BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, December 13, 2022
10:00 AM to 2:00 PM

Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
1st floor Conference Rooms A&B

DRAFT AGENDA

#	Item	Presenter
1	Call to order	Mr. Michael Cook, Chair
2	Approval of 9.20.2022 Meeting Minutes	
3	Director's Report	Cheryl Roberts, Director
4	CFO Report	Chris Gordon, Deputy of Finance
5	Unwinding	Sarah Hatton, Deputy of Administration
6	Managed Care Contracts Discussion	
7	Service Recognition	Cheryl Roberts, Director
8	New Business/Old Business	
9	Regulations	
10	Adjournment	

BOARD OF MEDICAL ASSISTANCE SERVICES

DRAFT MINUTES
Tuesday September 20, 2022
10:00 AM

Present: Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Ashley Gray, Elizabeth Noriega, Paul Hogan, Tim Hanold, Ashish Kachru

Absent: Patricia T Cook MD
Virtual Attendees: Greg Peters, Kannan Srinivasan

1. Call to Order

Michael Cook, Board Chair called to order the regular meeting of the Board of Medical Assistance Services at 10:14 am on September 20, 2022 at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

2. Approval of Minutes

The minutes from the June 14, 2022 meeting were introduced and approved.

Moved by Ashish Kachru; seconded by Ashley Gray to Approve The
Motion : 8 - 0
Voting For: Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Ashley Gray, Elizabeth Noriega, Paul Hogan, Tim Hanold, Ashish Kachru
Voting Against: None

3. Director's Report

Acting Director Cheryl Roberts reported to the Board on the return of remaining staff back into the building after Labor Day. Director Roberts reported on priority updates with the agency including the Partnership for Petersburg which is Governor Younkin's project. The public health emergency unwinding was discussed along with July 1 Budget Initiative, Objectives and Key Results (OKRs) and Managed Care Organization (MCO) contracting. Additional priority updates discussed were Provider Services Solution (PRSS), MES Module Certification, Maternal & Child Health, Early and Periodic Screen, Diagnostic and Treatment (EPSDT), Traumatic Brain Injury Workgroup, Nursing Home Value Based Purchasing (VBP) project and Community Stabilization.

4. CFO Updates

Chris Gordon, CFO, provided the Board with updates on the current position of FY23 Appropriation, historical trends, and Public Health Emergency (PHE) impacts, MES certification status and the upcoming RFPs. In summary, Federal Public Health Emergency creates instability for Commonwealth appropriation and contingent financial need. Medicaid Expansion population is rising faster than any other group, within six years will be largest population if growth trend continues along with PHE, particularly Childless Adults. Medicaid policy decisions need to be contextualized relative to market forces, provider network, labor workforce, and member needs.

5. State Based Exchange - SCC

Kevin Patchett, Acting Director of the State Corporation Commission presented to the Board on the Virginia Health Benefit Exchange. The Virginia Health Benefit Exchange was created by the Virginia General Assembly in 2020, as a new division within the State Corporation Commission.

The statutory duties of the Exchange include:

- To transition Virginia from Healthcare.gov to a Virginia based marketplace
- Support health insurance continuity
- Reduce the number of uninsured
- Promote a transparent and competitive marketplace
- Promote consumer choice and education
- Assist individuals with access to programs, policies, and procedures related to obtaining health insurance coverage
- Assist individuals with premium tax credits and cost sharing reductions

The Individual Market is the private marketplace that serves people who do not receive group coverage through their employer and who do not qualify for Medicaid.

Independently funded by user assessment fees.

Immediate Benefits of a State-Based Marketplace:

- Allows Virginia to manage the full scope of Virginia marketplace services provided to Commonwealth consumers.
- DMAS, DSS, and other state agencies will be able to closely coordinate with the marketplace to help Virginia consumers access and maintain health coverage.
- Greater flexibility to tailor the consumer experience to better meet the needs of Virginians.
- Engage directly with consumers to address issues locally.

Exchange Snapshot

- 307,946 plan selections, ~15% increase from the same period in 2021.
- 76,300 SHOP plan selections
- 12 insurance carriers offering plans on the Exchange.
- 8 standalone dental carriers offering plans on the Exchange.
- 1,400 agents and brokers have signed exchange agreements.
- 35 navigators and 34 certified application counselor designated organizations (CDOs).
- All Virginia counties covered by plan offerings on the Exchange.
- For the first time since 2014, Virginia's individual ACA market will now have at least 2 carriers in every region of the Commonwealth (Plan Year 2023).

6. SDOH Update - Aetna & VA Premier

Paula Starnes, Chief Operating Officer of Aetna and Margaret Wise, Director of Clinical Health Services presented to the Board on Aetna's Membership Outreach and Engagement Strategies, Care Management Strategies and Health Improvement Incentives.

Chantel Neece with Virginia Premier presented to the Board on Vaccination Status.

7. New Business/Old Business

8. Regulations

Regulations were provided to Board members and the public via Townhall.

9. Adjournment

Michael Cook, Board Chair motioned for adjournment at 12:54 pm.

Moved by Ashley Gray; seconded by Ashish Kachru to Adjourn
Motion Passed: 8 - 0
Voting For: Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Ashley Gray, Elizabeth Noriega, Paul Hogan, Tim Hanold, Ashish Kachru
Voting Against: None

10. **Sub-Committee**

Present: Maureen S Hollowell, Michael H Cook Esq., Ashley Gray-Chair, Elizabeth Noriega, Paul Hogan, Tim Hanold, Ashish Kachru

Absent: Patricia T Cook MD, Basim Khan
Virtual Attendees: Greg Peters

The subcommittee met immediately following the regular BMAS Board meeting to discuss the Boards role within DMAS.

Topics of discussion included:

- What other State agencies are doing that have a Policy setting Board
- Need focal issues or five-year strategic plan
- Decision Packages
- Emergency Regulations
- Additional meetings
- Retreat focused on what the Board is going to do
- Reporting to the Board and not representing your organization's or it's interest

In summary, the Board wants to engage and be of service to DMAS.

Ashley Gray, Chair motioned and moved for adjournment at 2:17pm.; seconded by Paul Hogan to Adjourn
Motion Passed: 7 - 0
Voting For: Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Ashley Gray, Elizabeth Noriega, Paul Hogan, Tim Hanold, Ashish Kachru
Voting Against: None

BOARD OF MEDICAL ASSISTANCE SERVICES

DRAFT MINUTES
BOARD OF MEDICAL ASSISTANCE SERVICES
ORIENTATION

Tuesday September 20, 2022
9:00 AM

Present: Michael H Cook Esq., Ashley Gray, Paul Hogan, Tim Hanold, Ashish Kachru

Absent: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Patricia T Cook MD, Elizabeth Noriega

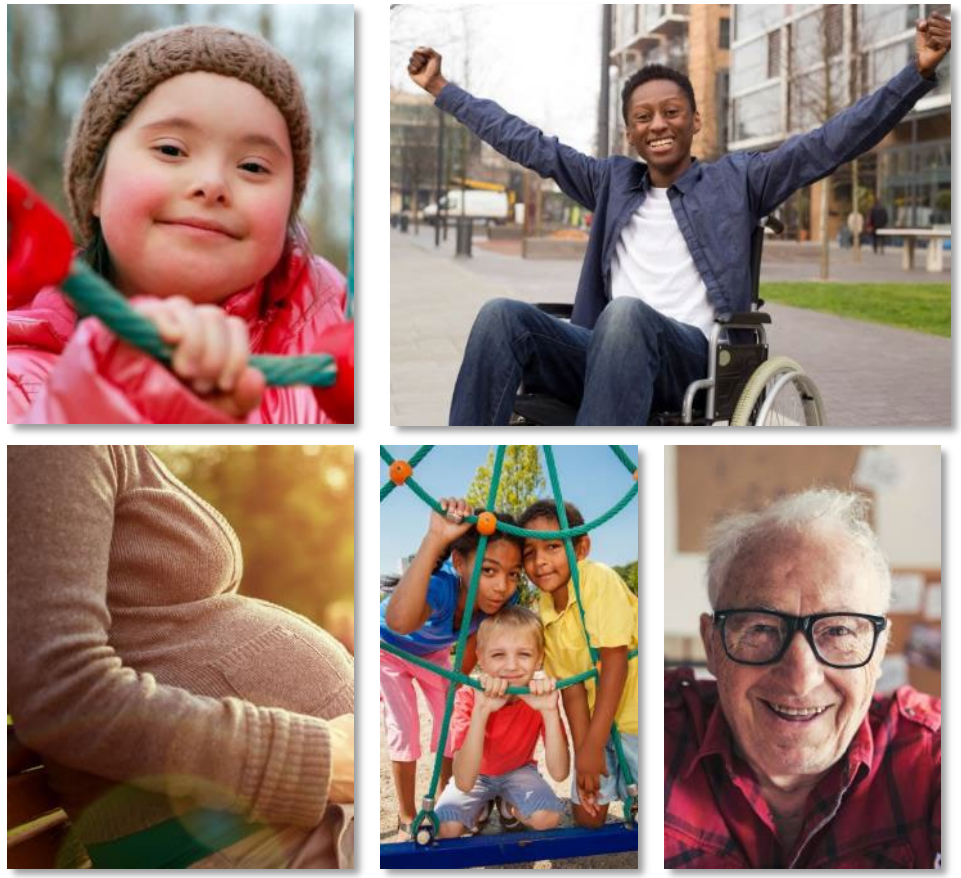
Call to Order
Michael Cook, Board Chair called to order the Orientation meeting of the Board of Medical Assistance Services at 9:05 a.m. on September 20, 2022 at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

Staff members with the Department of Medical Assistance Services presented the Board with an Overview of Medicaid.

- ❑ **Medicaid Overview**
  - DMAS Mission and Values
  - Organization Chart
  - Medicaid and Children's Health Insurance Program (CHIP) Authority
  - Waivers
  - Who We Cover
  - Eligibility
  - How to Apply
  - Enrollment SFY 21
- ❑ **Programs and Benefits**
  - Medicaid Services
  - Financing Care Delivery
  - Transition to Managed Care
  - Home and Community-Based Waivers
  - Specialized Medicaid Programs
- ❑ **Funding**
  - Enrollment and Expenditures
  - Medicaid Budget
- ❑ **Agency Priority Initiatives**
  - Partnership for Petersburg
  - Maternal and Child Health
  - Coverage Redetermination

- Behavioral Health
- Details on BRAVO Services

- **Resources**
  - Digital Communications, Websites and Social Media
  - Dashboards
  - Board Materials
  - Studies and Reports
  - Publications



BOARD OF MEDICAL ASSISTANCE SERVICES

CHERYL ROBERTS
DIRECTOR
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

DECEMBER 6, 2022

DMAS Mission & Values

Who Do We Cover?

Medicaid plays a critical role in the lives of more than 2.1 million Virginians


Children 855,264


Pregnant Members 32,728


Older Adults 86,425


Individuals with Disabilities 153,141


Adults 851,277


Limited Benefit Individuals 142,110

Source: December 1, 2022 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

Delivery System : Managed Care Transitions

Two managed care programs focused on the diverse needs of the populations serving over 97% of full-benefit populations through six statewide managed care plans*

Medallion 4.0	Commonwealth Coordinated Care Plus
1,599,988	**298,617**
▪ Serving infants, children, pregnant women, adults, including most Medicaid expansion	▪ Serving older adults and individuals with disabilities; includes Medicaid-Medicare eligible
▪ Acute, chronic, primary care and pharmacy services for adults and children, and also includes Substance Use Disorder, and behavioral health services, excludes LTSS	▪ Full continuum of services (same as Medallion), but also includes long-term services and supports (LTSS) in the community and in nursing facilities and hospice. **ID/DD services are in FFS
▪ Implemented statewide August 2018	▪ Implemented statewide January 2018

DMAS is currently working to consolidate the two programs by 1st quarter 2023 for improved care and foundation for the re-procurement for future growth and innovations

Source: September 15, 2022 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

2022 Highlights

Rate and payment changes

Safe and Sound

Early release

Doulas

COVID vaccinations

CardinalCare

Cardinal Care

Nursing Home Quality Project

Crisis services

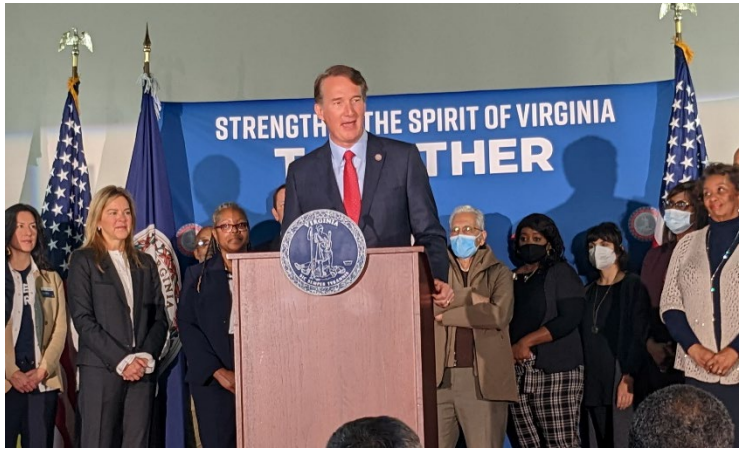
Early and Periodic Screening, Diagnostic and Treatment

Getting back to “normal”

Partnership for Petersburg

- In August, Governor Youngkin and state agency partners made a public commitment to work toward improving the City of Petersburg
- Managed Care Organizations joined Secretary Littel in the Governor's commitment and have so far contributed the following toward our goals of improving health care outcomes and access to maternity, pediatric, and primary care:
  - 40+ community and health events, many including screenings and vaccinations
  - More than $3M invested into projects directly serving Petersburg, including support of a maternity hub, partnership with Conexus for glasses for all students, as well as donations of necessities, such as toothbrushes, cribettes, diapers and food
- Next Steps: Sustainability, provider engagement

Partnership for Petersburg



- Our MCO partners are also actively engaged in the Petersburg community through participation in over 40 community and health events since August, many of these events including mobile screenings, vaccinations, and preventive health care services.
- To-date, MCOs have invested more than $3M into projects directly serving Petersburg, including support of a maternity hub, partnership with Conexus for glasses for all students, and donations of necessities, such as toothbrushes, cribettes, diapers and food.

Partnership for Petersburg

- Next Steps:
  1. Engaging Petersburg-area providers on community needs and sustainable strategies to increase health care outcomes:
     - Meeting with Pathways ED on December 16th
     - Maternity Provider meeting on January 4th at the Petersburg Library
     - Collaboration with CVHS
     - Ongoing discussions with VDH, DSS, VHHA
  2. Focus on access and utilization, tracking data to evaluate impact of Partnership for Petersburg engagement

Nursing Facility VBP

In 2021, the Virginia General Assembly directed the Department to develop a unified, value-based purchasing (VBP) program for NFs under Medicaid to begin by July 1, 2022.

What

- The Value-Based Purchasing Program (VBP) provides rewards for performance and improvement among eligible Nursing Facilities (NF).

Why

- In an effort to support appropriate staffing and improve the quality of care furnished to Medicaid members in nursing facilities (NF) across Virginia.

Performance Measure & Weights, Program Years 1 and 2

Domain	Measure	Description	Weight
Staffing 	**Days without Minimum RN Staffing**	Facility reported RN staffing hours each day within a quarter. Required standards addressed 42 CFR§ 483.35(b).	20%
	Total Nurse Staffing, Case-Mix Adjusted	Total nurse staffing hours per resident day within a quarter, adjusted for case-mix.	20%
Avoidance of Negative Care Events 	**Number of Hospitalizations per 1,000 Long-Stay Resident Days**	Number of unplanned inpatient admissions or outpatient observation stays that occurred during a one-year period among long-stay residents.	15%
	Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	Number of all-cause outpatient ED visits occurring in a one-year period while the individual is a long-term NH resident.	15%
	Percentage of long-stay High-Risk Residents with Pressure Ulcers	Percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers.	15%
	Percentage of long-stay Residents with a Urinary Tract Infection (UTI)	Percentage of long-stay residents who have had a UTI within the past 30 days.	15%

The NF VBP program uses existing measures from federal data sources to reduce additional reporting burden on Nursing Facilities. Please see the program methodology for more information regarding data sources.

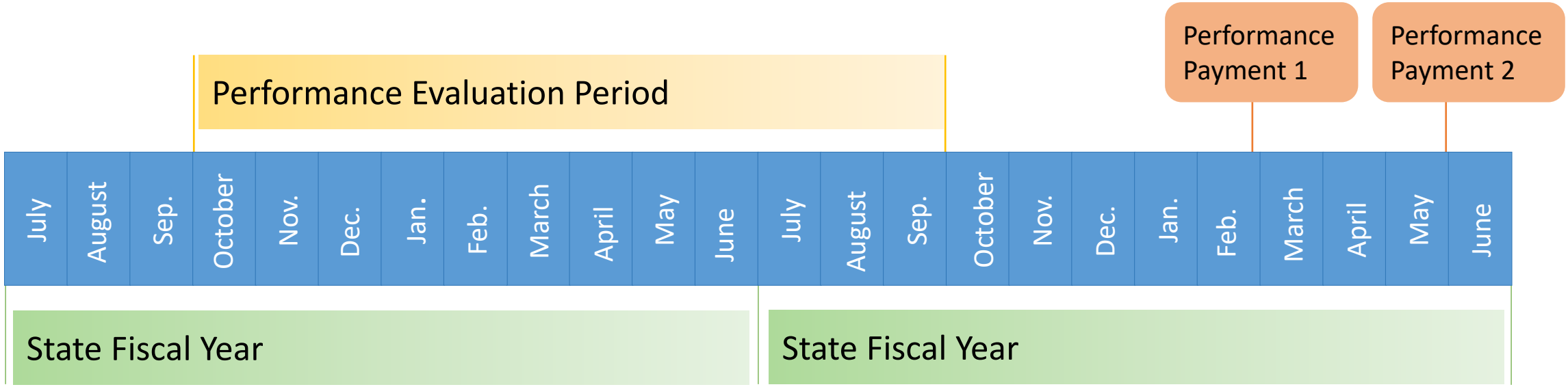
NF VBP Program Timeline Overview

✓The performance period for NF VBP is October 1 through September 30.

- Program Year 1 Performance Period is October 1, 2021 – September 30, 2022.
- Program Year 2 Performance Period is October 1, 2022 – September 30, 2023.

✓The performance payments are made in February and May

- Program Year 1 Performance Payments will be initiated in February and May of 2023.




what's next?

Part 1

- 1
- 2
- 3
- 4
- 5

Part 2

- 1
- 2
- 3
- 4
- 5

DMAS Workforce Update

Welcoming New Leadership

New Executive Leaders

John Kissel
Deputy Director for
Technology and Innovation

Adrienne Fegans
Deputy Director of Programs
and Operations

New Division Leader

Carla Bennett
Division Director for
Procurement & Contracts
Management

Workforce Initiatives

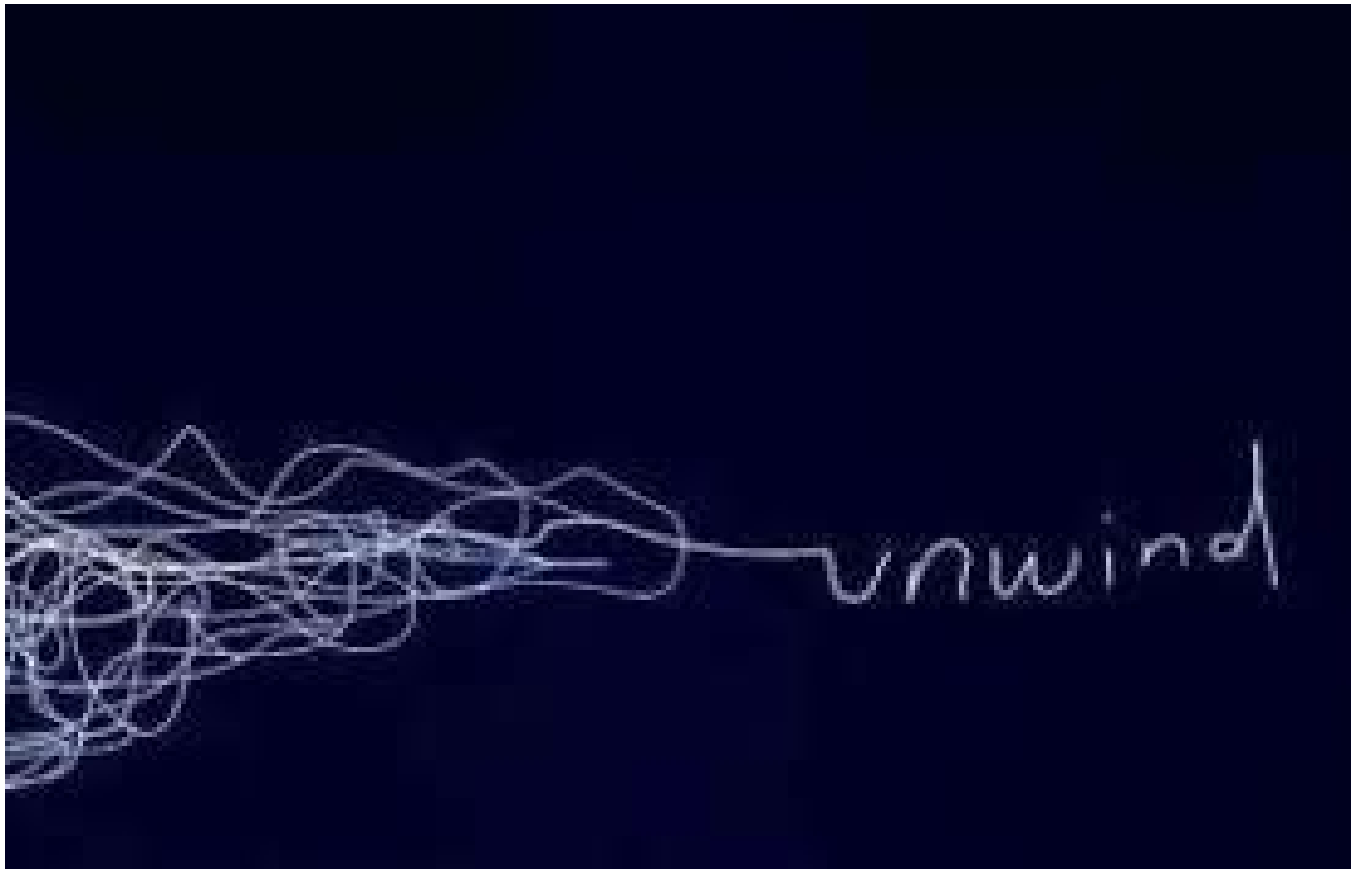
- Enhanced new employee orientation and onboarding
- Comprehensive, tiered employee recognition program with planned enhancements in early 2023
- Employee engagement opportunities through charitable giving and community service projects
- Learning opportunities through DMAS Academy
- Ongoing workforce engagement surveys

Governor’s Budget and General Assembly

Behavioral Health System Transformation

- Governor Youngkin is committed to enhancing and transforming the Behavioral Health System

The End of the Federal Public Health Emergency



State Based Exchange

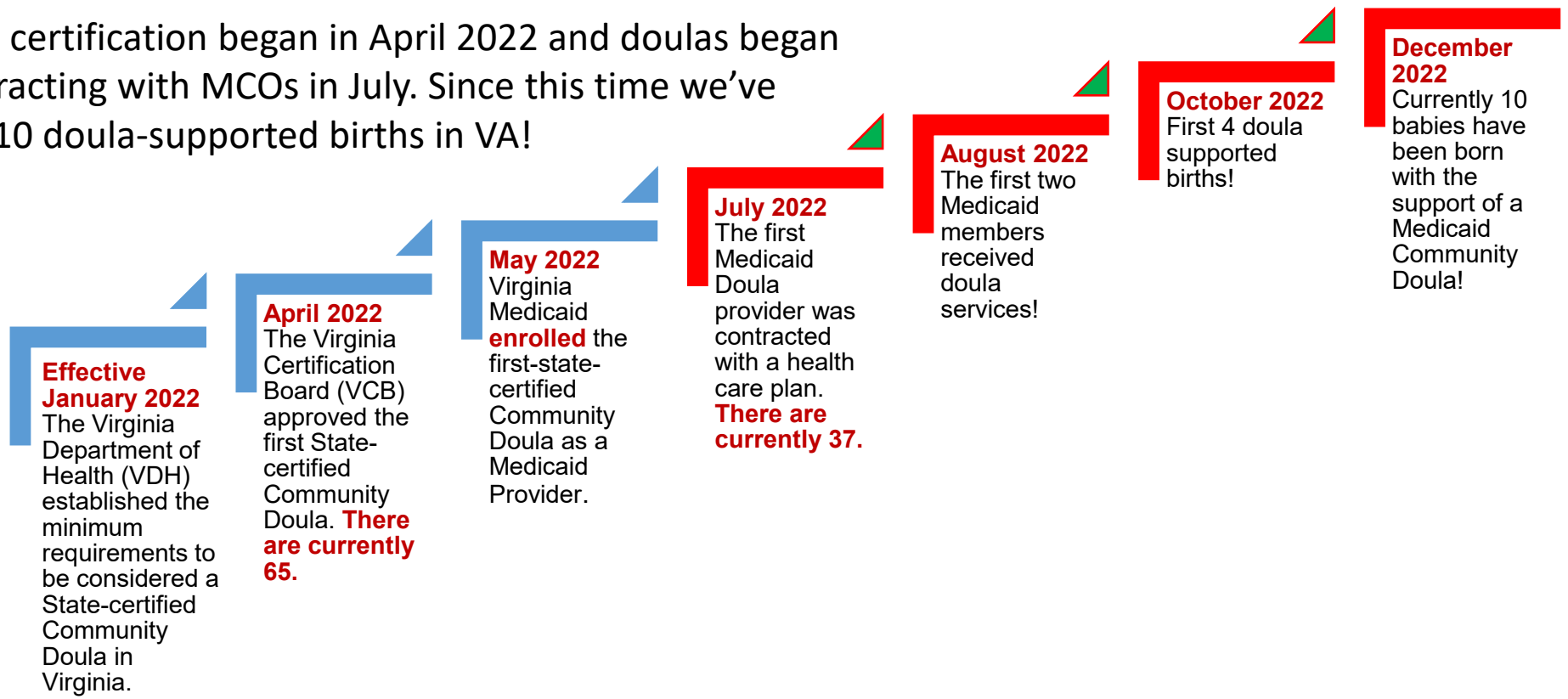
Virginia intends to transition to a fully state-run health exchange marketplace near the end of 2023.

Post-Partum and Infant Care

Community Doula Implementation

Virginia Medicaid was the 4th state in the nation to implement doula services for Medicaid members.
The Community Doula program is committed to maternal and infant health and is working to build a network of Medicaid Doula providers.

State certification began in April 2022 and doulas began Contracting with MCOs in July. Since this time we've Had 10 doula-supported births in VA!



Long-Term Services and Supports

Brain Injury Services

- 2022 Virginia General Assembly authorized the implementation of a new Targeted Case Management Service in the Medicaid program for individuals with severe traumatic brain injury.
  - The Appropriation Act supported this bill by issuing funds in the DMAS medical budget targeted for the implementation of the service.
- The legislature approved DMAS to convene a workgroup with relevant stakeholders to assess and estimate costs for a potential brain injury services waiver and to develop a facility based neuro-rehabilitation service option.
  - DMAS was given administrative funding to support this item, the funds are to be used to implement a rate study for the services identified by the DMAS workgroup.

Brain Injury Services

Budget Processes
- GA Report has been Completed
- Submitted to HHR

Rate Development
- Vendor procurement in progress

Targeted Case Management (TCM)
- Ongoing Technical Assistance Planning and Programmatic Research Support Through New Editions*

Waiver Development
- Workgroup Sessions Ongoing
- Exploring Alternate Institutional Placement Options
- Exploring Waiver Type Options

Upcoming Key Tasks and Milestones	Expected Completion
Proposal Ranking	October 2022
All TCM Service Requirements Defined	November 2022
TCM Population Definition Completed	December 2022
Alternative Eligibility Definitions Agreed upon (ABI, SCI, TBI, etc.)	December 2022
Service location visits and research	December 2022
Selection of Waiver Services	December 2022
TCM Reimbursement and Operational Structures Finalized	December 2022
Waiver Service Options discussed	December 2022

Brain Injury Services – Workgroup Timeline

August, 2022-Sept, 2022	October, 2022-June, 2023	January, 2023-August, 2023	February, 2023-December, 2023
Gather Input, Share Project Plan and Policy Overview	**Rate Development/Cost Assessments**	**Populations and Program, Submit Budget Request for 2024 Session**	**TCM Implementation**
Gather Stakeholder Design Input	Assess Population Data	Deliver Budget package for Waiver and Facility Services	Provider enrollment rules finalized
Design and Development/Waivers 101	Assess Community Service Options	Finalize Reimbursement Rates for Services	Claims processing rules finalized
Population and Service Design Input	Assess Facility Service Options	Finalize Population/Eligiblity Rules	Provider Training/Recruitment
Deliver GA Report with Stakeholder Input	Select Waiver Type for Design	Finalize Population and utilization estimates for budget	TCM goes live July-December, 2023 GOAL: Budget Approval for BIS Waiver July 2024

Integrity: Program and Fiscal

Performance Withhold Program

- 1% of capitation is withheld in both CCC+ and M4 that is earned through performance - SFY22 was the first pay-for-performance year
- PWP results are based on EQRO audit for designated performance measures
- Percent Earned by Program for SFY22:

	SFY21 Illustrative Percent Earned	SFY22 Percent Earned
CCC+	78%	83%
M4	66%	66%

CCC+ PWP Overall Performance - HEDIS

Measure	SFY22 CCC+ Program Performance	National 50th Percentile
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence – 7 day	14.55%	13.39%
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence – 30 day	22.57%	21.24%
Follow-Up After ED Visit for Mental Illness – 7 day	45.40%	40.38%
Follow-Up After ED Visit for Mental Illness – 30 day	61.04%	54.51%
Initiation of AOD Abuse or Dependence Treatment	45.22%	43.79%
Engagement of AOD Abuse or Dependence Treatment	12.94%	14.03%
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing	85.23%	85.89%
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0 %)	47.39%	39.90%
Comprehensive Diabetes Care - HbA1c Control (<8.0 %)	45.11%	50.12%
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	50.79%	51.09%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	51.04%	60.83%

M4 PWP Overall Performance - HEDIS

Measure	SFY22 M4 Program Performance	National 50th Percentile
Child and Adolescent Well-Care Visits	50.27%	48.93%
Childhood Immunization Status	63.22%	63.26%
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing	84.85%	85.89%
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0 %)	47.45%	39.90%
Comprehensive Diabetes Care - HbA1c Control (<8.0 %)	42.20%	50.12%
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	45.78%	51.09%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	54.64%	60.83%
Follow-Up After ED Visit for Mental Illness – 7 day	43.04%	40.38%
Follow-Up After ED Visit for Mental Illness – 30 day	55.53%	54.51%
Timeliness of Prenatal Care	76.44%	85.40%
Postpartum Care	66.76%	85.40%

Procurement


thank
you

FINANCE UPDATE

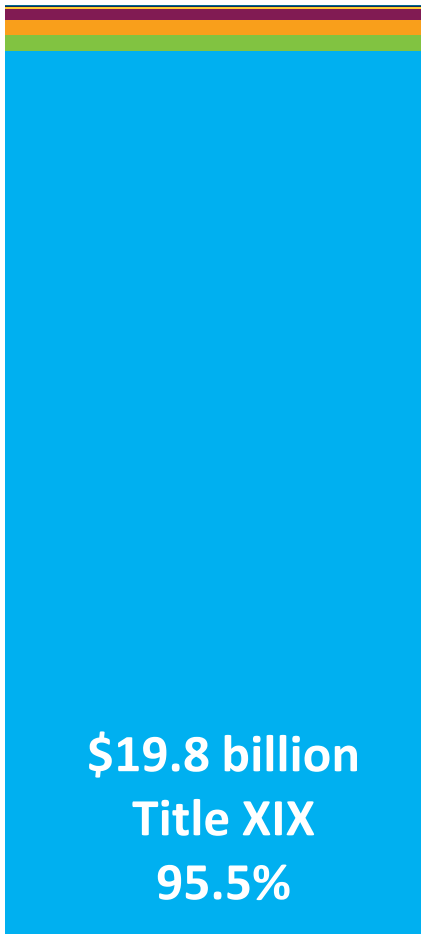
Chris Gordon, CFO

Deputy Director of Finance

Agenda

- FY23 Appropriation
- FY23 Appropriation to Actuals by Program & Fiscal Month
- Enrollment & Expenditures
- Summary

DMAS FY23 Appropriation



$20.8 billion

Admin— 1.7%
- $345 million

CHIP— 1.5%
- $316 million

MCHIP—1.2%
- $249 million

ARPA—0.07%
- $14 million

TDO—0.08%
- $15 million

UMCF—0.004%
- $822K

Source: Department of Planning & Budget Operating Plan; https://pbreporting.virginia.gov/rdPage.aspx

Comparing: FY20-23 first four months

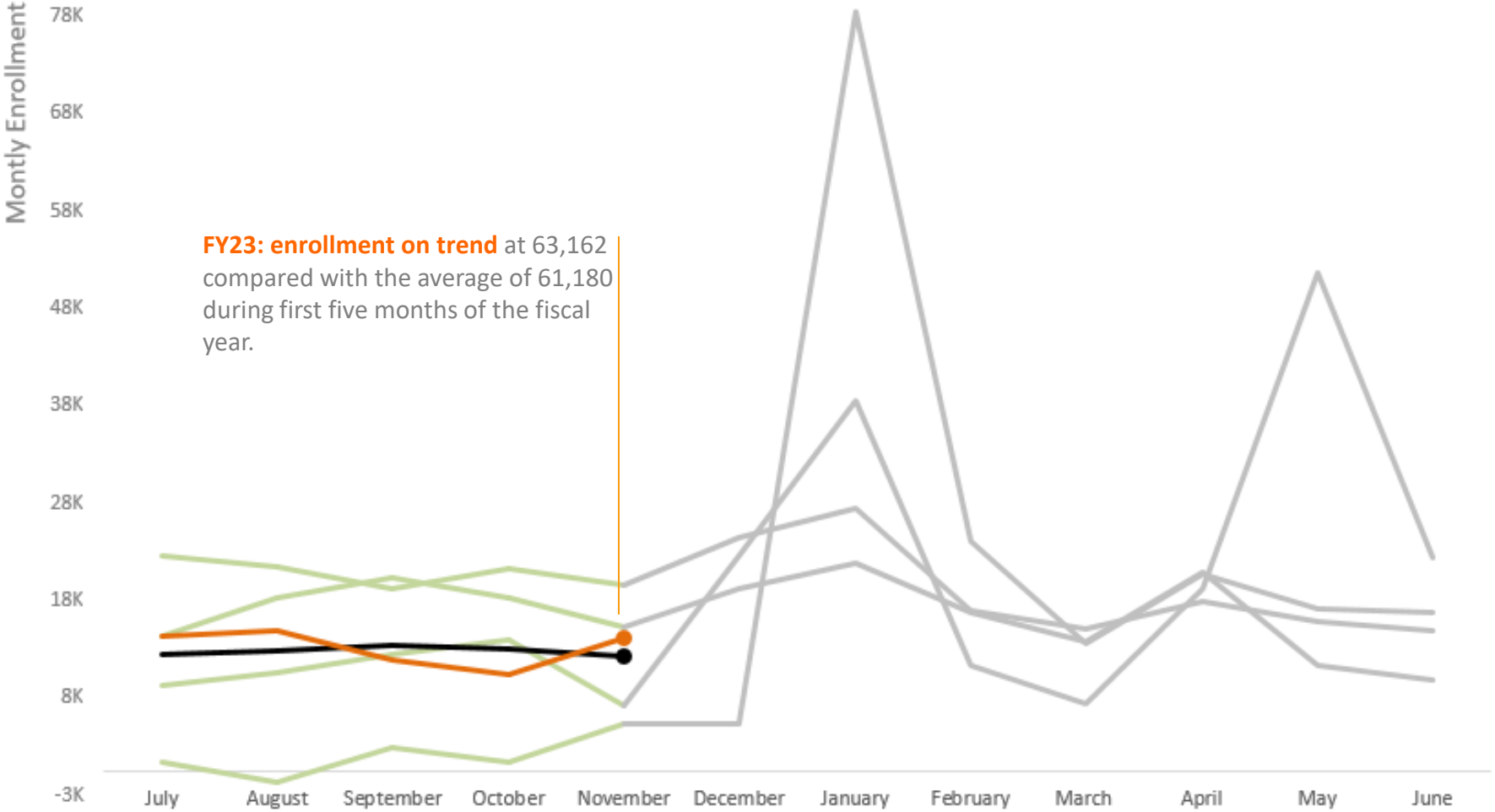
In Millions

	Actuals through October				FM4 FY23	
Expenditures	**FM4 FY20**	**FM4 FY21**	**FM4 FY22**	**FM4 FY23**	**Change**	**% Change**
Managed Care: Medallion 4	$ 1,329.9	$ 1,631.6	$ 1,903.1	$ 2,226.5	$ 323.4	17.0%
Managed Care: CCC+	1,737.5	1,987.6	2,157.0	2,428.3	$ 271.3	12.6%
Fee-For-Service: General Medical Care	534.6	512.1	552.1	626.9	$ 74.8	13.5%
Fee-For-Service: Behavioral Health & Rehabilitative Svcs	15.8	21.9	31.9	15.8	$ (16.1)	-50.5%
Fee-For-Service: Long-Term Care Services	495.7	516.1	550.8	740.9	$ 190.1	34.5%
Hospital Payments	175.4	145.2	246.8	286.9	$ 40.1	16.2%
Supplemental Rate Assessment Payments	276.1	291.4	410.4	509.5	$ 99.1	24.1%
Total Title XIX	**$ 4,565.0**	**$ 5,105.9**	**$ 5,852.1**	**$ 6,834.8**	**$ 982.7**	16.8%
Total GF Expenditures (Title XIX)	**$ 1,606.6**	**$ 1,301.5**	**$ 1,582.6**	**$ 1,784.1**	**$ 201.5**	

Source: Department of Medical Assistance Services Monthly Accuracy Reports for FM1 through FM4 FY20 through FY23, https://www.dmas.virginia.gov/data/financial-reports/

Monthly Enrollment in Medicaid

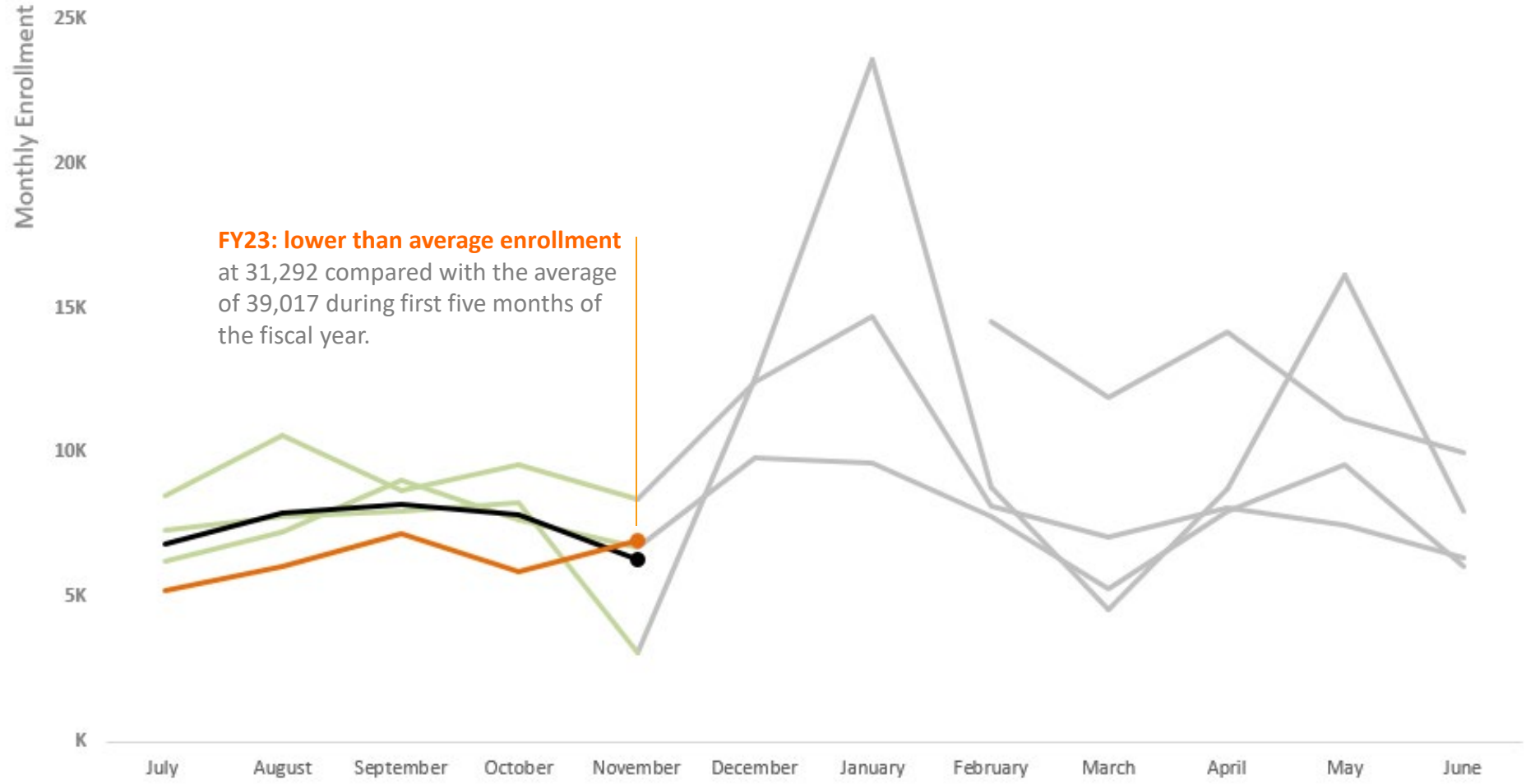
FY23 Monthly Enrollment: **on trend** with last four years



Source: DMAS Enrollment Report retrieved November 27, 2022

ACA Childless Adult Enrollment

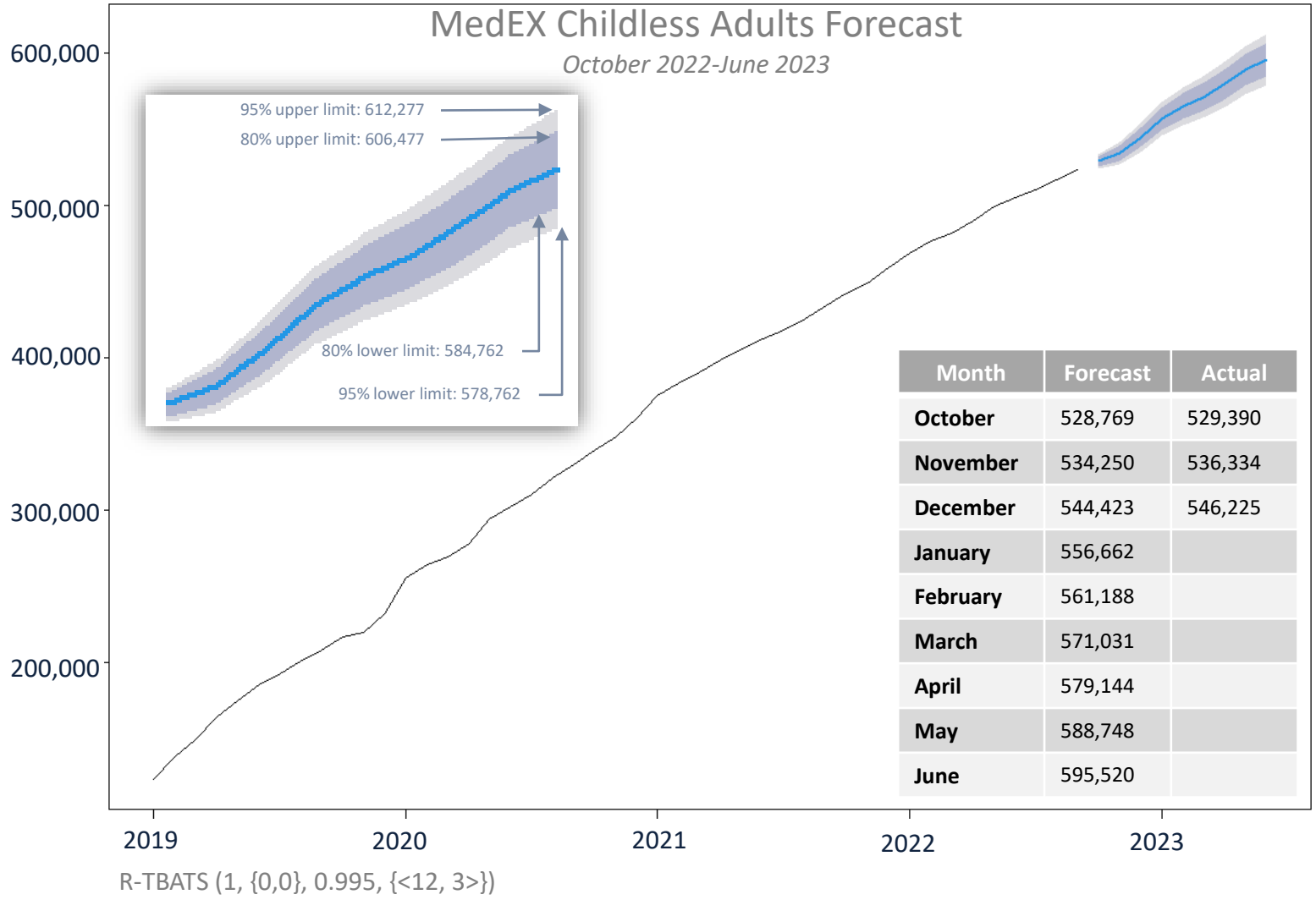
FY23 Childless Adult Enrollment: **below average** compared to last four years



Source: DMAS Enrollment Report retrieved November 27, 2022

ACA Childless Adult Forecast

9-month Forecast for MedEX Childless Adults: October 2022 –June 2023



Month	Forecast	Actual
October	528,769	529,390
November	534,250	536,334
December	544,423	546,225
January	556,662	
February	561,188	
March	571,031	
April	579,144	
May	588,748	
June	595,520	

Source: DMAS Enrollment Report retrieved September 2, 2022, and R-TBATS Forecasting

Summary

- Medicaid Title XIX Expenditures **increased nearly 17%** over last year
- Medicaid population still **growing at 12.5K per month**, ACA Childless Adults at **6.2K per month**
- ACA Childless Adults on forecast, accounting for **nearly half of all Medicaid growth** in first 5-months

COVID-19 PHE: UNWINDING UPDATES

VIRGINIA'S MEDICAID PROGRAM DMAS

COVER VIRGINIA

Medicaid Continuous Coverage Requirements Under the Families First Coronavirus Response Act (FFCRA)

To support states and promote stability of coverage during the COVID-19 pandemic, FFCRA provided a 6.2 percentage point increase in the regular Medicaid matching rate, tied to certain conditions that states must meet in order to access the enhanced funding.

- As one of several conditions of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase under FFCRA, **states are required to maintain enrollment of individuals in Medicaid** until the end of the month in which the public health emergency (PHE) ends **(the "continuous coverage" requirement)**.
  - Since the beginning of the PHE, Virginia has received $2,001,653,414 in increased funding through Q4 FY22.

- The continuous coverage requirement **applies to individuals enrolled in Medicaid as of March 18, 2020 or who were determined eligible on or after that date**, and has allowed people to retain Medicaid coverage and get needed care during the pandemic.

- When continuous coverage is eventually discontinued **state will be required to redetermine eligibility for nearly all Medicaid enrollees**.

★ *The current federal Medicaid continuous coverage requirement ends on January 31, 2023.*

Source: FFCRA §6008(b)(3); SHVS, Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates.

Updates on CMS Guidance

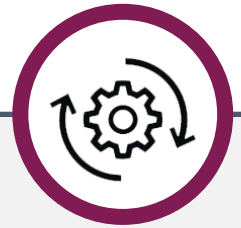
DMAS and DSS are working together to implement CMS' state based approach to keep eligible individuals enrolled, reduce churn, maximize successful transition to other coverage where appropriate, and achieving a sustainable renewal schedule.

- While states are still required to initiate all renewals within 12 months, CMS granted an additional two months for states to complete clean up actions to come into compliance with Federal requirements for a total of 14 months.

- HHS has committed to providing a 60-day PHE final end date notice to CMS/states
  - Current PHE expiration date is January 11, 2023, a 60-day notice would have been due on November 12, 2022 for January expiration.
  - Another extension of the PHE is expected prior to the January expiration date – it is anticipated this extension will last for a full 90 days.
    - If this extension is the final PHE, the 60-day notice would be given on February 10, 2023 with a new assumed end date of April 11, 2023.
    - First month coverage termination could begin May 1, 2023.
    - 6.2% FMAP would end June 30, 2023.

Medicaid Enrollment in the Commonwealth During the PHE

The end of the continuous coverage requirement in the Commonwealth will present the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA).



Historically, the Commonwealth has experienced **churn, which is enrollees who reapply and re-gain coverage shortly after being terminated**.

From March 2020 through November 1, 2022, the Commonwealth experienced an **increase of 560,375 enrollees (a 27% increase in enrollment growth).**

Enrollment growth has been the **fastest among non-elderly, non-disabled adults**, and slower among children and aged, blind, and disabled (ABD) eligibility groups.

Post continuous coverage, **roughly 14% of the state's total Medicaid enrollees may lose coverage, and up to 4% of members may lose and regain coverage within 1-6 months of closure. The national average for loss is around 20%.**

Preparations to Resume Normal Operations

In mid-2020, shortly after the PHE declaration, preparations for resuming normal operations began. Much of this work will require teams to pivot to finalize the changes and undo temporary policies and procedures to revert to normal operations.

System Updates (VaCMS & MES)

20 Changes Implemented

3 Changes in Progress

Clean Up & Pre-Unwinding Processes

5 New or Updated Processes Implemented

Stakeholder Outreach

4 Toolkits
18 Outreach Templates
65 Provider Memos Issued
2 PHE Website Pages

Member Outreach

1 million + Letters Mailed
1 Social Media Campaign
Radio Campaign in 5 Regions
3 PHE Website Page
1 Television Campaign

Training

7 Trainings Developed

Policy Flexibilities

9 Flexibilities Made Permanent

Unwinding Waivers

7 Waivers Submitted & Approved

Temporary Flexibilities

116 Total Implemented
(74: Ended, 42: in Progress)

Commonwealth of Virginia

Virginia Department of Medical Assistance Services

FOR IMMEDIATE RELEASE
Date: October 4, 2022

Contact: Christina Nuckols
Email: christina.nuckols@dmas.virginia.gov

Virginia Medicaid to Transform Managed Care

Major procurement will launch next year targeting a 2024 implementation

RICHMOND – Virginia Secretary of Health and Human Resources John Littel today announced that the Commonwealth's Medicaid agency plans to launch a transformational new procurement next year to drive innovation and strengthen quality and accountability in its managed care program.

"A best-in-class managed care delivery system is essential to the success of Governor Glenn Youngkin's priority health initiatives, including behavioral health redesign and improvements in maternal health outcomes," said Secretary Littel. "We are committed to reinventing this public-private partnership to improve health outcomes and maximize the value of the managed care model for both our members and our taxpayers throughout the Commonwealth of Virginia."

The target implementation date for this $14 billion procurement is July 1, 2024. State leaders will evaluate commercial health plans that participate in the competitive procurement based on their use of data-driven strategies to address challenges in the rapidly evolving health care environment, including value-based care models that tie funding to measurable improvements in health outcomes.

More than 90 percent of Virginia Medicaid members currently receive services through one of six health plans, which contract with the agency for both of its current managed care programs.

The larger of the two managed care programs, Medallion 4.0, previously sought bids from interested health plans in 2017. The Commonwealth Coordinated Care Plus program for members with higher intensity health needs completed a procurement in 2016 and launched in 2017.

“Managed care has empowered our agency to build committed partnerships that support our mission to improve the health and well-being of Virginians through access to high-quality health care coverage,” said Cheryl Roberts, Director of the Department of Medical Assistance Services. “We look forward to working closely with Governor Youngkin and Secretary Littel to design and implement this ambitious and impactful initiative.”

The Virginia Medicaid agency will hire nationally recognized consultants with expertise in the managed care field to assist in drafting the request for proposals. The agency also plans to seek input from the General Assembly, Medicaid members, health care providers, other state agency representatives and community stakeholders on the design of the new managed care program.

The Virginia Department of Medical Assistance Services (DMAS) plays an essential role in the Commonwealth’s health care system by providing lifesaving medical coverage to one in four Virginians. For more information, visit www.dmas.virginia.gov.

###

Regulatory Activity Summary December 13, 2022
(* Indicates Recent Activity)

2022 General Assembly

***(01) Removal of Cost Sharing:** The purpose of this regulatory action is to remove co-payments for Medicaid and FAMIS enrollees in accordance with a General Assembly mandate. The 2022 Appropriations Act, Item 304.FFFF, required DMAS to remove co-payments for Medicaid and FAMIS enrollees effective, April 1, 2022. DMAS has not been imposing co-payments on Medicaid and FAMIS members during the federal public health emergency (PHE) related to the Coronavirus Disease 2019 (COVID-19) pandemic. However, as of a result of 2022 Appropriations Act, Item 304.FFFF, co-payments have been permanently removed and they will not be reinstated after the federal PHE ends. The project is currently circulating for internal review.

***(02) Post Eligibility Special Earnings:** The 2022 Appropriations Act, Item 304.ZZ, requires DMAS to adjust the post eligibility special earnings allowance for individuals in the Commonwealth Coordinated Care Plus (CCC Plus), Community Living (CL), Family and Individual Support (FIS), and Building Independence (BI) waiver programs to incentivize employment for individuals receiving waiver services. The purpose of this action is to incentivize employment for individuals receiving DD waiver services by allowing a percentage of earned income to be disregarded when calculating an individual's contribution to the cost of their waiver services when earning income. This enables individuals enrolled in the DD waiver to keep more of their income, without losing financial eligibility for the waiver. This does not result in new individuals being added to the DD waiver. The project is currently circulating for internal review.

***(03) Medicaid Works:** In accordance with Item 313.WWWW of the 2020 Appropriations Act, this state plan amendment will allow DMAS to increase the income eligibility for participation in the Medicaid Works program to 138 percent of the Federal Poverty Level. Medicaid Works is a program that offers individuals with a disability who are employed, or who want to go to work, the ability to earn more income and save more of their earnings than otherwise allowed by Medicaid rules. Medicaid Works allows individuals to keep their health coverage from Virginia Medicaid while they work and gain greater independence. The SPA is currently circulating for internal review.

***(04) Medicaid Enterprise System:** The purpose of this final exempt regulatory action is to make technical updates to several of the agency's regulations to reflect the Department's transition of several key information management functions handled through the Virginia Medicaid Management Information System (VAMMIS) to a new technology platform called the Medicaid Enterprise System (MES). The MES replaced the department's VAMMIS on April 4, 2022. These regulations are currently circulating for internal review.

***(05) Program of All-Inclusive Care for the Elderly:** This SPA will allow DMAS to update sections of the state plan that pertain to the Program of All-Inclusive Care for the Elderly

(PACE) to align with the Department's current practices pursuant to the Code of Virginia, state regulations, and federal regulations. This project is currently circulating for internal review.

***(06) Anesthesia for Children's Dental Procedures:** In accordance with Item 304.PPPP of the 2022 Appropriations Act, this state plan amendment will allow DMAS to cover medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Medicaid enrollee who is determined by a licensed dentist in consultation with the enrollee's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care to an enrollee age ten or younger. Following internal DMAS review and submission to DPB and to the Tribal Programs (on 7/15/22), the SPA was forwarded to CMS on 8/15/22 for review. DMAS submitted a request letter to CMS to withdraw the SPA on 10/11/22.

(07) Application Update: CMS requires state Medicaid agencies to submit the full set of their Medicaid application materials for review whenever there are changes to the application. DMAS is submitting a SPA to CMS to request approval for two changes to the Medicaid application: 1) update the pregnancy related question from 60 days to 12 months to align with Virginia's postpartum extension; 2) add language for MCO pre-selection for those that are found eligible for FAMIS. These changes will allow the Medicaid application to reflect current DMAS procedures and Virginia eligibility policy. The project is currently circulating for internal review.

***(08) Preventive Services:** Item 304.EEEE in the 2022 Appropriations Act requires DMAS to "amend the State Plan under Title XIX of the Social Security Act, and any waivers thereof as necessary to add coverage of the preventive services provided pursuant to the Patient Protection and Affordable Care Act (PPACA) for adult, full Medicaid individuals who are not enrolled pursuant to the PPACA." Following internal review, the DPB and Tribal notices were sent for review on 8/30/22. The SPA was submitted to CMS on 9/30/22 and approved by CMS on 12/7/22.

***(09) Institutional Provider Reimbursement Changes:** The 2022 Appropriations Act requires DMAS to make several institutional (inpatient and long-term care) changes to the state plan. Following internal review, the SPA was submitted to CMS for review on 9/2/22. The SPA was approved by CMS on 11/23/22.

***(10) Non-Institutional Provider Reimbursement Changes:** The 2022 Appropriations Act requires DMAS to make several changes to non-institutional provider reimbursement. Following internal review, the SPA documents were forwarded to DPB and to the Tribal Programs for review on 8/19/22. The SPA was submitted to CMS for review on 9/19/22.

(11) COVID Vaccines, Testing, and Treatment: This SPA adds new sections to the State Plan for Medical Assistance that affirm that DMAS is in compliance with federal statutes and regulations related to coverage of COVID vaccines, testing, and treatment. Following internal review, the SPA was submitted to CMS on 5/13/22 for review. The SPA was approved by CMS on 11/30/22.

***(12) Third Party Liability:** This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA was submitted to CMS on 6/27/22 and approved on 7/25/22. The corresponding fast-track project is currently circulating for internal review.

***(13) PACE (Rates & Payment Methodology):** DMAS has revised the state plan to update sections that pertain to the Program of All-Inclusive Care for the Elderly (PACE). Specifically, this SPA (1) incorporates the Rates and Payments language from the Center for Medicare & Medicaid Services' (CMS') most current PACE State Plan Amendment Pre-Print and (2) updates the PACE Medicaid capitation rate methodology to align with DMAS' current rate setting practices. DMAS has transitioned from fee-for-service data to managed care encounter data for development of the amount that would otherwise have been paid. The PACE program will continue to operate in the same way that is has based on regulations in the Virginia Administrative Code, and there will be no changes for providers as a result of this SPA. Following internal DMAS review, the SPA was submitted to CMS on 3/3/22. The SPA was approved by CMS on 4/26/22. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 6/29/22; to DPB on 10/13/22; and to HHR on 11/16/22.

***(14) Clinical Trials:** The purpose of this SPA is to make revisions to include reimbursement for coverage for routine patient costs furnished in connection with a member's participation in a qualifying clinical trial in accordance with Section 210 of the Consolidated Appropriations Act of 2021 and the CMS State Medicaid Director (SMD) letter #21-005. Per the SMD letter, DMAS will cover any item or service provided to the individual under the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver, including a demonstration project under section 1115 of the Social Security Act. Such routine services and costs also include any item or service required to administer the investigational item or service. Following internal DMAS review, the SPA was submitted to CMS on 3/28/22 and approved on 4/7/22. The corresponding reg project was submitted to the OAG for review on 4/28/22 and approved by the Governor's Ofc. and submitted to the Registrar on 10/4/22. The project was published in the Register on 10/24/22 and became effective on 11/23/22.

2021 General Assembly

(01) Mental Health and Substance Use Case Management: These regulation changes remove the limit on substance use case management for individuals in IMDs are to comply with the Medicaid Mental Health Parity Rule. The federal Mental Health Parity regulation can be found in 42 CFR 438.910(b)(1). Specifying that reimbursement is allowed, provided two conditions are met, for mental health and substance use case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in IMDs and individuals of any age who are inmates of public institutions, aligns DMAS regulations with 42 CFR 411.18(a)(8)(vii) and documents the

Department's existing practices. Clarifying ISP review timeframes and grace periods, and clarifying CSAC-Supervisees can bill for substance use case management services, document existing DMAS practices, rather than changes in practices. Following internal review, the project was submitted to the OAG on 1/13/22. DMAS received OAG inquiries on 1/19/22 and responded to those on 1/27/22. The regulatory action was approved by the OAG on 2/23/22 and was forwarded to DPB for review on 2/24/22. The project was forwarded to HHR on 4/5/22.

(02) Personal Care Rate Increase: This state plan amendment updates the date of the personal care fee schedule on January 1, 2022, in accordance with Item 313.SSSS.3 of the 2021 Appropriations Act. (A corresponding rate increase of 12.5% will be provided for personal care services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.) Following internal review, the SPA was submitted to CMS on 12/13/21 and approved on 4/28/22. The corresponding regulatory changes are currently circulating for internal review.

(03) Private Duty Nursing Services Under EPSDT: This regulatory action updates the Virginia Administrative Code to include the following items related to private duty nursing, in accordance with a mandate from the 2021 General Assembly: services covered, provider qualifications, medical necessity criteria**,** and rates. This regulation establishes the regulatory framework for individuals with the need for high-intensity medical care. Having regulations in place (rather than just language in Medicaid manuals) helps ensure that the rules are clear and transparent, and that they are applied equally across providers, and across members. This reg action includes a service description, a list of service components, provider qualifications, and service limits (which includes references to the documents needed to establish medical necessity). Following internal review, the regs were submitted to the OAG on 8/6/21 and then to DPB on 4/6/22. After edits were made to the regulations, the project was re-submitted to the OAG on 4/26/22 and sent to DPB on 5/18/22. The project was forwarded to the Secretary's Office for review on 6/1/22. Following additional internal revisions, the regulations were sent back to HHR on 8/1/22.

***(04) Update to Outpatient Practitioners:** The purpose of this action is to add licensed school psychologists to the list of allowed providers of outpatient psychiatric services. Several of Virginia's Child Development Clinics have identified the need to allow licensed school psychologists to bill for outpatient psychiatric services provided in their clinics to increase access to the number of children that they serve. Following internal review, the project was submitted to the OAG on 8/27/21. OAG questions were received on 11/10/21 and DMAS submitted responses to the OAG on 11/12/21. DMAS made Town Hall corrections on 11/16/21. DMAS responded to additional OAG questions on 2/7/22 and 2/8/22 and made project revisions on 2/11/22. The regulatory action was approved by the OAG on 2/22/22 and submitted to DPB on 2/23/22. DPB inquiries were received on 2/24/22 and DMAS sent responses to DPB on 3/2/22, 3/15/22, and 3/15/22. The regs were certified by DPB on 4/5/22. The project was submitted to the Secretary's Ofc. on 4/6/22. An Agency response to the Economic Impact Analysis (EIA) was posted on 4/12/22. The project was forwarded to the Gov. Ofc. for review on 6/17/22. The Gov. Ofc. approved the project on 9/21/22. The project was submitted to Registrar on 9/21/22, with a public comment forum from 10/24/22 thru 11/23/22. The regulations became effective on 12/8/22.

***(05) Consumer-Directed Attendants:** This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer-directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. DMAS reached out to the OAG to re-engage this project. The OAG sent additional revisions/questions on 9/12/22. DMAS forwarded responses to the OAG on 11/9/22. The OAG sent a request for additional edits on 12/6/22. DMAS is reviewing the regs and coordinating the responses.

***(06) Client Appeals Update:** This regulatory action seeks to comply with a 2021 General Assembly mandate that requires DMAS to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of documents and decision deadlines for de novo client hearings. Following internal DMAS review, the reg action was submitted to the OAG on 7/23/21; to DPB on 1/14/22; and to HHR on 1/27/22. The project moved the Gov. Ofc. on 7/13/22 and was approved by the Governor on 9/2/22. The regulations were sent to the Registrar on 9/6/2022 and were published in the Register on 9/26/22, with an effective date of 3/7/2023.

(07) School Services: The purpose of this SPA is to adhere to the 2021 Appropriations Act, Items 313.EEEE and VVVV, which require DMAS to make changes to the state plan. These changes will: 1) increase the rates for psychiatric services by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates; and 2) increase supplemental physician payments for a freestanding children's hospital serving children in Planning District 8. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by CMS and all other Virginia Medicaid fee-for-service payments. The project was submitted to CMS on 10/18/21. The request for additional information (RAI) for this project was received from CMS on 1/4/22. DMAS' RAI response was sent to CMS on 3/30/22. DMAS withdrew the RAI response and continues to work with CMS "off the clock" on this project.

(08) Office-Based Opioid Treatment Changed to Office-Based Addiction Treatment: This SPA will allow DMAS to expand the substance use disorder service called "Preferred Office-Based Opioid Treatment" (which has been available only to individuals with a primary diagnosis of opioid use disorder) to individuals with a substance-related or addictive disorder. Following internal review, the SPA was submitted to CMS on 7/23/21. DMAS responded to informal questions on 8/5/21, 8/6/21, and 8/11/21. CMS approved the SPA on 10/14/21. The

corresponding reg package, following internal review, was submitted to the OAG for review on 11/3/21. The OAG submitted additional questions and DMAS responded. The project was certified by the OAG on 12/10/21 and submitted to DPB on 12/13/21. DPB forwarded questions on 12/14/21 & 12/30/21; DMAS provided responses and made revisions to the regs. Following a call with DPB on 1/7/22, DMAS responded to additional DPB questions on 1/18/22, 1/29/22, and 1/20/22. The project was sent to HHR on 1/21/22. The reg action was forwarded to the Gov. Ofc. on and approved on 9/21/22. The project was submitted to the Registrar on 9/21/22, published on 10/24/22 and the regs became effective date: on 12/8/22.

(09) DSH Changes for Children's Hospitals: DMAS seeks to create additional hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs, effective June 2, 2017. As part of this SPA, these new hospital supplemental payments, for freestanding children's hospitals, shall equal what would have been paid to the freestanding children's hospitals under the current disproportionate share hospital (DSH) formula without regard to the uncompensated care cost limit. These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional hospital supplemental payments authorized, accordingly. Following internal review, the DPB and Tribal notices for this SPA were submitted on 5/6/21. DPB approved the SPA on 5/10/21 and the project was submitted to HHR on 5/18/21. Following HHR approval on 5/20/21, the SPA was submitted to CMS on 6/7/21. Informal questions were received from CMS on 7/12/21 and responses were forwarded to CMS on 7/19/21. The SPA was approved by CMS on 8/24/21. The corresponding regulatory action was circulated for internal DMAS review and submitted to the OAG for review on 9/28/21. The OAG sent additional question on 10/7/21 (DMAS response provided on 10/12/21) and 10/12/21 (DMAS response provided on 10/13/21). These regulations are currently on hold.

(10) Clarifications for Durable Medical Equipment and Supplies – Revisions: This state plan amendment proposes to amend a previous SPA. DMAS previously submitted SPA 20-011 entitled "Clarifications for Durable Medical Equipment and Supplies" which was approved by CMS on October 20, 2020. Following the approval of SPA 20-011, CMS discovered duplicative wording and the necessity to re-categorize a heading on multiple pages, and also requested that DMAS submit a new SPA to revise the text on those pages. There is no change to the content or meaning of the state plan text as a result of the change. Following internal review, and the submission of the DPB and Tribal Programs notifications, the SPA was forwarded to HHR for review on 3/8/21. The SPA was approved by CMS on 5/24/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 8/26/21. The project was re-submitted to the OAG for review on 8/11/22.

(11) Adult Dental: The purpose of this SPA is to align with Item 313.IIII in the 2020 Virginia Appropriations Act, which requires DMAS to provide a comprehensive dental benefit to adults, effective July 1, 2021. The DPB and Tribal Programs notifications were forwarded on 2/22/21. The SPA was submitted to CMS on 3/25/21. The SPA was approved on 6/14/21, with effective date of 7/121. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 6/23/21.

2020 General Assembly

***(01) Preadmission Screening and Resident Review (PASRR) Update:** In responding to the legislative mandate of the General Assembly, the purpose of this regulatory action is to establish regulatory requirements for (i) allowing qualified nursing facility staff to complete the LTSS screening for an individual who applies for or requests LTSS, and who is receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital; and (ii) protecting an individual's choice for institutional or community based services and choice of provider. Following internal review, the project was submitted to the OAG for review on 1/5/21. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/14/21. Additional revisions were submitted on 4/28/21. The project was submitted to DPB for review on 6/16/21 and to HHR on 6/29/21. The regs were forwarded to the Governor on 11/20/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21; published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22.

***(02) 90-Day Prescriptions:** The recent Medicaid Disaster Relief SPA allowed DMAS to provide 90-day prescriptions to Medicaid members (excluding Schedule II drugs), however, that SPA will end on the last day of the federal-declared emergency period. DMAS is filing a SPA to allow for the provision of a maximum of a 90-day supply for select maintenance drugs dispensed to Medicaid members (excluding Schedule II drugs) after the end of the federal emergency period. The 90-day supply will be available to Medicaid members after the member has received two (2) fills of 34 days or less of the drug. Following internal review, the SPA was filed with CMS on 11/9/20 and approved on 12/10/20. Following internal review, the corresponding regulatory action was submitted to OAG on 1/28/21. Status inquiries were forwarded to the OAG on 7/1/21, 8/10/21, 8/24/21, 9/14/21, 1/25/22, 3/9/22, 4/13/22, and 7/12/22.

***(03) 2020 Long Term Services and Supports (LTSS) Screening Changes:** For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in accordance with 2020 HB/SB 902 to allow qualified nursing facility staff to complete the Long-Term Services and Supports (LTSS) screening for individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The amendments to the Code include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community based services. Following internal review, the regulations were submitted to the OAG for review on 11/18/20. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/1/21 and 4/14/21. DMAS submitted the project to DPB on 6/14/21. Questions were received on 6/21/21 and responses were sent to DPB on 6/21/21. A conf. call was held on 6/22/21 to discuss the project. The reg action was submitted to HHR on 6/23/21. The regs were forwarded to the Governor on 11/10/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21 (w/ corrections sent on 12/29/21); published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal DMAS review, the fast-track stage regs were submitted to OAG on 7/26/22. DMAS received comments from the OAG on 10/4/22. DMAS sent revisions to the OAG on 10/7/22. The project was

submitted to DPB on 10/13/22 and DMAS responded to DBP questions on 10/18/22 and made addl. revisions. A conference call with DPB was held on 11/7/22 to discuss the project. The reg action was submitted to HHR for review on 11/21/22.

(04) Update Average Commercial Rate (ACR) for Physicians Affiliated with Type One Hospitals: DMAS is required to recalculate the ACR every three years. The last ACR is dated April 1, 2017, and CMS requires DMAS to submit a new ACR calculation, effective April 1, 2020. After performing calculations based on data provided by Type One hospitals, DMAS determined that the ACR must be reduced from 258% of Medicare to 236% of Medicare. The DPB notification for this SPA was sent to DPB on 4/20/20. Following internal review, the SPA binder was forwarded to HHR for review on 5/20/20 and to CMS on 5/28/20. CMS approved the SPA on 7/31/20. Following internal review, the corresponding regulatory action was submitted to the OAG on 1/27/21. These regulations are currently on hold.

2017 General Assembly

***(01) 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 6/28/20. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21; to DPB on 12/6/21; to HHR on 1/19/22; and to the Governor's Ofc. on 6/1/22. Following approval from the Gov. Ofc., the project was submitted to the Registrar on 11/2/22 and was published in the Register on 12/5/22.

2015 General Assembly

(01) 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.

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.