BOARD OF MEDICAL ASSISTANCE SERVICES

Wednesday, June 10, 2020
10:00 AM BMAS Meeting

Department of Medical Assistance Services
VIRTUAL MEETING
Meeting ID: meet.google.com/vby-dahn-iqj
Phone Number(US): +1 636-324-2845
PIN: 262 164 562#

#	ITEM	AGENDA	PRESENTER
1.	Call to Order		
2.	Approval of Minutes 2.A. Approval of Minutes		
3.	Special Recognition / Tribute for Dr. Karen Rheuban 3.A. Special Recognition / Tribute to Dr. Karen Rheuban		Karen Kimsey
4.	Election of Officers 4.A. Election of Officers		Karen Kimsey, Director
5.	Director's Report 5.A. Director's Report		Karen Kimsey, Director
6.	Budget Update 6.A. Budget Update		Chris Gordon, Chief Financial Officer
7.	COVID-19 Updates 7.A. Regulatory and Federal Flexibilities 7.B. New flexibilities for Members 7.C. Chief Medical Officer Updates 7.D. Â Flexibilities in LTSS		Deputy Director of Administration, Rachel Pryor Chethan Bachireddy, Chief Medical Officer Tammy Whitlock, Deputy Director of Complex Care

8. New Business/Old Business

9. Public Comment
9.A. Public Comments

10. Adjournment

Board Secretary Contact
Brooke Barlow (804) 371-4308 brooke.barlow@dmas.virginia.gov

BMAS
DIRECTOR'S REPORT

Karen Kimsey
Director

June 10, 2020

Agenda

- Recognition of Dr. Karen Rheuban
- Elections of Officers
- Adapting Internally to COVID-19
- The Value of Medicaid During COVID-19

Thank You, Dr. Rheuban

Election of Officers

- Chair
- Co-Chair
- Secretary

Adapting Internally to COVID-19

Transition to Telework

- **Coordinated pre-planning effort**
  - Continuity of Operations Plan (COOP)
  - Essential functions tracking
- **Reviewed and updated teleworking policies**
  - Increased flexibilities
  - Equipment
- **Transition to remote work, March 18**
  - COOP Location

Supporting Our Teams

Back to the Building

Adapting Internally to COVID-19

Transition to Telework

Supporting Our Teams

- **Offering flexibilities for those taking care of children and families**
- **Staff Engagement**
  - Virtual Community Blog
  - Mindful Moments, virtual yoga
- **Supervisor and Manager Training**
- **Staff Morale**
  - Living Our Values Awards
- **Daily staff communications & weekly Director's Updates**

Back to the Building

Adapting Internally to COVID-19

Transition to Telework

Supporting Our Teams

Back to the Building

- **Survey**
- **Listening sessions**
- **Operation Homecoming Plan**
  - Phased return to the building
  - Planned safety measures and supplies

The Value of Medicaid During COVID-19

We've got our members covered.

- **Access to Coverage**
  - 420,000+ newly eligible adults have coverage under Medicaid Expansion.
- **Access to Health Care**
  - No Medicaid members will lose coverage during the health emergency
  - Co-payments suspended
  - No pre-approvals needed and existing approvals automatically extended for many critical medical services
  - 90-day supply and early refills for many routine prescriptions
  - Telehealth is covered and encouraged
- **Health Equity and High Risk Populations**
  - Pursuing improvements in health equity through innovations in maternal and infant health, and behavioral health
  - Critical safety net for older adults
  - Addressing complex behavioral health needs and substance use disorders

The Value of Medicaid During COVID-19

We've got our health care providers covered.

- **Provider Retainer Payments and Rate Increases**
  - Retainer payments for adult day health centers and providers that offer day services
  - Increased nursing facility reimbursement rates
  - Medicaid continues to work closely with providers and their networks to identify unique needs and costs related to infections control and loss in revenue
- **New Staffing Flexibilities**
  - Emergency rules give home and community-based providers greater ability to sustain staffing capacity by giving them more flexibility with training, oversight and other requirements.
  - Spouses, parents of minor children, and legal guardians of a member can provide and receive reimbursement for personal care services.

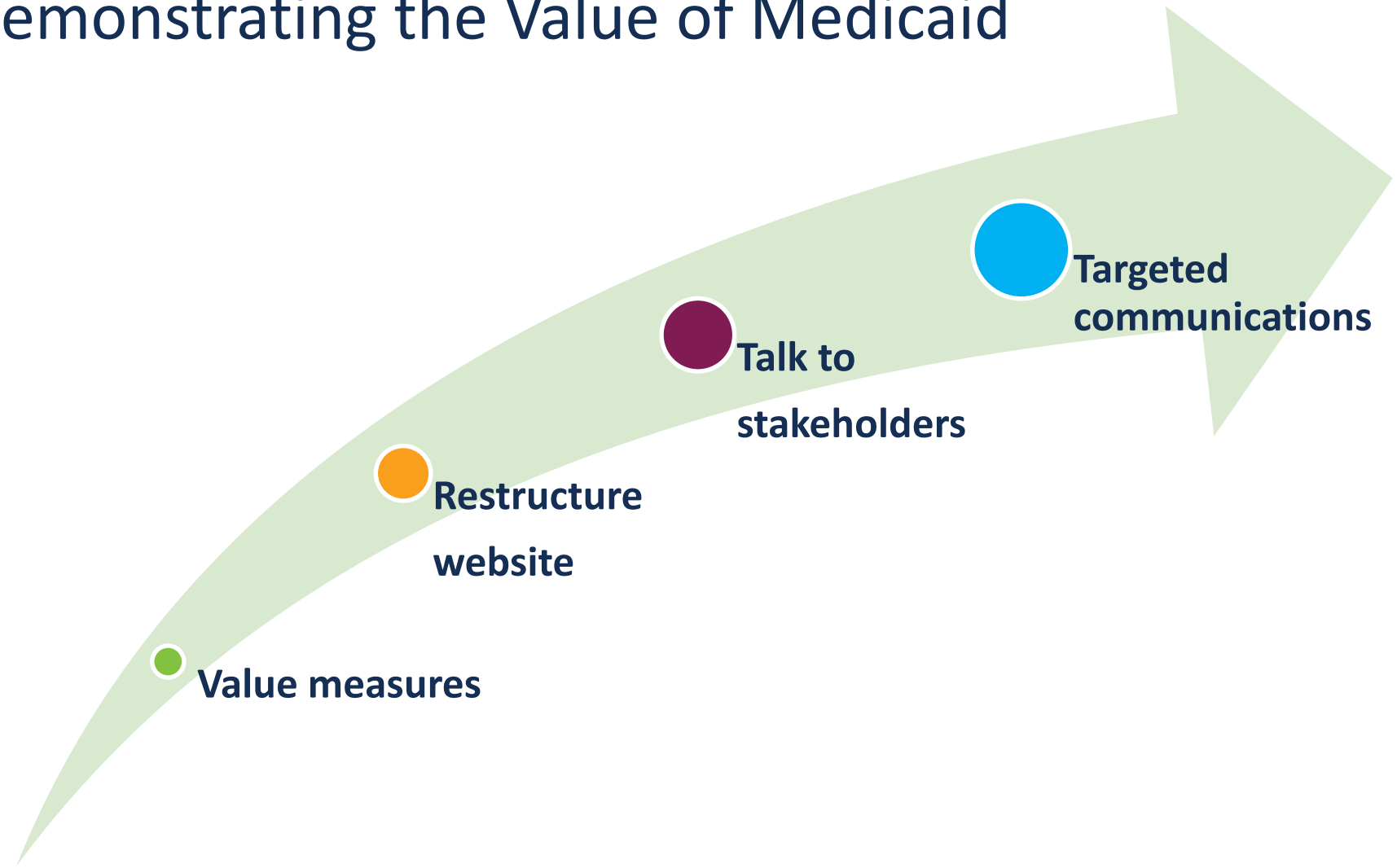
The Value of Medicaid During COVID-19

We've got our Commonwealth covered.

- Like many states, Virginia is facing a sudden, unprecedented **budget impact** due to COVID-19.
- DMAS is working closely with the Centers for Medicare and Medicaid Services to secure **increased federal funding** through emergency waivers and other opportunities to support our providers and reduce strain on the state budget.
- Virginia is committed to ensuring that these federal provider funds are used to prepare for, prevent the spread of, and respond to COVID-19 in communities that are most at risk for the spread of infection.

Looking Ahead

Demonstrating the Value of Medicaid



We've Got You Covered

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

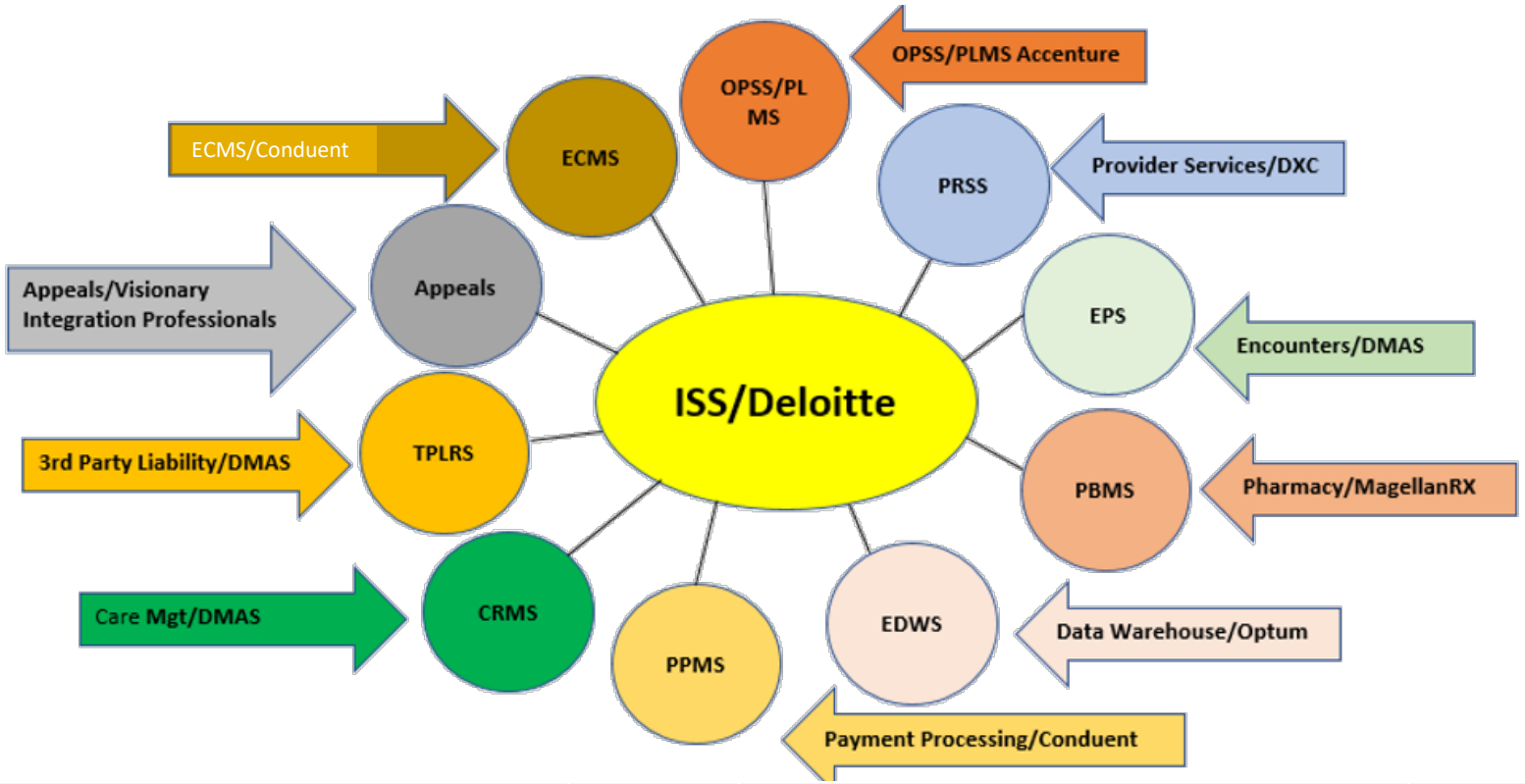
FINANCE & TECHNOLOGY UPDATE

Presentation to:

Board of Medical Assistance Services

June 10, 2020

Medicaid Enterprise System (MES) Timeline



Enterprise Data Warehouse (EDWS)	Live	Enterprise Content Management System(ECMS)	Aug 2020
Encounter Processing Services (EPS)	Live	Provider Services Solution (PRSS)	Sep. 2020
Pharmacy Benefit Management Solution (PBMS)	Live	Care Management Solution (CRMS)	July 2020
Third Party Liability Systems (TPLRS)	Live	Operations Services Solution & Plan Management (OPSS/PLMS)	Negotiations
Integration Services Solution (ISS)	July 2020	Payment Process Management Solution (PPMS)	Negotiations
Provider Appeals	Sep 2020		

Conduent MMIS Contract

CONDUENT

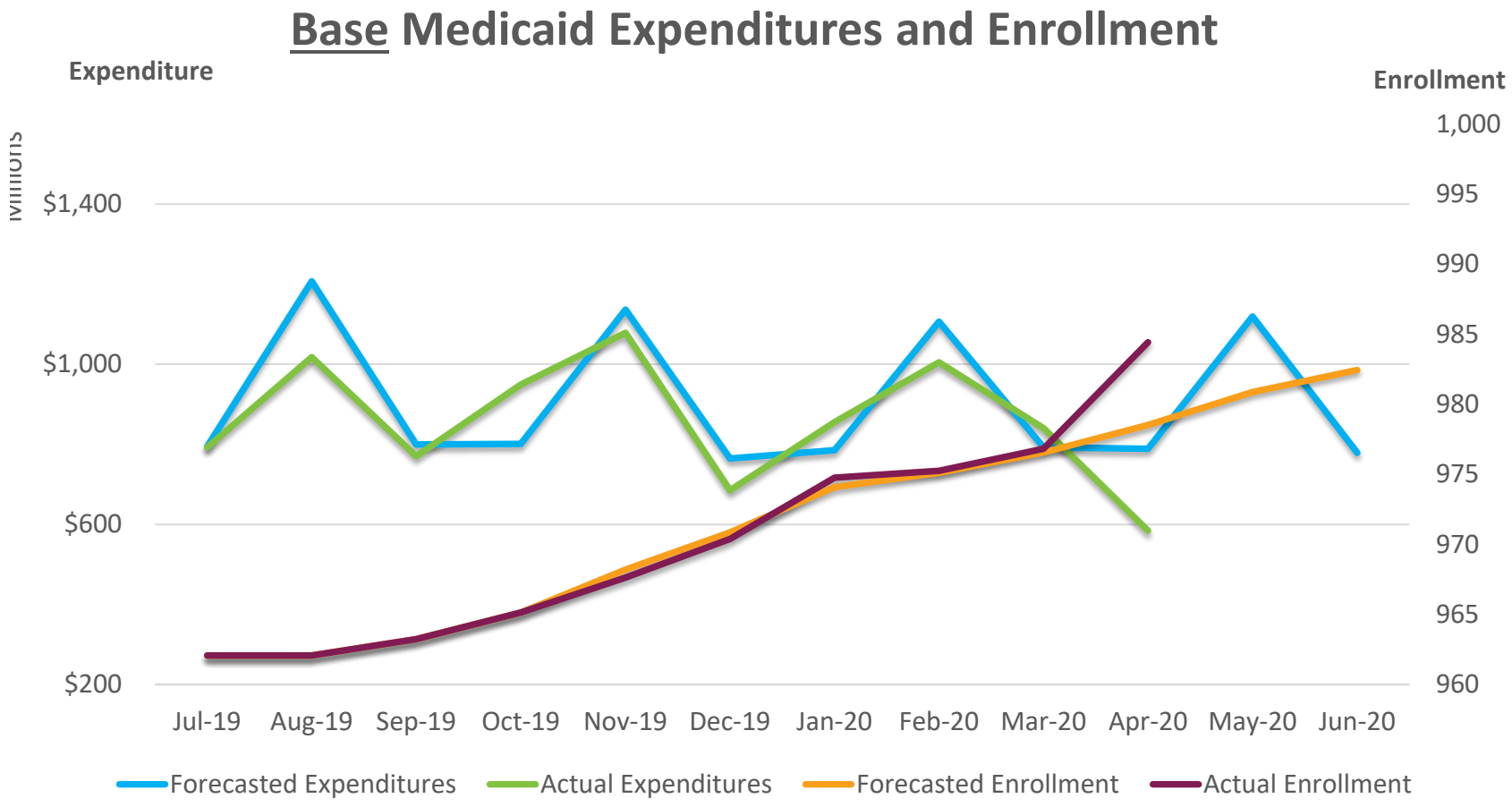
Late March

Contract negotiations

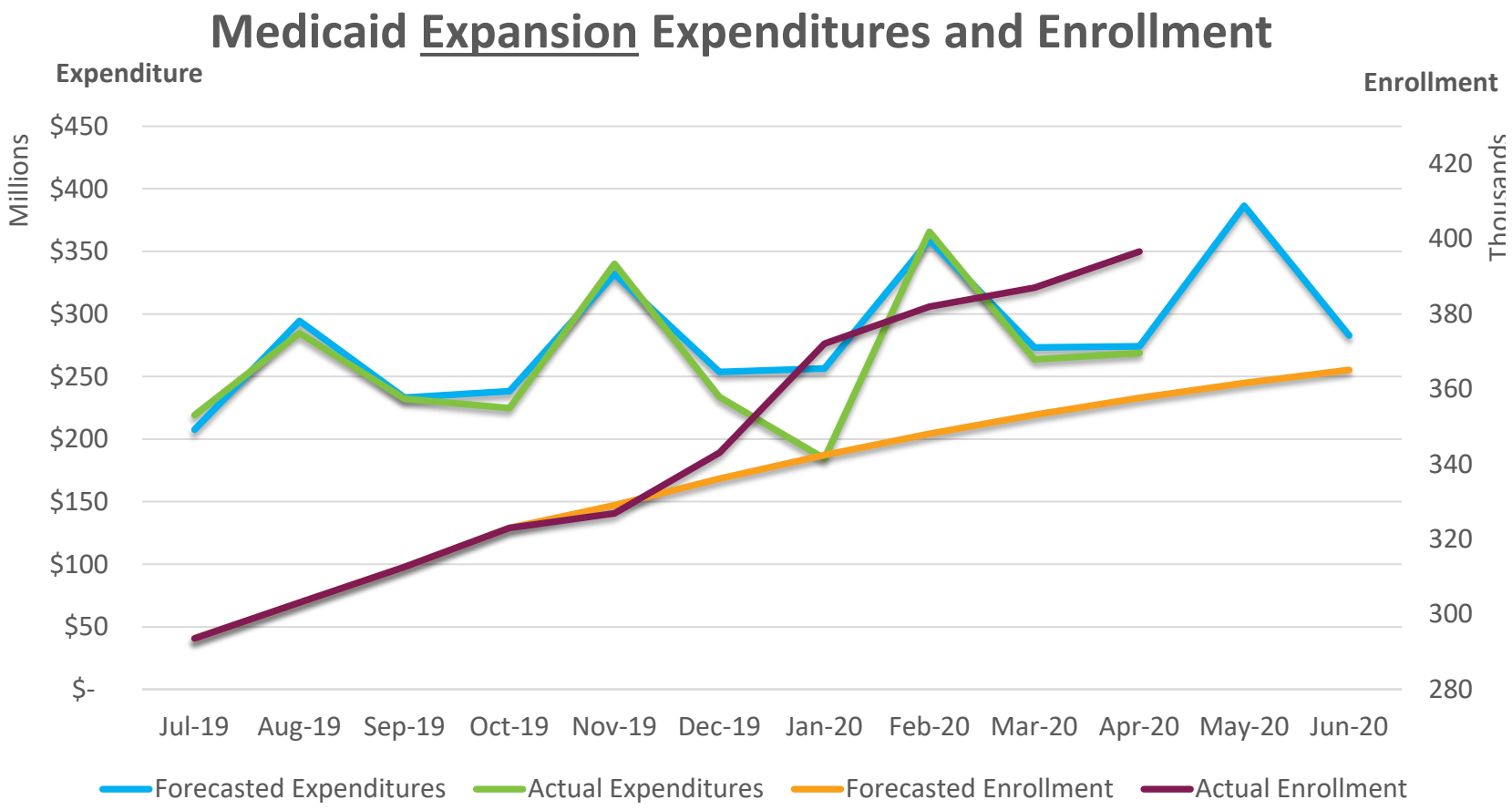
May1

Submitted Contract to CMS, OAG, and VITA

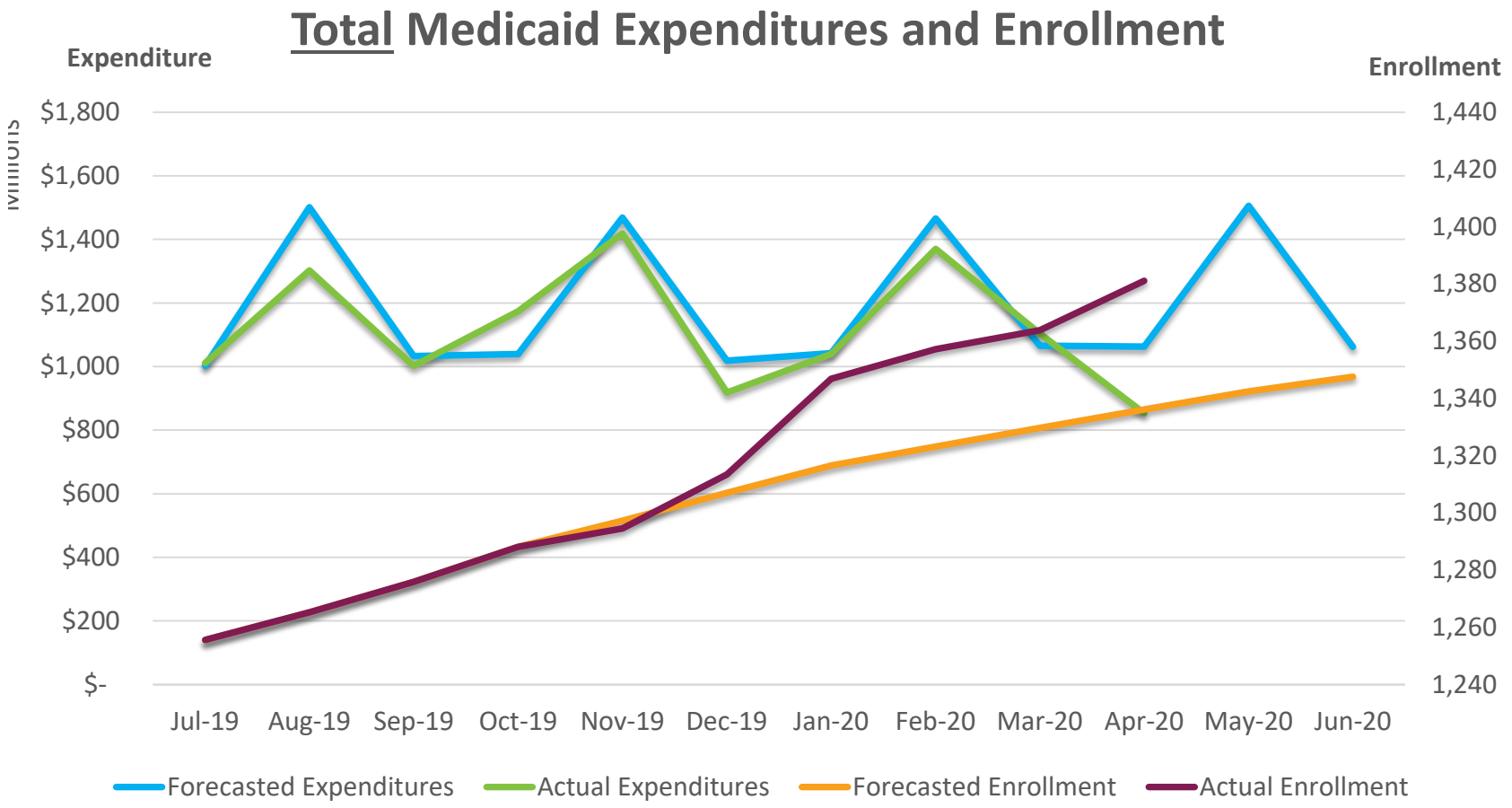
DMAS Forecast vs. Actuals – FY20



DMAS Forecast vs. Actuals – FY20



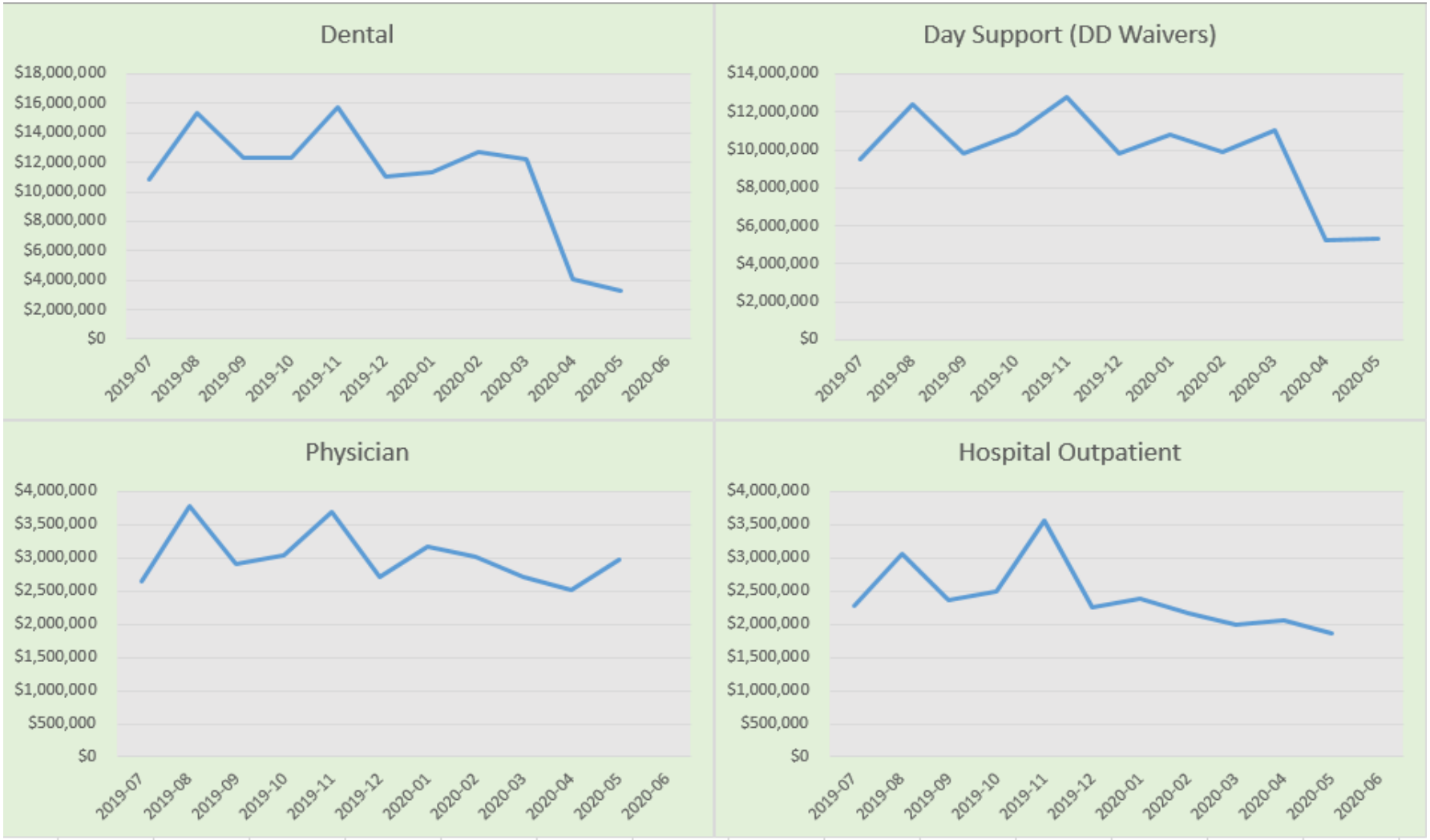
DMAS Forecast vs. Actuals – FY20



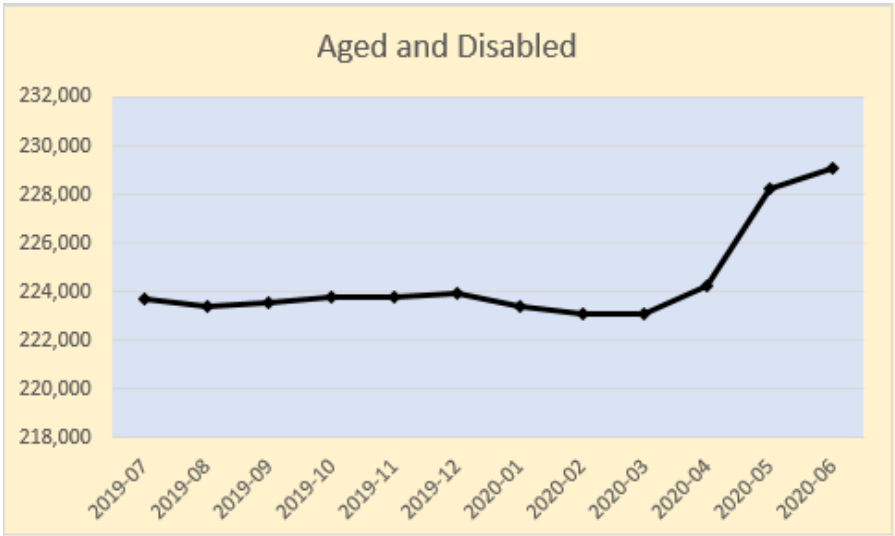
DMAS Administrative Expenditures – FY20

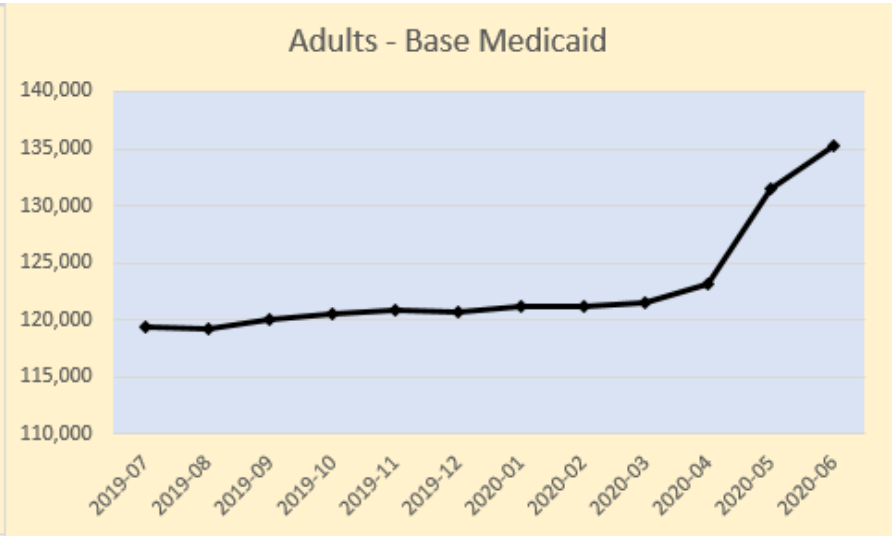
SFY20 ADMIN YE PROJECTIONS			
	GF Budget	YE GF Projections	Remaining GF Balance
Agency Operations	1,956,905	2,427,999	(471,094)
Contractual Services	28,076,566	26,857,373	1,219,193
Information Technology	14,106,501	11,373,767	2,732,734
Professional Development	431,393	341,909	89,484
Salaries & Benefits	21,376,717	21,223,968	152,749
TOTAL	$65,948,082	$62,225,016	$3,723,066
GF Pledge	($3,500,000)		($3,500,000)
TOTAL APPROPRIATION	$62,448,082	$62,225,016	$223,066

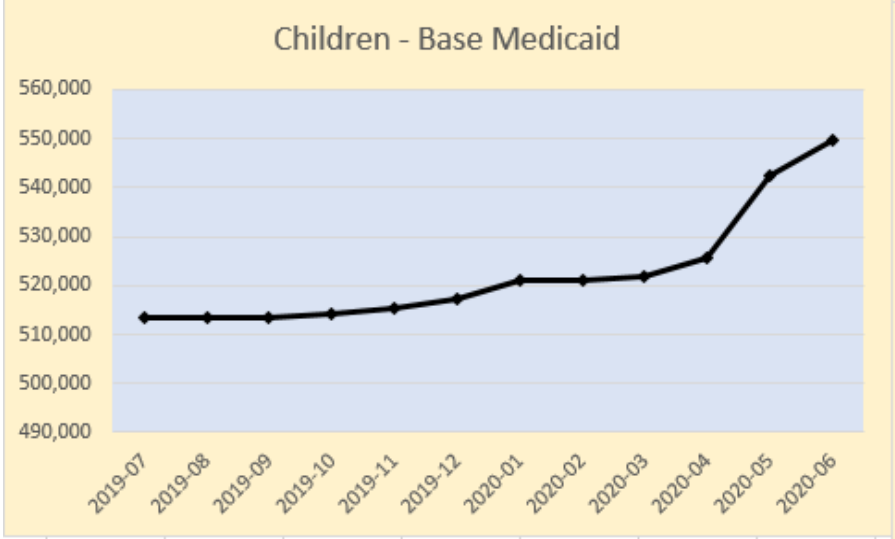
DMAS Medical FFS Expenditures-COVID19

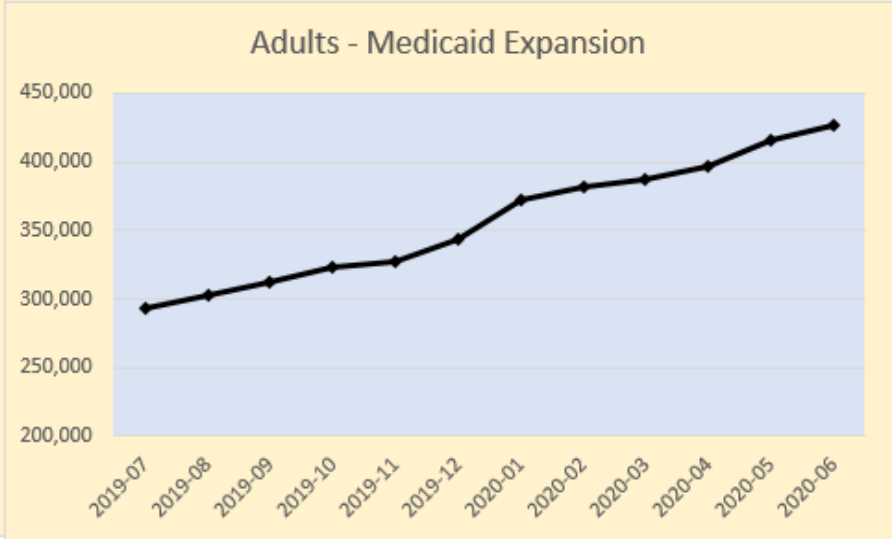


DMAS Medical Enrollment-COVID19

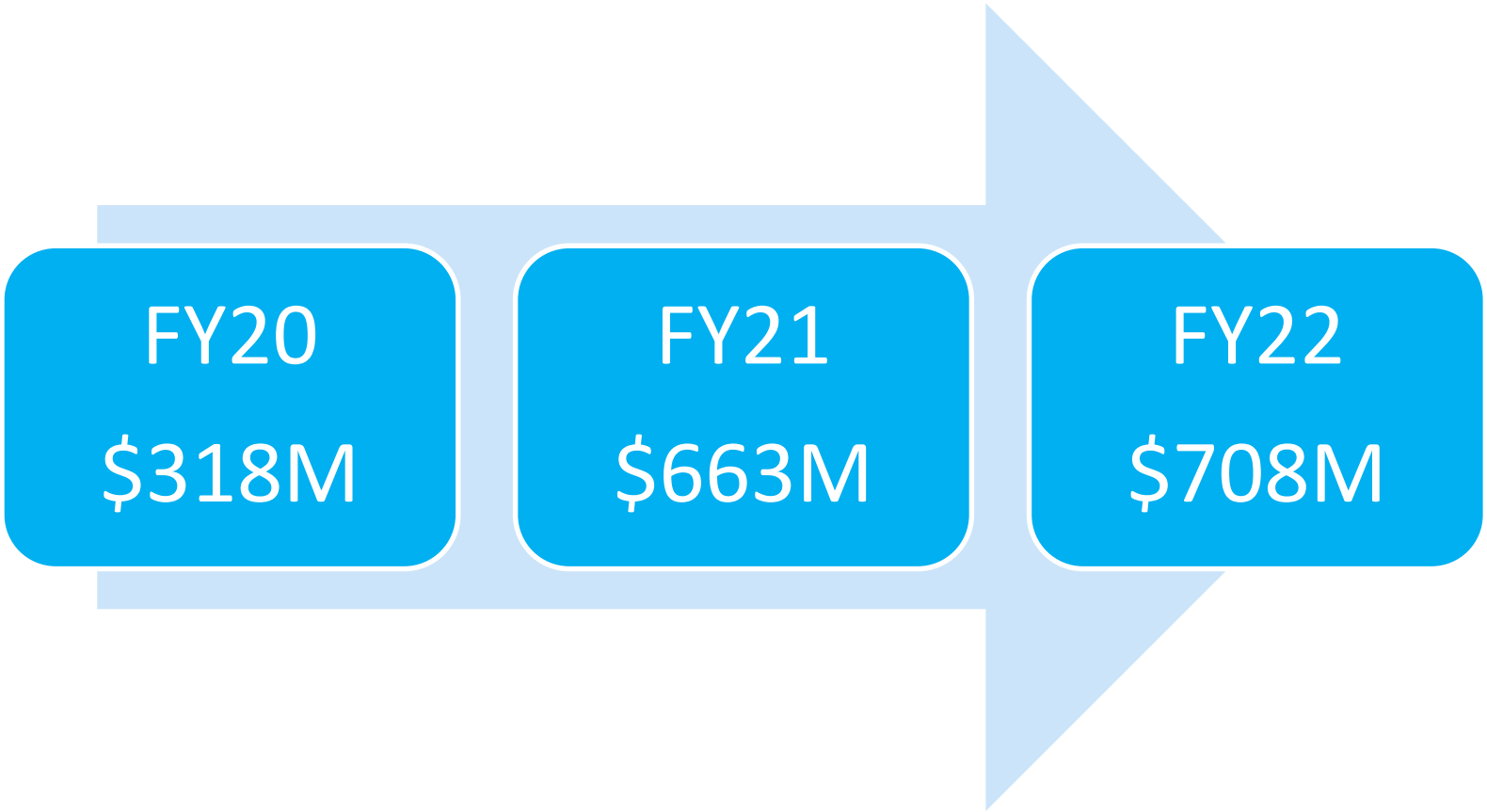








DMAS EFMAP-COVID19



DMAS FY20 Agency Year End Balances

PROGRAM	SFY2020 General Fund Appropriation	Projected Year End Balance*
Temporary Detention Orders	$17,991,740	$663,588
Family Access to Medical Insurance Security Plan (FAMIS)	$33,417,135 $14,065,627 (FAMIS Trust Fund)	$333,687 $0
Medical Assistance for Low Income Children (MCHIP)	$41,382,173	$7,208
Non-Medicaid Medical Assistance Services (HIV and UMCF)	$781,702	$335,425
Medicaid	$4,765,424,364 $408,419,831 (VHCF)	$83,715,021 $0
Medicaid & CHIP Forecasted Admin	$14,377,806	$2,435,706
Administrative and Support Services	$66,735,862	$223,066

**Projected balances includes the EFMAP unallotment and DMAS' general fund year end pledge*

Capitation Rate-Setting

Milestone in FY21 Capitation Rate Setting	Date
Send Draft Rates to MCOs.	**4/1/2020**
Initial FY21 Medallion and CCC Plus Rate Meeting with MCOs	4/8/2020
Host Q and A session with MCOs/CFOs	**5/8/2020**
Finalize and Send Interim Rates to MCOs	5/13/2020
Interim Final FY21 Rate Meeting.	**5/22/2020**
Finalize FY21 Rates, Notify DPB and Money Committees.	6/1/2020
Submit contract and rates to CMS for approval.	**6/19/2020**

Provider Health Information Breach Notification

March 2, 2020

Notify Internal Stakeholders:

- DSS
- CoverVA
- Others

March 5, 2020

Notify MCOs:

- Anthem
- Aetna
- Magellan
- Optima
- Virginia Premier
- United Healthcare

March 9, 2020

Notify Members:

- 6,120 members affected

March 26, 2020

Notify the Public:

- Posting in daily newspapers
- Website updated

Credit monitoring was provided to all affected members through Symantec Lifelock. DMAS established a call center to take member questions on the breach.

APPENDIX
HB30 FY21/22 Unallotted Items

Item Description (Includes Admin and Medical)	FY2021	FY2022
Supplemental Payments for Children's National Medical Centers	($354,766)	($354,766)
Fund Managed Care Contract Changes	($812,600)	($1,014,350)
Increase Medicaid Rates for Anesthesiologists	($253,376)	($262,491)
Increase payment rate by 9.5% for Nursing Homes with special population	($493,097)	($506,903)
Increase mental health provider rates	($2,374,698)	($2,458,479)
Add 500 DD Waiver Slots in FY 2022	$0	($4,133,500)
Modify Nursing Facility Operating Rates at Four Facilities	($733,303)	($754,247)
Modify Medicaid Nursing Facility Reimbursement	($6,794,541)	($6,984,788)
Increase DD waiver provider rates using updated data	($21,395,221)	($22,037,077)
Increase Developmental Disability (DD) waiver rates	($3,639,663)	($3,748,853)
Increase Rates for Skilled and Private Duty Nursing Services	($6,245,286)	($6,245,286)
Provide care coordination prior to release from incarceration*	($252,104)	($369,741)
Residential Psychiatric Facility Rates	($7,599,696)	($7,599,696)

APPENDIX
HB30 FY21/22 Unallotted Items Continued

	FY2021	FY2022
Add Adult Dental Benefit to Medicaid	($8,743,420)	($25,304,935)
Allow Overtime for Personal Care Attendants	($9,609,223)	($9,609,223)
Expand opioid treatment services	($421,476)	($1,273,633)
Medicaid MCO Reimbursement for Durable Medical Equipment	($345,621)	($352,534)
Modify Capital Reimbursement for Certain Nursing Facilities	($119,955)	($119,955)
Allow FAMIS MOMS to access substance use disorder treatment in an institution for mental disease	($307,500)	($356,775)
Fund home visiting services	$0	($11,750,159)
Fund costs of Medicaid-reimbursable STEP-VA services	($486,951)	($2,293,826)
Extend FAMIS MOMS' postpartum coverage to 12 months	($1,114,936)	($2,116,376)
Enhance behavioral health services	($3,028,038)	($369,741)
Medicaid Works for Individuals with Disabilities	($114,419)	($7,599,696)
Expand Tobacco Cessation Coverage in Medicaid	($34,718)	($25,304,935)
Fully Fund Medicaid Graduate Medical Residency Slots	($1,350,000)	($9,609,223)

APPENDIX
HB30 FY21/22 Unallotted Items Continued

	FY2021 GF	FY2022 GF
Increase Rates for Adult Day Health Care	($796,755)	($1,273,633)
Eliminate 40 quarter work requirement for legal permanent residents (medical costs)	($1,002,169)	($352,534)
Eliminate 40 quarter work requirement for legal permanent residents (admin costs)	($169,922)	($94,667)
Provide care coordination prior to release from incarceration	($95,699)	($95,699)
Medicaid Provider Rates Analysis	($300,000)	
Administrative Costs to Implement Live-In Caretaker Exemption	($507,500)	($373,000)
Total Unallotted Items	**($78,539,655)**	**($127,501,107)**

POLICY & ADMINISTRATION UPDATES

BOARD OF MEDICAL ASSISTANCE SERVICES (BMAS)

June 10, 2020

RACHEL PRYOR
DEPUTY DIRECTOR OF ADMINISTRATION

Virginia's COVID-19 Policy Strategy

Since the declaration of the public health emergency, DMAS has taken actions to extend flexibilities to support members, providers, and other stakeholders, and mitigate the impact of COVID-19.

- Two Executive Orders issued pertaining to Medicaid
- 86 provisions of state regulation waived
- Six provider memos have been issued
- Nine federal regulatory waivers filed
- COVID-19 landing page added to DMAS and Cover VA websites to include resources for advocates, providers and members

Key Provisions from Congress Related to Medicaid

COVID-Related Resources

- **6.2% FMAP Increase**. Contingent on DMAS meeting the Maintenance of Effort and continuation of coverage requirements per Section 6008 of the Families First Coronavirus Response Act (FFCRA)
- **COVID Relief Fund**. Approximately $3.1 B to Virginia plus $200 M for localities; totaling $3.3 B.
- **Provider Relief Fund.** $175 B (CARES bill) in direct funding to healthcare providers for expenses and lost revenue attributable to COVID-19 and not reimbursable through other sources.
- **Increased health-related spending**. Approximately $180 B in increased health-related spending in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, with much of it aimed directly at providers – unclear how much will go to Virginia and its providers (CRFB).
- **4th stimulus package likely on the way.** Details are unclear; may include additional Medicaid provisions, among other forms of assistance.

Federal Pathways

Authority Type	Description
Concurrence Letter	Allows a state to leverage flexibilities under specific circumstances without a requirement to amend the State Plan. Prior CMS concurrence is not required under regulation, but assists in the event of PERM review or audit.
State Plan Amendment Disaster Relief SPAs	During the emergency, revises eligibility, enrollment, cost sharing & benefit requirements in the State Plan. Requires CMS approval, lasts length of the emergency as declared by Secretary Azar.
Section 1135 Waiver	Authority to temporarily waive certain requirements to ensure sufficient health care items & services are available for emergency needs. Enables providers to furnish needed items & services, be reimbursed & exempted from sanctions. Requires CMS approval, ends at termination of emergency.
Section 1115 Waiver	Waives compliance with certain provisions of federal Medicaid law & authorizes expenditures not otherwise permitted by law. Disaster-related demonstrations can be retroactive to the date of the Secretary's declared public health emergency. Submissions are exempt from normal public notice process in emergent situations. Requires CMS approval.
1915(c) Waiver Appendix K	Submitted during emergency to document necessary changes to waiver operations, includes actions that can be taken under Section 1915(c) in an emergency, goes into effect in the event of a disaster.

Federal Flexibility Pathways

Teams have moved aggressively to assist members and providers during the COVID-19 crisis.

Federal Authority	Date Requested Flexibility to CMS	Current Status
Concurrence Letter	3/16/2020	Approved
Medicaid Disaster Relief State Plan Amendments (SPA)	3/13/2020 (Part I) 5/1/2020 (Part II)	Approved Approved
CHIP Disaster Relief SPA	3/16/2020 (Part I) 4/24/2020 (Part II)	Approved Approved
Section 1135 Waiver Part I	4/15/2020	Approved
Section 1135 Waiver Part II	4/23/3030	Approved
Section 1115 Waiver	5/29/2020	Pending
1915(c) Waiver Appendix K	4/17/2020	Approved

COVID-19: State Flexibility Pathways

Executive Order 51 (issued 3/12) – authorized executive branch agencies to waive any state requirement or regulation, and enter into contracts without regard to normal procedures or formalities

Executive Order 58 (issued 4/23) – waived additional provisions in the Code of Virginia

2020 Appropriations Act (Chapter 1289) Item 317.DD – allows DMAS updates to the State Plan & related waivers to address the pandemic. **HB30, Item 4-5.03 (Services and Clients)** – removed limits on altering & changing cost factors in response to COVID-19 when funding is from a non-general fund source or any source when approved by the Governor in response to the pandemic.

COVID-19 Related Eligibility & Enrollment Changes

Teams moved aggressively to assist members during the COVID-19 crisis.

Continuation of Coverage

- ✓ Delayed acting on changes affecting eligibility
- ✓ Expanded redetermination timelines
- ✓ Continuation of coverage for all Medicaid and CHIP members
- ✓ Waive out-of-pocket costs to member for duration of state emergency.

Additional Member Flexibilities

- ✓ Waive public notice and comment period requirements related to SPAs and modify tribal consultation timeframes.
- ✓ Suspend integration requirement for incarcerated individuals
- ✓ Consider Medicaid beneficiaries displaced from VA temporarily absent
- ✓ Accept attestation of medical expenses

COVID-19 Related Appeals Changes

Member Appeals

For appeals filed during the state of emergency, Medicaid members will automatically keep their coverage (i.e. Medicaid eligibility or an appealed existing medical service) while the appeal is proceeding. Medicaid managed health plans will also approve continued coverage while their internal appeal process is underway.

The timeframe to file an appeal is extended during the period of emergency.

DMAS will hold all hearings by telephone, but if the member is unable to participate at the scheduled time, DMAS will reschedule the hearing to a later date.

Provider Appeals

Providers affected by the COVID-19 emergency can request a hardship exemption to the normal deadline to file an appeal.

All deadlines after an appeal has been filed are extended for the period of the declaration of emergency.

All informal fact-finding conferences and formal hearings will be conducted by telephone during the period of emergency.

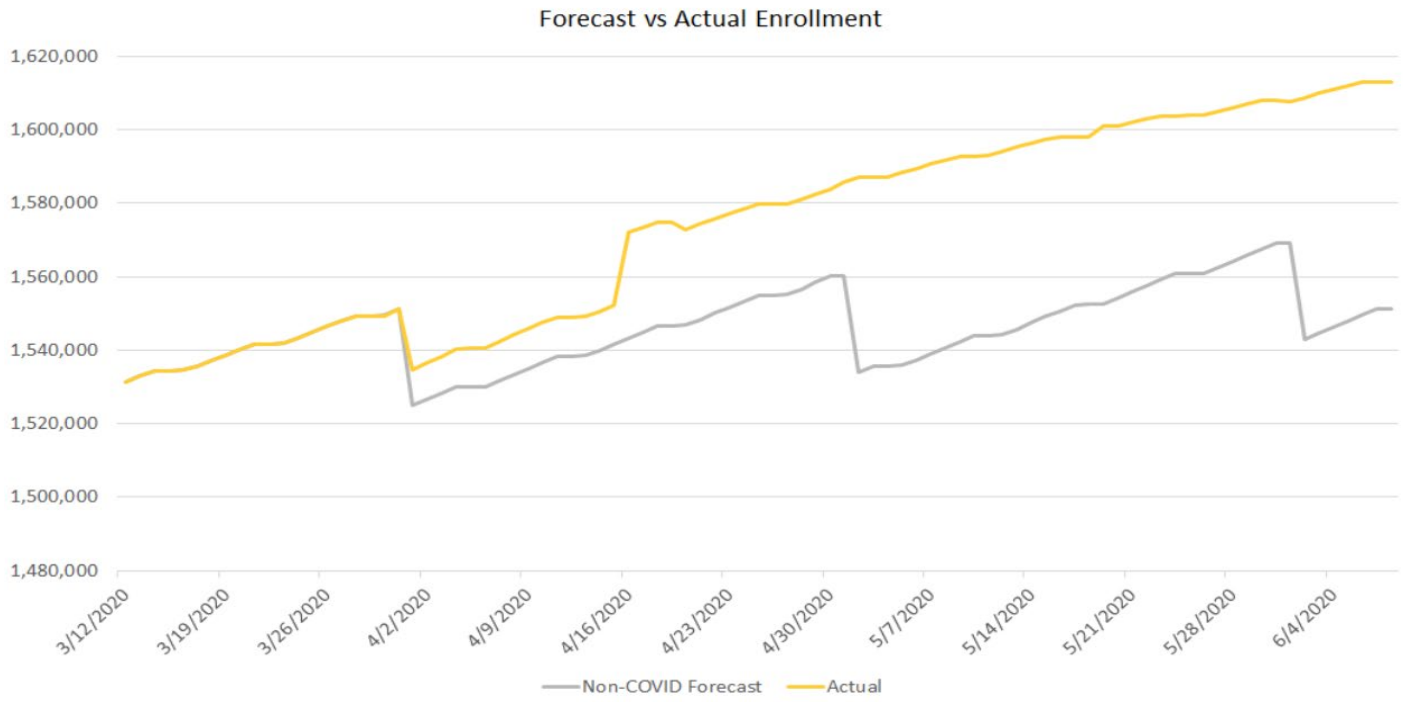
Additional Member Improvements

- **Cover Virginia Consumer Inbox** – A new inbox has been added to allow members and applicants to submit verifications that have been requested at application, renewal, or when a change is reported. Created in response to the emergency, this inbox will remain a permanent option for consumers

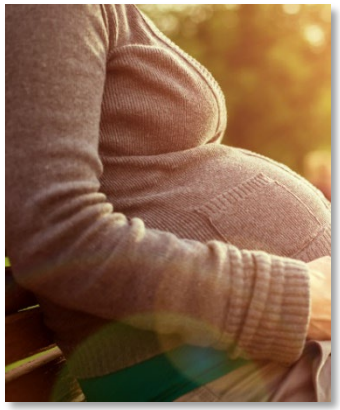
- **Authorization for Verbal Consent**: allows an individual to grant verbal consent to an application assister such as a navigator or Certified Application Counselor to file an application on the individual's behalf by paper, telephonically, or electronically

Enrollment Data in the Public Health Emergency

- A total of **1,612,996** members are enrolled in Virginia Medicaid
- Since the declaration of the state of emergency an additional **81,126** members have enrolled of which **35,402** are enrolled in the expansion group and **27,872** are children
- This is **61,687** enrollments above the non-COVID forecast
- **21,966** members were added during the month of May







MEDICAID DURING THE COVID-19 CRISIS

June 10, 2020

CHETHAN BACHIREDDY, MD, MSC

CHIEF MEDICAL OFFICER,
DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES

Agenda

The Crisis

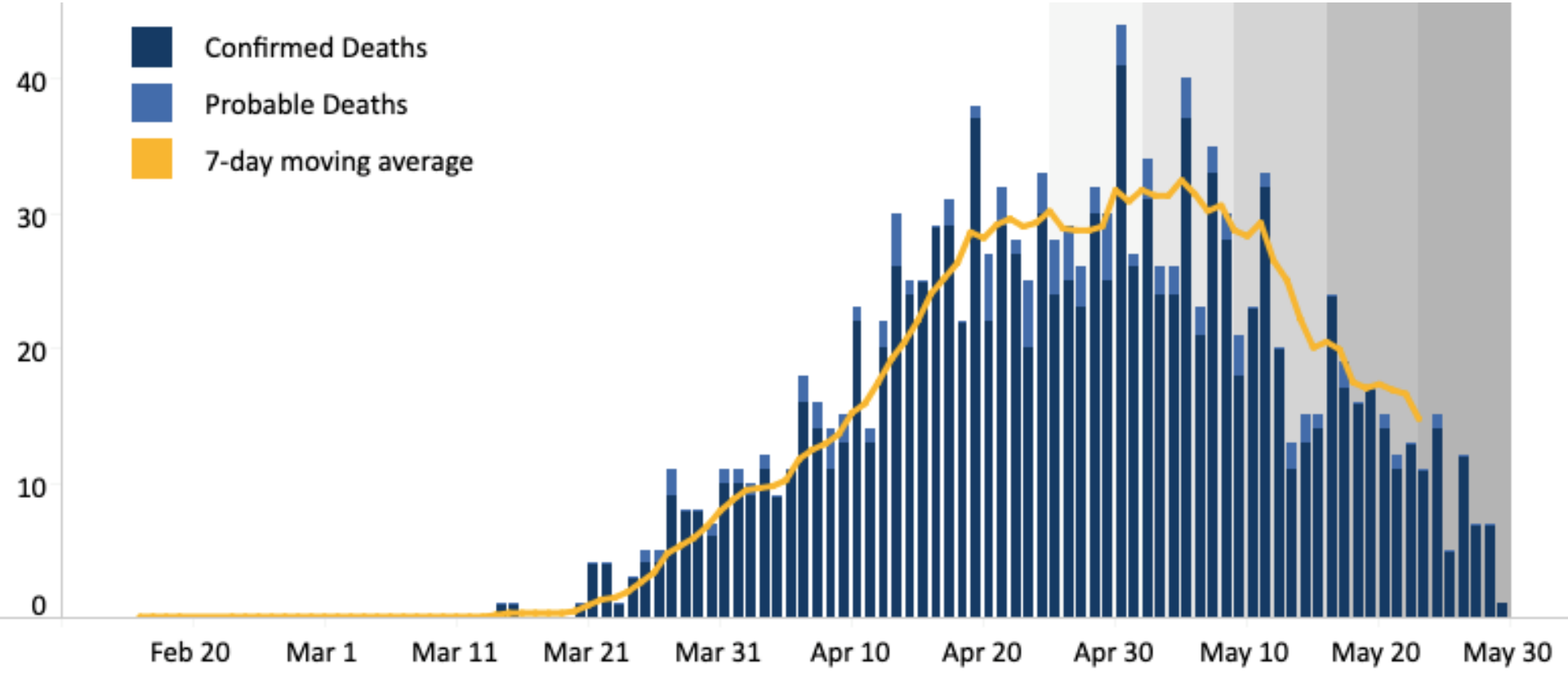
Testing

COVID Check

Telehealth

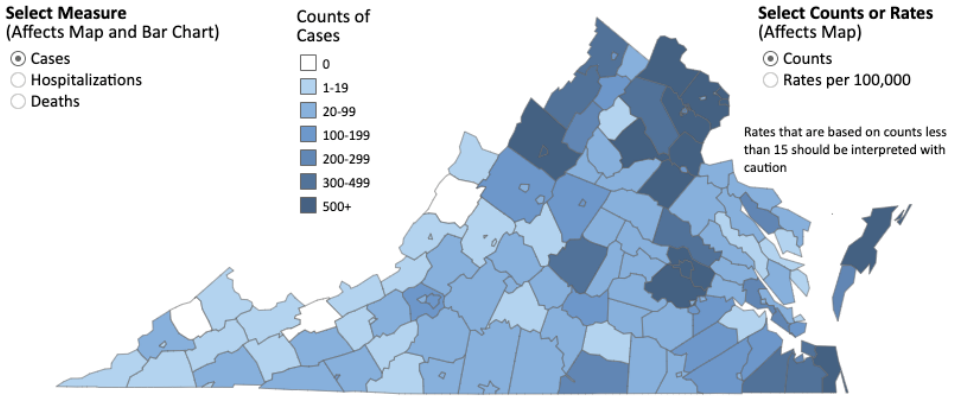
The COVID-19 Crisis

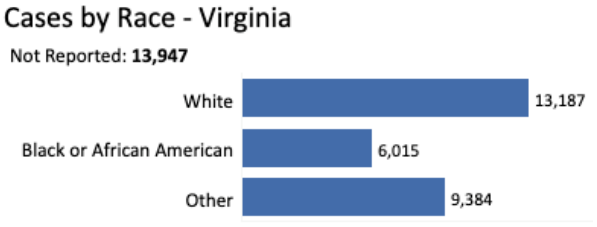
Total Cases*	Total Hospitalizations**	Total Deaths
43,611	4,601	1,370

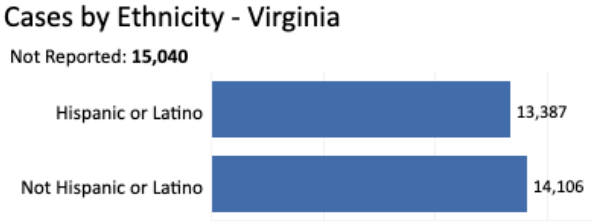


Source: VDH

Who is Impacted by COVID-19?



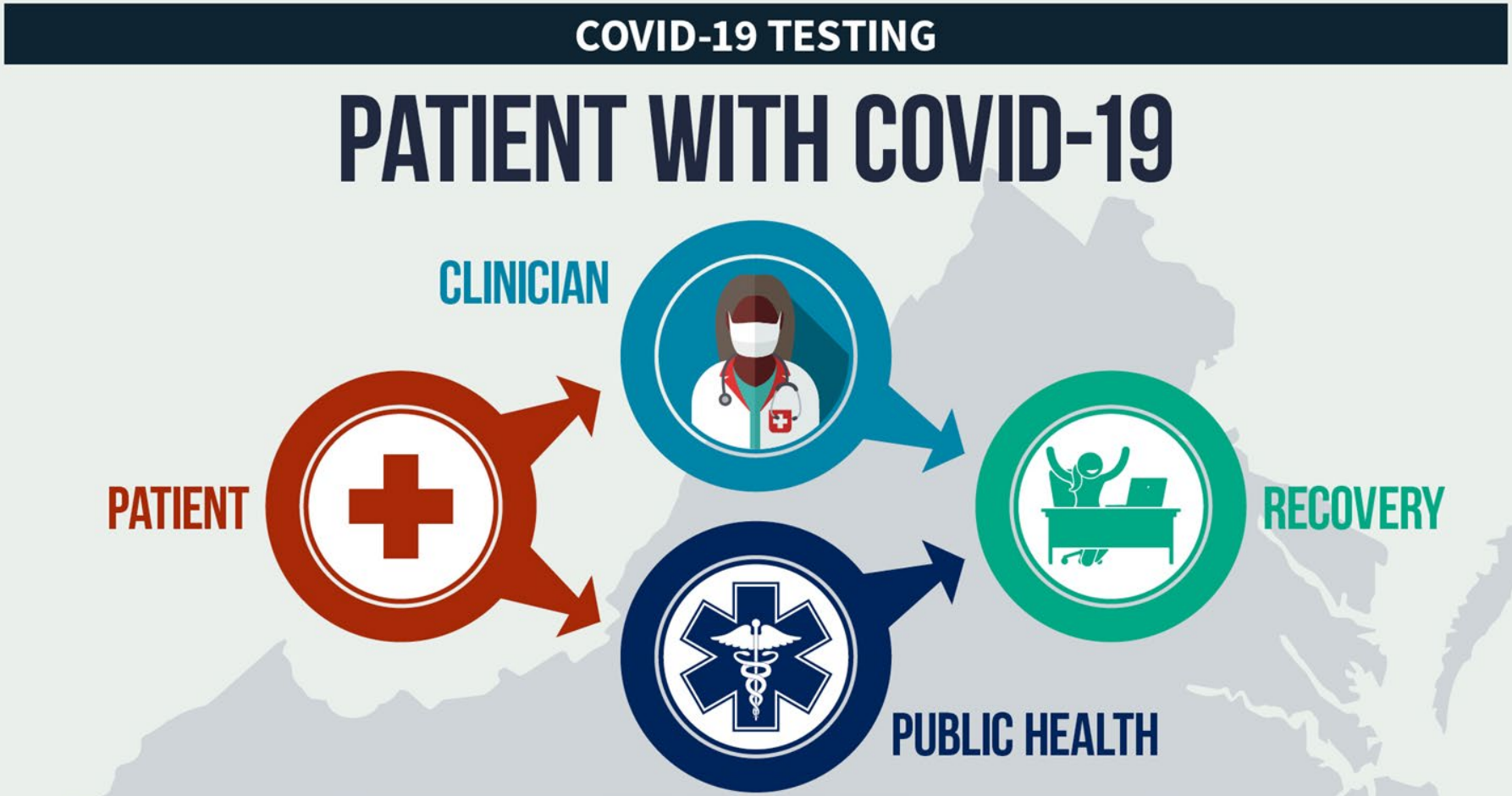




Cases and Deaths by Outbreak Facility Type - State Totals

Long Term Care Facilities	Cases	4,757
	Deaths	774
Congregate Setting	Cases	1,501
	Deaths	21
Correctional Facility	Cases	1,208
	Deaths	5
Healthcare Setting	Cases	111
	Deaths	4
Educational Setting	Cases	46
	Deaths	0

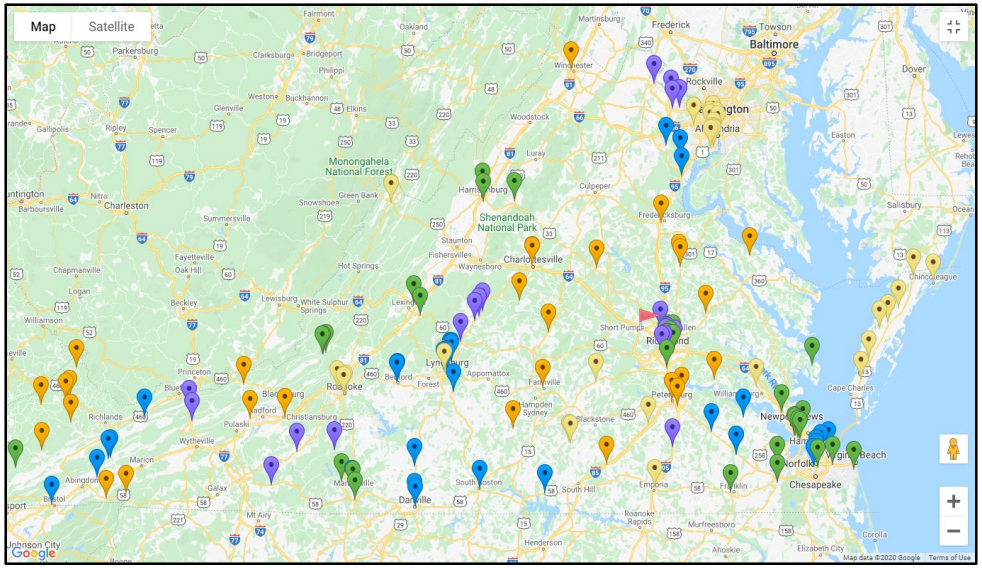
Testing


COVID-19 TESTING
PATIENT WITH COVID-19
CLINICIAN
PATIENT
RECOVERY
PUBLIC HEALTH

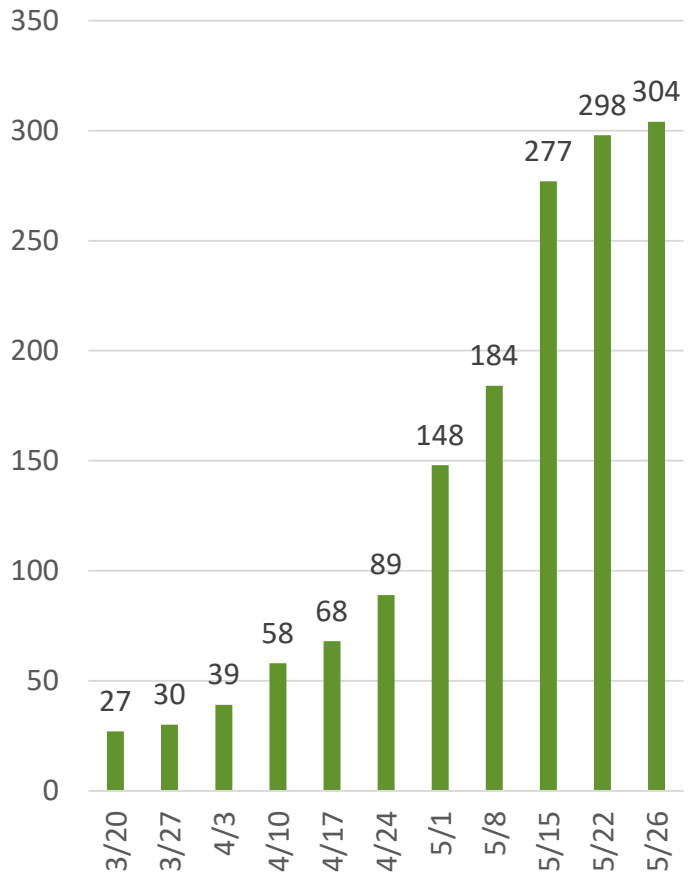
Activating Providers to Expand Testing

May 27, 2020:

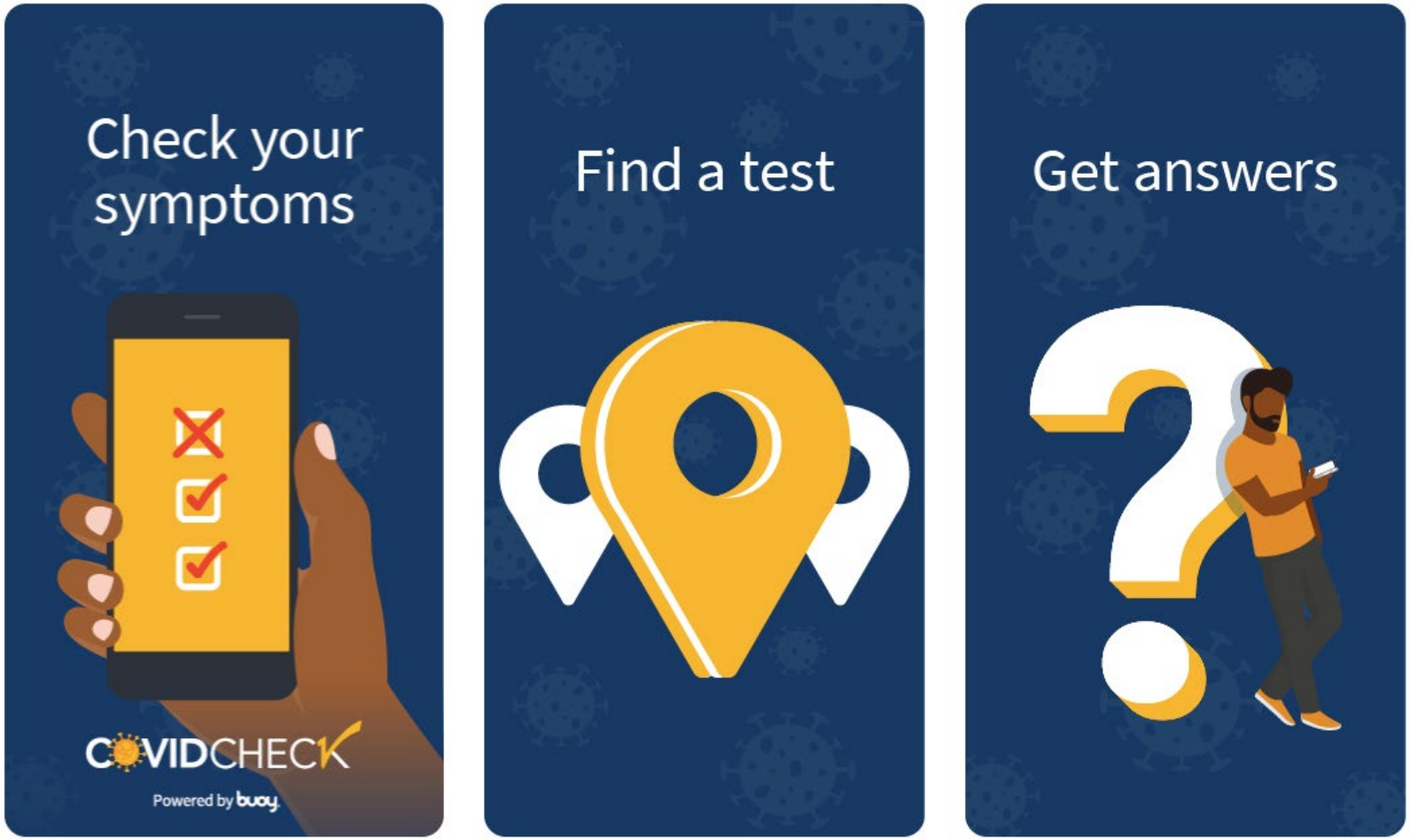
- Partnership with Virginia Community Healthcare Association.
- **31** FQHCs currently offering testing, with an additional **37** under consideration.



Public Testing Sites



Activating Members through COVID Check



COVID Check

Self-assessment → Guidance → Navigation → Care

This tool is not a substitute for professional medical advice, diagnosis, or treatment. If you are experiencing a life-threatening emergency that requires immediate attention please call 911 or the number for your local emergency service.

Let's assess your risk for coronavirus

Are you experiencing any of the following symptoms?

Please mark all that apply

- Chills
- Cough
- Fever
- Difficulty getting enough air

Contact a medical professional today

Because of your chills and pre-existing medical condition, it is possible that you have coronavirus.

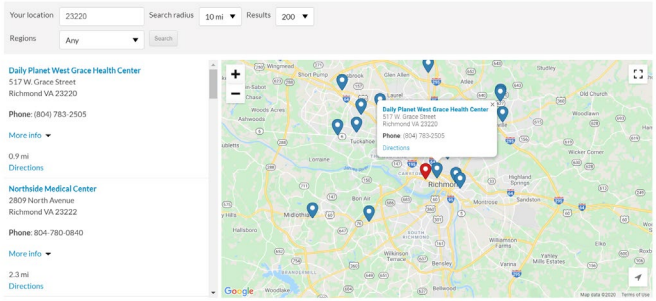
We recommend contacting a medical professional today.

Expect longer-than-average wait times and limited supply of tests in most areas.

If this feels like an emergency, visit the nearest emergency room.

COVID-19 Testing Sites

This map/list is intended to help provide information of known locations of various COVID-19 test sampling sites and does not constitute endorsement by VDH. There may be additional sites that offer test sampling that are not included on the map and the status of listed sites are subject to change (may no longer perform COVID-19 testing services).



All insurance plans within Virginia are waiving deductibles, copays, and coinsurance for telehealth visits related to coronavirus. If you can't reach your doctor or don't have one, select one of the options below. Contact your health plan to check for coverage before your visit.

VIRTUAL CARE

LiveHealth ONLINE

LiveHealth Online

24/7

Log in to see wait time

Last Updated 5/31 @ 7:59 PM

- Talk to a doctor about getting a required referral for coronavirus testing.
- Care for non-emergency illnesses and injuries.
- Prescriptions may be available as needed.

Connect Now

Ensuring Access to Care through Telehealth

- Home as an originating site
- Use of audio in addition to audio-visual modalities
- Payment parity with in-person visits
- Simplified billing and documentation
- Remote patient monitoring for COVID-19
- Enhanced specialty access through eConsults

Questions?

COVID-19 FLEXIBILITIES: LONG-TERM SERVICES AND SUPPORTS

BMAS
June 10, 2020

Tammy Whitlock, Deputy Director of Complex Care and Services

Waiving Service Authorization Requirements on Select Services

Medicaid Memo 3/19/20

- Service authorizations for specific Waiver or EPSDT services automatically extended for 60 days.
- Service authorization requirements for specific DME and Home Health services are waived during the emergency period.
- Suspension of Out-of-Network authorization requirements and pay these providers the Medicaid fee schedule.

Long-Term Services and Supports (LTSS)

- Remote services and telehealth are permitted for routine visits, level of care screenings, re-assessments, service plan development meetings, registered nurse supervisory visits, and service facilitator reassessment visits.
- Quality sampling requirements for waiver services are reduced due to limited provider capacity to complete files for quality management review desk audits.

Home and Community-based Settings (Appendix K)

Medicaid Memo 4/22/20

- Home and community-based settings are permitted to limit the number of visitors to their residences to minimize the spread of infection from COVID-19.

Coverage Protections for Members (Appendix K)

Medicaid Memo 4/22/20

- Members will retain waiver coverage even if they do not receive a service over a 30-day period.
  - For these members, MCOs will be reaching out monthly via telephone to do a safety check.
- Level of Care re-evaluations are extended from 12 months to 18 months.

LTSS Staffing Flexibilities (Appendix K)

Personal Care/Respite Services (effective 4/20/20)

Medicaid Memo 4/22/20

- Spouses, parents of minor children, and legal guardians can provide and be reimbursed for personal care services.
- Personal care, respite and companion aides employed by an agency can perform services prior to completion of the required 40 hours of training. Agency providers are required to ensure that aides:
  - Are proficient in the skills needed to care for Medicaid members prior to delivering services in the home.
  - Receive the required 40 hours of training within 90 days after they begin performing services.

LTSS Provider Sustainability (Appendix K)

Retainer Payments (effective 3/12/20 – 6/30/20)

Medicaid Memo 5/15/20

- Adult day health centers and day support providers that are closed and unable to perform services due to COVID-19 may be eligible for retainer payments from March 12, 2020 through June 30, 2020.

- Providers can submit individual claims with a modifier to receive a payment rate of 65%.

1135 Waiver

Access to Long-Term Services and Supports (effective 3/12/20)

Medicaid Memo 5/26/20

- Permit individuals who choose to move to a nursing facility directly from a hospital to be accepted without a long-term services and supports screening.
- The Pre-Admission Screening and Resident Review (PASSR), Level One and Level Two, must be conducted within 30 days of admission.
- Choice must still be documented.

1135 Waiver

Nursing Facilities

Medicaid Memo 5/26/20 (effective 3/12/20)

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

1135 Waiver

LTSS Provider Flexibilities

Medicaid Memo 5/26/20

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

1135 Waiver

Program for All-inclusive Care for the Elderly (PACE)

Medicaid Memo 5/26/20 (effective 3/12/20)

- PACE sites may use remote technology and telehealth options (including telephone communication) as appropriate, to review or gather member information that would normally be provided as a face-to-face service.
- Member consent of participation must be documented and written signatures obtained within 45 days after the end of the emergency.
- DMAS Quality Management Reviews will be desk reviews only.

1135 Waiver

Durable Medical Equipment (DME)

Medicaid Memo 5/26/20

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

1135 Waiver

Certificate of Medical Necessity (CMN)

Medicaid Memo 5/26/20

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

Nursing Facility (NF) Supplemental Payment

Governor's Budget Amendment (effective 3/12/20)

- Additional payment to nursing facilities of $20 per day for each Medicaid resident through the emergency period (Executive Order 51).

Civil Monetary Penalty Funding

Nursing Facility Funding

Medicaid Memo 5/19/20

- The 2020 procurement process for applications for Civil Monetary Penalty (CMP) Funds is on hold until the 2021 CMP Application Cycle.
- CMS has granted to the states the ability to approve requests that meet CMS parameters for use of CMP Reinvestment funds for communicative technology.
- Communicative technology devices of up to $3,000 per facility for residents to use for both social and telehealth visits can be authorized by DMAS (application deadline 5/27/20).

Behavioral Health & Addiction Recovery Treatment (ARTs) Provider Flexibilities

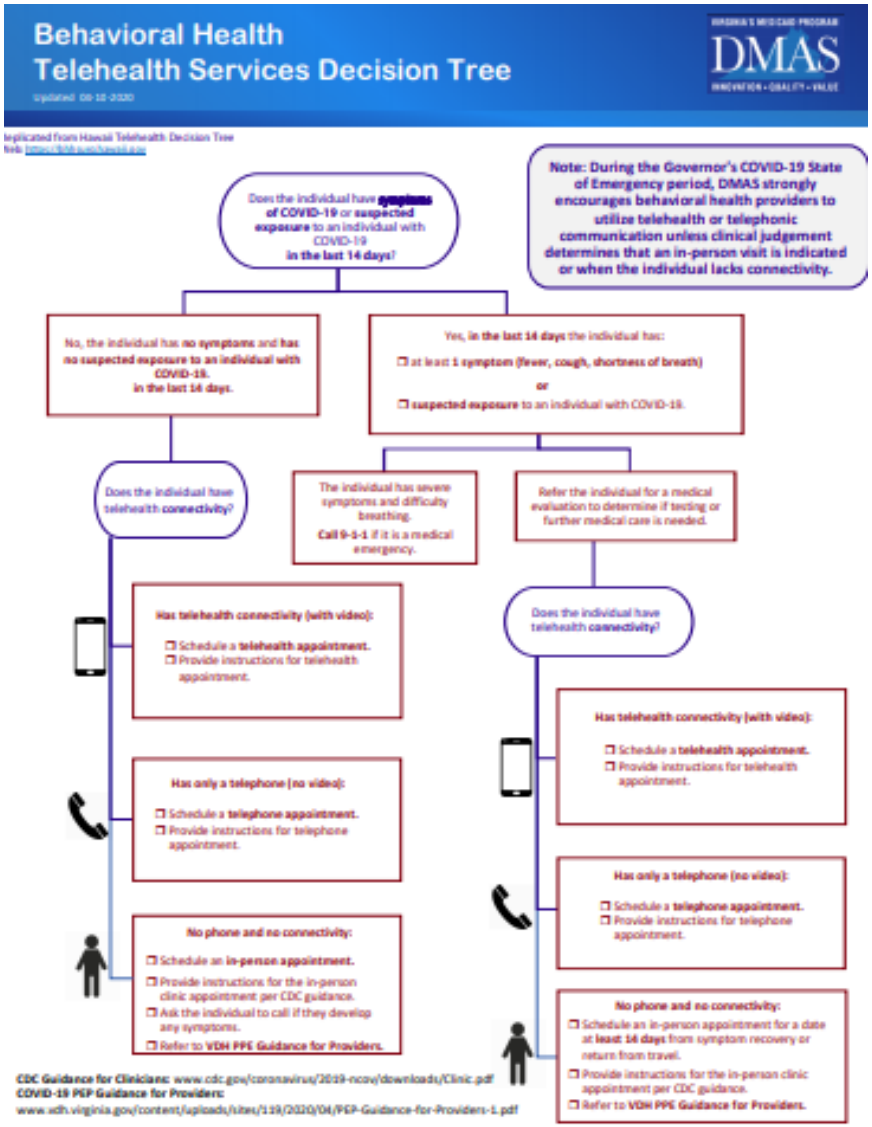
Behavioral Health Services

Medicaid Memo 3/27/2020

Enabling the delivery of various behavioral health services via telehealth or telephone, through trauma-informed care including:

- Crisis Response and Interventions;
- Care coordination, case management, and peer services;
- Service needs assessments (including the Comprehensive Needs Assessment and the IACCT assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities;
- Outpatient psychiatric services;
- Community mental health and rehabilitation services; and
- Addiction Recovery and Treatment Services (ARTS).

Behavioral Health Telehealth Decision Tree



Behavioral Health & Addiction Recovery Treatment (ARTS) Provider Flexibilities

ARTS Provider Flexibilities

Medicaid Memo 3/27/2020

- Opioid Treatment Programs (OTPs) can administer medication as take home dosages, up to a 28-day supply, to minimize exposure of COVID-19 to staff and patients.
- Reimbursement of the medication encounter for the total number of days' supplied of the take-home medication.
- Allowing the counseling component of Medication Assisted Treatment (MAT) to be completed via telehealth or telephone for patients suffering from substance use disorders.
- Preferred OBOTs or OTP's are not penalized for missed urine drug screens during the public health emergency.
- Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within Preferred OBOT or OTP.

Behavioral Health & ARTS Delivery of Services Flexibilities

Authorizations and Licensure Reciprocity

Medicaid Memo 3/27/2020, Provider Webinar 4/22/2020

- Allowing up to 14 days after the start of a new behavioral health service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO or Magellan of Virginia.
- Individuals unable to be discharged from inpatient psychiatric care due to COVID-19, may continue to receive authorizations for a continued stay until they can be safely discharged into the community.
- Licensed Mental Health Professionals (LMHPs) licensed in another state may provide behavioral and substance abuse services to Virginia residents and receive reimbursement from DMAS. LMHPs with an active license issued by another state may be issued a temporary license by endorsement.

Regulatory Activity Summary June 10, 2020
(* Indicates Recent Activity)

2020 General Assembly

***(01) Recovery Audit Contractor – Exemption:** This State Plan Amendment (SPA) seeks to request an exemption from CMS mandated RAC requirements. Section 1902(a)(42)(8) of the Social Security Act requires DMAS to have a Medicaid RAC program. However, 42 CFR §455.51 allows DMAS to file a request for an exemption to the RAC requirements, by submitting a written justification to CMS through the SPA process. In 2016, DMAS requested and received a temporary exemption from the RAC program, while research was conducted to procure a new RAC vendor. Since that time, DMAS has transitioned to a 90% managed care program environment, such that the claims-eligible RAC review was rendered largely obsolete. A search to secure a vendor to operate an efficient RAC program, in this new environment, proved unviable. A new vendor would entail additional state funding, in conjunction with the RAC contingency fee, and represents an impractical scenario for Virginia Medicaid. The DPB notification for this SPA was sent to DPB on 12/30/19. Following internal review, the SPA binder was forwarded to HHR for review on 4/29/20. HHR approved the SPA on 5/27/20 and the package was submitted to CMS on 5/28/20 for review.

***(02) 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.

***(03) 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.

***(04) 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.

***(05) Home Health Changes Due to Federal Regulatory Change:** DMAS intends to file a SPA with CMS in order to comply with new federal regulations that allow nurse practitioners, clinical nurse specialists, and physician assistants to order and certify home health services. (Previously, only physicians could order or certify these services.) CMS amended its regulations for Home Health on May 8, 2020 (in 85 Federal Register 27626) to allow practitioners other than physicians to order and certify home health services. DMAS is amending the state plan in order to comply with the new federal requirements. Both the SPA and corresponding regulatory action are currently circulating for internal DMAS review.

2019 General Assembly

***(01) Federal Changes to PACE:** The purpose of this regulatory action is to amend three sections of 12VAC30-50-335, General PACE Plan Requirements, in order to align the regulation with the federal PACE regulations. On May 28, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized a rule to update and modernize the Programs of All-Inclusive Care for the Elderly (PACE) program. This rule enforces best practices regarding the care for frail and elderly individuals. The first major proposed update to PACE since 2006, this action allows PACE organizations to operate with greater efficiency, while ensuring they continue to meet the needs and preferences of participants. More than 45,000 older adults are currently enrolled in more than 100 PACE organizations in 31 states, and enrollment in PACE has increased by over 120 percent since 2011. With the increased demand for PACE services, the federal updates are timely and will provide greater operational flexibility, remove redundancies and outdated information, and codify existing practice. The project was circulated for internal review on 10/30/19 and forwarded to the OAG for review on 1/16/20. DMAS is currently awaiting a status update.

***(02) Pooling of State Supplemental Drug Rebates:** Currently, Virginia Medicaid enters into state-specific contracts with pharmaceutical manufacturers. The purpose of this State Plan Amendment is to allow Virginia to participate in multi-state purchasing pools to enable Virginia to enter into value based purchasing agreements for high cost drugs. DMAS sent the DPB notification of the SPA on 9/24/19. Following internal review, the SPA was submitted to HHR on 10/25/19; forwarded to CMS on 11/1/19; and approved by CMS on 1/3/20. The corresponding regulatory action began circulating for internal review on 1/8/20. The regs were forwarded to DPB on 3/11/20 and submitted to HHR on 4/17/20.

***(03) Processing Medicaid Applications Using SNAP Income:** This SPA will enable DMAS to use gross income determined by SNAP to support Medicaid eligibility determinations at the 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.

***(04) Cover Virginia and Eligibility Determinations:** Individuals at the CoverVA call center currently enter Medicaid applications into the VaCMS system and process modified adjusted gross income (MAGI) applications. This SPA seeks to add language to the state plan to reflect that the CoverVA call center is operated under a contract. (Conduent holds the current contract to perform CoverVA services.) This text addition is not a change in practice, but updates the text of the state plan to reflect current DMAS practice. The SPA notification was submitted to DPB on 11/12/19. Following internal DMAS review, the SPA was sent to HHR on 2/3/19. The SPA was forwarded to CMS for review on 12/17/19 and approved on 2/28/20.

***(05) 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.

(06) 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.

***(07) Incontinence Supplies:** The purpose of this State Plan Amendment (and corresponding fast-track action) is to remove a sentence that indicates that DMAS reimburses incontinence supplies based on a selective contract with one vendor. When the contract ends on December 31, 2019, DMAS will allow multiple vendors to provide incontinence supplies to Medicaid members. The rate and pricing for incontinence supplies will not change, and the oversight and

controls of these providers will remain the same. The SPA folder began circulating for internal review on 8/22/19 and was sent to HHR on 10/22/19. The SPA was approved by CMS on 11/5/19. The corresponding fast track project was sent for review on 8/22/19. The reg action was submitted to the OAG on 9/27/19. DMAS responded to OAG inquiries on 12/2/19; the regs were certified by the OAG on 12/30/19; and then forwarded to DPB on 1/7/20. The project was sent to HHR on 2/13/20. DMAS is awaiting further direction.

(08) Fair Rental Value for New and Renovated Nursing Facilities: This State Plan Amendment revises the state plan to clarify payment rules for new nursing homes or renovations that qualify for mid-year rate adjustments, effective July 1, 2019. The 2019 Appropriations Act, Item 303.VVV, requires DMAS to take this action. Following internal review, the SPA was sent to CMS on 11/1/19 for review and approved by CMS on 11/26/19. The corresponding regulatory action circulated for review on 1/7/20 and was submitted to the OAG on 2/25/20, and certified on 3/30/20. The project was submitted to DPB on 3/31/20 and forwarded to HHR on 5/4/20.

***(09) ARTS Updates:** This fast-track regulatory package seeks to streamline, simplify, and clarify existing requirements for ARTS services and ARTS providers. The Addiction and Recovery Treatment Services (ARTS) program regulations became effective on April 1, 2017. Now, the regulations need minor modifications to address program needs as well as to answer questions that have been raised by providers. Following internal DMAS review and coordination, the reg project was forwarded to the OAG on 8/13/19. A conf. call was held on 9/18/19 to discuss the regs. The OAG requested revisions and corrections were sent on 9/25/19. Additional requested changes were sent to the OAG on 10/8/19. The OAG certified the regulations on 10/11/19; the project was submitted to DPB on 10/15/19; and forwarded to HHR for review on 11/22/19. The regs were submitted to the Registrar on 12/18/19; published in the Register on 1/20/20; and became final on 3/5/20. The corresponding SPA began circulating for internal review on 4/28/20.

***(10) CMH and Peers Updates:** This fast-track regulatory package updates the references to the Behavioral Health Services Administrator (or BHSA), which are stricken and replaced with references to "DMAS or its contractor." The BHSA contract was extended for one year, and will end in 2020, and these references are being updated in anticipation of that change. Also, clarifications are being made to the Peers regulations, including changes to correct the accidental omission of LMHP-Resident, Resident in Psychology, and Supervisee in Social Work so that they may perform appropriate functions within Peer Recovery Support Services. The reg package also includes changes that remove the annual limits from certain community mental health services. These limits are prohibited because they conflict with mental health parity requirements under federal law. There is no cost to this change, because these limits have not been enforced since the Magellan BHSA was brought on to administer these services. The Magellan BHSA has approved requests for community mental health services when the individual meets medical necessity criteria for the service, even if the amount of service will exceed these outdated annual limits. Following internal DMAS review and coordination, the reg project was forwarded to the OAG on 7/24/19. DMAS responded to OAG inquiries on 8/23/19. Additional revisions were requested by the OAG on 9/4/19, 9/5/19, and 9/9/19 and the edits were made. The project was submitted to DPB on 12/12/19 and forwarded to HHR on 1/21/2020.

2018 General Assembly

***(01) Service Authorization:** This emergency regulatory action clarifies the documentation requirements for service authorization for Community Mental Health and Rehabilitative Services (CMHRS). This regulation is essential to protect the health, safety, or welfare of citizens in that it ensures that Medicaid members receive appropriate behavioral health services based on their documented needs. The regulatory changes reflect the transfer of community mental health rehabilitative services from the behavioral health services administrator (BHSA) to DMAS managed care contractors. Following internal DMAS review and coordination, the regs were forwarded to the OAG on 10/29/18 for review. Responses to OAG inquiries were forwarded on 4/29/19. The OAG sent additional comments on 7/9/19 and DMAS forwarded a revision on 7/10/19. More changes were requested on 7/12/19 and additional revisions were forwarded to the OAG on 7/16/19 and 7/29/19. More change requests were received and revisions were sent on 9/10/19. Following a conf. call on 10/31, revised text was sent to the OAG on 11/1/19 and additional revisions were sent on 11/25/19. The regulatory action was forwarded to DPB on 12/4/19; sent to HHR on 12/12/19; and forwarded to the Governor on 3/24/20.

(02) Expansion – Alternative Benefit Plan: This regulatory action incorporates changes made to the Virginia State Plan in order to implement Medicaid expansion. Specifically, this action includes the alternative benefit plan (ABP) that is available to individuals who are covered by Medicaid expansion. The Centers for Medicare and Medicaid Services (CMS) requires state Medicaid agencies to create an ABP for expansion populations. The purpose of this regulation is to incorporate the CMS-approved Medicaid expansion ABP into the Virginia Administrative Code. This regulation is essential to protect the health, safety, and welfare of citizens in that it implements the General Assembly mandate to expand Medicaid coverage to new populations. Following internal DMAS review and coordination, the regs were forwarded to the OAG on 11/9/18 for review. The OAG forwarded comments on 3/1/19 and DMAS sent responses back on 3/6/19. The regs were submitted to DBP for review on 4/4/19. The regs were forwarded to HHR on 4/16/19; to the Gov.'s Ofc. on 5/27/19; and to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with no comments received. The corresponding fast-track began circulating for review on 9/5/19. The regulatory action was forwarded to the OAG on 10/30/19.

***(03) Medicaid Expansion — Determination State (Medicaid):** This state plan amendment is designed to allow Virginia to change from the Assessment Model of eligibility determination to the Determination Model of eligibility determination. In the Assessment Model, which Virginia currently follows, the Federally Facilitated Marketplace (FFM) makes an initial assessment of eligibility and the State Medicaid agency must then re-determine eligibility to make a final decision. In the Determination Model, the FFM makes the final Modified Adjusted Gross Income (MAGI) or CHIP determination and transmits the determination to the State Medicaid agency. The state must then accept the FFM determination as final. The Virginia General Assembly has directed DMAS to expand Medicaid eligibility to individuals age 19 or older and under age 65, who have household income at or below 138% of the federal poverty level, effective January 1, 2019. As a result of Medicaid expansion, many more FFM applicants will now qualify for Virginia Medicaid and the application determination backlog that is currently experienced during open enrollment is expected to increase. Movement to the Determination Model will significantly reduce the number of applications forwarded from the FFM that require a Medicaid determination by state/local/contractor staff. This change is particularly important due to the anticipated increase in applications from all sources due to interest in Medicaid expansion coverage combined with the 2019 Open Enrollment Period. Following internal DMAS review, the SPA was submitted to HHR, and then forwarded to CMS on 7/23/18. A conf. call with CMS was held on 8/2/18 and CMS requested edits on 8/7/18. Additional follow-up questions from CMS were received and responses were returned to CMS on 8/20/18. The SPA was approved 10/9/18. The corresponding reg package was forwarded to the OAG on 11/9/18. OAG comments were forwarded to DMAS on 2/28/19. Responses were returned on 3/7/19 and 3/19/19. The regs were submitted to DPB on 4/4/19; to HHR on 4/16/19; and to the Governor on 5/27/19. The project was sent to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with one comment received. The corresponding fast-track began circulating for internal review on 9/6/19 and was submitted to the OAG on 10/10/19. DMAS requested an ER extension on 2/19/20 that will expire on 9/17/21.

***(04) 2018 Institutional Provider Reimbursement:** This final exempt regulatory action pertains to the 2018 institutional provider reimbursement updates as required by the 2018 Acts of Assembly. These amendments update the current state regulations to indicate that an additional indirect medical education (IME) payment will be made to the Children's National Medical Center (CNMC). The regs also eliminate disproportionate share hospital (DSH) payments to out-of-state children's hospitals, to include CNMC. Furthermore, the proposed amendments update existing regulations to allow additional supplemental payments to be issued to each non-state government owned acute care hospital for inpatient services provided to Medicaid patients. Lastly, the revisions update existing regulations to reflect supplemental payments to state-owned nursing facilities owned or operated by a Type One hospital. Following internal coordination and review, the action was submitted to the OAG on 8/21/18 for review. DMAS received questions from the OAG on 10/9/18, 12/26/18, 1/22/19 and 3/15/19, and the Agency coordinated responses. The regs were certified by the OAG and submitted to the Registrar on 8/9/19. The regs were published in the Register on 9/2/19 and became effective on 10/2/19. The corresponding fast-track project was submitted to HHR on 9/18/19 and forwarded to the Governor/'s Ofc. for review on 11/4/19. The reg action was submitted to the Registrar on 12/18/19; was published on 1/20/20; and became effective on 3/5/20.

(05) 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.

(06) 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.

***(07) Electronic Visit Verification (EVV):** This NOIRA action intends to amend regulations in order to include provisions related to Electronic Visit Verification (EVV) as required by the 21st Century CURES Act, 114 U.S.C. 255, enacted December 13, 2016 (the CURES Act) and the 2017 Appropriations Act Chapter 836, Item 306. YYYY. The CURES Act requires states to implement an EVV system for personal care services by January 1, 2019 and home health care services by January 1, 2023. The 2017 Appropriations Act authorizes DMAS to require EVV for personal care, respite care and companion services. The CURES Act requires that the EVV system must verify: 1) The type of service(s) performed; 2) The individual receiving the service(s); 3) The date of the service; 4) The location of service delivery; 5) The individual providing the service, and 6) The time the service begins and ends. DMAS sought input regarding the EVV system from individuals receiving services, family caregivers, providers of personal, respite and companion care services, home health care services, provider associations, managed care organizations, health plans and other stakeholders. DMAS also sought input on the current use of EVV in the Commonwealth and the impact of EVV implementation. The NOIRA was circulated for internal DMAS review and submitted to DPB on 4/30/18. The NOIRA was approved by DPB on 5/11/18 and forwarded to the Gov. Ofc. The Gov. approved the regs on 8/22/18. The regs were filed with the Registrar's Ofc. on 8/23/18, with the comment period ending on 10/17/18. With no comments received, the proposed phase review began on 10/25/18. The regs were forwarded to the OAG for review on 1/17/19. The OAG forwarded regulatory questions on 4/23/19, and DMAS sent responses back on 4/29/19. Additional changes were sent to the OAG on 6/7/19. The OAG forwarded inquiries on 7/19/19 and DMAS responded. The regs were sent to DPB for review on 7/29/19. A conf. call w/ DBP was held on 8/20/19, and DMAS sent additional responses/revisions on 8/21/19. DMAS fielded several DPB questions the weeks of 9/9/19 and 9/16/19. The reg action was submitted to HHR, approved on 9/15/19, and sent to the Governor on 9/15/19. The EIA response was posted to the TH on 9/18/19. The Gov. Ofc. completed its review on 12/17/19. The project was submitted to the Registrar on 12/18/19, with a publication date of 1/20/20. The 60-day public comment period expired on 3/21/20. The Town Hall proposed stage comment review was complete/categorized on 4/10/20 and a notification e-mail was submitted to commenters. The final stage phase of the reg action is currently under internal review.

2017 General Assembly

(01) Reimbursement of PDN, AT, and PAS in EPSDT: This state plan amendment serves to add text to the state plan regarding reimbursement practices that currently are in place relating to reimbursement of private duty nursing, assistive technology, and personal assistance services under EPSDT. The SPA was submitted to CMS on 9/22/2017. Per request, revisions were sent to CMS on 11/7/17. Additional questions were received from CMS on 11/21; and DMAS forwarded the responses on 12/1/17. The SPA was approved by CMS on 12/7/17. The corresponding fast-track regulatory changes are currently being drafted.

(02) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and additional inquiries on 2/22/18, 3/19/18, 4/10/18, and 5/16/18. The regs were approved by the OAG and forwarded to the Governor's Ofc. for review on 6/19/18. The emergency regulations were signed by Governor and became effective on 6/29/18, and published in the Register on 7/23/18. The NOIRA comment period was held between 7/23/18 - 8/22/18. An ER Extension request was submitted on 10/16/18, and the ER was extended through 6/28/2020.

***(03) Clarifications for Durable Medical Equipment and Supplies:** This NOIRA regulatory action will serve to update coverage and documentation requirements to better align them with best practices and Centers for Medicare and Medicaid (CMS) guidance, and to eliminate unnecessary elements that create confusion among DME providers. Specifically, these proposed changes include elements around: enteral nutrition, implantable pumps, delivery ticket components, and replacement DME after a natural disaster. It is expected that these changes will clarify coverage of DME and supplies for DME providers and Medicaid beneficiaries, and reduce unnecessary documentation elements for DME providers. Further, the changes will improve coverage by permitting newer and better forms of service delivery that have evolved in recent years and align Virginia's coverage with recent guidance from CMS for enteral nutrition. Following an internal DMAS review, the package was submitted to DPB on 3/13/17. DPB moved the regs to the Governor's Office for review/approval on 3/27/17. The Governor signed the regulatory action on 4/14; and the regs were published on 5/15, with the comment period ending on 6/14/17. The Proposed Stage regs were drafted on 6/16 and submitted to the OAG on 10/25. The OAG submitted questions on 12/11 and DMAS coordinated and submitted responses on 1/3/18. Additional revisions were forwarded to the OAG on 2/13/18. The regs were certified by the OAG on 3/8/18 and submitted to DPB on 3/9/18. A conf. call w/ DPB was held on 4/17/18 to discuss the regs. Revisions were made and DMAS revised text and resubmitted the regulatory action. DPB approved the project on 4/26/18 and it was also moved to the Secretary Ofc. for review on 4/26/18. The EIA was posted on 4/26 and the Agency response to EIA was posted on 4/27/18. HHR completed its review on 10/24/18, and the regs were forwarded to the Gov. Ofc. on 10/24/18. The Proposed Stage regs were approved by the Gov. on 2/5/19 and submitted to the Registrar on 2/6/19. The regs were published in the Register on 3/4/19, with a 60-day comment period, ending on 5/3/19. The Final Stage reg package was circulated internally for review on 5/13/19. The regs were submitted to DPB on 7/26/19. DMAS received and fielded DPB questions to SMEs on 8/7/19. The Agency submitted responses to DPB's inquiries on 8/13/19 and 8/21/19. A conf. call w/ DPB was held on 9/4/19, resulting in additional edits. The reg action was submitted to the Gov. on 9/10/19 for review. The reg action was approved by the Gov. on 12/09/19, with a 30-day public comment that expired on 2/06/20. The regs became effective on 2/21/20. The corresponding SPA is currently circulating for internal review.

2016 General Assembly

***(01) CCC Plus (MCOs - B Waiver) – formerly known as 'Managed Long Term Care Services and Supports (MLTSS)':** This emergency regulatory action is required by 2016 budget language. The regulation changes will transition the majority of the remaining Medicaid fee-for-service populations into an integrated, managed long-term services and supports (MLTSS) program. DMAS intends to launch an MLTSS program that provides a coordinated system of care that focuses on improving quality, access, and efficiency. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 3/9/2017. DMAS received requests for revisions from the OAG on 3/16, 3/20 and 3/21. Following conference calls on 4/7 and 4/11 and a meeting on 5/1, the action was certified on 5/12 and then submitted to the DPB. The regs were forwarded to HHR on 5/22/17 and on to the Governor on 5/29. The Gov. signed the action on 6/16/17, with an effective date between 6/16 and 12/15/2018. The regs were published in the Register on 7/10, with a comment period through 8/9 (three comments were submitted). DMAS drafted the next stage of the regulatory review. The regs were submitted to the OAG on 1/9/18. DMAS received inquiries from the OAG and responded on 2/26/18. Following internal edits, DMAS sent additional revisions to the OAG on 3/5/18, 3/21/18, 4/9/18, and 4/23/18. The regs were sent to DPB for review on 5/7/18. The EIA for this project was posted on 7/16/18, in addition to the corresponding DMAS response. The regs were forwarded to HHR on 7/16/18 and they were certified on 7/17/18. The Proposed Stage regs were signed by the Gov. on 12/18/18 and published in the Registrar on 1/21/19; with a public comment period through 3/22/19. The Final Stage reg package was circulated internally for review on 5/7/19. The regs were submitted to the OAG on 7/19/19. DMAS received inquiries from the OAG on 8/14/19 and forward responses on 8/20/19. Additional revisions were sent to the OAG on 9/3/19. The project was submitted to DPB on 1/7/20 and forwarded to HHR for review on 1/27/20. DMAS is awaiting a response.

2015 General Assembly

(01) Three Waiver Redesign: This emergency regulatory action is required by 2016 budget language. The Individual and Family Developmental Disabilities Support Waiver is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver is changing to the Community Living Waiver (CL), and; the Day Support Waiver for Individuals with Mental Retardation is changing to the Building Independence Waiver (BI). This redesign effort, ongoing between DMAS, DBHDS, consultants, and stakeholders for the last two years, combines the target populations of individuals with both intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. The regulatory action was OAG-certified on 8/18/2016 and DPB and the Secretary's Office approved the regulations on 8/22/16. The action was approved by the Governor on 8/24 and published in the Register on 9/19/16, with a public comment period through 10/24 (1 comment submitted). The Proposed Stage regs were drafted on 12/2016 and following internal DMAS review, submitted to the OAG on 7/31/17, and re-submitted on 9/7/17. Following a conference call on 9/18/17, DMAS coordinated revisions and submitted changes on 11/1/17. DMAS submitted an ER extension request for this project on 12/8/17. The ER had been extended until 8/30/18. The regs were forwarded to DPB on 5/23/18; certified by HHR on 7/16/18; and the Proposed Stage regs were approved by the Gov. on 12/18/18. The regs were published on 2/4/19, with a public comment that ended on 4/5/19. Following the public comment review, the Final Stage reg package was circulated for internal review on 6/4/19. The regs were

submitted to the OAG on 9/17/19 for review. DMAS held a meeting with the OAG on 10/15/19 to discuss the project and is awaiting additional feedback.

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

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

(04) No Coverage of Overtime Hours for CD Personal Assistance, Respite and Companion Services: This regulatory action is required by 2016 session of the Virginia General Assembly. This action establishes that DMAS will not reimburse for more than 40 hours per week for consumer-directed personal assistance, respite and companion services for any one provider or working for any one consumer. An attendant may exceed 40 hours of work in a week working for multiple consumers. This limit will not apply to live-in attendants consistent with the U.S. Department of Labor's requirements (Fact Sheet 79B). This change, which will eliminate inconsistencies regarding pay for services in excess of 40 hours, applies to EPSDT-covered attendant services as well as waiver-covered attendant services. The regulations were sent to the OAG on 9/26 and subsequently revised. A submission was sent to DPB on 10/18/16. DPB submitted the action to HHR for review on 11/1; the regs were forwarded to Governor on 11/3; and the Governor signed the regulatory action on 12/6. The item was published in the Register on 12/26, with a 30-day comment period to follow (one comment was generated). This regulatory action is currently in the Proposed Stage and the package was drafted internally on 5/16. The regs were submitted to the OAG on 8/16/17 for review. Following a conf. call with the OAG on 10/3, the action was submitted to DPB on 10/10/17. A call with DPB was held on 11/9. The regs were submitted to HHR for review on 11/28/17. The regs were forwarded to the Governor on 5/9/18. DMAS is currently awaiting approval.

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