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

December 12, 2017
DRAFT Minutes

Present:
Cara L. Coleman, JD, MPH
Michael H. Cook, Esq.
Patricia T. Cook, M.D.
Alexis Y. Edwards
Rebecca E. Gwilt, Esq.
Maureen Hollowell
Peter R. Kongstvedt, M.D.
Vice Chair
McKinley L. Price, D.D.S.
Karen S. Rheuban, M.D.
Chair
Kannan Srinivasan

Absent:
Vilma T. Seymour

DMAS Staff:
Kate Neuhausen, MD, Chief Medical Officer
Karen Kimsey, Deputy Director for Complex Care
Cheryl Roberts, Deputy Director for Programs
Abrar Azamuddin, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration (OCLA)
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Linda Nablo, Chief Deputy Director
Suzanne Gore, Deputy Director for Administration
Scott Crawford, Deputy Director for Finance

Guests:
W. Scott Johnson, First Choice Consulting
Charles Smith, Myers & Stauffer
Patrick W. Finnerty, Myers & Stauffer
Richard Grossman, Vectre
Steve Ford, VHCA
Ben Peel, VCU
Katie O'Connor, RTD Reporter
Stephanie Papps, DMAS Staff
Seon Rockwell, DMAS Staff
Rebecca Anderson, DMAS Staff
Hope Richardson, DMAS Staff

CALL TO ORDER

Dr. Karen S. Rheuban called the BMAS meeting to order at 10:00 a.m. and welcomed the members and others in attendance. Then, Dr. Rheuban asked other members to introduce themselves, and introductions continued around the room.

Dr. Rheuban announced the scheduled 2018 BMAS meetings: April 10, June 12, September 11 and December 11 and asked members to notate their calendars.

APPROVAL OF MINUTES FROM SEPTEMBER 12, 2017 MEETING

Dr. Rheuban asked for a motion to approve the Minutes from the September 12, 2017 meeting. Dr. Price made a motion to accept the minutes and Mr. Cook seconded. The vote was unanimous-**10-yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

APPROVAL OF MINUTES FROM NOVEMBER 15, 2017 DASHBOARD SUBCOMMITTEE MEETING

Dr. Rheuban asked for a motion to approve the Minutes from the November 15, 2017 Dashboard Subcommittee meeting. Ms. Hollowell made a motion to accept the minutes and Mr. Cook seconded. The vote was unanimous-**10-yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Linda Nablo, Chief Deputy Director of DMAS, provided a brief update on the project status of the key programs the agency is currently focused on: Request for Proposals (RFPs), and the Medicaid Comprehensive Quality Strategy submitted to CMS for approval. Ms. Nablo noted that Virginia has been the first state to submit this comprehensive quality strategy to CMS.

Dr. Rheuban, Mr. Cook and Dr. Kongstvedt made a motion to draft a resolution to commend Director Jones for her many years of service and to express deep appreciation to Director Jones for her extraordinary service to the Board, the Commonwealth of Virginia, the beneficiaries served and for her leadership of the agency. Mr. Srinivisan seconded. The vote was unanimous-**10-yes (Coleman, M. Cook, P. Cook, Edwards, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

REPORT OF THE FINDINGS OF THE DASHBOARD SUBCOMMITTEE

Dashboard Chair, Dr. Peter Kongstvedt, provided a brief update on the Dashboard Subcommittee meeting November 15, 2017. Dr. Kongstvedt thanked members who contributed comments and asked for members to continue to send in their comments to the Board Secretary for discussion at a future subcommittee meeting (see attached handout).

UPDATE ON MEDICAID FORECAST

Mr. Scott Crawford, Deputy Director for Finance, provided a brief summary of the Medicaid forecast for FY 2018 and the new biennium, FY 2019-FY 2020. He also provided a summary of the uncertainty surrounding federal CHIP funding (see attached handout).

DMAS ACCOMPLISHMENTS DURING GOVERNOR MCAULIFFE'S ADMINISTRATION

Ms. Suzanne Gore provided highlights on accomplishments and projects involving the agency during the past four years (2014 to present). Dr. Rheuban commended the agency staff for all of their amazing work in achieving these successes.

CHIP REAUTHORIZATION: VIRGINIA IMPLEMENTATION ISSUES

Ms. Linda Nablo, Chief Deputy Director, presented an update on the status of the CHIP reauthorization and explained the potential impact the decisions made by Congress would have on the program. Ms. Nablo also provided a copy of the letter being mailed to members regarding their coverage potentially ending January 31, 2018, and a copy of Governor McAuliffe's release regarding DMAS notifying CHIP recipients of potential loss of benefits due to Congressional inaction (see attached handout).

Currently, funding for this program expired on September 30, 2017, and states are using left-over prior year funds to pay for coverage. Virginia will run-out of these prior year funds on January 31, 2018. If Congress does not extend federal CHIP funding by that time, Virginia will be forced to terminate coverage for approximately 68,000 children and 1,100 pregnant women enrolled in FAMIS.

Ms. Gwilt left the meeting after this discussion.

1332 WAIVER DISCUSSION

Ms. Gore provided a brief summary of 1332 waivers. 1332 waivers are not Medicaid waivers, these are waivers related to the Patient Protection and Affordable Care Act (PPACA) that allow states to experiment with approaches to the individual health insurance market that may make coverage more accessible or affordable. 1115 waivers are Medicaid demonstration waivers. There has been discussion about using 1332 and 1115 waivers together to achieve greater results in terms of accessibility and affordability.

REGULATORY ACTIVITY SUMMARY

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

NEW BUSINESS

ADJOURNMENT

Dr. Rheuban made a motion to adjourn the meeting at 11:38 a.m. Mr. Cook seconded. The vote was **9-yes (Coleman, M. Cook, P. Cook, Edwards, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

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September 12, 2017
Minutes

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

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

DMAS Staff:
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Abrar Azamuddin, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration (OCLA)
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Cynthia B. Jones, Director
Linda Nablo, Chief Deputy Director
Scott Crawford, Deputy Director for Finance
Kate Neuhausen, MD, Chief Medical Officer
Lacy Heiberger, Senior Policy Advisor
Daniel Plain, Health Care Services Director

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

CALL TO ORDER

Dr. Karen S. Rheuban called the BMAS meeting to order at 10:01 a.m. and welcomed the members and others in attendance. Then, Dr. Rheuban asked other members to introduce themselves, and introductions continued around the room.

APPROVAL OF MINUTES FROM June 13, 2017 MEETING

Dr. Rheuban asked for a motion to approve the Minutes from the June 13, 2017 meeting. Dr. Price made a motion to accept the minutes and Mr. Cook seconded. The vote was unanimous-**7-yes (M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.**

DIRECTOR'S REPORT AND STATUS OF KEY PROJECTS

Ms. Cynthia B. Jones, Director of DMAS, provided a brief update on the project status of the key programs the agency is currently focused on: Requests for Proposals (RFPs), Medicaid Expansion, Commonwealth Coordinated Care (CCC) Plus, Behavioral Health, and Addiction Recovery and Treatment Services (ARTS).

FEDERAL ACTIONS AND IMPACT ON VIRGINIA MEDICAID

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

CHIP REAUTHORIZATION: VIRGINIA IMPLEMENTATION ISSUES

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

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

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

UPDATE ON CCC PLUS/MEDALLION 4.0/JLARC RECOMMENDATIONS

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

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

DMAS DASHBOARD DISCUSSION

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

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

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

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

REGULATORY ACTIVITY SUMMARY

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

NEW BUSINESS

ADJOURNMENT

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

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Board of Medical Assistance Services
600 East Broad Street, Suite 1300
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November 15, 2017
Minutes

Present:
Michael H. Cook, Esq.
Patricia T. Cook, M.D.
Rebecca E. Gwilt, Esq.
Maureen Hollowell
Peter R. Kongstvedt, M.D.
Karen S. Rheuban, M.D.
Chair

Absent:
Kannan Srinivasan

DMAS Staff:
Cynthia B. Jones, Director
Linda Nablo, Chief Deputy Director
Karen Kimsey, Deputy Director for Complex Services
Suzanne Gore, Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Elizabeth Guggenheim, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration (OCLA)
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Beth Ferrara, Digital Communications Manager
Bhaskar Mukherjee, ODA Director
Rhonda Newsome, ODA Senior Policy Analyst
Matthew Harrison, ODA Data Researcher

Guests:
Alan Dickerson, DMAS Staff
Stephanie Papps, DMAS Senior Advisor, Finance
Lacy Heiberger, DMAS Senior Policy Advisor

CALL TO ORDER

Dr. Karen S. Rheuban called the BMAS Dashboard Subcommittee meeting to order at 10:05 a.m. and welcomed the members and others in attendance. Then, Dr. Rheuban asked other members and staff to introduce themselves.

Dr. Rheuban inquired about the status of a letter requested to be sent to Governor-elect Northam to congratulate him for his election victory, and to voice BMAS support for Medicaid expansion. The Board Secretary provided a copy of the letter for Dr. Rheuban and Dr. Kongstvedt's signature.

Dr. Rheuban appointed Dr. Peter Kongstvedt to chair the Dashboard Subcommittee and turned the meeting over to him and the meeting continued.

OVERVIEW OF CURRENT MEDICAID DASHBOARDS PRODUCED BY OTHER STATES

Ms. Beth Ferrara, DMAS Digital Communications Manager, provided a brief overview of the current Medicaid dashboards produced by other states. She explained the dashboards that states are providing typically fall in one of two categories: 1. static infographics or 2. automated interactive dashboards. The Centers for Medicare and Medicaid Services (CMS) has offered guidance to states on building interactive dashboards. This approach takes thorough planning and a cross functional team. (see attached handout).

FUTURE DMAS DATA WAREHOUSE AND VISUALIZING DATA

Ms. Bhaskar Mukherjee, Director of the Office of Data Analytics (ODA), provided a demonstration and data warehouse update expanding on background information provided at a previous Board meeting. A health services and innovation company, Optum, was awarded the data warehouse contract on October 23, 2017. (see attached handout).

Ms. Rhonda Newsome, Mr. Matthew Harrison and Mr. Mukherjee provided additional 'live' and concrete examples of an array of different types of information already available and shared examples of existing dashboards in an effort to share information which could possibly be helpful in the Subcommittee's consideration for the development of an agency/BMAS dashboard.

DMAS DASHBOARD DISCUSSION

Dr. Kongstvedt provided introductory remarks to open the discussion of the dashboard. After ODA staff and DMAS staff shared a broad amount of information to stimulate discussion and inform members of key statistics already available at the agency, Dashboard subcommittee members were asked to share their thoughts on what Board members would want to focus on in developing an agency/BMAS dashboard.

The discussion ended with Dr. Rheuban requesting members to send their comments regarding the dashboard to the Board Secretary for compilation and presentation of their findings at the next BMAS meeting on December 12, 2017.

ADJOURNMENT

Dr. Kongstvedt adjourned the meeting at 11:33 a.m.

Dashboards and Reports, and Data, Oh My!

Peter Kongstvedt MD FACP

November 27, 2017

Introduction

Members of the Board of Medical Assistance Services (BMAS) had previously requested the development of a dashboard. Little further definition followed, however. Around the same time, DMAS was transitioning to new information technology (IT) systems and operations, including preliminary work on data and reporting. In late October of this year, DMAS selected Optum to assist with their development of a Data Warehouse. Subsequently, a BMAS Subcommittee on the dashboard met on Nov. 15 of this year.

During that meeting, it became clear that among those BMAS members who attended, there were differing ideas and concepts about what a dashboard is, what it should include, and what it should do. I made some remarks to help things into context, and the BMAS members in attendance felt that it would be important to communicate those organizing principles about dashboards to better allow us to define what we want.

It is important to keep in mind that DMAS overall, as well as specific divisions within DMAS, already have dashboards or are in the process of creating them; examples include medical quality, CHIPAC (for children's health), and various IT initiatives. This means two things: a BMAS dashboard may be populated by information that has already been defined; and that information useful to some BMAS members but not to BMAS as a whole, can be handled by including a board member's name to a distribution list. This can be sorted out later, however.

What follows are ten guidelines I am putting forth for defining dashboard requirements for BMAS members, and a homework assignment for you to complete. Yes, seriously – homework, but voluntary homework. We are asking BMAS members take some time to identify the specific items that they would like to have us consider as a board for inclusion on a dashboard, while applying these guidelines as appropriate.

In addition, a BMAS-specific ad hoc reporting function is a related but distinct information reporting tool that we may also consider having created or aggregated; either later, or in parallel to creating a BMAS-specific dashboard. This would be a tool that BMAS members could use on their own to retrieve information that they would like to have on the fly, but that does not need to be, or cannot readily be displayed on a dashboard. An example would be the ability to know how many individuals in a specific district are, or would be, affected by an issue involving any of the programs administered by DMAS (though this information exists right now though a link on the DMAS Home Page). It may therefore be helpful to know if there are specific ad hoc reports that you would like to have available to you on a relatively frequent basis, using many (but not all) of the same guidelines provided in the next section.

Finally, dashboards are not sculptures, meaning they are not carved in stone. It is useful and necessary to periodically reassess the usefulness of any dashboard element to discard, add or modify as appropriate. It is good for a dashboard to be relatively stable; it is not good for it to be inert.

Ten Guidelines for Dashboard Development

To make progress on a dashboard for BMAS members, we must agree on some guidelines. This allows us to focus and define what we want in a dashboard, and it helps us avoid a great deal of wasted time and energy. Having been involved developing, and using, dashboards at board and senior leadership levels, I offer the following ten overlapping guidelines, in no particular order other than the first guideline:

Ten Guidelines for Dashboard Requirements for BMAS

1) Dashboards Have No Magical Powers

Dashboards have no magical powers, and cannot solve any problems on their own. We all understand this intellectually, but at a deeper level we hope it to be true nevertheless.

2) No One Dashboard Fits All

No one dashboard fits all constituents because there are far, far too many possible elements to include. A dashboard should be focused on its primary constituency or group of users. Said another way, we should not try to meet what we perceive (or believe) to be the needs of other types of constituents. Said another, another way, a BMAS dashboard should be focused on BMAS members only. If it's useful for others, great, and it should be publicly available in some way. But those other constituencies need to be involved in developing dashboards that suit them.

3) No Dashboard Can Tell You What You Haven't Specifically Asked It to Tell You

A dashboard, or any reporting tool, must be told *exactly* what information you are looking for.[*] If you want it to show you something that is not really defined in specific terms, a dashboard or any reporting tool can do nothing. For example, wanting it to know about "satisfaction" or "quality of care" can only be done if those terms are defined in enough detail to be able to locate and retrieve those specific data. The machine has no idea what "quality" is; in fact, the machine has no ideas at all because it's a machine. Machines do not think, they do.

4) Dashboard Information Must Be Relevant, Actionable, Consistent, and within The Primary Users' Scope of Responsibilities

This becomes particularly important to a appointed position in a state government, for which responsibilities and duties are defined in laws and subject to regulations.

A good way to think about this is to not ask for data that you, as a member of BMAS, are outside the scope of your responsibilities and duties. This helps to keep things focused on what is useful and/or necessary for BMAS. Always bear in mind that BMAS does not run DMAS; that is the responsibility of DMAS leadership and managers.

The easiest way to stick to this guideline is to ask yourself the following questions before requesting any data or data set to be reported on a BMAS dashboard:

1. Which BMAS responsibility is specifically addressed by this data?
2. What can I or will I do with it?

[*] Said more accurately, you have to tell the programmers what to look for.

3. Is it something that I want or need to know on a regular and continually updated basis, or is it really a one-time request?
4. Am I trying to do somebody else's job?

Note that "usable/actionable" is not a strict requirement. It is possible that there may be some information that would qualify as need-to-know, but would not be something that you, personally would or could act upon.

5) Keep It Simple, Simpler, and Simpler Still

The ideal dashboard has a single screen on a laptop or a monitor. The data displayed is large enough to actually read, and may be best presented graphically; though not a requirement, it improves usability. A user should be able to understand the information on a dashboard right away, without squinting or going colorblind (from too many differently colored graphics). Simple also means limiting the amount of data displayed or shown. The more cluttered the page, the less it will be used.

6) Metrics are Only Useful When You Know What It Is and What It Is Supposed to Be

A metric, or number, tells you nothing if you don't know what it is or what it is supposed to be. As for what it is, that can be met by simply describing the metric at the top of the information element using one or a combination of descriptors; a few examples of this include things such as:

- Numbers of "X" in Thousands (or whatever is appropriate, with "X" being the metric being displayed);
- Time span for data being used, such as the 1st Quarter or the Month; or
- Percentage progress towards goal.

You need to also know how that number compares to something else; a few examples include things such as:

- Progress towards a goal,
- Progress of a major project
- Performance compared to budget, or
- An expected value (e.g. covered lives, utilization, etc.).

7) A Dashboard is Not the Same as a Data Retrieval and Reporting Tool

This means that a dashboard, while not static, is meant to be a compact set of data used to monitor things, and therefore does not change on the fly. If one can drill down into any set of data, all the better, but that's not the point. If you have specific things you want to know that are not really an ongoing need for the majority of BMAS members, that's a better time to use an ad hoc reporting tool, and if used frequently it may be a candidate for a BMAS-specific ad hoc reporting tool.

8) Information Takes Time

Don't get hung up on "real time" data and information. It takes time for transactions to occur, for data to be reported and downloaded into the DMAS systems form vendors, to correct problematic data, and to put it all through a process that will make data from different sources into consistent formats. And then it takes more time to turn data into information because it must go through data retrieval and collation,

calculation(s), and creation of usable information in formats that humans can understand.[†] So as-fresh-as-reasonably-possible" results in usable information.

9) Focus, Focus, Focus

Stay focused on the guidelines described above. It is an easy and understandable human trait to think of something or multiple somethings related to a single item of information; each of those can do the same thing.

10) See Guideline Number 1

See Guideline Number 1. Repeat.

Summary List of Guidelines

1. Dashboards Have No Magical Powers
2. No One Dashboard Fits All
3. No Dashboard Can Tell You What You Haven't Specifically Asked It to Tell You
4. Dashboard Information Must Be Relevant, Actionable, Consistent, and within the Primary Users' Scope of Responsibilities
5. Keep It Simple, Simpler, and Simpler Still
6. Metrics are Only Useful When You Know What It Is and What It Is Supposed to Be
7. A Dashboard is Not the Same as a Data Retrieval and Reporting Tool
8. Information Takes Time
9. Focus, Focus, Focus
10. See Guideline Number 1

Homework Assignment

Before the next schedule BMAS meeting on Dec. 12th, it would be very helpful for BMAS members with any interest in a dashboard, provide specific input to take some time to communicate that by sending your thoughts and comments to Ms. White at DMAS so she can collect and collate them. Using the guidelines described above, here are the four elements to address for each thing you want to include on a dashboard:

1. What specific information do you want to see?
2. Which BMAS responsibility is specifically addressed by this information?
3. What can or will you do with that information?
4. Is it something that I want or need to know on a regular and continually updated basis, or is it really a one-time request?
5. Extra Credit Question: Have you subconsciously assigned any magical power to this information?

If you want to do a bit more, you could also help by identifying certain information you would like to be considered for including in an ad hoc reporting tool for BMAS members.

Thank you

Dr. Rheuban submitted the following dashboard metrics be considered for the dashboard:

1. Enrollment data by category (age, program – such as Medallion, CCC+, FFS, Famis, other)
2. Enrollment by region
3. Spending by category
4. Spending by region
5. Performance metrics of our contracted MCOs including quality data and network adequacy
6. GAP program data
7. ARTS benefit data
8. Progress of data warehouse efforts with Optum

Ms. Cara Coleman submitted the following comments:

As to dashboard homework, here are my responses:

-it would be great to have enrollment data in terms of numbers on a dashboard as well as how much DMAS receives as a budget from the general assembly. Additionally, it might be helpful to also know how much each program costs- and if there is available long run cost saving data. Many of the program updates you send have enrollment data, but it would be helpful to have on one page rather than searching through documents.

- I use this data several times a year when teaching medical students, residents and when doing other healthcare advocacy work (with Virginia Medicaid as my example).

- I could handle getting this info once a year and indicate that it is a yearly estimate.

Ms. Rebecca Gwilt submitted the following comments:

1. What specific information do you want to see? Whether vendor projects are on budget - perhaps info on contract mods (that add additional $$). I assume they internally have performance metrics based on care of patients--the board may be interested in those as well. I would like to see a list of performance metrics in the existing major contracts. Also, I want to see rates of contracting with SWAM businesses
2. Which BMAS responsibility is specifically addressed by this information? Making sure DMAS money is being spent appropriately; remaining informed about spending, which is the focus of the GA when setting budgets; making sure we are committed to diversity in VA government
3. What can or will you do with that information? I will use it to determine whether we need to focus on unnecessary spending or inefficient contracting and whether we need to put pressure on DMAS to commit to hiring SWAM contractors
4. Is it something that I want or need to know on a regular and continually updated basis, or is it really a one-time request? ongoing
5. Extra Credit Question: Have you subconsciously assigned any magical power to this information? I tried!

Mr. Michael Cook submitted the following comments:

I had intended to comment on the performance metrics for the MCOs similar to Dr. Rheuban's but had not had time to focus yet. However, I would amplify one of Dr. Rheuban's comments. In terms of data from the MCOs, I would like to make sure that the performance metrics for the MCOs include the waiting time for physicians' visits – both primary and specialty care by MCO and area of the state, and satisfaction metrics, e.g. a synopsis of complaints and appeals and resolutions, or if they conduct one, the results of any satisfaction survey by MCO.

I will likely comment further after reviewing Peter's synopsis; however, I agree with his concern expressed at the meeting that we not seek too much data on the dash board – especially data that we will not use in our role.

SUGGESTED INFORMATION TO BE DISPLYAED ON BMAS DASHBOARD – MICHAEL COOK

1. For the Medallion Program, I would like to see the following information by Region and Plan:

a. Average wait time (on a rolling basis if feasible) for a three-month period for an appointment for a physician's visit, separated between primary care and specialist;
b. Average length of inpatient hospital stay on a quarterly basis;
c. Number of ER visits on a quarterly basis;
d. Number of hospital readmissions for the same condition over a 60-day period (or other period reported by the plan), on a quarterly basis;
d. Each quarter, the number of complaints if we or the plans have a compliant mechanism, in categories of beneficiary and provider;
e. Each quarter, number and types of beneficiary and provider appeals for service and resolution as either fully provider favorable, beneficiary favorable, or plan favorable, or partial for each category;
f. Synopsis of any satisfaction surveys (broken down by broad categories as specified in the contracts);
g. If the contracts have requirements or goals for number and types of providers, the progress of each of the plans in meeting those goals on a quarterly basis;
h. On a yearly basis, the difference between expenses (broken down between administrative and patient care as categorized by DMAS in its contracts) and revenue;
i. On a quarterly basis, by type of provider, the number of providers that withdraw from or are terminated from the plans;
j. If available, the number of adult hospital admissions for conditions that are related to the failure to obtain dental care;
k. On a monthly basis, the number of plan members.

2. For CCC program, separated by plan and region, I would like to see the following:

a. On a quarterly basis, the number of patients being served I nursing facilities as opposed to receiving long term care services in their homes. By long term care services , I am referring to non-MR/DD beneficiaries receiving these services;
b. On a quarterly basis, the number and types of providers that have contracts with the plans;
c. On a quarterly basis, the number of avoidable hospital admissions from a nursing facility, if tracked under the contract and as defined under the contracts;

e. On a quarterly basis, the number of providers by category, and for those services for which Medicare has a 5-star rating plan, the star rating of those providers;
f. If the contracts have requirements or goals for number and types of providers, the progress of each of the plans in meeting those goals on a quarterly basis;
g. On a quarterly basis, by type of provider, the number of providers that withdraw from or are terminated from the plans
h. On a monthly basis, the number of plan members.

The purpose of this information is to try to determine the level of access to care and quality, thereby giving us the ability to know the type of information that we would need to drill down on these issues.

OVERVIEW OF THE FY 2018-2020 FORECAST

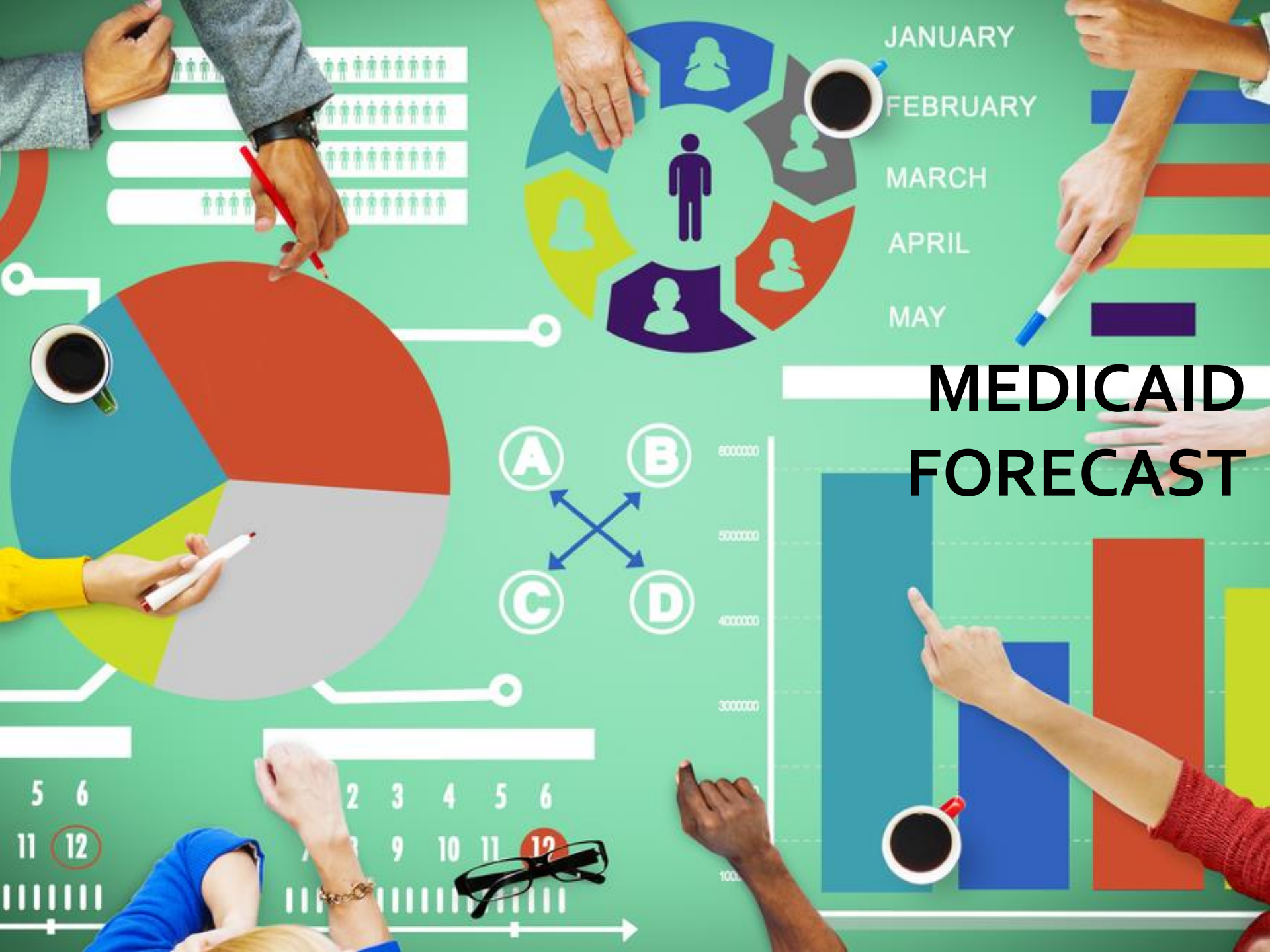
Presentation to:
Board of Medical Assistance Services

Scott Crawford
Deputy Director, Finance

December 12, 2017

Agenda

- Medicaid Forecast
- CHIP Uncertainty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Forecast Overview

Medicaid forecasts in even-year General Assembly sessions have 2 parts

Caboose
Forecasted changes in the current fiscal year (FY 2018)

Caboose Budget (FY 2018)

- Provides for changes to the budget for the current fiscal year that began 7/1/2017 and ends 6/30/2018
- Need in the Caboose budget equals the forecast minus the existing FY 2018 budget

New Biennium
Forecasted changes in the next 2 fiscal years (FY 2019 & FY 2020)

New Biennium (FY 2019 & FY 2020)

- Provides a new budget for the next 2 fiscal years
- Need is larger because the starting point is last year's budget
- Need equals the forecast for each of the next 2 years minus the 2018 budget

New Medicaid Forecast Results in a $86.7M GF Need in Current Year

		Appropriation ($millions)	Consensus Forecast ($millions)	Surplus/(Need) ($millions)
FY 2018	**Total Medicaid**	**$9,625**	**$9,910**	**($285.1)**
	State Funds	$4,917	$5,003	($86.7)
	Federal Funds	$4,709	$4,907	($198.3)

FY17-FY18 Biennium State Funds Surplus/(Need)	($86.7 GF) (1.8% change)

Figures may not add due to rounding

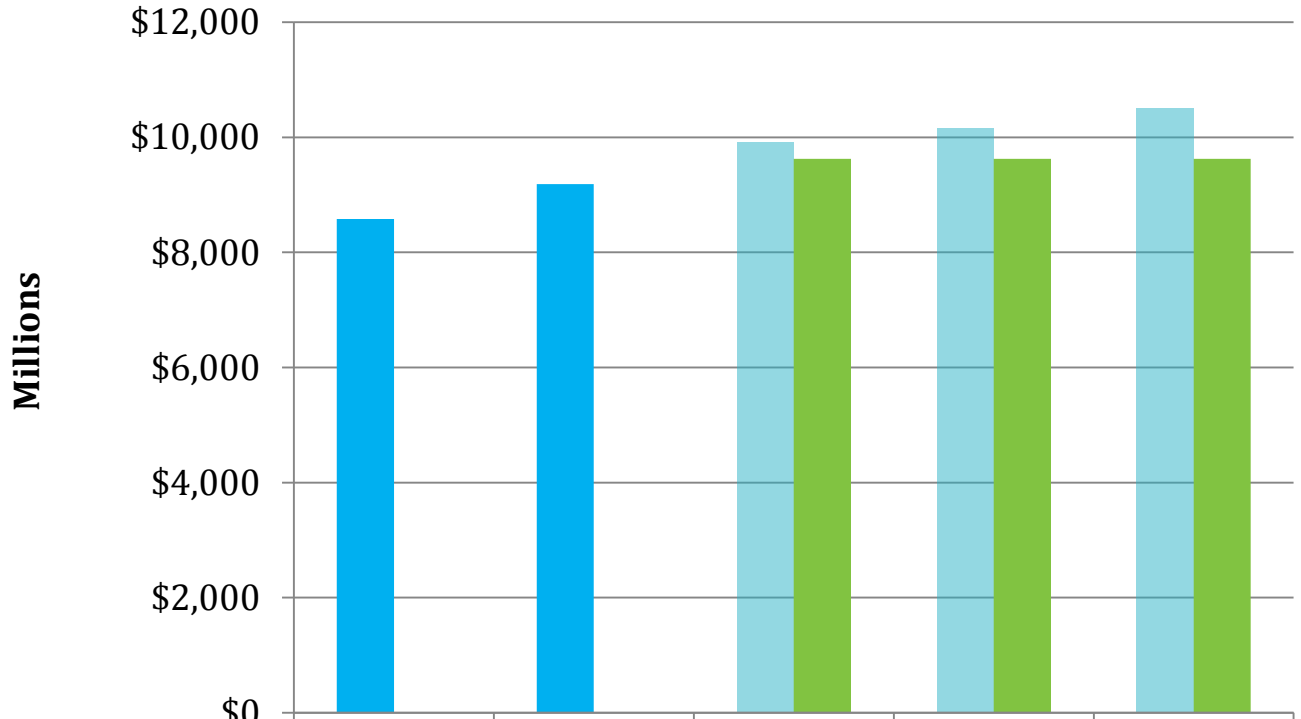
New Medicaid Forecast Results in a $583.9M GF Need in New Biennium

		Appropriation ($millions)	Consensus Forecast ($millions)	Surplus/(Need) ($millions)
FY 2019	**Total Medicaid**	**$9,625**	**$10,159**	**($533.8)**
	State Funds	$4,917	$5,116	($199.5)
	Federal Funds	$4,709	$5,043	($334.4)
FY 2020	**Total Medicaid**	**$9,625**	**$10,508**	**($882.5)**
	State Funds	$4,917	$5,301	($384.4)
	Federal Funds	$4,709	$5,207	($498.1)
		FY19-FY20 Biennium State Funds Surplus/(Need)		**($583.9 GF) (5.9% change)**

Figures may not add due to rounding

New Medicaid Projections

New forecast shows a $670.6M GF need for FY 18 and FY19-FY20 Biennium



	FY16	FY17	FY18	FY19	FY20
Medicaid Expenditures/Forecast	$8,582	$9,189	$9,910	$10,159	$10,507
Medicaid Appropriation			$9,625	$9,625	$9,625

Drivers of Forecast Changes

	Description	FY18?	FY19/FY20?
Hospital Payments	• Lump sum payments in FY18 delayed from past years	Yes	No
	• Increase in non-GF payments required by the 2017 budget	No	Yes
Medicare Premium Changes	• Smaller rate change than in previous years – 0% change in Part B; 1.22% change in Part D	Yes	Yes
Low Income Adult Growth	• Adult population has grown in 2017 as more members remain in Medicaid and are not disenrolled	Yes	Yes
Managed Care Rate Assumptions	• Rate changes for existing services smaller than previously anticipated	Yes	Yes

Other Forecast Changes

Other Trends and Assumptions Impacting the Forecast

Waiver Redesign

- New services began in September 2016

Behavioral Health

- Increased growth but moving under managed care

Hospital and Nursing Home Rates

- Inpatient hospital rates increase by 2.8% in FY19 and 3.0% in FY20
- Nursing home rates increase by 2.9% in FY19 and 3.0% in FY20

2017 General Assembly Actions Impacting the Forecast

GAP Eligibility

- Increased from 80% to 100% FPL effective 10/1/2017

New ARTS Services

- Residential treatment services began 4/1/2017
- Peer supports began 7/1/2017

CHKD Rates

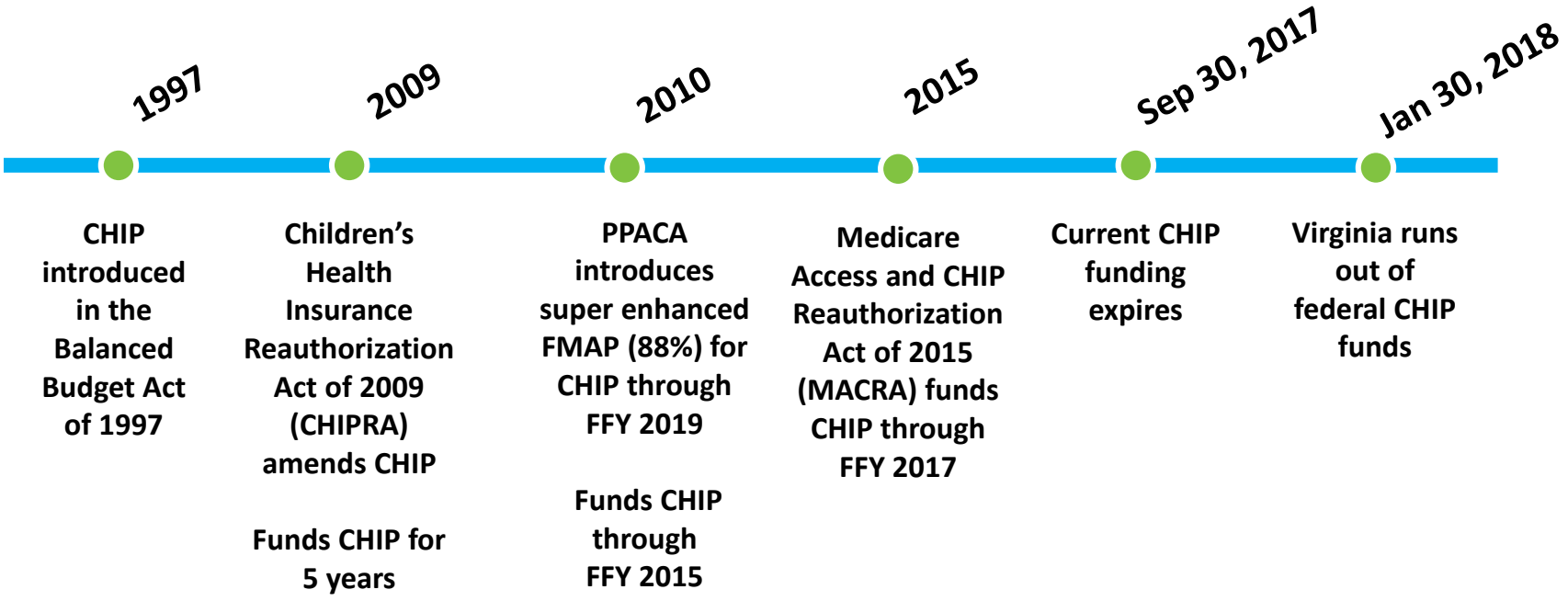
- FY18 inflation adjustment restored

CSB Same Day Access

- Increased Medicaid utilization at CSBs due to services rendered same day


CHIP
UNCERTAINTY

CHIP Timeline

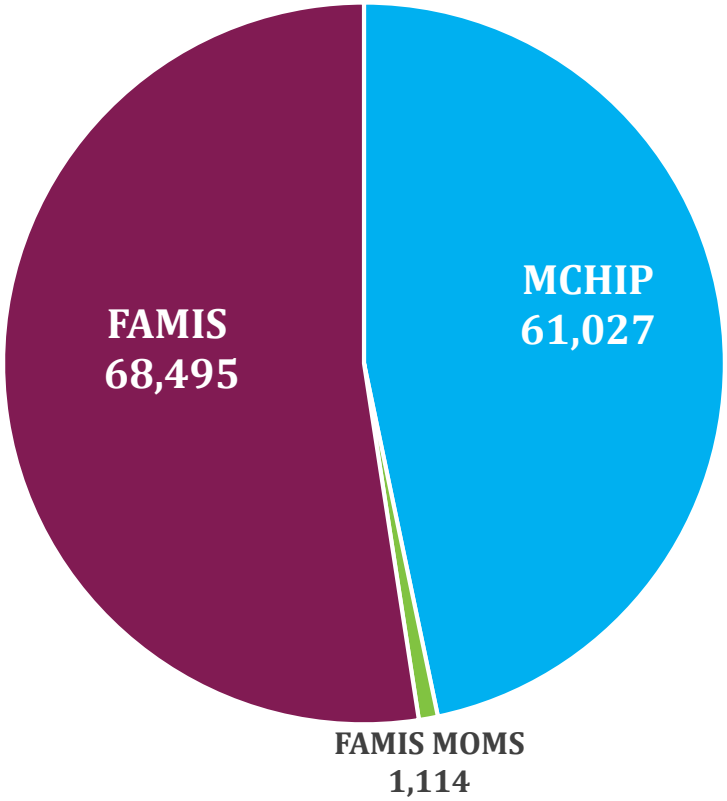


Congress has already missed the deadline for renewing funding for CHIP. Virginia, and other states, are using left-over funds from prior years to support the program. DMAS expects to run out of federal CHIP funds on January 31, 2018.

Maintenance of Effort Requirements Determine State Options

- Maintenance of Effort Requirements
  - PPACA requires that states maintain the same eligibility levels in place as of 3/23/2010 until 9/30/2019
  - If federal CHIP funding is not provided, does not apply to FAMIS recipients
  - BUT, would still apply to MCHIP recipients who would revert to a 50/50 match

- Over 68,000 children and 1,100 pregnant women could lose their coverage on 1/31/2018
- Enrollment as of 12/1/2017:



If CHIP Is Not Renewed, Additional GF Will Be Needed to Maintain MCHIP

	FY 2018	FY 2019	FY 2020
Additional GF Needed to Maintain MCHIP	**($26.4M)**	**($60.1M)**	**($47.9M)**
	Total GF Needed to Maintain MCHIP		**($134.4M)**

Figures may not add due to rounding

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

2017 General Assembly

***(01) 2017 Institutional Provider Reimbursement and 2017 Non-Institutional Provider Reimbursement:** These final exempt regulatory actions are required by the *2017 Acts of Assembly*. These actions will allow DMAS to make supplemental payments to certain hospitals for a specified number of primary care residencies with the stipulation that the hospital maintains residency slots and required documentation annually to verify that required criteria is met. Preference for the residency slots shall be given to those in underserved areas. DMAS shall adopt criteria for primary care, high need specialties, and underserved areas developed by the Virginia Health Workforce Authority. Additional language has been added to clarify that effective July 1, 2017, IME payments will continue to be limited for freestanding children's hospital with greater than 50 percent utilization to not exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject, excluding third party reimbursement for Medicaid eligible patients. The corresponding SPA packages (which implement mandates in the Virginia 2017 Acts of Assembly pertaining to payment methodology and inflation in state fiscal year 2018) are being processed concurrently with the regulatory changes. The regs were drafted and submitted to the OAG for review on 8/2/1. DMAS responded to OAG inquiries on 9/7. The Institutional Provider Reimbursement SPA package was drafted and forwarded to HHR on 9/5/17; submitted to CMS on 9/29; and following a conf. call on 10/5/2017 with CMS, DMAS is currently drafting responses to CMS' inquiries. The Non-Institutional Provider Reimbursement SPA package was submitted to HHR on 9/13/17 and forwarded to CMS on 10/5. Following a conf. call with CMS, DMAS submitted responses to their inquiries on 11/7, 11/15, and 11/23. CMS approved the SPA on 11/30.

***(02) Outpatient Mental Health Service Limit Review:** This state plan amendment removes the 26-visit limit from outpatient psychiatric services in conformance to changes in federal law and state regulation. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and federal regulations (42 CFR Part 438, Subpart K (438.900 et seq.) and 42 CFR Part 440, Subpart C (440.395) require that Medicaid cover mental health and substance use disorder benefits to the same degree and in the same manner as medical/surgical benefits; that is, the financial requirements and treatment limitations must be the same. Medicaid is not permitted to impose financial limitations (such as a lifetime dollar benefit limit) nor service limits (such as a specified number of covered visits) for mental health and substance abuse treatment services that it does not also impose on medical/surgical services. In the past, DMAS limited its coverage of outpatient psychiatric visits to 26 visits in a year without prior authorization being required. Subsequent outpatient psychiatric services required prior authorization and were also limited to 26 visits per annum. This service limit was adopted in 1981 (State Plan Amendment 81-05). This update removes the 26-visit limit from outpatient psychiatric services from the State Plan in accordance with the mental health parity provisions. Following internal DMAS review, the SPA was sent to HHR on 7/19/17 and subsequently to CMS on 7/25/17. DMAS submitted updated information on 8/16, and responded to CMS inquiries on 8/28, 8/30, and 8/31. CMS approved the SPA on 9/18/17.

***(03) Reimbursement of Community Mental Health Services and Dental Interpretive Services:** This state plan amendment serves to add text to the state plan regarding reimbursement practices that currently are in place relating to reimbursement of community mental health services, private duty nursing, assistive technology, and personal assistance services, and to reflect the inclusion of updated dental procedure codes in the agency fee schedule. The SPA was drafted internally; submitted to HHR on 7/17; and forwarded to CMS on 7/25/17. DMAS fielded questions from CMS and sent responses on 8/25 and 9/1. Following a conf. call with CMS on 9/21/17, the SPA was approved on 10/17/2017. *(As a result of the conf. call on 9/21, Dental and CMHRS remained in this SPA, while PDN, AT, and PAS were moved to a new SPA).

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

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

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

***(07) Reimbursement for Nursing Facility Evacuation Costs:** In the event of a disaster resulting in an evacuation, nursing facilities seek to relocate individuals to nursing facilities in safer areas. DMAS is submitting this state plan amendment to clarify reimbursement provisions relating to reimbursement to the disaster-struck nursing facility. In November, 2016, CMS announced a final rule entitled "Emergency Preparedness" (42 CFR 483.73) which requires long term care facilities to establish and maintain an emergency preparedness program. The Virginia Department of Health, the Virginia Department of Emergency Management, the Virginia Hospital and Healthcare Association, and the long-term care provider community worked to establish a Long Term Care Mutual Aid Plan and a Memorandum of Understanding (MOU) for all facilities to sign. All nursing facilities in Virginia have signed this MOU, which details their responsibilities in the event of a disaster. Following a draft and internal review which began in March 2017, DMAS submitted the SPA to HHR on 5/30 for review. The action was then submitted to CMS for review on 6/6/17 and approved on 7/14/17. The corresponding regulatory changes 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.

***(08) Average Commercial Rate Calculation for Physicians Affiliated with Type One Hospitals:** DMAS is issuing this state plan amendment to update the average commercial rate calculation of supplemental payments for physicians affiliated with Type One Hospitals in Virginia. The state plan includes physician supplemental payments for physician practice plans affiliated with Type One hospitals (state academic health systems). A Type One physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, which has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10. This regulatory action will update the maximum rate to 256% of the Medicare rate effective April 1, 2017, and 258% effective May 1, 2017 based on the most recent information on the average commercial rate (ACR) furnished by the state academic health systems and consistent with appropriate prior public notices. Following a draft and internal review which began in May 2017, DMAS submitted the SPA to HHR on 6/8 for review. The SPA was then submitted to CMS on 6/22 for review. DMAS responded to CMS inquiries on 8/15/17 and split the SPA into two sections per CMS request. CMS approved the SPAs on 8/31. 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.

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

in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The Commonwealth has recently adopted the VIDES standards for the comparable level of waiver services in communities. By using the VIDES standards for institutional care in this action, the Commonwealth is restoring the consistency of functional standards for individuals regardless of whether they obtain their care in their communities or in ICF/IID institutions. The reg package has been drafted and is circulating internally for review as of 5/16/17.

***(10) Requirements for LTC Facilities:** This final exempt regulatory action amends DMAS' nursing facility requirements for Medicaid participation so that they are in line with CMS requirements. A series of CMS revisions to CFR Part 483 (Requirements for States and Long Term Care Facilities) necessitates changes to what are now outdated CFR citations in DMAS regulations. Beginning April 2017, the reg package was drafted and circulated for internal review. The regs were submitted to the OAG on 6/22. DMAS responded to OAG inquiries on 6/28 and 8/9/17. The regs were OAG certified on 8/14, submitted to DPB on 8/15, and submitted to the Registrar on 8/16. The regs were published in the Register on 9/4, with an effective date of 10/19/17. A notification of 'final reg available for review' was sent to Town Hall users on 9/5. The corresponding SPA package was circulated for internal DMAS review as of 9/25; forwarded to HHR on 11/1; and submitted to CMS on 11/13. Following a conf. call on 12/4 with CMS, DMAS submitted revised state plan pages on 12/5, and is awaiting CMS response.

***(11) Client Appeals Amendments to Comply with Federal Rules Changes:** This final exempt regulatory action will update DMAS regulations on client appeals to reflect two different federal regulatory changes. The first set of federal rule changes was published in the Federal Register under the title, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." (81 FR 27498, May 6, 2016.) The second set of rule changes was published in the Federal Register under the title "Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP." (81 FR 86382, November 30, 2016.) The regulatory package was drafted, reviewed internally, and submitted to the OAG on 5/18/17. DMAS Submitted responses to OAG inquiries on 6/26 and 8/3. Additional changes were forwarded to the OAG on 9/22. The regs were certified on 10/13, and submitted to the Register; published on 11/13/17, and will be final on 12/13/17. A notification of 'final reg available for review' was sent to Town Hall users on 11/13.

***(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 is currently coordinating a response.

***(13) Peer Support Services and Family Support Partners:** This fast track regulatory action responds to a legislative mandate to implement peer support services to children and adults who have mental health conditions and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. The experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in the delivery of a comprehensive mental health and substance use service delivery system. Peer Support Services shall target individuals 21 years or older with mental health or substance use disorder or co-occurring mental health and substance use disorders. A Peer Support service called Family Support Partners shall be provided to individuals under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their families or caregivers. The reg package was reviewed and prepared internally and submitted to the OAG on 4/21, with additional revisions forwarded on 4/27/17 and 5/11/17. Following a conf. call on 5/17 with the OAG, DMAS submitted revisions to the regs on 5/22, 5/24, 5/31, and 6/6. The regs were certified by the OAG on 6/13; forwarded to DPB on 6/19/17; and submitted to HHR on 7/28. The regs were submitted to the Governor on 8/1 and approved by the Governor on 9/8. The regulatory action was submitted to the Register on 9/8; published on 10/2; and became final on 11/17. A notification of 'final reg available for review' was sent to Town Hall users on 10/2. The corresponding SPA was submitted to HHR on 9/13/17 for review; submitted to CMS on 11/1; and approved by CMS on 11/21/17.

***(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. DMAS is awaiting a response.

***(15) Revision for CMS Conditions of Participation:** This final exempt regulatory action implements two changes: 1) updating a citation to an amended federal regulation related to Conditions of Participation (COPs) for Home Health Agencies (HHAs), and 2) updating regulations to comply with a Virginia Code section relating to exemptions from licensure requirements for HHAs. On January 13, 2017, U.S. Centers for Medicare and Medicaid Services (CMS) issued final regulations to amend the COPs for HHAs. Among the changes, the final rule recodifies 42 CFR 484.36 in the newly created 42 CFR 484.80. The final rule effective date is July 13, 2017. In order to comply with the federal final rule, Virginia regulations need to be amended to update the CFR citation that is referenced for home health aide requirements. Following an internal DMAS review, the package was submitted to the OAG for review on 3/31/17. Per OAG request, revisions were made on 4/26/17. Certified by the OAG and submitted to DPB on 5/9. Project was withdrawn from submission based on CMS regulations delay, which had the regs originally taking effect in July 2017, but is now postponed until January 2018. CMS issued an amended effective date on 7/10. The regs were submitted to the Registrar on 7/10; and published in the Register on 8/7/17. The final exempt effective date is Jan. 13, 2018. The corresponding SPA package was submitted to HHR on 10/27 and forwarded to CMS on 11/2/17. DMAS responded to CMS inquiries on 11/13 and participated in a conference call on 11/16. CMS approved the SPA on 11/27.

***(16) Home Health Accrediting Organizations:** This fast track regulatory action brings accreditation requirements in line with: 1) the state licensure requirements outlined in §32.1-162.8 of the Code of Virginia; and 2) the CMS list of approved accreditation organizations for Medicare HHAs. Consistency among approved accreditation organizations will clarify and streamline requirements for DMAS providers. This regulation is essential to protect the health, safety, or welfare of citizens in that it provides consistency between the regulations and the Code with regard to the licensure requirements for HHAs. This consistency will help ensure that HHAs are appropriately licensed to provide services to Medicaid members. The regs circulated for internal review and were forwarded to the OAG for review on 4/27/17. DMAS responded to an OAG inquiry on 5/12. The regs were OAG certified on 5/17 and were submitted to DPB on 5/17/17. Following a conf. call with DPB on 6/16, the regs were submitted to HHR on 6/23, and to Governor on 7/5/16. The Governor approved the action on 8/4, with an effective date of 10/19/2017. A notification of a 'final reg available for review' was sent to Town Hall users on 9/5. The corresponding SPA was drafted and reviewed internally and submitted to HHR on 12/6 for review.

(17) 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.

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. and Nov. 2017. DMAS is currently awaiting additional feedback.

***(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.

***(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 12/5.

(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 is currently drafting the next stage of the regulatory review.

(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 to discuss the regs. DMAS is currently coordinating the responses for the OAG.

***(06) Low Dose Computed Tomography (LDCT) Lung Cancer Screening:** This emergency regulatory action is required by the 2016 budget language. This regulation will serve to provide coverage of LDCT lung cancer screening as a preventive measure for at-risk beneficiaries. The regulations were drafted and sent to OAG on 10/19/16 and became OAG certified on 11/4/16. The regs were submitted to DPB on 11/7; to HHR on 11/16; to the Governor on 11/20/16; and were signed by the Governor on 12/6. The regs were published in the Register on 12/26, with comment period through 1/25/17. The Proposed Stage regulatory package circulated for internal DMAS review on 2/1/17 and was submitted to the OAG on 3/15 (the corresponding SPA for this regulatory action was approved by CMS on 3/13/17). The OAG approved/certified the regs on 4/6 and they were submitted to DPB on 4/10. DPB submitted the regs to HHR on 5/25. The action was submitted to the Governor's Ofc. for review on 5/29 and the Economic Impact Analysis (EIA) response was posted to the Town Hall on 5/31. The action was signed by Governor on 6/30 and submitted to the Registrar. The regs were published on 7/24, with a 60-day comment period. The final stage reg package began circulating for internal review on 9/29. The regs were submitted to DPB on 10/25/17; submitted to the Sec. Ofc. for review on 10/25; forwarded to the Governor on 11/1/17; and submitted to the Registrar on 11/13. The regs were published on 12/11, with a comment period through 1/10/2018. The regs will be effective date on 1/10/18. A notification of 'final reg available for review' was sent to Town Hall users on 12/11.

***(07) 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.

***(08) Reconsideration of Final Agency Decision:** This emergency regulation made necessary and authorized by action of the 2016 Virginia General Assembly in enacting *Code of Virginia* §2.2-4023.1. That new section provides for establishment of a reconsideration process by which appellants can petition the agency director to reconsider the agency's Final Agency Decision made pursuant to the *Code of Virginia* §2.2-4020. The statute specifically authorizes the agency to promulgate emergency regulations to specify the scope of the reconsideration review. This emergency regulation adopts the process and timeline set forth in the statute and specifies the scope of review. The regulation was drafted and sent to the OAG on 8/4. The regulatory action was certified and sent to DPB on 10/13; forwarded to HHR on 10/23; and submitted to the Governor on 11/20/16. The Governor signed on 12/6/16 and the regs were published in Register on 12/26, with comment period through 1/25/17. The corresponding SPA was drafted and began circulating on 12/1/2016. The SPA was submitted to HHR on 12/9. Following HHR approval, the SPA was submitted to CMS on 12/15 and approved on 1/10/17. The proposed stage regs were sent to the OAG and certified on 2/15/17 and forwarded to the DPB on 2/17. The EIA was posted on 3/28 and DMAS posted a response on 3/29. The regs were forwarded to HHR on 4/3/17; submitted to the Governor on 4/20; and signed by the Gov. on 5/19. The regs were published in the Register on 6/12/17, which opened a 60-day public comment period. The final stage regs were drafted and submitted to DPB on 9/6; forwarded to HHR on 9/13; and submitted to the Governor on 9/28/17. The Gov. Ofc. signed the regs on 10/20/17; the regs were published in the Register on 11/13; and will become final on 12/13/17. A notification of 'final reg available for review' was sent to Town Hall users on 11/14.

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.

***(02) FAMIS MOMS Eligibility for State Employees:** This regulatory action will permit low-income state employees and their dependents to obtain coverage through FAMIS MOMS. The NOIRA for this package is being printed in the Register on 9/7/2015, which will open a 30-day public comment period. The comment period closed on 10/7/2015, and

the proposed stage regulations were drafted and reviewed internally. The regs were submitted to the OAG on 1/22/2016 and became OAG-certified on 10/31. The action was submitted to DPB on 12/27; forwarded on to HHR on 2/23/17, and sent to the Governor on 3/28/17. The Gov. signed the regs on 4/26; and they were published on 5/29, with a comment period thru 7/28. The final stage phase was initiated and the regs were submitted to DPB on 9/8/17; forwarded to the HHR for review on 9/28; and sent to the Governor on 11/1. The Governor signed the action on 12/4. The regs will be published in the Register on 12/25/17 and will be finalized on 1/24/18.

***(03) 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 is currently underway, as of 9/26/17.

2014 General Assembly

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

OAG on 5/5. The action was pulled back from OAG review to make amendments on 5/9/17 and was re-submitted to the OAG on 6/15, with a revision sent to the OAG on 6/27.

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.

2011 General Assembly

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

6/15/17. DMAS submitted revisions to CMS on 8/30, 10/2, 10/18, 11/13, and 11/27. CMS approved the SPA on 11/30/17.

2010 General Assembly

***(01) Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications:** This Emergency/NOIRA action complied with the 2010 Appropriations Act that required DMAS to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. The final regulations became effective 1/30/2015. A SPA was submitted to CMS on 3/25/15. CMS sent a Request for Additional Information on 6/10/2015 and DMAS submitted responses. During a subsequent conference call with CMS, on 10/20/2015, DMAS took this project off the clock in order to prepare additional changes requested by CMS. DMAS resubmitted SPA changes to CMS on 3/1/2016 and again on 5/5/2016, in response to additional follow-up questions. The SPA was again taken off the clock to coordinate revisions. 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.

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.