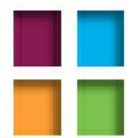


BOARD OF MEDICAL ASSISTANCE SERVICES

Wednesday, June 9, 2021
10:00 AM BMAS Meeting

Department of Medical Assistance Services
VIRTUAL VIA WEBEX

DRAFT AGENDA

#	ITEM	PRESENTER
1.	Call to Order	
2.	Approval of Minutes	
3.	Director's Report	
	3.A. Director's Report	Karen Kimsey, Director
4.	Bylaws	
	4.A. Presentation of Current Bylaws and Introduction of any additions	Karen Kimsey, Director
5.	Vaccinations	
	5.A. Vaccinations	Tammy Whitlock, Deputy Director of Complex Care Services
6.	Dental Update	
	6.A. Dental Update	Cheryl Roberts, Deputy Director of Programs
7.	American Rescue Plan Act of 2021 (ARPA)	
	7.A. American Rescue Plan Act of 2021 (ARPA)	Brian McCormick, Division Director, Constituent, Legislative & Intergovernmental Affairs
8.	New Business/Old Business	
9.	Adjournment	

BMAS
DIRECTOR'S REPORT

Karen Kimsey

Director

June 9, 2021

- Enrollment update
- COVID-19 vaccine information
- Project Cardinal status
- Operation Homecoming

Agency Priorities

COVID-19

Behavioral Health

Maternal & Child Health

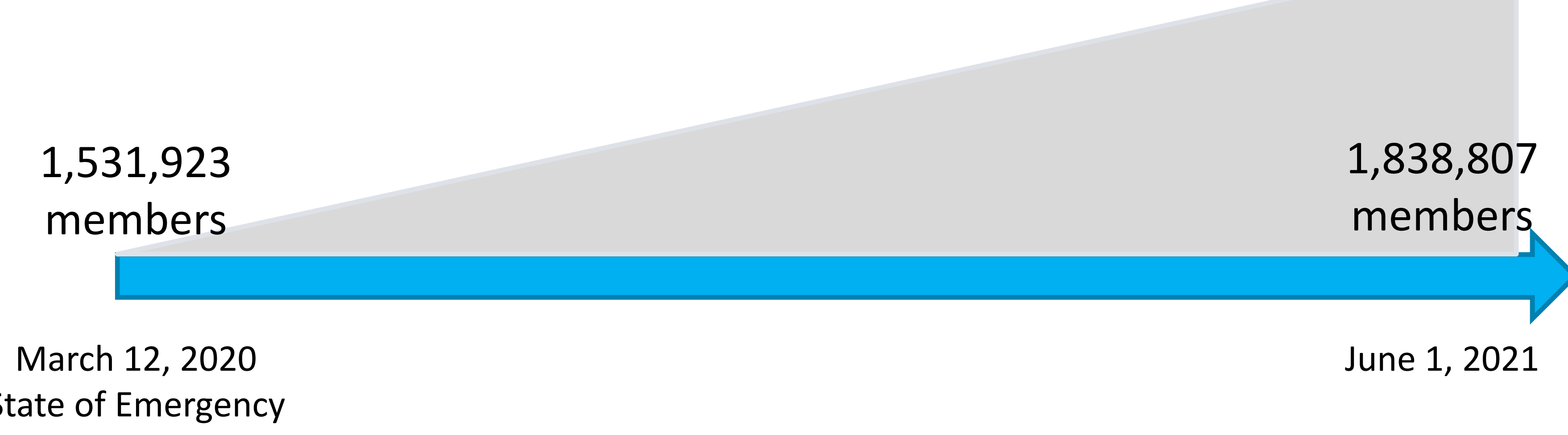
Health Equity

Adult Dental

Access to Care

Value of Medicaid

Medicaid Enrollment - Update



- Since the State of Emergency was declared, Medicaid has gained **305,102 new members**
  - 162,252 are in Medicaid Expansion
  - 92,460 are children
- Medicaid gained more than 1,400 new members this week

Vaccination Efforts

Flying Squirrels game

SUNDAY, JUNE 13, 2021

MEET US AT THE FLYING SQUIRRELS GAME!

Join Virginia Medicaid at this special game thanking our first responders and sign up for a COVID-19 vaccine!

Find a vaccine: vaccinate.virginia.gov
Flying Squirrels tickets: milb.com/richmond

Vaccination Efforts

Video series

- https://youtu.be/PGC5JJOEiyg

Project Cardinal Status and Timeline

July – Nov 2020
****Building the nest****

Convened initial work groups to develop high-level implementation plan and report for the General Assembly: https://rga.lis.virginia.gov/Published/2020/RD567/PDF

Nov 2020 – Feb 2021
****Baby birds!****

Pre-implementation phase:

- Contract alignment work begins
- Convening key work groups
- Rebranding planning work commences
- Calls with other states to gather best practices

Feb – June 2021
****Leaving the nest****

Implementation planning phase:
Hiring Contractor to:

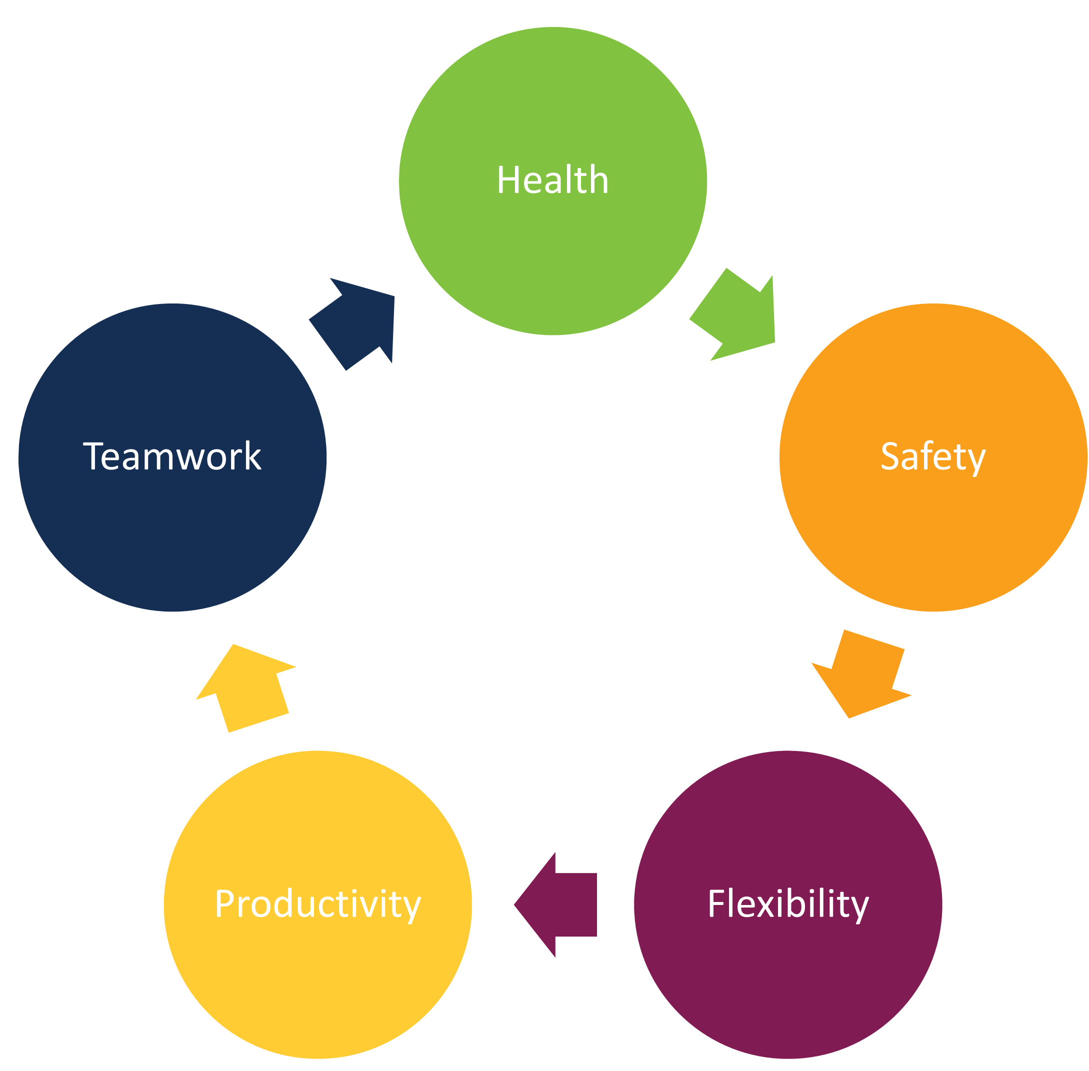
- Provide project management and strategic guidance,
- Incorporate federal regulations/ guidance,
- Leverage federal flexibilities and national best practices,
- Facilitate stakeholder design sessions
- Drive the Commonwealth's priorities to improve access, quality, and efficiency,
- Strengthen organizationall infrastructure for improved monitoring, oversight, and transparency

Contract to be finalized and signed this week.

June 2021 –July 2022
****Taking flight****

Project in full implementation mode, including stakeholder engagement, for July 1, 2022 implementation date

Operation Homecoming



BOARD OF MEDICAL ASSISTANCE SERVICES

BYLAWS

ARTICLE I

Board Structure

1.1 Name - This body shall be known as the State Board of Medical Assistance Services, hereinafter referred to as "the Board."

1.2 Composition - The Board shall consist of eleven residents of the Commonwealth, five of whom are health care providers and six of whom are not, all to be appointed by the Governor. Any vacancy on the Board, other than by expiration of term, shall be filled by the Governor for the unexpired portion of the term. The Director of the Department of Medical Assistance Services ("the Director") shall be the executive officer of the Board but shall not be a member thereof.

1.3 Term of Office - Board members shall be appointed for four year terms. No person shall be eligible to serve on the Board for more than two full consecutive terms. Should any Board member be unable to fulfill his/her term on the Board, that member shall provide written notice to the Chairperson of the Board at least 30 days prior to resignation, and shall also provide written notice to the Governor.

1.4 Orientation of New Members - When a new member is appointed to the Board, the Board Chairperson shall assign responsibility for orientation of the new member to one veteran member of the Board. New Board members shall be expected to spend time at the office of the Department of Medical Assistance Services ("the Department") for program orientation provided by Department staff, and to become familiar with issues requiring Board action.

ARTICLE II

Board Meetings

2.1 Regular Meetings - The Board shall hold regular meetings at least quarterly at such times and places as it shall determine.

2.2 Special Meetings - The Board may meet at such other times and places as it determines to be necessary and appropriate. Special meetings of the Board may be called by the Chairperson of the Board or by any three (3) members of the Board. Reasonable effort must be made by the Chairperson to personally notify each Board member of the meeting.

2.3 Meeting Notice - Each member shall file with the Director the address and/or telephone number at which such notice is to be given.

Written notice of all regular meetings shall be sent to the Board at least ten (10) days in advance of the time and place of the meeting. Notice of all regular meetings shall also be announced in advance by publication in the Virginia Register, and a proposed agenda sent to persons on the public participation list.

2.4 Quorum - Six (6) members of the Board shall constitute a quorum.

2.5 Executive Session - Prior to meeting in an executive session, the Board must vote affirmatively to do so and must announce the purpose of the session. This purpose shall consist of one or more of the purposes for which executive or closed meetings are permitted in accordance with §2.2-3711 of the Code of Virginia, the pertinent portion of the Virginia Freedom of Information Act.

Discussion in the executive session must be limited to the subject or subjects stated in the motion. No final action may be taken in executive session. Upon return to open session, any action taken or motion adopted must be re-stated, voted upon, and placed in the minutes in order to become effective.

2.6 Conduct of Business - The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Board in all cases to which they are applicable, to the extent that they are not inconsistent with the laws of Virginia, these Bylaws, or any special rule which the Board may adopt.

ARTICLE III

Board Authority

3.1 Powers and Duties - The Board shall have the powers and duties as prescribed in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia. (See memorandum of April 13, 2004, from the Office of the Attorney General.)

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided. The Board shall also initiate such cost containment or other measures as are set forth in the Appropriations Act.

The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provision of this chapter.

The Board shall submit biannually a written report to the Governor and the General Assembly.

3.2 Representation of the Board - Individual members of the Board shall represent official positions of the Board only upon action of the Board. When the Board is requested to appear before the General Assembly, legislative committees, study committees, etc., the Board shall be represented by duly designated member(s) who are nominated by the Chairperson and, when practicable, confirmed by the Board.

Individual members of the Board are free to make comments to the media, individual legislators, local boards of health members, legislative committees, etc. Any comments made shall be identified as their personal views and not the position of the Board unless they have been authorized by the Board to express the Board's official position or unless the position they express is a position that has been officially taken by the Board.

3.3 Authority of the Director - The Director shall be vested with the authority of the Board as set forth in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia.

ARTICLE IV

Board Officers

4.1 Term of Office - At the first meeting of the Board after March 1 of each year, the Board shall elect officers from its membership for the coming year. Those elected shall assume their offices at the meeting following their election and shall serve, unless sooner removed, until their successors are elected.

4.2 Type of Officers - The Board shall have a Chairperson and a Vice Chairperson.

4.3 Duties of Officers

4.3.1 The Chairperson of the Board shall preside, when present, at all meetings of the Board; appoint members to committees of the Board; serve as ex-officio member of all committees; act for the Board in executing resolutions of the Board and communicating the actions of the Board to others; call such special meetings as may be deemed necessary; vote as any other member of the Board on any issue; perform other duties which may be delegated by the Board; and delegate to the Vice Chairperson such duties as may be appropriate.

The Chairperson shall work closely with the Director of the Department, or his/her designee, in determining the type of Board meetings, agenda, reports, communications and involvement that will enable Board members to carry out the responsibilities imposed on the Board by Acts of the General Assembly.

4.3.2 The Vice Chairperson shall assume all the powers and duties of the Chairperson in the absence of the Chairperson at any meeting or in the event that the Chairperson is disabled or of a vacancy in the office. The Vice Chairperson shall also perform such other duties as requested by the Board or by the Chairperson.

4.3.3 The Secretary shall be selected by the Board, but shall not be a member of the Board. The Secretary shall assist the Board in carrying out its administrative duties including the maintenance of minutes and records. The Secretary shall be a member of the Director's staff within the Department.

ARTICLE V

Board Committees

5.1 Special Committees - Special Committees may be constituted at any time by action of the full Board or the Chairperson. Such committees shall be formed when necessary for the efficient functioning of the Board. Members of a special committee and its chairperson shall be appointed by the Chairperson from among the membership of the Board. At the time a special committee is created, its mission shall be specifically established by action of the Board or by the Chairperson. In creating such special committees, the Chairperson shall specify the time within which the Committee is to make its report(s) to the Board.

5.2 Advisory Groups - The Board may, from time to time, seek the advice of various advisory groups, committees or individuals other than members of the Board on issues of concern to the Board and may form a group of such individuals for such purpose. Any member of the Board or the Director may request that such advice be sought. Selection of individuals to serve in such capacity shall be made by the Board with the advice of the Director.

Since the Board possesses legal powers which cannot be delegated or surrendered, all recommendations for action by such individual or group must be submitted to the Board for decision.

5.3 Participation in Various Department Workgroups and Committees – In order to facilitate involvement of Board members in key policy issues and activities of the Department, the Chairperson and Director shall identify and recommend, from time-to-time, Department workgroups or committees to which Board members should be appointed as full and active participants. In addition, Board members also may identify and recommend Department workgroups or committees for which they believe Board participation would be appropriate. Such participation in Department workgroups or committees shall not conflict with any pertinent statutory or regulatory requirements that may exist regarding the composition of such workgroups or committees. Members selected to serve on a Department workgroup or committee shall be appointed by the Chairperson from among the membership of the Board.

5.4 Department Committees - In addition to participation in Department workgroups or committees pursuant to Section 5.3, Board members are encouraged to attend meetings of any committee of the Department with stakeholders, including, but not limited to, the Dental Advisory Committee, the Drug Utilization Review Board, the Family Access to Medical Insurance Security (FAMIS) Outreach Oversight Committee, the Managed Care Advisory Committee, the Medicaid Hospital Payment Policy Advisory Council, the Medicaid Physician Advisory Committee, the Medicaid Transportation Advisory Committee, the Pharmacy and Therapeutics Committee, and the Pharmacy Liaison Committee. DMAS staff shall provide information regarding meeting schedules to the Board to facilitate member attendance and involvement.

ARTICLE VI

Board Documents

6.1 Official Papers - All official records of the Board shall be kept on file at the Department and shall be open to inspection. All files shall be maintained for five years. Minutes of Board meetings shall be permanently retained.

ARTICLE VII

Public Participation

7.1 Public Participation - Citizens may attend all Board meetings, except executive sessions as defined by the Freedom of Information Act, and may record the proceedings in writing or by using a recording device. The Board may make and enforce reasonable rules regarding the conduct of persons attending its meetings.

7.2 Presentations to the Board - Opportunities shall be provided for individuals or citizens representing a group or groups to appear on the agenda of a regular meeting of the Board. Requests to appear before the Board should be made in writing 10 days before a scheduled meeting of the Board in order that they may be included on the agenda. The 10 days may be waived by the Board Chairperson. The request must include the subject to be discussed and the name of the speaker. In honoring such requests, the Board will limit presentations to five (5) minutes, unless an extension is granted by the Board Chairperson.

ARTICLE VIII

Revision and Compliance

8.1 Amendments - The Bylaws of the Board may be amended at any regular meeting of the Board by a majority vote, provided that the proposed amendment was submitted in writing at the previous regular meeting of the Board and is included in the notice of the meeting at which a vote is to be taken.

8.2 Review - The Bylaws shall be reviewed in total at least every two years, with a limited annual review for compliance with the Code of Virginia. Revisions shall be made as necessary, and the Bylaws signed and dated to indicate the time of the last review.

8.3 Effective Date - The foregoing Bylaws shall go into effect on the 25th day of September 2018.

Approved:

9/25/18

Chairperson, Board of Medical Assistance Services

9/25/18

Director, Department of Medical Assistance Services

DMAS COVID-19 VACCINE EFFORTS

June 9, 2021

Tracking Vaccination Rates for Medicaid Members
Data as of 5/25/2021

Growth in Medicaid Member Vaccinations

Date	Fully Vaccinated	At least one dose
14-Mar-21	64,972	124,315
21-Mar-21	72,045	144,966
28-Mar-21	79,398	162,767
4-Apr-21	103,152	212,053
11-Apr-21	131,664	253,842
18-Apr-21	154,092	277,850
25-Apr-21	191,199	312,465
2-May-21	219,667	336,664
9-May-21	247,098	359,405
16-May-21	274,795	377,683
23-May-21	301,072	405,597

 1Source: https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary

Vaccination Rate* Highlights

VDH partnered with DMAS in executing specialized strategies to vaccinate DMAS' Medically Fragile and Homebound Populations

- Vaccination rate in DMAS Homebound population increased from 4% to 53% since April.
- Vaccination rate in DMAS Waiver Population now matches rate* of Virginia's general population
- Virginia began vaccinating 12-15 year olds on May 12th To date, 6% have received at least one dose.

I/DD Waiver

- 69%

CCC Plus Waiver

- 50%

Homebound

- 53%

Total Population >16 years

- 34%

 *Receiving at least one dose as of May 25, 2021

Efforts to Vaccinate Medicaid Members

- As Virginia transitioned into Phase 2, DMAS developed tailored communication strategies to ensure equitable access for all members.
  - Managed Care, FFS and Medicaid News Subscribers Messaging Campaign launched utilizing targeted texts, emails, direct mailings, and/or social media platforms.
- Rite Aid Pharmacies and Norfolk/Virginia Beach Health Departments partnered with DMAS to hold vaccination clinics in Richmond and Norfolk in April and May.
  - Virginia Premier and Optima hosted a 2 day clinic in Richmond for their members and employees.
  - Disability Advocacy Service provider, Endependence Center, Inc., hosted clinics in Norfolk for their clients, attendants, and other Medicaid members. Over 200 total 1st and 2nd doses given.
- MCOs continue to track and report on weekly outreach activities for all members over 12 years old.

Adult Dental Services 2021 – Overview

Effective Date

July 1, 2021

New Benefit

Approximately 750,000 adult members

Benefit Model

Comprehensive benefits based on a preventive, and restorative model

Strategic Partnership

Work with key partners to assist with design, delivery of new services and recruitment

A Healthy Body Starts With A Healthy Mouth

IMPACTS BEYOND THE MOUTH

Growing evidence connects a healthy mouth with a healthy body. Here are some examples showing why oral health is about much more than a smile:

High Blood Pressure

- Putting off dental care during early adulthood is linked to an increased risk of having high blood pressure.[1]
- Patients with gum disease are less likely to keep their blood pressure under control with medication than are those with good oral health.[2]

Diabetes

- Untreated gum disease makes it harder for people with diabetes to manage their blood glucose levels.[3]
- Diabetes raises the risk of developing gum disease by 86%.[4]

Obesity

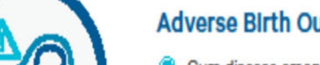
- Brushing teeth no more than once per day was linked with the development of obesity.[5]
- Frequent consumption of sugar-sweetened drinks raises the risk of both obesity[6] and tooth decay among children[7] and adults.[8]

Dementia

- Having 10 years of chronic gum disease (periodontitis) was associated with a higher risk of developing Alzheimer's disease.[9]
- Researchers report that uncontrolled periodontal disease "could trigger or exacerbate" the neuroinflammatory phenomenon seen in Alzheimer's disease.[10]

Respiratory Health

- Research shows that improving oral hygiene among medically fragile seniors can reduce the death rate from aspiration pneumonia.[11]
- Patients with ventilator-associated pneumonia (VAP) who engaged in regular toothbrushing spent significantly less time on mechanical ventilation than other VAP patients.[12]
- Improving veterans' oral hygiene reduced the incidence of hospital-acquired pneumonia (HAP) by 92%, preventing about 136 HAP cases and saving 24 lives.[13]



Adverse Birth Outcomes

- Gum disease among pregnant women is associated with preterm births, low birthweight babies and preeclampsia, a pregnancy complication that can cause organ damage and can be fatal.[14]

Adult Dental Services 2021 – Overview

Implementation Steps:

- Federal Approval – In process
- Design Benefit Package – Complete
- Provider Recruitment – Ongoing
- System Changes – Complete
- Vendor Contract Changes – Complete
- Member & Provider Education – Ongoing
- Stakeholder Engagement – Ongoing
- Hiring a Dental Program Lead – Ongoing

Adult SFC Dental 2021- Benefit Design Overview

The Process

Design Framework

Patient Comfort	Focus on overall oral health	Preventive and Education Restorative Model of Care

Stakeholder Engagement

Added new members to DAC per budget language	Created and engaged an Adult Dental Committee with community providers: FQHC dentists, an ID/DD provider, DAC Members and the former VDA President

Benefit Development

Focus on prevention, keeping disease-free, then restore	First 18-24 month period focused on procedures that promote healthy gum tissue and supporting structures

Mantra for Adult Dental

- Prevention and Education
  - Strong periodontal goals
  - Up to 3 cleanings / year / medical necessity
- Build around what is salvageable
  - Restorations that support longevity
  - Extractions when needed for long term success
- Periodontal Maintenance
  - Gingival Health, Gingivectomy, Scaling/ Root Planing
  - Prosthetics (Dentures, Partials with time)

Adult SFC Dental 2021- Benefit Coverage Chart

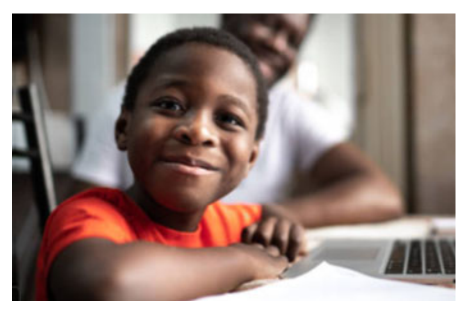
Specialty Area	Description	Services Covered	Limitations
Diagnostic and Preventive Care	Services that are used to detect and recognize caries and periodontal disease. Up to three routine cleanings may be permissible	Exams, Routine cleanings, X-rays	• Non routine X-rays such as imaging and cone beam technology would require prior authorization
Restorative Care	Specialty allows dentists to restore teeth to proper function	Fillings and crowns	• Crowns are covered when a root canal is done while member is under the adult dental program • Bridges
Endodontics	Specialty allows dentists to perform root canals on teeth that have sound below the gum structure (root) yet the above gum structure is compromised (decay or trauma)	Root canals Pulpal Debridement	• Retreatments, apicoectomies, periradicular surgery and apicoectomies
Periodontics	Specialty focuses on keeping gums and the bone below the gums healthy.	Scaling and Root Planing Gingivectomies Periodontal maintenance procedures	• Periodontal flap procedures, crown lengthening procedures, bone replacement grafts
Dentures and Partials	Specialty focuses on replacing teeth with removal appliances	Dentures, Partials, and Repair procedures	• Partials are covered as a part of a definitive treatment plan
Oral Surgery	Specialty routinely extracts teeth and performs extractions requiring surgical methods such as removing bone	Extractions Alveoplasty	• Non-tooth extraction procedures • Surgery necessitated by trauma • Implants
Adjunctive General Services	This area while not a specialty is important in that it allows coding for anesthesia services and many other dental procedures not listed elsewhere.	Anesthesia Services	• Non anesthesia services may require prior authorization

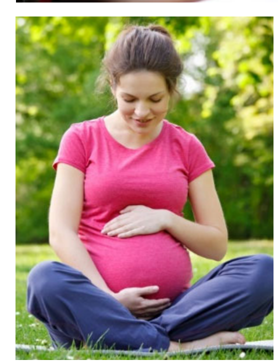
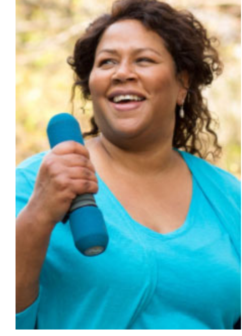
Countdown Updates

- **Member, Provider and Stakeholder Engagement/Communications**
  - Governor Northam signed provider recruitment letter and Virginia Dental Association sent to its 3900 members
  - Virginia Health Catalyst engaging members, providers, and stakeholders
  - DentaQuest
    - Provider and Member Communications
    - Network Development
    - DentaQuest Member Communications
  - DMAS – communication team
- **Contractor/Program Readiness**
  - Currently working with a vendor to conduct an independent review to measure the readiness of DentaQuest in the following areas: Systems and Claims Payment Capability, Member/Provider Services and Networks

Challenges

- Network Adequacy
  - Recruitment efforts
  - Specialists
  - Targeted populations
  - DentaQuest provides weekly reports and updates
  - Contracted Pat Finnerty to assist
  - Meeting with regional groups
- Rates
  - Last rate increase was in 2005
  - Noted in DQ survey, by VDA, and Catalyst as a barrier



AMERICAN RESCUE PLAN ACT (ARPA)

Brian McCormick, Director
Legislative & Intergovernmental Affairs
June 9, 2021

American Rescue Plan Dashboard

Section	Summary	Effective Dates	DMAS Impact
9811 Mandatory for DMAS	Sec. 9811 – Mandatory coverage of COVID-19 testing and treatment; 100% FMAP for vaccine administration Requires medical assistance for vaccines and the administration of such vaccines for limited coverage groups, specifically including those limited to family planning services and supplies.	Mandatory coverage: March 11, 2021 100% FMAP for vaccine administration: April 1, 2021 through end of quarter following one year post-PHE	Extending vaccine coverage to Plan First members is a current federal mandate.
9821 Mandatory for DMAS	Same mandatory vaccine coverage for CHIP		

American Rescue Plan Dashboard

Section	Summary	Effective Dates	DMAS Impact
9819 Applies to DMAS	Sec. 9819 – Adjusts DSH allotments to account for 6.2 percentage point FMAP enhancement during the PHE.	Retroactive to start of the PHE, ends in the quarter in which the PHE ends.	Directs HHS to recalculate states' annual DSH allotments to ensure that total payments that a state may make for a FY are equal to the total payments that the state could have made without receiving the 6.2% FFCRA FMAP increase. Applies in any FY when the FFCRA increase is in effect, and ends beginning with the first FY after the PHE ends. DSH payments, once calculated, are limited to the lower of hospital specific DSH limits or uncompensated care costs and federal DSH allotments. The increased FMAP will not impact DSH calculations and DSH payment limits but will reduce the state share of payments.

American Rescue Plan Dashboard

Section	Summary	Effective Dates	DMAS Impact
9813 State Option	Sec. 9813 – Community-based mobile crisis services coverage option. 85% FMAP available for first 3 years of this option, which must supplement, not supplant any existing spending on such services.	April 1, 2022 – March 31, 2027 85% FMAP available April 1, 2022 – March 31, 2025	Community –based mobile crisis services are State Optional; enhanced FMAP for this service implements 4-1-22. Creates state option to cover community-based mobile crisis intervention services with 85% federal matching funds for 1st 12 fiscal quarters, provided that additional federal funds supplement, not replace, the level of state spending for these services.

American Rescue Plan Dashboard

Section	Summary	Effective Dates	DMAS Impact
9817 Higher FMAP Available	Sec. 9817 – 10-percentage point FMAP enhancement for HCBS improvement activities. FMAP must supplement, not supplant, existing spending.	April 1, 2021 – March 31, 2022	• Gives states the option to claim an additional 10% FMAP for one-year beginning April 1, 2021 for HCBS improvements. The increase is added to other current enhanced state FMAP options (like the 6.2% increase under the Families First Coronavirus Response Act), as long as FMAP does not exceed 95%. • Funds must be used to supplement, not replace, the level of state funds spent for HCBS in effect on April 1, 2021, and must be used to implement one or more activities to enhance, expand, or strengthen HCBS. • Applies to state plan home health, personal care, PACE, § 1915 (i) self-directed personal assistance, Community First Choice, case management, and rehabilitative option, § 1915 (c) and § 1115 waivers, and alternative benefit plans. CMS has not yet provided guidance on what enhancements qualify.

American Rescue Plan Dashboard

Section	Summary	Effective Dates	DMAS Impact
9818 Available Federal Funding	Sec. 9818 – Funding for state strike teams to assist nursing homes with COVID-19 outbreaks. $250 million in grant funds.	Funds available through one-year post-PHE.	Provides $250 million to increase capacity to respond to COVID-19 by implementing state strike teams deployed to nursing facilities with diagnosed or suspected cases of COVID-19 among residents or staff to assist with clinical care, infection control, or staffing during PHE. The purpose of the strike teams is to assist with clinical care, infection control or staffing during the COVID-19 public health emergency period. Funds remain available until expended and are for strike team visits during the COVID-19 public health emergency period and one-year post-PHE.

American Rescue Plan Dashboard

Section	Summary	Effective Dates	DMAS Impact
9911 Available Federal Funding	COVID-19 relief funds for rural providers	January 1, 2021	Provides $8.5 billion in FY 2021 for payments to Medicaid, CHIP, and Medicare rural providers who diagnose, test, or care for individuals with possible or actual COVID-19, for health care related expenses and lost revenues attributable to COVID-19.
9816 Savings Available to State	Sec. 9816 – Terminates SSA section 1927(c)(2)(D) at the end of 2023, eliminating the current 100% Average Manufacturer Price (AMP) ceiling on drug rebates to the Medicaid program.	January 1, 2024	Since 2010, the total Medicaid rebate that drug manufacturers had to pay states was capped at 100% of the AMP for Medicaid-covered drugs. This meant that manufacturers did not pay rebates in excess of their cost of a given drug. These rebates are essentially a discount off the purchase price; with cap lifted, these discounts for Medicaid may increase beyond the price Medicaid pays for the drug, providing greater savings for state Medicaid programs.

Questions

Regulatory Activity Summary June 9, 2021
(* Indicates Recent Activity)

2021 General Assembly

***(01) 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 is currently circulating for internal review.

***(02) 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. This project is currently circulating for internal review.

***(03) COVID Vaccine Administration Fee:** In the March 15, 2021 CMS toolkit entitled "Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program" it states that: "States will need to submit SPAs to describe payment for the vaccine administration to the extent that the payment is different from what is otherwise approved under the state plan. DMAS has adopted the Medicare payment rate of $40 for COVID-19 Vaccine Administration, which is different from the administration fees for other vaccines, and is filing this SPA as a result. After internal and oversight agency review, this SPA was submitted to CMS on 6/1/21.

***(04) 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.

***(05) COVID Vaccine for Plan First:** In accordance with Section 9811 of the American Rescue Plan Act of 2021, DMAS will be making changes to the State Plan in order to cover COVID-19 vaccines and vaccine administration fees for the limited benefit program called Plan First. (Typically, individuals in this program only receive Medicaid coverage for services that delay or prevent pregnancy.) The costs of both the vaccine and the vaccine administration fee will be covered by the federal government. This project is currently circulating for internal review.

***(06) Removal of 40 Quarters Requirements:** The purpose of this SPA is to align with the 2020 Appropriations Act, Item 313.XXX, which states: "Effective upon federal approval but no earlier than April 1, 2021, the Department of Medical Assistance Services shall amend the State Plan under Title XIX of the Social Security Act to eliminate the 40 quarter work requirement for Lawful Permanent Residents who otherwise meet all Medicaid eligibility requirements. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this Act." Following internal review, this SPA was submitted to CMS on 1/20/21. The SPA was approved by CMS on 4/16/21.

***(07) Repeal of CCC Program:** This regulatory action repeals the regulations associated with the Commonwealth Coordinated Care (CCC) Program, a managed-care program launched in 2014 to improve quality, access, and health care experiences for dual-eligible recipients of Medicare and Medicaid. The program reduced Medicare and Medicaid costs by streamlining benefits into one plan and provided individuals with services that are more coordinated and person-centered. DMAS, with support from the Governor and the General Assembly, implemented a new managed long-term services and supports (LTSS) initiative, known as CCC Plus in 2017. CCC Plus operates statewide across six regions as a mandatory Medicaid managed care program, and serves individuals (adults and children) with disabilities and complex care needs. Nearly half of the CCC Plus participants are dually eligible for Medicare and Medicaid and many individuals (dual and non-dual) receive care through nursing facilities or through one of the DMAS home and community based services. Once the CCC Plus program was implemented, all members who had been served by the old CCC program were transitioned into the new program, and the CCC program ended on December 31, 2017. As a result, the CCC regulations are no longer in effect, and are being repealed. Following internal DMAS review, this reg project was submitted to the OAG on 3/5/21; to DPB on 3/30/21; to HHR on 4/28/21; and to the Governor's Ofc. on 5/20/21. The corresponding SPA was filed with CMS on 5/18/21. DMAS is awaiting approval.

***(08) 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.

***(09) 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.

***(10) Tribal Health Clinic:** This SPA includes language allowing the Upper Mattaponi Tribe to collect Medicaid payment for health care services provided through a new Tribal Health Clinic (THC). The Upper Mattaponi Tribe has established a THC to meet the primary care health needs of Tribal members, including those enrolled in Virginia Medicaid. Federal law requires DMAS to file a SPA to recognize and reimburse THCs as Medicaid providers. The THC will be enrolled as a Federally Qualified Health Center and will be reimbursed for services to Medicaid members at a rate set annually by the federal government. CMS will cover 100% of DMAS' payments to the Upper Mattaponi THC for services to Medicaid members. The DPB and Tribal Programs notifications were forwarded on 2/17/21 and the prior public notice was posted on 2/23/21. The SPA was submitted to CMS for review on 3/26/21.

***(11) Coverage of Mandatory MAT Drugs:** DMAS currently has robust coverage of all three FDA approved medications for the treatment of opioid use disorder (OUD): Buprenorphine; Methadone; and Naltrexone. DMAS also covers behavioral therapies for the treatment of OUD per requirements of 1905(ee)(1). Current coverage includes all three forms and over 130 FDA approved medications of opioid use disorder (MOUD), all of which have a federal rebate with the Secretary of Health and Human Services (HHS). DMAS does not cover pharmaceuticals which do not have a federal rebate with the HHS Secretariat per the rebate requirements in section 1927. The change in law per the SUPPORT Act amends this section, requiring Medicaid state agencies to begin covering these non-rebatable medications effective October 1, 2020. This results in DMAS covering an additional 11 medications for the treatment of OUD from five pharmaceutical repackaging manufacturers. Since DMAS currently covers all varieties of MOUD and the non-rebatable medications covered by these additional manufacturers offer no variety in ingredients, thus DMAS does not estimate a cost impact. Thus, DMAS must submit this SPA to allow for coverage of all medications for MOUD to include those that do not have a federal rebate agreement with the HHS Secretariat. This SPA was submitted to CMS for review on 3/26/21 and approved by CMS on 6/2/21.

***(12) Tribal Consultation:** This state plan amendment proposes to amend the section dedicated to the *State Medical Care Advisory Committee*. The changes for this regulatory section are intended to meet the requirements of Section 1902(a)(73) of the Social Security Act §1902. Section 1902(a)(73) mandates that states that have Indian Health Programs: (1) develop and file a Tribal Consultation SPA and (2) solicit advice from Tribes and from Indian Health Programs prior to submitting any SPA or waiver amendment. Prior to the start of Virginia's Pamunkey Tribe Indian Health Program, DMAS was only required to solicit advice for 1915 and 1115 waiver applications/renewals. The DPB and Tribal Programs notifications were forwarded on 2/23/21 for review; to HHR on 3/17/21; and to CMS on 4/7/21. DMAS received CMS' informal questions on 5/7/21 and responses were submitted on 5/18/21, and additional responses were sent on 5/26/21.

***(13) Behavioral Health Enhancement – Part 1:** In accordance with the 2020 Special Session, DMAS intends to make the following Behavioral Health Enhancement changes by

amending the state plan: (1) Assertive Community Treatment, which will replace and serve as an "enhancement" of the current Intensive Community Treatment Service. This will continue to be a service for adults; (2) Mental Health Intensive Outpatient Programs, a new service for youth and adults; and (3) Mental Health Partial Hospitalization Programs for Youth and Adults, which will replace the current Partial Hospitalization Program for adults. The DPB and Tribal Programs notifications and the PPN were submitted on 2/22/21. The SPA was submitted to CMS on 3/25/21 for review.

2020 General Assembly

***(01) Repeal to GAP-SMI Regulations:** The Governor's Access Plan (GAP) was a Medicaid program implemented in 2015 to provide low-income individuals with a serious mental illness (SMI) access to medical and behavioral health care. Individuals enrolled in the GAP-SMI program were covered for limited mental health benefits. However, the vast majority were able to move into the Medicaid Expansion program, which allowed members to be covered for all Medicaid-covered services. This fast-track regulatory action was initiated to remove outdated reg text, which is no longer needed due to the January 2019 implementation of Medicaid Expansion. The GAP-SMI program closed due to the Expansion, and these regulations can now be repealed. Following internal review and coordination, the project was submitted to the OAG for review on 2/2/21 and certified on 2/23/21. The regs were submitted to DPB on 2/24/21 and edits were made and re-submitted on 3/17/21. Following submission to HHR on 3/23/21, the regs were forwarded to the Gov. Ofc. on 5/19/21.

***(02) 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.

(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. 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.

***(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." Following internal review, these final exempt regulations were submitted to the OAG for review on 11/4/20. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/14/21. The OAG approved the regs on 6/1/21; the regs were submitted to the Registrar on 6/2/21; will be published in the Register on 7/5/21; and the regs will become effective on 8/4/21.

***(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. 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 is currently awaiting feedback.

(06) 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.

(07) 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.

(08) 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.AAAAA, 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.BBBBB, 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 was submitted to HHR on 9/15/20 and to CMS on 9/25/20. DMAS responded to informal CMS questions on 10/30/20 and received additional inquiries on 11/6/20. Following internal review, the corresponding regulatory project was sent to the OAG on 9/15/20. Following OAG approval, the action was forwarded to the Register on 11/23/20; published on 12/21/20; and became effective on 1/20/21.

2019 General Assembly

***(01) 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 tme 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, he 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. Following internal review, the corresponding regs were submitted to the OAG on 12/2/20. While awaiting OAG review and certification, DMAS responded to a request for additional information on 2/10/21. The regs were sent to DPB 3/26/21; to HHR on 5/4/21; and to the Governor's Ofc. on 5/20/21.

***(02) 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. The regs were revised and re-submitted to the OAG on 12/2/20, as requested. The reg project was submitted to DPB on 3/3/21 for review; to HHR on 4/9/21; and to the Gov. Ofc, on 5/20/21. DMAS is awaiting approval.

(03) 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.

2018 General Assembly

***(01) 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; to DPB on 3/24/21; to HHR on 5/3/21; and to the Governor's Ofc. on 5/20/21.

(02) 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.

***(03) 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. The OAG approved the fast-track phase on 2/26/21 and the reg action was sent to DPB for review on 3/1/21. On 4/9/21, DPB approved the action and the project was submitted to HHR. The regs were forwarded to the Gov. Ofc. on 5/20/21.

***(04) 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 ended 10/15/20, with an effective date of 10/30/20. The corresponding SPA circulated for internal review and the project was sent to HHR on 3/29/21 and to CMS on 4/7/21. A conf. call with CMS was held on 5/12/21 to discuss the SPA. CMS sent comments on 5/27/21 and DMAS forwarded revised SPA pages and responses to CMS on 6/4/21.

***(05) 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 was sent to the OAG for review on 9/14/20. On 11/10/20, revisions were made and the project was sent back to the OAG. Additional reg changes were brought about by the GA 2020 Special Session and revisions were sent to the OAG on 11/10/20. The action was submitted to DPB on 3/22/21 and DPB submitted inquiries. DMAS sent responses on 4/7/21. DPB issued approval and the project was submitted to HHR on 4/12/21, and to the Governor on 5/20/21. The corresponding 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 and approved on 10/6/20.

2017 General Assembly

(01) Reimbursement of 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 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. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21.

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. The project was submitted to the Gov.'s Ofc. on 11/24/20. The regs were approved by the Gov. Ofc. on 2/5/21, and sent to the Registrar, and published in the Register on 3/1/21.

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 awaited addition al feedback. The final stage reg action was forwarded to the Governor for review on 11/24/20. The regs were approved by the Gov. Ofc. on 2/5/21, and sent to the Registrar, and published in the Register on 3/1/21.

(02) Barrier Crimes Not Permitted: This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 2/17/2017. The OAG issued inquiries on 3/21 and a conference call occurred on 4/26/17 to discuss the regs. The action had been placed on hold. Regulatory processing began again on 4/26/18 with a conf. call with the OAG. Revised text was forwarded to the OAG on 11/28/18 and an additional conf. call took place on 11/29/18. Additional revisions were sent to the OAG on 1/15/19. 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.