



BOARD OF MEDICAL ASSISTANCE SERVICES



Wednesday, September 9, 2020
10:00 AM BMAS Meeting

Department of Medical Assistance Services
Virtual Via WebEx

Date of the Event	Link to Access the WebEx Event	Phone Bridge for Audio ONLY	Access Code for Audio ONLY
September 09, 2020 10:00am – 12:00pm	Click Here to Enter the Event	866-692-4530	171 181 9220

AGENDA

#	ITEM	PRESENTER
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- | | | |
|-----|--|---|
| 1. | Call to Order | |
| 2. | Approval of Minutes | |
| 3. | Director's Report | |
| | 3.A. Director's Report | Karen Kimsey, Director |
| 4. | Budget Update | |
| | 4.A. Budget Update | Chris Gordon, CFO |
| 5. | MCO Overview | |
| | 5.A. MCO Overview | Cheryl Roberts, Deputy Director of Programs
&
Tammy Whitlock, Deputy Director of Complex Care |
| 6. | Health Equity | |
| | 6.A. Health Equity | Corey Pleasants, Office of Chief of Staff
& Mariam Siddiqui, Director's Office |
| 7. | Regulation Update | |
| 8. | New Business/Old Business | |
| 9. | Public Comment | |
| 10. | Adjournment | |

Next BMAS Meeting scheduled for December 9, 2020

Questions or Comments: Board Secretary: Brooke Barlow
Brooke.barlow@dmas.virginia.gov

COVID-19 IN MEDICAID

Sept 9, 2020

Karen Kimsey

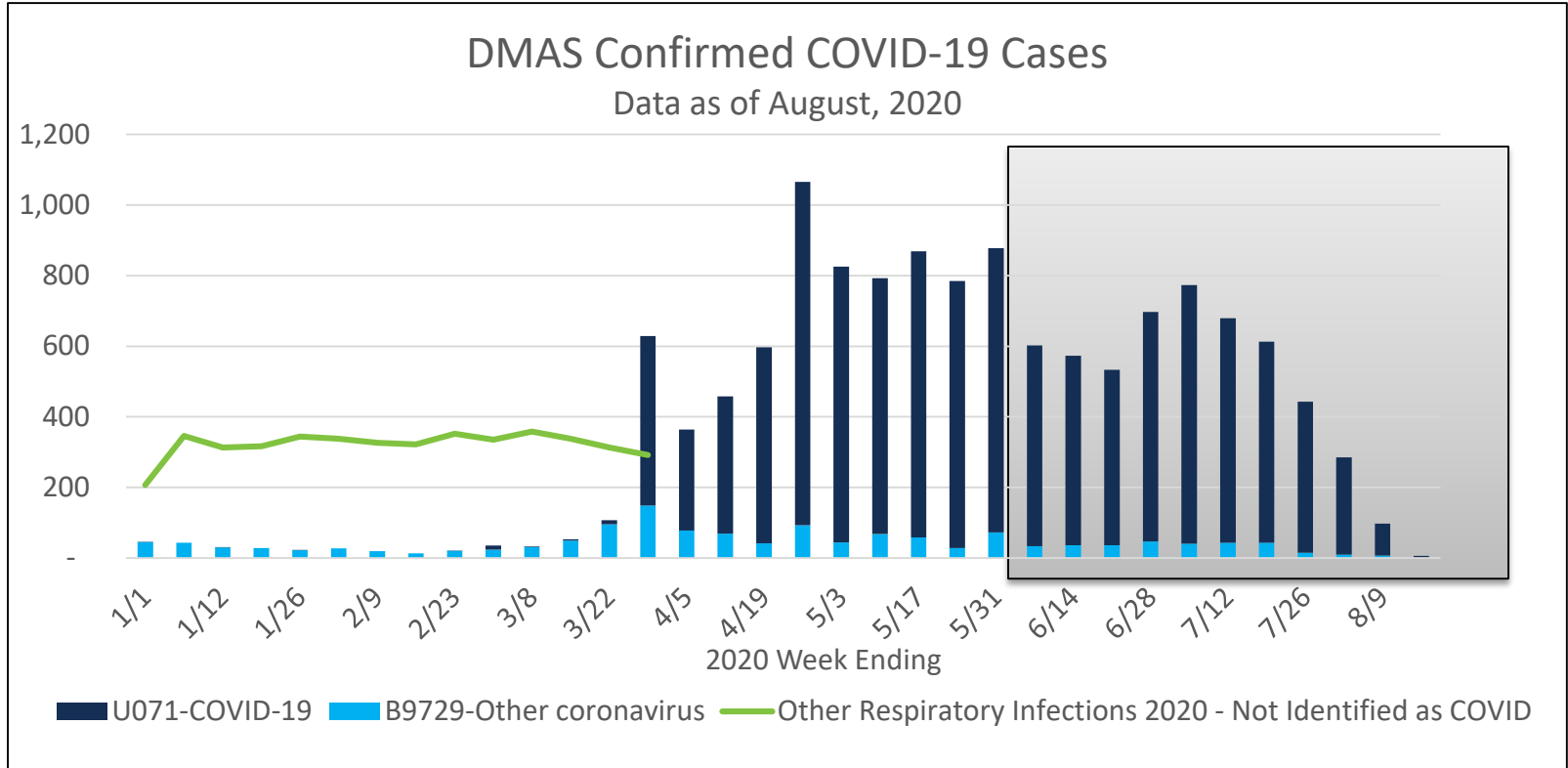
Director

Department of Medical Assistance
Services



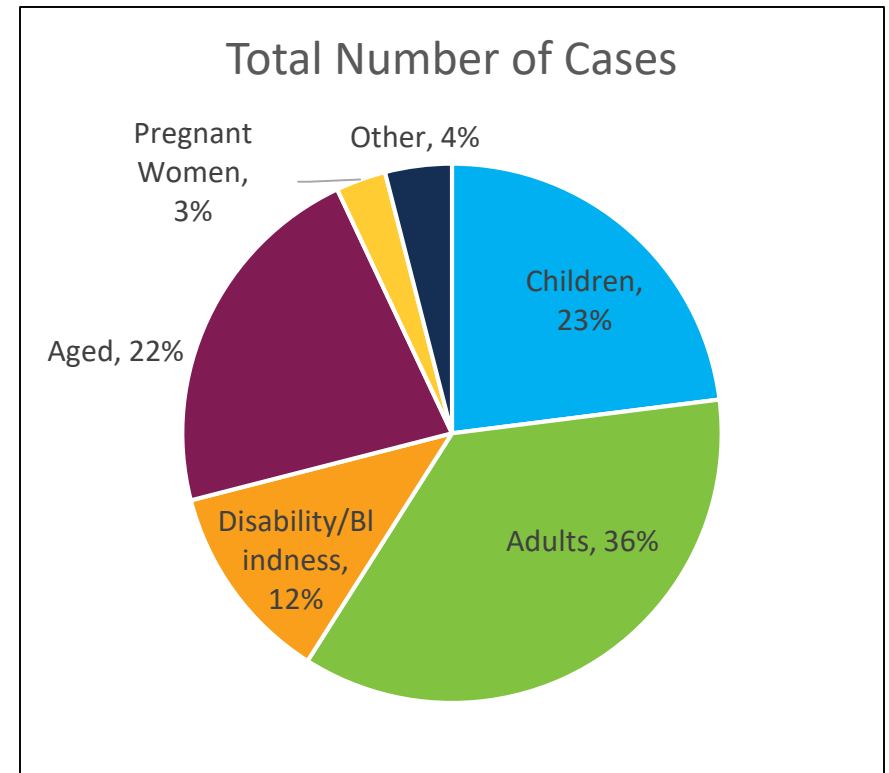
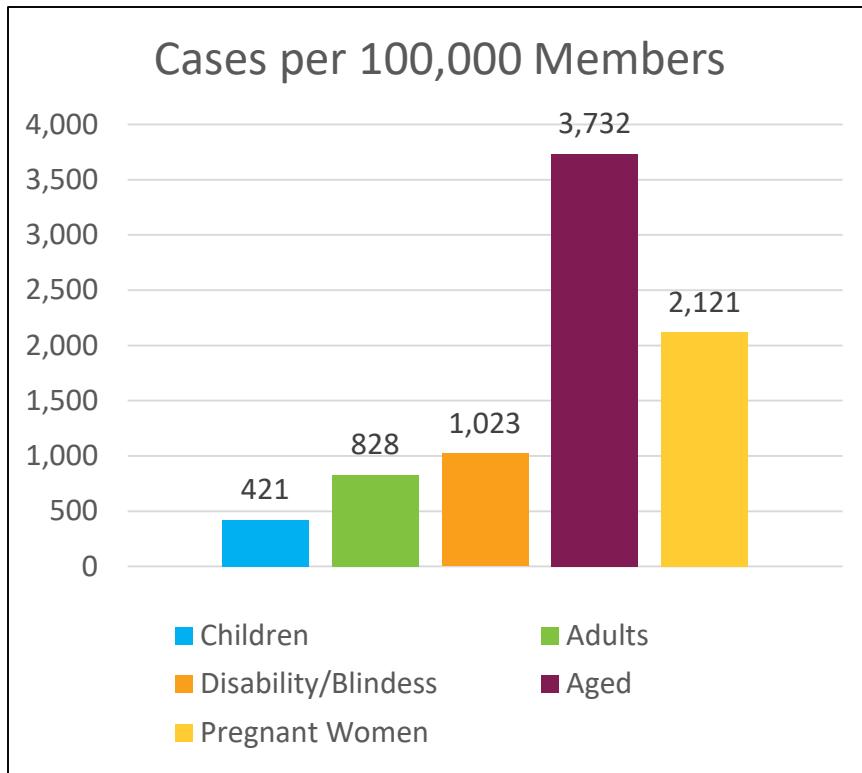
COVID-19 Cases in Medicaid

13,045 COVID-19 cases reported*
786 COVID-19 cases per 100,000 members*



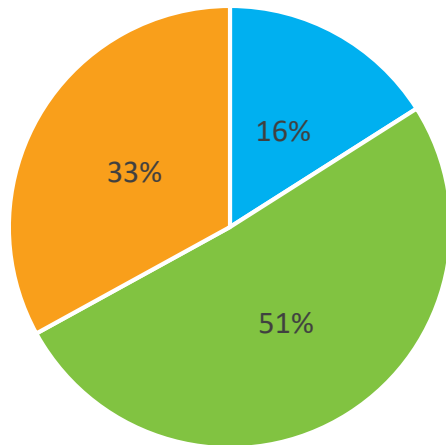
* Due to claims lag, we expect that claims for services in June, July, and August will continue to come in and add to member diagnoses in those months.

COVID-19 cases by population



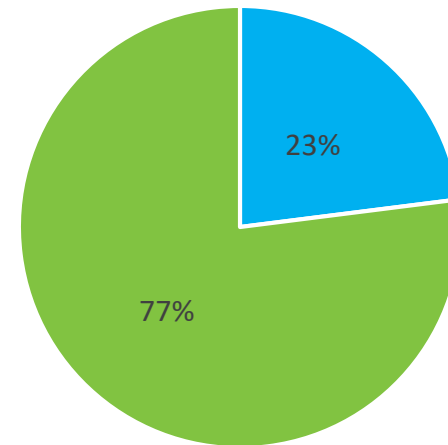
COVID cases by population

Delivery System



■ FFS ■ Med4 ■ CCCP

Nursing Facility



■ NF ■ Non-NF setting



BMAS DIRECTOR'S REPORT

***Karen Kimsey
Director***

June 10, 2020

Operation Homecoming

Phase 1: Monday January 4, 2021
COOP Location Transition

Phase 2: Monday February 1, 2021
Telework Adverse Functions

Phase 3: Monday February 8, 2021
Partial Workforce

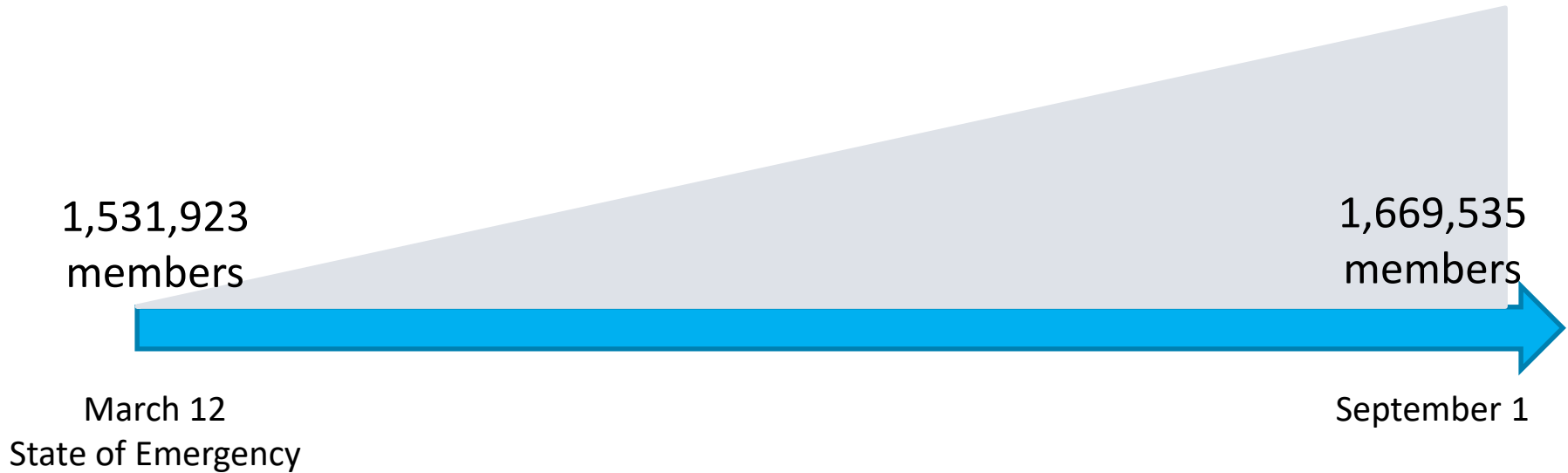
Phase 4 will be broken down as follows:

February 15th - Floors 1, 7, 8, 9

February 22nd - Floors 10, 11, 12

March 1st - Floors 1, 13, Remaining Staff

Medicaid Enrollment



- Since the State of Emergency was declared, Medicaid has gained **136,603 new members**
 - 65,595 are in Medicaid Expansion
 - 43,655 are children
- On average, Medicaid gains **4,800 new members each week**

Medicaid Enrollment

Eligibility Categories	
Grand Total	1,670,501
Children	724,400
Adults	581,928
Persons with a Disability or Blindness	150,122
Limited Benefit Individuals	112,963
Aged (65 or older)	79,336
Pregnant Women	21,752

**Data as of 8/31/2020*

The latest Medicaid and FAMIS enrollment data is available on our agency website: <https://www.dmas.virginia.gov/#/enrollmentdashboard>

Project Cardinal

DMAS has been directed by the GA to produce a plan for establishing a combined Medicaid managed care program

Strategic Planning,
Research and
Analysis

Overarching
Programmatic
Changes

Contract Analysis

Waiver Analysis

Regulatory Analysis

Organizational/
Staffing Changes

IT Systems Changes
Analysis

MCO Rate
Development and
Financial Analysis

Analysis of Other
Impacts (Vendors,
Processes, etc.)

Communications &
Stakeholder
Engagement Plan



FINANCE & TECHNOLOGY UPDATE

Presentation to:

Board of Medical Assistance Services

September 8, 2020





1. State Revenue & Impact on Budget
2. COVID19 Provider Payment Increases
3. FY21 Budget to Actuals

State Revenue & Impact on Budget

- **FY21 Revenue Shortfall:**
 - \$2.7 billion
- **GA2020 Special Session 1:**
 - No reductions to DMAS agency budget
 - Enhanced FMAP (6.2%)
 - FY20: \$337 million returned to state
 - FY21: MOE higher due to greater enrollment
 - Q1: \$128 million returned to state
 - Q2: \$114 million returned to state
 - Contingent on HHS declaration of public health emergency

COVID19 Provider Payment & Reimbursement

Long-term Services and Supports:

- A. Medicaid Nursing facilities \$20 Per Patient Day Surcharge(NF):
 - 1. March 12—June 30, 2020: funded by MCO underwriting gain
 - 2. July 1 through the end of EO 51: funded with standard FFP and general fund via FFS & capitation

- B. State CARES Act Funding for Licensed Nursing Facilities and Assisted Living Facilities:
 - 1. 100% CARES Act funds-must be spent by December 30, 2020
 - 2. Offers funding for COVID-19 expenses from July 1-October 31
 - 3. Covers expenses for All residents in All facilities
 - 4. Facilities must use other COVID-19 funding first (for example, Nursing Facilities have received \$153 million in CARES Act Provider Relief Funds and must use those funds first)
 - 5. Funding is capped but any unspent funds will be distributed proportionately to facilities with unreimbursed expenses

COVID19 Provider Payments

Other Medicaid Providers

A. Evaluation & Management Services:

- Payment: 29% increase in Medallion 4.0 (M4) program
- March 1—June 30, 2020
- Funded by MCO underwriting gain in M4

B. Adult Day Health Care:

- Payment: retainer, 65% of full rate
- March 12—July 31, 2020
- Funded:
 - FFS: unspent FY20 Medicaid funding
 - MCO: underwriting gain in CCC+

C. Day Support for DD Waiver:

- Payment: retainer, 65% of full rate
- March 12—July 31, 2020
- Funded: FFS only, unspent FY20 Medicaid funding

Other Payment Rate Increases

Other Medicaid Providers

A. FY21 Personal Care Rate Increase:

- Payment: 5% rate increase for all personal care attendants
- Funded with standard FFP and general funds via FFS & capitation

B. FY21 Annual Inflation Adjustments:

- Hospital payment: 2.4%
- Nursing facility payment: 4.1%
- Home health payment: 2.6%
- Outpatient rehab agencies payment: 2.8%
- Funded with standard FFP and general funds via FFS & capitation

FY21 Budget to Actuals

	Total Base + Expansion				
	FY 2021 Official Forecast	Funding Adjustments	FY 2021 Adjusted Budget	Expenditures through July FY2021	% Spent
Total Medicaid Expenditures	15,702,784,139	322,334,418	16,025,118,559	1,070,118,428	6.7%
Federal Funds	9,391,584,419	218,925,851	9,610,510,270	708,635,662	7.4%
Rate Assessment	477,145,058	-	477,145,058	-	0.0%
Coverage Assessment	372,401,159	1,153,211	373,554,370	29,878,630	8.0%
Virginia Health Care Fund	472,802,840	-	472,802,840	-	0.0%
State Funds	4,988,850,665	102,255,356	5,091,106,021	331,604,137	6.5%

BOARD OF MEDICAL ASSISTANCE SERVICES

MCO OVERVIEW

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

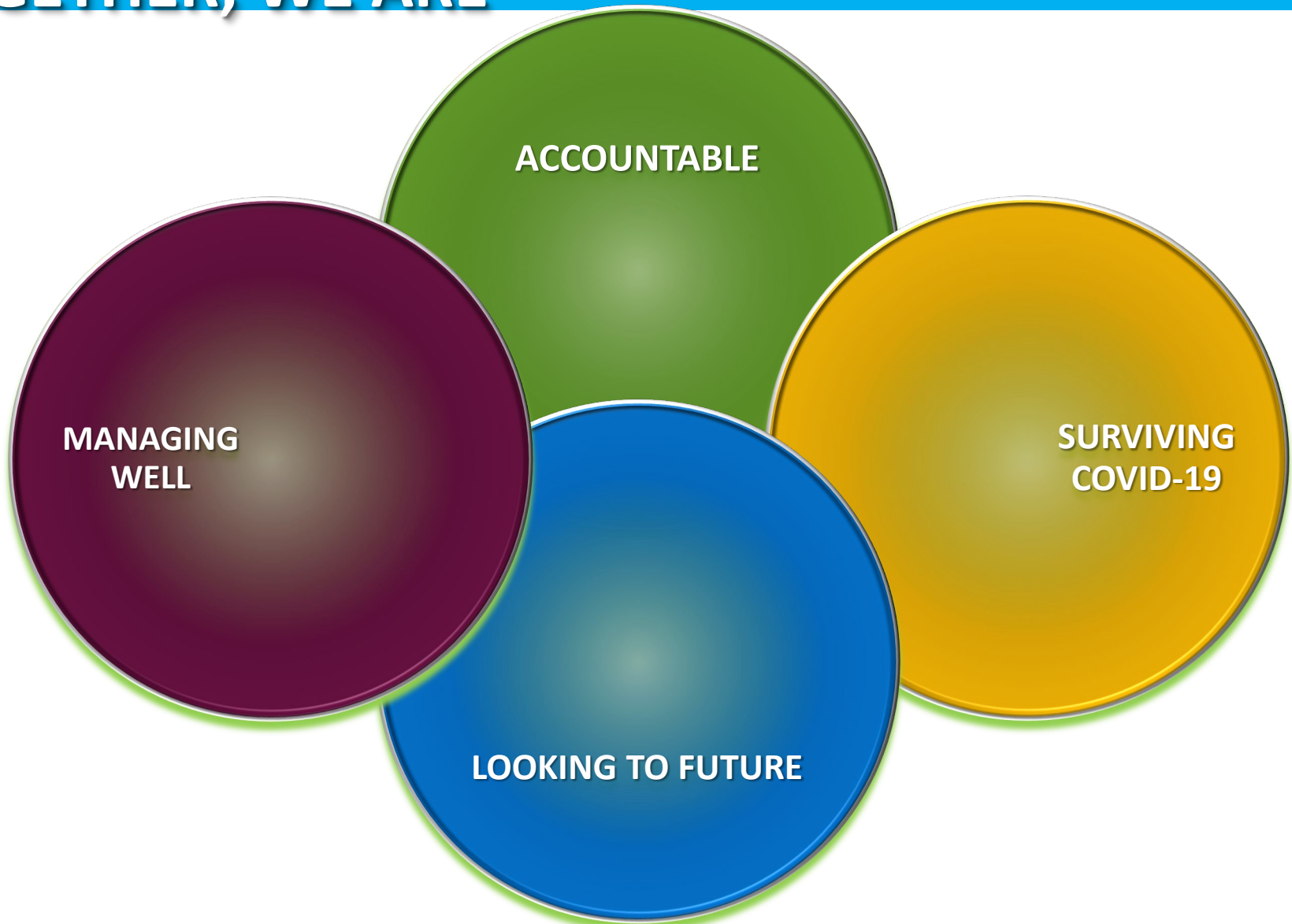
Tammy Whitlock, MSHA
***Deputy Director of
Complex Care***



AGENDA – PART I

- ❑ Managed Care Components
- ❑ Contract Cycle and Budgets
- ❑ COVID
- ❑ MCO Community Support During COVID

CCC PLUS AND MEDALLION 4.0: TOGETHER, WE ARE



MANAGED CARE PROGRAMS

90% of Medicaid members are now in managed care

Commonwealth Coordinated Care Plus (CCC Plus)

260,228 Members

Medallion 4.0

1,234,634 Members

Covered Groups



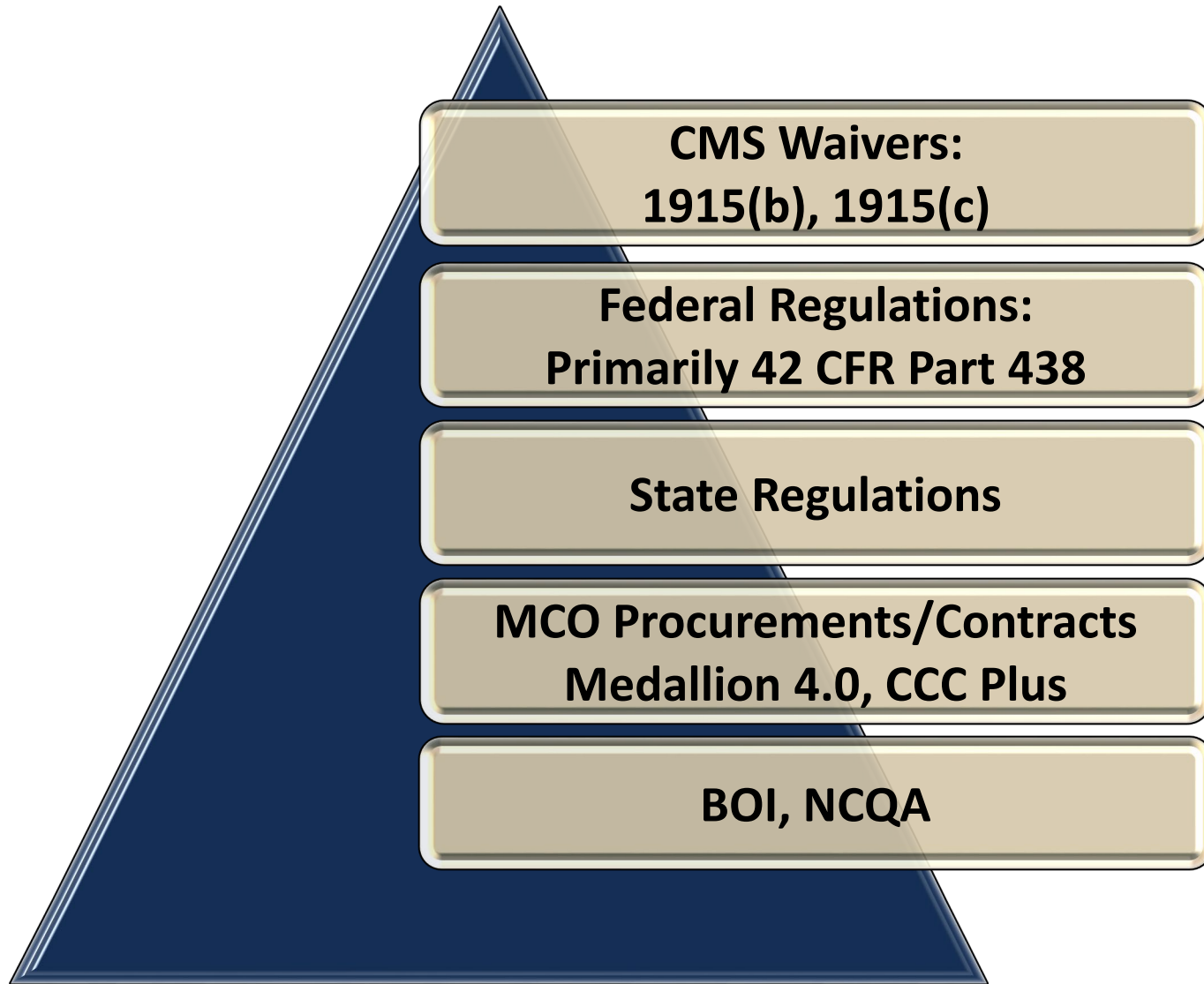
- Serving older adults, disabled children, disabled adults, medically complex newly eligible adults; includes individuals with Medicare and Medicaid (full-benefit duals)
- Serving infants, children, pregnant women, caretaker adults, and newly eligible adults

Covered Benefits

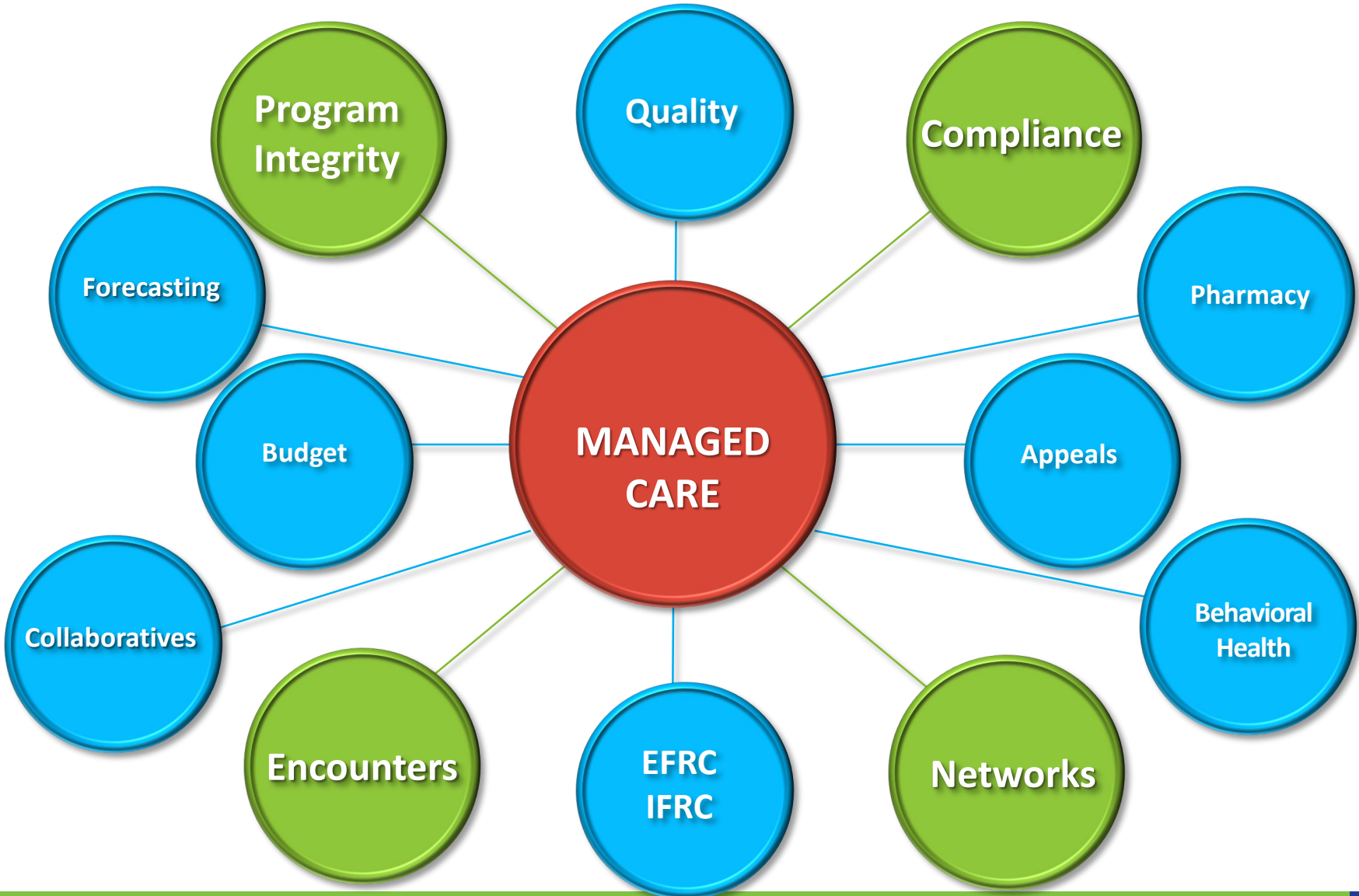


- Full continuum of services (same as Medallion), but also includes long-term services and supports (LTSS) in the community and in nursing facilities and hospice
- Births, vaccinations, well child visits, sick visits, acute care, pharmacy, ARTS, behavioral health services, including community mental health rehabilitation services; excludes LTSS

MANAGED CARE PROGRAM AUTHORITIES



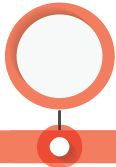
MANAGED CARE PROGRAM COMPONENTS



MEMBER INTERFACE WITH MANAGED CARE

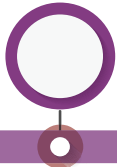


Medicaid Eligibility Determination



Welcome Letter

System generates a welcome letter to member indicating they may be enrolled into a health plan and provides options to find providers and choose a plan



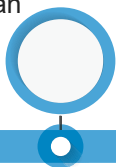
Assignment Letter

System generates a letter on 18th of month indicating the member's assigned health plan. Member has right to choose a different plan.



MCO Welcome Package

MCOs receive monthly enrollment file, makes calls, and sends welcome packages with ID cards to new members



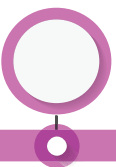
Member Assigned

Managed care enrollment always prospective and occurs on the 1st of month



Enrollment Broker

Member contacts enrollment broker to choose health plan and handle open enrollment changes
MED4 1-800-643-2273
<https://www.virginiamanagedcare.com>
CCCP 1-844-374-9159
<https://cccplusva.com/home>



Assessments/Screening

Health plans conduct health assessment to assist case managers in identifying member status and risk factors. Plans administer Member Health Screening to Medicaid Expansion members to determine medical complexity.



Program Specific Care Management

Includes face to face in CCC Plus. Care management also available to specific populations such as pregnant women and children with special health care needs.



Benefits

Optional services benefits and education including adult dental and vision, gym memberships, specialty programs, SDOH, etc.

VIRGINIA MANAGED CARE HEALTH PLANS

aetna[®]

Aetna Better Health[®] of Virginia

197,707 {CCCP=38,986/MED4=158,721}

OptimaHealth[®]

F a m i l y C a r e

288,070 {CCCP=43,034/MED4=245,036}



Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

455,180 {CCCP=73,640/MED4=381,540}



UnitedHealthcare[®]
Community Plan

151,296 {CCCP=30,578/MED4=120,718}

Magellan
COMPLETE CARE[®]

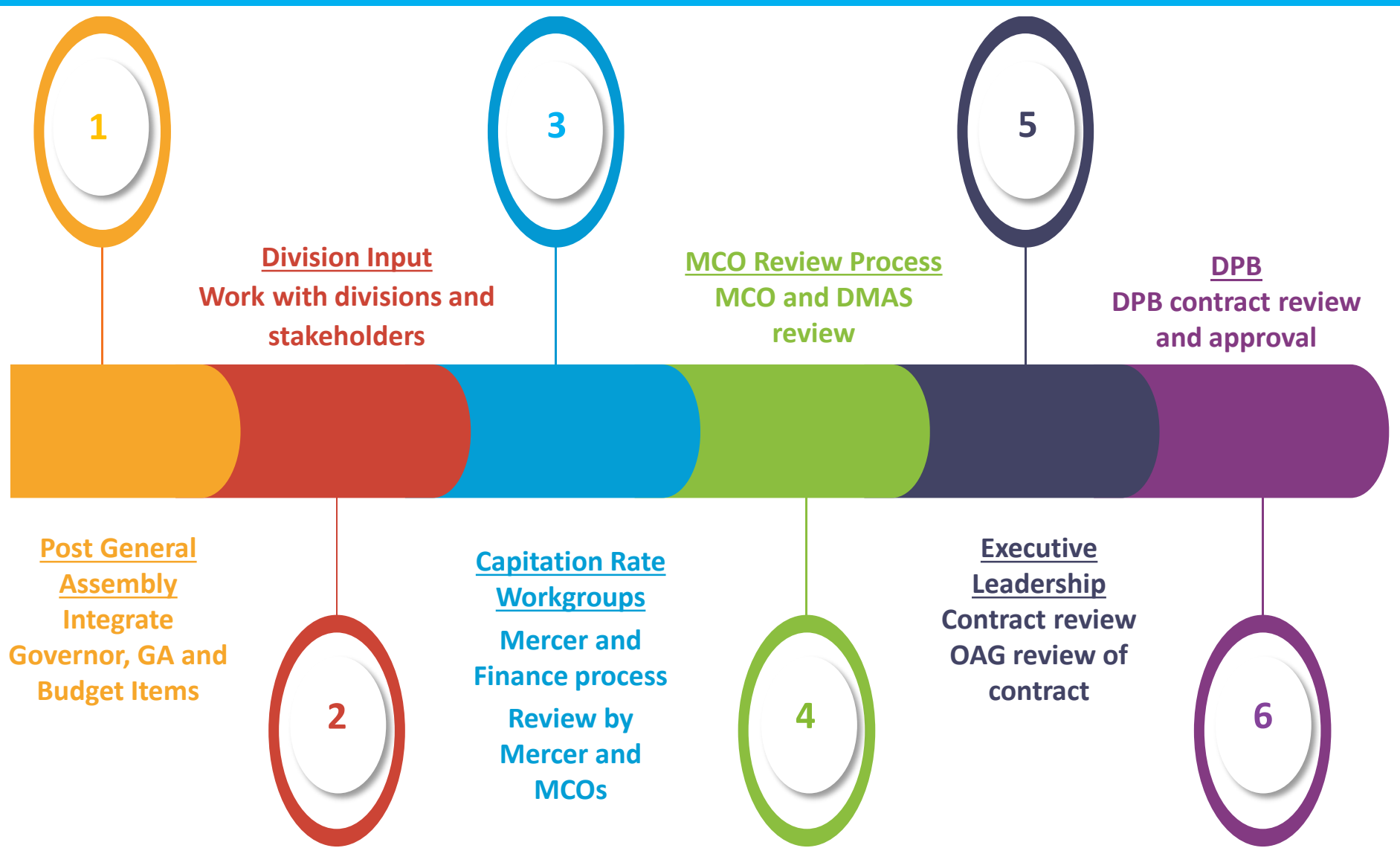
101,614 {CCCP=25,160/MED4=76,454}



VirginiaPremier[™]
Powered by VCU Health

300,995 {CCCP=48,830/MED4=252,165}

MCO CONTRACT AND RATE PROCESS CYCLE



MCO JULY 2020 CONTRACT CHANGES

- July 2020: the first time both Medallion 4.0 and CCC Plus are on the same contracting and rate cycle
- March-April: we followed the contract/rate cycle and the teams integrated the 2020 Governor, General Assembly bills, and Budget language into the contract and began rate meetings
- May 2020: the Governor unallotted funds that resulted in DMAS removing twelve (12) items from the MCO contracts that were previously approved in the 2020 session
- June 2020: the revised contract followed another cycle and were reviewed and approved by DPB
- The signed contract was submitted to CMS mid June
- July 2020: the following items remained in the contracts:

CONTRACT CHANGES THAT IMPACTED BOTH PROGRAMS

- Requirements to implement reimbursement reductions for hospital readmissions and preventable emergency room visits
- Prohibition on MCO Pharmacy Benefit Managers (PBMs) from spread-pricing
- Revised and added language related to mergers and acquisitions and significant operational changes
- Established payment targets for the total portion of medical spending covered under a value based payment arrangement
- Rewrote section regarding Emergency and Post-Stabilization to reflect current operational practices
- Clarified non-emergency transportation services and requirements to allow for Uber, LYFT, etc.
- General alignment between contracts

PROGRAM SPECIFIC CONTRACT CHANGES

CCC Plus

- Moved CCC Plus contracting from renewing on CY to SFY
- Rate increase for personal care, respite and companion services (approved by the budget)
- Named and clarified ongoing care coordination subpopulation groups (high-risk, moderate risk, etc.)
- Clarified MCO responsibilities with LTSS level of care review
- Allowed nursing facility staff to conduct LTSS level of care screenings

Medallion 4.0

- Made changes in the FAMIS coverage addendum to comply with mental health parity
- Removed FAMIS language and placed in an addendum to the contract
- Corrected section reference errors and improved readability

COVID CHANGES

- Transportation collaborative efforts and changes to meet the needs of the crisis
- Temporarily ceased provider enrollment and audit activities
- Created targeted outreach effort for pregnant women
- Medallion 4.0: primary care provider increase in payments by 29% for E&M codes rendered between March 1, 2020 and June 30, 2020
- Increased meetings with MCO Leadership – meet at least week and held plan specific quarterly meetings

MCO COMMUNITY SUPPORT DURING COVID

- Virtual baby showers - “What to expect when you are expecting during a pandemic”
- COVID-19 Social Posts - COVID-19 Myth Buster Mondays, COVID-19 coverage updates
- #BeSafeBeWell - Campaign promoting it is safe to return to in-person care
- “Contactless” Food Drive - benefitting the Foodbank of Southeastern Virginia and the Eastern Shore
- Virtual population health events to continue closing care gaps and provide needed care
- Delivery of diapers, urgently needed in areas without diaper banks or closed resources
- Delivery of Pak n Play to member with no safe sleep space for newborn
- Provided car seats so members can bring babies home from the hospital
- Facilitated approval and delivery for blood pressure monitors for telehealth visits

MCO COMMUNITY SUPPORT DURING COVID

- Financial donations to various community organizations
- Provided 8,000 bags to food banks that had no bags or boxes for distribution
- Food delivery to member homes practicing social distancing when they had no transportation to get to food banks
- Chromebooks to youth in foster care transitioning out due to age
- Gathering donations from CVS to distribute
- Assistance to access local resources for housing, food, transportation, applying for unemployment and Virginia rent and mortgage relief programs
- Deployed a COVID-19 symptom tracker
- Provided volunteer support, food, funding and school supplies in Roanoke, Central & Tidewater regions

MEMBER STORY

Dennis-Anthem in Action-HealthKeepers Plus



Dennis

Anthem Healthkeepers Plus Member

AGENDA

- ❑ Waiver Operations Flexibilities
- ❑ Behavioral Health Updates
- ❑ Personal Protective Equipment
- ❑ Retainer Payments
- ❑ Dual Special Needs Plans
- ❑ Project Cardinal Timeline

FEDERAL AUTHORITY: 1135 WAIVER

The emergency 1135 waiver grants flexibilities for ensuring access to care for Medicaid members and supports for providers

The August 5, 2020 Medicaid Memo describes the extension of specific flexibilities through October 22, 2020

ACCESS TO LONG-TERM SERVICES AND SUPPORTS

1135 Waiver



Individuals who choose to move to a nursing facility directly from a hospital may be accepted without a long-term services and supports screening.



The Pre-Admission Screening and Resident Review (PASSR), Level One and Level Two, must be conducted within 30 days of admission.

NURSING FACILITIES

1135 Waiver

- Minimum Data Set (MDS) Assessments for new admissions may be completed in 30 days (instead of 14 days)
- Nursing facilities may temporarily employ individuals, who are not certified nurse aides, to perform the duties of a nurse aide for more than four months, on a full-time basis if they can demonstrate necessary skills and techniques

LTSS PROVIDER FLEXIBILITIES

1135 Waiver

- Waive in-person supervision by a registered nurse every two weeks for Home Health and waive 14 day in-person supervision for hospice (telephonic supervision is encouraged)
- Home health agencies may perform certifications, initial assessments, and determine a patient's homebound status remotely by telephone or via video communication in lieu of a face-to-face visit

DURABLE MEDICAL EQUIPMENT (DME)

1135 Waiver

- DME providers may deliver up to a 1-month supply at a time
- DMAS will allow National Coalition for Assistive and Rehab Technology (NCART) recommendations for remote protocol, for complex rehab equipment
- Telehealth visits are allowed for therapy evaluations unless it is determined a face-to-face evaluation is warranted
- Face-to-face requirement for authorization of durable medical equipment for specific codes are waived
- DMAS will allow temporary coverage for short-term oxygen use for specified acute conditions

CERTIFICATE OF MEDICAL NECESSITY (CMN)

1135 Waiver

- Temporary extension of current CMNs until the end of the state of emergency
- Temporary suspension of the requirement for a CMN for new orders (effective April 13, 2020)
- The DME provider must have a written, faxed, emailed or verbal order from the practitioner that includes the members name, item(s) being ordered and a diagnosis

FEDERAL AUTHORITY: 1915C WAIVER APPENDIX K

Per Medicaid Memo 08/11/20, extended through 01/26/21



Impacts Developmental Disabilities waivers and CCC Plus waiver

Affords opportunities to **modify waiver operations** during a state emergency

The flexibilities help to **sustain current systems and supports** for members during an emergency

FLEXIBILITY FOR FAMILIES

Appendix K

DMAS is temporarily allowing spouses and parents of Medicaid members under age 18 to provide personal care services and be paid for those services under these waivers

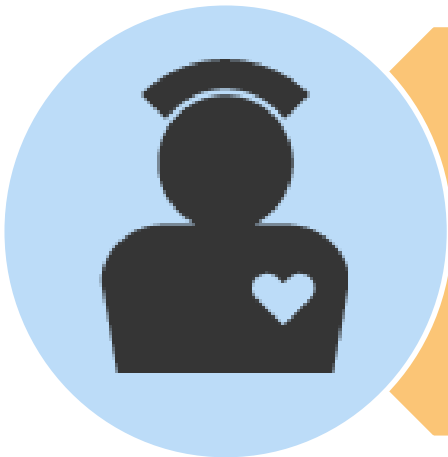


FACE-TO-FACE MEETINGS

Appendix K



Allow specific visits for assessments, planning meetings and evaluations to be conducted by video-conferencing or telephone instead of face-to-face



Allow care coordination and case management to be provided by telephone/video-conferencing remotely in the home setting

TELEHEALTH SERVICE DELIVERY

Appendix K



Therapeutic Consultation activities that do not require direct intervention by the behaviorist can be conducted through telephonic/video-conferencing methods

TELEHEALTH SERVICE DELIVERY

Appendix K

New service authorizations for services conducted through video-conference or telephone will be considered for in home support, community engagement and community coaching beginning August 15, 2020

- Prior to August 15, 2020 only service authorizations in place on March 12, 2020 were allowed to deliver services via telehealth during the pandemic
- Authorizations will only be approved through October 31, 2020

BEHAVIORAL HEALTH UPDATES

- As of July 1st, 2020 DMAS resumed reimbursement for face-to-face delivery of group-based services
- DMAS advised that providers carefully weigh the vulnerabilities and benefits of resuming face-to-face group services
- Group-based providers were reminded that they retain, until further notice, the ability to offer services individually or through individual or group tele-health or telephonic contact
- Providers were encouraged to prioritize the health and safety of members and their staff and to consider member preferences, engagement and optimal access to care

BEHAVIORAL HEALTH RESOURCES FOR MEMBERS

The COVID-19 pandemic, resulting economic downturn and racial injustices have negatively affected many people's mental health and created new barriers for people already suffering from mental illness and substance use disorders.

In a recent KFF poll, nearly half (45%) of adults in the United States reported that their mental health has been negatively impacted due to worry and stress over recent events.

<https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

Behavioral Health Resources for Medicaid Members



HEALTH CARE COVERAGE INFORMATION

Medicaid members can learn more about available health services by calling the member benefits number on the back of their insurance card for their managed care organization (Aetna, Anthem, Magellan, Optima Health, United Healthcare, and Virginia Premier). Examples of what the cards look like: [https://www.dmas.virginia.gov/files/links/2541/Member%20ID%20Cards%20by%20Plan%20\(07.31.2018\).pdf](https://www.dmas.virginia.gov/files/links/2541/Member%20ID%20Cards%20by%20Plan%20(07.31.2018).pdf)

NATIONAL BEHAVIORAL HEALTH RESOURCES

National Suicide Prevention Lifeline provides 24/7, free and confidential support for people in distress. Call 1-800-273-TALK <https://suicidepreventionlifeline.org/help-yourself/>

National Disaster Distress Helpline offers 24/7 emotional support and the opportunity to speak with a trusted health care provider about medical concerns. 1-800-985-5990 or text TalkWithUs to 66746

Vibrant Emotional Health Safe Space provides crisis support by chat and phone, coping tools and distraction exercises. https://vibrant.org/safespace?_ga=2.152460537.1336160752.1585580512-1385357376.1585580512

National Child Traumatic Stress Network has a guide for families for coping during COVID-19. https://www.nctsn.org/sites/default/files/resources/fact-sheet/outbreak_factsheet_1.pdf

Mental Health America provides a variety of resources related to coping tools, mental health information and financial support information. Visit <https://mhanational.org/covid19>

Teenline offers peer-based support for teens (currently only chat and email options are available). Text TEEN to 839863 or chat online at <https://teenlineonline.org/>

The Trevor Project offers crisis support specifically for LGBTQ Youth. Call 1-866-488-7386, Text START to 678678 or visit <https://www.thetrevorproject.org/> for live chat.

Veteran's Crisis Line is available 24/7 for all veterans, service members, National Guard and Reserve and ANY family members and friends.

- Call 1-800-273-8255 and Press 1 or Text 838255
- For those who are deaf or hard of hearing, call 1-800-799-4889
- Chat online at the website <https://www.veteranscrisisline.net/>

Updated 4/7/2020

TELEHEALTH FLEXIBILITIES INCREASING ACCESS TO SUBSTANCE USE DISORDER TREATMENT

Intensive outpatient restrictions loosened, allowing for addiction telehealth therapy

"I think sometimes it makes it even a little easier to talk cause we are still face to face, but there's that one layer of removal it seems," ... "It's almost like internet anonymity."



<https://www.wdbj7.com/content/news/DMAS-loosens-intensive-out-patient-restrictions-allowing-for-addiction-telehealth-therapy-569433421.html>

PERSONAL PROTECTIVE EQUIPMENT

- In July and August DMAS distributed a one time supply of 120,000 cloth masks by mail to Medicaid members who receive consumer-directed services
- In September, Employers of Record will be able to order monthly supplies of disposable masks, hand sanitizer and gloves at no cost through an online system developed with CARES Act funding
- DMAS is working with the Virginia Industries for the Blind (VIB) and a private company to supply over 18,000,000 nitrile gloves, 5,500,000 disposable masks, and hand sanitizer to Employers of Record - all products are scheduled to be available on September 18



RETAINER PAYMENTS

- DMAS provided retainer payments for Adult Day Health Centers (ADHC) and Day Support (DS) providers
- The effective dates of the payments was March 13, 2020 – July 31, 2020

MILESTONES:

- ADHC provider billed retainer payments in the amount of \$2,307,770.12 to date
- DS providers billed retainer payments in the amount of \$20,634,152.25 to date

CMS released FAQs on retainer payments on June 30, 2020

DMAS may have to amend retainer payment structures to align with the CMS interpretation

DUAL SPECIAL NEEDS PLAN (DSNP) ENROLLMENT

- As of August 1, 2020 there are just under 40,000 DSNP enrollees - increase of roughly 13,500, or 34%, over the same time last year
- 65% of all enrollees have “aligned” their enrollment
- Aligned enrollment means enrolling in the same health plans for DSNP and CCC Plus
- Aligning ones health plan reduces fragmentation and eases the burden of navigating dissimilar systems
- Enrollees in aligned Medicare-Medicaid plans tend to have higher satisfaction rates and better health outcomes

DSNP DEFAULT ENROLLMENT

- Allows health plans to automatically enroll CCC Plus members that will soon become eligible for Medicare into the health plans accompanying DSNP
- Designed to increase aligned enrollment
- All six CCC Plus/DSNPs are approved by CMS for default enrollment
- Very early in implementation, as of August 1, roughly 1,100 members were default enrolled with an opt-out rate of 4.5%

DSNP CY 2021 CHANGES: FIDE SNP

- Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are a type of DSNP that are designed to promote integration and coordination of Medicare and Medicaid benefits for dual eligible beneficiaries by a single health plan
- Due to timing of the budget approval, COVID-19 and the CMS filing process, DMAS allowed an exception for CY 2021
- Of the six health plans, two will offer FIDEs while the other four are targeting CY 2022
- Requested budget approval for FIDE SNPs and exclusively aligned enrollment - was approved for FIDE but not exclusively aligned enrollment

NEXT STEPS



PROJECT CARDINAL TIMELINE

Nov 15, 2020
Report Due to
General Assembly

Implement
Project Cardinal
Plan

July 1, 2022
Merged Contract

Regulatory Activity Summary September 9, 2020
(* Indicates Recent Activity)

2020 General Assembly

***(01) 2020 Provider Reimbursement Changes:** This regulatory action implements three mandates from the 2020 General Assembly. These relate to specialized care operating rates, personal care rates, and a supplemental DSH payment for non-state government public acute care hospitals. Following internal review, which began on 6/22/20, the regs were submitted to the OAG for review on 8/26/20. The corresponding State Plan Amendment (SPA) is currently circulating for review.

***(02) Update of Dental Fee Schedule:** The purpose of this state plan amendment, as it relates to reimbursement of dental services, is to reflect the inclusion of updated dental procedure codes in the agency fee schedule. Following internal review, HHR approved the SPA on 7/16/20. The SPA was submitted to CMS for review on 7/27/20.

***(03) 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. The SPA is currently circulating for internal review.

***(04) 2020 Program of All-Inclusive Care for the Elderly (PACE) Changes:** These regulatory amendments are being made pursuant to HB/SB902, passed by the 2020 General Assembly, which make the following changes to § 32.1-330.3 of the Code of Virginia: (1) remove the definition of and references to Pre-PACE; (2) update references to the U.S. Health Care Financing Administration with references to the Centers for Medicare and Medicaid Services; and (3) change “preadmission screening” to “long term services and supports screening.” The final exempt regulations are currently circulating for internal review.

***(05) 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. This regulatory action is currently circulating for internal review.

***(06) Recovery Audit Contractor – Exemption:** This SPA seeks to request an exemption from CMS mandated RAC requirements. Section 1902(a)(42)(8) of the Social Security Act requires DMAS to have a Medicaid RAC program. However, 42 CFR §455.51 allows DMAS

to file a request for an exemption to the RAC requirements, by submitting a written justification to CMS through the SPA process. In 2016, DMAS requested and received a temporary exemption from the RAC program, while research was conducted to procure a new RAC vendor. Since that time, DMAS has transitioned to a 90% managed care program environment, such that the claims-eligible RAC review was rendered largely obsolete. A search to secure a vendor to operate an efficient RAC program, in this new environment, proved unviable. A new vendor would entail additional state funding, in conjunction with the RAC contingency fee, and represents an impractical scenario for Virginia Medicaid. The DPB notification for this SPA was sent to DPB on 12/30/19. Following internal review, the SPA binder was forwarded to HHR for review on 4/29/20. HHR approved the SPA on 5/27/20 and the package was submitted to CMS on 5/28/20 for review. CMS approved the SPA on 6/12/20.

(07) Update of the DMAS-225 Form: This reg project is designed to clarify that the DMAS-122 Form (Adjustment Process) has been updated and re-numbered as the DMAS-225 Form (Long-Term Care Communication) in the regulations. This action conforms with current DMAS practice, as the DMAS-225 is currently in use to administer payments and adjustments. The DMAS-122 is no longer in use. Two definitions and multiple regulatory references to the DMAS-122 form are being updated to reflect that the form is now the DMAS-225 form. Following internal review, the regulatory action was submitted to the OAG on 2/10/20 for review.

***(08) 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.

***(09) Hospital and ER Changes:** The purpose of this SPA is to comply with multiple mandates. Pursuant to the General Assembly mandate in bill HB30, Item 313.AAAAAA, DMAS will amend the State Plan to allow the pending, reviewing, and the reducing of fees for avoidable emergency room (ER) claims for codes 99282, 99283, and 99284, both physician and facility. (Managed Care Organizations are authorized by waivers rather than the state plan, and MCO changes related to ER claims paid by will not be part of the SPA.) Also, pursuant to the General Assembly mandate in bill HB30, Item 313.BBBBBB, DMAS will amend the State Plan to modify the definition of readmissions to include cases when patients are readmitted to a hospital for the same or similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice. If the patient is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at 50 percent of the normal rate, except that a readmission within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. The SPA DPB notification was forwarded to DPB and the PPN was posted to the Town Hall on 5/19/20. Tribal notice for this SPA was sent on 5/28/20. DMAS fielded questions from

CMS on a conf. call on 6/8/20. The SPA is undergoing internal review to address CMS' questions. The corresponding regulatory project is circulating for internal DMAS review as well

***(10) Home Health Changes Due to Federal Regulatory Change:** DMAS intends to file a SPA with CMS in order to comply with new federal regulations that allow nurse practitioners, clinical nurse specialists, and physician assistants to order and certify home health services. (Previously, only physicians could order or certify these services.) CMS amended its regulations for Home Health on May 8, 2020 (in 85 Federal Register 27626) to allow practitioners other than physicians to order and certify home health services. DMAS is amending the state plan in order to comply with the new federal requirements. Following internal DMAS review, the DPB SPA notification and tribal notification letters were submitted on 7/16/20. The SPA was sent to CMS on 8/17/20. The corresponding reg package, following internal DMAS review, was submitted to the OAG on 6/22/20. Following approval, the regs were sent to the Registrar, with an effective date of 8/19/20.

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 was circulated for internal review on 10/30/19 and forwarded to the OAG for review on 1/16/20. Following a conf. call with the OAG on 6/2/20, DMAS submitted the requested edits on 6/26/20, and the reg action was approved by the OAG on 7/15/20. The regs were submitted to the Registrar on 7/16/20 for the 8/17/20 Issue, with an effective date of 9/16/20.

(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; forwarded to CMS on 11/1/19; and approved by CMS on 1/3/20. The corresponding regulatory action began circulating for internal review on 1/8/20. The regs were forwarded to DPB on 3/11/20 and submitted to HHR on 4/17/20.

***(03) 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. CMS approved the SPA on 3/12/20. The corresponding reg docs are currently circulating for internal review.

***(04) 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. Following internal review, the SPA was forwarded to HHR on 12/10/19; submitted to CMS on 12/17/19; and CMS approved the SPA on 3/4/2020. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 8/13/20.

(05) 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. Following internal DMAS review, the project was submitted to the OAG on 12/30/19.

(06) Incontinence Supplies: The 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 SPA was approved by CMS on 11/5/19. 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; the regs were certified by the OAG on 12/30/19; and then forwarded to DPB on 1/7/20. The project was sent to HHR on 2/13/20. DMAS is awaiting further direction.

(07) 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. Following internal review, the SPA was sent to CMS on 11/1/19 for review and approved by CMS on 11/26/19. The corresponding regulatory action circulated for review on 1/7/20 and was submitted to the OAG on 2/25/20, and certified on 3/30/20. The project was submitted to DPB on 3/31/20 and forwarded to HHR on 5/4/20.

(08) 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. The regs were submitted to the Registrar on 12/18/19; published in the Register on 1/20/20; and became final on 3/5/20. The corresponding SPA began circulating for internal review on 4/28/20.

(09) 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. The project was submitted to DPB on 12/12/19 and forwarded to HHR on 1/21/2020.

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; sent to HHR on 12/12/19; and forwarded to the Governor on 3/24/20.

(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) 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. DMAS requested an ER extension on 2/19/20 that will expire on 9/17/21.

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

***(05) 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. The Gov. Ofc. approved the regs on 8/12/20. The regulatory action was submitted to the Registrar on 8/20/20, with an Issue date of 9/14/20. The comment period will end on 10/15/20, with an effective date of 10/30/20.

***(06) 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. The Gov. Ofc. completed its review on 12/17/19. The project was submitted to the Registrar on 12/18/19, with a publication date of 1/20/20. The 60-day public comment period expired on 3/21/20. The Town Hall proposed stage comment review was complete/categorized on 4/10/20 and a notification e-mail was submitted to commenters. The final stage phase of the reg action is currently under internal review. The SPA DBP notification was submitted to DPB on 11/4/19. Following internal review, the SPA was submitted to HHR on 3/2/20 and HHR approval was received on 3/26/20. The Tribal notification was sent on 6/11/20. The SPA was submitted to CMS for review on 9/1/20.

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 6/28/20.

***(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. The reg action was approved by the Gov. on 12/09/19, with a 30-day public comment that expired on 2/06/20. The regs became effective on 2/21/20. The corresponding SPA began circulating for internal review on 5/27/20. After HHR approval on 7/22/20, the SPA was submitted to CMS on 7/27/20. Following a conf. call with CMS on 8/3/20, DMAS is coordinating responses to additional CMS inquiries.

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. The project was submitted to DPB on 1/7/20 and forwarded to HHR for review on 1/27/20. DMAS is awaiting a response.

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. DMAS held a meeting with the OAG on 10/15/19 to discuss the project and is awaiting additional feedback.

(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.