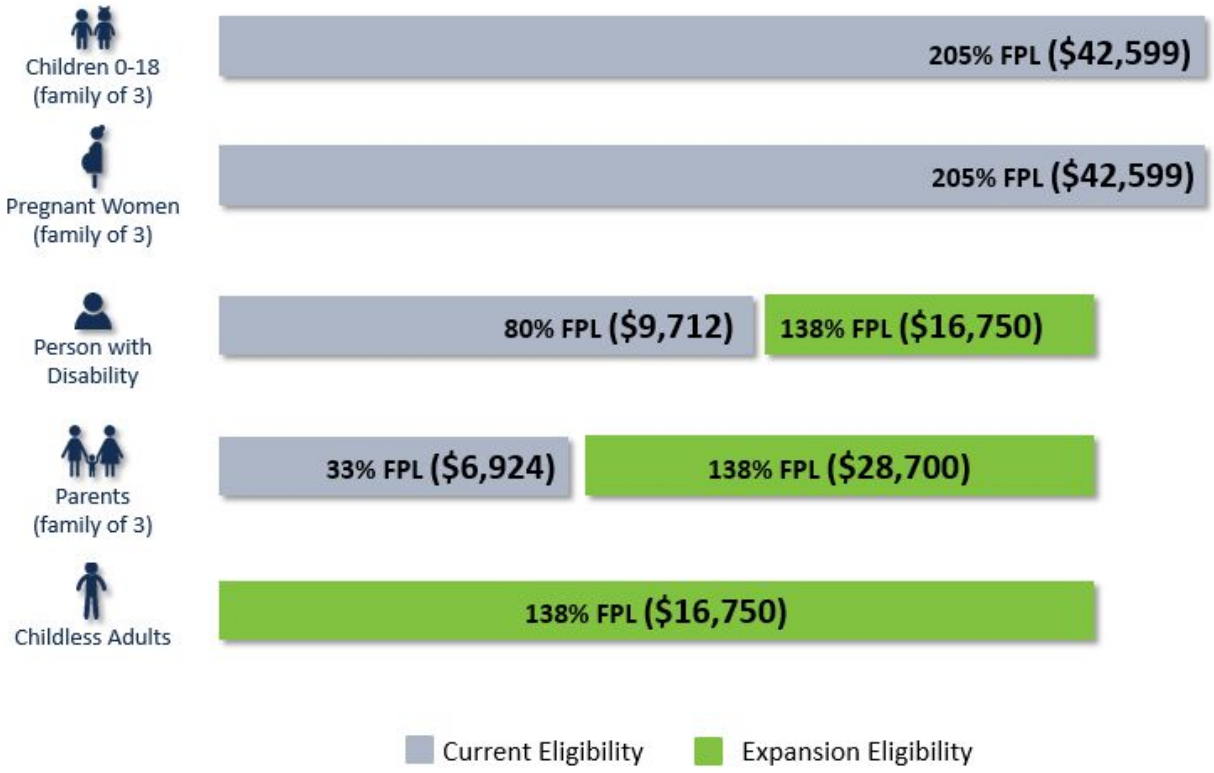
Childless Adults

Not Eligible

Who Qualifies for Virginia Medicaid Under Expansion?

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

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



*Percent income may vary by locality

What Services are Covered?

New enrollees will receive all State Plan services and additional federally required preventive services

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

New Adult Coverage Uses Current Delivery Models

Coverage will be provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

Expansion Delivery Systems

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

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

Fee for Service will serve populations excluded from managed care, including:

- incarcerated adults,
- adults identified as presumptively eligible, and
- newly eligible individuals until they are enrolled in an MCO

6 Health Plans Contracted Statewide

Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0

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

Over 90% of Medicaid enrollees will be in two managed care programs

Who Are Virginia's Uninsured?

A recent focus group with uninsured adults in Virginia who have incomes below 138% FPL offered key findings:

- Cost has been the main barrier to coverage as well as working in jobs or for employers that do not offer coverage
- Most have been putting off getting health care services, paying out of pocket at a clinic when sick, or going to ERs when they become seriously ill
- The new adult population has a strong interest in enrolling in Medicaid and almost all say they will apply
- Most are unaware that Virginia will expand Medicaid
- Many fear "rejection" if they apply, as they have been unsuccessful in the past

Expansion Population in the Workforce

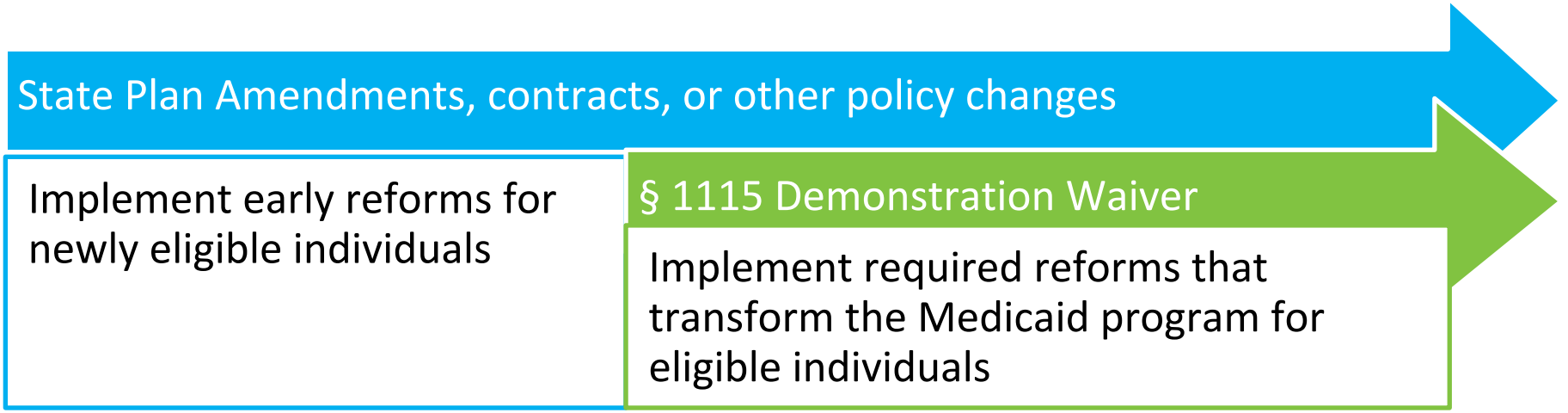
Industries with Largest Number of Workers Covered by Medicaid, 2016

Industry	Number of Adult Workers with Medicaid
Restaurant and food services	1,486,000
Construction	974,000
Elementary and secondary schools	461,000
Grocery stores	396,000
Hospitals	354,000
Department stores and discount stores	328,000
Home health care services	311,000
Services to buildings and dwellings	294,000
Nursing care facilities	275,000
Child day care services	274,000
Total for Listed Industries (38% of adult Medicaid enrollees who are workers)	5,153,000

Note: Includes nonelderly adults who do no receive Supplemental Security Income (SSI)
Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey

Medicaid Expansion

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



DMAS is working in parallel to begin the process of applying for a § 1115 waiver while submitting the State Plan Amendments to CMS

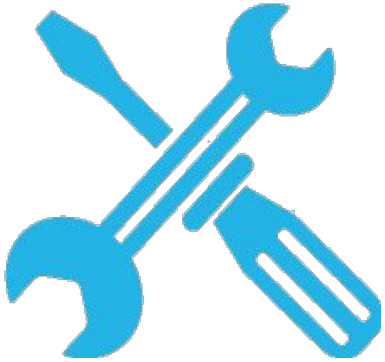
Early Medicaid Reforms

Empower individuals to improve their health and well-being and gain employer-sponsored or other commercial coverage, while ensuring fiscal sustainability

Health and Wellness Accounts

- Health and Wellness Accounts
- Healthy Behavior Incentives

Work Referrals



- Referrals to job training, education, and job placement assistance for all unemployed, able-bodied adults

Appropriate Utilization of Services

- Appropriate Utilization of ED Services
- Enhanced Fraud Prevention Efforts

Future Medicaid Reforms (Under § 1115 Waiver)

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

Healthy Behavior Incentives

- Cost-sharing to promote healthy behaviors (e.g. avoidance of tobacco use)
- Cost-sharing reductions for compliance with healthy behaviors

Personal Responsibility

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

Future Medicaid Reforms (Under § 1115 Waiver)

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

Gradually Increasing Participation

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

Community Engagement Activities

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

Certain Populations Are Exempt

- Medically Complex
- Children < Age 18
- Individuals > Age 55
- Primary Caregivers with a Dependent Child < Age 18
- Others

Next Steps – Implementation

- Program Authorities – Several SPAs, 1115 Waiver
- Systems Changes
- Streamlined Enrollment Strategies
- Contract Modifications and Rates
- Communications and Outreach
- Education and Training
- Testing and Readiness
- **Go-Live on January 1, 2019**

Key Accomplishments To Date
Project Management and Program Authorities

DMAS is working hard to ensure the successful implementation of Virginia's new health coverage for adults

- ✓ Implemented a Governance and Project Team structure, including Executive leadership, Project Leads and Coordinators, and Subject Matter Expert Team Members; includes daily and weekly reporting streams and a forum to elevate issues identified by teams for rapid-fire problem solving and resolution.
- ✓ Developed comprehensive project plan that identifies key requirements, deliverables and milestones
- ✓ SharePoint work site functions as the hub for housing project deliverables and educational materials (slide-decks, FAQs, one-pagers); keeps staff informed and tracks key decisions and action items
- ✓ Prepared three critical State Plan Amendments (SPAs), including Adult Expansion Eligibility, Federal Medical Assistance Percentage (FMAP) and Health Insurance Premium Payment (HIPP);
- ✓ Developed the Alternative Benefit Plan (ABP) SPA; posted for public comment on 6/7; hosted a public forum on 6/15; comment period ended 6/21.
- ✓ Developed 3 additional SPAS for fast track populations (related to SNAP and hospital presumptive eligibility)
- ✓ Working to develop the 1115 Demonstration Waiver (Track 2 work requirements)

Key Accomplishments To Date – Success Through Collaboration

Systems and Operational Requirements

DMAS is working hard to ensure the successful implementation of Virginia's new health coverage for adults

- ✓ Developed requirements for the DMAS Medicaid system (VAMMIS)
- ✓ Developed service delivery pathway for medically complex populations, including a health screening and mechanisms for data capture and reporting for these complex populations
- ✓ Participate in collaborative and strategic work sessions with VDSS to address key components of eligibility and enrollment, including VaCMS systems changes. Developed strategy and work-flow for enrolling eligible populations through a "fast-track" efficient process.
- ✓ Developed strategic communications plan for engaging newly eligible populations & key stakeholders.
- ✓ Working collaboratively with VDSS and the Office of the Chief Workforce Adviser to discuss the 1115 waiver including Training, Education, and Employment (TEEOP) features per the 2018 Budget
- ✓ Worked to create public-facing dashboards for reporting on enrollment and service utilization of expansion populations.
- ✓ Ongoing discussions with CMS, consulting groups, national organizations and other states for lessons learned and best practices.
- ✓ DMAS began discussions with CSB/DBHDS and DOC leadership to coordinate Medicaid expansion enrollment for eligible individuals served by these agencies

Mock Dashboard

New Health Coverage for Adults
MOCK DASHBOARD
Created by VCU Department of Health Behavior and Policy

November 2019 and Beyond (Biweekly)

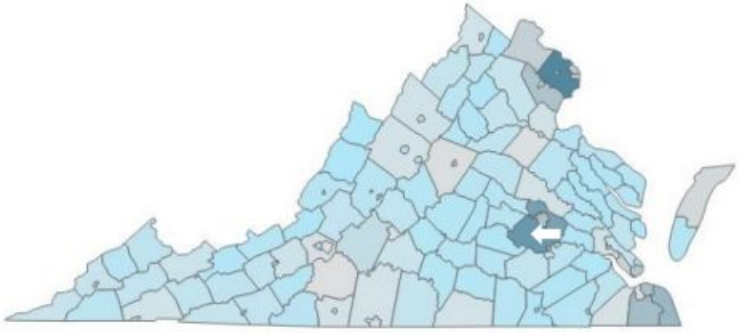
Health insurance		Details
313,000	Adults enrolled in new health coverage	
Primary and preventive care		Details
87,861	Adults who visited a primary care provider or received preventive health care services	
Diabetes		Details
8,770	Adults treated for diabetes	
High blood pressure		Details
17,769	Adults treated for hypertension	
Women's preventive care: mammograms		Details
24,025	Women who have received a mammogram or other diagnostic breast imaging	
Preventive care: colon cancer screening		Details
14,015	Adults received colon cancer screening	
Mental health		Details
25,424	Adults receiving mental health services	
Addiction and recovery treatment services		Details
6,123	Adults receiving addiction and recovery treatment services	

New adult Medicaid enrollment by county

As of November 30, 2019

Total number of adults enrolled in new Medicaid health coverage

150 — 18,000



County name:	Chesterfield
Number of adults enrolled in new health coverage:	15,088
Number of members who had a visit to a primary care provider or received preventive health care services:	6,276
Number of women who have received a mammorgram or diagnostic breast imaging:	1,201
Number of adults who received colon cancer screening:	701
Number of adults treated for diabetes:	487
Number of adults treated for high blood pressures:	987
Number of adults receiving mental health services:	1,487
Number of adults receiving addiction and recovery treatment services:	265

Mock Dashboard

New Health Coverage for Adults

MOCK DASHBOARD

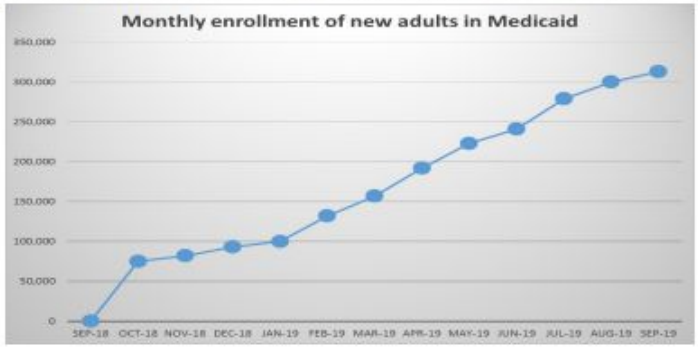
Created by VCU Department of Health Behavior and Policy

November 2019 and Beyond (Biweekly)

Health insurance Details

313,000	Adults enrolled in new health coverage
63,000	Enrollees have incomes below 50% of the federal poverty level*
140,000	Enrollees have incomes between 50% and 100% of the federal poverty level*
110,000	Enrollees have incomes between 100% and 138% of the federal poverty level*

*The federal poverty level is $12,140 annually for a single person, or $20,780 annually for a family of 3 people.



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Diabetes Details

New adult Medicaid enrollment by county

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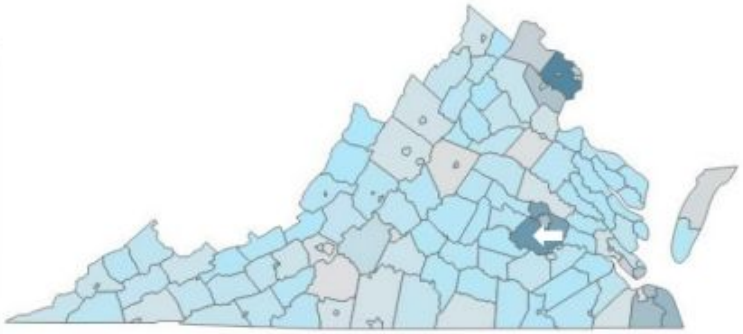

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Regular Updates About Adult Coverage

Please visit www.coverva.org regularly for updates. More information will be coming soon on the timing and process for enrollment. Outreach materials will be posted on the website so that our partners can share them in their communities.

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Partner With Us

You can help spread the word about new health choices for adults

- Visit the Cover VA Website at www.coverva.org for information and updates
  - Share the Cover VA widgets and link to the Cover VA Website on your website and social media pages
- Assist with intensive marketing and outreach to educate and inform newly eligible individuals, providers, and stakeholder groups
- Support enrollment efforts and access to services

JOURNEY TO REFRESH THE DMAS MISSION AND VALUES

Management Team Retreats

- ✓ May 14th – Defining Our Values
- ✓ June 13th – Mission and Goals Discussion
- ❑ July 18th (Planned)

Updating the DMAS Mission

Draft Mission Statement

Defining DMAS Values

Collaboration

Service

Trust

Adaptability

Problem-Solving

AGENCY SCORECARD





OVERVIEW OF 2018 GENERAL ASSEMBLY BUDGET ACTIONS

Presentation to:
Board of Medical Assistance Services

Scott Crawford
Deputy Director, Finance

June 26, 2018

Summary of 2018 Regular Session

Governor's Introduced Budget included Medicaid Expansion and a provider assessment on hospitals – resulted in $421.6M in GF savings and new revenue over the 2019/2020 Biennium

House Budget retained Medicaid Expansion and the provider assessment, coupled with work requirements and some other reforms

Senate Budget eliminated Medicaid Expansion and the provider assessment – resulting in a need for a $421.6M GF reduction throughout the budget

General Assembly did not come to a budget agreement during regular session

Summary of 2018 Special Session

Governor's Introduced Budget included Medicaid Expansion and a provider assessment on hospitals – resulted in $421.6M in GF savings and new revenue over the 2019/2020 Biennium

House Budget retained Medicaid Expansion and the provider assessment, coupled with work requirements and some other reforms

Senator Hanger and Delegate Jones agreed to a substitute budget that included Medicaid Expansion, two provider assessments, work requirements and some other reforms

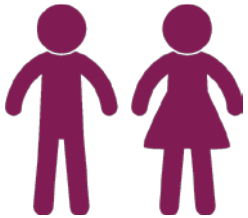
Both chambers adopted the substitute budget on May 30 and the Governor signed on June 7

Comparison of Governor's Introduced vs. Adopted Budget

Major Budget Items	GIB	Adopted
Medicaid Expansion	✓ (10/1/18)	✓ (1/1/19)
Work Requirements		✓
Other Reforms (cost sharing, premium assistance)		✓
Coverage Assessment on Hospitals	✓	✓
Payment Rate Assessment on Hospitals		✓
Fully funds forecasted growth	✓	✓
Hospital Inflation	Full	Full
Overtime for Consumer Directed (CD) Attendants	✓	
CSB Same Day Access (STEP VA)	✓	✓
New Waiver Slots	✓	✓
Rate Increase for Personal Care Attendants	✓ (CD Only)	✓ (CD & Agency)
Study merging CoverVA Call Center with DSS Call Center		✓
Funds Federally Required Evaluations	✓	✓
Increased legislative oversight of Medicaid forecast process		✓

Two Hospital Assessments

Coverage Assessment



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

Payment Rate Assessment

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

Two assessments have many of the same features

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

BOARD OF MEDICAL ASSISTANCE SERVICES

MEDALLION 4.0 UPDATES
JUNE 26, 2018

Cheryl J. Roberts, J.D.
Deputy Director of Programs & Operations

MEDALLION 4.0

Will cover approximately 740,000 Medicaid and FAMIS members regionally beginning August 1, 2018


GROWING STRONGER...
TOGETHER

MEDALLION 4.0 RFP PROCESS

- RFP released July 2017
- Evaluation team included DMAS and VDH staff and 22 subject matter expert consultants
- 10 MCO proposals received September 2017
- Technical score drivers, oral presentations, networks, acceptance of contracts and rates

Technical Score Drivers

Population and Services (Section 4)

- ✓ Minimum of three (3) years' experience
- ✓ Data, outcomes, and trends for past three (3) years
- ✓ Efforts to control utilization trends over the past three (3) years
- ✓ Proposed innovations to improve the care, health and well-being of the population by region

Provider Networks (Section 3.9)

- ✓ Network adequacy
- ✓ Provider recruitment
- ✓ On-going provider support
- ✓ Provider training

ODA Provider Scorecard represents the percentage of MEDALLION 4.0 members with access the provider type in that region

Scorecard total for critical providers provided benchmark score – points added or subtracted for other components of Section 3.9

PROPOSAL EVALUATION CRITERIA	SUB WEIGHT	WEIGHT
2. Technical Requirements		
The following requirements as demonstrated in the written proposal of the Offeror's experience and strategies or innovations as a Medicaid contracted health plan to:		
a) Provide services to the populations specified in the RFP, particularly experience with women, pregnant women, infants, children, and children/youth with special health care needs.	20%	
b) Improve the efficiency and effectiveness of strategies, policies and procedures in order to positively impact the populations specified in the RFP, including integration of primary, acute, and behavioral health, and needs of the Medicaid/FAMIS population.	10%	
c) Develop strategic innovation priorities that address value-based payment designs, delivery system innovations, or payment innovations.	5%	
d) Develop programs that recognize the importance of social determinants of health.	5%	
e) Fulfill the State's requirements for information management and data interfaces and any prior experience/qualifications in meeting similar data interface requirements.	10%	
f) Be good corporate citizens, investments in each region/community, and processes for regional community engagement/social responsibility activities.	5%	70%
g) Outreach to and promote the delivery of services in a culturally competent manner, including interpretive services, to support all members including those with limited English proficiency and diverse cultural and ethnic backgrounds.	5%	
h) Develop regional provider network management systems to ensure network adequacy standards, access standards, and an ethnically diverse provider network that provides the highest quality care to members.	20%	
i) Develop an overall strategy for quality improvement with regional variation for program improvement purposes and to assess the program's overall impact on various outcomes.	10%	
j) Develop regional, coordinated patient care systems and supports for all members	5%	
k) Develop operational infrastructure to effectively and efficiently manage all aspects of the program.	5%	

BEST PRACTICE - ELECTRONIC SCORE SHEET

Offeror Name:			Evaluator:				
	Proposal Evaluation Criteria	Criteria SubWeights	Criteria Weights	Evaluators Score	Criteria SubScore (Criteria SubWeight x Evaluators Score)	Criteria Score (Total Criteria Subscore x Criteria Weight)	Section Reference
1. Qualifications							
a.	Corporate qualifications and experience to serve as a Contractor for the MEDALLION 4.0 Medicaid/FAMIS Managed Care Program, including experience as a Medicaid contracted health plan.	50.0%	**20%**	50	25.00		3.1, 3.2, 8.3
b.	Demonstration in the written proposal of the Offeror's experience and capacity to provide all administrative requirements as they apply to the operation of a health plan for the Medicaid populations specified in the RFP, including but not limited to staffing, provider network and relations management, quality, compliance, etc.	50.0%		50	25.00		3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 3.10, 3.12, 3.13, 3.14, 3.15
	SubTotal	**100.0%**		**Total**	50.00	**10.00**	
2.Technical Requirements							
a.	Provide services to the populations specified in the RFP, particularly experience with women, pregnant women, infants, children, and children/youth with special health care needs.	20.0%	**70%**	50	10.00		4.1, 4.2, 4.4, 4.5
b.	Improve the efficiency and effectiveness of strategies, policies and procedures in order to positively impact the populations specified in the RFP, including integration of primary, acute, and behavioral health, and needs of the Medicaid/FAMIS population.	10.0%		50	5.00		4.2
c.	Develop strategic innovation priorities that address value-based payment designs, delivery system innovations, or payment innovations	5.0%		50	2.50		5.1, 5.2, 5.4, 5.5
d.	Develop programs that recognize the importance of social determinants of health.	5.0%		50	2.50		5.3
e.	Fulfill the State's requirements for information management and data interfaces and any prior experience/qualifications in meeting similar data interface requirements.	10.0%		50	5.00		3.12, 7.1, 7.2, 7.5
f.	Be good corporate citizens, investments in each region/community, and processes for regional community engagement/social responsibility activities.	5.0%		50	2.50		3.2.5, 3.8
g.	Outreach to and promote the delivery of services in a culturally competent manner, including interpretive services, to support all members including those with limited English proficiency and diverse cultural and ethnic backgrounds.	5.0%		50	2.50		3.7
h.	Develop regional provider network management systems to ensure network adequacy standards, access standards, and an ethnically diverse provider network that provides the highest quality care to members.	20.0%		50	10.00		3.9
i.	Develop an overall strategy for quality improvement with regional variation for program improvement purposes and to assess the program's overall impact on various outcomes.	10.0%		50	5.00		3.10
j.	Develop regional, coordinated patient care systems and supports for all members	5.0%		50	2.50		4.3
k.	Develop operational infrastructure to effectively and efficiently manage all aspects of the program.	5.0%		50	2.50		10.5
	SubTotal	**100.0%**		**Total**	50	**35.00**	
3. References							
a.	References that demonstrate the Offeror's Medicaid experience with the following: value-driven care, care transitions, value-based payments design and implementation, integration of behavioral health and acute care, and social determinants of health, and needs of the Medicaid population. DMAS will not accept DMAS employees as references.	75.0%	**10%**	100	75.00		8.1, 8.2.1
b.	References from stakeholders	25.0%		100	25.00		8.2.2
	SubTotal	**100.0%**		**Total**	100.00	**10.00**	
			100%			**55**	

MEDALLION 4.0 RFP PROCESS

- And the winners are . . .

MEDALLION 4.0 HEALTH PLANS

Aligned With CCC Plus

aetna®

Aetna Better Health® of Virginia

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

Magellan COMPLETE CARE®

OptimaHealth Family Care

UnitedHealthcare® Community Plan

VirginiaPremier™
Powered by VCU Health

MEDALLION 4.0 PROGRAM DESIGN

1. Serve as the platform, along with CCC Plus, for access to health care for Medicaid expansion adults
2. Best of Medallion 3, new initiatives, and alignment with CCC Plus
3. Focus on member-centric care for pregnant women, infants, children, parents/caregivers, and expansion adults
4. Takes a holistic and integrated approach to delivering care
5. Members have a choice of six plans in each of the six regions

MANAGED CARE ALIGNMENT

Medallion 4.0 and CCC Plus Managed Care Programs Are Now Able to Align In Many Ways

- ✓ Six Managed Care Organizations with statewide service
- ✓ Services – Early Intervention, Community Mental Health
- ✓ Internal collaboration
- ✓ Provider and member engagement
- ✓ Strong compliance, program integrity, and reporting
- ✓ Streamlined processes and shared services {Common Core Formulary, ARTS, ED Care Coordination, Telehealth}

MEDALLION 4.0 AND EXPANSION MEMBERS

The first and foremost goal and expectation of Medallion 4.0 and the expansion is to improve the quality of life and health outcomes for enrolled individuals

IT'S ALL ABOUT THE MEMBER

- ***MEMBER CHOICE***
- ***MEMBER FOCUS***
- ***MEMBER ENGAGEMENT***

Members choose health plan by contacting Maximus at 1-800-643-2273

my choice
CHOOSE WHAT'S RIGHT FOR YOU.

MATERNITY

- Early Prenatal Care
- Case Management
- Post-Partum Care
- Support for Full-term Deliveries
- Breast Feeding Care
- Family Planning
- Outreach and Education
- Oral Health

INFANTS (0 – 3)

- Immunizations
- Well Visits
- Early Assessments
- Safe Sleep Education
- Support for Neonatal Abstinence Syndrome
- Preventing Infant Death (Three Branch Workgroup)
- Early Intervention
- Oral Health

CHILDREN & ADOLESCENTS (3 – 18)

- Oral Health
- Vision
- Well Visits
- Early and Periodic Screening, Diagnosis and Treatment
- Support for Special Needs
- Foster Care Services
- Focus on Trauma Informed Care
- Community Mental Health Services
- Adolescent Focused Care

ADULTS

- Wellness
- Chronic Disease Support
- Family Planning/LARC
- Addiction Recovery Treatment Services
- Behavioral Health and Community Mental Health Rehabilitative Services


time for expansion

EXPANSION ADULTS

- Provides coverage for up to 400,000 more adults
- Adults ages 19 – 64
- Not already in or eligible for Medicare
- Income from 0% to 138% Federal Poverty Level

MEDICAID EXPANSION DELIVERY MODELS

Coverage will be provided for most individuals through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

Expansion Populations

1. Caretaker Adults
2. Childless Adults
3. GAP
4. Plan First
5. SNAP
6. Marketplace
7. Pregnant Women
8. Incarcerated Adults and DOC
9. Presumptive Eligible Adults

Expansion Delivery Systems

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

Commonwealth Coordinated Care Plus (CCC Plus) will serve populations who are *medically complex*

Fee for Service will serve populations excluded from managed care, including:

- incarcerated adults,
- presumptively eligible adults, and
- newly eligible individuals until they are enrolled in a MCO

Integration is more than an operational change

It is an investment in the whole spectrum of care

MEDALLION 4.0 SERVICES

NEWLY IN

- Early Intervention (EI) Services
- Community Mental Health and Rehabilitation Services (CMHRS)
- Third Party Liability (TPL)

STILL OUT

- Dental Services
- School Based Services
- Plan First

HOLISTIC INTEGRATION - EI

- Full integration improves the health outcomes of eligible infants and toddlers birth to age three who are not developing as expected
- Enrollment as of 06/01/18 = 5,710 Medicaid/FAMIS infants
- Served by 1,128 certified early intervention providers
- To assist in a smooth transition, DMAS has
  - developed EI training for both the MCOs and EI provider to address program operations, billing, etc.
  - mailed letter to the parents of EI children to explain the transition of EI services into managed care

HOLISTIC INTEGRATION - CMHRS

- Integrated delivery model that includes medical services and the full spectrum of traditional and non-traditional behavioral health services
- MCOs responsible for care coordination, provider management, and reimbursement of CMHRS
- In 06/01/18 services provided to 644,529 of children served by approximately 15,000 CMHRS providers (providers may provide multiple services)
- CMHRS will go live 08/01/18 in Tidewater (Regional roll-out)
- Residential Treatment Services consisting of Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home Services (TGH) for Medallion 4.0 and CCC Plus individuals transition Summer 2019
- Dedicated email: M4.0-CMHRS@dmas.virginia.gov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NEW INITIATIVES

Member Engagement Social Media and Apps	Social Determinants Of Health and Supportive Services	Women's Health Family Planning/Long Acting Reversible Contraceptive (LARC)	Transition Planning To Help Teens and Young Adults
Trauma-informed Care ACES and Resilience	Infant and Early Childhood Physical and Mental Health	New Contract New Rates	Enhanced Services
Value-Based Purchasing Arrangements	Expansion Track 1	Expansion Track 2	Behavioral Health Transformation ARTS SUD

OPERATIONS AND PERFORMANCE MANAGEMENT

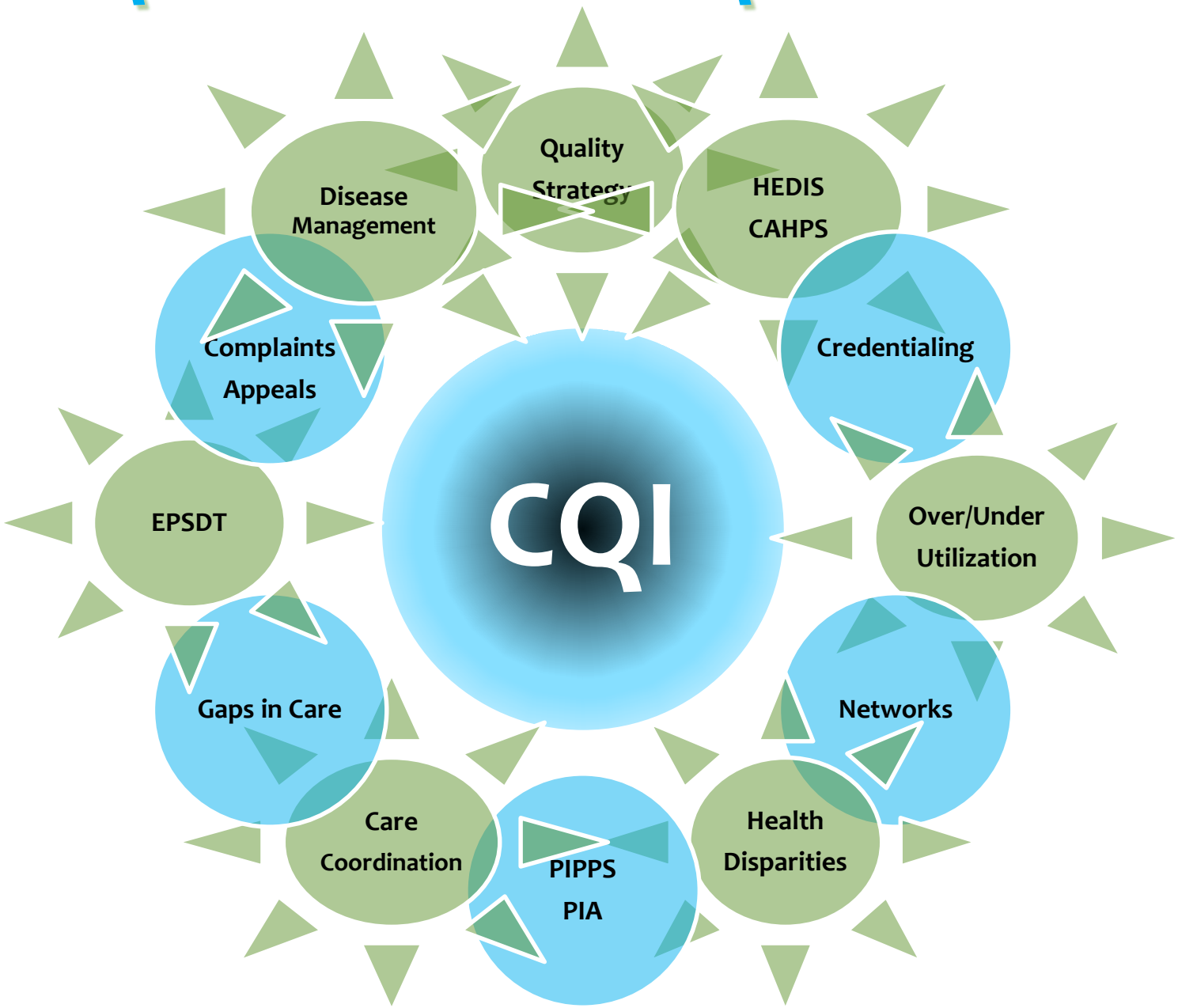
Enhancing the five main functions of Operations and Performance Management:

- **Contracts and Administration** ensures MCO operations are consistent with the contract requirements
- **Member and Provider Solutions** resolves service and care management concerns identified by members and providers
- **Quality Improvement** measures MCO performance against standard criteria, such as HEDIS, and facilitates focused quality projects to improve care for all members
- **Compliance** oversees, develops and monitors MCO corrective action plans and sanctions
- **Systems and Reporting** manages data submissions from the MCOs in accordance with the DMAS Managed Care Technical Manual

COMPLIANCE


Contract Deliverables and Performance
Monitoring and Onsites
Reporting and Technical Manual
Review (Business, Compliance, Management)
Collaboratives
Enforcement Action and Assessment
Follow-up/Corrective Action and Monthly Reports

QUALITY – IT'S NCQA PLUS. . .



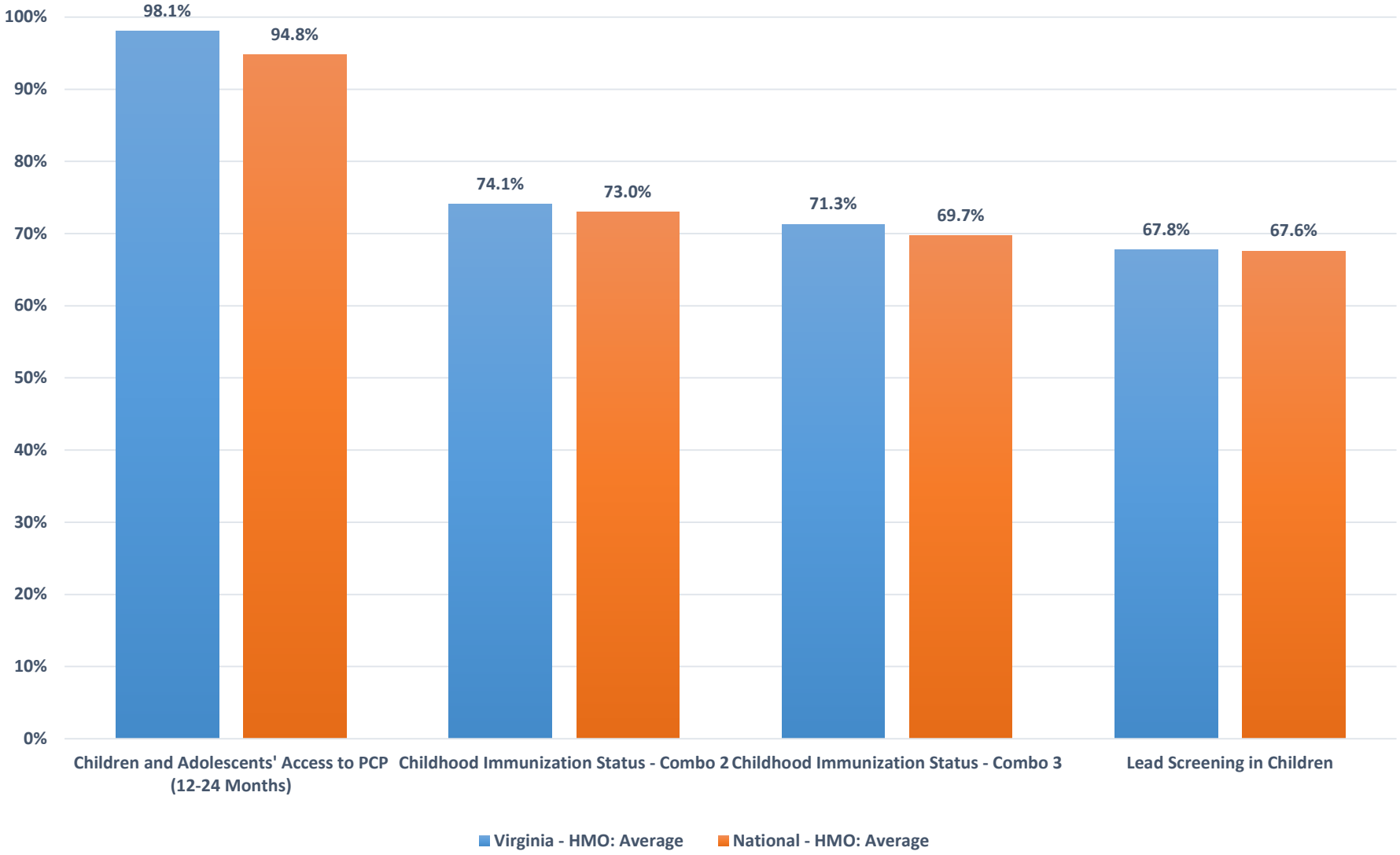
CONTINUOUS QUALITY IMPROVEMENT UPGRADES

DMAS Quality Strategy:

- Joint effort with OCMO, IC, and HCS and our EQRO
- Quality strategy spans the continuum from birth to long-term care services
- HEDIS bar: Participate in adult and child core measures - goal is to raise the bar
- Performance quality withhold: Established for two years - will add more measures and increase withhold
- Quality collaborative: includes OCMO, IC, and HCS
- Quality Strategy available at http://www.dmas.virginia.gov/Content_atchs/mc/Virginia%20Medicaid%20Comprehensive%20Quality%20Strategy%202017%20-%202019.pdf

Health Aims	Goals	Examples of Measures
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)
		HEDIS: Children and Adolescents' Access to Primary Care
	Decrease inappropriate utilization and total cost of care	All-Cause PQI Admission Rate
		CMS/NQF #1768: Plan All-Cause Readmissions
		HEDIS: Ambulatory Care - Emergency Department Visits
		Per Capita Healthcare Expenditures (future measure)
	Emphasize member experience of care	CAHPS/HEDIS/NQF #0006: Member Rating of Health Plan
	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)
		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
		HEDIS/NQF #0576: Follow Up After Hospitalization for Mental Illness, 7-day Follow Up
		CMS/NQF #2605: Follow Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
		CMS: Transition of Members Between SUD LOCs, hospitals, NF and the Community
	Encourage appropriate management of prescription medications	Use of High-risk Medications in the Elderly
		NCQA: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
		HEDIS: Follow-up Care for Children Prescribed ADHD Medication - Initiation and Continuation/Maintenance Phases
		HEDIS: Antidepressant Medication Management - Effective Acute Phase Treatment, Effective Continuation Phase Treatment
		PQA: Use of Opioids at High Dosage in Persons Without Cancer
		PQA: Use of Opioids from Multiple Providers in Persons Without Cancer
		PQA: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer
Focus on Screening and Prevention	Cancers are prevented or diagnosed at the earliest stage possible (3.4)	HEDIS/NQF #2372: Breast Cancer Screening
		NQF #0034: Colorectal Screening
		HEDIS/NQF #0032: Cervical Cancer Screening
	Prevention of nicotine dependency (3.2)	AMA-PCPI/NQF #0027: Tobacco Use - Screening and Cessation
	Virginians protected against vaccine-preventable diseases (3.3)	HEDIS: Childhood Immunization Status (Combo 10)
		HEDIS: Immunizations for Adolescents
		HEDIS: Pneumococcal Vaccination Status for Older Adults

VIRGINIA'S FFY 2017 HEDIS RATES



VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

DMAS Performance Inventive Awards (PIA) Program 2017 – Year 2

Division of Health Care Services

Administrative Measures & Weight:

- Assessments of Foster Care Population (12%)
- MCO Claims Processing (12%)
- Monthly Reporting Timeliness and Accuracy (10%)

HEDIS Measures & Weight:

- Childhood Immunization Status - Combo 3 (22%)
- Controlling High Blood Pressure (22%)
- Timeliness of Prenatal Care (22%)

The PIA is designed as a "zero sum" approach where the total MCOs' awards are equal to the total MCOs' penalties.

The maximum amount at risk for each MCO is 0.15% of the total annual MCO capitation amount. The maximum award amount is 0.15% of the total annual MCO capitation amount. is 0.15% of the total annual MCO capitation amount.

The PIA program assesses each MCO's performance on three (3) HEDIS® measures and three (3) administrative measures that DMAS has determined to be instrumental to their goals and objectives for managed care quality.

Table 1 – 2017 PIA Results by MCO

Table 1—Final Calculated Scores
This table presents final point values for each MCO's PIA measures.

Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier
Assessments of Foster Care Population	3	2	2	0	2	3
MCO Claims Processing	3	2	1	1	3	3
Monthly Reporting Timeliness and Accuracy	3	3	3	3	3	3
Childhood Immunization Status— Combination 3	1/0	2/0	0/0	2/1	1/0	1/0
Controlling High Blood Pressure	2/0	2/0	0/0	2/1	1/0	1/0
Prenatal and Postpartum Care—Timeliness of Prenatal Care	1/0	2/0	0/0	2/1	1/0	1/1

*For the HEDIS measure scores, the first number represents the points awarded for performance, and the second number represents the points awarded for improvement.

Table 2 – Funds Allocation Results

MCO	Final Award	Final Penalty	Final Award/Penalty Percentage
Aetna	$58,583.36	—	0.03%
Anthem	$424,097.99	—	0.04%
INTotal	—	$(237,610.93)	-0.12%
Kaiser Permanente	$18,329.92	—	0.04%
Optima	—	$(557,118.41)	-0.07%
VA Premier	$293,718.08	—	0.03%
All MCO Total	**$794,729.34**	**$(794,729.34)**	

*MCO = Managed Care Organization; DMAS = Virginia Department of Medical Assistance Services; HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA) = Healthcare Effectiveness Data and Information Set

Methodology

Administrative Measures:

- 7/1/2016 – 6/30/2017

HEDIS Measures:

- 1/1/2016 – 12/31/2016

PIA Measure Scoring:

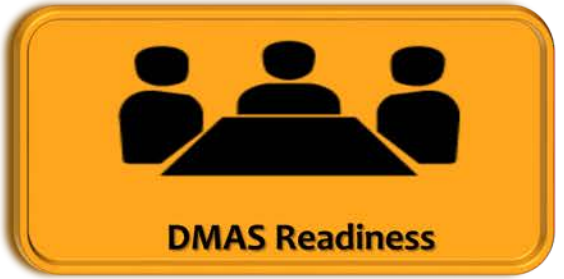
- HEDIS Performance Score 0 – 2 pts
- HEDIS Improvement Score 0 – 1 pts
- Administrative Measures 0 – 3 pts

PIA Measure Weighting:
See "Overview" for the measure weight of each administrative & HEDIS measure.

The full annual performance reports, methodology, and technical specifications can be found on the DMAS website, under Medallion 3.0 Performance Incentive Awards


WHAT
IS
NEXT

KEY IMPLEMENTATION AREAS



MEDALLION 4.0 REGIONAL IMPLEMENTATION

Phased in Regionally August 2018 – December 2018

Tidewater	Central	Northern/ Winchester	Charlottesville/ Western	Roanoke/ Alleghany	Southwest	EXPANSION
161,421	189,438	178,416	88,486	72,827	46,558	400,000
August	September	October	November	December	December	January

Implementation Highlights:

- ✓ April 2018: MCO contracts signed
- ✓ May 2018: CMS waiver authority 1915(b) submitted
- ✓ May – August 2018: MCO readiness activities
- ✓ June – October 2018: Regional member/provider on-site trainings, webinars, calls
- ✓ July 2018: Final MCO contracts and rates to MCOs

COMMUNICATIONS

- Scheduled series of on-site trainings, webinars, and conference calls to engage members, providers, and stakeholders
- Schedule can be found at http://www.dmas.virginia.gov/Content_pgs/medallion_4-meetings.aspx
- Mailed first letter to members with information on MEDALLION 4.0 and invitations to trainings
- Presentations to date to: VACBP, VACSB, BPRO, VALCPA and Medicaid Physician, Managed Care Liaison Committee

YOUR TURN

- As we move forward, we value your input
- Send comments or questions to
  - M4.0Inquiry@dmas.virginia.gov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TOGETHER

AGENCY REPORTING DASHBOARD

Kannan Srinivasan
Ivory Banks
Joanna Fowler
JUNE 26, 2018

Purpose

- To determine the how effective we are as an Agency in providing superior health care to the Medicaid members of the Commonwealth of Virginia; in addition to understanding some areas where we can become more efficient.
- In addition to help escalate “red flags”, celebrate successes, and provide further transparency and documentation of our current processes and protocols. Lastly, to promote teamwork across the Agency, and be good stewards of our budget.

Phase 1: "Preparation"

"The journey to the Agency Scorecard"

- ✓ Kannan Srinivasan, our BMAS Board Member was gracious enough to assist us with the performance measurement and Agency Scorecard development.
  - Conducted several onsite 1:1 meetings with division leads and/or their designee(s).
- ✓ Each Division Director compiled a presentation based upon Kannan's feedback, to share with Management Team.

Phase 2: "Implementation"

"The journey to the Agency Scorecard"

- ✓ The following week after their initial presentation, each Division wound participate in the weekly Agency "Round Robin Report".
  - The Team developed a process, as well as a standard format.
- ✓ Ivory and Joanna scheduled meetings with each Division Director after their initial presentations, to assist in determining the top 3 metrics that would help determine our success as an Agency.

Phase 2: "Implementation"

"The journey to the Agency Scorecard"

- ✓ Each Division's measures are compiled into one scorecard and sent out to Management Team to review prior to our next meeting.
  - The Team developed a process, as well as a standard format.
- ✓ Each Division takes 2-3 minutes to share their top 3 metrics, during our "Reporting Round Robin" each Management Team Meeting.
  - To include any urgent items that need to be escalated.

Agency Reporting Dashboard Example

DMAS

Weekly Management Team Round Robin Report

Reporting Period: June 18th – 22nd

Current Agency Reporting Metrics, Successes, and Red Flags

Division	Division Metric:	Division Metric:	Division Metric:	"Red Flags"
Program Operations	**1.) Proper Payments and Training:**	**2.) Quality of NEMT Transportation Services:**	**3.) Temporary Detention Order:**	(Escalated Items)
Division	**Division Metric:**	**Division Metric:**	**Division Metric:**	**"Red Flags"**
Appeals	1.) **Compliance**	2.) **Quality**	3.) **Pinks**	

Next Steps

- Complete all initial Divisions Presentations to Management Team.
  - There are currently 4 Divisions left to do so.
- Finalize a completed “Round Robin Report” to compile the Agency Scorecard.
  - As a team, determine which metrics we would like to see weekly and monthly.
- We will meet with Kannan again to determine where we can focus more on specific areas.
- Transition our Agency Scorecard to a dynamic Agency Dashboard.
- Utilize our Agency Scorecard to:
  - Determine how our members and providers are utilizing our services; and their level of satisfaction with our customer service.
  - Determine the effectiveness of our contractors in serving our members and providers.

Questions ?

MEDICAID MEMBER ADVISORY COMMITTEE

A Proposal for Virginia Medicaid

Board of Medical Assistance Services

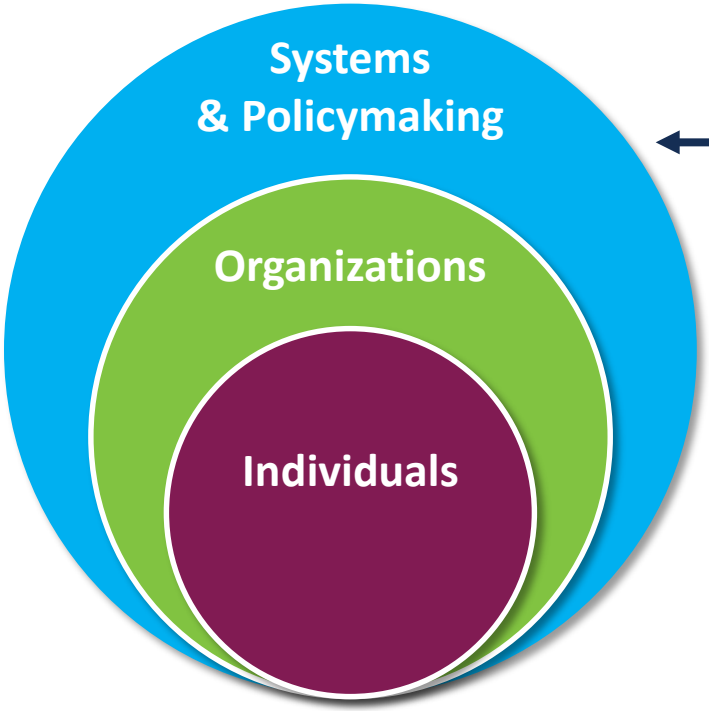
Tuesday, June 26, 2018

Brian McCormick, Acting Deputy Director
for Administration

Enhancing DMAS Member Engagement

Medicaid members currently engage with DMAS' contractors at both the individual and organizational levels

Member engagement can occur in the health care eco-system at three different levels



A Medicaid Member Advisory Committee will enhance our member engagement at the Systems and Policymaking level

Graphics credit: Center for Consumer Engagement in Health Innovation

Member Advisory Committee Core Functions

Meaningful insight into the Medicaid member experience is a key input to member-focused decision making and care delivery

Member Insight

Giving a voice to the member experience that may not otherwise have been heard

General Feedback

Seeking opportunities to explore member feedback on policies and programs

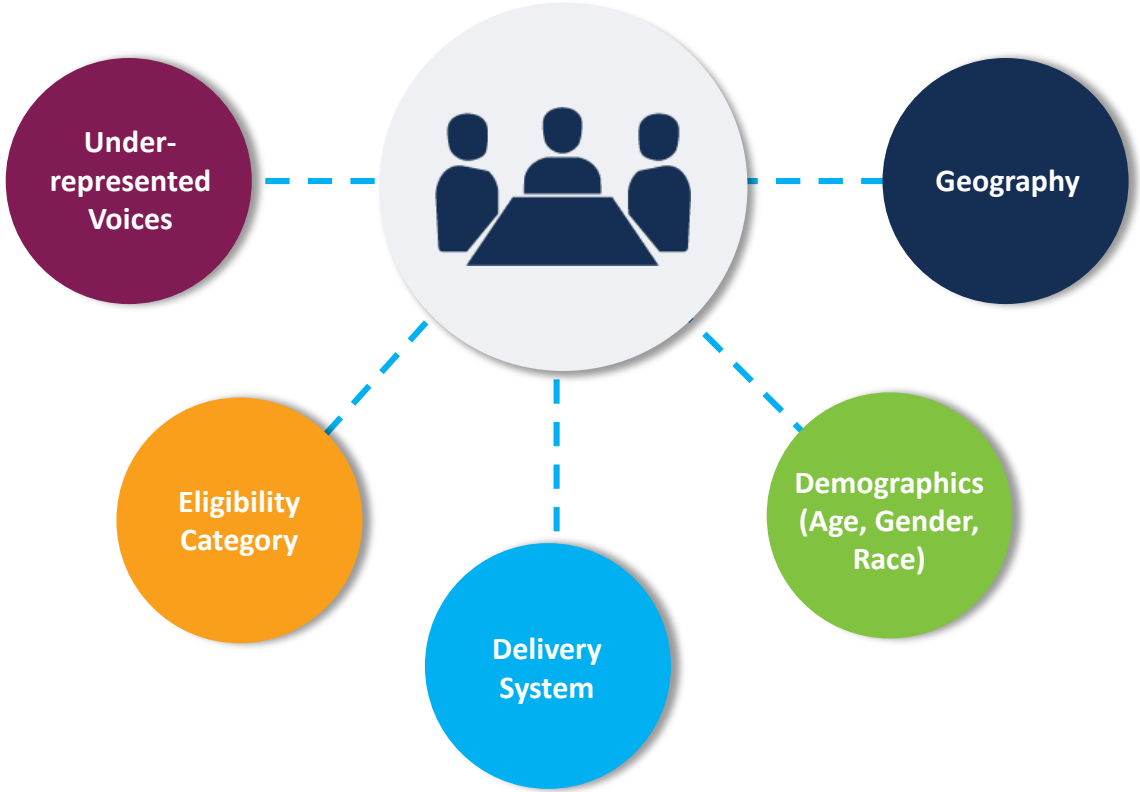
Testing Ideas

Forum for testing new ideas or materials to determine if we hit the mark

Our knowledge is incomplete without the expertise of our consumers

Member Advisory Committee Composition

The Member Advisory Committee (MAC) is intended to be a representative sample of the diverse Medicaid population



Key MAC Considerations

Governance:	Reporting Structure Compliance with Virginia FOIA
Budget:	Incentivizing participation through travel support and a meal
Logistics:	Quarterly meetings in Richmond
Recruitment	Identifying and selecting membership
Communications	Informing champions

Next Steps

VCHI is supporting efforts through best practice environmental scan and recommendations for recruitment strategy

Determining our timeline, interviewing stakeholders and developing project plan and recruitment strategy

Assembling MAC Appointment Committee and developing communications materials

Please share your feedback and ideas regarding a Medicaid Member Advisory Committee with sarah.broughton@dmas.virginia.gov

Regulatory Activity Summary June 26, 2018
(* Indicates recent activity)

2018 General Assembly

***(01) Dental & CMHS FFS Provider Update — Dec. 2017 Update:** This fast-track regulatory action serves to amend the regulation at 12 VAC 30-80-30 pertaining to fee-for-service providers. DMAS is adding text to existing regulatory language regarding reimbursement practices that are currently in place relating to the reimbursement of community mental health and dental services. Additional language has been added pertaining to dental services clarifying the section of the VAC where service limits and provider qualifications may be found and identifying the location of the dental fee schedule. Following internal DMAS coordination and review, the regs were submitted to the OAG on 3/20/18 for review.

***(02) Medicaid Expansion — Coverage of Adult Group:** This state plan amendment (SPA) proposes to expand Medicaid eligibility to individuals age 19 or older and under age 65, who have household income at or below 133% of the federal poverty level, as the Virginia General Assembly has directed DMAS to implement. Virginia is submitting an amendment on the pre-printed CMS state plan page indicating that the adult group described in 42 CFR 435.119 will be covered, effective December 1, 2018. Following internal DMAS coordination and review, the SPA was submitted to CMS on 6/7/18 for review.

***(03) Medicaid Expansion — Premium Assistance [HIPP]:** The Virginia General Assembly has directed DMAS to expand Medicaid eligibility to individuals age 19 or older and under age 65, who have household income at or below 133% of the federal poverty level. As part of this expansion effort, DMAS is submitting this SPA to broaden access to the Health Insurance Premium Payment program. The changes that will accomplish this objective are: 1) removing the exclusion for individuals covered under a high deductible health plan; 2) removing the exclusion for individuals covered under a family health plan that covers three or more individuals; and 3) updating the cost effectiveness evaluation for individuals enrolled in managed care. Following internal DMAS coordination and review, the SPA was submitted to CMS on 6/7/18 for review.

***(04) Medicaid Expansion — FMAP Claiming:** The Virginia General Assembly has directed DMAS to expand Medicaid eligibility to individuals age 19 or older and under age 65, who have household income at or below 133% of the federal poverty level. This state plan amendment accomplishes that objective by allowing DMAS to collect the appropriate federal match rate, also called the Federal Medical Assistance Percentage, or FMAP. Virginia is submitting an amendment on the pre-printed CMS state plan page indicating the required information relating to the populations covered in the new adult group. Following internal DMAS coordination and review, the SPA was submitted to CMS on 6/7/18 for review.

***(05) Limit Dental Services for NF Residents:** Under 42 CFR 435.725(c)(4)(ii), institutionalized individuals who contribute to their costs of institutional care may reduce their 'patient pay' amounts by the amount of expenses incurred for medical and dental services that Medicaid does not cover. DMAS is permitted to establish reasonable limits on the amounts of these expenses, but had not yet done so for dental services. This state plan amendment proposed to limit the amount of routine dental services that residents of nursing facilities are permitted to use to modify their patient pay amounts. DMAS submitted this state amendment to add reasonable limits to dental services for individuals in nursing facilities. The limits are: (i) routine exams and x-rays, and dental cleaning twice yearly; (ii) full mouth x-rays once every three years; and (iii) deductions for extractions and fillings shall be permitted only if medically necessary as determined by the department. Authorizations for other dental procedures, such as dentures, remain unchanged by this state plan amendment. Nursing facility residents will still be able to secure these additional services with the appropriate modifications to their patient pay amounts as is currently permitted. Following internal DMAS coordination and review, the SPA was submitted to HHR on 4/23/18 and approved on 4/27/18. The SPA was submitted to CMS on 4/30/18. A conf. call was held on 5/11 and revised plan pages were sent to CMS on 5/11/18. CMS approved the SPA on 5/17/18. The corresponding fast-track regulatory action began circulating internally for review on 3/12/18. The regs were submitted to the OAG for review on 5/14/18. DMAS forwarded requested info to the OAG on 5/14. A conf. call w/ the OAG was held on 6/13/18 to discuss minor changes. The edits were implemented on 6/13/18 and DMAS is awaiting further instruction.

***(06) Amendments to Marketing Requirements:** This fast-track regulatory action amends the marketing rules found in 12 VAC 30-130-2000 to clarify that Community Mental Health (CMH) providers no longer need to submit their marketing plans and materials to DMAS for review. This requirement does not make sense for providers who are operating under the oversight of a Managed Care Organization (MCO) and is also being eliminated for fee-for-service (FFS) providers in order to ensure that providers have the same requirements no matter whether they operate in an MCO or in FFS. Most CMH providers are moving into MCOs and will be complying with MCO contract requirements related to marketing practices. This regulation is essential to protect the health, safety, and welfare of citizens in that it prevents rules that were originally designed for fee-for-service providers from applying to MCO providers. To require MCO providers to submit marketing materials and marketing plans to DMAS for approval would interfere with the oversight responsibilities of the MCO. It is essential that MCO providers remain in compliance with their MCO contract requirements, and repealing this regulation ensures that providers will have one set of rules to follow so that Medicaid members are provided with only appropriate marketing materials using appropriate marketing practices. Internal DMAS review for this project began on 4/5/18.

***(07) Repeal of VICAP Regulations:** This fast-track regulatory action serves to repeal the regulations associated with the Virginia Independent Clinical Assessment Program (VICAP), which ended on November 30, 2016. On July 18, 2011, DMAS began requiring the VICAP for several Community Mental Health Rehabilitative (CMHR) services: Intensive In-Home Services, Therapeutic Day Treatment and Mental Health Support Services for individual up to the age of 21. The VICAP was designed to better manage access to these services by requiring

providers to obtain an independent clinical assessment to determine that these CMHR services were clinically appropriate. The VICAP was required before a CMHR provider initiated these CMHR services. However, after DMAS established that the BHSA's administrative functions of conducting medical necessity reviews, level of care assessments, and service authorizations could fulfill the role of the VICAP, the VICAP program was terminated on November 30, 2016. Based on a comprehensive review of the BHSA's administrative functions, which include medical necessity review, level of care assessments, and authorization of services, and a DMAS evaluation of data relative to VICAP assessments, it was determined in August 2016 that the VICAP was no longer needed to ensure appropriate access to services. Providers were notified in a DMAS Memorandum dated August 30, 2016 that the VICAP assessment would do longer be required as of December 1, 2016. These functions are currently performed by the CCC Plus Medicaid MCOs for their enrolled members. The BHSA continues to perform these functions for individuals enrolled in Fee-For-Service (FFS) and individuals enrolled in the Medallion 3.0 and FAMIS programs, until those individuals are rolled into the Medallion 4.0 program, beginning on August 1, 2018. Internal DMAS review began on 4/17/18 and the project folder is currently circulating.

***(08) Removal of the 21 Out of 60 Day Limit:** This fast-track regulatory action is necessary to comply with the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Rule, issued on March 30, 2016. The overall objective of the Medicaid Mental Health Parity Rule is to ensure that accessing mental health and substance use disorder services is no more difficult than accessing medical/surgical services. To comply with the Medicaid Mental Health Parity Rule, DMAS must remove the limit of 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan for psychiatric inpatient hospitalization, as this limit for coverage of non-psychiatric admissions was removed on July 1, 1998. (Medicaid managed care plans do not apply the limit of 21 out of 60 days, and both the limit and the change only apply to fee for service.) Psychiatric inpatient hospitalizations must be service authorized based on medical necessity and not be limited to 21 days per admission in a 60 day period. The citation for the federal regulation to remove the "21 out of 60 day limit" can be found in 42 CFR 438.910(b)(1). Internal DMAS review began on 6/20/18 and the project folder is currently circulating.

***(09) EVMS & VA Tech Carilion Supplemental Payments:** This fast-track regulatory action serves to add new regulation regarding supplemental payments for certain teaching hospitals. A LCME affiliated teaching hospital, known as Sentara Norfolk General, and a LCME affiliated teaching hospital, known as Carilion Medical Center, began receiving quarterly supplemental payments effective July 1, 2017 for inpatient services. This regulation is essential to protect the health, safety, and welfare of citizens in that implementation of these supplemental payments will assist in increasing access to care for the citizens of the Commonwealth. These two primary teaching hospitals are affiliated with public medical schools that will transfer the funds to DMAS for the state share for these payments. Following internal DMAS coordination and review, the regs were submitted to the OAG on 2/13/18 for review, and to DBP on 3/26/18. The regs were forwarded to the Sec. Ofc. on 5/3/2018, and to the Gov. Ofc. on 5/9/18.

***(10) CHKD Hospital Inflation, FFS Providers, & Reimbursement Services on a Cost Basis:** The methodology for hospital reimbursement includes an annual inflation adjustment. In state fiscal year 2017, the inflation adjustment was 50% of inflation and in state fiscal year

2018, the inflation adjustment was eliminated. This regulatory action aims to create an update which will allow an exception of 100% inflation for the Children's Hospital of the King's Daughters (CHKD) in both FY2017 and FY2018. These technical changes incorporate language into the regulations that CMS has approved in State Plan amendments in order to provide more clarity. Internal DMAS coordination and review was conducted, and the regs were submitted to the OAG on 2/21/18 for review. The reg project was re-packaged as a final exempt project, following budget approval, and submitted to the OAG again on 6/7/18 for review.

***(11) Utilization Control: Nursing Facilities – Contract Termination (Fast Track):** DMAS terminates specialized care provider contracts when one or more of three conditions have been met. Currently, the State Plan includes a section on contract termination however, this language does not exist within the VAC. This regulatory action seeks to bring the VAC in-line with the State Plan and to include this long-standing DMAS policy in regulatory language. Following internal DMAS coordination and review, the regs were submitted to the OAG on 2/6/18 for review. Per request, additional info was forwarded to the OAG on 5/3/18.

***(12) DSH Payments for Inpatient Psychiatric Hospitals:** This fast-track action is an amendment to existing regulations to update the procedure for the Disproportionate Share Hospital (DSH) payment calculations for inpatient psychiatric hospitals. Beginning July 1, 2017, the annual DSH payment was calculated for each eligible hospital by dividing the total inpatient psychiatric hospital allocation by each hospital's percentage of the total uncompensated care costs for the most recent DSH audit year. Prior to July 1, 2017, the DSH per diem for state inpatient psychiatric hospitals was calculated by dividing the total state inpatient psychiatric hospital allocation by the number of DSH days and multiplying each hospital's DSH days by the DSH per diem. Following internal DMAS coordination and review, the regs were submitted to the OAG and forwarded to DPB on 4/4/2018. DMAS posted the agency response to the EIA to the Town Hall and forwarded the regs to the Sec. Ofc. for review on 5/7/18.

(13) Peers Amendments: This fast-track regulatory action corrects citations and removes an annual caseload limit that was found to be a barrier to receiving peer support services. (A limit of 12 to 15 individuals in a peer support specialist's care at any one time remains in place). This action serves to replace incorrect citations with either correct citations or text, and an annual caseload limit has been removed. Following internal DMAS review, the regs were submitted to the OAG on 3/30/18 for review.

***(14) Community Mental Health Services Documentation of Qualifications:** This emergency regulatory action will require providers to maintain documentation to establish that Community Mental Health Services (CMHS) are rendered by individuals with appropriate qualifications and credentials, including proof of licensure or registration when applicable. The Department of Health Professions has begun to register Qualified Mental Health Professionals, and those working toward registration as Qualified Mental Health Professionals, and this regulation specifically includes documentation requirements for those individuals. The regs were reviewed internally, and approved by the Agency Director on 3/23/18.

***(15) Electronic Visit Verification (EVV):** This NOIRA action intends to amend regulations in order to include provisions related to Electronic Visit Verification (EVV) as required by the 21st Century CURES Act, 114 U.S.C. 255, enacted December 13, 2016 (the CURES Act) and the 2017 Appropriations Act Chapter 836, Item 306. YYYY. The CURES Act requires states to implement an EVV system for personal care services by January 1, 2019 and home health care services by January 1, 2023. The 2017 Appropriations Act authorizes DMAS to require EVV for personal care, respite care and companion services. The CURES Act requires that the EVV system must verify: 1) The type of service(s) performed; 2) The individual receiving the service(s); 3) The date of the service; 4) The location of service delivery; 5) The individual providing the service, and 6) The time the service begins and ends. DMAS sought input regarding the EVV system from individuals receiving services, family caregivers, providers of personal, respite and companion care services, home health care services, provider associations, managed care organizations, health plans and other stakeholders. DMAS also sought input on the current use of EVV in the Commonwealth and the impact of EVV implementation. The NOIRA was circulated for internal DMAS review and submitted to DPB on 4/30/18. The NOIRA was approved by DPB on 5/11/18 and forwarded to the Gov. Ofc.

2017 General Assembly

***(01) Reimbursement of PDN, AT, and PAS in EPSDT:** This state plan amendment serves to add text to the state plan regarding reimbursement practices that currently are in place relating to reimbursement of private duty nursing, assistive technology, and personal assistance services under EPSDT. The SPA was submitted to CMS on 9/22/2017. Per request, revisions were sent to CMS on 11/7/17. Additional questions were received from CMS on 11/21; and DMAS forwarded the responses on 12/1/17. The SPA was approved by CMS on 12/7/17. The corresponding fast-track regulatory changes are currently being drafted.

***(02) LMHP-R, RP, and S May Provide Outpatient Psychiatric Services:** This fast-track regulatory action updates the Virginia regulations related to physicians, other licensed practitioners, and clinics to incorporate Licensed Mental Health Professional Residents and Supervisees into the regulatory text and to reflect text changes required by CMS. Residents in professional counseling, residents in psychology, and supervisees in social work have completed the education requirements for licensure, but have not yet completed the experience requirements for licensure, and the resident/supervisee status allows them to gain that experience while practicing under licensed clinical supervision. The Department of Health Professions permits these individuals to practice under licensed clinical supervision, and DMAS permits these individuals to provide billable outpatient behavioral health services to Medicaid members, provided that they practice in accordance with the DHP supervision requirements. This regulatory action includes this long-standing DMAS policy in regulatory language. The regs were sent to the OAG on 12/1/17 for review, and forwarded to DPB on 1/3/2018. Following a conf. call with DPB on 1/25/18, DPB posted the EIA on 2/12, and DMAS posted the corresponding response on 2/13 and received approval. The regs were sent to HHR on 2/13/18 and forwarded to the Gov. Ofc. on 5/9/18 for review.

***(03) Supplemental Payments to State Owned or Operated Clinics:** This fast-track regulatory action serves to add a new section and revised provider reimbursement language (required by the 2015 *Acts of Assembly, Chapter 665, Item 301*, the 2016 *Acts of Assembly,*

Chapter 780, Item 306 and the 2017 *Acts of Assembly, Chapter 836, Item 306*) to the regs, to implement supplemental payments to state-owned or operated clinics. This action also brings state regulations into line with federal rules and current Virginia practice. The action is essential to protect the health, safety, and welfare of citizens of the Commonwealth in that these reimbursement rules help to ensure the continued financial viability of the Virginia Medicaid Program. Following internal DMAS coordination and review, the project was submitted to the OAG 9/20/17; forwarded to DPB on 10/10/17; and sent to the Sec. Office on 12/8/17 and forwarded to the Gov. Ofc. on 5/9/18.

***(04) Former Foster Care Youth:** This state plan amendment proposes to update current regs to add a new section entitled "Coverage of Former Foster Care Youth." Currently, language exists, outlining Medicaid coverage for former foster care youth who aged out of care while receiving Medicaid in a state other than Virginia. Due to a recent review and decision made by the Centers for Medicare and Medicaid Services (CMS), this coverage is no longer available under the State Plan, but instead has been approved under an 1115 waiver. As a result, this language must be moved to the "state only" section of the VAC. Following internal review, the SPA was submitted to HHR on 9/12/17 and forwarded to CMS on 9/21. CMS issued informal questions on 11/3/17, which DMAS responded to on 11/9/17, 11/15, and 11/17. The SPA was approved on 12/12/17. The corresponding VAC regulatory package was drafted and circulated for internal review on 12/14/17. The regs were forwarded to the OAG for review on 2/8/2018. The regs were certified by the OAG on 4/12/18; then submitted to the Registrar with a publication date of 5/14/18; with an effective date of 6/15/18.

***(05) Reduction of Inpatient Cost Sharing to Comply with Federal Regulation:** This state plan amendment serves to bring DMAS into compliance with 42 CFR 447.52(b)(2). Amendments to 42 CFR 447.52 require states to limit cost-sharing for inpatient hospitalization to $75 on or before July 1, 2017. As of July 1, 2017, DMAS has reduced its cost sharing for inpatient hospitalization from $100.00 to $75.00. In federal fiscal year 2017, the total cost is $45,250.00, half of which ($22,625.00) will be covered with federal funds. In federal fiscal year 2018, the total cost is $79,028.00, half of which ($39,514.00) will be covered with federal funds. The SPA was submitted to HHR for review on 9/15/17 and forwarded to CMS on 9/21. Following internal project coordination and conf. calls with CMS on 9/27 and 10/26, DMAS received a Request for Additional Information (RAI) on 12/15/17. This SPA was taken off the clock on 2/7/18, and DMAS is awaiting additional feedback from CMS. Internal DMAS review has begun for the corresponding regs as of 5/21/18.

***(06) CMHRS Changes Required by CMS:** This NOIRA regulatory action serves to comply with CMS requirements related to service definitions, service components, and staffing requirements for community mental health rehabilitative services. CMS also required DMAS to provide detail on the unit of service and date that reimbursement rates were set; these are not changes in DMAS rates or units, but instead, include existing DMAS rates and units in the regulations. DMAS last updated these regulations on January 30, 2015. During the following two years, CMS reviewed those regulatory changes and required that DMAS clarify that community mental health rehabilitative services fit under the umbrella of "rehabilitative services" under 42 CFR 440.130(d): services that are recommended by a physician or licensed practitioner for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. More specifically, CMS

required DMAS to more clearly define each service, list and define the subcomponents of each service, specify what type of professional could provide each subcomponent, specify what a unit of service is for each service, and the date that existing reimbursement rates were set. The NOIRA regs began circulating for internal review on 9/28/17. The action was forwarded to DPB on 11/8/17 and to HHR on 11/21/17. The regs were sent to the Gov. Ofc. for review on 5/9/18.

***(07) 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. The SPA was approved by CMS on 9/7/17. VAC changes are required following the SPA approval. DMAS circulated the Fast Track regulation revisions for internal review on 11/6. The regs were submitted to the OAG on 2/13/18 for review; forwarded to DPB on 3/13/18 (with a conf. call on 4/5); and the agency response to the EIA was posted on 4/18/18. The regs were submitted to the HHR on 4/19/18 and then to the Gov. Ofc. on 5/9/18.

(08) 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 were drafted internally. The SPA was submitted to HHR on 9/15 and forwarded to CMS on 9/21. Following conf. calls with CMS on 9/27 and 10/26, DMAS is currently drafting responses to CMS inquiries. This SPA is currently off the clock, as DMAS awaits responses from CMS regarding reimbursement information. Internal DMAS review began for the corresponding regs on 5/21/18 and the review folder is currently circulating.

(09) 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 were drafted on 7/20 and circulated for internal review and forwarded to the OAG on 9/22. DMAS received inquiries from the OAG on 9/28 and sent responses back on 10/3 and 10/5. Following a conf. call with the OAG on 11/6, the regs were submitted to DPB for review on 11/7. DMAS responded to DBP inquiries on 12/6 and 12/12. The Agency response to the Economic Impact Analysis (EIA) was posted on 12/15. DBP submitted the regs to HHR for review on 12/15/17.

***(10) 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 was drafted, circulated internally for review, and subsequently submitted to OAG on 2/2/18. Following a call, revisions were sent to the OAG on 2/22. The fast-track project was submitted to DPB on 3/14. Following a conf. call with DPB on 4/5/18, revisions were made and the package and EIA analysis were forwarded to the Sec. Ofc. for review on 4/23/18. The EIA response was loaded to the Town Hall on 4/24/18.The corresponding SPA was drafted and approved internally on 2/22; forwarded to HHR on 2/27; and submitted to CMS on 3/7/18. CMS sent informal questions on 4/12/18, to which DMAS forwarded a response. The SPA was approved on 5/17/18 by CMS, with an effective date of 5/1/2018.

***(11) 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. The corresponding VAC changes were drafted, reviewed internally, and submitted to the OAG on 11/2/17. DMAS responded to an OAG inquiry on 11/9. The regs were forwarded to DPB for review on 11/14. DMAS posted the EIA on 12/11. DBP submitted the regs to HHR for review on 12/15/17. The reg package was forwarded to the Gov. on 5/9/18 for review.

***(12) 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 submitted to the OAG on 10/25. The OAG submitted questions on 12/11 and DMAS coordinated and submitted responses on 1/3/18. Additional revisions were forwarded to the OAG on 2/13/18. The regs were certified by the OAG on 3/8 and submitted to DPB on 3/9/18. A conf. call w/ DPB was held on 4/17/18 to discuss the regs. Revisions were made and DMAS revised text and resubmitted the regulatory action. DPB approved the project on 4/26/18 and it was also moved to the Secretary Ofc. for review on 4/26/18. The EIA was posted on 4/26 and the Agency response to EIA was posted on 4/27/18.

***(13) 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 was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and additional inquiries on 2/22/18, 3/19/18, 4/10/18, and 5/16/18. Awaiting further direction from the OAG.

***(14) 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. The corresponding fast-track regs were drafted and reviewed internally, and submitted to the OAG on 9/14/17 for review. OAG certification was received; the reg projected was submitted to DPB; and the DPB economic statement was posted on 2/14/18. The regs were forwarded to the Secretary's office for review on 3/16. The Agency response to the EIA was posted 3/26/18. The regs were forwarded to the Gov. Ofc. for review on 5/9/18.

2016 General Assembly

(01) 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 coordinated the next regulatory phase, and forwarded the regs to the OAG on 7/19/17. DMAS responded to several rounds of OAG inquiries between Sept 2017 and Jan. 2018. The regs were forwarded to DPB on 1/11/18. Following a meeting with DPB on 1/30, the EIA was posted. A response to the EIA was posted on 2/16/18. The regs were submitted to HHR on 2/21/18.

***(02) 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. A comment summary was submitted to commenters on 10/13. The final stage reg package began circulating internally on 10/13. The regs were forwarded to the OAG on 12/1/17 for review. Following a call with the OAG on 2/21/18, DMAS made revisions to the regs. The final stage regulations were submitted to DPB on 3/14/18. The regs were submitted to HHR for review on 3/28/18 and forwarded to the Gov. Ofc. for review on 5/9/18.

(03) 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 7/31/17, and re-submitted on 9/7/17. Following a conference call on 9/18, DMAS coordinated revisions and submitted changes on 11/1/17. DMAS submitted an ER extension request for this project on 12/8/17. The ER has been extended until 8/30/18.

***(04) 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 drafted the next stage of the regulatory review. The regs were submitted to the OAG on 1/9/18. DMAS received inquiries from the OAG and responded on 2/26/18. Following internal edits, DMAS sent additional revisions to the OAG on 3/5/18, 3/21/18, 4/9/18, and 4/23/18. The regs were sent to DPB for review on 5/7/18.

***(05) 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 4/26/17 to discuss the regs. The action had been placed on hold. Regulatory processing began again on 4/26/18 and DMAS is awaiting further guidance from the OAG.

***(06) 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. Following a conf. call with the OAG on 10/3, the action was submitted to DPB on 10/10/17. A call with DPB was held on 11/9. The regs were submitted to HHR for review on 11/28/17. The regs were forwarded to the Governor on 5/9/18.

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. Comments were received from DARS, VHHA, and VDH and were summarized. The agency summary of comments received was sent to commenters on 11/20/17. The final stage reg package was created and circulated for internal review on 11/30 and approved at the DMAS-level on 2/27. The regs were submitted to the OAG on 2/28/18. DMAS responded to OAG inquiries on 4/10/18, 4/23/18, and 4/27/18. The action was forwarded to DPB on 5/3/18 and DMAS addressed DPB questions on 5/7/18 and 5/8/18. DPB approval was received on 5/9/18 and the action was forwarded to HHR for review.

(02) 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. The final stage reg processing began internally on 9/26/17. The regulatory project was forwarded to the OAG on 3/15/18.

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 was initiated. The reg action was submitted to DBP for review on 12/5/17. Questions were received from DPB on 12/13, with responses provided. The regs were forwarded to HHR on 12/15/17. HHR approved the action on 5/9/18 and forwarded the regs to the Gov. Ofc. for review.

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 NOIRA 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. Additional questions were received on 9/7, and responses were sent to CMS on 9/11. More questions were received on 10/4, 10/10, 10/12, and 10/23; and DMAS forwarded responses on 10/20 and 10/26. CMS submitted a RAI on 11/9 and draft responses were returned to CMS on 11/17. Following conference calls on 11/27 and 12/4, responses and revised state plan pages were forwarded to CMS on 12/4/17. A RAI response was sent to CMS on 1/25/18. Following additional questions (received and responded to) from CMS on 1/27, the SPA was approved on 2/12/18, with effective date of 7/1/17. The corresponding proposed reg text began circulating for internal review on 12/7. The regs were forwarded to the OAG on 1/11/2018. Revisions were sent to the OAG on 1/29, 2/12, and 2/20/18. Questions were received from the OAG on 4/9/18 and DMAS is currently coordinating responses.

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.