Meeting of the Board of Medical Assistance Services and
Public Hearing on the Proposed 1115 Waiver (Virginia COMPASS Demonstration)
600 East Broad Street, Conference Rooms 7A/B
Richmond, Virginia

September 25, 2018
Minutes

Present:
Raziuddin Ali, M.D.
Michael H. Cook, Esq.
Patricia T. Cook, M.D.
Alexis Y. Edwards
Maureen Hollowell
Peter R. Kongstvedt, M.D.
Vice Chair
Karen S. Rheuban, M.D.
Chair
Vilma T. Seymour
Kannan Srinivasan

Absent:
Cara L. Coleman, JD, MPH
Rebecca E. Gwilt, Esq.

DMAS Staff:
Karen Kimsey, Chief Deputy Director
Brian McCormick, Acting Deputy Director for Administration
Cheryl Roberts, Deputy Director for Programs
Tammy Driscoll, DMAS Senior Program Advisor
Abrar Azamuddin, Legal Counsel
Craig Markva, Manager, Office of Communications, Legislation & Administration
Brooke Barlow, Public Relations Specialist, Office of Communications, Legislation & Administration
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

Speakers:
Jennifer S. Lee, M.D., Director
Ellen Montz, Ph.D., Chief Health Economist
Kristin Dahlstrand, Health Plan Program Analyst
Joanna Fowler, DMAS Senior Policy Advisor

Guests:
See Sign Up Sheets (attached)

CALL TO ORDER

Dr. Karen S. Rheuban called the Board meeting to order at 10:02 a.m. Dr. Rheuban noted this is the first Board meeting ever associated with a public hearing. Other members and DMAS staff were asked to introduce themselves and Dr. Rheuban recognized the attendance of new Board Member Doctor Raziuddin Ali.

APPROVAL OF MINUTES FROM JUNE 26, 2018 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the June 26, 2018 meeting. Dr. Ali made a motion to accept the minutes and Mr. Cook seconded. The vote was 8-**yes (Ali, M. Cook, P. Cook, Hollowell, Kongstvedt, Rheuban, Seymour and Srinivasan); and 0-no.**

REPORT ON REMOTE AREA MEDICAL (RAM) CLINIC

Kristin Dahlstand, Health Plan Program Analyst, provided an overview of the Remote Area Medical (RAM) Clinic held in Wise on July 20-22, 2018. This RAM event created access to medical examinations, dental care and vision correction for over 1,300 uninsured people. Ms. Dahlstand explained what RAM is and shared a short video to give a recap of what this experience was like for those attending.

DIRECTOR'S REPORT AND UPDATE ON MEDICAID EXPANSION

DMAS Director Dr. Jennifer Lee announced the appointment of several new staff: Office of Data Analytics, Jacob Wieties; Director of Integrated Care, Jason Rachel; Behavioral Health Clinical Director, Dr. Alyssa Ward; Director of Internal Audit, Susan Smith, Deputy Director for Complex Care Services, Tammy Whitlock; and coming on board soon, Rachel Pryor, Deputy Director for Administration. Dr. Lee also thanked Brian McCormick for serving as Acting Deputy Director for Administration.

Dr. Lee shared the updated DMAS mission statement and core values developed through a collaborative and agency-wide effort.

Then Dr. Lee explained the steps necessary to implement Medicaid expansion as outlined in the budget and the process to develop and seek approval for an 1115 Waiver while awaiting CMS approval of State Plan Amendments. She highlighted several initiatives being worked on and advised the best place to go to stay updated on expansion activities is to "coverva.org" (see attached handout).

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

OVERVIEW OF THE VIRGINIA COMPASS DEMONSTRATION

Ellen Montz, Ph.D., Chief Health Economist, provided an overview of the 1115 Waiver (known as the Virginia COMPASS Demonstration) extension application that is out for public comment. Dr. Montz stated the slides, full public notice, full application, and waiver extension application will be available on the DMAS website at dmas@virginia.gov (see attached handout).

PUBLIC COMMENTS

Dr. Rheuban explained the public comment process, stated speakers would be called to the podium in chronological order and allowed two minutes to speak. Dr. Rheuban introduced the

moderator for the public comment period, Joanna Fowler, Senior Policy Assistant. The following individuals commented:

Rhonda Thissen, NAMI Virginia
David DeBiasi, AARP
Dora Muhammad, Virginia Interfaith Center for Public Policy
Jill Hanken, Virginia Poverty Law Center
Rebecca Bowers Lanier, B2L Consulting
Ashley Kenneth, National MS Society
Beth O'Connor, Virginia Rural Health Association

After considering the public's ideas and comments about the proposed changes, DMAS will make final decisions about what changes to make to the Virginia COMPASS Waiver and then submit a revised application to CMS. The summary of comments, as well as copies of all written comments received, will be posted for public viewing on the DMAS website along with the waiver extension application when it is submitted to CMS.

All information regarding the Virginia COMPASS Waiver application can be found on this web page. DMAS will update this website throughout the public comment and application process.

For more information about Virginia's current 1115 Demonstration, which the Commonwealth is seeking to extend, please visit the CMS website at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf.

REGULATORY ACTIVITY SUMMARY

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

ADJOURNMENT

Mr. Srivivasan made a motion to adjourn the meeting at 11:36 a.m. Dr. Kongstvedt seconded. The vote was 9-**yes (Ali, M. Cook, P. Cook, Edwards, Hollowell, Kongstvedt, Rheuban, Seymour and Srinivasan); and 0-no.**

BMAS **DMAS VISITOR LOG** 9-25-18

DATE	TIME	NAME	SIGNATURE	PURPOSE OF VISIT	ASSIGNED WORK AREA/ESCORT	ID TYPE	DEPARTURE TIME
9/25/18	9[10]	Karen Rhem		Public Hearing	7/AB	BMAS	12:15
9/25/18	9:25	Kurt Hrivnyi		Public Hearing	7/AB	VADL	11:48
9/25/18	9:30	Rick Shinn		Public Hearing	7/AB	VADL	11:55
9/25/18	9:40	Rhonda Thissen		Public Hearing	7/AB	VADL	12:00
9/25/18	9:45	Maureen Hollow		PublicHearing	7/AB	VADL BMAS	12:20
9/25/18	9 47	Patricia Cook		Public Hearing	7/AB	VADL BMAS	12:00
9/25/18	949	RAZIUDDIN Ali		Public Hearing	7/AB	VADL BMAS	1:10
9/25/18	9 50	Kannan Srinivasan		Public Hearing	7/AB	VADL BMAS	1:00
9/25/18	9:50	Katherine O'Connor		Public Hearing	7/AB	VADL	12:00
9/25/18	9:50	David DeBiasi		Public Hearing	7/AB	VADL	11:45
9/25/18	9:50	Mitch Cook		Public Hearing	7/AB	VADL BMAS	11:45
9/25/18	9:50			Public Hearing	7/AB	MCO	11:45
9/25/18	9:50	P. Kongsiveda		Public Hearing	7/AB	BMAS	1:20

REVIEWED BY: Marnie White DATE: 9/25/18

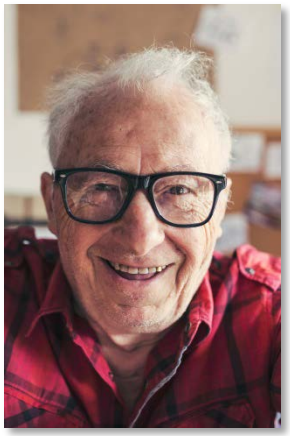
BMAS **DMAS VISITOR LOG** 9-25-18

DATE	TIME	NAME	SIGNATURE	PURPOSE OF VISIT	ASSIGNED WORK AREA/ESCORT	ID TYPE	DEPARTURE TIME
9/25/18	9:50	Karin Addison		Public Hearing	7/AB	VADL	11:49
9/25/18	9:50	Doug Gray		Public Hearing	7/AB	VADL	NOON
9/25/18	9:50	Brandon Robinson		Public Hearing	7/AB	VADL	NOON
9/25/18	9:55	Victoria Seymour		Public Hearing	7/AB	DMAS VADL	1:15
9/25/18	9:58	Dora Muhammad		PublicHearing	7/AB	VADL	11:59
9/25/18	10-	Jill Hanken		Public Hearing	7/AB	VADL	12:20
9/25/18	10:10	Becky Bowers-Lane		Public Hearing	7/AB	VADL	12:45
9/25/18	10:13	Ashley Kennen		Public Hearing	7/AB	STATE ID	12:00
9/25/18	10:18	Alexis Y. Edwards		Public Hearing	7/AB	State ID	12:15
9/25/18	10:40	Beth O'Connor		Public Hearing	7/AB	State ID	1:45
9/25/18	11:25	Marvin Figueroa		Public Hearing	7/AB	STATE ID	1:00
9/25/18	9:51	Jennes Vaccarelli		Public Hearing	7/AB	VADL	NOON
9/25/18				Public Hearing	7/AB		

REVIEWED BY: Marnie White DATE: 9/25/18







DIRECTOR'S UPDATE FOR THE BOARD OF MEDICAL ASSISTANCE SERVICES (BMAS)

SEPTEMBER 25, 2018

JENNIFER LEE, MD

DIRECTOR,
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Agenda

- **Director's Report**
- Medicaid Expansion Update
- Virginia C.O.M.P.A.S.S. Demonstration

Growing the DMAS Team

- Dr. Alyssa Ward, Behavioral Health Clinical Director
- Jacob Wieties, Director, Office of Data Analytics and Business Intelligence
- Jason Rachel, Director, Integrated Care
- Rachel Pryor, Deputy Director, Administration (Effective 10/10)
- Susan Smith, Director, Internal Audit
- Tammy Whitlock, Deputy Director, Complex Care Services

Agency Mission and Values

UPDATED MISSION

To improve the health and wellbeing of Virginians through access to high-quality health care coverage.

UPDATED VALUES

Agenda

- ✓ Director's Report
- ❑ **Medicaid Expansion Update**
- ❑ Virginia C.O.M.P.A.S.S. Demonstration

Medicaid Expansion Implementation

- Policy and Authorities
- Section 1115 Demonstration Waiver
- Provider Assessments
- Delivery System
- Systems Changes
- Eligibility and Enrollment
- Outreach and Communications
- Reporting and Evaluation

Overview of Medicaid Expansion Requirements

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

State Plan Amendments, contracts, or other policy changes

Implement new coverage for adults with incomes up to 138% FPL and implement early reforms for newly eligible individuals

§ 1115 Demonstration Waiver

Implement required reforms that transform the Medicaid program for certain individuals

DMAS is working in parallel and will submit a § 1115 Waiver while awaiting CMS approval of State Plan Amendments

Policy and Authorities

DMAS is working to ensure all State Plan Amendments (SPAs) and waivers are submitted to CMS in a timely fashion to seek proper authority for the Medicaid expansion

Submitted SPAs and Waivers	Approved SPAs and Waivers
▪ Federal Medical Assistance Percentage (FMAP) SPA	✓ Federal Medical Assistance Percentage (FMAP) SPA
▪ Health Insurance Premium Payment (HIPP) SPA	✓ Health Insurance Premium Payment (HIPP) SPA
▪ FFS Supplemental Payment SPA (Outpatient)	✓ FFS Supplemental Payment SPA (Outpatient)
▪ Adult Expansion Eligibility SPA	✓ Provider Assessment (P1/P2)
▪ Hospital Presumptive Eligibility SPA	✓ Alternative Benefit Plan (ABP) SPA
▪ Determination SPA	✓ SNAP SPA
▪ Changes to Medicaid Application SPA	
▪ FFS Supplemental Payment SPA (Inpatient)	
▪ 1915(b) waiver amendments	
▪ 1915(c) waiver amendments	

Section 1115 Waiver

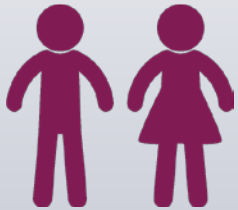
DMAS is working on the Section 1115 Demonstration Waiver to seek authority from CMS for the TEEOP program and other reforms, as outlined in the 2018 Appropriations Act.

- DMAS moving forward with timeline as outlined in Appropriations Act
  - Will submit the Section 1115 Demonstration Waiver Application to CMS for approval no later than 150 days from passage of HB 5001 (no later than November 4th)
- Negotiations have started: Biweekly regular calls scheduled with CMS
- 30-day public comment period opened on 9/20
  - Event details for upcoming Public Hearings will be available on the DMAS website

At the conclusion of the public comment period, DMAS will begin compiling and responding to comments as part of the Section 1115 Waiver Application

Provider Assessments: Overview

Coverage Assessment



- Same as included in Governor's Introduced Budget
- **Covers the full cost of Medicaid 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"

Delivery System Will Use Current Managed Care Plans

Coverage will be provided for 96% of Medicaid enrollees through the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs

Medicaid Delivery Systems

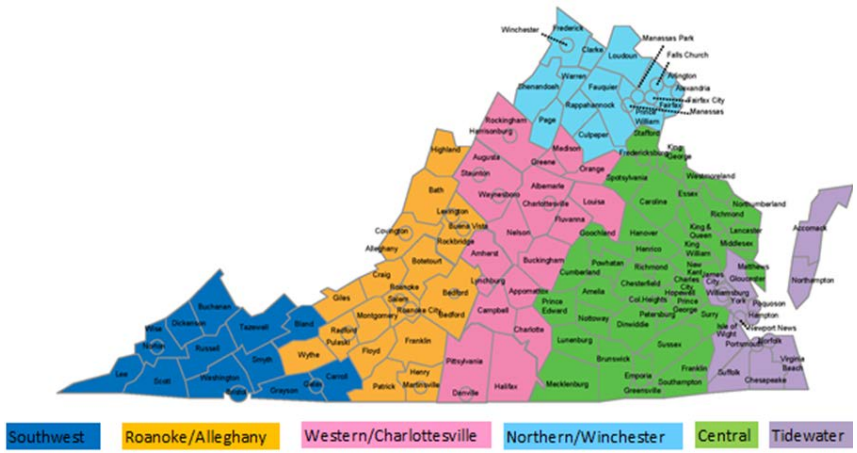
Commonwealth Coordinated Care Plus (CCC Plus) will serve populations who are *medically complex* (individuals with a complex behavioral or medical condition and functional impairment)

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

Fee for Service will serve populations until they are enrolled in an MCO and the populations and services that are excluded from managed care

6 Health Plans Contracted Statewide

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



What Services are Covered?

New enrollees will receive coverage for all Medicaid covered services including evidence-based, 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 (ARTS)
- 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

Key Systems Changes for Medicaid Expansion

Significant systems changes are required for the VAMMIS (Medicaid system) and VaCMS (eligibility system)

Data Shared Between Two Systems

VaCMS

Integrated Eligibility System.
Shared with the Virginia Department of Social Services (VDSS).
Housed at VDSS.

- **Determines Medicaid eligibility, which may vary by population**
- **Integrated system determines eligibility for other benefit programs including SNAP and TANF**

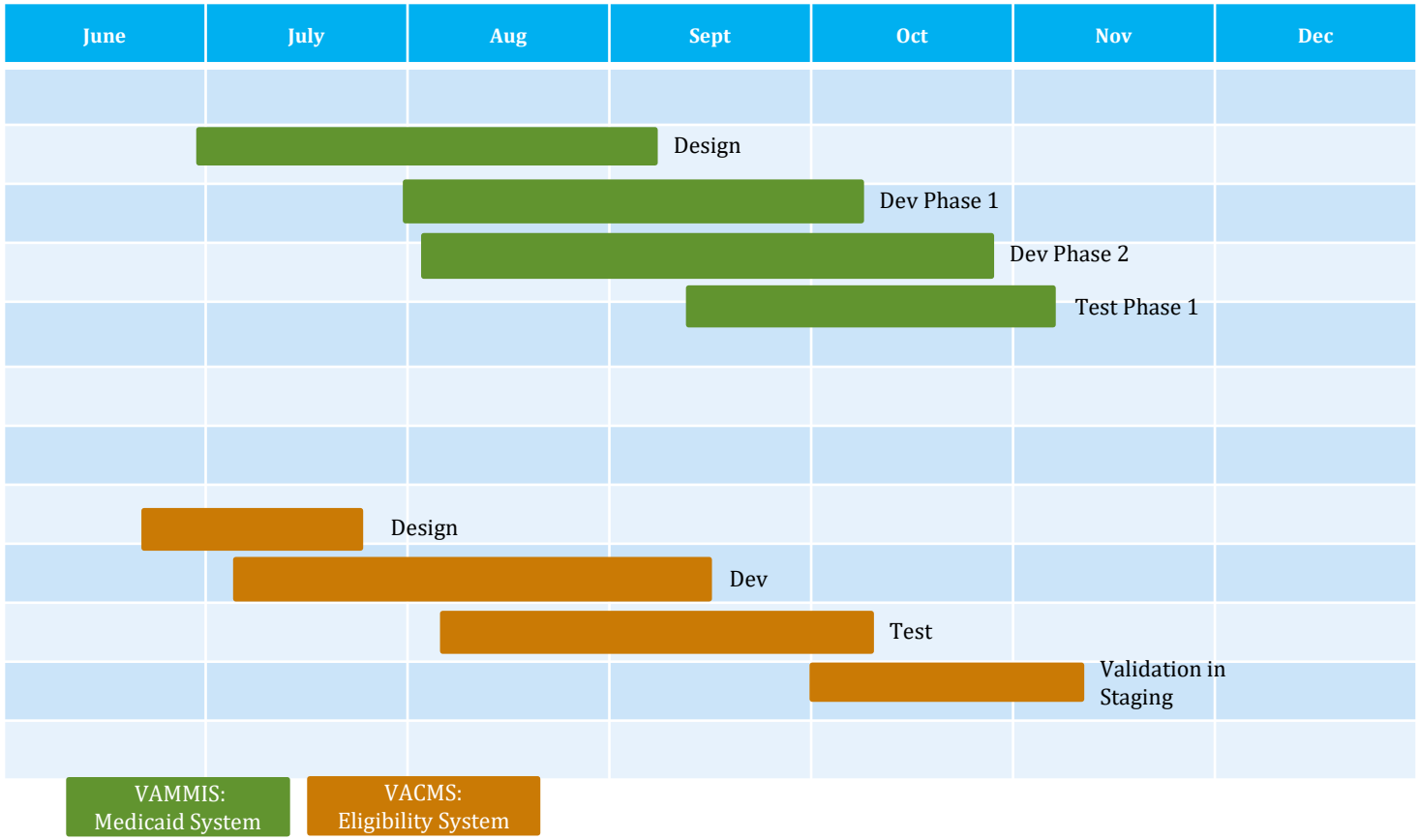
VAMMIS

Medicaid Management Information System.
Housed at DMAS; Interfaces with VaCMS, MCOs and other Contractors

- **Shares member eligibility and MCO enrollment with MCOs and other Contractors;**
- **Validates MCO encounters and processes FFS claims**

DMAS and VDSS are working collaboratively to ensure systems readiness for the Jan. 1, 2019 go-live date

IT Systems Timeline



DMAS and VDSS are working collaboratively to ensure systems readiness for the Jan. 1, 2019 go-live date

Eligibility & Enrollment

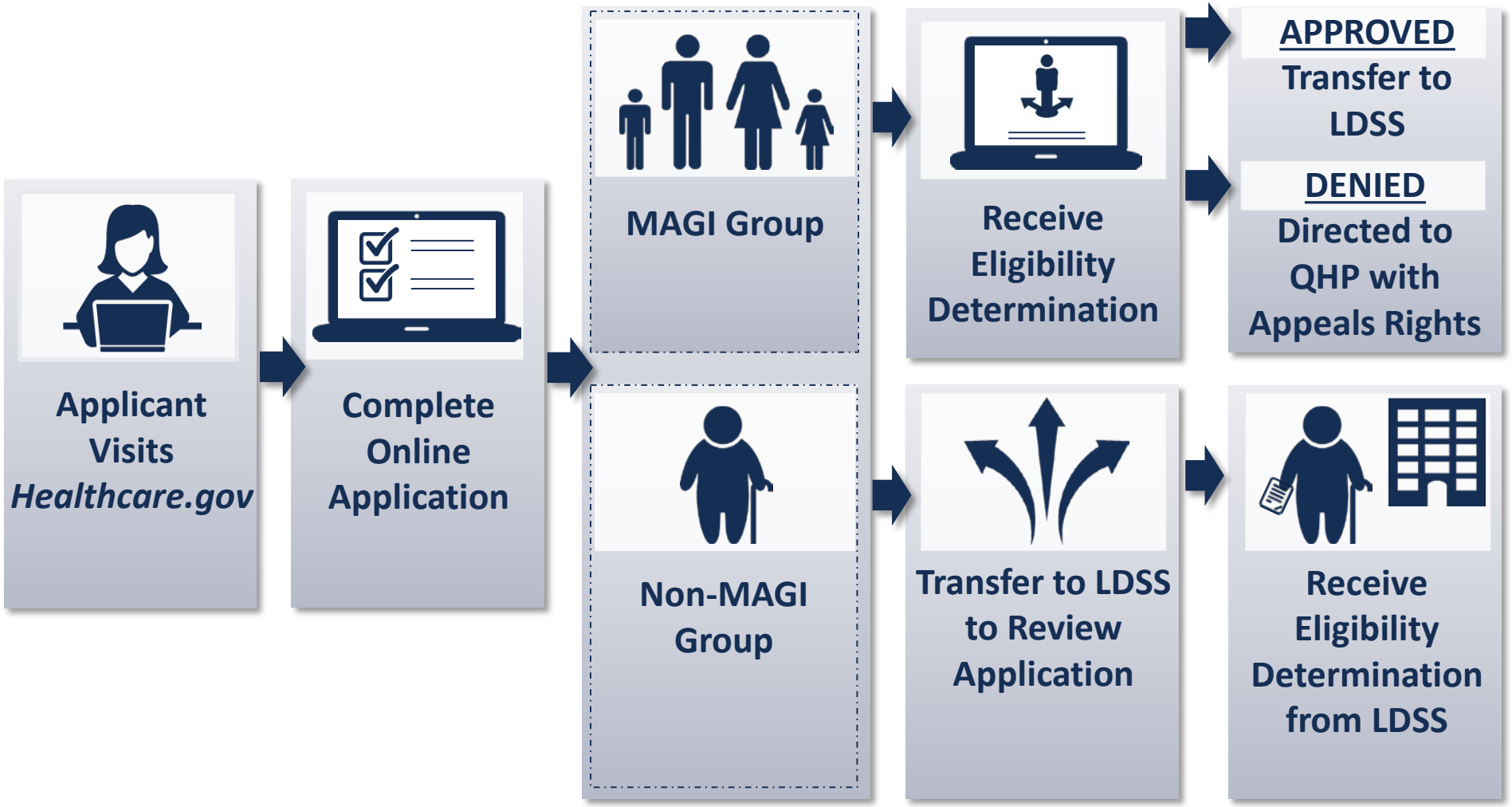
Enrollment Pathways

The new adult population will enroll in coverage through a variety of enrollment pathways, including streamlined enrollment processes

Transition to Full Benefit Medicaid **Limited Benefit Programs**	**GAP (Governor's Access Plan)** Adults 21 to 64 years of age with Severe Mental Illness (SMI) **Plan First** Family planning services ≤ 138% FPL
Express Application	**SNAP beneficiaries** Supplemental Nutrition Assistance Program formerly know as Food Stamps **Parents of Child(ren) enrolled in Medicaid**
Transition to Virginia Medicaid	**Individuals currently enrolled in a qualified health plan (QHP)** from the Federally-facilitated Exchange (FFE), also known as the Marketplace or Healthcare.gov
General Public	**Newly eligible adults not captured in Streamlined Enrollment groups**
Priority Populations	**Uninsured individuals served through other systems of care**

Federally Facilitated Exchange (FFE)
Transition to a Determination State Model

Applying for Medicaid through the Federal "Marketplace"



Modernized Program Integrity Model

DMAS employs a dedicated eligibility audit unit comprised of state and nationally recognized contractor staff that conducts a variety of robust audit activities to ensure the accuracy and integrity of the Virginia Medicaid member enrollment processes:

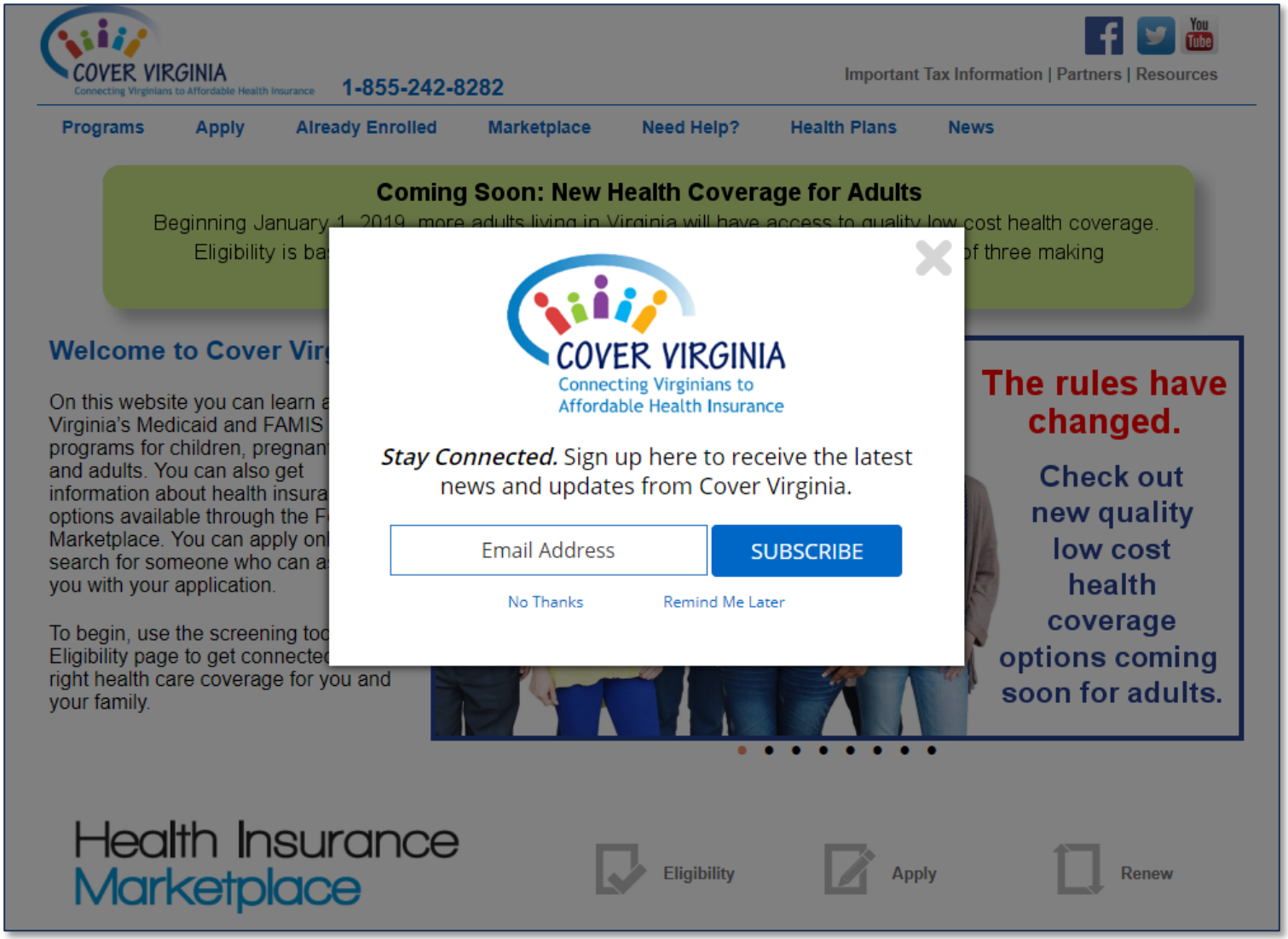
- **Recipient Eligibility Audits** – DMAS conducts approximately 2000 recipients audits per year. These audits can lead to administrative recoveries or criminal prosecution.
- **Eligibility Quality Review Program (EQRP)** - This program utilizes data mining strategies to identify error prone areas of eligibility determinations.
- **Public Assistance Reporting Information System (PARIS)** - The PARIS program reduces improper Medicaid payments by identifying members who are enrolled in multiple State Medicaid programs.
- **Fraud and Abuse Detection System (FADS) –** Developing a fraud detection system that allows programming of advanced algorithms and recognition of outliers to identify potentially fraudulent behavior. Integrates FFS and MCO encounters with provider and member data into a single model.
- **Medicaid Expansion –** DMAS, along with our contractor, will be developing a special audit plan and review initiative focused on the Expansion population.

Outreach and Communications

New DMAS Website

Outreach and Communications

Sign up on the Cover Virginia Website to Receive Updates!



Outreach and Communications
Strategic Communications Plan

A comprehensive strategic communications plan drives stakeholder engagement

KEY STAKEHOLDER ENGAGEMENT ACTIVITIES

Cover VA Countdown: 100 Days to Coverage

Preparing advocate groups through an interactive strategy session led by national communications experts

Provider Events, including "Medicaid Expansion: What Providers Need to Know"

Engage with providers through a series of provider outreach events in regions across Virginia

State Agency Workshops, Live Webinars, and Fall Advertising Campaign

Supporting intensive, continuing outreach to state agencies, newly eligible adults, and other stakeholders

Visit www.coverva.org to access advocate resources, information on provider outreach events, a recorded webinar, and more!

Outreach and Communications

"Medicaid Expansion: What Providers Need to Know"

September 26	**Richmond** *(HCA Chippenham Hospital)*
October 2	**Norfolk/Hampton Roads** *(Sentara Norfolk General Hospital)*
October 9	**Winchester** *(Valley Health Winchester Medical Center)*
October 11	**Tri-Cities** *(Southside College of Health Sciences)*
October 15	**South Hill** *(VCU Community Memorial Hospital)*
October 17	**Lynchburg** *(Centra Lynchburg General Hospital)*
October 18	**Roanoke** *(Virginia Tech Carilion School of Medicine)*
October 22	**Charlottesville** *(University of Virginia Medical Center)*
October 25	**Abingdon** *(Ballad Health Johnston Memorial Hospital)*
October 29	**Fairfax** *(Inova Center for Personalized Health)*
November 1	**Richmond** *(Bon Secours St. Mary's Hospital)*

Visit http://www.coverva.org/providerMedEx/ for event details and to register to attend (required)

Reporting and Evaluation

MOCK Dashboard (Early 2019)

New Health Coverage for Adults

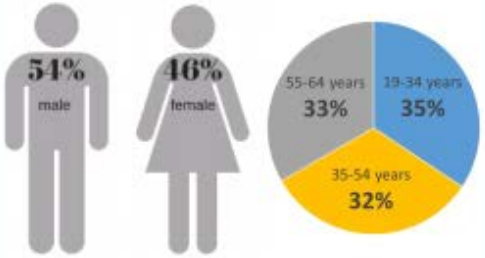
MOCK DASHBOARD

Overall Enrollment

100,000 Adults newly enrolled in Medicaid

21,000 new enrollees are parents

Age and Gender of Enrollees



Family Income of Enrollees

- Enrollees with incomes below 50% FPL
- Enrollees with incomes between 50% and 100% FPL
- Enrollees with incomes between 100% and 138% FPL

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

Adults Enrolled in New Health Coverage by County

As of February 28, 2019

Total number of adults enrolled in new Medicaid health coverage

Reporting and Evaluation

Example of Cost-Savings Report in Montana

Montana Medicaid Expansion Has Saved the State More than $36 Million Through SFY 2017

17

State Savings from Medicaid Expansion (millions)

	Total	Moving some Medicaid populations to enhanced federal match				Replacing some State spending with federal match		
		Waiver	Pregnant women	Medically needy	Breast & cervical cancer	Mental health services	SUD treatment	Inmate care
Total	**$36.5**	**$9.8**	**$5.0**	**$4.0**	**$1.0**	**$3.1**	**$3.0**	**$10.5**
SFY 2016	$11.3	$2.8	$0.7	$1.9	$0.2	$1.3	$1.5	$2.9
SFY 2017	$25.2	$7.0	$4.3	$2.1	$0.8	$1.8	$1.5	$7.7

State Costs for Medicaid Expansion*

Total	**$29.4 million in state spending (remaining $706.0 million funded by federal government)**
SFY 2016	$5.0 million in state spending (remaining $153.6 million funded by federal government)
SFY 2017	$24.5 million in state spending (remaining $552.4 million funded by federal government)

Note: Sum of components may not equal total due to rounding.
* Excludes premium revenues, which are shared with the federal government at existing federal matching rates. Includes benefit and administrative spending.

MONTANA HEALTHCARE FOUNDATION manatt

Montana expanded Medicaid effective January 1, 2016 and reported on cost savings by early 2018.

Next Steps

Major Milestones:

- **Coverage Assessment Begins Fall 2018**
- **Section 1115 Waiver Submission to CMS in Early November 2018**
- **Enrollment Begins Fall 2018**
- **Medallion 4.0 Implemented Statewide by December 1, 2018**
- **Coverage Begins January 1, 2019**

Regular Updates

Visit the Cover VA Website at www.coverva.org

or call 1-855-242-8282

for information and regular updates

Agenda

- ✓ Director's Report
- ✓ Medicaid Expansion Update
- ❑ **Virginia C.O.M.P.A.S.S. Demonstration**

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES:

VIRGINIA COMPASS DEMONSTRATION

Public Hearing
September 25, 2018

Virginia Department of Medical Assistance Services (DMAS)
600 E Broad St., Richmond, VA 23219

Agenda

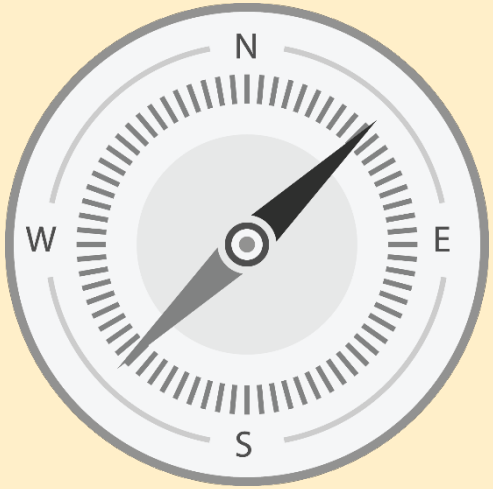
I. Background

II. Changes to the Waiver

III. Waiver Evaluation

IV. Submission of Public Comment

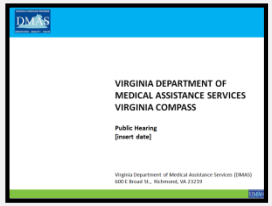
Objective of Today's Meeting



In today's meeting we will review Virginia's COMPASS Demonstration and take public comments.

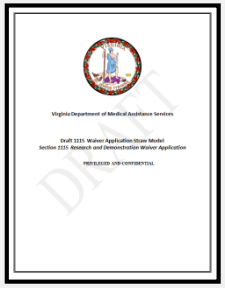
Accessing Virginia COMPASS Materials

Information on Virginia COMPASS can be found on the DMAS web page: www.dmas.virginia.gov/#/1115waiver.
DMAS will update the website during the public comment process.



This Presentation

The Public Notice



The Virginia COMPASS Application

Background on Section 1115 Authority

Under Section 1115 of the federal Social Security Act, the Secretary of Health and Human Services has authority to approve a state's requests to waive compliance with provisions of federal Medicaid law.

An 1115 Waiver must be:

- An experimental, pilot or demonstration project;
- Likely to assist in promoting the objectives of the Medicaid program;
- Budget neutral to the federal government; and
- Limited in duration to the extent and period necessary to carry out the demonstration.

States must provide a public process for notice and comment on proposed demonstration applications and extensions.

Source: Social Security Act (SSA) § 1115.

COMPASS Today and in the Future

Governor's Access Plan	**Today**: Provides a targeted benefit package of physical and behavioral healthcare services to adults without children with serious mental illnesses ages 21-64 with incomes up to 100% of the federal poverty level (FPL). **Future:** Due to Medicaid expansion, Virginia will phase out GAP and move current enrollees into the newly eligible Medicaid expansion group where they will receive more benefits.
Addiction Recovery Treatment Services	**Today**: Offers an expanded Substance Use Disorder (SUD) benefit package to all Medicaid enrollees who have a SUD diagnosis and meet the medically necessary criteria. **Future:** State will continue this benefit package under Virginia COMPASS.
Former Foster Care Youth	**Today**: Provides Medicaid coverage to former foster care youth who were enrolled in Medicaid and aged out of foster care in another state but now live in Virginia. **Future:** State will continue to cover this population under Virginia COMPASS.

2018 Appropriations Act

On June 7, 2018, Governor Northam signed a law called the 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) which approved Medicaid expansion and changes to the Medicaid program.

What the State Law Says

- Authorized DMAS to change Virginia's Medicaid State Plan to expand Medicaid coverage to newly eligible adults ages 19 to 64 with incomes up to 138% of the FPL effective January 1, 2019.

- Directed DMAS to submit a waiver asking for federal approval to add new features to the Virginia Medicaid program "designed to empower individuals to improve their health and well-being and gain employer-sponsored coverage or other commercial health insurance coverage".

Source: 2018 Virginia Acts of Assembly Chapter 2

Agenda

I. Background

I. Changes to the Waiver

III. Waiver Evaluation

IV. Submission of Public Comment

State Law Requires Waiver Changes

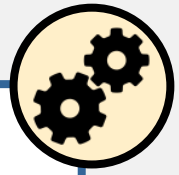
The 2018 Appropriations Act requires changes to the Medicaid Program.

- **Work and Community Engagement**
- **Premiums, Co-Payments, Health and Wellness Accounts**
- **Housing and Employment Supports Benefit**

Source: 2018 Virginia Acts of Assembly Chapter 2

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION · QUALITY · VALUE

Work and Community Engagement: Overview



Summary of State Law

- Virginia will implement the Training, Education, Employment Opportunity Program (TEEOP) to promote work and community engagement.

- The Commonwealth will phase in a requirement that makes participation in TEEOP a condition of eligibility for all Medicaid enrollees between the ages of 19 and 64 with incomes up to 138 percent of the FPL who are not exempt.

Source: 2018 Virginia Acts of Assembly Chapter 2

Work and Community Engagement: Exemptions

Some people in Medicaid will be exempt from – meaning they don't have to meet – work and community engagement requirements.

Standard Exemption Examples:

- ✓ Pregnant and 6-months postpartum women
- ✓ Children who are age 19 and younger
- ✓ Students in post-secondary education
- ✓ Medically frail individuals
- ✓ Individuals meeting SNAP and/or TANF requirements
- ✓ Individuals age 65 and older
- ✓ Individuals who have blindness or a disability
- ✓ Victims of domestic violence

Hardship/Good Cause Exemption Examples:

- ✓ Individuals who experience a hospitalization or serious illness or who live with an immediate family member who experiences a hospitalization or serious illness
- ✓ Birth or death of a household member
- ✓ Family emergency
- ✓ Change in family living circumstances (e.g., separation, divorce)
- ✓ Individuals living in geographic areas with high unemployment rates

The length of the hardship/good cause exemption will be dependent on the individual's circumstance.

Work and Community Engagement: Participation Requirements

People who aren't exempt must participate in one or more qualifying work or community engagement activities for 20 to 80 hours per month to continue to stay in Medicaid.

Activities

- Employment
- Job skills training or job search activities/readiness
- Participation in a workforce program
- Education
- Training and apprenticeships
- Community or public services
- Caregiving services
- Other activities

People who do not meet the work/community engagement requirement for any three months within a 12-month period will have their Medicaid coverage suspended until : 1) the end of the year or 2) demonstrating compliance with the work and community engagement requirements for one month, or 3) qualifying for another Medicaid eligibility category not subject to work and community engagement requirements, or 4) qualifying for an exemption.

TEEOP Employment Supports

To help people meet TEEOP requirements and get jobs, Virginia will offer employment support services.

Employment Support Services	
Educational Services	✓ Subsidies for industry certification
Pre-Employment Services	✓ Job-related assessments ✓ Person-centered employment planning ✓ Job development and placement ✓ Job carving ✓ Benefits and education planning ✓ Transportation to pre-employment services
Employment Sustaining Services	✓ Career advancement services ✓ Negotiation ✓ Job analysis ✓ Job coaching ✓ Benefits education and planning ✓ Asset development ✓ Follow-along supports ✓ Transportation to employment support services

The State will provide assessments and referrals for employment.

Health and Wellness Program

Virginia will implement premiums co-payments and Health and Wellness Accounts to empower people to take greater responsibility for their health and well-being.

- **Premiums**
- **Healthy Behavior Incentives**
- **Co-Payments for Non-Emergent Use of the Emergency Department**
- **Health and Wellness Accounts & Health Rewards**

Health and Wellness Program

- **Medicaid enrollees with incomes from 100-138% of the FPL will be required to pay monthly premiums for Medicaid. Premium amounts are:**

Income	Annual Income Range for a Household of 1*	Monthly Premium
100-125% FPL	$12,140 - $15,175	$5 per month
126-138% FPL	$15,296 - $16,753	$10 per month

- **Premium payments will go into Health and Wellness Accounts (HWAs). The State may also add money to these accounts if the State Legislature approves funding.**
- **People who make the required number of premium payments and do at least one healthy behavior will be able to receive a Health Rewards gift card to pay for health-related services (e.g., eyeglasses or vitamins).**
- **People who make the required number of premium payments but do not do a healthy behavior will not be able to get a Health Reward. But, their HWA money will roll over to the next year, and they will have another chance to earn a Health Reward.**

People who do not pay their premiums for three months will have their Medicaid coverage suspended until making premium payment, meeting an exemption or reporting a change in circumstances that reduces family income to less than 100% of FPL

Housing Supports for High-Need Population

Virginia will provide housing supports for people in Medicaid with high health needs who are ages 18 and older if the State finds they have a need for these services.

Housing Supports

✓ **Housing Transition Services, such as:**

- Help with budgeting for housing and living costs
- Making the living space safe for move-in
- A security deposit to get a lease on an apartment/home

✓ **Housing and Tenancy Sustaining Services, such as:**

- Entitlement assistance
- Education and training on the role, rights, and responsibilities of the tenant/ landlord
- Advocacy and linking to community resources to prevent eviction

Employment Supports for High-Need Population

Virginia will also provide employment supports for people in Medicaid with high health needs who are ages 18 and older if the State finds they have a need for these services.

Employment Supports

- ✓ **Case Management**
- ✓ **Educational Services, including:**
  - **Subsidies for industry certification**
- ✓ **Pre-Employment Services, such as:**
  - **Job carving**
  - **Benefits and education planning**
  - **Transportation to pre-employment services**
- ✓ **Employment Sustaining Services, such as:**
  - **Negotiation with employers**
  - **Job analysis and coaching**

Agenda

I. Background

II. Changes to the Waiver

III. Waiver Evaluation

IV. Submission of Public Comment

Virginia COMPASS Evaluation Approach

1115 waivers must test and evaluate the goals of the waiver's components.

New Waiver Evaluation Hypotheses

Through this demonstration extension, Virginia will have the opportunity to test hypotheses to help refine this demonstration and the development of future programs. For example:

- Members enrolled in the demonstration will secure sustained employment.
- Work and community engagement requirements will not cause Medicaid members to lose Medicaid coverage unless the loss is related to obtaining private coverage.
- Participation in work and community engagement requirements will improve member health and well-being.
- Conditioning coverage on payment of premiums will promote continuous coverage and continuity of care.
- Participation in housing and employment supports will improve member housing and employment stability and health and well-being

Upon approval of Virginia COMPASS, the State will work with CMS to develop an evaluation design.

Agenda

I. Background

II. Changes to the Waiver

III. Waiver Evaluation

IV. Submission of Public Comment

Ways to Provide Public Comment

Submit public comments by email, regular mail, or in-person until midnight on Wednesday, October 17, 2018.

By Phone	(804) 225-2726
By Email	1115Implementation@dmas.virginia.gov
By Regular Mail	Susan Puglisi Virginia Department of Medical Assistance Services (DMAS) Attn: Virginia COMPASS 600 E Broad St., Richmond, VA 23219
In Person	Public Hearings; and Department of Medical Assistance Services (DMAS) 600 E Broad St., Richmond, VA 23219

Opportunities to Provide Public Comment: Public Hearings

The Virginia DMAS is holding 4 public hearings.
All verbal public comments submitted at these hearings shall be limited to 2 minutes each.

Medical Assistance Services Board Meeting	Roanoke Elks Lodge No. 197	Great Falls Library	MEO Central Library
Tuesday September 25 10:00 AM – 12:00 PM 600 E Broad St., Richmond, VA 23219	Wednesday October 3 3:00 – 5:00 PM 1147 Persinger Rd SW Roanoke, VA 24015	Tuesday October 9 3:30 – 5:00 PM 9830 Georgetown Pike Great Falls VA 22066	Thursday October 11 1:30 – 3:00 PM 4100 Virginia Beach Blvd Virginia Beach, VA 23452

All information related to Virginia COMPASS can be found on the DMAS web page, www.dmas.virginia.gov/#/1115waiver.

Opportunities to Provide Public Comment: Web Conference

The Medical Assistance Services Board Meeting will have web conference capabilities.

Medical Assistance Services Board Meeting

If unable to attend in-person, you may:

- **Participate online by clicking the link below:**
  https://webinar.ringcentral.com/j/1495928570
- **Join by phone: (646) 357 3664; Webinar ID: 149 592 8570**
- **If you require a toll free audio-only option, please dial: (866) 842 5779; when prompted, dial: 3284486931**

All information related to Virginia COMPASS can be found on the DMAS web page, www.dmas.virginia.gov/#/1115waiver.

Regulatory Activity Summary September 25, 2018
(* Indicates recent activity)

2018 General Assembly

***(01) Medicaid Expansion — Determination State (Medicaid):** This state plan amendment is designed to allow Virginia to change from the Assessment Model of eligibility determination to the Determination Model of eligibility determination. In the Assessment Model, which Virginia currently follows, the Federally Facilitated Marketplace (FFM) makes an initial assessment of eligibility and the State Medicaid agency must then re-determine eligibility to make a final decision. In the Determination Model, the FFM makes the final Modified Adjusted Gross Income (MAGI) or CHIP determination and transmits the determination to the State Medicaid agency. The state must then accept the FFM determination as final. 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 138% of the federal poverty level, effective January 1, 2019. As a result of Medicaid expansion, many more FFM applicants will now qualify for Virginia Medicaid and the application determination backlog that is currently experienced during open enrollment is expected to increase. Movement to the Determination Model will significantly reduce the number of applications forwarded from the FFM that require a Medicaid determination by state/local/contractor staff. This change is particularly important due to the anticipated increase in applications from all sources due to interest in Medicaid expansion coverage combined with the 2019 Open Enrollment Period. Following internal DMAS review, the SPA was submitted to HHR, and then forwarded to CMS on 7/23/18. A conf. call with CMS was held on 8/2/18 and CMS requested edits on 8/7/18. Additional follow-up questions from CMS were received and responses were returned to CMS on 8/20/18.

***(02) Medicaid Expansion — SNAP:** The Virginia General Assembly has directed DMAS to utilize the income determination for the Virginia SNAP program to support Medicaid eligibility determinations. This state plan amendment accomplishes that objective. As part of this expansion effort, DMAS is submitting this SPA on the pre-printed CMS state plan page indicating that the income used to determine SNAP eligibility will be used to support Medicaid eligibility determinations as a part of Medicaid expansion. This change will be effective January 1, 2019. The SPA was submitted to CMS on 6/22/18, along with the 1902(e)(14) waiver letter. A CMS call was held on 6/25/18, and a follow-up call with CMS occurred on 8/20/18. Additional questions were received and returned to CMS on 8/21, 8/23, and 8/27/18. The SPA was approved by CMS on 9/20/18.

***(03) 2018 Institutional Provider Reimbursement:** This final exempt regulatory action pertains to the 2018 institutional provider reimbursement updates as required by the 2018 Acts of Assembly. These amendments update the current state regulations to indicate that an additional indirect medical education (IME) payment will be made to the Children's National Medical Center (CNMC). The regs also eliminate disproportionate share hospital (DSH) payments to out-of-state children's hospitals, to include CNMC. Furthermore, the proposed amendments update existing regulations to allow additional supplemental payments to be issued to each non-state government owned acute care hospital for inpatient services provided to Medicaid patients. Lastly, the revisions update existing regulations to reflect supplemental payments to state-owned nursing facilities owned or operated by a Type One hospital. Following internal coordination and review, the action was submitted to the OAG on 8/21/18 for review. The corresponding SPA is currently circulating for review within the agency.

***(04) Settlement Agreement Discussion Process:** This regulatory action establishes a more formalized process by which to address administrative settlement agreements, in a timely fashion. The proposed new regulation, 12 VAC 30-20-550, describes the process for settlement agreement discussions between a Medicaid provider and DMAS and how it affects the time periods currently set forth in the existing informal and formal appeal regulations at 12 VAC 30-20-500 et. seq. The proposed amendments to 12 VAC 30-20-540 and 12 VAC 30-20-560 are necessary for these sections to be consistent with the proposed new regulation, 12 VAC 30-20-550. The amendments affect the timelines for issuing either the informal decision in an informal administrative appeal or recommended decision of the hearing officer in a formal administrative appeal when the proposed new regulation 12 VAC 30-20-550 pertaining to the settlement agreement process is used. The project is currently circulating internally for review.

***(05) Medicaid Expansion — Changes to Medicaid Application:** This state plan amendment is designed to update the current version of Virginia's single, streamlined application with language pertaining to Medicaid Expansion. Virginia is submitting an amendment on the pre-printed CMS state plan pages indicating the edit being made to the Medicaid application to reflect questions pertaining to medically complex conditions as a result of Medicaid Expansion. Following internal coordination and review, the SPA was submitted to CMS on 8/10/18. A conf. call with CMS was held on 8/23/18 to discuss the project. DMAS is awaiting approval.

***(06) FAMIS MOMS - Remove Third Trimester Managed Care Exclusion:** This regulatory action incorporates updates to the FAMIS MOMS regulations, to accommodate changes in the Code of Federal Regulations related to the implementation of Medallion 4.0 and upcoming Medicaid Expansion. This action serves to bring Virginia regulations into alignment with current FAMIS MOMS contracts and current Medicaid Managed Care practice. DMAS intends to remove regulations that deal with an exclusion for individuals in the third trimester of pregnancy. These changes will stipulate that members in their third trimester of pregnancy will no longer be allowed to request exclusion from their Managed Care Organization (MCO) enrollment. With the implementation of Medallion 4.0 and the upcoming Medicaid Expansion, this exemption is no longer necessary to ensure access to care. The Medicaid Managed Care health plans all have 100% network adequacy for prenatal and obstetric care, including Obstetricians/Gynecologists, nurse practitioners, family physicians, and Certified Nurse Midwives (CNMs) in all regions of the Commonwealth. Furthermore, the regulations are essential to protect the health, safety, and welfare of citizens in that the regulatory changes

ensure compliance with federal requirements, which ensures continued federal financial participation, and enables continued funding for Medicaid managed care programs. The project is currently circulating internally for review.

***(07) 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. The regs were forwarded to DBP for review on 8/14/2018. Following a conf. call with DBP on 8/30/2018, the EIA for this project was posted and the Agency response was uploaded to the Town Hall. DPB certified the regs on 9/5/2018 and the project was sent to HHR. The regs are with the Governor's. Ofc., as on 9/6/2018.

(08) 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.

***(09) 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. A call was held with CMS on 6/22/2018. Revisions were made and forwarded to CMS on 8/22/2018. CMS requested additional revisions on 8/28/2018, which were made. Currently awaiting CMS final approval.

(10) 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.

***(11) 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 (the Town Hall was updated with a revised ABD, and revised regs were input to RIS). The OAG was notified of the updates on 6/13/18. DMAS responded to Registrar inquiries and made revisions to VAC sections on 7/30/18. The regs were submitted to the Registrar on 7/30/18 and Published on 8/20/18, with an effective date of 7/1/18.

***(12) 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. Following that review, the regs were submitted to the OAG on 7/17/18.

***(13) 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 received final DMAS approval on 6/29/18. The project was submitted to the OAG for review on 7/9/18.

(14) 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.

***(15) 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. The regs

were submitted to the Registrar on 8/9/18, with a publish date of 9/13/18, and an effective date of 10/18/18.

***(16) 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. In coordination with the OAG, this reg package was withdrawn on 8/7/18.

***(17) 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. The regs were submitted to the Governor for review on 6/19/18 and completed on 8/22/18. The regs were submitted to the Registrar, with a publish date of 9/17/18, and an effective date of 11/1/18.

***(18) 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. The regs were certified by OAG and submitted to DPB 7/11/18. Following a call with DPB on 8/13/18, DMAS responded to multiple rounds of questions. The EIA for this project was posted on 8/28/18. The regs were submitted to HHR on 8/30/18. The Agency response to the EIA was uploaded on 8/31/2018. The package was forwarded to the Governor's Office for review on 9/5/18.

***(19) 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. Following a 2018 Budget-related hold, the regs were submitted to the OAG on 6/14/18. Edits were made to the regs on 7/11/18; the project was OAG-certified on 7/13/18; and sent to DPB. The regs were forwarded to HHR on 7/26/18 and forwarded to the Governor's Ofc. on 9/5/18.

***(20) 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. The Gov. approved the regs on 8/22/18. The regs were filed with the Registrar's Ofc. on 8/23/18, with the comment period ending on 10/17/18. The proposed phase review is currently underway.

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. The regs were forwarded to the Registrar on 8/9/18; with a publication date of 9/13/18, and an effective date of 10/18/18.

***(04) 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 for the corresponding final exempt regs (which 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)) began on 5/21/18. The regs were forwarded to the OAG and certified by the OAG on 7/13/18; and submitted to the Registrar on 7/16/18, with a publication date of 8/6/18, and an effective date of 7/1/17.

(05) 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.

(06) 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.

***(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. 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. The regulatory action was approved by HHR and submitted to the Gov. Ofc. on 6/19/18. The Gov. approved the regs on 7/17/18, and the action was submitted to Register. The regs were published on 8/6/18 and became final on 9/20/18.

***(08) 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 regs were forwarded to the Gov. for review on 9/5/18. 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.

***(09) 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 8/31/17. The corresponding VAC changes were drafted, reviewed internally, and submitted to the OAG on 11/2/17. DMAS responded to an OAG inquiry on 11/9/17. The regs were forwarded to DPB for review on 11/14/17. DMAS posted the EIA on 12/11/17. 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. VAC changes were submitted to the Registrar on 8/9/18, with a publication date of 9/13/18, and an effective date of 10/18/18.

(10) 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.

***(11) 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. The regs were approved by the OAG and forwarded to the Governor's Ofc. for review on 6/19/18. The emergency regulations were signed by Governor and became effective on 6/29/18, and published in the Register on 7/23/18. The NOIRA comment period was held between 7/23/18 - 8/22/18. Further DMAS coordination is currently underway regarding the next regulatory phase.

(12) 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) 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.

***(02) 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 had been extended until 8/30/18. Further internal DMAS coordination is underway.

***(03) 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. The EIA for this project was posted on 7/16/18, in addition to the corresponding DMAS response. The regs were forwarded to HHR on 7/16/18 and they were certified on 7/17/18. The regulatory action is currently under review at the Gov. Ofc.

(04) 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.

(05) 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. The Gov. Ofc. certified the regs on 7/2/18. The reg action was submitted to the Registrar with a publication date of 7/23/18, and an effective of 8/22/18.

***(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. DMAS is currently addressing inquiries and coordinating revisions sent by the OAG on 6/25/18.

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. The Gov. approved the regs on 8/22/18. The regs were submitted to the Registrar on 8/22/18, with a publication date of 9/17/18 and an effective date of 10/17/18.

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. Additional questions were received from the OAG on 4/9/18 and 8/16/18, and subsequently addressed. The regs were certified by the OAG and also submitted to DBP on 9/14/18.

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.