

BOARD OF MEDICAL ASSISTANCE SERVICES (BMAS) MEETING

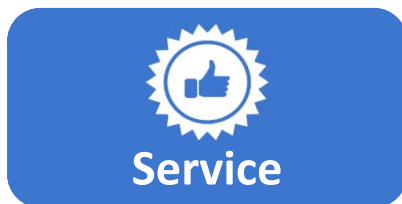
Tuesday, June 4, 2019
 10:00 a.m. – 12:00 p.m. BMAS Meeting
 Department of Medical Assistance Services
 Conference Room 7A/B
 600 East Broad St. Richmond, VA 23219

Agenda

	ITEM	PRESENTER	ACTION
10:00 AM	Call to Order and Introductions	Karen S. Rheuban, M.D., Chair	
10:05 AM	Approval of April 16, 2019 Minutes	Karen S. Rheuban, M.D., Chair	Vote
10:10 AM	Election of new Board Officers	Jennifer S. Lee, M.D., Director	Vote
10:20 AM	Director's Report	Jennifer S. Lee, M.D., Director	Briefing
10:40 AM	COMPASS (1115) Waiver Update and Medicaid Expansion: Utilization, Member and Provider Survey Results	Karen Kimsey Chief Deputy Ellen Montz, Ph.D., Chief Health Economist	Briefing
10:50 AM	Member Focused Initiatives Update <ul style="list-style-type: none"> ▪ Member Focused Activities 	Rachel Pryor, Deputy Director for Administration	Briefing
11:00 AM	Medicaid Health Plans <ul style="list-style-type: none"> ▪ Care coordination ▪ Update on CIL issues ▪ Behavioral Health Redesign Update 	Nichole Martin Director of Office of Community Living Alyssa Ward, M.D. Behavioral Health Clinical Director	Briefing
11:10 AM	Preventive care coverage Maternal and child health disparities	Cheryl Roberts, Deputy Director of Programs	Briefing
11:20 AM	Finance Report <ul style="list-style-type: none"> ▪ Rate Setting ▪ Milliman Report ▪ Managed Care Financial Status 	Chris Gordon, Chief Financial Officer (CFO) William Lessard, Director of Provider Reimbursement	Briefing
11:30 AM	MES Update	Mukundan Srinivasan Chief Information Officer	Briefing
11:40 AM	Old Business/New Business		
11:50 AM	Public Comments		Public Comment
12:00 PM	Adjournment		

DMAS Mission & Values

“To improve the health and well-being of Virginians through access to high-quality health care coverage.”





1115 COMPASS WAIVER UPDATE

BOARD OF MEDICAL ASSISTANCE SERVICES
(BMAS) 6/4/2019



DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES



Overview of the Virginia “Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency” (COMPASS) Waiver

Section 1115 Demonstration Waiver Components



Work/Community Engagement (TEEOP)

- Requirement to participate in training, education, employment and other community engagement opportunities for up to 80 hours per month in order to maintain Medicaid coverage.
- Applies to all “able-bodied adults” in the Medicaid program who do not meet an exemption (e.g., parents of dependent children, medically-frail, disabled).



Health & Wellness Program

- Requirement for premiums and co-payments, health & wellness accounts and healthy behavior incentives.
- Applies to Medicaid enrollees with incomes between 100-138% FPL, who do not meet an exemption. Exemptions are the same as in the TEEOP program.



Housing & Employment Supports for High-Risk Enrollees

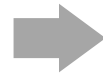
- A supportive housing and employment benefit for high-risk Medicaid enrollees, including those with severe mental illness, substance use disorder, or other complex, chronic conditions.

COMPASS 1115 Waiver Process Overview

*September 20, 2018 –
October 20, 2018*



DMAS released the COMPASS waiver for public notice. Over 1,800 public comments were received.



November 20, 2018



DMAS submitted the COMPASS waiver to the federal government.



*December 7, 2018 –
January 6, 2019*



The federal government released the COMPASS waiver for the federal public comment period.



*January 6, 2019 –
Present and Ongoing*



DMAS is currently negotiating the COMPASS waiver features with the federal government.

CMS Negotiation Status Update: Overview

Current Phase

Negotiations of 1115 Special Terms and Conditions (STCs)

- DMAS is currently in active negotiations with CMS on the 1115 waiver STCs, which serve as the agreement between the federal government and the state on the policy for the waiver programs

Next Phase

Negotiations of Implementation and Evaluation Protocols

- After the waiver approval letter is sent, DMAS and CMS will negotiate the implementation and evaluation protocols, which outline how the waiver programs will be operationalized, monitored and evaluated

Additional Authorities

Seeking Additional Federal Authorities for Key Components

- This will include submission of multiple state plan amendments (SPAs) to secure authority for certain waiver components and advanced planning documents (APDs) to secure federal match for IT systems changes

DMAS has simultaneously been working with sister agencies to plan for operationalization of the waiver programs.

Overview of Changes Required for Virginia COMPASS Waiver

New Business Processes and Systems Changes for TEEOP

- Develop new eligibility business processes for exemptions, automated reporting, suspensions of coverage and reenrollment
- Develop member compliance and reporting processes
- Develop member assessment processes, including connecting individuals to services
- Establish systems requirements, modify existing contracts, and implement new technology services
- Implement new systems and make systems changes, including changes to eligibility system (VaCMS) to ensure interoperability across systems (including Workforce and Medicaid)

Stand Up Health & Wellness Program

- DMAS does not currently have Health & Wellness accounts or premiums
- Develop new business processes
- Create systems to operationalize premiums, accounts and copayments with contractor/managed care organization support
- Connect new systems and processes to TEEOP processes and eligibility systems

Outreach, Training & Stakeholder Engagement

- Extensive training of state and contractor staff
- Outreach and education campaign to ensure enrollee, provider, advocate and other stakeholder understanding of requirements and penalties

Bolster Workforce Programs to Meet Need

- Estimated 1.3 to 5.2 million additional hours per month in community engagement activities needed to meet the need
- Build upon existing workforce programming
- Seeking federal resources for additional supportive employment services

Medicaid Expansion

- ✓ Virginia's Medicaid expansion began on **January 1, 2019**
- ✓ Virginia expanded Medicaid coverage to adults with incomes \leq **138% FPL**
- ✓ Virginia has enrolled **over 280,000** newly eligible adults as of May 21, 2019



COVER VIRGINIA
Connecting Virginians to
Affordable Health Insurance

Now Available: New Health Coverage for Adults
More adults living in Virginia now have access to quality, low- and no-cost health coverage. Applications accepted year-round.
Get more information at coverva.org.



A diverse group of approximately 15 adults of various ages and ethnicities are smiling and standing together. The group includes men and women of different ethnicities, including African American, Asian, and white individuals, representing the community served by Cover Virginia.

Medicaid Expansion Enrollment Dashboard

www.dmas.virginia.gov

New Health Coverage for Adults

Enrollment Week*

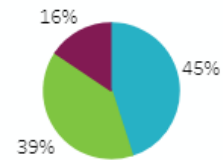
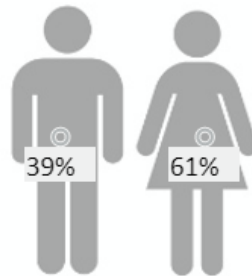
5/17/2019

Overall Enrollment

279,489 adults newly enrolled in Medicaid

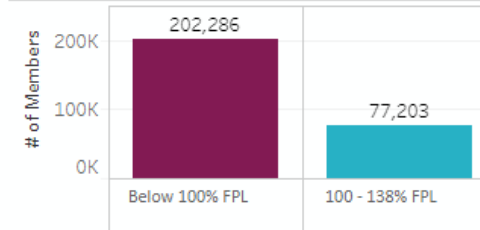
97,420 newly enrolled adults are parents

Age and Gender of Enrollees



Age Group
19 - 34 Years
35 - 54 Years
55+ Years

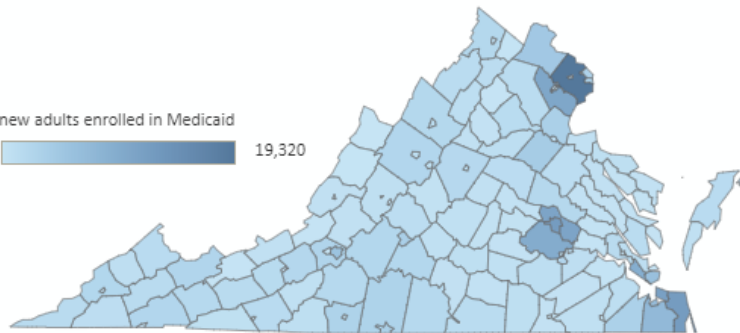
Enrollee Family Income



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

Adults Enrolled in New Health Coverage by Locality

of new adults enrolled in Medicaid
37 19,320



Enrollment by City / County

Central	70,389
Charlottesville / Western	36,017
Northern & Winchester	54,854
Roanoke / Alleghany	29,988
Southwest	22,269
Tidewater	65,972
Grand Total	279,489

Medicaid Expansion Members: Medical Conditions and Service Utilization

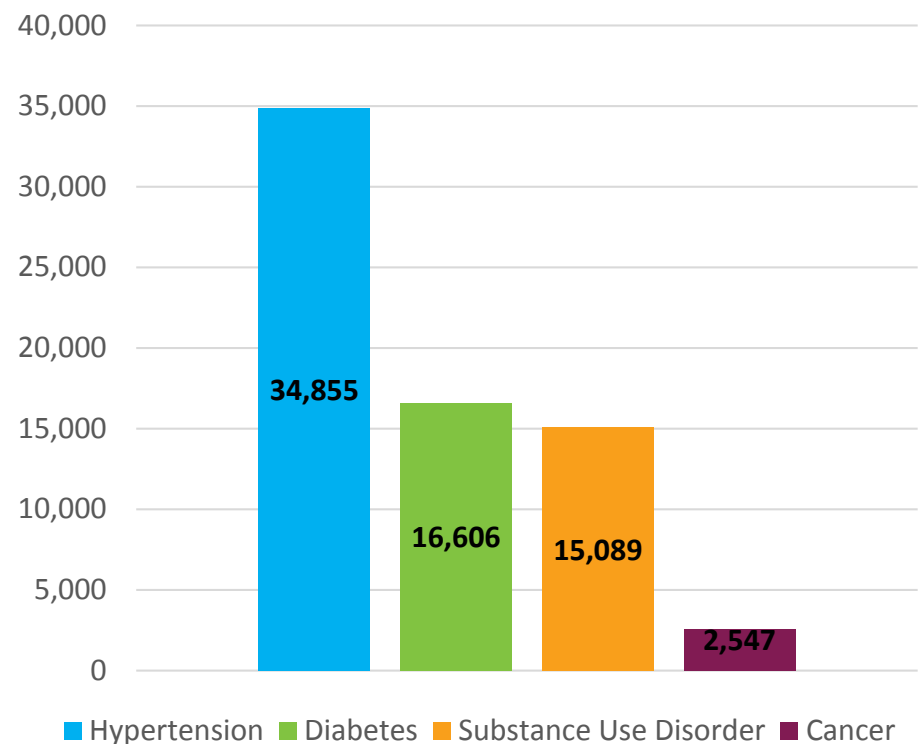


More than **175,000**
Medicaid expansion members
have visited a provider*



More than **81,000** Medicaid
expansion members have
received a prescription*

Medicaid Expansion Members Diagnoses*



**Due to claims lag, numbers largely reflect services provided in January and February and the 230,000 adults enrolled at that time (85% of current expansion enrollment).*

Healthcare needs of expansion adults

- VCU is conducting a survey of new expansion adults on health care needs *prior* to enrolling

Preliminary results of on-going survey
Members report significant unmet needs



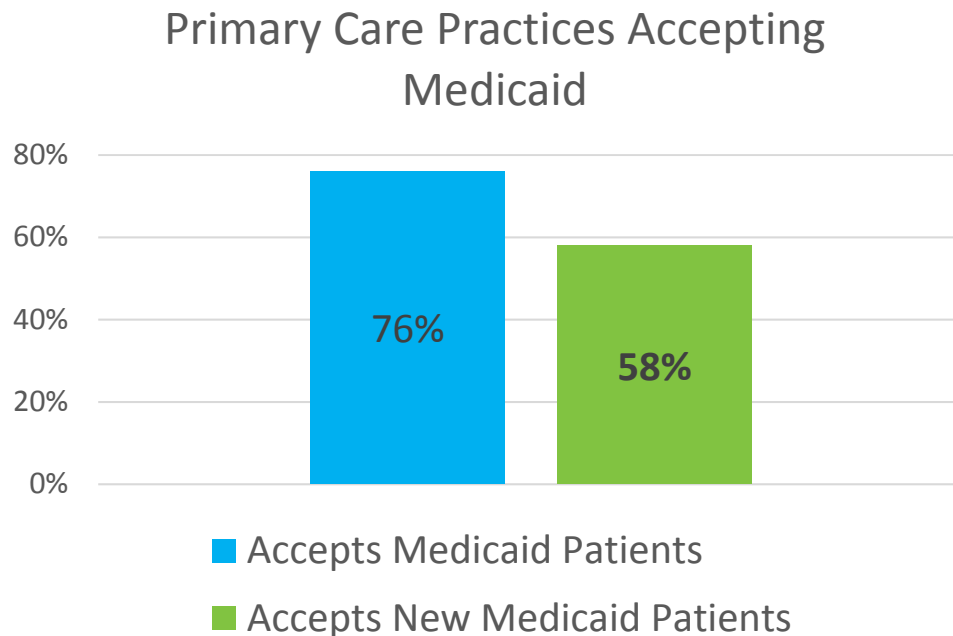
Two-thirds of new members report dental care as an unmet need



1 in 5 members report mental health care as an unmet need

Primary care workforce

- ❑ Virginia has 1,622 adult primary care practices
- ❑ Respondents report that primary care offers expanded access to a broad range of services



Top 3 Factors Clinicians Report Influencing Decision to Accept more Medicaid Patients



MEMBER FOCUSED INITIATIVES UPDATE

BOARD OF MEDICAL ASSISTANCE SERVICES (BMAS)

JUNE 4, 2019

RACHEL PRYOR

**DEPUTY DIRECTOR OF ADMINISTRATION,
DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES**

Overview



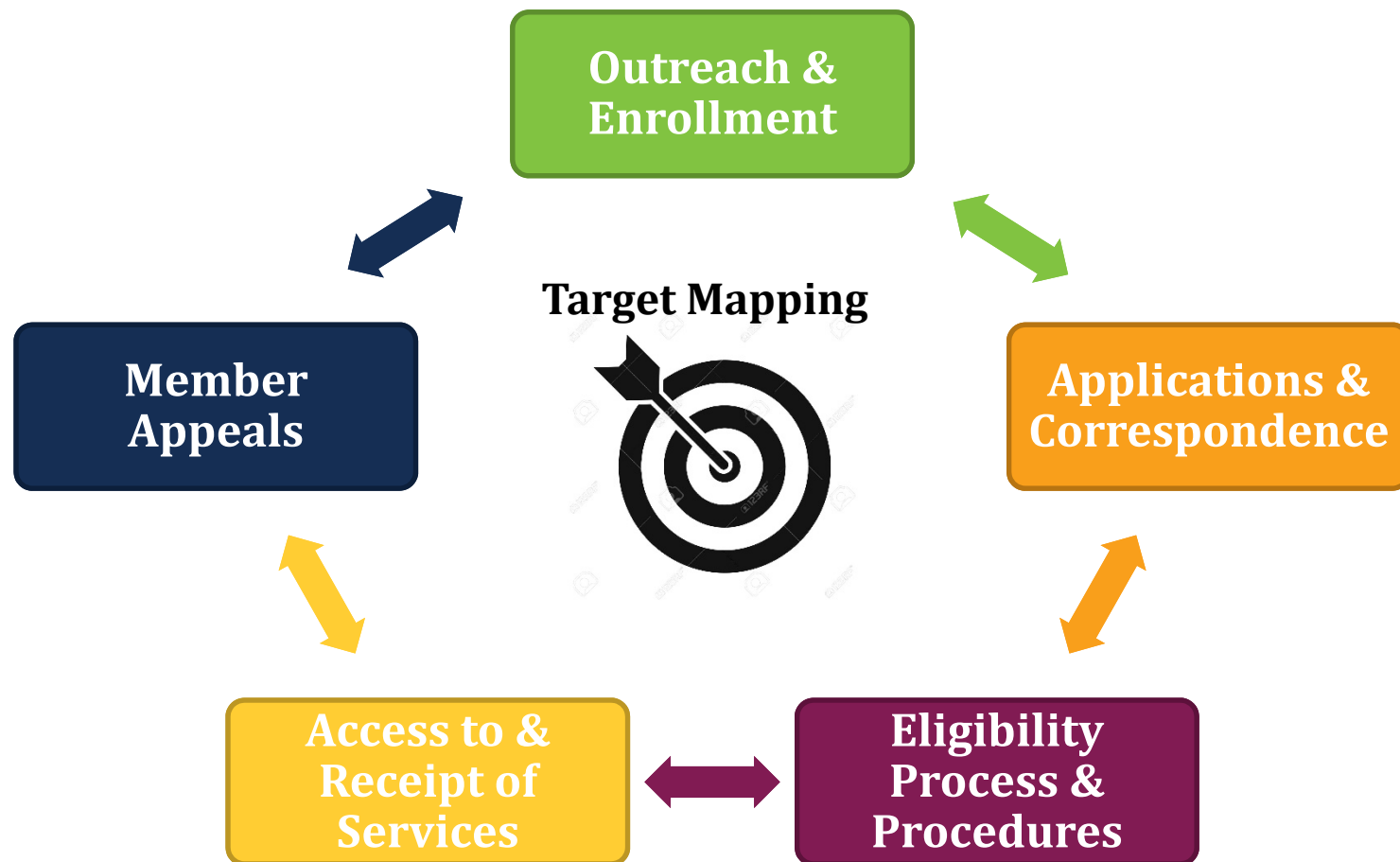
**Member Engagement Initiatives:
Consumer Mapping**

Member Focused Initiatives

Member Advisory Committee



Member Engagement Initiatives

Consumer mapping work continues through updating of policies and processes geared to the member's experience. Several new initiatives and updates are planned for Open Enrollment 2019.



Member Focused Initiatives

Improving Consumer Notices & Communication

 <p>Phase I: Member Notices & Updates to Cover Virginia Website</p>	<ul style="list-style-type: none">✓ Notice of Action✓ Notice of Temporary Approval✓ Verification Checklist✓ Inserts: Language Taglines, Spend-down Fact Sheet, & Marketplace Referral✓ Cover Virginia Website Additions & Improvements
 <p>Phase II: Remaining Member Notices</p>	<ul style="list-style-type: none">✓ Renewal Notice✓ Manual Verification Checklist✓ Notice of Obligation

Member Focused Initiatives

- **Language and ADA Policy Improvements**

- Ensure meaningful access to language assistance:
 - Assess all points of contact with members and evaluate language & ADA access needs
 - Ensure that individuals with limited English proficiency (LEP) are aware that reasonable language assistance is available free of charge and that language assistance is timely provided
- Recruitment of Language Access/ADA Coordinator
- DMAS staff development, including developing and disseminating training materials

- **40-Quarter Work Requirement**

- There is a requirement that lawful permanent residents* meet two requirements to be eligible for full benefits under Virginia Medicaid, in addition to other eligibility criteria:
 - ✓ Five years of residence in the U.S.
 - ✓ 40 qualifying quarters of work (~10 years)
- While the “five year bar” is federally required, Virginia is one of **only 6 states** with the 40-Quarter requirement, which significantly limits coverage available to many lawful permanent residents.

- **Enrollment of Pregnant Women**

- System improvements for auto-evaluation & enrollment of pregnant women into ongoing coverage at end of pregnancy coverage.

Medicaid Member Advisory Committee (MAC)

Member-selected themes for the upcoming meeting on June 5, 2019:

DMAS outreach and enrollment strategies

Feedback from the MAC on new changes to consumer Medicaid correspondence

Member discussion on member services and consumer accessibility in Medallion 4.0 and CCC Plus

Opportunity for free discussion on other topics desired by members

Medicaid Member Advisory Committee (MAC)



Virginia Medicaid
Member Advisory Committee
(MAC)

April 1, 2019



Consumer Direction Updates

- DMAS convened a workgroup with MCOs and Services Facilitators (SF) on 5/3
- Meeting with Virginia Association of Centers for Independent Living (VACIL) on 5/14
 - MCO Authorizations and Claims
 - MCOs clarified authorization requirements
 - SFs identified claims issues resulting in one MCO to make a system edit
 - MCOs agreed to automatically renew respite authorizations
 - Communications
 - MCOs identified where SFs can get assistance
 - MCOs will provide at least 30 day notice prior to any program change

Consumer Direction Updates

- Consumer Direct Care Network
 - Web portal – full SF access on 5/31
 - Communication challenges
 - CDCN completed root cause analysis
 - Revised the procedure for processing employer/employee packets
 - Additional training for customer service staff
- Employer of Record manual
 - Will be updated by 7/1/19 to reflect current fiscal/employer agents

Consumer Direction Updates

- Follow-up workgroup meeting being scheduled
- DMAS agreed to on-going meetings with VACIL to ensure continued progress in all areas



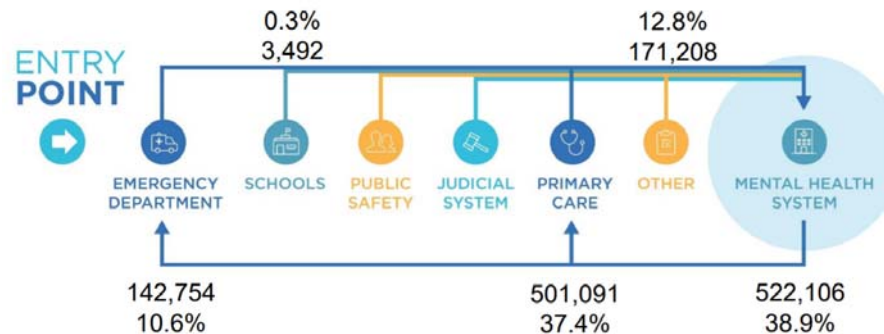
BEHAVIORAL HEALTH REDESIGN

JUNE 2019

The Vision for Redesign

Develop an evidence-based, trauma-informed, cost-effective continuum of care

- Keep Virginians well and thriving in their communities
- Improve behavioral health services and outcomes for members in current and expansion populations
- Meet people's needs in environments where they already seek support such as schools and physical health care settings
- ***Invest in prevention and early intervention services that promote resiliency and buffer against the effects of adverse childhood experiences***



Current Medicaid-funded Behavioral Health Services

Prevention

Recovery

Outpatient

Community Mental Health
Rehabilitation Services

Inpatient / Residential

Early intervention Part C • Screening • EPSDT services

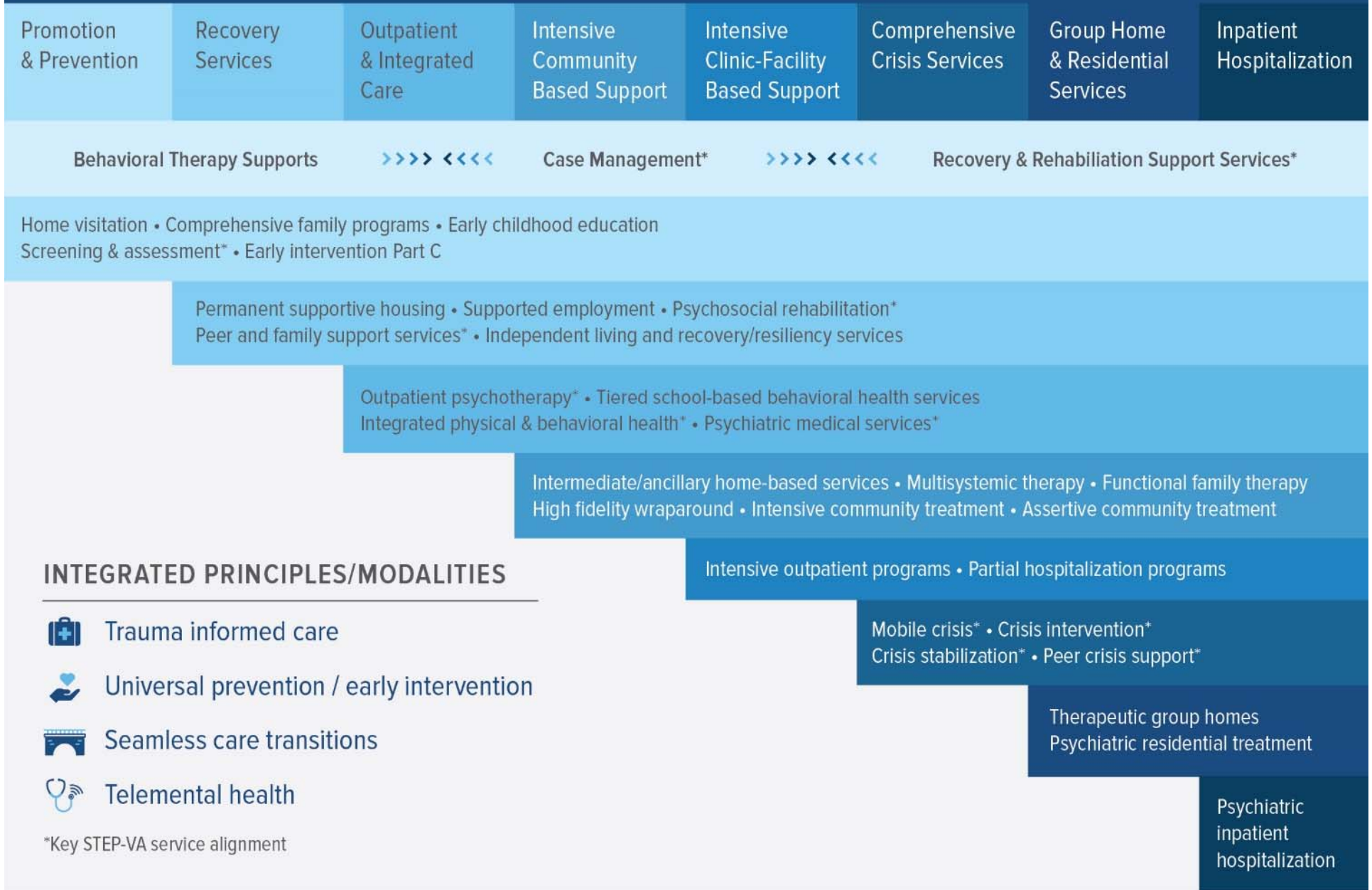
Peer and family support partners

Outpatient psychotherapy • Psychiatric medical services

Therapeutic day treatment
Mental health skill building services
Intensive in-home services
Crisis intervention & stabilization
Behavioral therapy
Psychosocial rehabilitation
Partial hospitalization / Day treatment
Mental health case management
Treatment foster care case management
Intensive community treatment

Inpatient hospitalization
Psychiatric residential treatment
Therapeutic group home

Continuum of Behavioral Health Services Across the Life Span



Redesigned Behavioral Health Continuum



These services are emphasized for delivery across all levels of care to promote integrated the principles of trauma informed care, Universal Prevention / Early Intervention and Seamless Care Transitions.

The Future for the Commonwealth:

A comprehensive spectrum of behavioral health services

- Bring the Commonwealth into the Top 10 in national rankings for behavioral health outcomes
- Shift from working with a reactive, crisis-driven, high-cost system reliant on intensive services to one that is proactive/preventive, cost-efficient, and focused on providing services in the least restrictive environments
- Build upon existing statewide behavioral health transformative initiatives and create sustainability and expansion for evidence based services
- Integration of trauma-informed care principles across the continuum to empower individuals to build resiliency and overcome the impact of adverse experiences so that they can lead meaningful, productive lives in our communities
- Build a robust children's behavioral health system to address prevention and early intervention of mental health problems to allow each child the chance to reach their full developmental potential

BOARD OF MEDICAL ASSISTANCE SERVICES

ADULT PREVENTIVE CARE
COVERAGE

MATERNAL AND CHILD HEALTH
DISPARITIES

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



Adult Preventive Care History

- Commercial markets basic benefits began with high-risk services
- In the 70-80s, they added preventive services, routine exams, detection tests and labs as a basic benefit
- Preventive care is important because it helps members stay healthy and access prompt treatment when necessary and it can also help reduce overall medical expenses
- This focus on routine exams and preventive care led to the development of the Primary Care Provider (PCP) and the development of a provider/patient relationship that went from the gamut of gatekeeper to now the coordination and integration of care
- All beginning with routine exams and lab tests

The ACA and Preventive Care

Under the ACA, the marketplace exchanges and Medicaid expansion benefits include

FREE PREVENTIVE SERVICES
Even before you've met your deductible



Adult Preventive Services

ACA Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella
- Learn more about immunizations and see the latest vaccine schedules.
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

Adult Preventive Care

State

- In State Medicaid programs, preventive services are optional vs mandate services
- Virginia, to date, has elected not to cover preventive services for Medicaid recipients
- Therefore, Virginia expansion members have preventive services as a mandated benefit and adult Medicaid members do not
 - For example nutritional counseling is covered for expansion members but not in Medicaid

MCOs

- MCOs offer a variety of enhanced services, which may include adult preventive services
- These are not mandated services and the health plans provide them as part of their strategic and altruistic footprint
- Plans can cease enhanced services or limit them
- DMAS cannot monitor the enhanced services as they are not required by contract nor do we reimburse the health plans for the provision of the services

Adult Preventive Care

- Adding adult preventive services as a mandated Medicaid service in Virginia is a small investment with big dividends
 - The services help to develop a PCP relationship and provide early detection and outcomes
- Services would be required by contract, which would allow DMAS to monitor utilization and outcomes and support some of the Commonwealth's public health initiatives such as smoking cessation, obesity, vaccines, etc.
- Provision of preventive services assists with MCO value based purchasing initiatives and well care incentives
- Ends the disparity between expansion and non-expansion members

Maternal and Child Health Disparities



Maternal Health



Newborn Health



Child Health

World View

- Pakistan is the riskiest country to be born:
 - 1 in 22 babies die before they turn one month old
- Japan leads the world for lowest newborn mortality (0.9), followed by Iceland (1.0), Singapore (1.1), Finland (1.2), Estonia and Slovenia (1.3)*
- The United States performs low (5.8) compared to other westernized counties**
- Virginia's infant mortality rate ranked 26th among states with a rate of 5.9 deaths per 1,000 live births**

* Source: UNICEF Every Child Alive 2018

** Source: CDC National Center for Health Statistics 2017

Maternal Mortality

- Maternal mortality affects U.S. women from all backgrounds; if a woman is able to become pregnant, she risks experiencing complications such as preterm labor, infections, gestational diabetes, and even death due to her pregnancy
- Among women who survive pregnancy and childbirth, women each year experience life-threatening pregnancy-related complications, also known as severe maternal morbidity (SMM)
- SMM disproportionately affects women of color, with African American women twice as likely to experience SMM compared with non-Hispanic white women
- African American mothers are twice as likely to have an infant who dies by their first birthday as African Americans have the highest infant mortality rate of any racial or ethnic group in the United States



Maternal and Child Health Disparities

- DMAS delivers 1/3 of all babies born in the Commonwealth – 33,000 deliveries per year
- DMAS covers a full spectrum of services for pregnant woman from prenatal care to opioid treatment
- All MCOs have a variety of maternity programs focused on prenatal care
- DMAS partners with VDH and DBHDS on initiatives
- VHHA has a maternal death project
- DMAS has participated in several grants and initiatives
- Yet Medicaid women still have racial and health disparities

Birth outcomes for Virginia Medicaid by population, CY 2017

	National benchmark	Adequate prenatal care	National benchmark	Preterm births (< 37 weeks)	National benchmark	Low birth weight (< 2,500 grams)	National benchmark	Newborns with 2+ PCP visits in first 30 days	National benchmark	Newborns with an ED visit in first 30 days
		%		%		%		%		%
Maternal Age	77.6%		8.1%		6.6%		N/A		N/A	
17 Years and Younger		61.2%		11.4%		9.4%		37.9%		12.5%
18-24 Years		68.0%		7.7%		8.2%		45.2%		9.5%
25-34 Years		69.6%		9.3%		8.9%		45.0%		7.5%
35+ Years		69.2%		13.0%		10.3%		43.1%		6.9%
Maternal Race/Ethnicity										
White, Non-Hispanic		71.0%		8.2%		7.1%		45.7%		7.3%
Black, Non-Hispanic		67.5%		11.0%		11.8%		40.1%		9.2%
Asian, Non-Hispanic		69.7%		5.9%		5.6%		54.3%		8.0%
Hispanic, Any race		65.2%		7.8%		6.3%		52.2%		8.6%
Other/Unknown		70.1%		7.4%		6.9%		50.1%		9.0%
Region										
Central		68.4%		9.9%		9.6%		45.8%		9.4%
Charlottesville		73.9%		9.1%		7.8%		45.6%		7.3%
Far Southwest		61.0%		7.1%		7.2%		43.0%		9.2%
Halifax/Lynchburg		73.9%		8.3%		9.7%		35.3%		8.1%
Northern/Winchester		64.3%		8.1%		6.8%		53.0%		8.7%
Roanoke/Alleghany		70.2%		7.1%		7.4%		33.2%		6.2%
Tidewater		72.2%		10.4%		10.4%		42.8%		7.4%
Out of state		64.0%		9.8%		7.1%		47.5%		12.1%
TOTAL		68.8%		9.1%		8.7%		44.8%		8.3%

Source: HSAG 2017-2018 Birth Outcomes Focused Study, January 2019

Health Disparities: Maternal and Baby Health



Agency Project for Healthy Moms and Babies

DMAS is working on improving care and eradicating health disparities:

- Internal operational components such as eligibility and education and performance incentives for prenatal care
- One of eight states that will participate in the NASHP Maternal and Child Health Policy Innovations Program Policy Academy
- DMAS is committed to tackle the issues with all of our resources, knowledge and technology

BOARD OF MEDICAL ASSISTANCE SERVICES (BMAS)

June 4, 2019

CHRIS GORDON
BILL LESSARD



Agenda

- ❑ Milliman Report Recap
- ❑ Rate Setting Update & Managed Care Financial Status



MILLIMAN REPORT RECAP

Chris Gordon
Chief Financial Officer

Milliman Report: Background

- In February 2019, DMAS procured the services of Milliman, an actuarial and consulting firm, to conduct an independent, top-to-bottom review of Virginia's Medicaid forecasting and rate-setting processes.
- Milliman conducted its review over a period of 60 days, which included:
 - ✓ Interviewing DMAS and external stakeholders;
 - ✓ Reviewing documentation and communication of current processes; and
 - ✓ Benchmarking against other states' Medicaid forecasting and rate-setting processes (Arizona, Florida, Indiana, Ohio, and South Carolina) to share best practices.
- A final report with 10 recommendations was delivered to DMAS leadership on May 6, 2019.

Milliman Report: Review Highlights

Continue

- Developing knowledgeable internal staff
- Education for internal and external stakeholders

Expand

- Monitoring of forecast variances
- Documentation of forecast process and assumptions

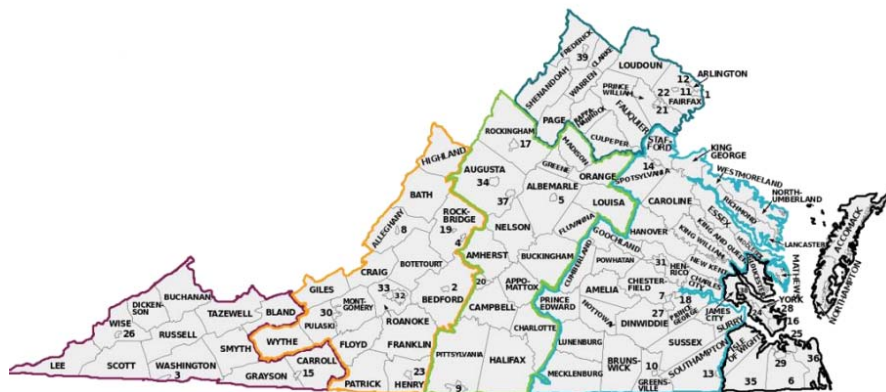
Start

- Performing forecast updates more than one per year
- Formalizing layers of internal review
- Being proactive in external communications

Milliman Report: Recommendations

Forecast Process Areas and Recommendations

Forecast Process	Recommendations
Data	Re-evaluate data used for forecast
Produce Forecast	Update the forecast more frequently than once per year
	Update forecast methodology
	Develop detailed forecast documentation
Analysis of Results	Build a robust review process into the forecast development timeline
Communication	Improve collaboration and communication within DMAS
	Re-evaluate and restructure involvement of external stakeholders
	Expand education for external stakeholders
Monitoring	Re-evaluate forecast monitoring
	Proactively address changes to the budget language



RATE SETTING UPDATE & MANAGED CARE FINANCIAL STATUS

Bill Lessard

Director, Provider Reimbursement

Rate Setting Update

- Met with MCOs on May 22
 - CY19 mid-year CCC+ rates
 - FY20 Medallion rates
 - FY20 PACE rates
- Mercer reviewed MCO contract changes and determined that there was no material fiscal impact.
- No additional cost to the admin load of the FY20 rates.
- Notification submitted to DPB on May 31.
- CY19 CCC+ mid-year and FY20 Medallion capitation rate changes are slightly **LESS** than forecasted.

Managed Care Financial Status

- MCOs lost a total of \$244 million in CY18 (a profit of \$39 million for Medallion and a loss of \$283 million for CCC Plus).
- Some plans are likely to hit the profit cap for Medallion even though they are incurring losses overall.
- New plans (United and Magellan) experienced losses for both programs.
- This represents the first full year of operation for CCC+. While we would expect plans to improve significantly in CY19, they may still incur losses overall.



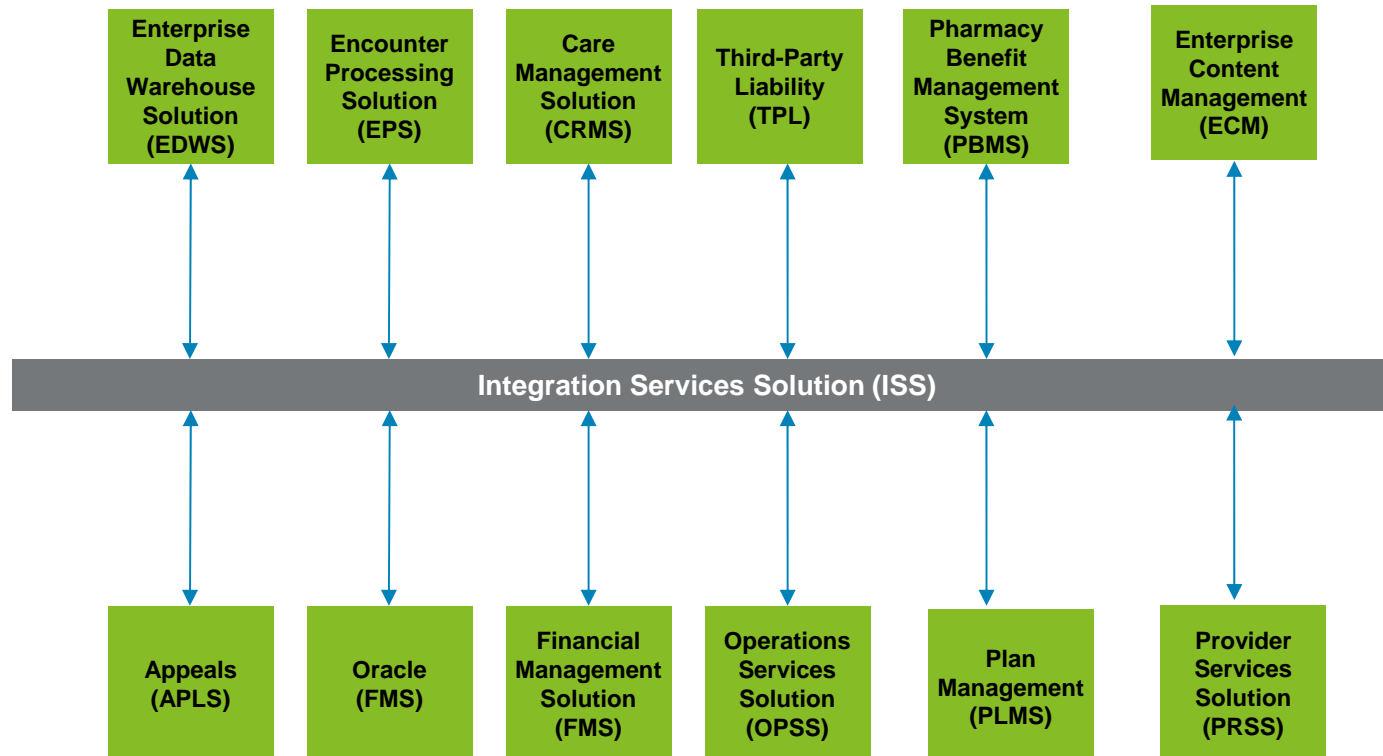
MEDICAID ENTERPRISE SYSTEM PROGRAM STATUS

May 30, 2019

AGENDA

- Program Accomplishments
- Program Status / Oversight
- Flight Plan

Deloitte's HealthInteractive Platform High-level Conceptual Diagram



Accomplishments

- **Systems Integration (ISS) - Deloitte**
 - Integration Master Schedule
 - Program Risk Register
 - Earned Value

- **Encounter Processing Solution (EPS) - DMAS**
 - Release 4 is targeted for a 10/2019 implementation. Integration for data exchanges in progress.

- **Pharmacy Benefit Management Solution (PBMS)- Magellan**
 - Initial Project is closed out. Integration for data exchanges in progress.

- **Payment Processing Management Solution (PPMS) – Conduent**
 - Design sessions in full swing.
 - Integration for data exchanges in progress.

Accomplishments

- **Financial Management Solution (FMS) – Oracle / TBD**
 - Oracle Move and Improve on hold.
 - Budget Module Project underway.

- **Enterprise Data Warehouse Solution (EDWS) - Optum**
 - Fraud and Abuse system went live with single sign-on in April
 - OTAAS reporting is in User Acceptance Testing.

- **Operations Services (OPSS) and Plan Management (PLMS) - Accenture**
 - Accenture has started Systems Integration Testing. They are starting Integration 3 of 6. The SIT is scheduled for 5 months. UAT will overlap SIT.

Accomplishments

- **Provider Management Solution (PRSS) - DXC**
 - User Acceptance has started

- **Care Management (DMAS)**
 - Project has been running weekly meetings with a minimum viable product due by 12/1/19. Integration data exchanges underway.

- **Third Party Liability System (Oracle, DMAS)**
 - Completed upgrade of forms and system is functional

MES Program Status

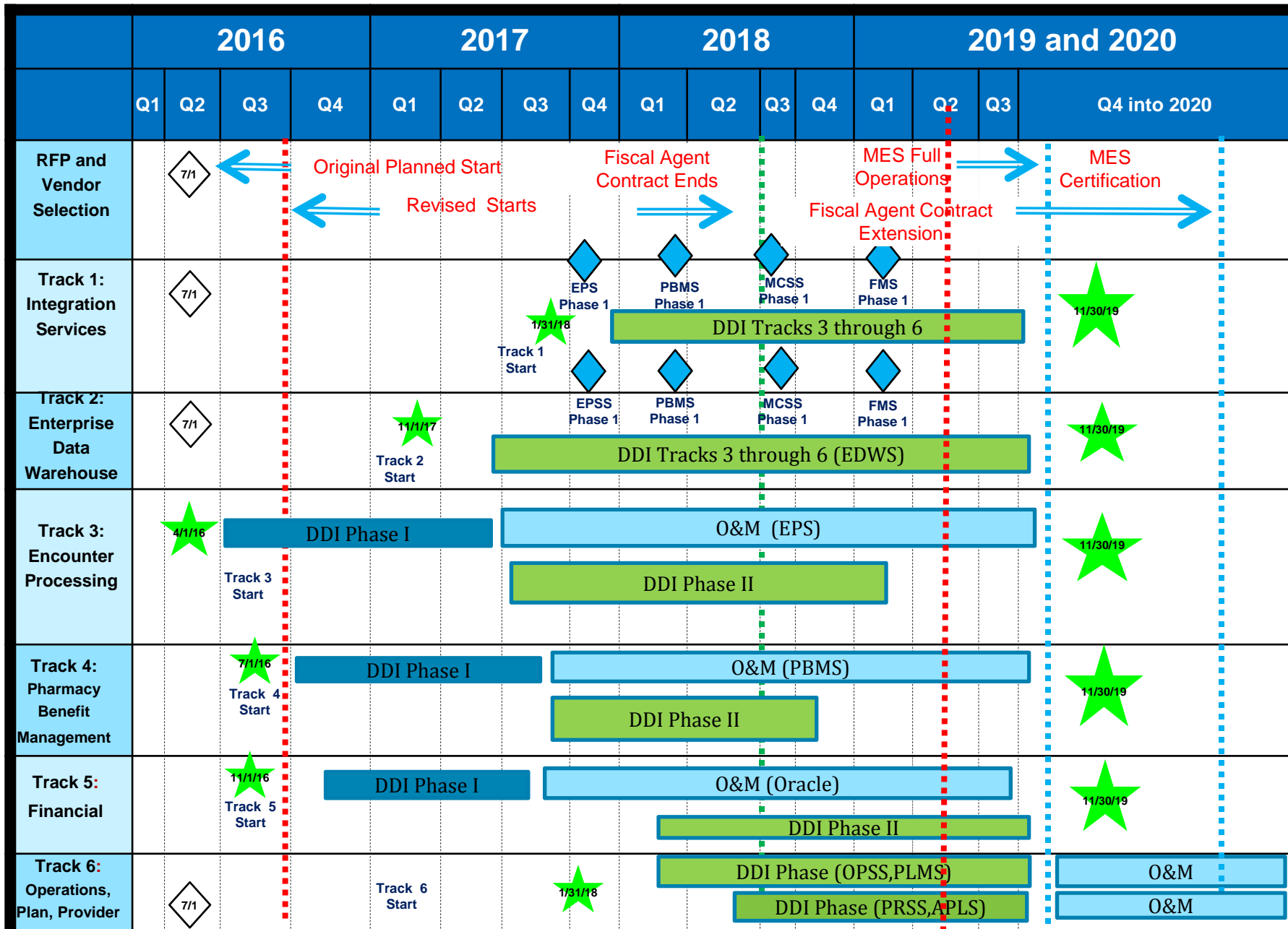
➤ MES Program Summary

- Modular solutions are evolving for Medicaid independent modules. CMS workgroups of vendors and states are collaborating on Modular Procurements, Governance, and Certifications. CMS continues to emphasize reuse, interoperability and cloud services Software as a Service (SaaS) solutions. Virginia is a national front runner for modular solutions. MES continues to be presented with challenges and opportunities in movement to a new modular integrated environment.

➤ State and Federal Oversight

- VITA PMD continues to report the MES Program as *Green*.
- DMAS provides CMS with monthly reporting on project status.
- Auditor of Public Accounts participate in monthly IAOC meetings and receives monthly status reports for each project.
- CMS/DMAS EMT/IV&V

MES PROJECT IMPLEMENTATION FLIGHT PLAN



Regulatory Activity Summary June 4, 2019
(* Indicates recent activity)

2019 General Assembly

***(01) ARTS Updates:** This fast-track regulatory package seeks to streamline, simplify, and clarify existing requirements for ARTS services and ARTS providers. The Addiction and Recovery Treatment Services (ARTS) program regulations became effective on April 1, 2017. Now, the regulations need minor modifications to address program needs as well as to answer questions that have been raised by providers. Internal DMAS review and coordination are currently underway.

***(02) CMH and Peers Updates:** This fast-track regulatory package updates the references to the Behavioral Health Services Administrator (or BHSA), which are stricken and replaced with references to “DMAS or its contractor.” The BHSA contract was extended for one year, and will end in 2020, and these references are being updated in anticipation of that change. Also, clarifications are being made to the Peers regulations, including changes to correct the accidental omission of LMHP-Resident, Resident in Psychology, and Supervisee in Social Work so that they may perform appropriate functions within Peer Recovery Support Services. The reg package also includes changes that remove the annual limits from certain community mental health services. These limits are prohibited because they conflict with mental health parity requirements under federal law. There is no cost to this change, because these limits have not been enforced since the Magellan BHSA was brought on to administer these services. The Magellan BHSA has approved requests for community mental health services when the individual meets medical necessity criteria for the service, even if the amount of service will exceed these outdated annual limits. Internal DMAS review and coordination for this project are currently underway.

***(03) Medallion Coverage for State Psychiatric Hospitals:** The purpose of this fast-track regulatory action is to permit individuals with Medicaid coverage through Medallion managed care plans to continue to participate in managed care if they receive care in a state mental health hospital. This change means that inpatient psychiatric care will be treated consistently whether the individual receives care in a private hospital or a state hospital. This action is budget neutral because inpatient psychiatric care at state hospitals is currently covered through the fee-for-service (FFS) system. This action will shift the costs from the FFS system to the Medallion managed care providers. There will be no increase in the capitation rate to Medallion providers as a result of this change. Internal DMAS review and coordination for this project are currently underway.

(04) Sunset Supplemental Payments — Collaboration & Private Qualifying Hospitals: Effective October 1, 2018, DMAS received approval to levy a payment-rate assessment that is disbursed to fund the non-federal share to increase inpatient and outpatient rates to private acute care hospitals operating in Virginia therefore, conflicting supplemental payments for qualifying private hospitals need to be sunset. The purpose of this state plan amendment is to sunset supplemental payments effective January 29, 2019 to private qualifying hospitals which are in conflict with payments which were approved for private acute care hospitals operating in

Virginia effective October 1, 2018. The PPN for this SPA was posted to the Town Hall on 1/28/19. The DPB notification letter for this SPA was sent on 1/31/19. Following internal DMAS review and coordination, the SPA was forwarded to HHR on 3/18/19 for review.

***(05) Graduate Medical Education Residency:** This final exempt regulatory package explains that, effective July 1, 2018, supplemental payments shall be made for medical residency slots for primary care, high need specialties, and underserved areas to the following sponsoring institutions for the specified number of primary care residencies: Sentara Norfolk General (1 residency), Maryview Hospital (1 residency), and Carilion Medical Center (6 residencies). Additionally, supplemental payments shall be made to Carilion Medical Center for 2 psychiatric residencies and to Sentara Norfolk General for 1 OB/GYN residency and 2 psychiatric residencies. Effective July 1, 2019, supplemental payments shall be made to the following sponsoring institutions for the specified number of primary care residencies: Sentara Norfolk General (1 residency), Maryview Hospital (1 residency), Carilion Medical Center (6 residencies), Centra Health (2 residencies), and Riverside Regional Medical Center (2 residencies). Additionally, supplemental payments shall be made to the following sponsoring institutions for the specified number of specialty residencies: Inova Fairfax Hospital (1 general surgery residency), Carilion Medical Center (2 psychiatric residencies), Sentara Norfolk General (2 psychiatric residencies, 1 OB/GYN residency, and 2 urology residencies). Supplemental payments for a one year fellowship in Addiction Medicine shall be made to both the University of Virginia Health System and to the Virginia Commonwealth University Health System. Following internal DMAS review and coordination, the reg package was submitted to the OAG for review on 5/9/19.

***(06) Update of Average Commercial Rate Calculation for Eastern Virginia Medical School:** The purpose of this State Plan Amendment is to update the ACR calculation of supplemental payments for physicians affiliated with EVMS, effective November 1, 2018. The supplemental payment amount is the difference between Medicaid payments otherwise made for physician services and 145% of Medicare rates. A physician affiliated with EVMS is employed by a publicly funded medical school in a political subdivision of the Commonwealth of Virginia who provides services through the faculty practice plan affiliated with the publicly funded medical school, and who has entered into a contractual agreement for the assignment of payments in accordance with 42 CFR 447.10. Supplemental payments are made quarterly. The DPB notification letter for this SPA was sent on 12/3/18. Following internal DMAS review and coordination, the SPA was forwarded to HHR on 12/13/18 for review. SPA submission to CMS occurred on 12/19/18, and funding questions were submitted to CMS on 1/9/19. The SPA was approved by CMS on 2/1/19. The corresponding fast-track regs circulated for internal review on 2/7/19. The reg project was forwarded to the OAG for review on 4/10/19.

2018 General Assembly

***(01) Service Authorization:** This emergency regulatory action clarifies the documentation requirements for service authorization for Community Mental Health and Rehabilitative Services (CMHRS). This regulation is essential to protect the health, safety, or welfare of citizens in that it ensures that Medicaid members receive appropriate behavioral health services based on their documented needs. The regulatory changes reflect the transfer of community mental health rehabilitative services from the behavioral health services administrator (BHSA)

to DMAS managed care contractors. Following internal DMAS review and coordination, the regs were forwarded to the OAG on 10/29/18 for review. Responses to OAG inquiries were forwarded on 4/29/19. DMAS is awaiting further direction.

***(02) Expansion – Alternative Benefit Plan:** This regulatory action incorporates changes made to the Virginia State Plan in order to implement Medicaid expansion. Specifically, this action includes the alternative benefit plan (ABP) that is available to individuals who are covered by Medicaid expansion. The Centers for Medicare and Medicaid Services (CMS) requires state Medicaid agencies to create an ABP for expansion populations. The purpose of this regulation is to incorporate the CMS-approved Medicaid expansion ABP into the Virginia Administrative Code. This regulation is essential to protect the health, safety, and welfare of citizens in that it implements the General Assembly mandate to expand Medicaid coverage to new populations. Following internal DMAS review and coordination, the regs were forwarded to the OAG on 11/9/18 for review. The OAG forwarded comments on 3/1/19 and DMAS sent responses back on 3/6/19. The regs were submitted to DBP for review on 4/4/19. The regs were forwarded to HHR on 4/16/19.

***(03) Therapeutic Group Home Staff Requirements:** This state plan amendment updates DMAS wording to align with the Department of Behavioral Health and Developmental Services (DBHDS) requirements for services provided in Therapeutic Group Homes by non-licensed and non-registered staff. Once this SPA is approved, a regulatory package will incorporate these same changes into the Virginia Administrative Code. The DPB notification letter for this SPA was sent on 10/25/18. Following internal DMAS review and coordination, the SPA was forwarded to HHR on 3/1/19 for review. Submission to CMS occurred on 3/11/19. A follow-up conference call with CMS took place on 3/19/19. DMAS is awaiting further direction.

***(04) 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. The SPA was approved 10/9/18. The corresponding reg package was forwarded to

the OAG on 11/9/18. OAG comments were forwarded to DMAS on 2/28/19. Responses were returned on 3/7/19 and 3/19/19. The regs were submitted to DPB on 4/4/19; to HHR on 4/16/19; and to the Governor on 5/27/19.

(05) 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. Following internal revisions and addressing follow-up questions from the OAG, currently awaiting approval from the OAG office. The corresponding SPA is currently circulating for review within the agency.

***(06) 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. Following internal review, the project was submitted to the OAG for review on 10/16/18. DMAS received questions from the OAG on 4/29/19. Responses were forwarded to the OAG on 5/8/19. DMAS is waiting further direction.

***(07) 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. Following internal review, the project was submitted to the OAG for review on 10/29/18. The regs were certified by the OAG on 1/25/19 and submitted to DPB on 1/28/19. DPB began analysis on 1/31/19. A conf. call with DBP was held on 3/6/19. Info was forwarded to DPB following the call. DPB posted the Economic Impact Analysis (EIA) on 3/8/19, and DMAS provided its response on 3/13/19. The project was submitted to HHR on 3/8/19. The HHR review was completed and submitted to the Gov. Ofc. for review on 3/27/19.

***(08) 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. The regs were OAG-certified on 12/28/18; submitted to DPB for review on 1/2/19/18; and forwarded to HHR on 2/11/19. The EIA response was requested on 2/11/19. DMAS posted the agency EIA response on 2/13/19. The project was forwarded to the Gov. Ofc. for review on 4/14/19.

(09) 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.

***(10) 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. The Gov. Ofc. approved the regs on 10/23/18. The ER/NOIRA comment period closed on 12/12/18 with no comments. The Fast Track review phase of this project began on 12/13/18. Following internal DMAS review, the regs were submitted to the OAG on 2/7/19. A conf. call with the OAG was held on 2/13/19 to discuss the project. The reg project was forwarded to DPB for review on 5/17/19.

***(11) 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. With no comments received, the proposed phase review began on 10/25/18. The regs were forwarded to the OAG for review on 1/17/19. The OAG forwarded regulatory questions on 4/23/19, and DMAS sent responses back on 4/29/19. DMAS is currently editing the regs due to recent system changes and will forward the revised project back to the OAG soon.

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) 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. Thirty-nine comments were received during the NOIRA phase, and the comments were summarized. An ER Extension request was submitted on 10/16, and the ER was extended through 6/28/2020.

***(03) 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 3/8/18 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. HHR completed its review on 10/24/18, and the regs were forwarded to the Gov. Ofc. on 10/24/18. The Proposed Stage regs were approved by the Gov. on 2/5/19 and submitted to the Registrar on 2/6/19. The regs were published in the Register on 3/4/19, with a 60-day comment period, ending on 5/3/19. The Final Stage reg package was circulated internally for review on 5/13/19.

2016 General Assembly

(01) 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 Proposed Stage regs were signed by the Gov. on 12/18/18 and published in the Registrar on 1/21/19; with a public comment period through 3/22/19. An Emergency Extension request was submitted on 10/16/18, and the ER has been extended until 6/16/19.

***(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 9/18/17, 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. The regs were forwarded to DPB on 5/23/18; certified by HHR on 7/16/18; and the Proposed Stage regs were approved by the Gov. on 12/18/18. The regs were published on 2/4/19, with a public comment that ended on 4/5/19. DMAS is currently reviewing the comments that were received.

2015 General Assembly

***(01) 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 coordinated revisions, based on questions sent by the OAG on 6/25/18. The reg project was returned to the OAG for review on 1/30/19 and DMAS is awaiting feedback.

***(02) 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 with a conf. call with the OAG. Revised text was forwarded to the OAG on 11/28/18 and an additional conf. call took place on 11/29/18. Additional revisions were sent to the OAG on 1/15/19 and DMAS is awaiting further direction.

(03) 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. DMAS is currently awaiting approval.

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. The EIA was posted on 10/29/18; the regs were submitted to HHR on 10/29/18; and forwarded to the Governor's Ofc. on 11/25/18. The Gov. approved the regs on 2/5/19. The regs were published in the Register on 3/4/19, with a comment period through 5/3/19. The Final Stage regs were circulated internally for review on 5/8/19. DMAS submitted an ER extension request on 10/16/18; and the ER was extended until 7/2/19.

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.