BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, September 20, 2022
10:00 AM BMAS Meeting

Department of Medical Assistance Services
Conference Room 102 A & B
600 East Broad St. Richmond, VA 23219

TO ATTEND VIRTUALLY
Click here to join the meeting
Meeting ID: 240 671 066 683
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+1 434-230-0065,,54058234#
Phone Conference ID: 540 582 34#

AGENDA

#	ITEM	PRESENTER
1.	Call to Order	
2.	Approval of Minutes	
3.	Director's Report 3.A. Director Report	Cheryl Roberts, Acting Director
4.	CFO Updates 4.A. CFO Update	Chris Gordon, CFO
5.	State Based Exchange - SCC 5.A. State Based Exchange	Keven Patchett & Holly Mortlock
6.	Social Determinants of Health (SDOH) Update - Aetna & VA Premier 6.A. SDOH	Paula Starnes & Maggie Wise, Aetna Chantel Neece, VA Premier
7.	New Business/Old Business	
8.	Regulations	
9.	Adjournment	
10.	Sub-Committee Discussion Decision Package Feedback	

BOARD OF MEDICAL ASSISTANCE SERVICES

FINAL BMAS MINUTES
Tuesday June 14, 2022
10:00 AM

Present: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Michael H Cook Esq., Elizabeth Noriega, Tim Hanold

Absent: Ashley Gray
Virtual Attendees: Patricia Cook, Paul Hogan, Ashish Kachru

1. **Call to Order**

2. **Introduction of New Board Members**

   Paul Hogan, Ashish Kachru, Tim Hanold

3. **Approval of 03/08/2022 BMAS Draft Minutes**

   Moved by Greg Peters Dr; seconded by Kannan Srinivasan to Approve
   Motion Passed: 7 - 0
   Voting For: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Michael H Cook Esq., Elizabeth Noriega, Tim Hanold
   Voting Against: None

4. **Vote on Bylaw Amendment:**
   2.7 Electronic Participation in Meetings

   Voted by roll call with all members present voting "aye"
   Motion: 7 - 0
   Voting For: Greg Peters Dr, Basim Khan, Kannan Srinivasan, Maureen S Hollowell, Michael H Cook Esq., Elizabeth Noriega, Tim Hanold
   Voting Against: None

5. **Director's Report – Cheryl Roberts, Acting Director**

   Acting Director Roberts agenda for the meeting included current enrollment, agency priorities and DMAS returns to 600 East Broad Street.

   Current Enrollment:
   - Virginia's Medicaid Program plays a critical role in the lives of nearly 1.76 million Virginians.
   - Virginia Medicaid serves: Children, pregnant women, older adults, individuals with disabilities, and low-income adults.
   - Medicaid generally covers the full continuum of health care services similar to other commercial insurance.

- We also cover additional services for certain populations not covered by commercial insurance, like long-term services and supports that is, nursing home or community-based care.

Agency Priorities:

- July 1, 2023, General Assembly Initiatives
    - New initiatives, rate increases and studies
    - Win: we were able to quickly resolve concerns
    - Modifying forecast, trends, utilization, and contracts
    - There will be program, contracts, and rate delays
- Unwinding/Redetermination for 2.2 million
- Provider Enrollment Module – Hard launch in April 2022
    - Focus to Improving productivity
    - Need to enroll 30,000 MCO providers into MES portals
- Earned Credit Release for 4,000 inmates June-July 2022
    - Working with DOC and DSS on transition and long-term solutions
- Maternal and Child Health
    - Continued work on 12-month post-partum (#3 in country)
    - and Community Doula benefit (#4 in country)
- Long Term Services and Supports
    - Working to provide $1,000 COVID support payments for home care aides who delivered agency-directed or consumer-directed personal care, respite care, or companion care services to Medicaid members during the first quarter of the State Fiscal Year (SFY) 2022
- COVID-19
    - Vaccinations- need to increase Medicaid vaccination rate beyond 54%
    - VDH/DMAS/MCO collaborative
    - Focus on increasing preventive and acute care
- Procurements
- Compliance and Oversight
    - Program and financial oversight including dashboards

Provider Enrollment (PRSS)

- We are working with Gainwell, the vendor for Provider Services Solution (PRSS), to address a high volume of provider requests for assistance with the transition to this new module. Many of these requests are for providers whose primary account holder information was not up to date in the former Medicaid Management Information System (MMIS). We also have a number of providers requesting assistance as we transition to the use of taxonomy codes for identification of provider types and areas of specialization.

- Taxonomy codes are a national best practice that will ensure consistency for our providers who serve Medicaid members in multiple states. Taxonomy codes will also improve our agency's ability to fulfill federal reporting requirements.

- Gainwell has added additional staff to assist with our response to provider questions and processing of primary account holder and enrollment submissions. We have made progress in addressing the number of pending requests related to both primary account holder and taxonomy questions. We also are working individually with providers to ensure that they are able to make this transition, including advanced payments to certain providers as needed.

Behavioral Health

Medicaid is the dominate Behavioral Health payer in country

- Crisis: The need for behavioral health and supportive services increased
- Need to increase access to behavioral health services
- BRAVO services
- ARTS
- Governor‘s Safe and Sound Task Force

DMAS Returns to 600 East Broad Street

- In May, Governor Youngkin announced changes to the state employee telework policy bringing staff back into the office 5 days a week.
    - Agency head can approve 1 day of telework
    - OSHHR can approve 2 days on a case-by-case basis
    - All other requests are reviewed by the Governor’s Chief of Staff
    - Are some ADA and childcare exceptions (especially through the summer)
- DMAS leadership turned around new telework agreements for ~500 employees
- Preparing office spaces, training management, developing new routines

6. Medicaid Public Health Emergency (PHE) Unwinding Update – Sarah Hatton

Deputy Hatton spoke on the Public Health Emergency unwinding.

To support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Response Act provided a 6.2% enhanced Federal Medical Assistance Percentage (FMAP) matching rate tied to certain conditions that states must meet, primarily the requirement to maintain enrollment of individuals in Medicaid through the end of the federally declared Public Health Emergency.

- As a result of the continuous coverage requirement, enrollment has grown 30% during the public health emergency, to more than 2 million individuals. All of these individuals will require a redetermination when continuous coverage requirements end.
    - DMAS estimates between 14% and 20% of members will lose coverage during the unwinding period.
    - An additional 4% will lose and regain coverage within one to six months after closure of the unwinding period.
    - The current federal COVID-19 PHE expires on July 15, 2022. Federal officials continue to indicate to states that they will provide a 60-day notice prior to the end of the PHE.
    - States did not receive the 60-day notice in time for the July expiration date; this means another PHE extension will likely be announced prior to July 15th.
    - The Maintenance of Effort (MOE) to keep individuals enrolled continues through month in which the PHE ends (currently July 31, 2022). The 6.2% enhanced FMAP continues through the end of the quarter in which the PHE ends (currently September 30, 2022).

- Closures from redeterminations may not occur prior to the month after the PHE ends. Redeterminations must be managed over a 12-month period to ensure an even distribution of overdue redeterminations combined with currently due renewals, and a sustainable workload for local agencies in future years. Assuming a PHE end date of July 15, 2022, normal Medicaid operations would resume in September 2023. As states did not receive 60-day notice for a July 15, 2022 end date, this timeline will shift based on the extension.
    - CMS has defined month one of the unwinding period to occur when a state has initiated the ex-parte process.
    - A full redetermination is required for all members.
    - Previously submitted verifications may not be used in redetermination.
    - States should not initiate redeterminations for more than 1/9 of the total population per month.
- Local DSS agencies face a significant increase in Medicaid workloads when the PHE ends. Increased enrollment and the redetermination of over 2 million individuals is expected to have major impacts to call centers, member appeals, and other operational areas within both agencies.
    - To address the redetermination effort, DMAS and DSS are working closely to ensure readiness in three major areas:
        - **Outreach & Communication**
            - Health plans are collaborating closely with DMAS to align all communication and outreach and to follow the three-prong approach:
            - Strategy 1: Encourage Members to Update Contact Information
            - Strategy 2: Sharing Renewal Files with Plans to Conduct Outreach and Provide Support to Individuals Enrolled in Medicaid during their Renewal Period
            - Strategy 3: Enabling Plans to Conduct Outreach to Individuals Who Have Recently Lost Coverage for Procedural Reasons
            - Strategy 4: States encourage Medicaid managed care plans that also offer a Qualified Health Plan (QHP) to share information with enrollees who are determined ineligible for Medicaid.
            - Health plans are communicating with members through multiple modalities: Mail, email, texts, phone, social media, and other digital marketing.
            - Outside of using the Health Plan Toolkit, DMAS reviews all language for any other outreach material.
        - **System Improvements**
            - System improvements to increase automation and no touch processing will be critical to ensure timely and accurate redeterminations while balancing staffing shortages, attrition rates, and training needs. DMAS has allocated American Rescue Plan Act (ARPA) funding, totaling $1.6 million, for seven system enhancements. Improvements are expected in June 2022, with final changes in September 2022.
            - The planned system enhancements include seven updates to the DSS-owned eligibility determination system and one change to the DMAS-owned Medicaid enrollment system. Of those changes:
                - Five enhancements are permanent, or ongoing, solutions which will increase accuracy and decrease worker intervention.

- Six enhancements *may* result in cost savings for the Commonwealth, either through complete automation of a process or decreasing the need for manual work.
- Five enhancements will result in more timely processing at application, annual redetermination, or when a change occurs, which will result in improved customer service for Virginians.
- One enhancement provides federally required reporting during the unwinding period.

- **Staffing**
  - Strategy 1: Creation of Agile Taskforce
    - Temporary contracted staff to augment existing workforce.
    - Structure has been built with some positions already filled.
    - Taskforce currently working to assist local agencies in clearing backlogs and making needed manual corrections in preparation for unwinding.
  - Strategy 2: Overtime for local agencies:
    - DSS is exploring the use of overtime for local agencies for the 14-month unwinding period.
  - Additional strategies being researched include:
    - Strategy 3: Creation of a state-wide determination pool.
      - Status: LDSS staffing shortages and attrition rates may impact the feasibility of this strategy. DMAS/VDSS analyzing workload distribution and availability at 120 local agencies.

7. Finance and Technology Update

Chris Gordon, CFO presented on Key Metrics, FY22 Appropriation, Medical Spend, MCO Performance and Appropriation Act

Key metrics discussed included:

- Prompt pay – VA code requires all providers be paid within 30 days of billing; at 96%, DMAS is exceeding its 95% target
- SWaM – While the target is 55%, DMAS chose to exceed that rate, currently 63%
- Admin Spending – Slightly under target at $59.5m but on track to end year with $1m in the general fund
- Medical spending – Currently at $15.47b and we are on track to leave $22m in the general fund

Of the 20.6 billion, 19.7 billion reflects Title 19, which is both Medicaid base and expansion. Our admin budget is 1.6% of our total budget. This not only includes funds to run the agency, but also administrative services and organization contracts. Chip is 1.5%. Under the American Rescue Plan Act (ARPA) we were given $41 million from the administration prior.

In summary, agency key Finance &Technology metrics continue to exceed targets. Ongoing extensions of PHE continue to create enrollment and expenditure forecasting challenges. Five MCOs did not meet MLR targets, all six made more than 3% profit in FY21.

8. Medicaid Managed Care Organization & Social Determinants of Health

Ms. Tameeka Smith – Chief Executive Director – United Health Care – Ms. Smith spoke addressing Social Determinants of Health and UnitedHealthcare's Housing + Health Program

Housing + Health Program
Intentionally goes beyond traditional care to remove barriers to care — social and clinical.

- Evidence-based solution to stabilize members with complex socio-clinical needs and improve outcomes
- Addresses the underlying issues that resulted in homelessness
- Provides transitional apartment or congregate housing
- Integrated physical and behavioral health care, and end-to-end care management
- Provides 1:1 support from an expert interdisciplinary team
- Incorporates wrap-around services that empower and enable: health coaching, goal planning, employment navigation, non-emergent transportation, addiction recovery support, ongoing guidance after graduation

Mr. Randy Ricker – Plan President – Optima Health – Mr. Ricker spoke on addressing Social Determinants of Health.

The U.S. Department of Health and Human Services defines social determinants of health (SDOH) as the conditions in the environments where people are born, live, learn, work, play, and worship that affects a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health have a major impact on people's health, well-being, and quality of life. These conditions can affect anyone, regardless of age, race, or ethnicity.

Housing Instability: Current State

- In the U.S. each year, 1.5 million individuals experience homelessness[1]
- Housing instability may negatively impact health outcomes and increase the risk of premature death.[2]
- Homelessness has higher incidents of diabetes, hypertension, asthma, major depression, and a substance use disorder. [2]

1: Source: http://www.rootcausecoalition.org/wp-content/uploads/2016/11/White-Paper-Housing-and-Health.pdf
2: Source: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability

Equity in Action

Access:
- Tools and resources
- Needs of individual communities
- Reduce gaps and disparities

Opportunity:
- Meet the demands of the communities
- Building a pipeline and network of community and faith-based organizations and outreach programs to address SDOH

Engagement:
- Ingrain in the community

- Trust and buy-in of our members

Power of Partnership

Partnerships aimed at building capacity help connect our most vulnerable members to healthcare, shelter, and support services.

Goal 1: To create programs that provide social, physical, and economic platforms to support a member in attaining his/her full potential for health and well-being.

Goal 2: To create a social support system through the convergence of the Health Plan, the community, technology, and innovation to achieve health equity.

Boosting care and referral options

Optima Health has partnered with Virginia Supportive Housing to launch a two-year pilot program to support members with housing instability and an acute mental health condition. Through this partnership, Optima Health will help identify permanent stable housing situations, obtain appropriate care for chronic and behavioral health conditions, and work to reduce non-emergency department visits and non-emergency psychiatric acute inpatient visits.

9. SUD/ SUPPORT Act Grant Update – Ashley Harrell, ARTS Senior Program Advisor

Ashley Harrell provided an overview of the Substance Use Disorder Prevention that Promotes Opioid Recover and Treatment for Patients and Communities (SUPPORT) Act: Section 1003. The program's purpose is to increase the number of SUD treatment and recovery providers through ongoing assessment of the state's needs; recruitment, training, and technical assistance for SUD providers; and improved reimbursement. SUPPORT Act goals include appreciating successes while learning from challenges, reduce workforce entrance barriers, focus on members who have legal/carceral experiences and/or who may be pregnant or parenting (60% of these members were identified as having SUD) and maintaining our person-centered, recovery-oriented core values.

Virginia Medicaid's SUPPORT Act Grant Goals:

- Learn from Addiction and Recovery Treatment Services (ARTS) benefit program
    - Appreciate successes
    - Learn from challenges
- Decrease barriers to enter workforce
- Focus on specific subpopulations
    - Members who have legal/carceral experience
    - Members who are pregnant and parenting
- Maintain our core values
    - Person-centered, strengths-based, recovery-oriented

Support Act Gran Achievements

- Strengthened relationships with state Departments of Corrections, Health, and Social Services
- Provided policy-specific recommendations to leadership on opportunities to address gaps, barriers, and challenges for substance use disorder treatment
- Identified opportunities to improve continua of care for pregnant/parenting members and members with legal/carceral involvement
- Provided more than 225 training and technical assistance sessions (virtual and in person) to more than 11,000 professionals
- Identified and addressed challenges and opportunities for implementation and expansion of peer recovery services

- Provided trainings on race-based trauma and culturally sensitive treatment practices that were attended by more than 1,200 individuals
- Addressed challenges for Medicaid members who have substance use disorders as well as infectious diseases such as HIV and hepatitis C

Support Act Grant Overview

Highlights of Completed Contracts

•VCU Department of Health Behavior and Policy (DBHP)
- Medicaid member survey, including semi-structured in-depth follow-up to better understand member experiences
    - This produced Virginia's first ever look at Medicaid member experiences with ARTS
    - Survey found overall positive experiences with ARTS, and improved outcomes as a result of engaging in ARTS services
- Review of Department of Corrections data to examine impact of substance use disorders (SUD)
- Analysis of Peer Recovery Supports to examine utilization and capacity
- Multi-faceted review of buprenorphine-waivered professionals and providers, including:
    - Surveys of buprenorphine-waivered physicians and office-based addiction treatment providers to understand successes and challenges in buprenorphine treatment
    - Analysis of Drug Enforcement Administration data to determine frequency of prescribing done by waivered professionals, and how that compares to other states

- Manatt Health – SUD-specific Policy Landscape Review
    - Assessed SUPPORT Act and other federal and state SUD-related policy requirements and opportunities
    - Performed 44 stakeholder interviews
    - Identified key strengths and opportunities for DMAS, which were presented to agency leadership;
        - Strengths include covering full spectrum of American Society of Addiction Medicine levels of care, utilizing data to improve service provision and efficiency, and offering ongoing technical assistance
        - Opportunities include strengthening and evolving current care coordination system, increasing utilization of peer recovery services, and strengthening enrollment and linkages for members with legal/carceral experience
- Health Management Associates (HMA) – Legal/carceral system, SUD, and Medicaid
    - Completed an environmental scan of current system, including surveys of and focus groups with stakeholders
    - Conducted systems analyses with five pilot sites, including "current state" assessments and individualized site reports with "future state" goals
    - Convened two regional cross-sector stakeholder events to bring stakeholders together to identify and address opportunities for growth and collaboration
    - Presented findings to DMAS Justice-Involved Workgroup
- Carilion Clinic: Emergency Department Bridge Clinic
        - Expanded and enhanced existing Bridge Clinic services
        - Expanded Bridge Clinic staff, including licensed social worker and peer recovery specialist
        - Developed a curriculum for bridge clinic implementation based on quality improvement work done in partnership with Virginia Department of Health
        - Established Virginia Emergency Department Bridge Replication program, with an initial cohort of five non-Carilion hospitals and three Carilion expansion sites that are hoping to implement their own bridge clinic programs

- Subaward program
  - Awarded seven grants to providers throughout the Commonwealth – Lynchburg, Norfolk, Northern Virginia, Richmond, and Roanoke
  - Accomplishments include:
    - Expansion of telehealth services
    - Expanded peer recovery services
    - Expanded Harm reduction services
    - Creation of Patient navigation for pregnant and parenting members

Projects Update – Contracts ending September 2022

- VCU Wright Center and Institute for Drug and Alcohol Studies
  - Provider webinar survey
  - Brightspot Assessment
- Emergency Department Virtual Bridge Clinic Model
  - VCU Emergency Department Virtual Bridge Clinic (VBC)
    - Implementing a VBC at VCU ED to VCU MOTIVATE Clinic
- Virginia Department of Health – Harm Reduction Organizations
  - "One stop shop" approach to provide potential members opportunity for enrollment
  - Telemedicine: connecting to MOUD, hepatitis C and HIV treatment, and behavioral health treatment

10. New Business/Old Business

Topics of interest for next meeting:

- Conversation/questions regarding pay to home health providers/personal care.
- Compliance and oversight.
- Behavioral health crisis.

12. Adjournment

Moved by Michael Cook; seconded by Maureen Hollowell, Elizabeth Noriega and Greg Peters. Motion: 7 - 0
Voting For: All members present voted 'aye'
Voting Against: None

DMAS DIRECTOR'S REPORT TO BMAS

September 20, 2022

Cheryl Roberts

DMAS Acting Director

Back to the Office

Priority Updates

Partnership for Petersburg- Governor Youngkin's Project

- Project with all Secretariats and City of Petersburg
- Launched August 27, 2022 in Petersburg
- Health and Human Resources (HHR) and DMAS commitment: Working with Managed Care Organizations (MCOs) and providers on community outreach and mobile clinic access
- Working to increase primary care services and access
- MCOs investing in the community, including work toward Social Determinants of Health and community hubs

Priority Updates

Public Health Emergency Unwinding

- The current PHE is scheduled to end 10/13/22 but states have not received a 60 day notice and expect another extension before on this date.
- Currently, Virginia Medicaid covers 2.1 million members
- Enrollment increasing 20K per month due to moratorium on termination of coverage
- DMAS and DSS are working on proactive system enhancements, outreach and communication, as well as the State Based Exchange
- CMS named Virginia as a best practice state for PHE end preparations

Priority Updates

Budget- July 1 Initiatives

Objective and Key Results (OKRs)

MCO Contracting

Priority Updates

Provider Services Solution (PRSS)

- Encourage all managed care providers to enroll in Medicaid via the PRSS module

MES Module Certification

- Enterprise Data Warehouse System (EDWS) and Fraud Abuse Detection System (FADS) are certified.
- Certification anticipated this month for Appeals Information Management System (AIMS)
- Provider Services Solution (PRSS) certification review is scheduled for October 18, 2022

Priority Updates

Maternal & Child Health

- July 1 - Postpartum coverage for 12 months
- 38 state-certified doulas and 20 contracted doulas – 1 seeing patients

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

- DMAS conducted an EPSDT training in July with the managed care plans, DMAS and Department of Behavioral Health and Developmental Services staff and contractors to provide information on the basics of the EPSDT benefit.
- The EPSDT benefit provides the delivery of comprehensive pediatric health care services to all Medicaid-enrolled children and youth under 21.

Priority Updates

Traumatic Brain Injury Workgroup

- Develop and implement community-based and facility-based system of services through a Centers for Medicare and Medicaid Services (CMS) waiver program

Nursing Home Value Based Purchasing (VBP) Project

- Nursing Facility VBP aligns financial incentives to reward performance attainment and improvement for staffing and avoidance of negative events.
- Regular stakeholder meetings

Community Stabilization

- Launched new crisis services in January 2022: 988 number, mobile response and community stabilization
- Course modification: September 1, 2022, DMAS changed from registration to preauthorization and modified protocols

QUESTIONS?

FINANCE & TECHNOLOGY UPDATE

Chris Gordon, CFO

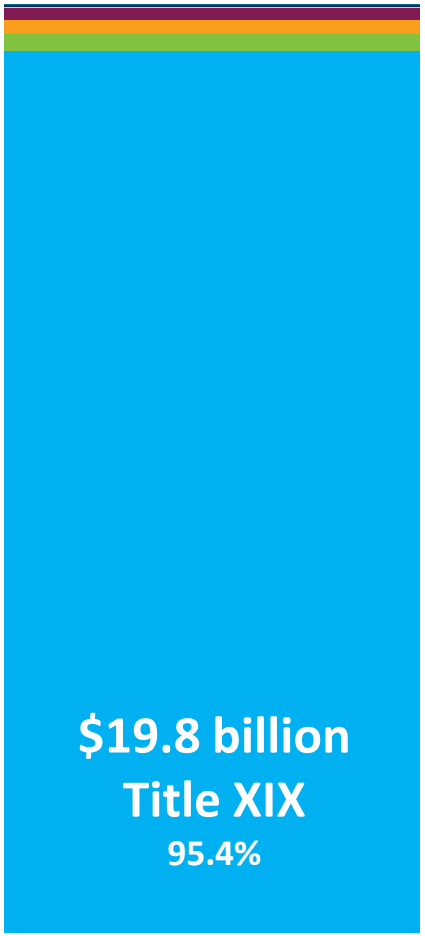
Deputy Director of Finance and Technology

September 20, 2022
BMAS Meeting

Agenda

- Current position: FY23 Appropriation
- Historical Trends & PHE Impacts
- MES Certification Status
- Upcoming RFPs

DMAS FY23 Appropriation



$20.7 billion

Admin— 1.7%
- $344 million

CHIP— 1.5%
- $316 million

MCHIP—1.2%
- $248 million

TDO—0.08%
- $15.7 million

ARPA—0.07%
- $14 million

UMCF—0.005%
- $821K

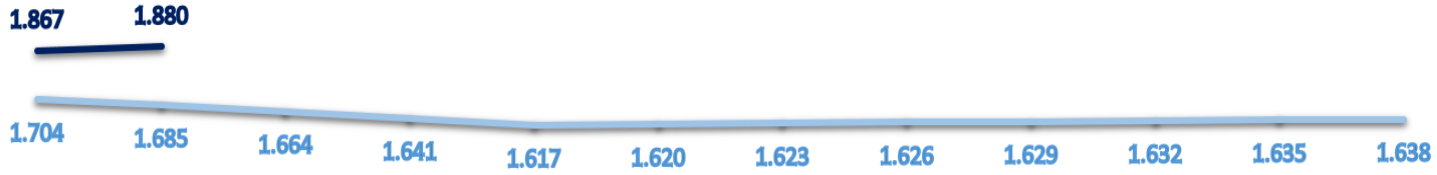
 Source: 2022 Appropriation Act

Total Enrollment & Expenditures

Title XIX

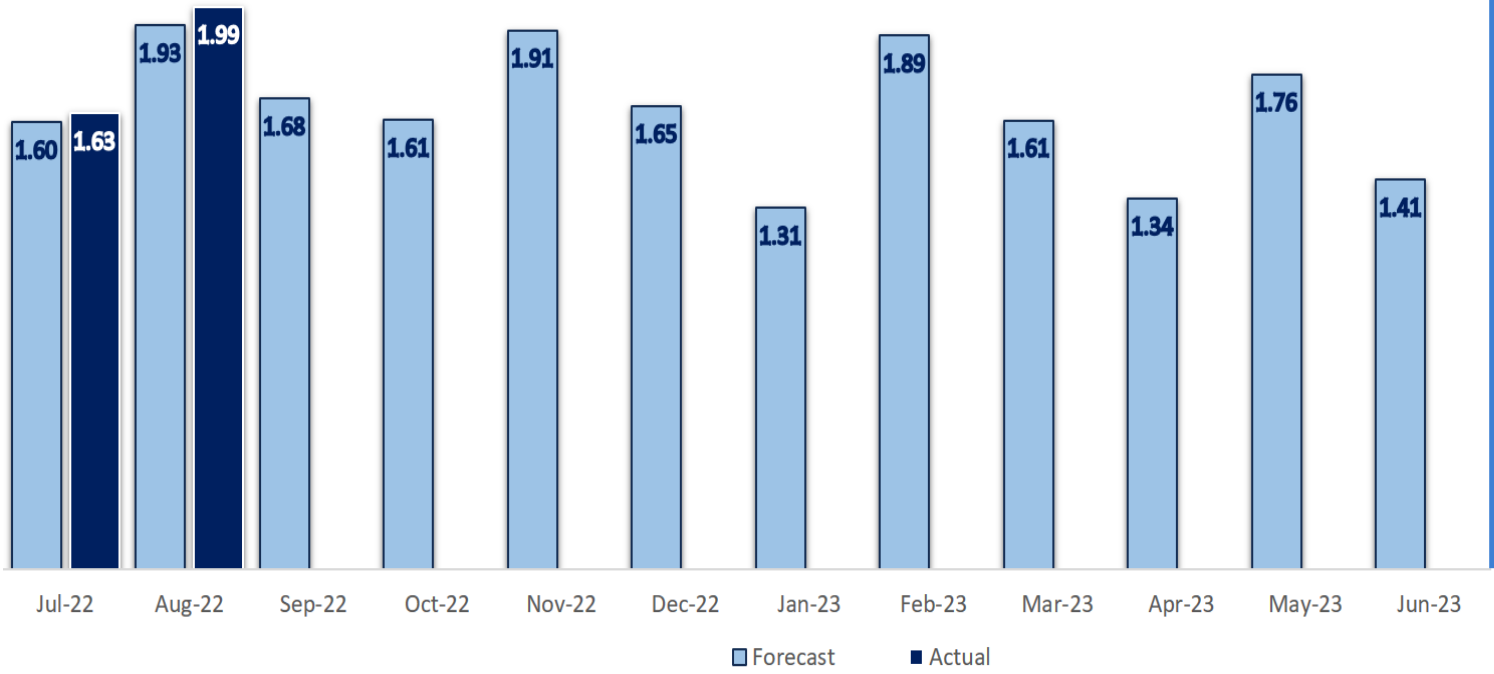
Total Medicaid Enrollment

millions



Total Medicaid Expenditures

$billions



August 2022 Enrollment

Forecast: 1,684,594

Actual: 1,879,937

$

FY23

(YTD August 2022)

Expenditures

Forecast: $3,526,662,248

Actual: $3,617,761,208

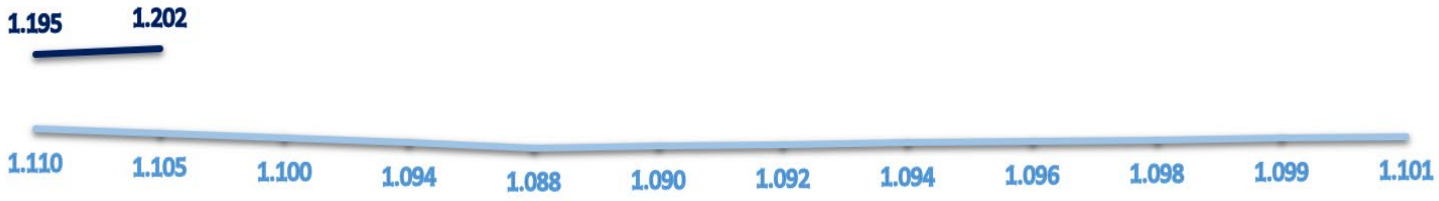
 Source: Cardinal Financials retrieved September 15, 2022

Base Enrollment & Expenditures

Title XIX

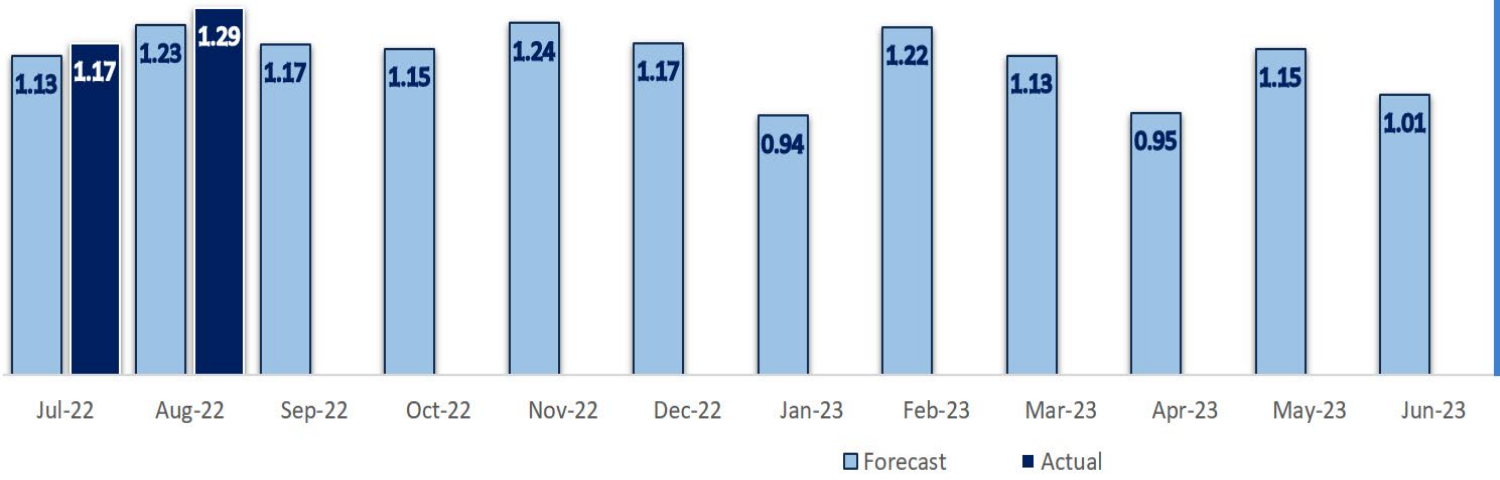
Base Medicaid Enrollment

millions



Base Medicaid Expenditures

$billions



August 2022 Enrollment

Forecast: 1,105,065

Actual: 1,201,917

FY23

(YTD August 2022)

Expenditures

Forecast: $2,362,367,703

Actual: $2,458,414,159

 Source: Cardinal Financials retrieved September 15, 2022

MedEX Enrollment & Expenditures

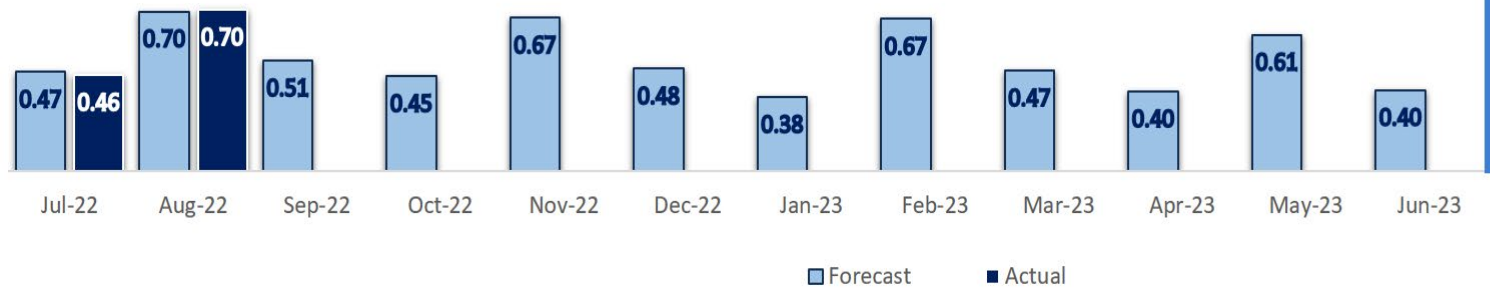
Title XIX

Medicaid Expansion Enrollment

millions

Medicaid Expansion Expenditures

$billions



August 2022 Enrollment

Forecast: 579,529

Actual: 678,020

$

FY23

(YTD August 2022)

Expenditures

Forecast: $1,164,294,545

Actual: $1,159,347,049

 Source: Cardinal Financials retrieved September 15, 2022

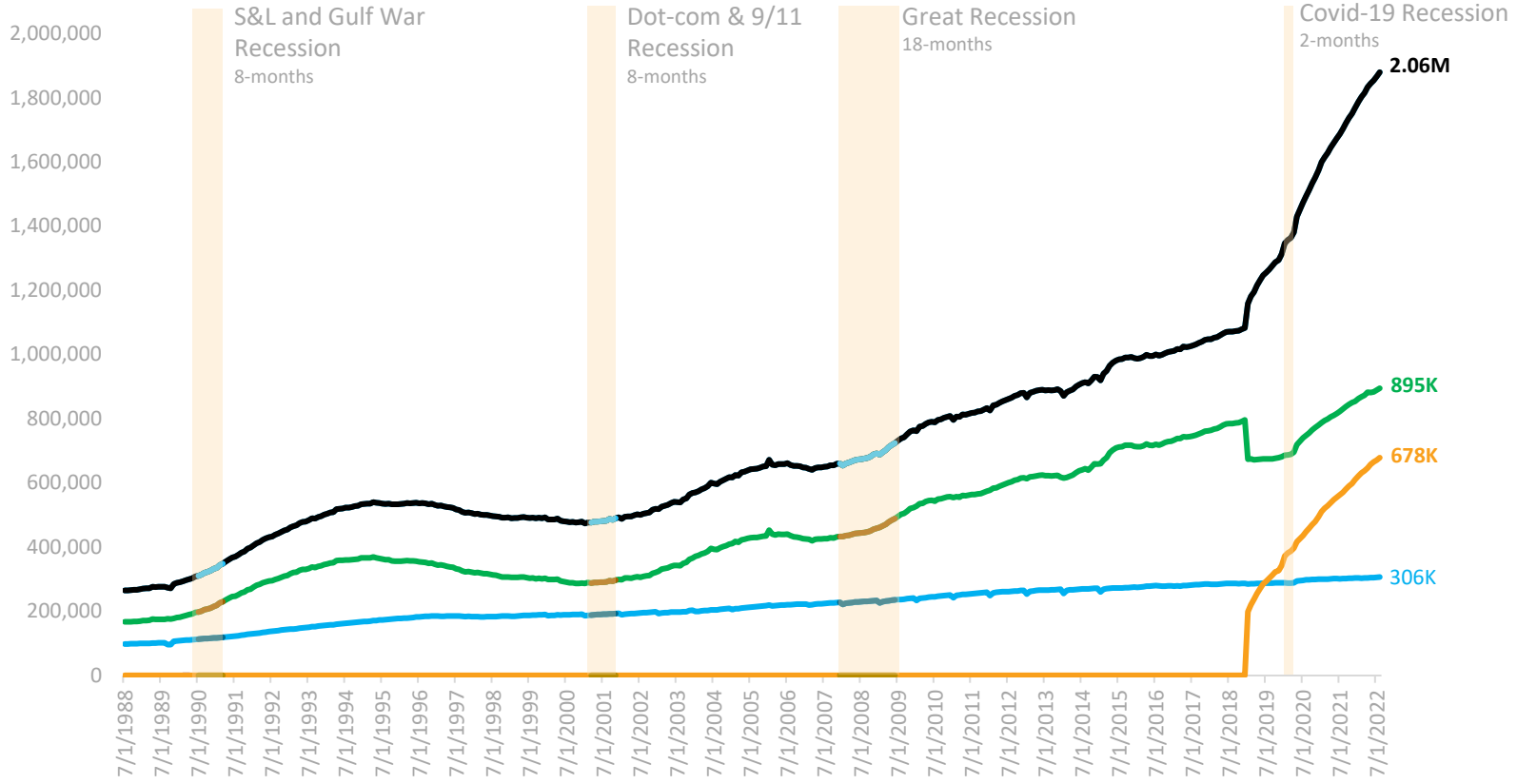
Medical Expenditure Historical Spend
(In Millions)

	Actuals			Chapter 2 Appropriation	FY21 to FY22 Actuals		FY22 Actuals to FY23 Appropriation	
Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**Change**	**% Change**	**Change**	**% Change**
Managed Care: Medallion 4	$ 4,377.2	$ 5,340.2	$ 6,186.4	$ 6,461.0	$ 846.2	15.8%	$ 274.6	4.4%
Managed Care: CCC+	5,212.4	6,141.9	6,886.9	7,342.1	745.1	12.1%	455.2	6.6%
Fee-For-Service: General Medical Care	1,517.6	1,497.1	1,589.2	1,927.4	92.1	6.2%	338.2	21.3%
Fee-For-Service: Behavioral Health & Rehabilitative Svcs	195.3	174.8	163.8	190.9	(11.0)	-6.3%	27.1	16.5%
Fee-For-Service: Long-Term Care Services	1,478.1	1,450.4	1,675.8	2,313.5	225.4	15.5%	637.8	38.1%
Hospital Payments	532.9	530.3	770.6	676.5	240.3	45.3%	(94.1)	-12.2%
Supplemental Rate Assessment Payments	1,035.5	1,539.1	2,095.6	1,705.0	556.5	36.2%	(390.6)	-18.6%
Total Title XIX	**$ 14,349.1**	**$ 16,673.7**	**$ 19,368.3**	**$ 20,616.4**	**$ 2,694.7**	**16.2%**	**$ 1,248.1**	**6.4%**
Total GF Expenditures (Title XIX)	**$ 4,477.1**	**$ 4,318.6**	**$ 4,377.1**	**$ 5,572.0**	**$ 58.5**		**$ 1,194.9**	
CHIP Expenditures (Title XXI)	**$ 421.6**	**$ 422.0**	**$ 499.7**	**$ 565.2**				
Total GF Expenditures (Title XXI)	**$ 62.3**	**$ 102.5**	**$ 134.8**	**$ 178.9**				

 Source: Cardinal Financials retrieved September 15, 2022, and 2022 Appropriation Act

Historical Medicaid Enrollment

1988 to present

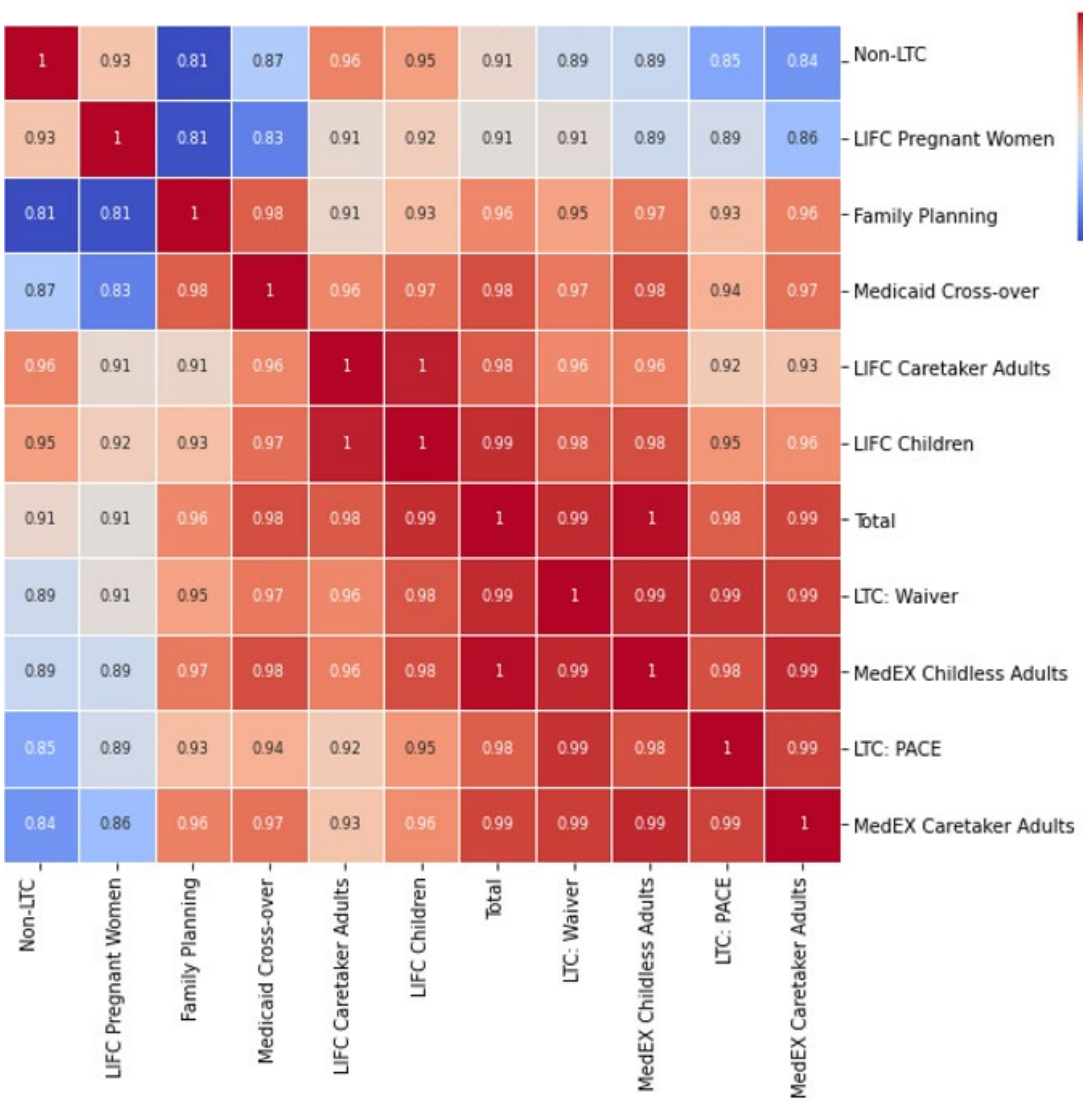


FY23 Average Per Member Per Month (PMPM) Rates

- LIFC Non-Expansion: $ 292.64
- LIFC Expansion: $ 552.39
- LTSS Non-Expansion: $ 2,223.40
- LTSS Expansion: $ 2,072.78

 Source: Department of Medical Assistance Services: Fiscal Agent Services module, retrieved August 1, 2022

MedEX Childless Adults Drive Enrollment

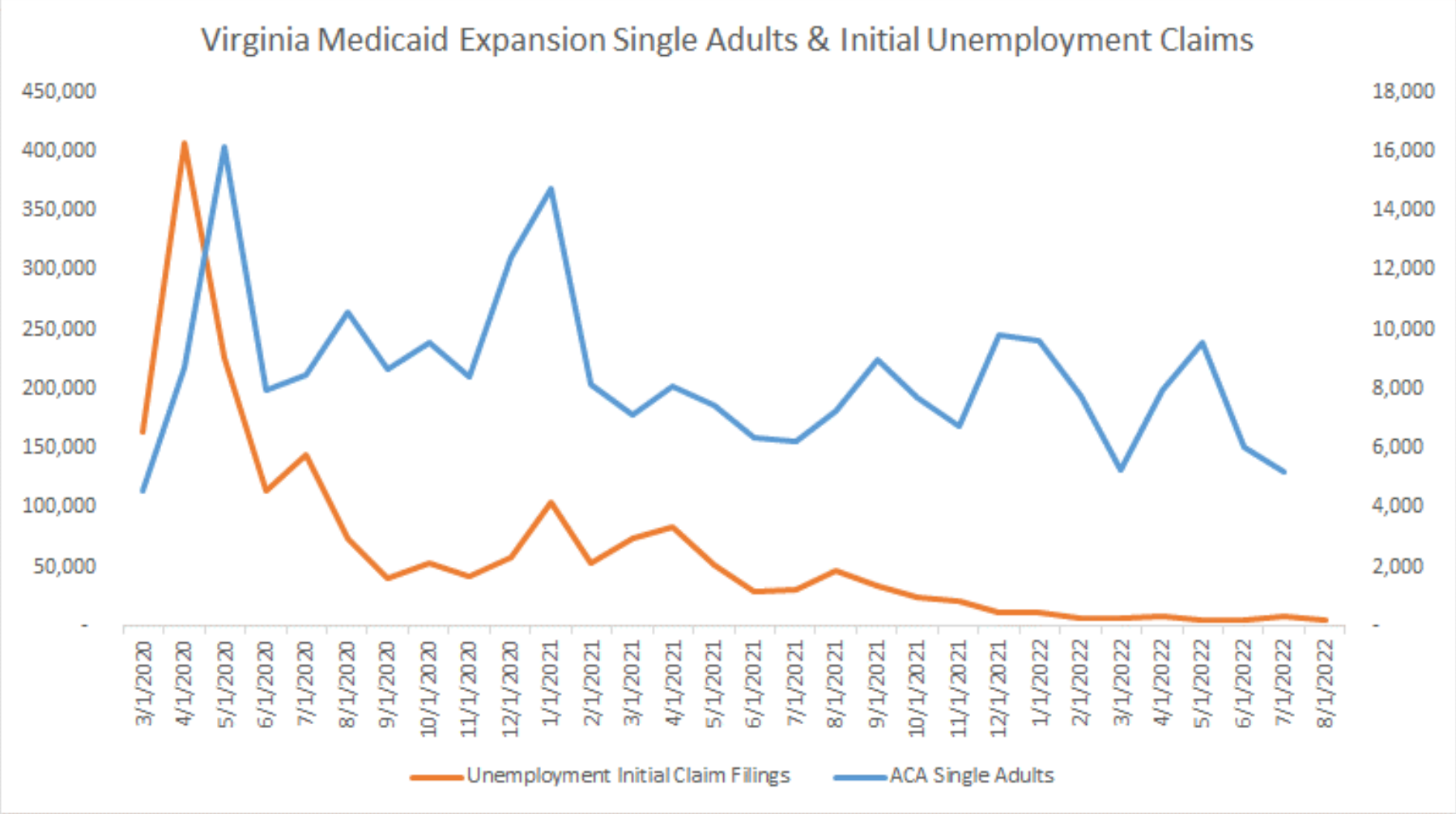


Date	Enrolled
January 1, 2019	123,443
March 20, 2020	269,049
July 1, 2020	310,445
July 1, 2021	418,269
September 1, 2022	523,507

 Source: DMAS Monthly Enrollment Report, retrieved September 2, 2022; Heatmap in Python using SNS

Forecasting Medicaid Expansion

Correlating Unemployment Claims

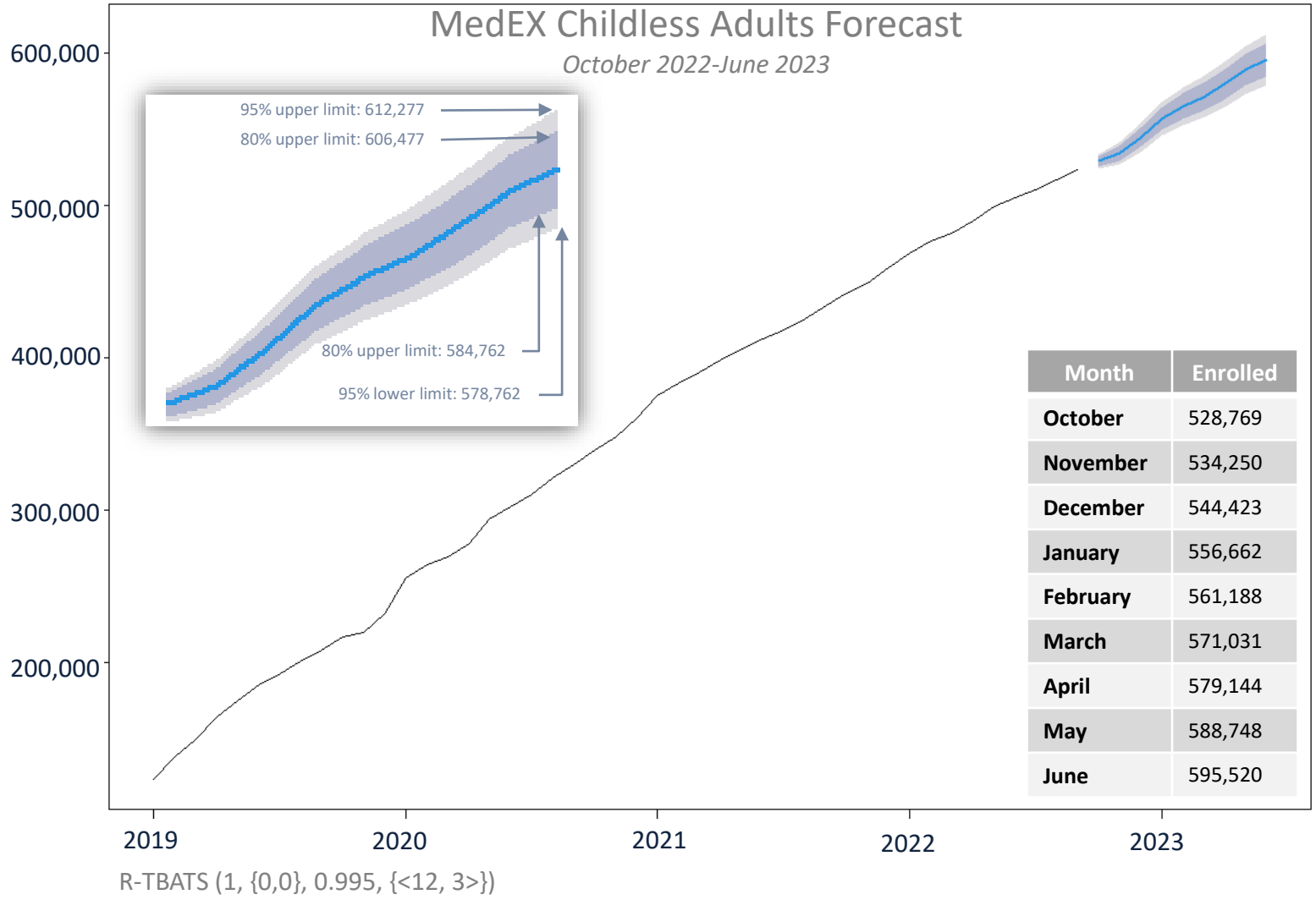


Strong positive monotonic relationship @ 0.52 for one-month lag

 Source: US Dept. of Labor Unemployment Insurance Weekly Claims Data through 9/3/22, and DMAS Enrollment Report retrieved September 2, 2022

Forecasting Medicaid Expansion

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



Month	Enrolled
October	528,769
November	534,250
December	544,423
January	556,662
February	561,188
March	571,031
April	579,144
May	588,748
June	595,520

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

Enhanced FMAP Impacts

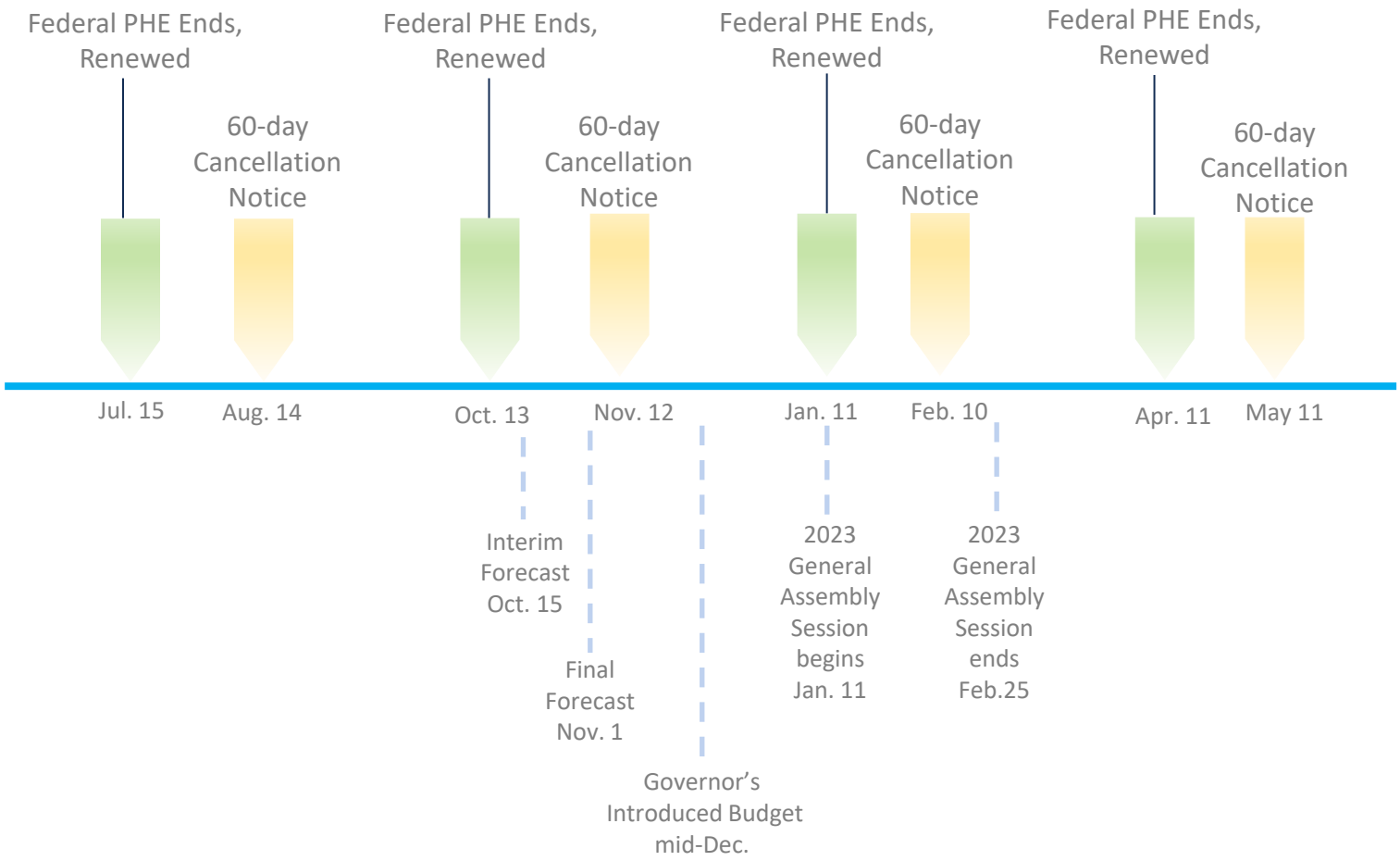
PHE Ending January 2023

		GF Savings Related to FMAP	MOE Cost Estimate	Annual GF Savings
SFY2020	Q3	($152,983,089)	$0	
SFY2020	Q4	($152,983,089)	$6,056,117	
SFY2021	Q1	($167,196,657)	$23,140,671	
SFY2021	Q2	($180,483,296)	$30,152,432	
SFY2021	Q3	($167,855,155)	$36,880,565	
SFY2021	Q4	($155,362,202)	$42,997,768	**$537,725,874**
SFY2022	Q1	($186,848,670)	$43,673,475	
SFY2022	Q2	($193,040,514)	$51,931,708	
SFY2022	Q3	($178,201,519)	$54,000,123	
SFY2022	Q4	($164,766,107)	$57,250,822	**$516,000,682**
SFY2023	Q1	($211,408,159)	$64,685,685	
SFY2023	Q2	($208,684,542)	$67,453,603	
SFY2023	Q3	($194,127,120)	$68,928,609	
SFY2023	Q4		$50,917,512	**$362,234,412**
SFY2024	Q1		$31,561,507	
Total		**($2,313,940,119)**	**$629,630,597**	**$1,684,309,522**

 Source: Cardinal Financials, retrieved August 31, 2022

Federal Public Health Emergency

Impacts on Appropriation



 Source: Federal HHS https://aspr.hhs.gov/legal/PHE/Pages/default.aspx, 2023 Virginia General Assembly Calendar, and 2022 Appropriation Act

MES Certification Status

MES Module	Certification Status
Fiscal Agent Services (FAS)	• Certification not required • Match: 75:25
Integrated Services Solution (ISS)	• Certification not required • Match: 75:25
Encounter Processing Solution (EPS)	• **Certified** • Match: 75:25
Pharmacy Benefit Management System (PBMS)	• **Certified** • Match: 75:25
Enterprise Data Warehouse System (EDWS)	• DMAS received **CMS certification approval on 08/10/2022** • Expected Recoupment: 10/2022 • Match: 75:25
Fraud Abuse Detection System (FADS) [EDWS]	• DMAS received **CMS certification approval on 08/10/2022** • Expected Recoupment: 10/2022 • Match: 75:25
Appeals Information Management System (AIMS)	• DMAS/VIP responding to action items due 08/31/2022 • **Expected Certification: 09/2022;** Expected Recoupment: 12/2022 • Match: 75:25
Provider Services Solution (PRSS)	• Certification Review scheduled for 10/18/22; preparation underway • **Expected Certification: 12/2022**; Expected Recoupment: 03/2023 • Match: 50:50
Care Management Solution (CRMS)	• CRMS Phase II in active development • **Expected Certification: 06/2023**; Expected Recoupment: 09/2023 • Match 50:50
Medicaid Administrative Reporting System (MARS) [EDWS]	• MARS remains in development • **Certification being planned with CMS** • Match: 50:50

 Source: CMS Advanced Planning Documentation

FY23 Upcoming RFPs

RFP	Date
1. Traumatic Brain Injury	Q1 FY23
2. Mailing Services	Q2 FY23
3. Auditing Services	Q2 FY23
4. Third-party Liability Verification	Q2 FY23
5. Enrollment Broker	Q3 FY23
7. Actuarial Services	Q3 FY23
6. Non-emergency Transportation	Q4 FY23
In Process	
1. Service Authorization	
2. Dental Services	

 Source: DMAS Procurement and Contract Management

Summary

- Federal Public Health Emergency creates instability for Commonwealth appropriation and contingent financial needs
- Medicaid Expansion population rising faster than any other group, within six years will be largest population if growth trend continues along with PHE, particularly Childless Adults
- Medicaid policy decisions need to be contextualized relative to market forces, provider network, labor workforce, member needs

Virginia Health Benefit Exchange Update

Keven Patchett, Acting Director

September 20, 2022

SCC Commonwealth of Virginia
STATE CORPORATION COMMISSION

Exchange Overview

- The Virginia Health Benefit Exchange was created by the Virginia General Assembly in 2020, as a new division within the State Corporation Commission.
- The statutory duties of the Exchange include:
  - To transition Virginia from Healthcare.gov to a Virginia-based marketplace
  - Support health insurance continuity
  - Reduce the number of uninsured
  - Promote a transparent and competitive marketplace
  - Promote consumer choice and education
  - Assist individuals with access to programs, policies, and procedures related to obtaining health insurance coverage
  - Assist individuals with premium tax credits and cost-sharing reductions
- The Individual Market is the private marketplace that serves people who do not receive group coverage through their employer and who do not qualify for Medicaid.
- Independently funded by user assessment fees.

Immediate Benefits of a State-Based Marketplace

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

Exchange Snapshot

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

Sources: https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot.
https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot.

Q & A

Contacts:

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Holly Mortlock, Chief Government Relations Officer

Holly.Mortlock@scc.virginia.gov

Membership Outreach and Engagement Strategies

Paula Starnes
Chief Operating Officer

Margaret Wise
Director, Clinical Health Services

Board of Medical Assistance Services (BMAS) Quarterly Meeting
September 20, 2022

Agenda

- Marketing Outreach and Engagement Strategies
- Care Management Strategies
- Health Improvement Incentives

Overview

- Member engagement is a powerful tool for Medicaid plans and managed care organizations (MCOs). When members are actively engaged, everyone involved can benefit.
- Increased engagement compels members to focus on high-value activities, making them more likely to take actions that prevent serious or chronic conditions.
- Member engagement needs to factor in the social determinants of health (SDoH) that affect members. Understanding and acknowledging uncertain circumstances helps plans and MCOs communicate with their members more effectively.

Key Strategies for Member Engagement

- Targeted Marketing Campaigns
- Embracing mobile technology and text messages
- Understanding our Medicaid population's SDOH needs
- Using health risk assessments (HRAs) as a launching point to understand and engage with members
- Offering incentives members consider valuable (Healthy Rewards)
- Hosting and attending high-impact community events (increased community outreach activity)
- Educating participating providers on the programs and benefits we offer our members

Targeted Marketing Campaigns

ABHVA utilizes targeting marketing campaigns to get members to engage on specific services and benefits that we believe will be beneficial to them.

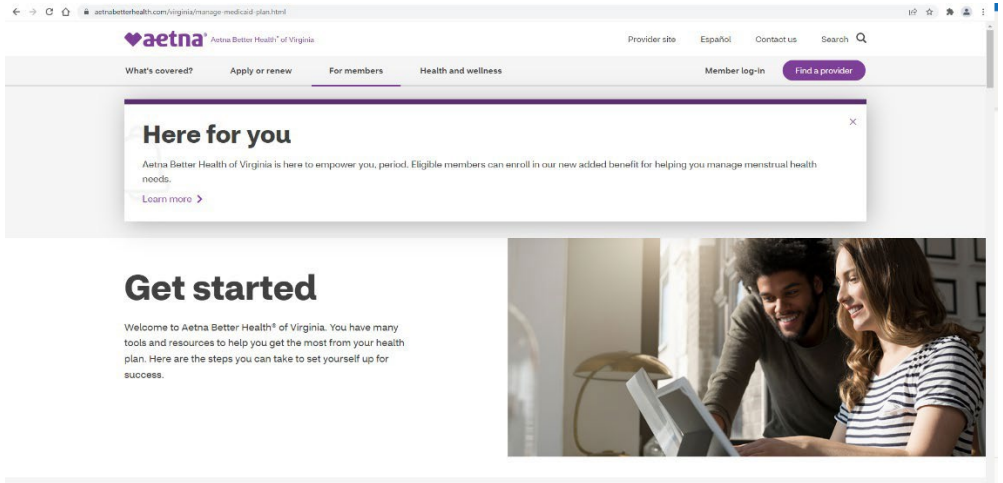
Period Pack Campaign

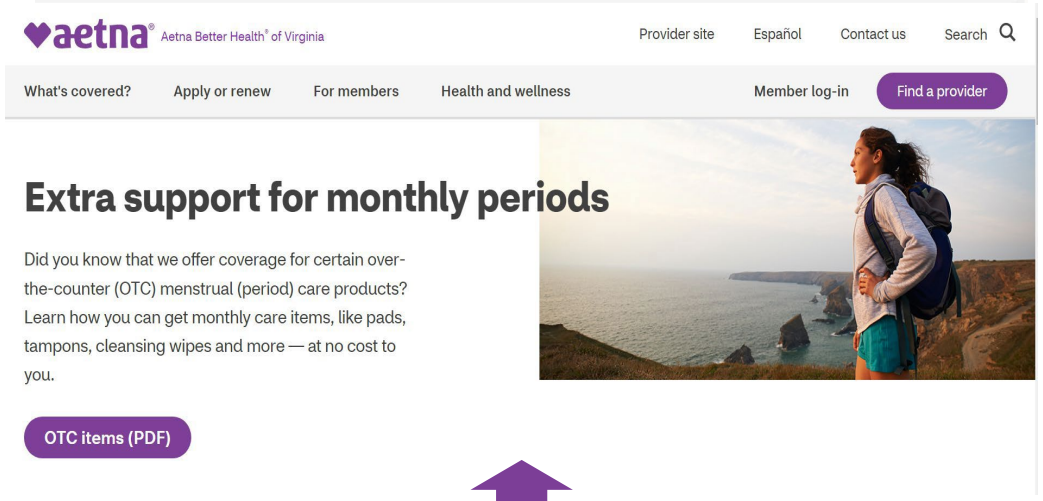
Purpose of campaign: To educate members on new Period Pack campaign and increase usage of menstrual equity added benefit

Channels used:

- **Community Outreach Events –** handed out Period Pack boxes to members of local communities during community events
    - United Way of the Virginia Peninsula Feminine Hygiene Drive, health plan handed out 100+ Period Pack boxes.
- **Text message campaign** to identified eligible members
- **Provider Engagement –** distributed Period Packs and posters to various provider partners (FQHC/OB-GYN/Pediatrics) to promote new benefit.
- **Health plan newsletters**
    - Member newsletter: Provided member education and how to access benefit
    - Provider newsletter: Provided provider education and how providers can help members access benefit

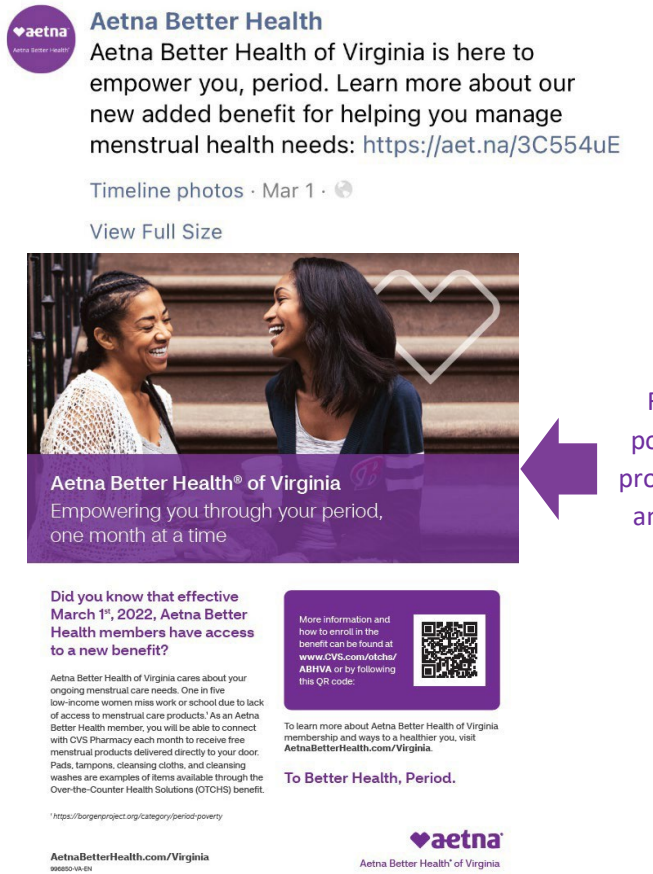
Marketing & Communication



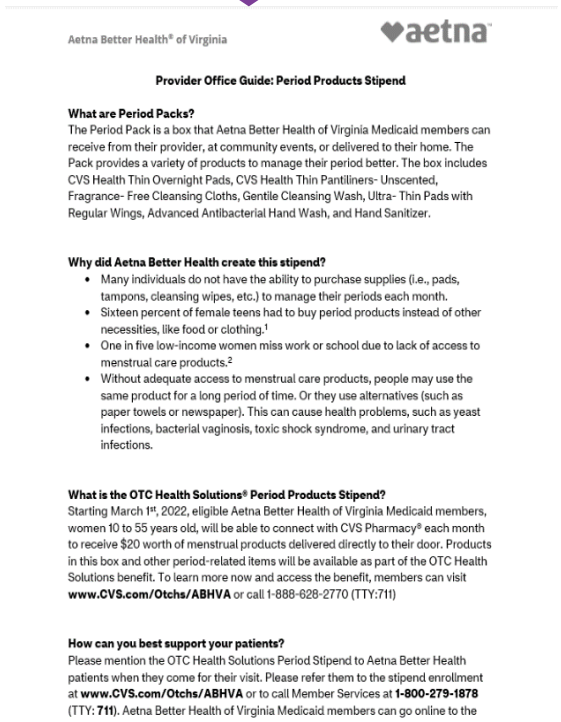


Pop up banner at the top of the member website and additional sections explaining benefit.

Social Media posts (Instagram, Facebook, LinkedIn)



Provider FAQ explaining the new benefit



Flyers and postcards for provider offices and member events

Care Management Strategies

Care Management Engagement Strategies

- Motivational Interviewing training - Training provided to ensure staff can utilize those skills when working with members. We want members to increase their knowledge and understanding of their condition and how they can self-manage.
  - Empathetic and person-centered practice centered around reflective listening.
  - Involves paying close attention and responding to client “change talk”
  - Reinforces the client's spoken motivation for behavior change.

- Leadership ensures CM staff have all needed resources for members – and how to link them to those resources.
- Individualized staff supervision to discuss difficult to engage members.
- Present members at Transition Care Coordinator (TCC) rounds to assess and approach members from a collaborative perspective.
- Instilling values in CM staff – setting clear expectations, developing rapport, establishing trust and allowing members to provide feedback. Feedback is key to drive improvement strategies.
- Targeted population caseloads (i.e. Maternity, Foster Care) – Allows CMs to become SME’s around that population's barriers and resources.

CM Engagement Strategies cont'd

Membership Engagement Strategies

- **Conversational Screenings** – Treating the questionnaires like a conversation
  - Responses should be genuine, filled with compassion, empathy and appropriate.
  - CMs shouldn't just respond with the next question on the list, need to be responsive to the actual responses being given.

- **Active listening Strategies** – Effectively communicate with members to build trust. Members tend to trust CMs who are honest, stand by their values and those who they feel like are there to help. The follow up, active listening and effective communication helps to build a relationship with the member making it easier to outreach and communicate.

- **Next Best Action (NBA) Campaigns** - Aetna's NBA approach is an innovative way that Aetna focuses on individuals — using claims, HEDIS data, and prior interaction with Aetna, to target members/guardians and encourage them to engage in their care and help close care gaps

Next Best Action Campaigns

- **Emergency Department (ED) Utilization Education**

The goal of this campaign is to reduce avoidable Emergency Department visits by educating members about alternative options and site of care that includes telehealth, urgent care centers, the member's PCP and the 24-hour nurse line.

- **Maternity Medicaid C-section Education**

The goal is to encourage Medicaid members to learn more about the benefits of a vaginal delivery over a C-section and feel empowered to advocate for their preferred birth plan in order to reduce non-clinically-necessary C- sections.

- **RX Adherence**

The goal of this campaign is to improve members' medication adherence, resulting in medical cost savings and potentially improved health outcomes.

- **Medicaid Annual Well visit**

Outreach to members with chronic conditions and encourage them to get an annual checkup with their PCP. Increased focus on Members over 36 who have at least 1 comorbidity, who are unlikely to have an annual checkup

Quality Health Improvement Incentives “Wellness Rewards”

- Aetna uses wellness rewards to incentivize members to engage and take a more active role in their health.
- Members can receive rewards for completing healthy activities such as yearly wellness exams, annual screenings, and receiving vaccines.
- Providers complete the incentive form and return to Aetna Better Health of Virginia, serving as verification of the completed activity

Wellness Rewards

Screenings

Members can receive rewards of varying amounts for the following screenings.

- Mammogram screening
- Cervical cancer screening
- Diabetic wellness exam, including blood pressure test, eye exam and A1C testing (Medallion)
- Diabetic dilated eye exam (CCC Plus)
- Initial colonoscopy (CCC Plus)
- Prostate cancer screening (CCC Plus)

Pregnancy and birth care

- Earn rewards for going to pre-and postnatal visits

Wellness visits

- Completion of annual wellness exam (includes HbA1c labs and LCL-C screening) (CCC Plus)

Vaccines

- Annual Flu Shot
- Back-to-school immunizations

Ted E. Bear M.D. Wellness Club

- Members earn rewards for getting important childhood care such as wellness exam, shots (as needed), weight and nutrition counseling, and growth and development checks.
- Age-appropriate prizes are also available once members enroll in our Ted E. Bear M.D. Wellness Club. Examples include:
  - Portion plates, Sippy cups, Onesies
  - Coloring book, Crayons/ Coloring pencils, Drawstring bags, Jump rope

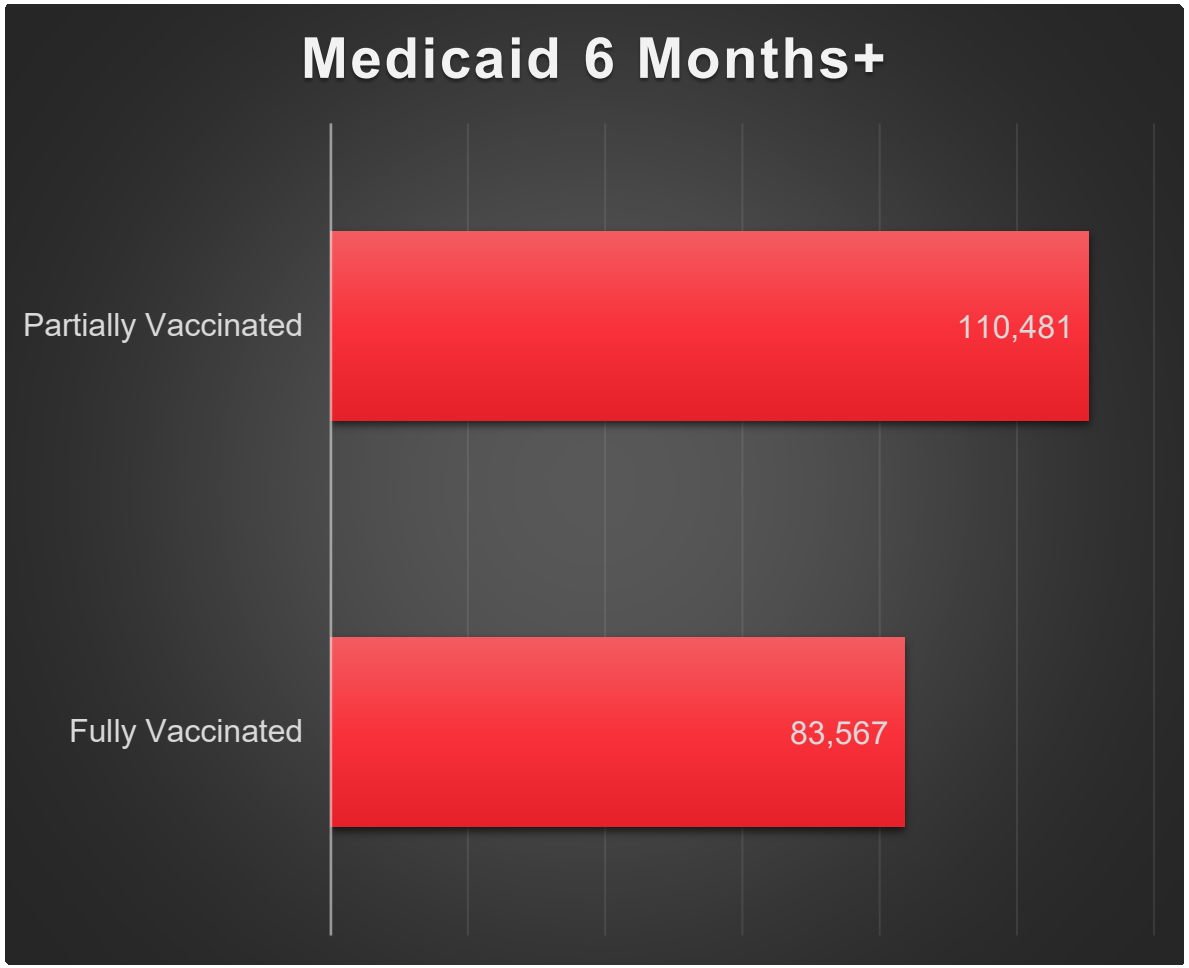

Questions?
aetna

Vaccination Status

Chantel Neece

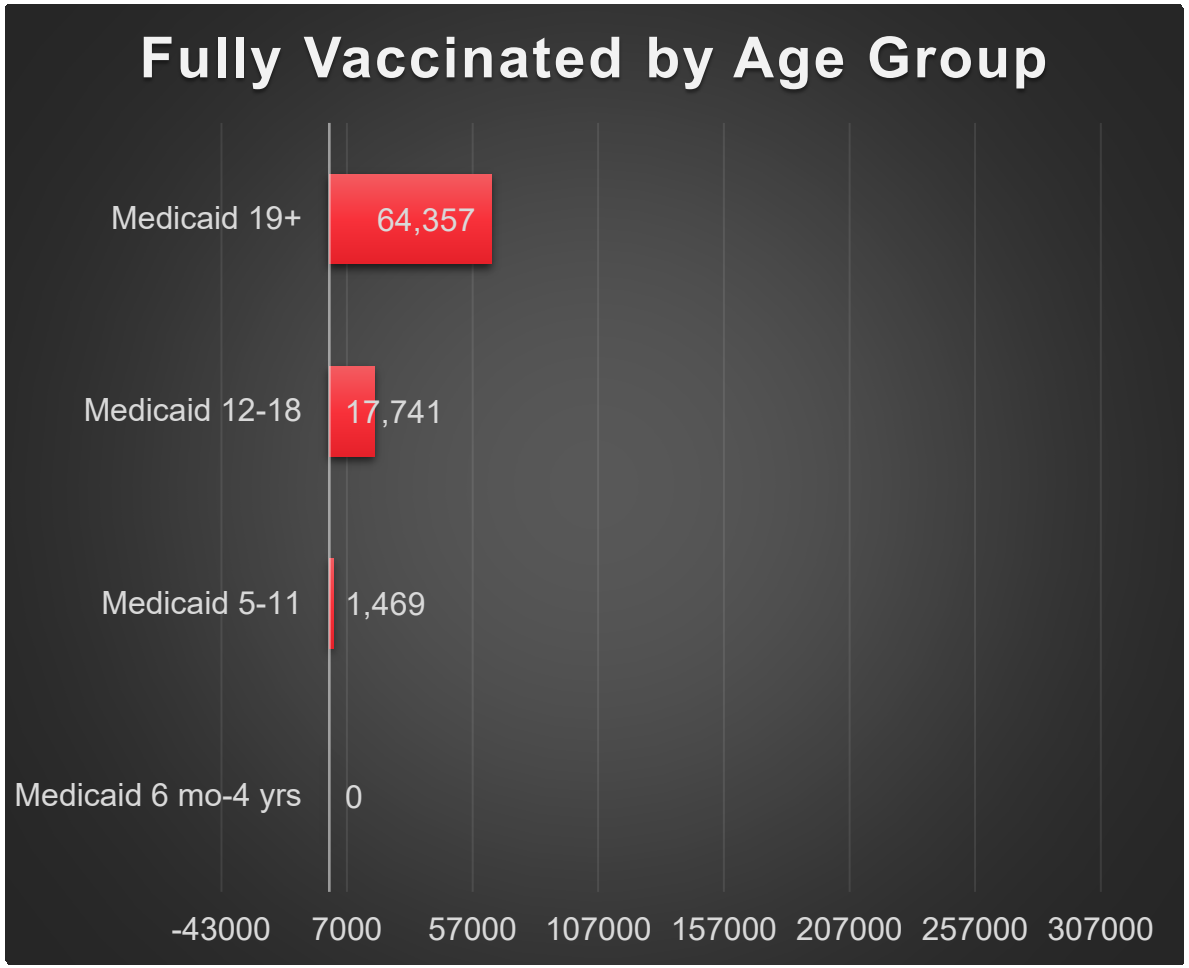
VirginiaPremier™

COVID-19 Vaccination Distribution



Medicaid 6 Months+		% of Eligible
Medicaid Active Members 6 mon+	306,934	
Completed at Least 1 Vaccine	110,481	36.0%
Fully Vaccinated	83,567	27.2%

Vaccination by Age Category



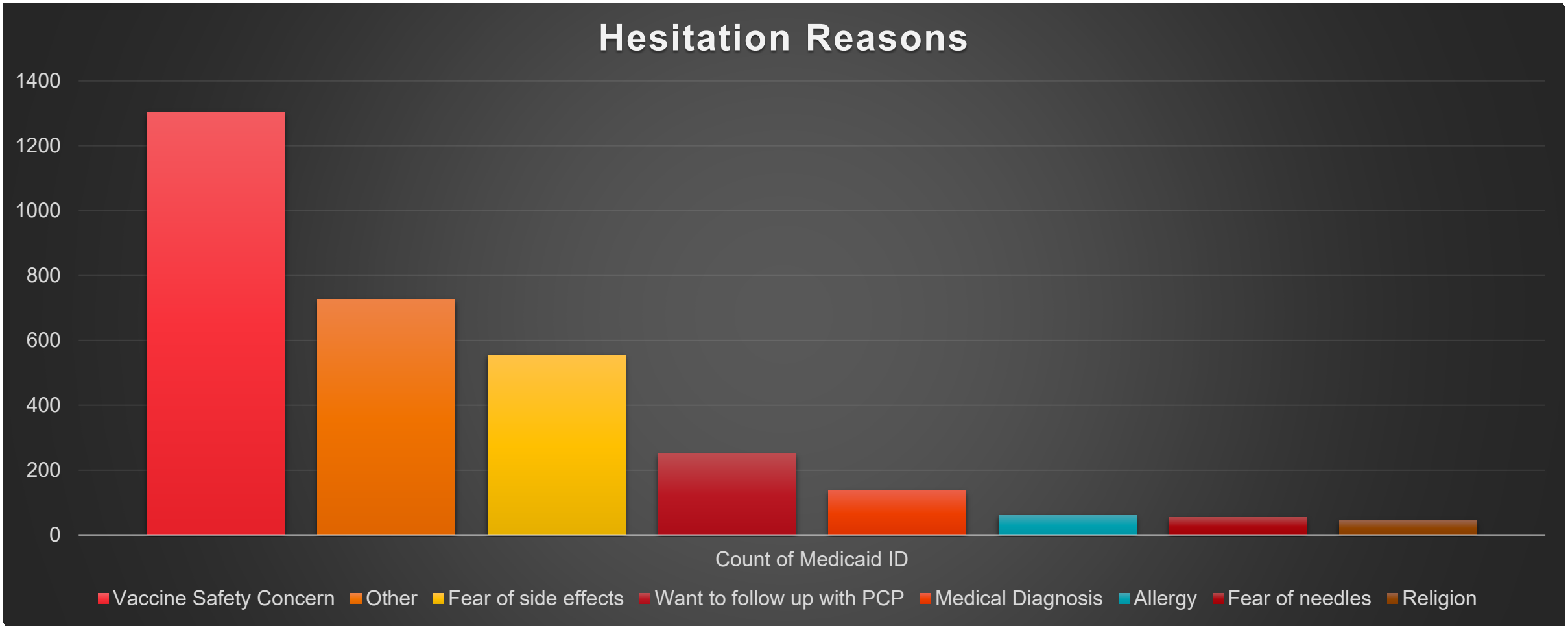
Medicaid 6 mo- 4		% of Eligible
Medicaid Active Members 6 mo	32,044	
Completed at Least 1 Vaccine	8	0.00%
Fully Vaccinated	0	0.00%
Scheduled Vaccines	18	0.10%
Refused or UTC	101	0.30%
Booter Received	0	0.00%

Medicaid 5-11		% of Eligible
Medicaid Active Members 5-11	58,164	
Completed at Least 1 Vaccine	9,644	16.60%
Fully Vaccinated	1,469	2.50%
Scheduled Vaccines	38	0.10%
Refused or UTC	393	0.70%
Booter Received	0	0.00%

Medicaid 12-18		% of Eligible
Medicaid Active Members 12-18	57,289	
Completed at Least 1 Vaccine	21,352	37.30%
Fully Vaccinated	17,741	31.00%
Scheduled Vaccines	88	0.20%
Refused or UTC	1,035	1.80%
Booter Received	755	1.30%

Medicaid 19+		% of Eligible
Medicaid Active Members 19+	159,437	
Completed at Least 1 Vaccine	79,477	49.80%
Fully Vaccinated	64,357	40.40%
Scheduled Vaccines	1,321	0.80%
Refused or UTC	12,243	7.70%
Booter Received	3,521	2.20%

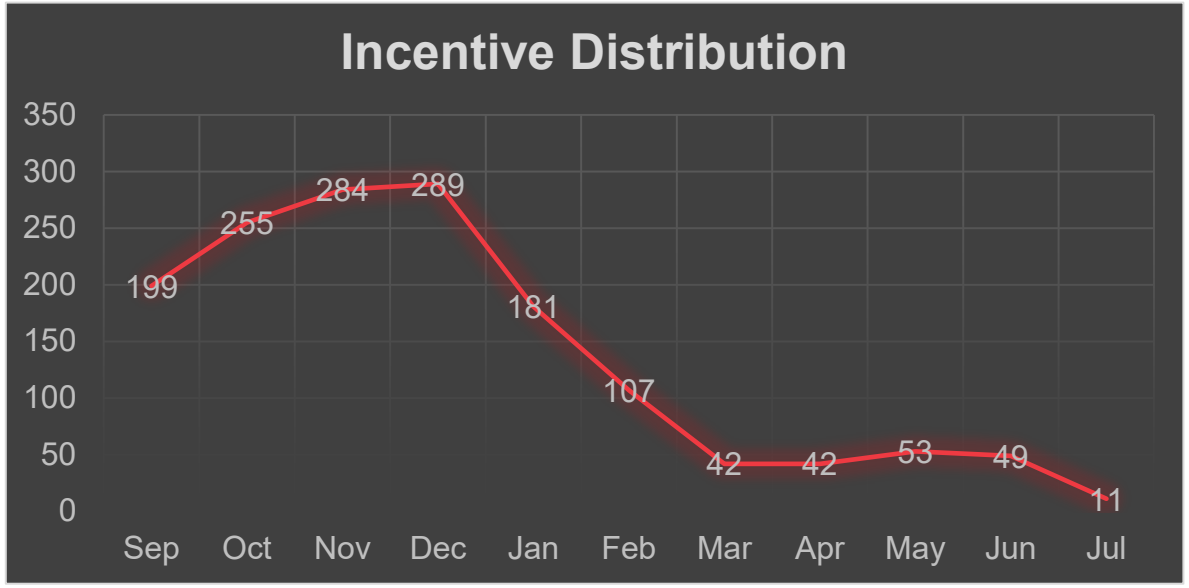
Vaccination Hesitation



Vaccination Activities

Member Incentives

- Member incentive program for COVID vaccinations since September 1, 2021.
  - $50 Wal-Mart gift card for members fully vaccinated for COVID.
  - Total Amount Distributed: $58,565
    - $43,215 (Sept. 2021-December 2021)
    - $15,350 (Jan. 2022-July 2022)



Clinic Partnerships

- **Rite-Aid**- Implemented clinic at Virginia Premier's Liberty Plaza office building
- **Food City-** Clinic held in Bristol, Virginia at Food City store
  - Offered NASCAR race tickets as incentive
- **Virginia Department of Health-**
  - Roanoke Health Department
  - Feeding Southwest Virginia
    - Food Box donations for mobile clinics
  - Mount Rogers Health Department
  - Richmond Health Department
  - Norfolk Health Department
- Pending discussions with FQHCs and Kaiser

Vaccination Activities

Outreach/Communication

- Member outreach makes direct phone calls to those unvaccinated to notify them of upcoming clinics
- Care Coordination verifies COVID status, educates members on vaccine, determines hesitation, and assists with making vaccination appointments.
  - Bi-weekly submission on outreach to DMAS
- Focused outreach campaigns- Southwest area
  - Phone calls, emails, social media, webpage

Education

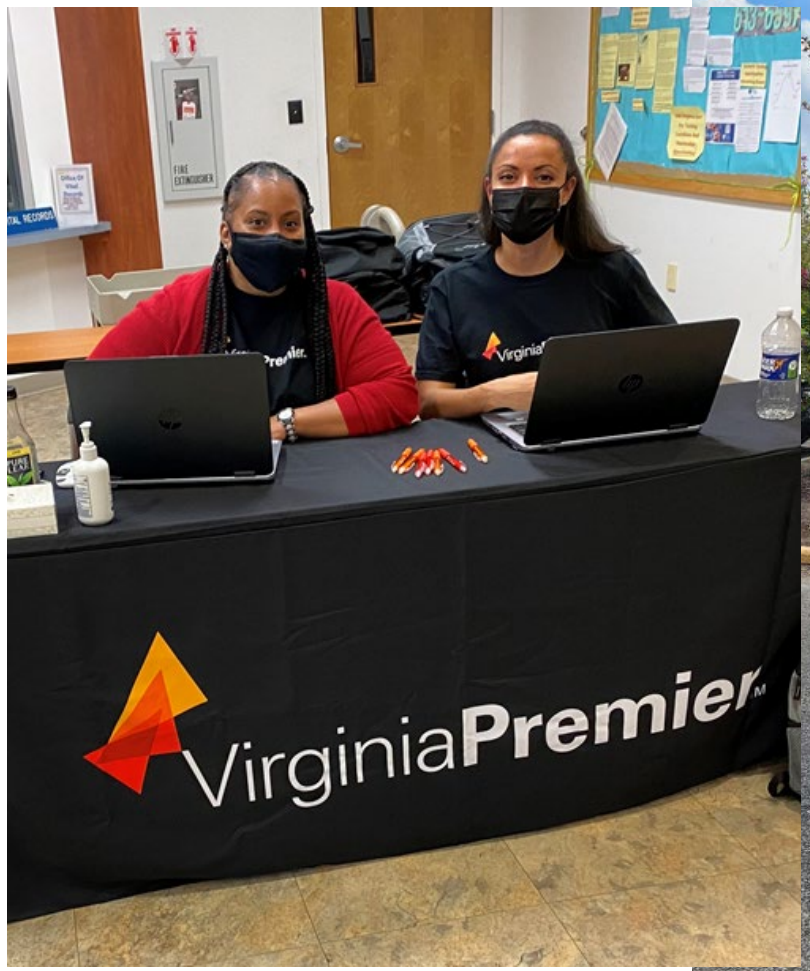
- Facebook live townhall held with Virginia Premier's Medical Director, Dr. Valerie Hicks.
- Member Advisory Committee meetings- Education on vaccinations and announcements on clinics and incentive programs.
- COVID-19 dedicate resource page on website
- Member Interview with Dr. Valerie Hicks- Posted on social media https://fb.watch/aGPDbEcEXB/

Other Vaccination Activities

Childhood/Adolescent Immunizations

- $50 Wal-Mart incentive for childhood and adolescent immunizations
- Provider incentive program (September 1, 2021-December 31, 2021)
  - Increased vaccination administration payment from $11 to $15
- Back-to-school immunization partnerships with Roanoke and Richmond Health Department
- Communication campaign in Southwest Virginia for back-to-school immunizations
  - Offering $50 Wal-Mart incentive and NASCAR race ticket for September 2022

Member Story

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UnitedHealthcare
VirginiaPremier


VirginiaPremier

Regulatory Activity Summary September 20, 2022
(* Indicates Recent Activity)

2022 General Assembly

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

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

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

***(04) Recovery Audit Contractor (RAC) - Exemption Request:** This state plan amendment requests an exemption from the Centers for Medicare and Medicaid Services (CMS) mandated Recovery Audit Contractor (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 2020, DMAS requested and received a temporary exemption from the RAC program, while research was conducted to procure a new RAC vendor. That exemption expired on July 1, 2022, so DMAS needed to file a request for another exemption. Following internal review, the SPA was submitted to DPB and to the Tribal Programs on 6/30/22; to HHR on 7/7/22; and to CMS on 8/8/22 for review. Following a conf. call, DMAS sent plan page corrections to CMS on 8/17/22. The SPA was approved on 8/29/22.

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

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

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

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

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

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

2021 General Assembly

***(01) Mental Health and Substance Use Case Management:** These regulation changes remove the limit on substance use case management for individuals in IMDs are to comply with the Medicaid Mental Health Parity Rule. The federal Mental Health Parity regulation can be found in 42 CFR 438.910(b)(1). Specifying that reimbursement is allowed, provided two conditions are met, for mental health and substance use case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in IMDs and individuals of any age who are inmates of public institutions, aligns DMAS regulations with 42 CFR 411.18(a)(8)(vii) and documents the Department's existing practices. Clarifying ISP review timeframes and grace periods, and clarifying CSAC-Supervisees can bill for substance use case management services, document existing DMAS practices, rather than changes in practices. Following internal review, the project was submitted to the OAG on 1/13/22. DMAS received OAG inquiries on 1/19/22 and responded to those on 1/27/22. The regulatory action was approved by the OAG on 2/23/22 and was forwarded to DPB for review on 2/24/22. The project was forwarded to HHR on 4/5/22.

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

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

***(04) Update to Outpatient Practitioners:** The purpose of this action is to add licensed school psychologists to the list of allowed providers of outpatient psychiatric services. Several of Virginia's Child Development Clinics have identified the need to allow licensed school psychologists to bill for outpatient psychiatric services provided in their clinics to increase access to the number of children that they serve. Following internal review, the project was submitted to the OAG on 8/27/21. OAG questions were received on 11/10/21 and DMAS

submitted responses to the OAG on 11/12/21. DMAS made Town Hall corrections on 11/16/21. DMAS responded to additional OAG questions on 2/7/22 and 2/8/22 and made project revisions on 2/11/22. The regulatory action was approved by the OAG on 2/22/22 and submitted to DPB on 2/23/22. DPB inquiries were received on 2/24/22 and DMAS sent responses to DPB on 3/2/22, 3/15/22, and 3/15/22. The regs were certified by DPB on 4/5/22. The project was submitted to the Secretary's Ofc. on 4/6/22. An Agency response to the Economic Impact Analysis (EIA) was posted on 4/12/22. The project was forwarded to the Gov. Ofc. for review on 6/17/22.

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

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

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

(08) Office-Based Opioid Treatment Changed to Office-Based Addiction Treatment: This SPA will allow DMAS to expand the substance use disorder service called "Preferred Office-Based Opioid Treatment" (which has been available only to individuals with a primary diagnosis of opioid use disorder) to individuals with a substance-related or addictive disorder. Following internal review, the SPA was submitted to CMS on 7/23/21. DMAS responded to informal questions on 8/5/21, 8/6/21, and 8/11/21. CMS approved the SPA on 10/14/21. The corresponding reg package, following internal review, was submitted to the OAG for review on 11/3/21. The OAG submitted additional questions and DMAS responded. The project was certified by the OAG on 12/10/21 and submitted to DPB on 12/13/21. DPB forwarded questions on 12/14/21 & 12/30/21; DMAS provided responses and made revisions to the regs. Following a call with DPB on 1/7/22, DMAS responded to additional DPB questions on 1/18/22, 1/29/22, and 1/20/22. The project was sent to HHR on 1/21/22. The reg action was forwarded to the Gov. Ofc. on 6/17/22.

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

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

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

2020 General Assembly

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

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

***(03) 2020 Long Term Services and Supports (LTSS) Screening Changes:** For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in accordance with 2020 HB/SB 902 to allow qualified nursing facility staff to complete the Long-Term Services and Supports (LTSS) screening for individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The amendments to the Code include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community based services. Following internal review, the regulations were submitted to the OAG for review on 11/18/20. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/1/21 and 4/14/21. DMAS submitted the project to DPB on 6/14/21. Questions were received on 6/21/21 and responses were sent to DPB on 6/21/21. A conf. call was held on 6/22/21 to discuss the project.

The reg action was submitted to HHR on 6/23/21. The regs were forwarded to the Governor on 11/10/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21 (w/ corrections sent on 12/29/21); published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal DMAS review, the fast-track stage regs were submitted to OAG on 7/26/22.

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

2017 General Assembly

(01) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and additional inquiries on 2/22/18, 3/19/18, 4/10/18, and 5/16/18. The regs were approved by the OAG and forwarded to the Governor's Ofc. for review on 6/19/18. The emergency regulations were signed by Governor and became effective on 6/29/18, and published in the Register on 7/23/18. The NOIRA comment period was held between 7/23/18 - 8/22/18. An ER Extension request was submitted on 10/16/18, and the ER was extended through 6/28/20. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21; to DPB on 12/6/21; to HHR on 1/19/22; and to the Governor's Ofc. on 6/1/22.

2015 General Assembly

(01) Barrier Crimes Not Permitted: This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 2/17/2017. The OAG issued inquiries on 3/21 and a conference call occurred on 4/26/17 to discuss the regs. The action had been placed on hold. Regulatory processing began again on 4/26/18 with a conf. call with the OAG. Revised text was forwarded to the OAG on 11/28/18 and an additional conf. call took place on 11/29/18. Additional revisions were sent to the OAG on 1/15/19. Another conf. call was held on 8/9/19 and revised regs were sent to the OAG on 8/16/19 for review.

Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.