BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, December 10, 2019
10:00 AM BMAS Meeting

Department of Medical Assistance Services
Conference Room 7A/7B
600 East Broad St. Richmond, VA 23219

AGENDA

#	ITEM	PRESENTER
1.	Call to Order	
	1.A. Call to Order	Karen S. Rheuban, M.D., Board Chair
2.	Approval of Minutes	
	2.A. Minutes from 8/27/19 Meeting	
3.	Director's Report	
	3.A. Director's Report	Karen Kimsey, Director
4.	Appeals Presentation	
	4.A. Appeals Presentation	Sam Metallo, Appeals Division Director John Stanwix Jessie Bell
5.	Forecast Update	
	5.A. Forecast Update	Chris Gordon, CFO
6.	Value Based Payment	
	6.A. Value Based Payment	Rusty Walker - Division Director, Office of Value Based Purchasing
7.	Medicaid Expansion & Member Survey	
	7.A. Medicaid Expansion & Member Survey	Mel Boynton

8. Update on MES (Medicaid Enterprise System)

8.A. Medicaid Enterprise System (MES) Update — Mike Jones, Acting Division Director of Information Management

9. Diversity Council Update

9.A. Diversity Council Update — Ivory Banks, Chief of Staff

10. Regulation Update

10.A. Regulation Update

11. New Business/Old Business

12. Adjournment

DIRECTOR'S BRIEFING

BOARD OF MEDICAL ASSISTANCE SERVICES

December 10, 2019

KAREN KIMSEY, MSW
Director,
Department of Medical Assistance Services

What We've Accomplished, Together

Expanding Medicaid to over 340,000 Virginians

Seeking ways to innovate, modernize and improve efficiency across core Agency processes, support functions and IT systems

Expanding managed care to new populations and services, with over 90 percent of our members now served by managed care organizations

Creating and reorganizing multiple divisions to ensure our organizational structure aligns with our Agency mission and priorities

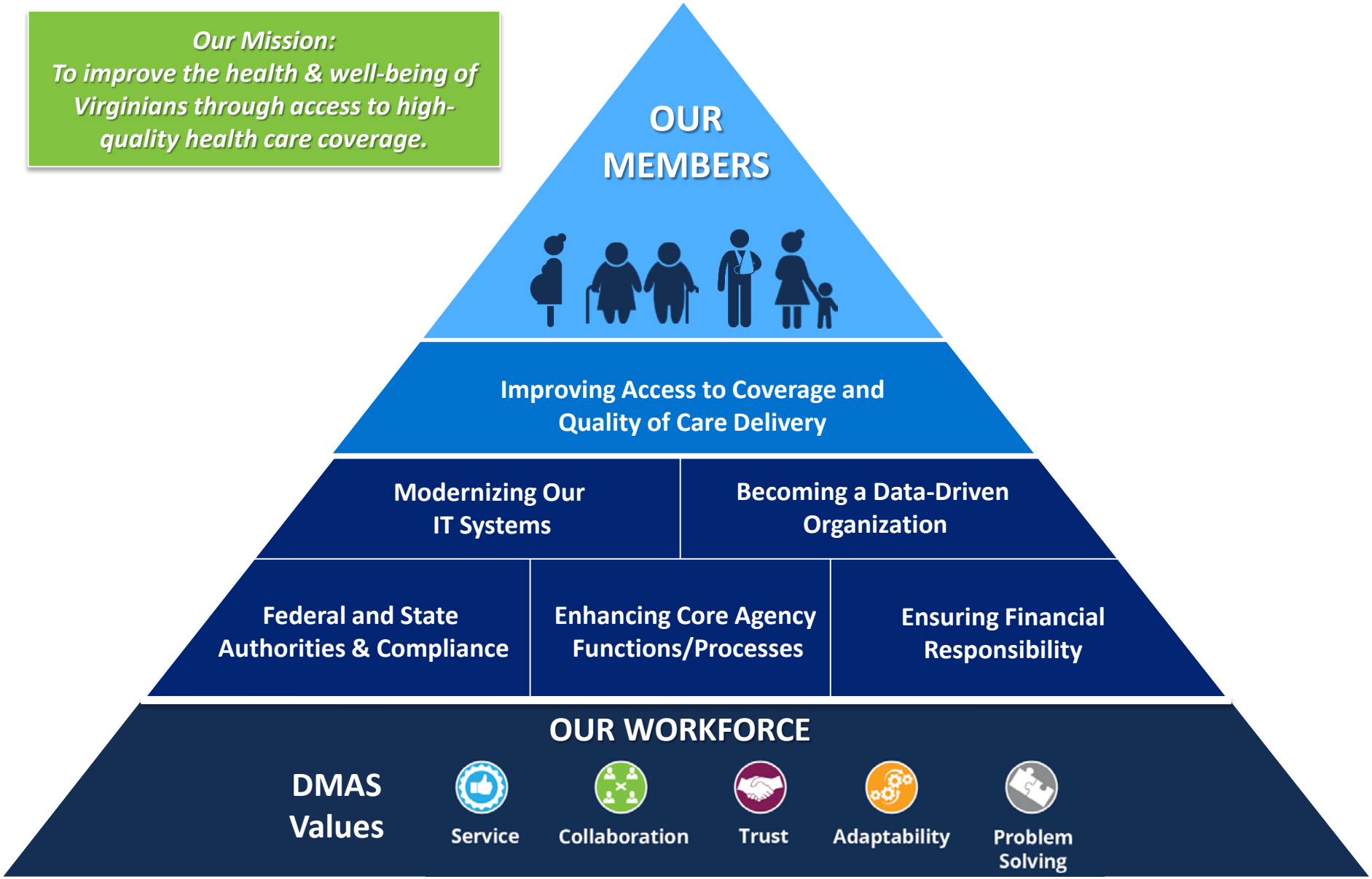
Taking steps to ensure our entire workforce feels well-supported, valued and respected

Improving the way we engage with our members, and making sure their voices are heard

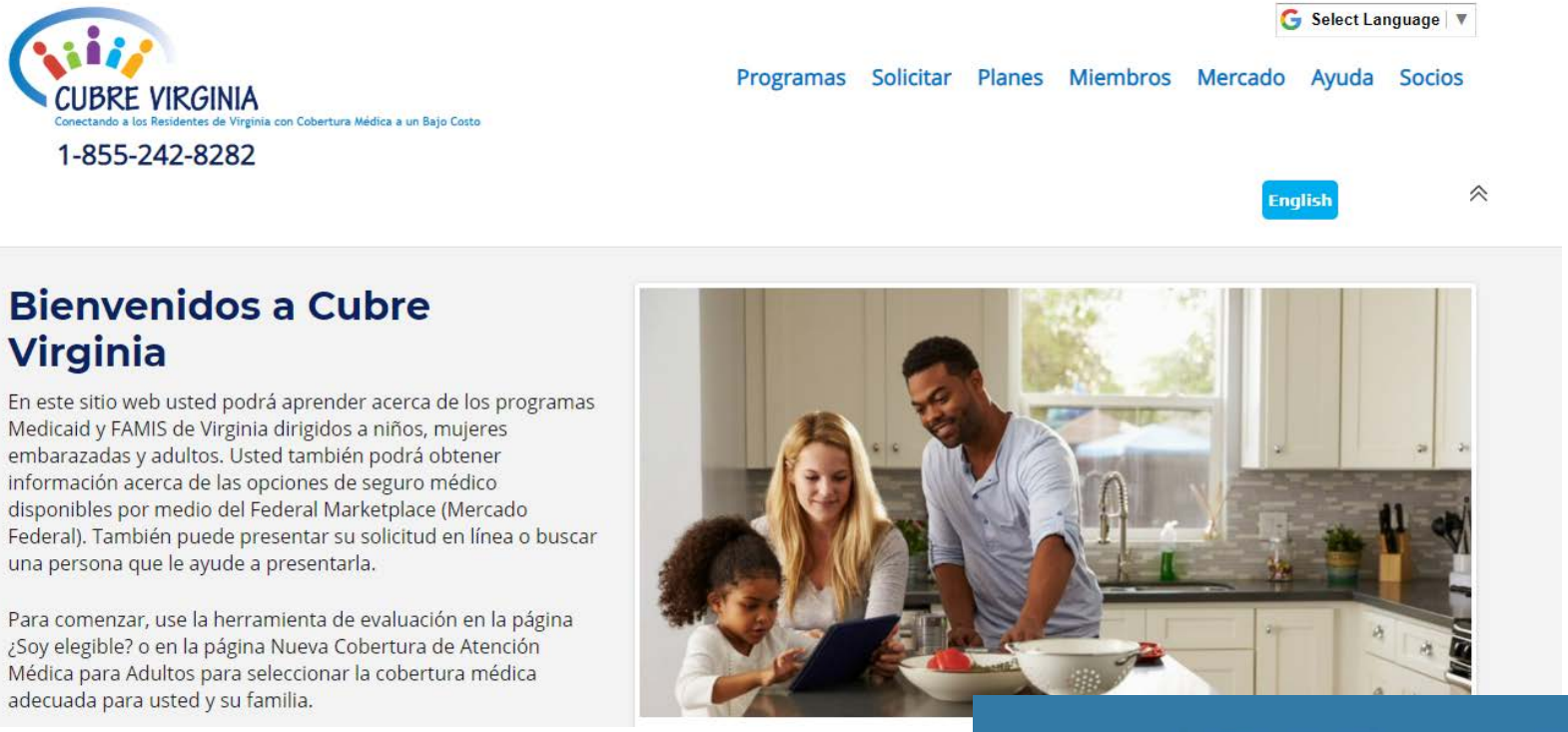
Where We're Going: DMAS Priorities

DMAS Strategic Pyramid

Our Mission:
To improve the health & well-being of Virginians through access to high-quality health care coverage.



Improving Access to Coverage and Quality of Care Delivery



www.CubreVirginia.org

CHCS Assessment of the DMAS Organizational Structure

DMAS contracted with the Centers for Health Care Strategies (CHCS) to assess and provide recommendations around the Agency's organizational structure

CHCS Activities:

Conducted interviews with members of the DMAS management team, including executive leadership and managers/supervisors

Facilitated multiple workshops with EMT focused on issues facing DMAS, strategic challenges/opportunities, and identifying a core set of guiding strategies and tools

Met with each EMT member separately to identify projects for completion within the next 3 years, and developed a strategic management grid that allows EMT to identify, track, and manage projects in alignment with Agency priorities

CHCS Key Findings

DMAS's structure is comparable with other state agencies

- ✓ EMT has a good mix of established and new agency talent that will help advance strategies that support the Agency mission/values
- ✓ DMAS has ability to advance strategic priorities with speed and intensity, as demonstrated by the successful implementation of Medicaid expansion in concert with addressing day-to-day demands associated with administering existing state Medicaid programs

CHCS recommends that DMAS continue these program improvements

- ✓ Centralize and streamline where possible for improved organizational health
- ✓ Strategies to keep management and workforce staff aware of and engaged in priority initiatives
- ✓ Opportunities to enhance staff development and capacity to better position the Agency to move new priorities forward

APPEALS DIVISION

Sam Metallo

John Stanwix

Jessie Bell

Agenda

- Appeals Division Overview
- Client Appeals
- Provider Appeals
- CY20 Strategic Goals and Supporting Initiatives

The Appeals Division is Driven by its Mission, Values, and Goals

DMAS Mission:

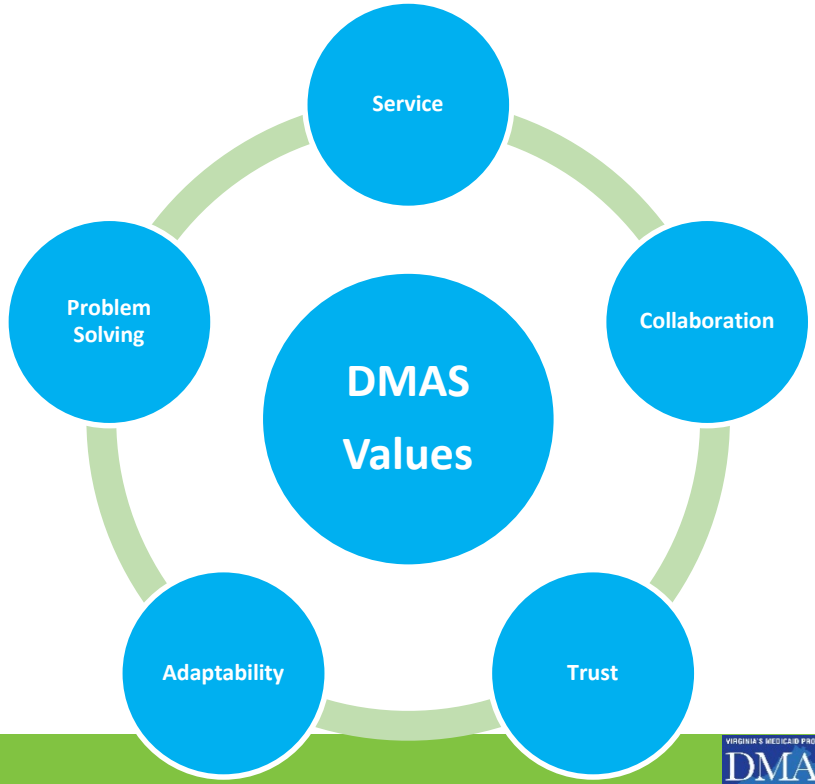
To improve the health and well-being of Virginians through access to high-quality health care coverage.

Appeals Division Mission:

To provide a neutral forum where Virginians and healthcare providers can understand and challenge adverse decisions made by DMAS or its contractors and receive due process in a fair and just manner.

Appeals Division Goals:

- **Service**: Ensure that all Virginians and healthcare providers receive their right to a fair appeal hearing conducted with dignity, professionalism, and respect for all parties
- **Collaboration**: Work together as a unified, high-performing team
- **Trust**: Process appeals in compliance with federal and state mandated timeframes
- **Adaptability**: Pursue continuous improvement to increase operational effectiveness
- **Problem Solving**: Maintain a strong feedback loop to escalate trends and issues we identify with our sister agencies and other DMAS Divisions



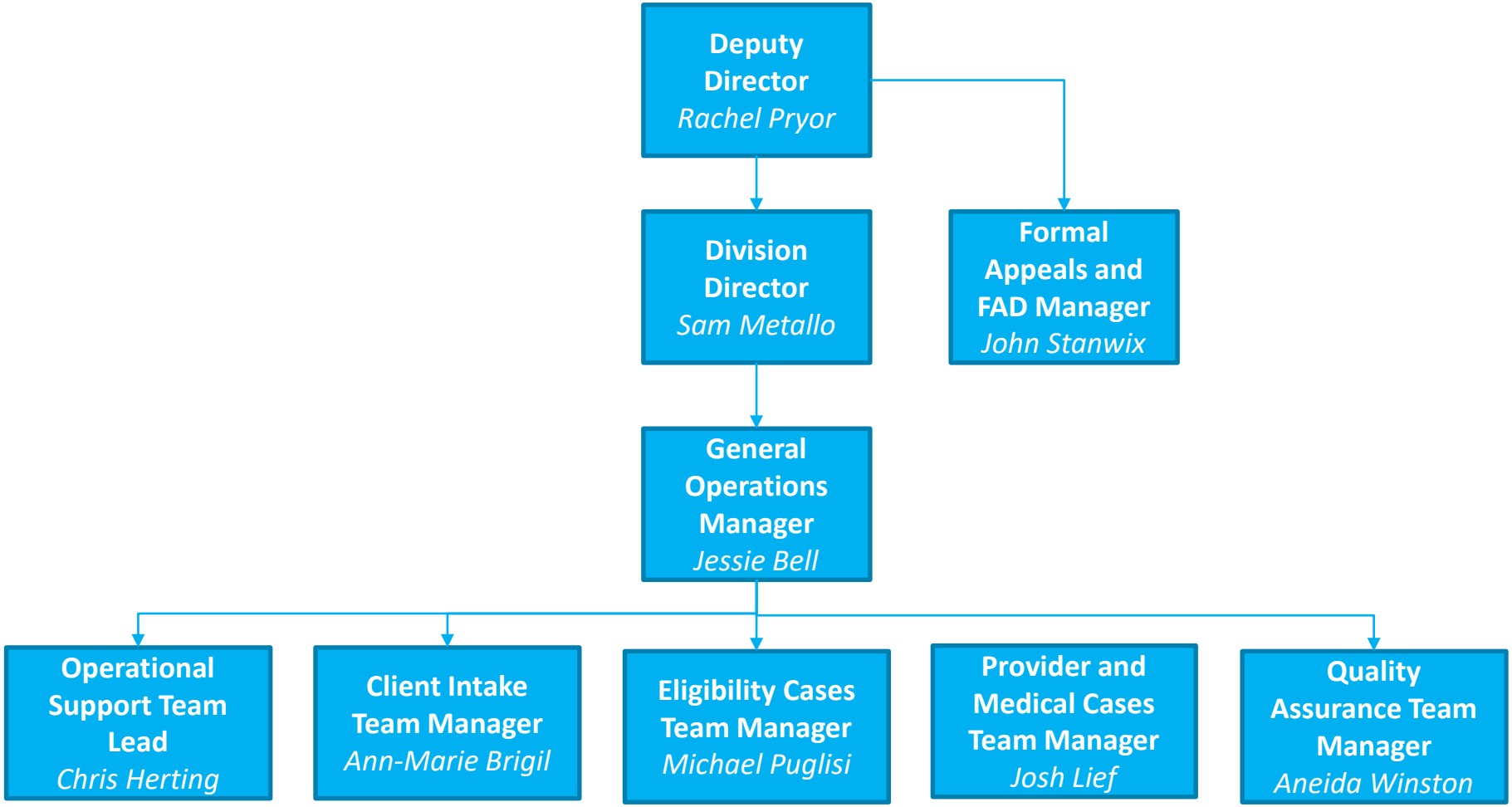
The Purpose of Appeals

- Provide due process to applicants, members, and providers
- Afford an opportunity to be heard
- Guarantee a neutral review of agency action
- Render a decision in accordance with law

The Appeals Division has Two Core Functions

- Client Appeals:
  - Individuals enrolled with Virginia Medicaid or seeking enrollment; case types include eligibility for Medicaid and service authorization
  - One level of appeal with DMAS for eligibility appeals
  - First level of appeal conducted by the MCO for medical appeals
- Provider Appeals:
  - Providers enrolled with Virginia Medicaid or seeking enrollment; case types include service authorization, billing, and audits
  - Two levels of appeal with DMAS: Informal and Formal

The Appeals Division is Organized into Six Teams



Regulations that Govern Client Appeals

Code of Federal Regulations

Generally – 42 CFR Part 431, Subpart E

Managed Care – 42 CFR Part 438

Virginia Administrative Code

12VAC30-110 through 12VAC30-110-370

Rules of the Supreme Court of Virginia

Code of Virginia Part Two A – Appeals Pursuant to the Administrative Process Act

Client Population and Most Appealed Issues

- There are over 1.46 million Medicaid and FAMIS clients in Virginia
- Client appeals involve eligibility for Medicaid or FAMIS benefits and medical necessity for every service / equipment that Medicaid covers

Top 10 Eligibility Issues CY19

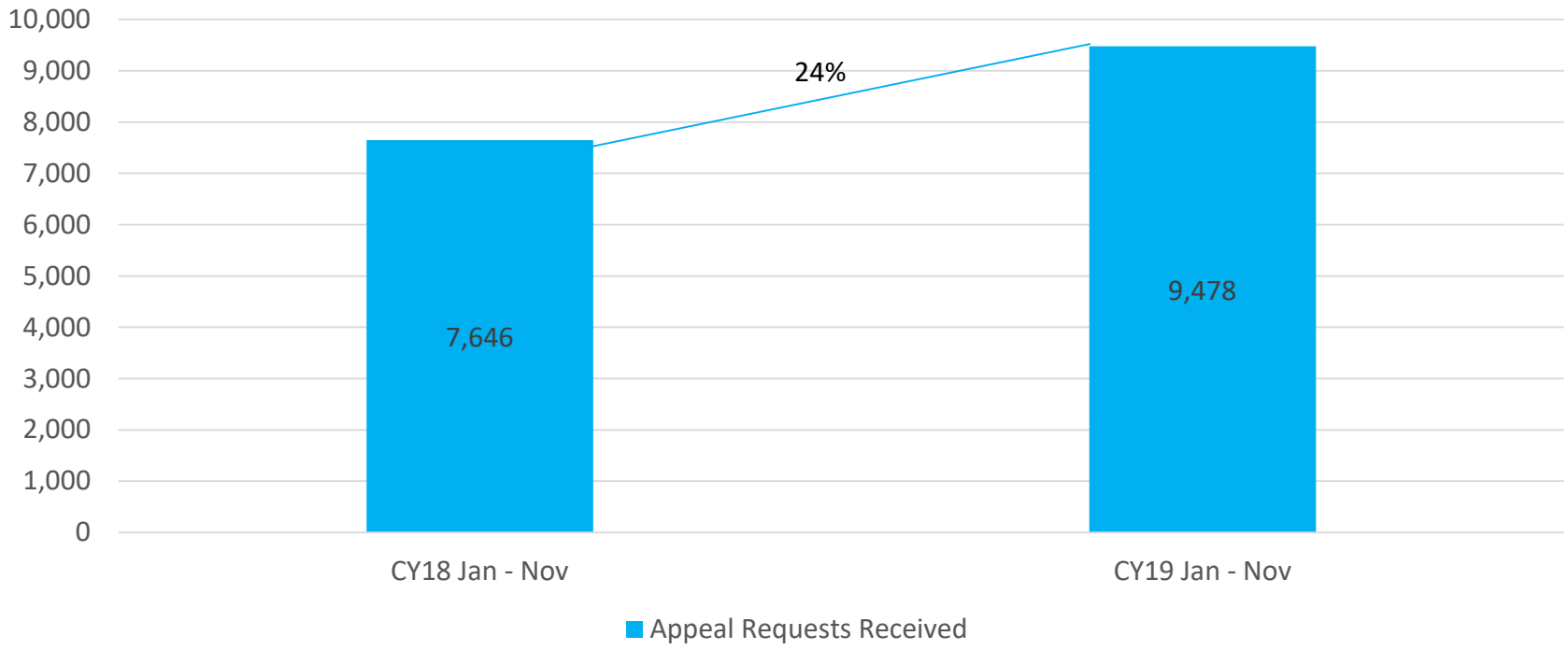
- Verifications (3308, 46.7%)*
- Income / Spenddown (911, 12.9%)
- Timely Processing (593, 8.4%)
- Alien Status / Emerg. (274, 3.9%)*
- Duplicate Application (241, 3.4%)
- Buy-in (176, 2.5%)
- Covered Group (124, 1.75%)
- Plan First (120, 1.7%)
- Income and Resources (92, 1.3%)
- Resources (80, 1.1%)

Top 10 Medical Issues CY19

- Personal Care Hours (447, 27%)
- Pre-Admission Screen (430, 26%)
- Ortho (176, 11%)
- Nursing Home Discharge (109, 7%)
- Non-Surg Med Procedure (72, 4%)
- Behavioral Health Treatment (72, 4%)
- Term Waiver – LOC (64, 4%)
- Drug Denial (44, 3%)
- Durable Medical Equipment (36, 2%)
- Surgical Procedure (29, 2%)

*Verification notices were incorrectly issued for some alien status denials during CY19

The Appeals Division Received 24% More Client Appeal Requests YTD



Regulations that Govern Provider Appeals

Code of Virginia

Section 2.2-4000 *et seq.* (Administrative Process Act)

Section 32.1-325.1 (Specific to DMAS Appeals)

Virginia Administrative Code

12VAC30-20-500 through 570

Rules of the Supreme Court of Virginia

Code of Virginia Part Two A – Appeals Pursuant to the Administrative Process Act

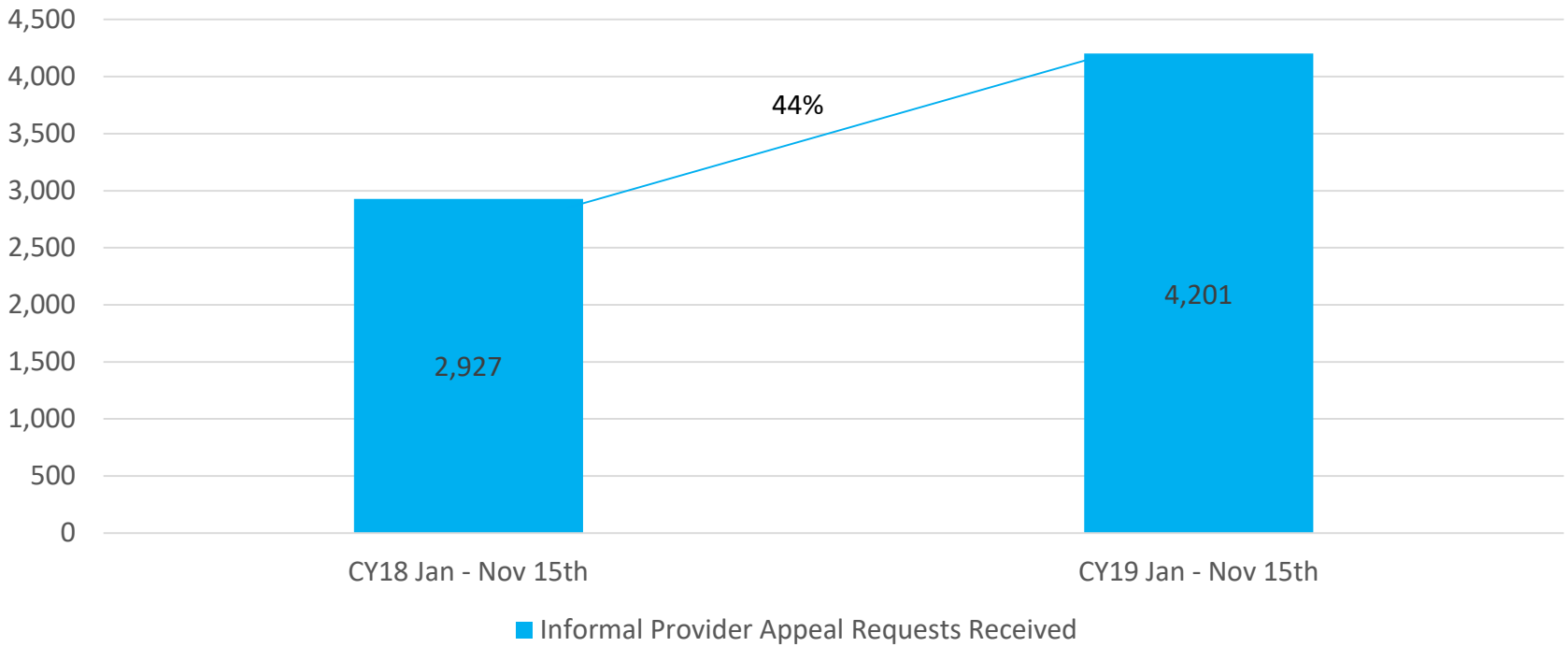
Provider Overview and Appealed Issues

- Services have already been rendered and the Provider is seeking payment
- Provider appeals involve every type of provider with whom the Department contracts, including physicians, hospitals, residential treatment facilities, nursing homes, adult care residences, home health agencies, durable medical equipment suppliers, pharmacists, etc.

Informal Provider Issues CY19 Jan – Nov 15th

- Claims (2939; 70.0%)
- MCO (603; 14.4%)
- Service Authorizations (392; 9.3%)
- DentaQuest (81; 1.9%)
- Audits (56; 1.3%)
- Magellan Behavioral Health (45; 1.1%)

The Appeals Division Received 44% More Informal Provider Appeal Requests YTD



Provider Appeals – Formal Level

- Formal Appeals are presided over by a Hearing Officer appointed by the Virginia Supreme Court. DMAS is represented by a staff attorney.
- The Hearing Officer submits a Recommended Decision ("RD") to the DMAS Director, who must issue a Final Agency Decision ("FAD") within 60 days. The Director must accept the Hearing Officer's recommendation unless there was an error of law or policy.

Volume

Period of Jan – Nov 15th

	2018	2019
Filed	112	102
FAD Issued	12	17
Accept RD	10/12	16/17

Issues in FADs

CY 2019 Jan-Nov 15th

- Audit (11, 64.7%)
- Timeliness (3, 17.6%)
- Air Ambulance (2, 11.8%)
- Claims (1, 5.9%)

CY20 Strategic Goals and Supporting Initiatives

1. **Provide a high-quality client-focused operation from start to finish**
   - Develop a customer facing portal to allow for the online submission of appeal requests and supporting documents
   - Make all communications available in Spanish and develop taglines for the top 15 languages
   - Continue development and implementation of a standardized feedback loop to escalate trends and issues we identify with our sister agencies and other DMAS Divisions → Regular communication and resolution of "frequent flyer" issues will ultimately reduce volume of overall appeals
   - Maintain 100 percent compliance with processing timelines as required under federal law
2. **Identify innovative operational improvements to process record volume in both client and provider appeals**
   - Design and implement an appeals management system to automate manual processes and go paperless by fall 2020
   - Facilitate weekly Appeals Division leadership team meetings to identify and implement additional operational efficiencies
3. **Increase the quality of client and provider appeals correspondence and decisions**
   - Revise appeal form letters and decision templates to standardize and increase readability
   - Coordinate with DMAS subject matter experts for training opportunities for hearing officers and QA reviewers
   - Implement regular training and outreach to community partners: for instance, DSS and Cover VA

QUESTIONS?

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

MEDICAID CONSENSUS FORECAST

Presentation to:

Board of Medical Assistance

December 10, 2019

Topics

- Forecasted Appropriations for 2020-2022
- Key Forecast Drivers
- Rate Change Assumptions
- Expansion Update
- Questions

Budgets and Forecasts

- **Budget**: plan of what an organization wants to achieve, typically one-year
  - Example: DMAS budgets to hire 535 classified positions in FY20
- **Forecast**: expectations of how results will look, uses historical data
  - Example: To run Medicaid in FY20, DMAS forecasts it will need $211 million less than predicted in November 2018

Summary of Forecast

General Fund Surplus / (Need) for 2020-2022

Dollars in Millions

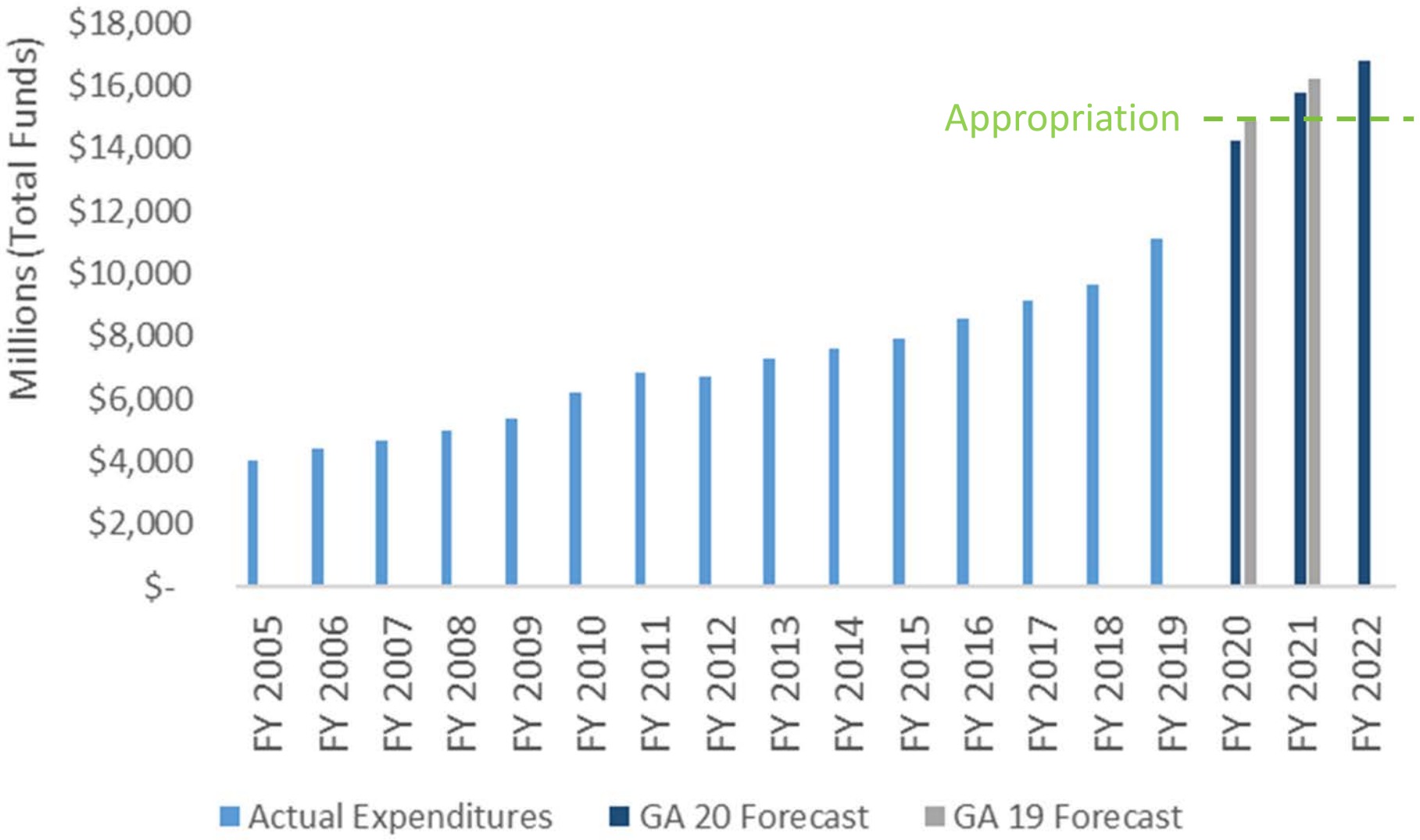
	2020 Surplus	2021 Need	2022 Need	2021-2022 Biennium Need
General Funds	$211.7	($174.4)	($500.5)	($674.9)

Comparison to Proposed GA Medicaid Targets†

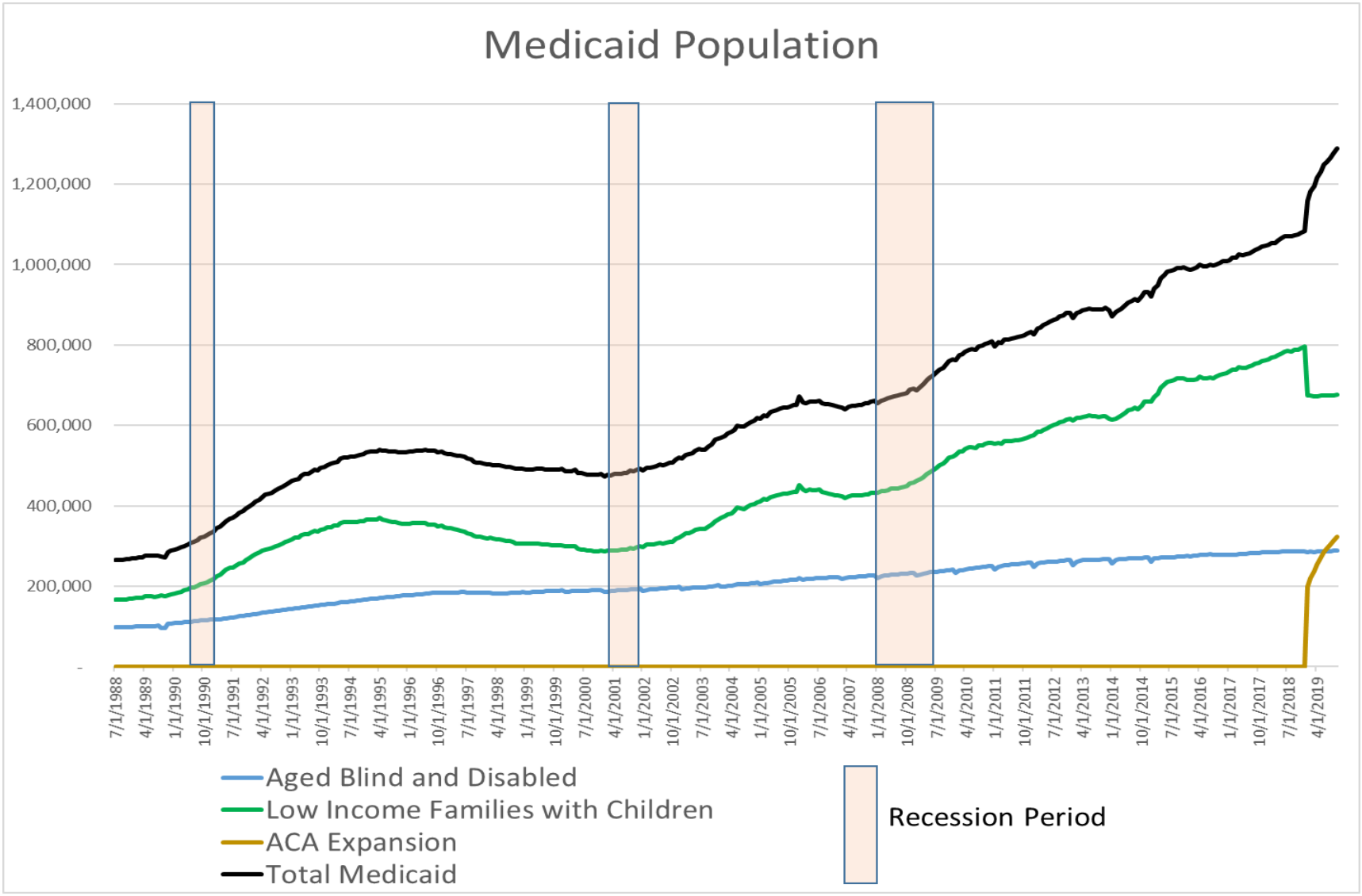
	FY 2021	FY 2022
2020 Forecast	7.2%	5.9%
Forecast using 2019 Forecast Base	3.2%	5.9%
GA Target using 2019 Forecast Base	5.8%	6.0%

† Excludes payments to DBHDS, administrative expenditures, and Medicaid Expansion.

Medicaid Expenditure History



Forecast Drivers: Population Growth



Forecast Drivers – FY 2020

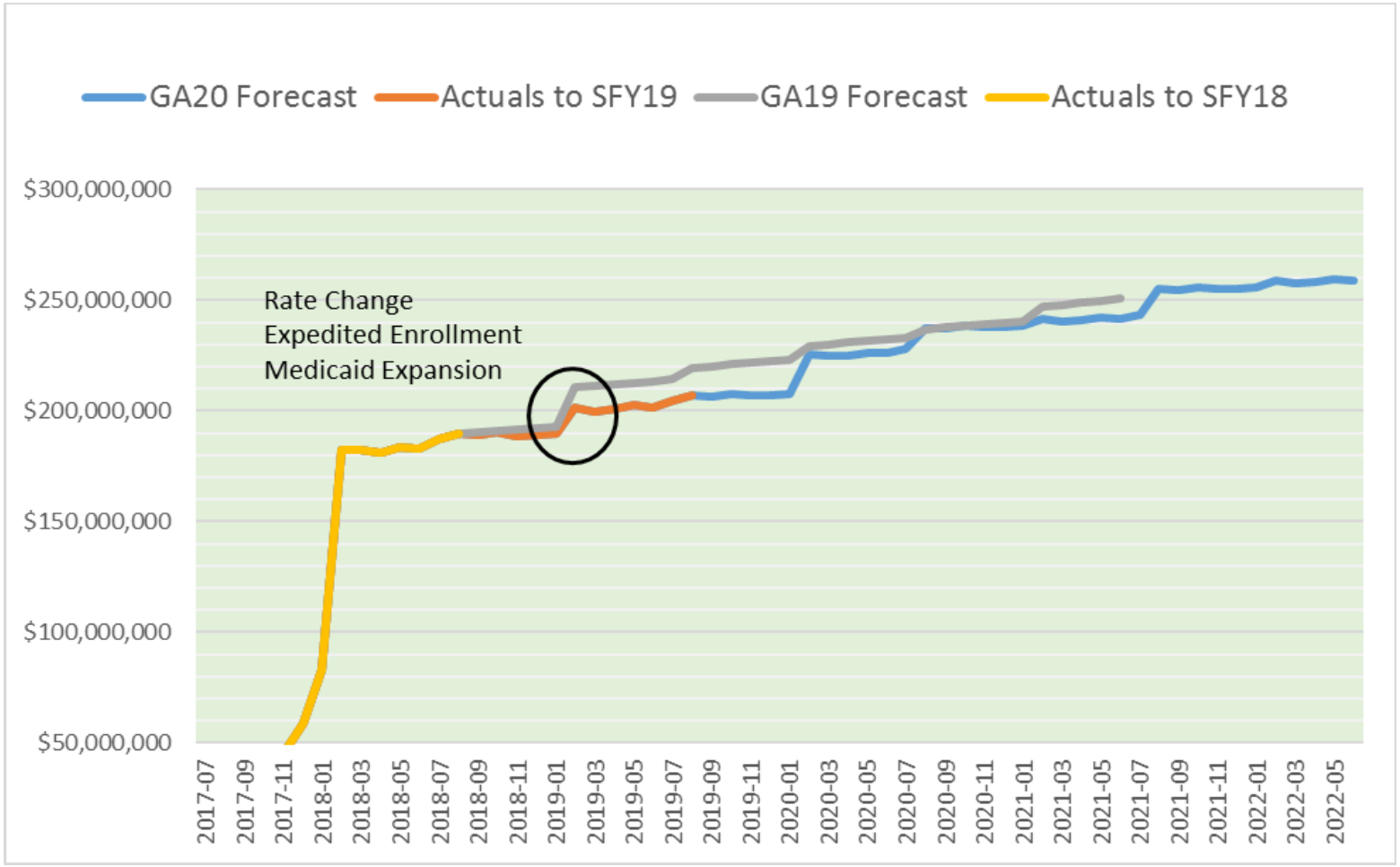
Updated Fiscal Year 2020 Changes $ in millions (GF only)	Percentage of Total	Cost / (Savings)
Lower expenditures in CCC+ populations- Nursing Home Eligible and Non-Long Term Care	41%	($87)
Decreases in fee for service hospital and practitioner expenditures	31%	($65)
Expectations of managed care pharmacy rebates adjusted higher	17%	($36)
Base Medallion caretaker adults and children	9%	($19)
All other fee for service: dental, behavioral health, nursing facility, personal care, developmentally disabled waiver services, plus Medicare premiums and hospital payments	2%	($3)
Total	100%	($212)*

* May not add due to rounding

Commonwealth Coordinated Care Plus

Nursing Home Eligible

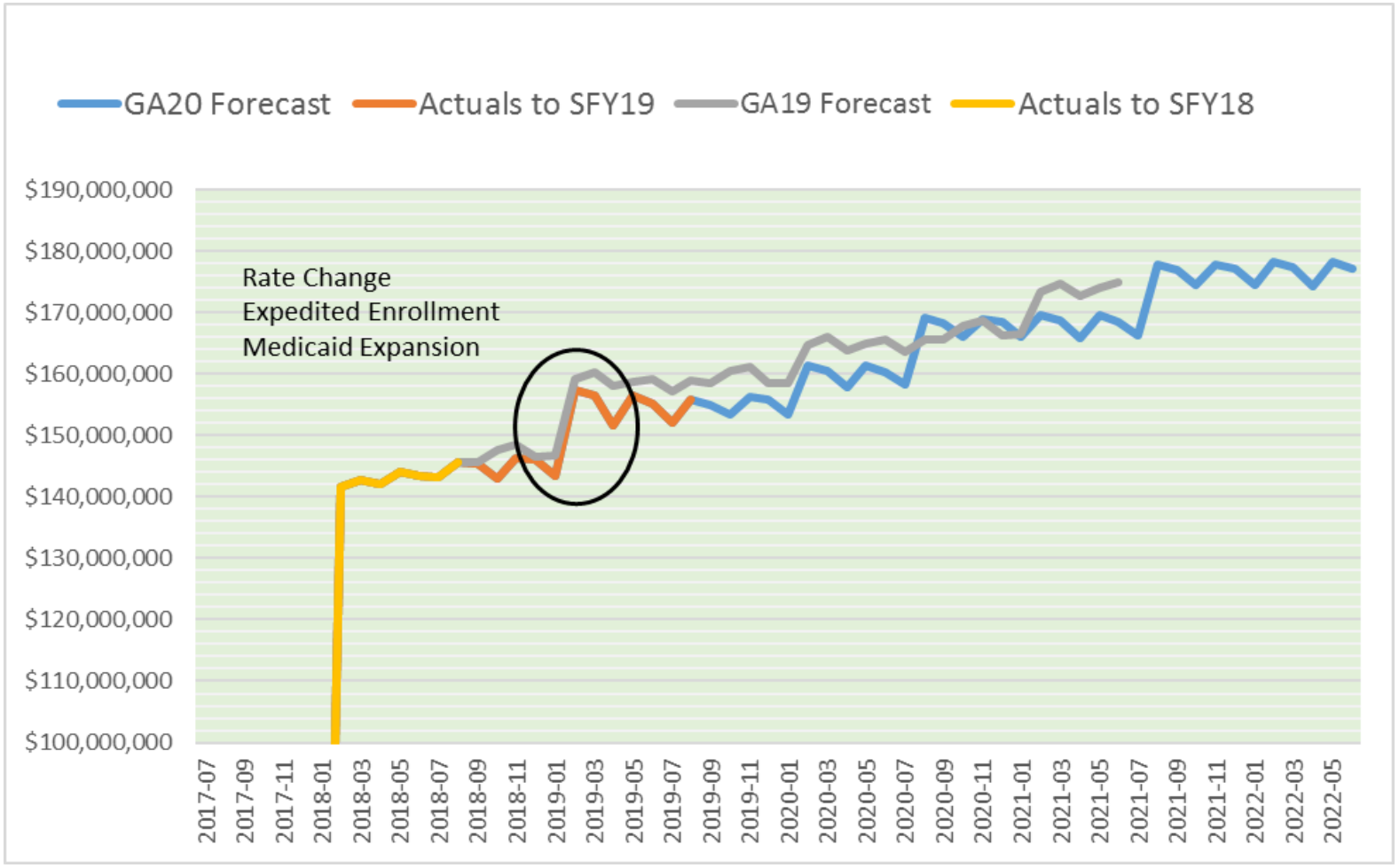
Total Funds, capitation payments



Commonwealth Coordinated Care Plus

Non-Long Term Care

Total Funds, capitation payments

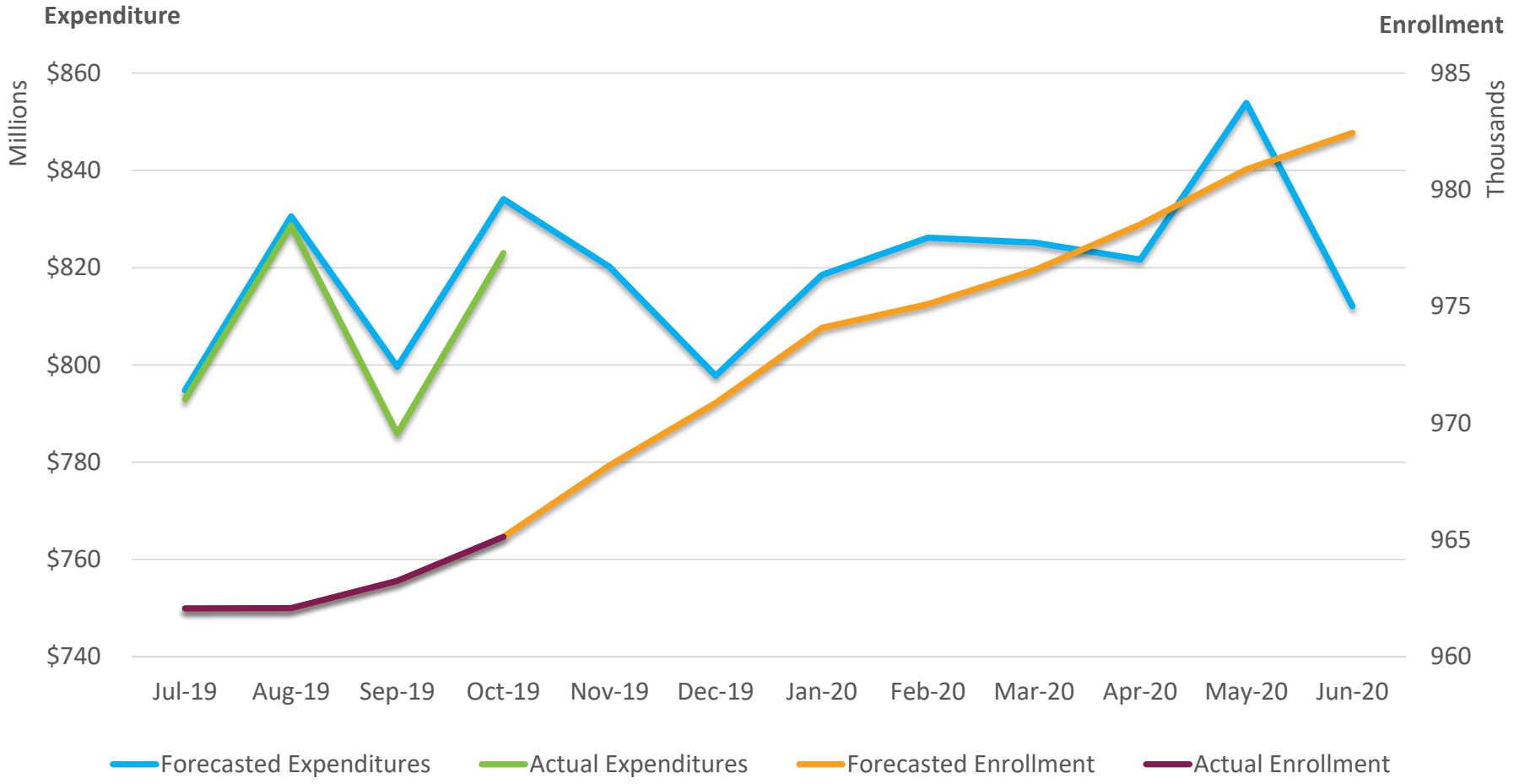


Forecast Drivers – FY 2021-2022

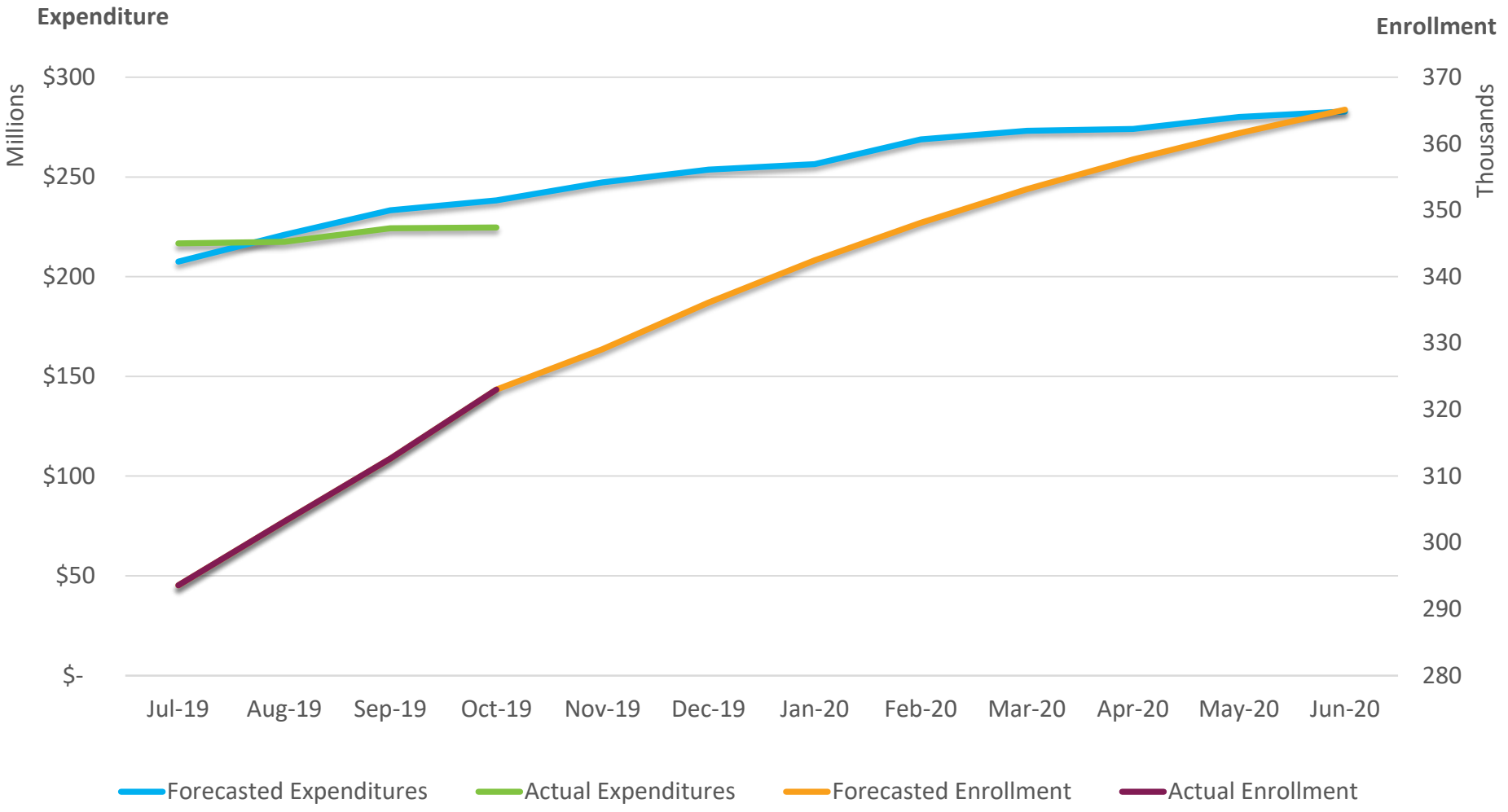
	FY2020	FY2021	FY2022
Total Funds Base Medicaid	$10.0 Billion	$10.8 Billion	$11.4 Billion
Change in Total Funds need	$98,012,089	$720,768,083	$637,886,241
Year over year changes:	1.0%	7.2%	5.9%

Forecast Drivers	FY2021	FY2022
Capitation Payments: CCC+ Program	$441,682,772	$353,591,139
Capitation Payments: Low-Income Adults & Children	$174,492,890	$183,992,686
Changes in Medallion 4.0 Lump Sum Payments	$50,454,859	$1,995,484
General Medical Care: Fee-For-Service	$50,434,573	$46,008,804
Changes in CCC+ Lump Sum Payments	$32,273,474	$839,975
Long-Term Care Services	$11,863,437	$18,646,954
Capitation Payments: Foster Care	$8,098,622	$9,161,267
Behavioral Health & Rehabilitative Services	($1,818,150)	($159,346)
Final CCC Program Withhold Payment	($9,284,032)	$0
MCO Pharmacy Rebates	($14,529,055)	($15,255,508)
Hospital Payments	($22,901,305)	$39,064,786

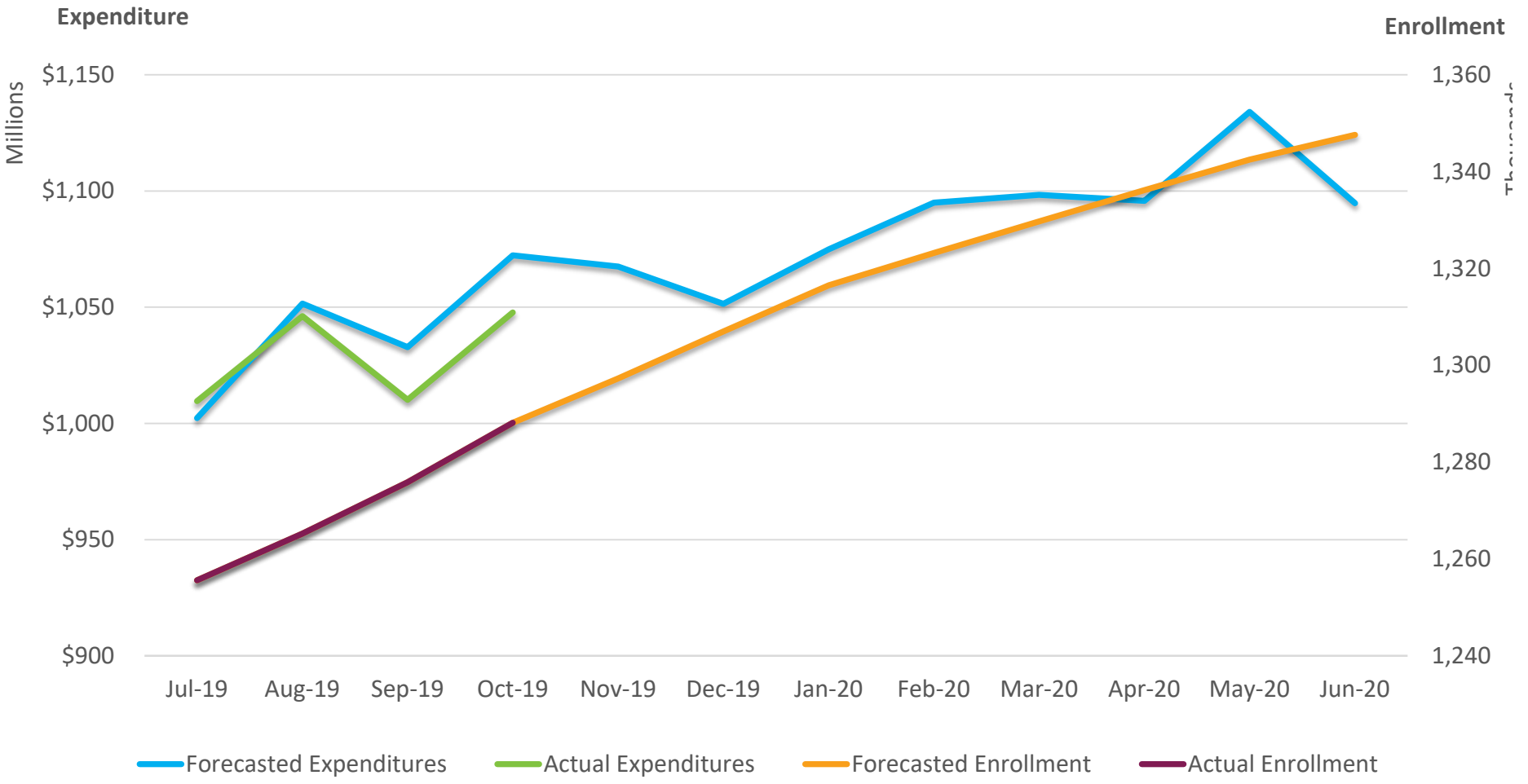
Base Medicaid Expenditures & Enrollment



Medicaid Expansion Expenditures & Enrollment



Total Medicaid Expenditures & Enrollment



Extreme Movers

	Greatest Increase		Greatest Decrease	
YTD Comparison	FAMIS Moms	31.5%	GAP	-100.0%
YTD Comparison	LTC: PACE	8.8%	Family Planning	-68.9%
YTD Comparison	FAMIS Kids	5.9%	Pregnant Women	-11.3%
Monthly Comparison	Family Planning	2.0%	Pregnant Women	-1.9%
Monthly Comparison	MedEx Childless Adults	1.4%	Non-LTC ABD	-0.1%
Monthly Comparison	MedEx Caretaker Adults	0.7%	FAMIS Moms	-0.1%

DMAS VALUE-BASED PURCHASING EFFORTS

December 10, 2019

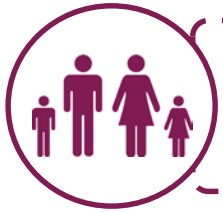
Value-Based Purchasing Terminology

Understanding the language of value

- "Value" is a big buzz word in health policy these days
- Can be difficult to understand the context
- For the purposes of this presentation we will use the following definitions:
  - Value-Based Payments → Payment structures that tie *provider* financial success to patient receipt of high-quality, efficient care
  - Value-Based Purchasing → A *broader concept* where both monetary and non-monetary incentives are used to drive performance at multiple levels within the health system

The ultimate goal of VBP policy is to promote the effective and efficient provision of care to Medicaid members; rewarding value, not volume of care.

The Need for Value Based Purchasing



DMAS plays a critical role in the provision of health care coverage to an increasing number of Virginians.

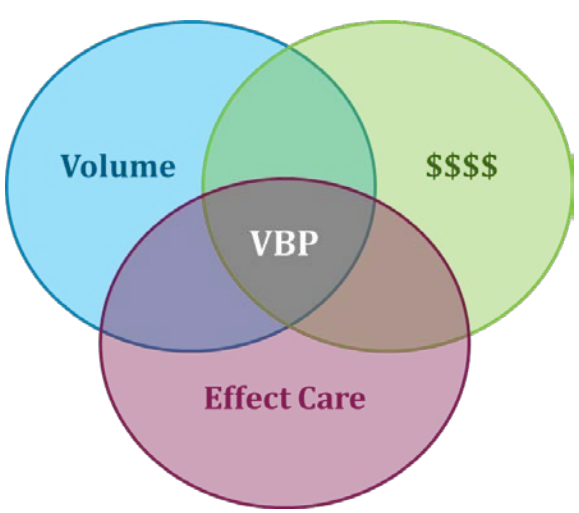
DMAS has a responsibility to members and the Virginia taxpayer to maximize the value it receives for state and federal health care dollars.

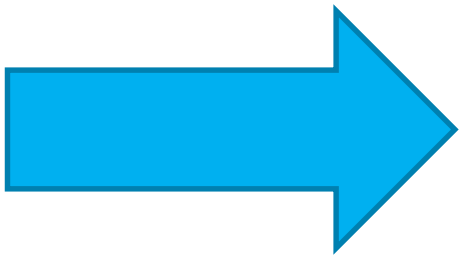
VBP is a powerful tool to promote quality and efficiency in the care Medicaid members receive.

CMS is actively encouraging efforts by purchasers, plans, and providers to change payment and improve care delivery.

Areas of VBP Focus for DMAS

VBP efforts need to effectively leverage limited resources to improve care outcomes





DMAS will focus on VBP initiatives and accountability structures that emphasize behavioral health, chronic conditions, maternity care, and prevention.

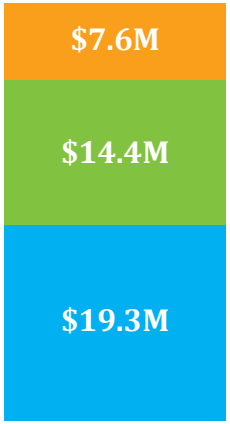
Current & Proposed VBP Efforts

Program	Accountability	Incentive
Clinical Efficiencies	• Evaluate levels of preventable utilization (i.e. ED visits, hospital admissions, hospital readmissions) • Develop performance measures to track MCO- & hospital-specific performance	**2020**: Adjust M4 capitation rate **2021 and Beyond:** MCOs have two-sided risk based on measure performance
Performance Withholds	• Performance targets for key process and outcome metrics • Focus on behavioral health, chronic conditions, maternity care, and prevention	**CCC+** → 1% capitation withhold beginning in CY 2018 **Medallion 4.0** → 1% capitation withhold beginning in SFY 2021
CCC+ Discrete Incentives	Support successful, sustained transitions of complex nursing facility residents into the community	MCO's can earn one-time bonus for each successful transition
Proposed New Initiative		
Episodic Payments	• DMAS Decision Package proposing to develop and implement episodes for maternity, asthma, and congestive heart failure (CHF) • Conditions represent: 1) areas of importance for members, 2) evidence improved care outcomes reduce spending, 3) available resources from other states	Establish provider accountability for spending & quality thresholds over the course of a defined period of care

DMAS Clinical Efficiencies (CE) Policies

Top 3 Adult Drivers: Diabetes, Urinary Tract Infections, & Pneumonia
Top 3 Pediatric Drivers: Asthma, Perforated Appendix, & Diabetes

Top 10 Drivers: Respiratory Issues (J06.9, J45.9), Ear Infection (H66.9), Fever (R50.9), Soar Throat (J02.9, J02.0), UTI (N39.0), Nausea (R11.2, R11.1), and Headache (R51.)



Base analysis of CY 2016/17 utilization identified over $41M in potentially preventable and/or medically unnecessary spending among *Medallion* members

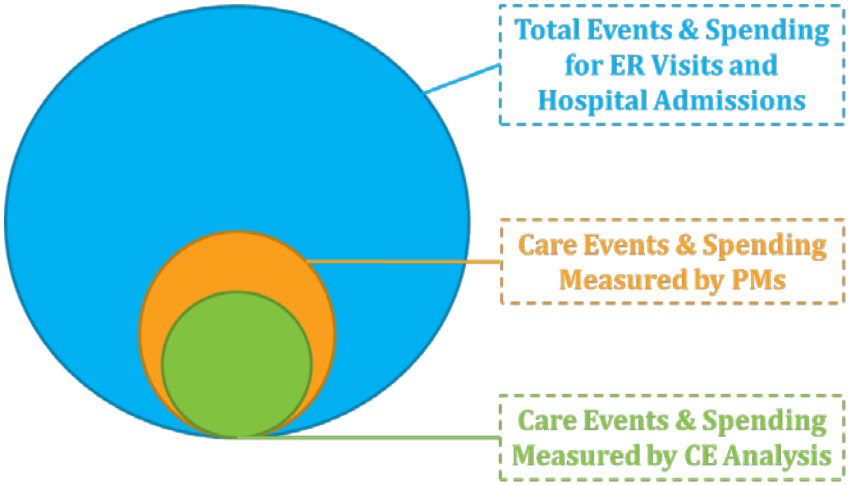
DMAS identified utilization that could be avoided through effective care management and access to/utilization of lower acuity care settings; specifically, potentially preventable and/or medically unnecessary ER visits, hospital admissions, and hospital readmissions.

Base Analysis

Future Policy

DMAS is working to turn its base CE analysis into a series of performance measures that can be tracked year-over-year to assess MCO efficiency improvement. In doing so it will expand the portion of care events relevant to the efficiency analysis and develop capabilities to evaluate hospitals in a similar manner.

Broader Scope from CE Analysis to Performance Measure



Medallion & CCC Plus Performance Withholds

By SFY 2021, at least 1% of all MCO capitation rates will be at-risk based on performance against quality measures focusing on behavioral health (BH), chronic conditions (CC), maternity care, and prevention

- CCC Plus withhold began in CY 2018 (CY 2018 and CY 2019 were pay-for-reporting)
- Medallion withhold will begin in SFY 2021

Performance Withhold Measure Composites			
Domain	**CCC Plus**	**Medallion 4**	**Measure Type**
BH	Follow-up after ER visit for mental illness		HEDIS
CC	COPD and/or asthma admissions rate		PQI
CC	Comprehensive diabetes care		HEDIS
BH	Follow-up after ER visit alcohol or other drug dependence		HEDIS
BH	Initiation and engagement of alcohol and other drug dependence treatment		HEDIS
CC	Heart failure admissions rate		PQI
Maternity		Prenatal and Postpartum Care	HEDIS
Prevention		Childhood immunization status – combo 3	HEDIS
Prevention		Adolescent well-care visits	HEDIS

The Performance Withhold Program places significant financial incentives behind MCO achievement for key member care events and outcomes.

Episodes of Care

An episode of care is a set of services provided for a **condition or procedure** over a **period of time**. Episodic payment VBP models assign **expectations and accountability** for **cost and quality** over the course of an episode.

Pregnancy and Delivery	280 days before delivery through 60 days after hospital discharge	Physician(s) billing delivery	C-Section rate, Follow-up care, Screenings
Acute Asthma Exacerbation	Asthma-related ER visit, Obs stay, or Inpatient admission to 30-days post-discharge	Facility treating at trigger	Follow-up care, Filled prescriptions, Repeat exacerbations
Congestive Heart Failure (CHF)	CHF-related ER visit, Obs stay, or Inpatient admissions to 30-days post-discharge	Facility treating at trigger	Follow-up care, Filled prescriptions, Readmission rate

DMAS Proposes 3 Episodic Payment Models

- >100,000 members have an asthma diagnosis (~70% children)
- Members w/ asthma account for >$600M in total spending annually (>$26M directly related to spending w/ a primary Dx of asthma)
- Accounted for >1,100 potentially preventable inpatient admissions in base CE analysis

- >22,000 members have a CHF diagnosis
- Members w/ CHF account for >$650M in total spending annually (>$90M directly related to spending w/ a primary Dx of CHF)
- Accounted for >1,200 potentially preventable inpatient admissions in base CE analysis

- Medicaid covers more than 1 in 3 Virginia births, with medical spending around deliveries along representing over $200M in annual costs
- Virginia low birth weight deliveries and C-Section rates are higher than the national average, resulting in much higher hospital and recovery costs than standard deliveries
- Care outcomes for better deliveries and healthier children can improve short term efficiency and long term population health

DMAS submitted a budget proposal to develop and implement 3 episodes; analysis of membership size and utilization for select conditions indicates strong potential for episodic payments





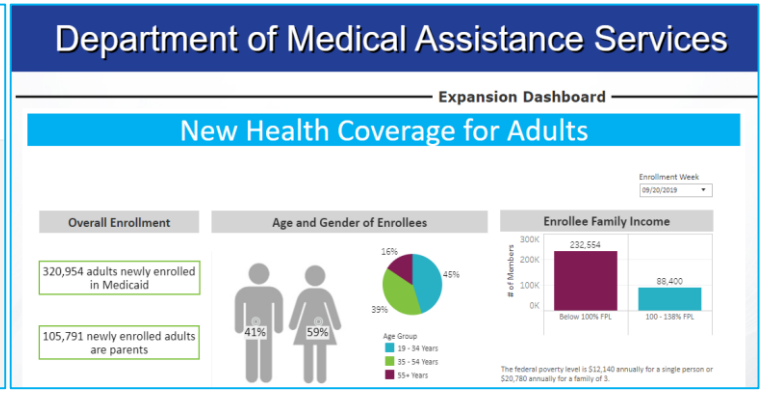
MEDICAID EXPANSION

Health Economics and Economic Policy

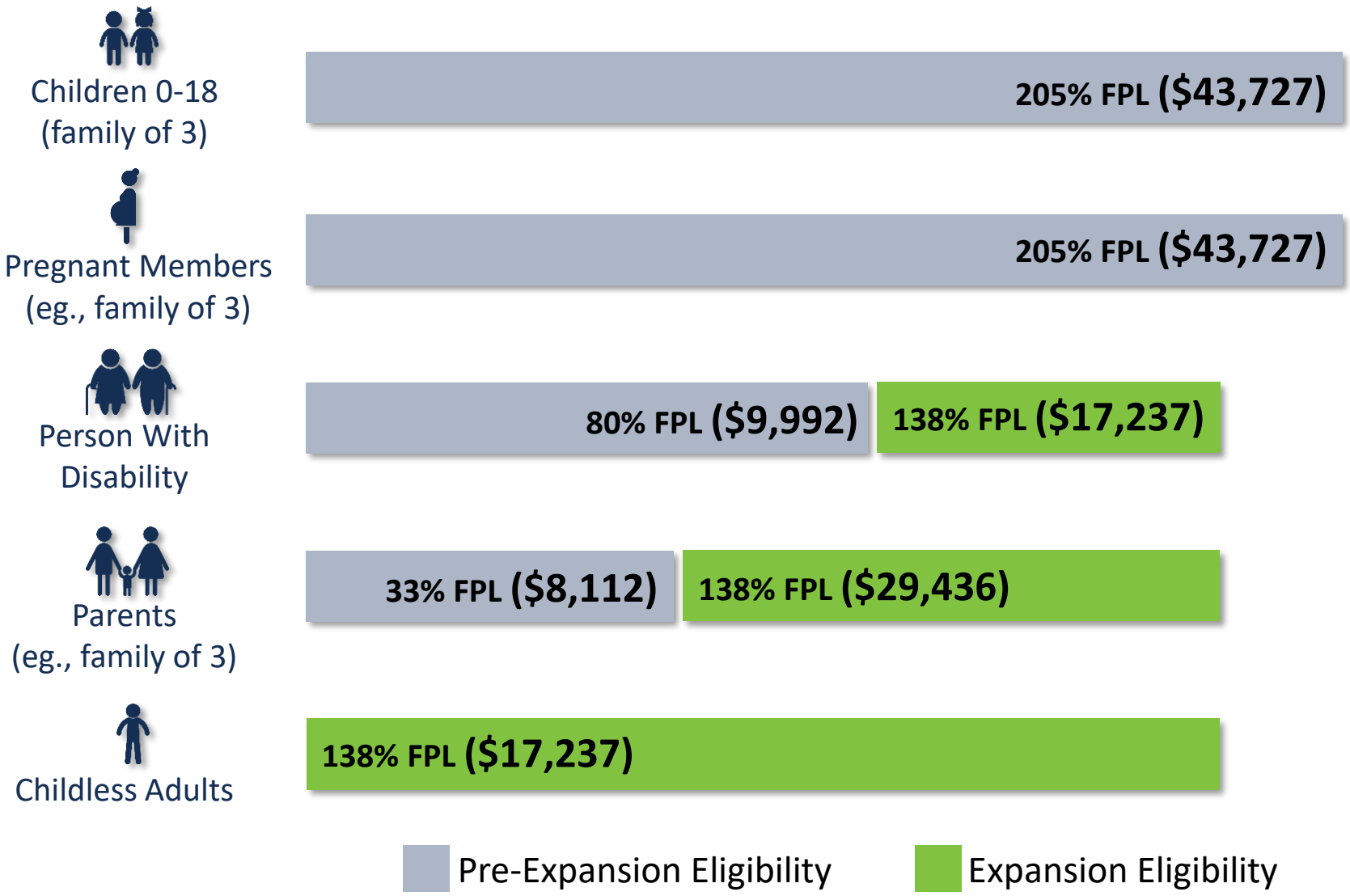
Office of Data Analytics

Medicaid Expansion

- On January 1, Virginia became the **33rd state to expand coverage to adults ≤ 138% FPL**.
- **More than 325,000 members** are enrolled in expansion as of October 1, with more than 375,000 members enrolled at some point since January.



Who Qualifies for Virginia Medicaid Under Expansion?

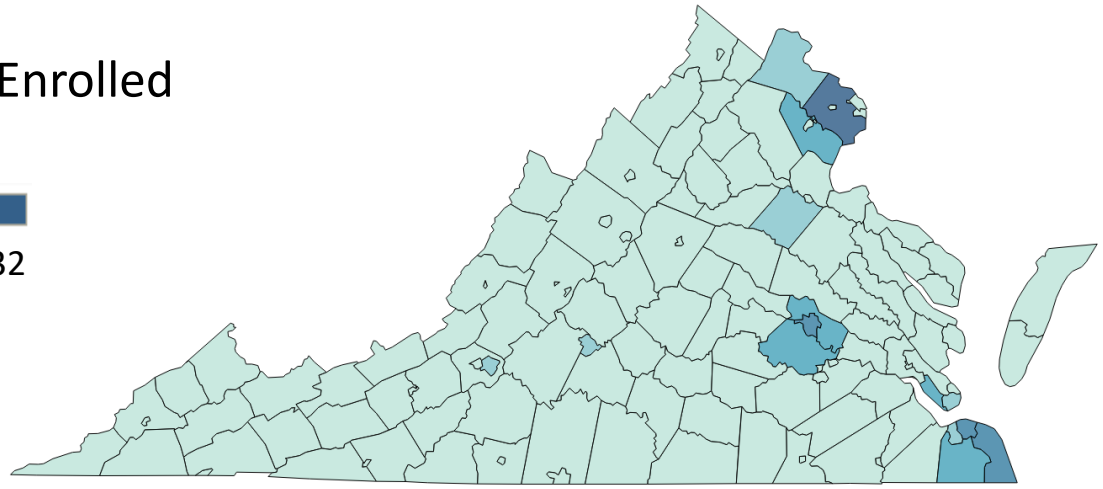


*Percent income may vary by locality

Where are our new members?

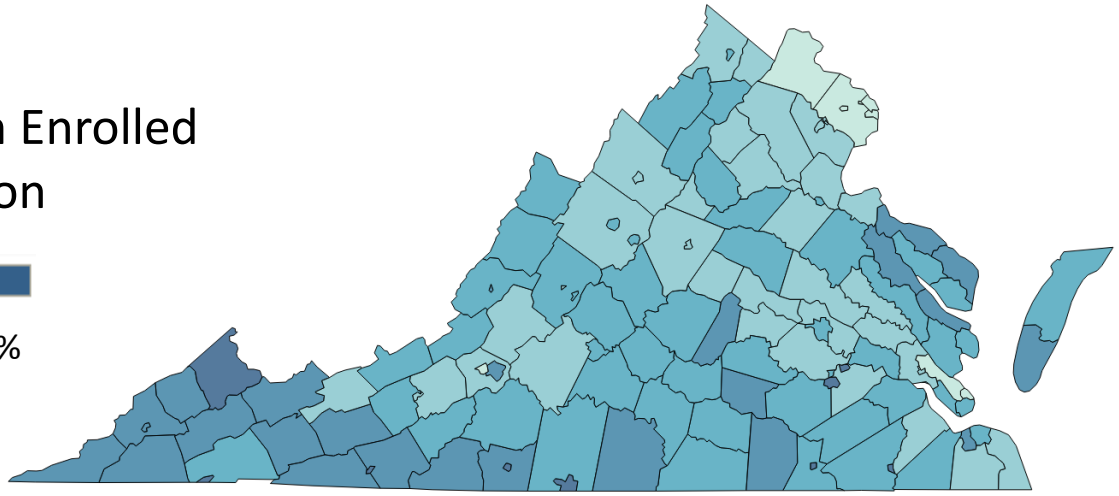
Total Number of Members Enrolled

21 21,532



Percent of Adult Population Enrolled in Medicaid Expansion

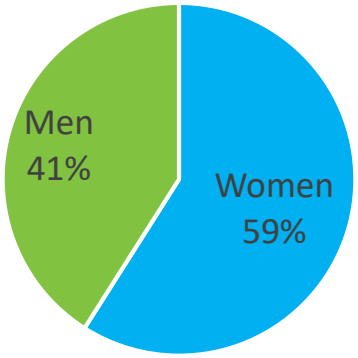
1% 18%



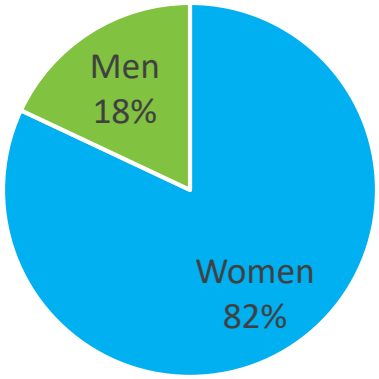
Who are our new members?

Gender

Expansion Adults

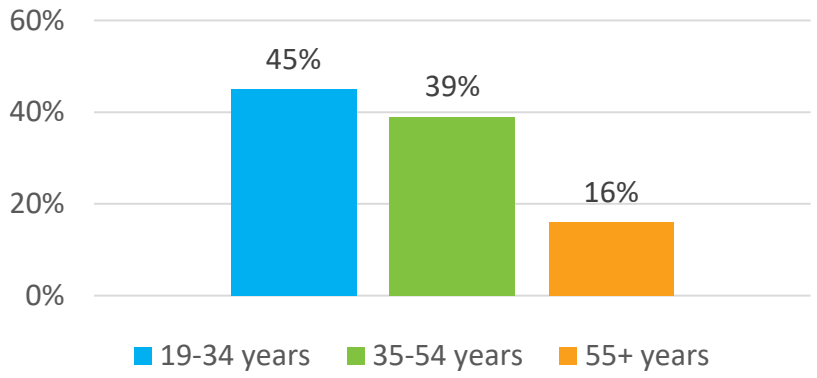


Non-Expansion LIFC Adults

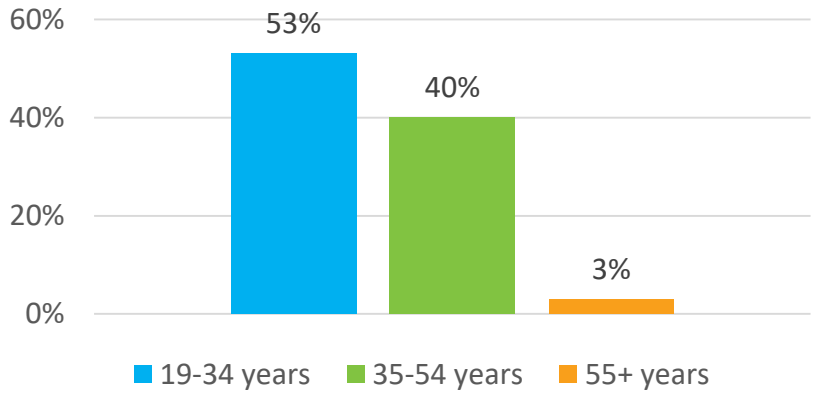


Age

Expansion Adults

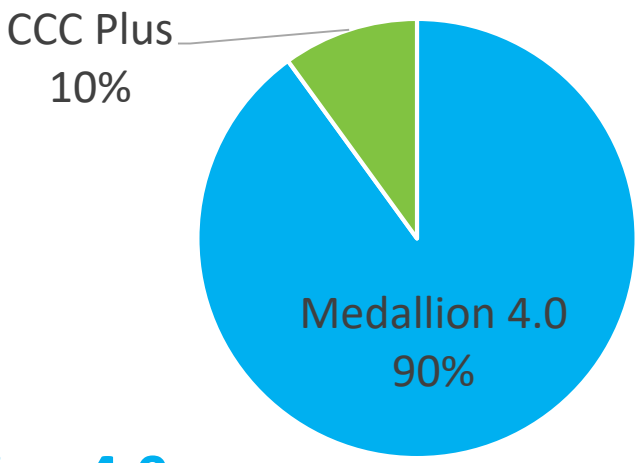


Non-Expansion LIFC Adults



How are our new members distributed?

Expansion Program Distribution



Medallion 4.0

- 290,000 members
- Expansion members make up 28% of total Medallion 4 enrollment

CCC Plus

- 29,000 members
- Expansion members make up 12% of CCC Plus enrollment

In the year prior to enrolling in Medicaid…

Two-thirds of new members went without needed medical care

New members went without needed primary care (59%) and a needed prescription (57%)

New members went without needed mental health care (22%) and substance use disorder treatment (8%)

New members went without needed dental care (67%) and eye glasses (51%)

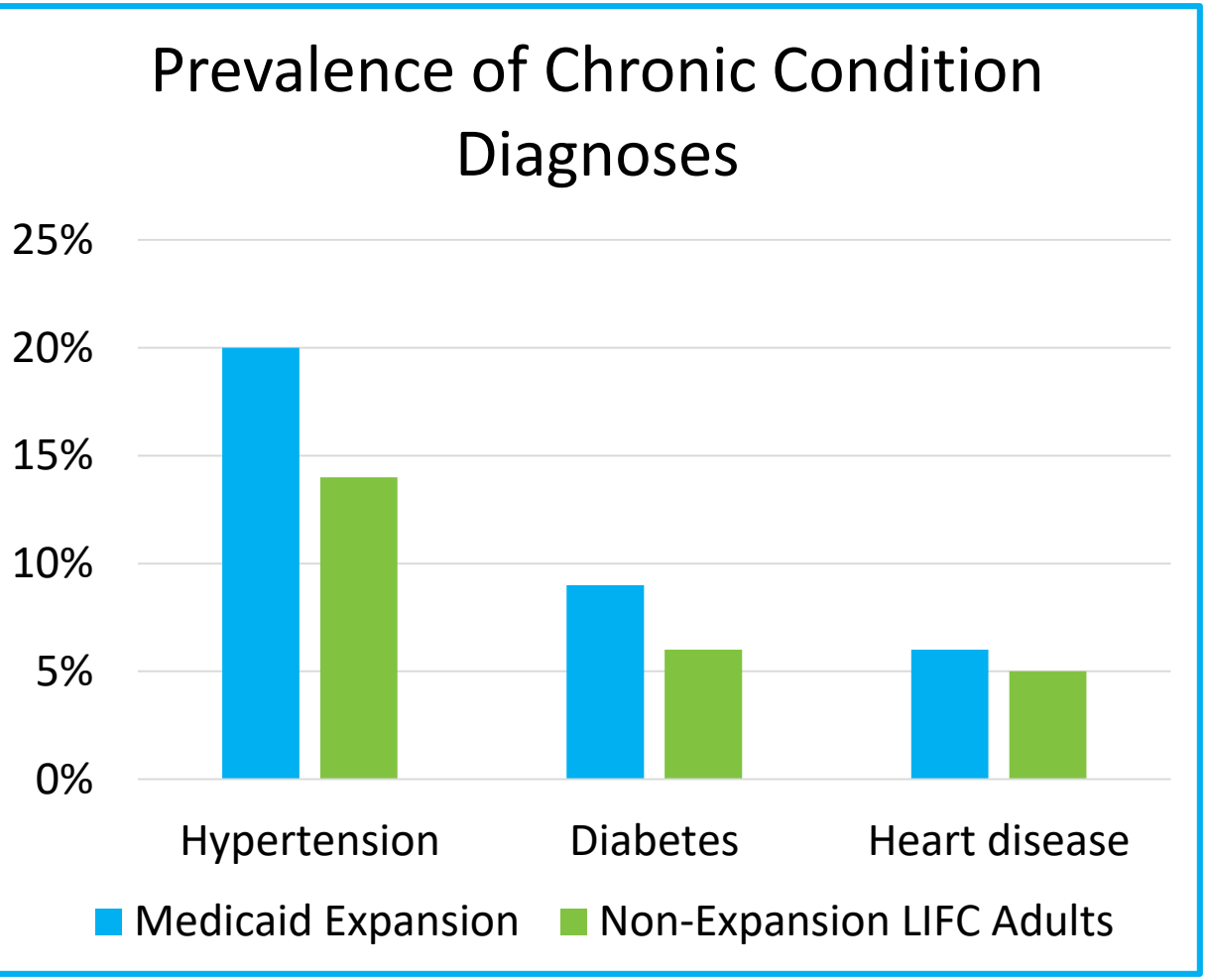
One in four (25%) of new members used the emergency room as their primary source of care

Healthcare *after* enrolling in Medicaid

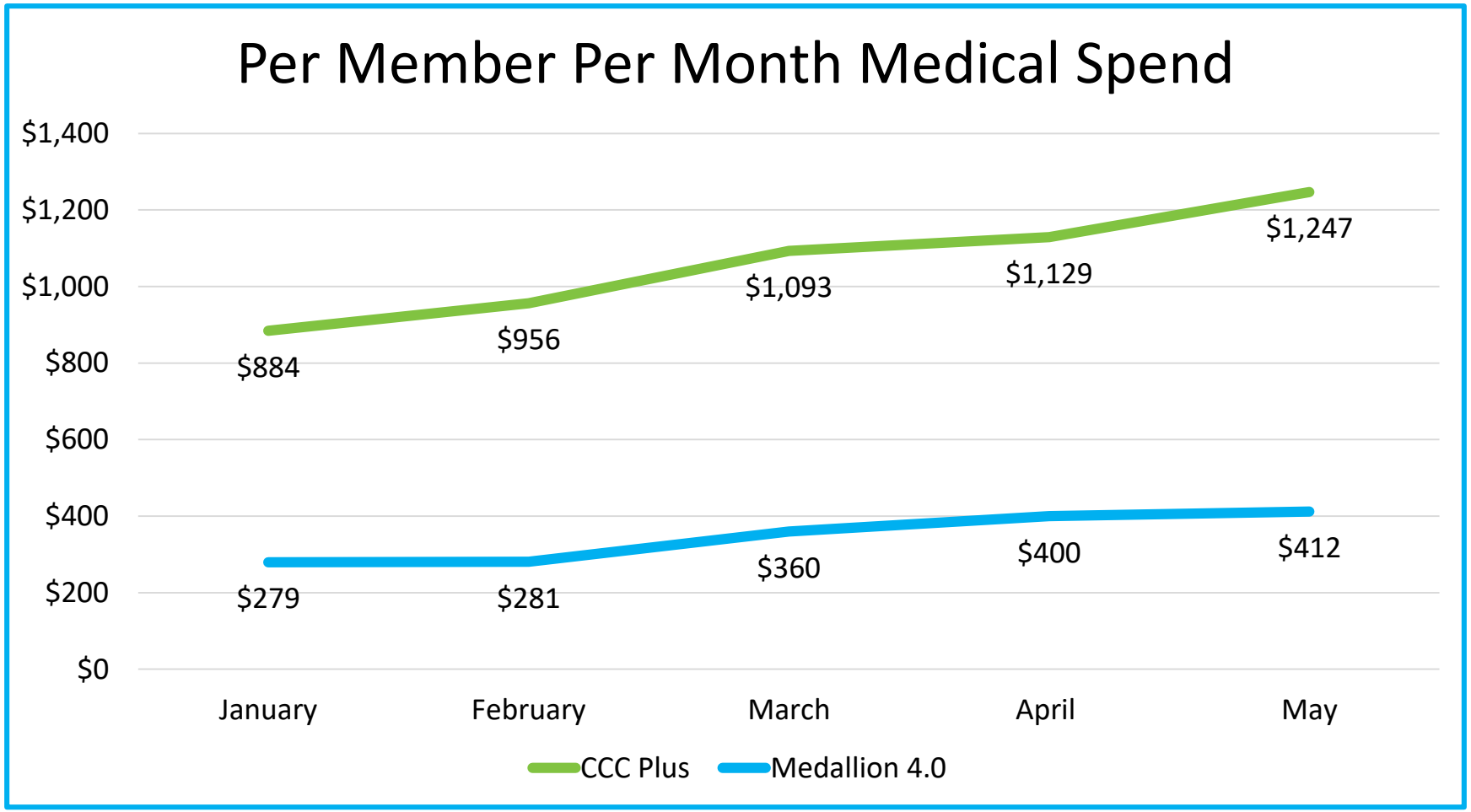
- Of the total number of members enrolled in expansion, **80% have used at least one service**
- More than **60% of members have had a general office visit**
- About **two-thirds have filled a prescription**
- More than **10% have required emergency dental** services
- More than **3,800 members have been treated for cancer**

Health of Expansion Adults

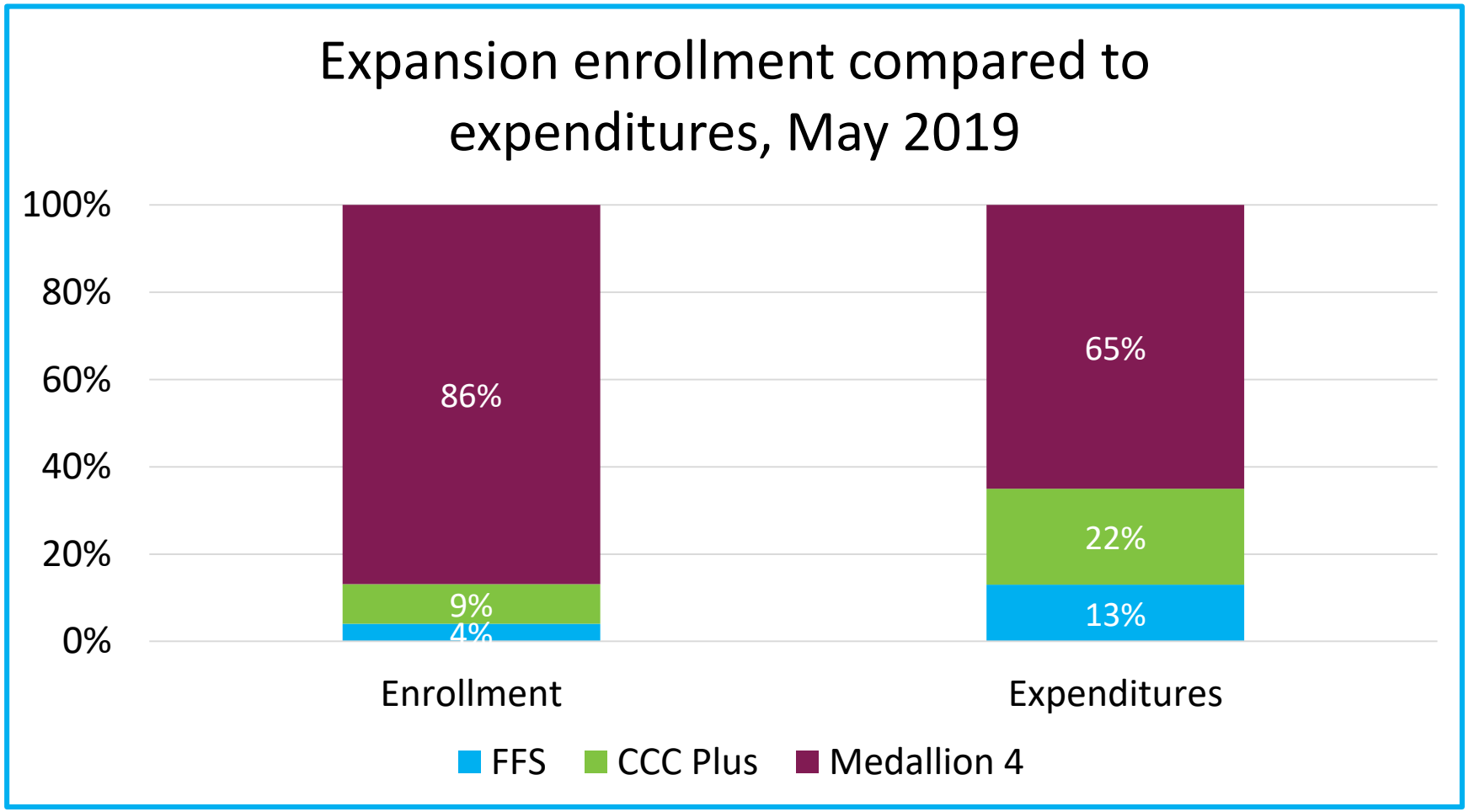
- On average, the expansion population has been diagnosed with **more chronic conditions** than non-expansion adults



Medical Spend



Medicaid Medical Spend and Enrollment



Who are our new members?

Based on a VCU survey of 1,500 new members…

Employment

- More than two-thirds of expansion members are either working, in school or retired
- 37% of new members report having a health condition that prevents part or full-time employment

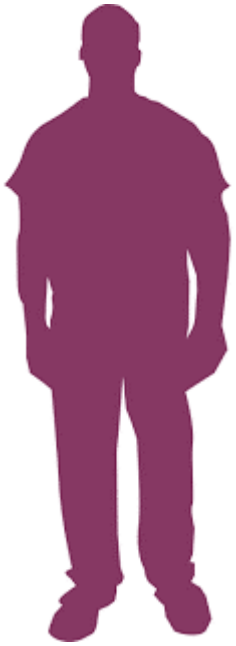
Medical Expenses

- More than one in four new members reported at least $500 in out of pocket medical expenses in the year prior to expansion
- Two-thirds of new members report difficulty paying medical bills in the year prior to expansion

General Expenses

- 71% worried about paying rent or a mortgage in the year prior to expansion
- 70% worried about not having enough money for food in the year prior to expansion

Member hopes for Medicaid expansion



"I will hopefully get the mental health assistance that I desperately need."

"Getting the yearly mammogram after missing last year."

"Having less stress worrying about healthcare coverage."

DMAS MES UPDATE

BOARD OF MEDICAL ASSISTANCE SERVICES

December 10, 2019

MICHAEL JONES

Acting Chief Information Officer,
Department of Medical
Assistance Services

Agenda

- Medicaid Management Transformation
- Modular Medicaid Enterprise System

Transformation from MMIS to MES

Center for Medicare and Medicaid Services (CMS) Initiative

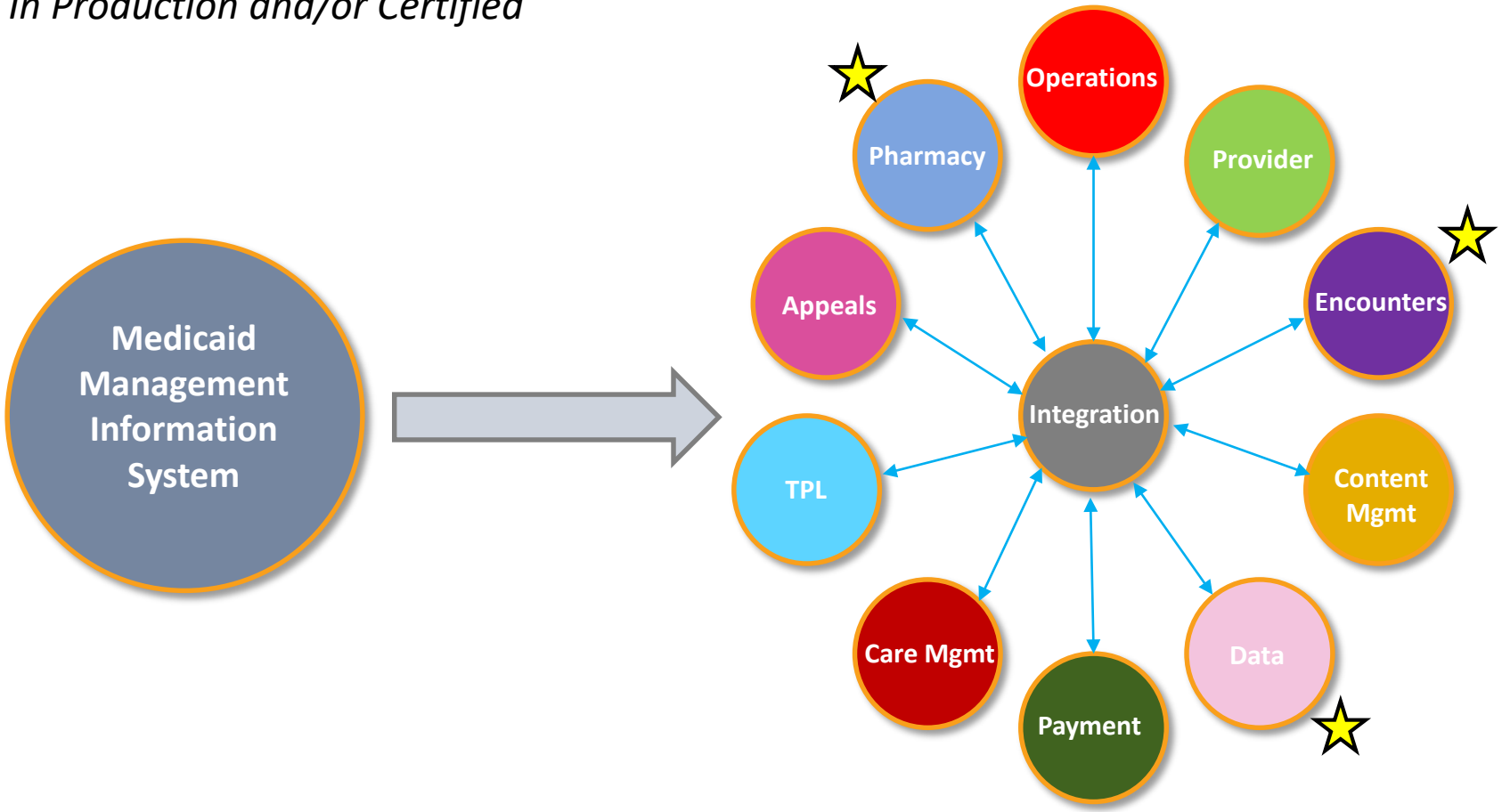
Current Medicaid Management Information System Implemented in 2003 (takeover by current Vendor in 2010)

First State to Undergo Effort for Complete Modularization

Encourages Competition and Enhances Maintenance Capability

Monolithic to Modular

In Production and/or Certified



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VIRGINIA'S MEDICAID PROGRAM DMAS

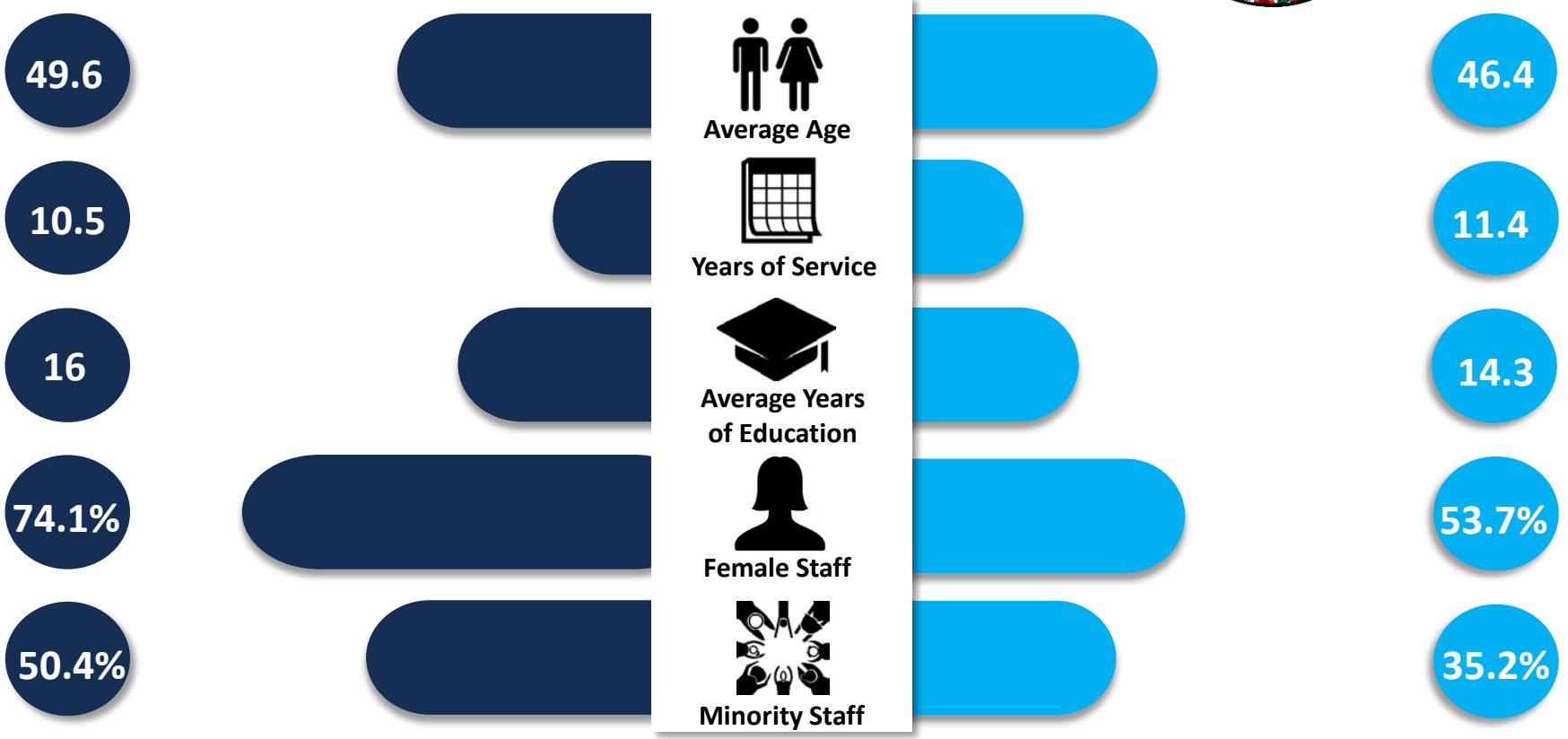
DMAS DIVERSITY COUNCIL

BOARD OF MEDICAL ASSISTANCE SERVICES

December 10, 2019

IVORY BANKS
Chief of Staff,
Department of Medical Assistance Services
Chair,
DMAS Diversity Council

Comparison Between DMAS and the Total State Workforce



Getting Started

"In a time where our society and culture can seem so divided, I'm hopeful to have an opportunity where I can make a difference using my talents and gifts."

-Council Member, February 2019

What Does Diversity Mean?

DIVERSITY: *a desire for acceptance, respect and understanding, regardless of race, ethnicity, gender, sexual orientation, socio-economic status, physical abilities or religious beliefs*

Diversity Council

VIRGINIA'S MEDICAID PROGRAM DMAS

Objectives

1. Encourage and support agency initiatives that maximize workplace diversity.
2. Organize and engage staff in events that celebrate and educate about all cultures represented within the agency.
3. Foster meaningful discussions through speakers and other collaborations that promote an inclusive workplace and a greater understanding and respect for different lived experiences and all dimensions of diversity.

Our Successes

Regulatory Activity Summary December 10, 2019
(* Indicates recent activity)

2019 General Assembly

***(01) Federal Changes to PACE:** The purpose of this regulatory action is to amend three sections of 12VAC30-50-335, General PACE Plan Requirements, in order to align the regulation with the federal PACE regulations. On May 28, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized a rule to update and modernize the Programs of All-Inclusive Care for the Elderly (PACE) program. This rule enforces best practices regarding the care for frail and elderly individuals. The first major proposed update to PACE since 2006, this action allows PACE organizations to operate with greater efficiency, while ensuring they continue to meet the needs and preferences of participants. More than 45,000 older adults are currently enrolled in more than 100 PACE organizations in 31 states, and enrollment in PACE has increased by over 120 percent since 2011. With the increased demand for PACE services, the federal updates are timely and will provide greater operational flexibility, remove redundancies and outdated information, and codify existing practice. The project is currently circulating for internal review.

***(02) Pooling of State Supplemental Drug Rebates:** Currently, Virginia Medicaid enters into state-specific contracts with pharmaceutical manufacturers. The purpose of this State Plan Amendment is to allow Virginia to participate in multi-state purchasing pools to enable Virginia to enter into value based purchasing agreements for high cost drugs. DMAS sent the DPB notification of the SPA on 9/24/19. Following internal review, the SPA was submitted to HHR on 10/25/19 and to CMS on 11/1/19. The corresponding regulatory action is currently circulating for internal review.

***(03) LTSS Screening – Remove Three-Day Allowance After Hospital Discharge:** Federal law requires that individuals who are seeking nursing facility placement be screened to determine if this placement is appropriate. Virginia regulations currently allow hospitals to take up to three days after discharge from the hospital to submit the screening forms. However, when hospitals take three additional days to submit the forms, individuals are discharged from a hospital, but are not able to be accepted by the nursing facility, due to a federal regulation that requires that these screenings occur prior to nursing facility admission. According to federal regulations, the appropriateness of an individual's placement in a nursing facility cannot be determined until a screening is completed. If a three-day delay occurs, the hospital may not determine if a planned discharge to a nursing facility is appropriate until after the individual has been discharged. This could leave the individual without care, and at risk of harm. Federal regulations require that the screenings be completed prior to admission to a nursing facility, and the delay in the completion of hospital screenings can result in hospitals discharging patients who cannot be accepted by nursing facilities. This final exempt regulatory action stipulates that the federal requirements mean that hospitals must complete the screenings by the time of discharge. Following internal DMAS review, the project was submitted to the OAG on 9/12/19. A conf. call was held on 10/1/19 to discuss the regs. The project was certified by the OAG and submitted to the Registrar on 10/25/19; published in the Register on 11/25; and will become effective on 12/25/19.

***(04) Processing Medicaid Applications Using SNAP Income:** This SPA will enable DMAS to use gross income determined by SNAP to support Medicaid eligibility determinations at the time of Medicaid application. Currently, DMAS uses a similar strategy at the time of annual Medicaid renewals. Medicaid eligibility criteria will remain the same, and there will be no change in the number or outcome of eligibility determinations made as a result of this change. The SPA notification was submitted to DPB on 9/24/19. Following internal DMAS review, the SPA was sent to HHR on 11/12/19 and forwarded to CMS on 12/5/19.

***(05) 2019 Provider Reimbursement Changes:** The purpose of the Institutional Provider Reimbursement Changes State Plan Amendment is to increase reimbursement for Critical Access Hospitals by using an adjustment factor or percent of cost reimbursement of 100% for inpatient operating and capital rates and outpatient rates, effective July 1, 2019. The state plan is also being revised to fund supplemental payments for the second and third years of graduate medical education for 13 funded slots for residents who began their residencies in July 2018 and the first year of graduate medical education of 20 funded slots for residencies in July 2019, and two one-year post graduate fellowships in July 2019. The purpose of the *Non-Institutional Provider Reimbursement Changes State Plan Amendment* is to (1) increase the practitioner rates for adult primary care services by five percent and rates for Emergency Department services by one percent to reflect the equivalent of 70 percent of the 2018 Medicare rates; (2) create a separate service category for psychiatric services and to increase practitioner rates for psychiatric services by 21 percent to reflect the equivalent of 100 percent of the 2018 Medicare rates; (3) increase the telehealth originating site facility fee to 100 percent of the Medicare rate and to reflect changes annually based on any changes in the Medicare rate; (4) increase the operating rate for critical access hospitals for outpatient services; (5) modify reimbursement for Hospice services provided to patients residing in facilities to include at least 100 percent of the relevant Medicaid facility rate for that individual; and (6) increase the rates for personal care in Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program by two percent. Following internal review, the SPAs were submitted to CMS on 7/12/19. A conf. call was held on 7/24/19, and responses to the standard funding questions were submitted to CMS on 8/20/19. SPA 19-007 was approved on 9/19/19, and following the submission of additional responses to CMS questions, SPA 19-008 approved 10/9/19. The corresponding fast-track regulations began circulating for internal review on 8/2/19. The project was submitted to the OAG on 9/18/1. Revisions were sent to the OAG on 10/31/19. The regs were certified on 11/12/19 and submitted to the Registrar on 11/13/19. The regulations were published in the Register on 12/9/19 and will become effective on 1/8/20.

***(06) Cover Virginia and Eligibility Determinations:** Individuals at the CoverVA call center currently enter Medicaid applications into the VaCMS system and process modified adjusted gross income (MAGI) applications. This SPA seeks to add language to the state plan to reflect that the CoverVA call center is operated under a contract. (Conduent holds the current contract to perform CoverVA services.) This text addition is not a change in practice, but updates the text of the state plan to reflect current DMAS practice. The SPA notification was submitted to DPB on 11/12/19. Following internal DMAS review, the SPA was sent to HHR on 2/3/19.

***(07) Revisions to Drug Utilization Review Program:** DMAS is implementing changes to the state plan text related to the Drug Utilization Review Program in accordance with the requirements of the Support Act (Public Law No. 115-271). The changes include Support Act provisions related to: claims review limitations; a program to monitor antipsychotic medications by children; fraud and abuse identification; and Medicaid managed care organizations requirements. The SPA notification was submitted to DPB on 10/22/19 and the project is currently circulating for internal review.

(08) Third Party Liability – Payment of Claims: Under current law, Medicaid is generally the "payer of last resort," meaning that Medicaid only pays for covered care and services if there are no other sources of payment available. Section 1902(a)(25) of the Social Security Act (the Act) requires that states take "all reasonable measures to ascertain the legal liability of third parties." The Act further defines third party payers to include, among others, health insurers, managed care organizations (MCOs), and group health plans, as well as any other parties that are legally responsible by statute, contract, or agreement to pay for care and services. This final exempt regulatory action mirrors this definition of third parties at 42 CFR 433.136. The Bipartisan Budget Act of 2018, which was signed into law on February 9, 2018, includes several provisions which modify third party liability (TPL) rules. This new law makes changes to the special treatment of certain types of care and payment, delays the implementation changes to the time period for payment of claims, repeals a provision regarding recoveries from settlements, and applies TPL to CHIP. The project is currently circulating for internal review.

***(09) Incontinence Supplies:** This purpose of this State Plan Amendment (and corresponding fast-track action) is to remove a sentence that indicates that DMAS reimburses incontinence supplies based on a selective contract with one vendor. When the contract ends on December 31, 2019, DMAS will allow multiple vendors to provide incontinence supplies to Medicaid members. The rate and pricing for incontinence supplies will not change, and the oversight and controls of these providers will remain the same. The SPA folder began circulating for internal review on 8/22/19 and was sent to HHR on 10/22/19. The corresponding fast track project was sent for review on 8/22/19. The reg action was submitted to the OAG on 9/27/19. DMAS responded to OAG inquiries on 12/2/19 and is currently awaiting further direction on both the reg project and SPA.

(10) Fair Rental Value for New and Renovated Nursing Facilities: This State Plan Amendment revises the state plan to clarify payment rules for new nursing homes or renovations that qualify for mid-year rate adjustments, effective July 1, 2019. The 2019 Appropriations Act, Item 303.VVV, requires DMAS to take this action. The project is currently circulating for internal review.

***(11) 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. Following internal DMAS review and coordination, the reg project was forwarded to the OAG on 8/13/19. A conf. call was held on 9/18/19 to discuss the regs. The OAG requested revisions and corrections were sent on 9/25/19. Additional requested changes were sent to the OAG on 10/8/19. The OAG certified

the regulations on 10/11/19; the project was submitted to DPB on 10/15/19; and forwarded to HHR for review on 11/22/19.

***(12) 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. Following internal DMAS review and coordination, the reg project was forwarded to the OAG on 7/24/19. DMAS responded to OAG inquiries on 8/23/19. Additional revisions were requested by the OAG on 9/4/19, 9/5/19, and 9/9/19 and the edits were made. DMAS is currently awaiting further direction.

***(13) 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. Following DPB submission on 6/6/19, a conf. call was held on 7/10/19. The project was sent to HHR on 7/16/19 and to the Governor on 8/12/19, for review. The reg action was approved by Gov.'s Ofc. on 10/17/19. The project was submitted to the Registrar on 10/17/19, with a publication date of 11/11/19. The 30-day public comment period will expire on 12/12/19 and the regs will become effective on 12/27/19.

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. The OAG sent additional comments on 7/9/19 and DMAS forwarded a revision on 7/10/19. More changes were requested on 7/12/19 and additional revisions were forwarded to the OAG on 7/16/19 and 7/29/19. More change requests were received and revisions were sent on 9/10/19. Following a conf. call on 10/31, revised text was sent to the OAG on 11/1/19 and additional revisions were sent on 11/25/19. The regulatory action was forwarded to DPB on 12/4/19.

***(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; to the Gov.'s Ofc. on 5/27/19; and to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with no comments received. The corresponding fast-track began circulating for review on 9/5/19. The regulatory action was forwarded to the OAG on 10/30/19.

(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. The project was sent to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with one comment received. The corresponding fast-track began circulating for internal review on 9/6/19 and was submitted to the OAG on 10/10/19.

***(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. DMAS received questions from the OAG on 10/9/18, 12/26/18, 1/22/19 and 3/15/19, and the Agency coordinated responses. The regs were certified by the OAG and submitted to the Registrar on 8/9/19. The regs were published in the Register on 9/2/19 and became effective on 10/2/19. The corresponding fast-track project was submitted to HHR on 9/18/19 and forwarded to the Governor/'s Ofc. for review on 11/4/19.

***(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. The project was sent to DPB on 7/9/19; to HHR on 7/23/19; to the Gov. Ofc. on 9/10/19; approved by the Gov. on 9/18/19; and submitted to the Registrar on 9/18/19. The reg publication date was 10/14/19, with a comment period though 11/13/19, an effective date of 11/14/19, and an expiration date of 5/13/21. The corresponding fast-track package was circulated for internal review on 10/9/19 and submitted to the OAG on 11/14/19.

***(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 the regs were submitted to the Gov. Ofc. for review on 3/27/19. The project was approved by the Gov.'s Ofc. on 10/15/19; submitted to the Registrar on 10/15/19, with a publication date of 11/11/19; and with a 30-day public comment period that expired on 12/12/19. The regs will become effective on 12/27/19.

***(08) Removal of the 21 Out of 60 Day Limit:** This fast-track regulatory action is necessary to comply with the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Rule, issued on March 30, 2016. The overall objective of the Medicaid Mental Health Parity Rule is to ensure that accessing mental health and substance use disorder services is no more difficult than accessing medical/surgical services. To comply with the Medicaid Mental Health Parity Rule, DMAS must remove the limit of 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan for psychiatric inpatient hospitalization, as this limit for coverage of non-psychiatric admissions was removed on July 1, 1998. (Medicaid managed care plans do not apply the limit of 21 out of 60 days, and both the limit and the change only apply to fee for service.) Psychiatric inpatient hospitalizations must be service authorized based on medical necessity and not be limited to 21 days per admission in a 60 day period. The citation for the federal regulation to remove the "21 out of 60 day limit" can be found in 42 CFR 438.910(b)(1). Following internal DMAS review and coordination, beginning on 6/20/18, the project was submitted to the OAG on 7/1/19. A conf. call w/ the OAG and SMEs to discuss the regs was held on 7/24/19. The OAG sent additional questions on 8/12/19, and DMAS responded on 8/21/19. The regs were certified by the OAG on 9/12/19 and submitted to DPB on 9/13/19. DMAS responded to DPB inquiries the week of 9/16/19 and to additional DBP inquiries following a conf. call on 10/1/19. DPB forwarded the regs to HHR on 10/21/19 and the action was sent to the Gov. Ofc. on 11/17/19.

***(09) 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 on 5/17/19; to HHR on 6/25/19; and to the Gov. on 8/12/19, for review. The Gov. Ofc. approved the action on 10/15/19 and the regs were published on 11/11/19, with an will be effective on 12/26/19.

***(10) 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. Additional changes were sent to the OAG on 6/7/19. The OAG forwarded inquiries on 7/19/19 and DMAS responded. The regs were sent to DPB for review on 7/29/19. A conf. call w/ DBP was held on 8/20/19, and DMAS sent additional responses/revisions on 8/21/19. DMAS fielded several DPB questions the weeks of 9/9/19 and 9/16/19. The reg action was submitted to HHR, approved on 9/15/19, and sent to the Governor on 9/15/19. The EIA response was posted to the TH on 9/18/19.

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. An ER Extension request was submitted on 10/16/18, 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. The regs were submitted to DPB on 7/26/19. DMAS received and fielded DPB questions to SMEs on 8/7/19. The Agency submitted responses to DPB's inquiries on 8/13/19 and 8/21/19. A conf. call w/ DPB was held on 9/4/19, resulting in additional edits. The reg action was submitted to the Gov. on 9/10/19 for review

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. The Final Stage reg package was circulated internally for review on 5/7/19. The regs were submitted to the OAG on 7/19/19. DMAS received inquiries from the OAG on 8/14/19 and forward responses on 8/20/19. Additional revisions were sent to the OAG on 9/3/19.

2015 General Assembly

(01) 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. Following the public comment review, the Final Stage reg package was circulated for internal review on 6/4/19. The regs were

Submitted to the OAG on 9/17/19 for review.

***(02) Utilization Review Changes:** DMAS drafted a NOIRA to implement regulatory changes to more accurately reflect current industry standards and trends in the area of utilization review. The regulatory action was submitted to the OAG on 11/2/2015, and comments were received on 11/10. A revised agency background document was sent to the OAG on 11/18. A NOIRA was sent to DPB on 11/30, and the regulatory action was moved to HHR on 12/4. The Governor signed the action on 12/11. The NOIRA was published in the Town Hall Register on 1/11/2016, with the comment period in place through 2/10. Following internal DMAS review, the regulatory action was submitted to the OAG on 6/23/16. Per request, further edits were made and submitted to the OAG on 7/21, 8/4, 10/7, 10/28, and 11/15/16. DMAS made additional edits on 2/21/17. The regs were forwarded to DPB on 3/28 and DMAS responded to follow-up questions from DPB on 4/20. The action was submitted to HHR on 5/12 and sent to the Governor's Office for review on 5/16. The action was signed by the Governor on 6/30 and submitted to the Register. The regs were published on 7/24, with an open 60-day public comment period. The Final Stage reg processing began internally on 9/26/17. The regulatory project was forwarded to the OAG on 3/15/18. DMAS coordinated revisions, based on questions received by the OAG on 6/25/18. Additional OAG questions were received on 1/15/19 and 1/30/19. The reg project was returned to the OAG for review on 1/30/19. The regs were forwarded to DPB on 6/6/19; to HHR on 6/23/19; and submitted to the to the Gov. Ofc. for review on 9/22/19.

***(03) 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. Another conf. call was held on 8/9/19 and revised regs were sent to the OAG on 8/16/19 for review.

(04) 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.

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.