



BOARD OF MEDICAL ASSISTANCE SERVICES



Tuesday, March 8, 2022
10:00 AM BMAS Meeting

Meeting will be held both in-person and virtually

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

To Join Meeting Virtually Click here to enter event
Meeting # (Access Code): 2428 556 3014 Meeting Password: DMAS1234
Dial in (Phone): US Toll Free: +1-866-692-4530 US Toll: +1-517-466-2023
Remote Conference Captioning Link: https://www.streamtext.net/player?event=HamiltonRelayRCC-0308-VA3347

AGENDA

#	ITEM	PRESENTER
1.	Call to Order	
2.	Approval of Minutes 2.A. 11/30/2021 BMAS Draft Minutes	
3.	Voting on Chair, Vice Chair and Board Secretary	
4.	Director's Report	Karen Kimsey, Director
5.	Budget Report	Chris Gordon, CFO
6.	Legislative Report	Will Frank, Senior Legislative Affairs Advisor
7.	Report on "Unwinding"	Sarah Hatton, Deputy for Administration Natalie Pennywell, Outreach & Community Engagement Manager
8.	New Business/Old Business	

8.A. Presentation of 2.7 Amendment

9. Regulations

10. Break for Lunch (12:00 – 12:30)

11. Policy Discussion Block (begins at 12:30- ends at 2pm)

- | | |
|---|-----------------|
| a) Discuss Vision of Policy Committee | Ashley Gray |
| b) Regulatory 101 | Emily McClellan |
| c) Discuss Issues or Concerns from the Field | All members |
| d) Discuss Topics for Future Committee Meetings | All members |
| e) Parking Lot | |

12. Adjournment

DRAFT BMAS MINUTES
Tuesday November 30, 2021
12:00 PM

Present: Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Patricia T Cook MD, Ashley Gray, Greg Peters, Elizabeth Noriega

Virtual Attendance: Peter R Kongstvedt MD, Kannan Srinivasan, Raziuddin Ali MD

Absent: Elizabeth Coulter

1. Call to Order

Meeting was called to order at 12:08p.m.

2. Approval of Minutes

Approval of BMAS Retreat Minutes 6/23/2021

Moved by Ashley Gray; seconded by Maureen S Hollowell to Approve.

Motion Passed: 7 - 0

Voting For: Greg Peters Dr, Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Patricia T Cook MD, Elizabeth Coulter, Ashley Gray

Voting Against: None

Approval of June 9, 2021 Minutes

Moved by Ashley Gray; seconded by Maureen S Hollowell to Approve.

Motion Passed: 0 - 0

Voting For: None

Voting Against: None

Approval of March 10, 2021 Minutes

Moved by Ashley Gray; seconded by Maureen S Hollowell to Approve.

Motion Passed: 7 - 0

Voting For: Greg Peters Dr, Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Patricia T Cook MD, Elizabeth Coulter, Ashley Gray

Voting Against: None

ByLaws Amendment Vote

5.4 ByLaws Amendment

Proposed Amendment

5.4 Department Committees – In addition to participation in the Department workgroups or committees pursuant to Section 5.3, Board members are encouraged to attend meetings of any committee of the Department with stakeholders. DMAS staff shall provide information regarding the current committees and meeting schedules to the Board in a timely manner to facilitate member attendance and involvement. Whenever such a committee is added or terminated, DMAS staff shall promptly provide such information to the Board.

Moved by Greg Peters Dr; seconded by Basim Khan to Approve.

Motion Passed: 7 - 0

Voting For: Greg Peters Dr, Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Patricia T Cook MD, Elizabeth Coulter, Ashley Gray

Voting Against: None

4. **Director's Report – Karen Kimsey**

At the instruction of the 2020 Appropriations Act, DMAS recently examined the programs as a whole to identify opportunities to derive greater value from our managed care delivery system.

Based on our review, DMAS has determined that unifying the two managed care programs under a single managed care contract and delivery system would result in a more efficient and well-coordinated system of care for members, would add value for our providers, and would allow DMAS enhanced capacity to focus on monitoring, oversight, and value.

The link to the legislative report is in the appendix area of this presentation.

The Department of Medical Assistance Services' Proposed Plan for Merging its Managed Care Programs <https://rga.lis.virginia.gov/Published/2020/RD567>.

Engaged stakeholders including managed care organizations and provider groups, and sought input through public forums, including the Managed Care Advisory Committee.

DMAS will continue to engage stakeholders for additional input as the project moves into future phases of consolidation and improvement

Project Cardinal Care started with two legislative reports:

1. HB 30 (Chapter 1289) Item 313.E.8: “The Department of Medical Assistance Services shall develop a plan to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 programs. The department shall submit the plan with a feasible timeline for such a merger to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 15, 2020.”
2. The 2020 Appropriations Act also included a requirement for a report on the costs and benefits of combining the medical loss ratios (MLRs) and underwriting gain provisions (Item 313.E.7): “The department shall conduct an analysis and report on the costs and benefits to amending the Commonwealth Coordinated Care Plus and Medallion 4.0 contracts to combine any applicable medical loss ratios and underwriting gain provisions to ensure uniformity in the applicability of those provisions to the Joint Subcommittee for Health and Human Resources Oversight. The report shall be completed by November 15, 2020.”

The 2021 Appropriations Act authorizes DMAS to merge the managed care programs effective July 1, 2022.

[DMAS] shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to merge the CCC Plus and Medallion 4.0 managed care programs, effective July 1, 2022, into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth.

Budget language also directs DMAS to complete two reports:

- Deliver legislative report on impact of merging the children's programs -FAMIS and children's Medicaid - by November 1.
- Conduct analysis of financial impact of a unified program

5. Subcommittee Updates

The Community Engagement and Learning subcommittee did not have a quorum to meet.

The Policy and Strategic Planning subcommittee met with attendance in person by Michael Cook, Ashley Gray, Greg Peters, Basim Khan, Maureen Hollowell, Elizabeth Noriega, Sarah Hatton, Rich Rosendahl, Chris Gordon, Scott Castro, Valentina Vega, Frederick Helm, Emily O'Brion. Virtual Attendance included Angie Vardell, Anne Kerr, Charlotte Arbo, Craig Markva, Denise Daly, Lanette Walker, Mariam Siddiqui, Sarah Craddock, Steven Ford, Tyler Cox, Andrew Mitchell, Chethan Bachireddy, Emily McClellan, Ivory Banks, Jessica Anecchini, Rebecca Dooley, Tammy Whitlock, Kannan Srinivisan.

Ashley Gray was appointed as subcommittee chair.

6. MES, ARPA, and Special Session Update – Chris Gordon

Special Session:

- **Addressing Eligibility Related Operational Backlog:** Address operational backlogs by hiring contractors to assist with eligibility re-evaluations and member appeals. Funding also will be used to perform COVID-19 related outreach and engagement activities
- **\$5 NF Per Diem Payment:** Funding to pay \$5 per diem payments to nursing homes
- **12.5% rate increase (HCBS):** Temporarily increase rates by 12.5% effective 7/1/21 for all Home and community Based Services (HCBS) services eligible "under guidance from CMS".
- **\$1,000 PCA Payment:** Issue one-time \$1,000 payments for personal care attendants (PCA), DMAS to begin implementing effective 10/1/2021
- **Additional use of reinvestment dollars (w/DBHDS):**
 - Develop strategies for consideration in the 2022 General Assembly to re-invest General Fund funding freed up by the 10% enhanced match from the federal government. By 10/1/2021,

DMAS must report these strategies including 6-year cost projections to Governor, Money committees, and Department of Planning and Budget.

- DMAS must:
 - Identify strategies to enhance HCBS by creating capacity to meet growing demand, and support structural changes to strengthen the HCBS system,
 - Work with DBHDS and CMS to identify opportunities to use reinvestment dollars to divert individuals who are at risk of institutionalization in state facilities, and
 - Prioritize strategies that do not require significant on-going obligations or rely on rate increases.

Medicaid Enterprise System (MES) Update:

- The MES program is currently in “**GREEN**” status and on track for implementation on **April 4, 2022**. The MES Integrated Master Schedule (IMS) currently reflects **75%** work complete across the program.
- Five modules have already gone live; the remaining modules (three in total) will launch with MES next year (see next slide).
- To create a more stable environment from which to launch MES, the program has instituted the following:
 - “Freeze” of the Medicaid Management Information System (MMIS): limits system development to only necessary, vetted items.
 - Provider Enrollment Abatement: a 45-day “pause” in provider enrollments prior to go-live within the Provider Services Solution (PRSS) module.
- Project teams are currently focused on executing modular User Acceptance Testing (UAT) and Integration activities.
- Major near term milestones include:
 - End to End Testing: tests the behavioral flow and cohesiveness of all the modules.
 - Operational Readiness & Implementation Planning: activities necessary to prepare the agency and its partners for cutover to MES next year (e.g., training, communications, etc.).

7. July 1st Implementations- Sarah Hatton, Cheryl Robert & Tammy Whitlock

- **Unborn Child Option (FAMIS Prenatal Coverage)**

Comprehensive prenatal coverage for pregnant individuals regardless of immigration status

The 2021 Special Session I budget created a new FAMIS/CHIP prenatal coverage option for individuals who otherwise meet eligibility criteria for FAMIS MOMS or Medicaid Pregnant Women but are ineligible because they do not have lawfully residing status.

Previously these individuals, primarily undocumented immigrants, were not eligible for Medicaid or FAMIS coverage, except that some (with income less than 148% of the federal poverty level) qualified for coverage of the birth through Emergency Medicaid.

Individuals are eligible to enroll when they learn they are pregnant and receive full comprehensive coverage during the prenatal period, through labor and delivery, and 60 days postpartum.

Covered benefits include, but are not limited to:

- ✓ Prenatal checkups

- ✓ Prenatal screening and testing
- ✓ Labor and delivery, including inpatient hospital stay
- ✓ General and specialty care for other health concerns
- ✓ Prescription medication
- ✓ Dental coverage
- ✓ Behavioral health care, including screening and treatment for mental health conditions, tobacco cessation, and substance use disorders

Enrollment Data as of 11/19/2021

- As of Nov 19, more than 3600 individuals have been enrolled in this program.
- Over 700 newborns are now receiving Medicaid or FAMIS coverage as a result of a parent receiving FAMIS PC.
- FAMIS PC individuals range from ages 13 to 50. The Northern Region has nearly 70% of the Commonwealth's current enrollment of FAMIS PC. Additionally, 15% live in the Central Region.
- Over half of the FAMIS PC population is receiving coverage in their 3rd trimester of pregnancy while at least 33% are still in their first trimester.
- 49% of members attested to Spanish as their primary language

- **Other Administrative implementations**

- **Other 7/1 Implementations**

- One Number for State Benefits

- DMAS and Virginia Department of Social Services (VDSS) collaborated to develop a new toll-free number for the state benefits call centers.
- The call centers include:
 - Cover Virginia
 - Enterprise Call Center
 - Medicaid Member Helpline
- The purpose of the new toll-free number is to route the calls to the appropriate call centers based on the brief description of the call centers purposes
- While the current call center numbers will remain accessible, DMAS & VDSS will work over the next year to update digital and print materials to display the new number.

- Digitized State Plan

- The Medicaid State Plan has now been published on the DMAS website: <https://www.dmas.virginia.gov/about-us/state-plan/>
- Submitted and approved State Plan Amendments can now be viewed.

- **American Rescue Plan Act (ARPA) Funding -Eligibility & Enrollment COVID-19 Unwinding**

Funding was requested to address the Medicaid application backlogs and unwinding efforts resulting from the COVID-19 Public Health Emergency. The agency will use a three pronged approach to address these efforts.

- ARPA Fund 9901: \$10 million approved in HB7001
- ARPA Fund 9901: \$5 million to be requested through a decision package in regular session for SFY23.
- Costs for ARPA funds may incurred through December 31, 2024.

- **American Rescue Plan Act (ARPA) Funding –Home and Community-based Services**
 - ❑ 12.5% temporary rate increase for early intervention, most Home and Community-Based waiver Services and specific Community-Based Behavioral Health Services between July 1, 2021 through June 30, 2022.
 - ❑ Medicaid Bulletin posted on October 6, 2021.
 - ❑ Lists specific eligible procedure codes and revenue codes
 - ❑ Provider guidance on prospective and retrospective claims
- **Enhancement of Behavioral Health Services – Project BRAVO**
- In recognizing the need for a phased process that focuses on the system’s most immediate needs, we have focused on prioritization of 6 services that our interagency team agrees are critical to begin the move to the north star and to address the inpatient bed crisis.
- Enhancement focuses on high quality services that have been shown to work.
- These are services that currently exist and are licensed in Virginia at large but are not covered or adequately funded by Medicaid.
 - ❑ PHP/IOP: These exist in Medicaid for ARTS and their addition has been shown to draw down costly ER visits and inpatient hospitalizations. A workforce exists, programs exist...they just need a rate and service definition to be able to also serve members with primary mental health problems.
 - ❑ MST/FFT: These evidence-based practices for high risk youth exist through the DJJ transformation but do not have a Medicaid Rate. This creates access and equity issues for Virginia’s kids wherein they need DJJ referral to participate in these high-quality services. These could help with diversion and step down from the Commonwealth Center and reduce the need for residential treatment.
 - ❑ PACT: This exists but is not reimbursed at a rate that covers the service, which limits the ability to adhere to the fidelity standards of the program and maximize effectiveness and access across the state. DBHDS has excellent data on cost efficiencies of this service and we see it as a critical component of the plan for those who are some of the most likely to use inpatient hospitalization on a frequent basis.
 - ❑ Comprehensive Crisis: This brings on medicaid rates for the services recommended through the Crisis workgroups of STEP-VA and assures we reimburse appropriately and draw down federal match for members who participate in crisis care. These services include mobile crisis response, community-based crisis stabilization (a crisis-avoidance service that provides short term support between immediate response and availability of referral to longer term services), crisis stabilization units (residential) and 23-hour beds.

Adult Dental Services 2021 – Overview

Implementation Steps:

- Federal Approval – Approved
- Design Benefit Package – Complete
- Dental Advisory Committee engagement – Ongoing
- Provider Recruitment – Ongoing
- System Changes – Complete
- Vendor Changes – Complete
- Member & Provider Education –Ongoing
- Stakeholder Engagement – Ongoing

- **79,000 unique members** and 133,000 claims under the adult dental benefit since July 1
- Operations are running smoothly
 - Calls are being answered
 - Claims are being paid (\$33M)
- Dental Advisory meetings for updates and guidance
- Numerous articles and presentations on the program

Program Challenges

- Network Adequacy
Dataquest provides weekly reports and updates
 - Ongoing recruitment and participation efforts
 - Dentists are retiring
- Inadequate Rates
 - Last rate increase was in 2005
 - Noted as a recruitment barrier in several surveys
- Increase Pediatric Utilization

Next Steps

- Hired a Dental Program Lead – Welcome Justin Gist
- Continuing provider recruitment efforts (focused on specialists and geographic areas)
- Working with Virginia Dental Association
- Pregnant women – new eligibility changes and working through transitions of the pregnant women benefit into adult benefit
- Focus on special populations
- Releasing the RFP for new Dental Contractor
- Watching the Governor’s budget and General Assembly for possible program and rate changes

8. Appeals Portal Launch

What is MES?

- MES is Virginia’s Medicaid Enterprise System for DMAS
- It moves DMAS to a modular system that can more easily adapt to change while supporting our Agency's mission

What is AIMS?

- AIMS is the Appeals Information Management System designed exclusively for DMAS
- A platform that produces efficiencies for Appeals Division staff, as well as allows clients and providers to file and track appeals online
- One of many building blocks (or modules) in the implementation of MES
- First MES module with public-facing component

Prior to AIMS:

- Used two different databases to process appeals –one for client appeals and one for provider appeals
- All paper case files prior to COVID, at which point DMAS used SharePoint as a stop-gap in order to continue to process appeals
- Scheduling for hearings was done by e-mail and telephone
- Only way to check the status was by calling or e-mailing the Division

Benefits of AIMS:

- One system for all appeals
- Electronic case files
- Automated workflows and queues
- Auto-generated letters and emails
- Streamline stakeholder interactions
- Enhanced user experience

AIMS Portal and Resources

AIMS Portal:

- Public-facing components for external stakeholders include:
 - Client portal
 - Provider portal
 - Agency portal

AIMS Resources:

- Google Meet informational sessions
- Email blasts and press release to over 21,000 recipients
- Updated appeal rights on notices of action
- Updated DMAS website
- MES training website with extensive training materials and resources:
 - Written User Guides
 - Demo Videos
 - Practice Exercises
 - FAQs
- AIMS Help support line and email box

AIMS would not have been possible without:

- DMAS Executive Leadership Team
- Information Management Division
- Project Management Office
- Procurement and Contract Management Division
- Budget Division
- Christina Nuckols/Communications
- Human Capital Division
- Appeals Division Staff
- Centers for Medicare & Medicaid Services (“CMS”)
- All who have helped test the system
(many DMAS employees!)

9. New Business/Old Business

10. Regulations

11. Adjournment

Moved by Ashley Gray; seconded by Maureen S Hollowell to Adjourn.

Motion Passed: 7 - 0

Voting For: Greg Peters Dr, Basim Khan, Maureen S Hollowell, Michael H Cook Esq., Patricia T Cook MD, Elizabeth Coulter, Ashley Gray

Voting Against: None

BMAS DIRECTOR'S REPORT

***Karen Kimsey
Director***

March 8, 2022

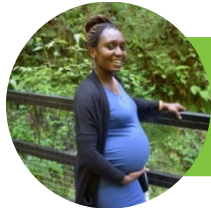


Who Does Medicaid Serve?



Children

821,899



Pregnant Members

28,217



Older Adults

83,289



Individuals with Disabilities

153,157



Adults

794,075

Medicaid plays a critical role in the lives of over 1.99 million Virginians

GO!

Decision

MES IMPLEMENTATION IS ON TRACK for April 4

✓ Decision Point: February 16

- 100% of test cases related to MMIS Mainframe Processing and MES Core Functions completed successfully
- Operation Readiness
 - Call Center
 - Help Desk
 - Staff Training
 - Provider Communications and Training

Provider Outreach and Training

Provider outreach and training will be available:

- Email alerts
- Training resources
 - Virtual instructor-led classes
 - Self-paced videos
 - User manuals
- FAQs
- Agency website
- Medicaid memos
- Stakeholder webinars

MES Provider Portal Pre-Launch FAQ

Common questions and answers for Providers leading up to the MES and PRSS portal launches on April 4, 2022. Click the +Plus signs below to expand the Q&As!

Taxonomy Related



Payment Pause & Old and New Websites



Updating Accounts and Primary Account Holders



Physicians/Providers who have accounts that have been locked. Can we get our account unlocked?

If your account is locked or you can't answer your security questions, please call the Web-Support Helpdesk at Toll Free 866-352-0496. You may make changes to your account through 3/7/2022 for the portal transition. The Web-Support Help Desk will cease taking calls beginning 3/30/2022. For questions about portal accounts after 4/4/2022, please contact the PRSS PES support number at 888-829-5373.

Our account was deactivated due to Inactivity. How can we reactivate our account?

If your account has been deactivated due to inactivity and Web Support cannot reactivate, your organization will need to complete and submit a PAH change form to have the account reactivated after 3/21/2022. The PAH Change form will be made available on this site on 3/21/2022.

How can I determine who is listed as our Primary Account Holder (PAH)?

<https://vamedicaid.dmas.virginia.gov/provider/faq>

MMIS Impacts and Mitigation



New Provider Services Solution portal implemented for provider enrollment and management

- Phase 1: **Fee-for-service providers** (April 4 launch)
- Phase 2: **Managed care network providers** (Two-year process starting June 2022)



Increased security for access to MMIS

- Single Sign On accounts requiring **2-factor authentication** to comply with MES security requirements
- Plan to **begin credentialing process** this month, including local social services, sister agencies and vendors.
- **Current access to the MMIS will be available** for a short period after April 4. DMAS will monitor MES access through the new portal and will send a warning message when access to the MMIS through the current portal ends.

MMIS Outage

***One important step in preparation for the MES launch will be a*
five-day outage of MMIS**

- This pause is necessary for key pre-launch steps to be executed without interruption
- All DMAS business areas are documenting/communicating potential impacts to operations, creating contingencies and preparing to execute their Continuity of Operations Plans
- From March 30 through April 3 the following agency functions will be affected:
 - Provider
 - Claims
 - Member Eligibility
 - Service Authorizations
 - Encounters



FINANCE & TECHNOLOGY UPDATE

Chris Gordon, CFO
Deputy Director of Finance
and Technology



- ❑ Key Metrics
- ❑ FY22 Appropriation
- ❑ Medical Spend
- ❑ MCO performance
- ❑ ARPA Projects
- ❑ Budget Amendments
- ❑ Summary

F&T Key Metrics

Metric	Target	Current	YTD
Prompt Pay¹	95%	98%	97%
SWaM²	55%	71%	61%
Admin Spend³	\$42.6m	\$43.1m	+5%
Medical Spend⁴	\$10.52b	\$10.59b	+0.6%
MES SPI⁵	1.0	1.12	93%

1. Prompt Pay as of February 2022

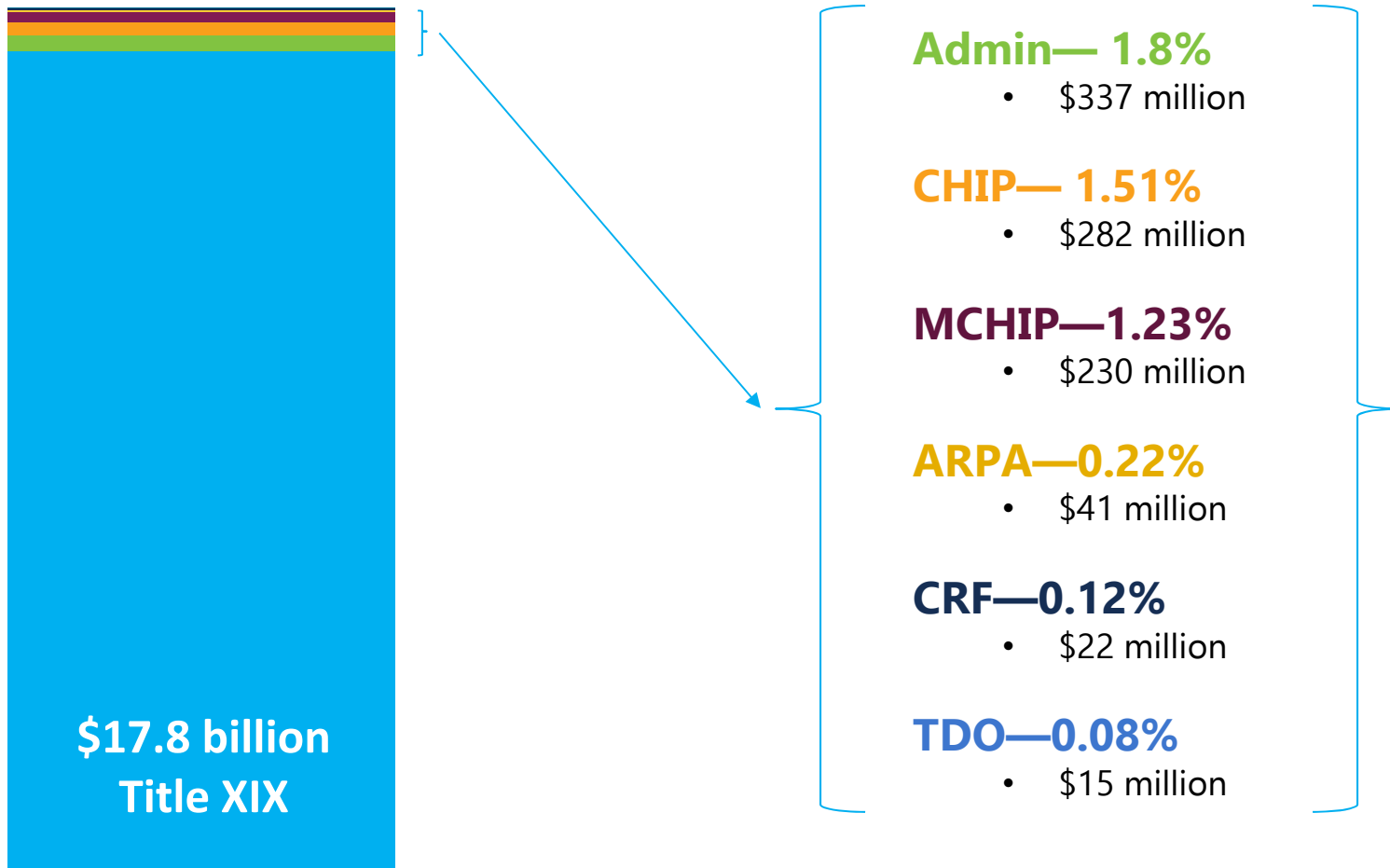
2. SWaM as of January 2022

3. Admin spend (GF) as of January 2022

4. Medical spend (total funds) as of January 2022

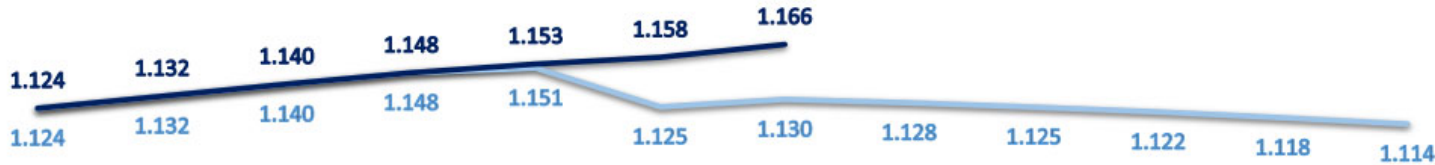
5. MES schedule performance index as of February 23

DMAS FY22 Appropriation



Base Enrollment & Expenditures

Base Medicaid Enrollment *millions*



Base Medicaid Expenditures *\$billions*



Based on official November 2021 Forecast

JANUARY 2022



Enrollment

Forecast: 1,130,278
Actual: 1,166,172

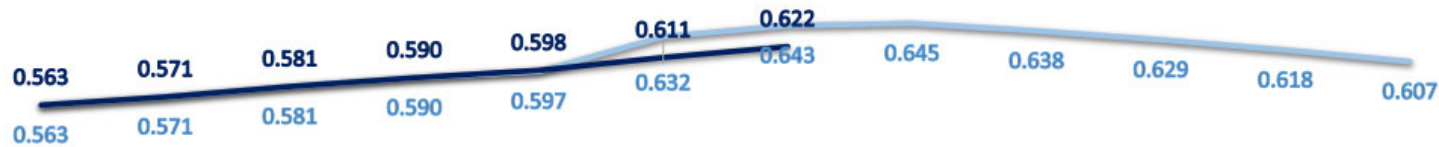


Expenditure

Forecast: \$850,095,724
Actual: \$1,030,661,467

MedEX Enrollment & Expenditures

Medicaid Expansion Enrollment *millions*



Medicaid Expansion Expenditures *\$billions*



Based on official November 2021 Forecast

January 2022



Enrollment

Forecast: 643,160
Actual: 621,800



Expenditure

Forecast: \$352,303,248
Actual: \$342,716,763

MCO Performance: Q1FY22

SFY2022 Q1 MCO Expenses

Report Year	Aetna	Anthem	Molina	Optima	United	VA Premier	KPI - Expenditure Type
2022	5.65%	4.31%	8.25%	5.89%	4.03%	8.18%	<input checked="" type="radio"/> Admin Expense Ratio <input type="radio"/> HQI Ratio <input type="radio"/> MLR <input type="radio"/> Operating Margin
Report Quarter							
(All)							
Contract							
<input checked="" type="radio"/> Grand Total MCO							

SFY2022 Q1 MCO Expenses

Report Year	Aetna	Anthem	Molina	Optima	United	VA Premier	KPI - Expenditure Type
2022	1.29%	2.53%	1.91%	1.95%	2.95%	2.30%	<input type="radio"/> Admin Expense Ratio <input checked="" type="radio"/> HQI Ratio <input type="radio"/> MLR <input type="radio"/> Operating Margin
Report Quarter							
(All)							
Contract							
<input checked="" type="radio"/> Grand Total MCO							

SFY2022 Q1 MCO Expenses

Report Year	Aetna	Anthem	Molina	Optima	United	VA Premier	KPI - Expenditure Type
2022	87.76%	82.31%	82.22%	86.50%	85.95%	86.87%	<input type="radio"/> Admin Expense Ratio <input type="radio"/> HQI Ratio <input checked="" type="radio"/> MLR <input type="radio"/> Operating Margin
Report Quarter							
(All)							
Contract							

SFY2022 Q1 MCO Expenses

Report Year	Aetna	Anthem	Molina	Optima	United	VA Premier	KPI - Expenditure Type
2022	5.30%	10.86%	7.62%	5.66%	7.07%	2.64%	<input type="radio"/> Admin Expense Ratio <input type="radio"/> HQI Ratio <input type="radio"/> MLR <input checked="" type="radio"/> Operating Margin
Report Quarter							
(All)							
Contract							
<input checked="" type="radio"/> Grand Total MCO							

American Rescue Plan Act (ARPA) Projects

- ❑ \$1K bonus for home health care workers
 - CMS approved plan February 17
 - Contract awarded to MSLC for execution

- ❑ 12.5% HCBS rate increases
 - FFS and MCO ongoing

- ❑ \$5 per diem for nursing facilities
 - Kick-off meeting held February 9
 - First payments expected by April 1

- ❑ \$15M Enrollment & Eligibility backlog
 - Spent \$419K
 - Obligated \$5.5M
 - SHHR Re-determination workgroup est. Feb.23

GA Actions on Budget Amendments

				HB30/SB30 (2/20/22)					
				FY2023			FY2024		
Source	Category	Ref#	Brief Description	MEL	GF	NGF	MEL	GF	NGF
SB30	Behavioral Health	304 #27s	Establish Behavioral Health Homes		\$ 3,000,000	\$ 3,000,000		\$ 3,000,000	\$ 3,000,000
SB30	DD Waivers	304 #20s	Feasibility of Adding Core Services Waiver for Developmental Disabilities		Language Only			Language Only	
HB30	Nursing Homes	304 #10h	HB 241 - Medicaid Coverage for Customized Wheelchairs		\$ 2,359,250	\$ 2,405,750		\$ 2,351,658	\$ 2,413,342
SB30	Nursing Homes	304 #6s	Medicaid Coverage of Customized Wheelchairs in Nursing Facilities		\$ 2,359,250	\$ 2,405,750		\$ 2,351,658	\$ 2,413,342
SB30	Personal Care	304#13s	Modify Limitation on Group Home Size		Language Only			Language Only	
SB30	TBI	308 #2s	Traumatic Brain Injury Waiver		\$ 250,000	\$ 250,000		\$ 0	\$ -
SB30	HCBS	304 #14s	Plan for a 1915(i) HCBS Benefit for Older Virginians		Language Only			Language Only	
SB30	Nursing Homes	304 #15s	Nursing Home Quality Improvement Program		Language Only			Language Only	
SB30	Cardinal Care	308 #5s	Remove Additional Funds for Merger of Managed Care Programs		\$ (421,498)	\$ (1,188,142)		\$ -	\$ -

GA Actions on Budget Amendments

				HB30/SB30 (2/20/22)						
				FY2023			FY2024			
Source	Category	Ref#	Brief Description	MEL	GF	NGF	MEL	GF	NGF	
SB30	Cardinal Care	308 #5s	Remove Additional Funds for Merger of Managed Care Programs		\$ (421,498)	\$ (1,188,142)		\$ -	\$ -	
SB30	Cardinal Care	308 #3s	Capture Administrative Savings from Merger of Managed Care Programs		\$ -	\$ -		\$ (500,000)	\$ (500,000)	
SB30	Reentry & Outreach	304 #26s	Modify Reentry Care Coordination and Outreach Initiative		\$ (1,062,185)	\$ (12,544,924)		\$ (1,385,199)	\$ (17,857,653)	
SB30	RPM	304 #29s	Expand Remote Patient Monitoring		\$ 733,009	\$ 820,357		\$ 1,309,667	\$ 1,470,587	
SB30	Nursing Homes	304 #4s	Nursing Facility Staffing Standards		\$ -	\$ -		\$ 19,436,686	\$ 19,436,686	
SB30	Supp Payments	304 #12s	Supplemental Payments to Private Hospitals		Language Only				Language Only	

Summary

- Agency key F&T metrics moving in positive direction
- Ongoing extensions of PHE continue to create enrollment and expenditure forecasting challenges
- MCO performance lagging in MLR, profit is exceeding expectations
- All five ARPA projects now underway
- DMAS tracking 39 budget amendments, 12 high priority



VIRGINIA MEDICAID GENERAL ASSEMBLY UPDATE

**WILL FRANK,
SENIOR ADVISOR FOR
LEGISLATIVE AFFAIRS**

MARCH 8, 2022

DMAS Legislative Role

- Monitor introduced legislation.
- Review legislation and budget language for Secretary and Governor.
- Make position recommendations to Secretary and Governor.
- Communicate Governor positions to General Assembly.
- Provide expert testimony and technical assistance to legislators on legislation.

2022 GA Session Stats

- 2,633 bills introduced.
- DMAS was assigned 21 bills.
- 12 bills are still alive.
- 9 bills failed.
 - These included bills with Amend, No Position, and Oppose positions.
- DMAS commented on another 23 bills assigned to other agencies.
- DMAS Tracked another 82 bills.

Key Bills 2022

HB241

- Requires DMAS to cover Medicaid durable medical equipment (DME) consisting of complex rehabilitative technology, including manual and power wheel chair bases and related accessories, for patients who reside in nursing facilities. This would make it easier for Medicaid members in a nursing facility to get complex rehab equipment such as custom wheelchairs.

HB680

- Requires DMAS to update the state plan for medical assistance services to include a provision for the payment of medical assistance for targeted case management services for individuals with severe traumatic brain injury.

HB800

- Requires DMAS to enroll eligible individual who is in the custody of a state correctional facility into limited coverage Medicaid. The bill also provides that when the person is released from custody, they will be reevaluated and if eligible, moved to full Medicaid coverage.

Key Bills 2022

HB987

- Directs DMAS to require every person that provides program information to Medicaid members or eligible individuals to ensure that this information is made accessible to (i) individuals with limited English proficiency, and (ii) individuals with disabilities through the provision of auxiliary aids services.

SB231

- DMAS shall amend the Family and Individual Supports, Community Living, CCC+, and Building Independence waivers and implement regulations to combine the maximum annual allowable amount for assistive technology, electronic home-based support services, and environmental modifications for an individual receiving waiver services.

SB426

- Requires DMAS provide for the payment of medical assistance for remote patient monitoring services provided via telemedicine (i) for patients who have experienced an acute health condition and for whom the use of remote patient monitoring may prevent readmission to a hospital or emergency department, (ii) for patient-initiated asynchronous consultations, and (iii) for provider-to-provider consultations.

Key Bills 2022

SB594

- Prohibits licensed providers from requiring payment from Medicaid participants for the prescription of an opioid for the management of pain or the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction, regardless of whether the provider participates in the state plan for medical assistance.

SB663

- Establishes a payment provision (“originating site fee”) for emergency medical service agencies to facilitate synchronous telehealth visits between a distant site provider and a Medicaid member at the location of the Medicaid member.

HB925 & SB405

- Requires coverage for medically necessary prosthetic devices, “including myoelectric, biomechanical, or microprocessor-controlled prosthetic devices which peer-reviewed medical literature has determined to be medical appropriate based on clinical assessment of the individual’s rehabilitation potential.”

Questions????

Thank you

Will Frank- will.frank@dmas.virginia.gov



MEDICAID CONTINUOUS COVERAGE REQUIREMENTS

SARAH HATTON,
DEPUTY OF ADMINISTRATION

MARCH 8, 2022



Background on Continuous Coverage

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

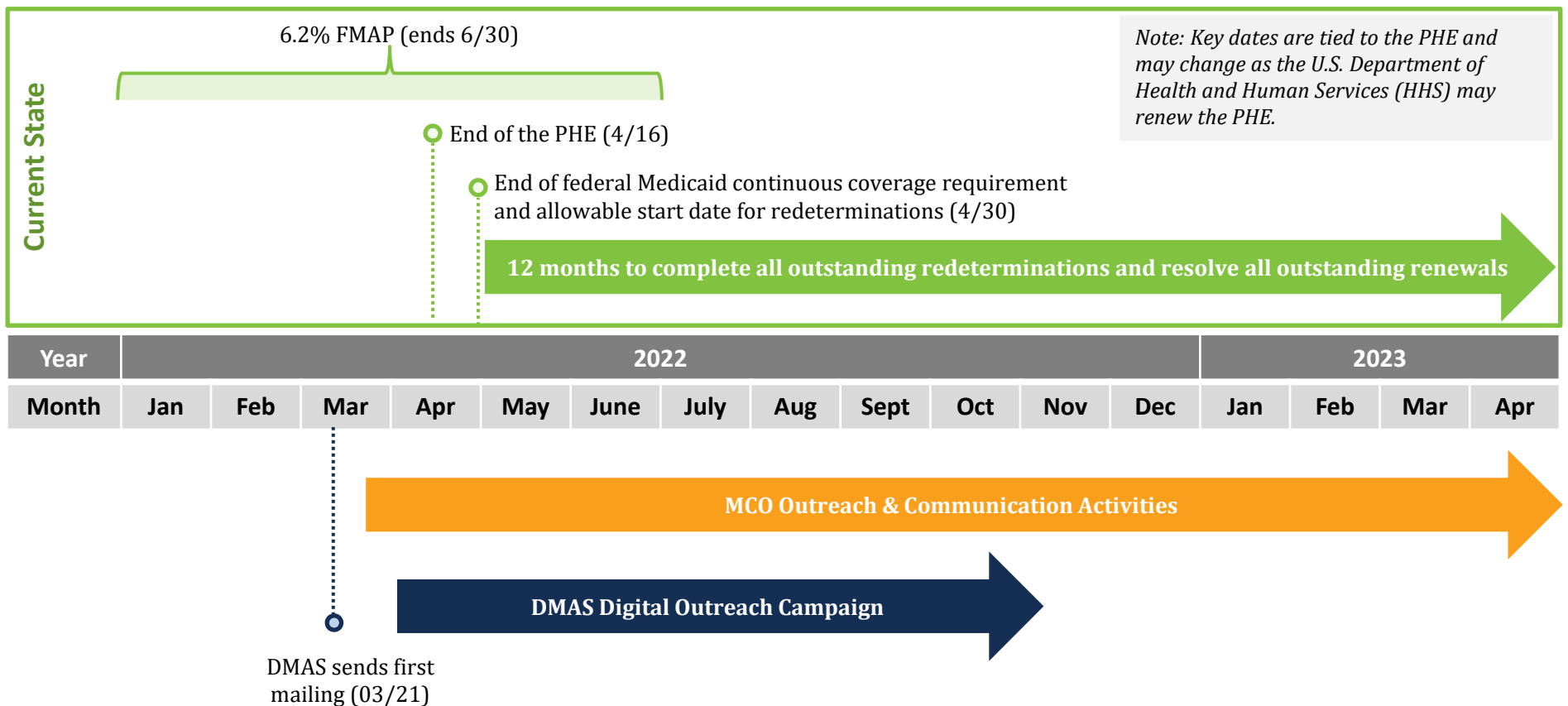
To support states and promote stability of coverage during the COVID-19 pandemic, FFCRA provided a 6.2 percentage point increase in the regular Medicaid matching rate, tied to certain conditions that states must meet in order to access the enhanced funding.

- As one of several conditions of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase under FFCRA, **states are required to maintain enrollment of individuals in Medicaid** until the end of the month in which the public health emergency (PHE) ends (**the “continuous coverage” requirement**).
- The continuous coverage requirement **applies to individuals enrolled in Medicaid as of March 18, 2020 or who were determined eligible on or after that date**, and has allowed people to retain Medicaid coverage and get needed care during the pandemic.
- When continuous coverage is eventually discontinued **state will be required to redetermine eligibility for nearly all Medicaid enrollees.**

★ *The current federal Medicaid continuous coverage requirement ends on April 30, 2022.*

Current Timeline – Redeterminations & Communications

The March 2022 guidance lays out a timeline of up to 12 months for states to initiate redeterminations. New federal guidance allows for an additional two months to allow time for processing and addressing any backlogs.



Continuous Coverage in the Commonwealth

Medicaid Enrollment in the Commonwealth During the PHE

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



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



From March 2020 through February 2022, the Commonwealth experienced an **increase of nearly 456,206 enrollees (a 30% increase in enrollment growth).**



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



Post continuous coverage, **roughly 20% of the state's total Medicaid enrollees may lose coverage, which is in line with national averages.**

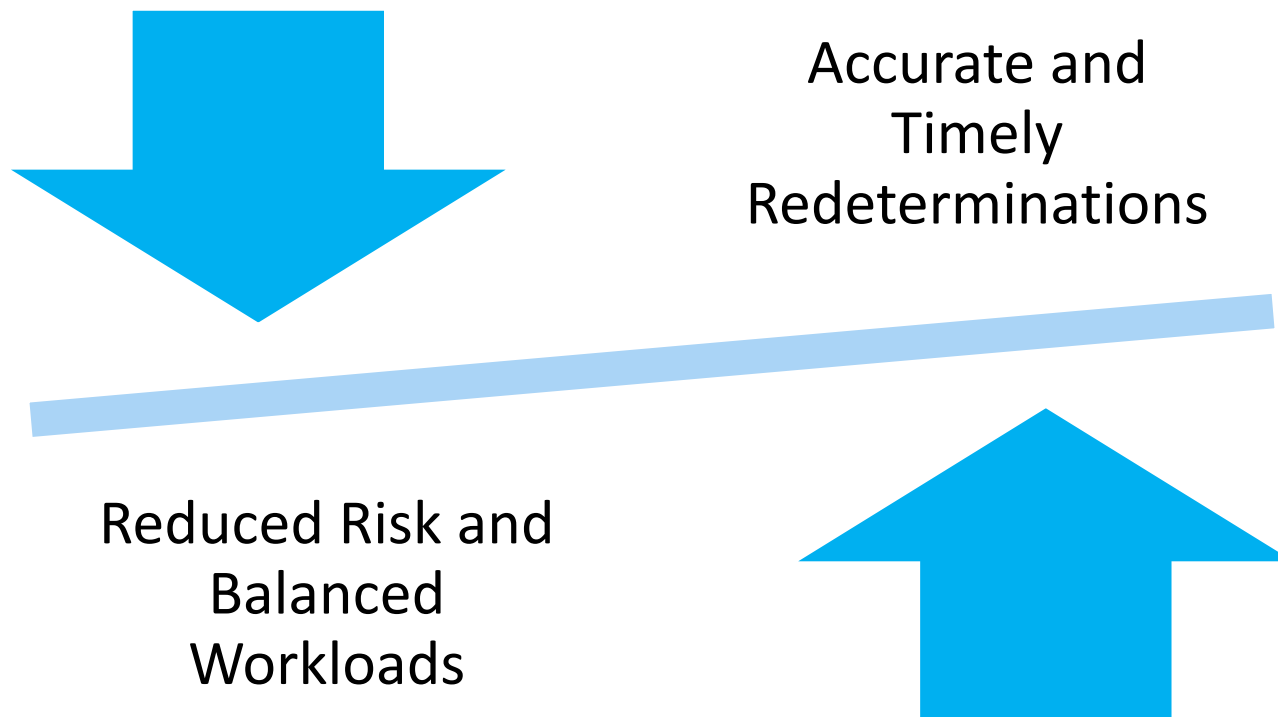
Unwinding/Renewal by Month

Current PHE Redetermination Schedule				
Automated Renewal Month	Current Due Renewals	Current Renewal Counts by Members	Overdue Renewal Month(s)	Overdue Renewal Counts by Members
1: April 2022	Jun-22	44,301	Mar-Sept 20	70,165
2: May 2022	Jul-22	52,890	Oct-Nov 20	98,803
3: June 2022	Aug-22	47,488	Dec 20-Mar 21	105,738
4: July 2022	Sep-22	114,444	Apr-May 21	59,442
5: August 2022	Oct-22	160,813	Jun-21	15,033
6: September 2022	Nov-22	169,321	July-Aug 21	26,010
7: October 2022	Dec-22	99,732	Sep-21	67,115
8: November 2022	Jan-23	61,952	Oct-21	95,712
9: December 2022	Feb-23	58,134	Nov-21	88,752
10: January 2023	Mar-23	not available	Dec 21-Jan 22	135,435
11: February 2023	Apr-23	not available	Feb-Mar 22	166,026
12: March 2023	May-23	not available	Apr-May 22	125,807
Total		809,075		1,054,038

Note: All dates are subject to change, contingent on reviewing data monthly, and system limitations. MMIS data as of 02/24/2022. Yellow shaded boxes are for months without full data.

Goal: Ensure all redeterminations are performed **accurately** the first time to **reduce risk** and balance future workloads.

Since August 2021, DMAS has utilized American Rescue Plan Act (ARPA) funding to take immediate action in preparation for the end of the continuous coverage requirements. The agency's priority is to ensure efficient and accurate redeterminations to ensure individuals who are eligible for services remain enrolled and to make appropriate referrals to the Federal Marketplace for those who are no longer eligible.



The Commonwealth's Unwinding Planning Efforts

The Commonwealth's Unwinding Planning Efforts

DMAS and DSS will be faced with a significant backlog of cases that await redeterminations at the end of the continuous coverage requirement. To date, the Department has made great strides in preparing for the end of the federal continuous coverage requirement by:



Making systems updates (e.g., new VaCMS automation) to improve the efficiency of the renewal/redetermination process. This is expected to reduce the number of individuals that are inappropriately terminated following the PHE.



Developing a detailed plan to stage redeterminations, including spacing redeterminations to allow timely and expeditious evaluations and by identifying actions that will be required for each coverage group.



Collaborating with managed care organizations (MCOs) to provide information/education to members post-PHE; ensure up-to-date contact information (e.g., addresses, phone numbers); and remind members to complete their renewal.



Addressing returned mail by engaging with a dedicated team within the Central Eligibility Unit. When the Commonwealth receives returned mail after sending initial notices, the state will have better insight into which enrollees have outdated mailing addresses and can target additional outreach to those enrollees through alternate modes of communication.



Communications plan (e.g., direct member mailing, digital outreach, updates to the Cover Virginia website, eligibility worker reinforcement, application assistance) to ensure members understand the steps they need to take, when to act, and what to do to maintain coverage.



Coordinating language approval and scheduled delivery of mailings/digital/telephonic outreach in order to ensure consistent messaging to members and coordinate timing of any outreach.



Identifying which federal flexibilities the Commonwealth will maintain and new strategies that the Department may want to leverage in order to help with the unwinding process.

Unwinding: Three Prong Approach

Funding has been allocated to DMAS to address the Medicaid application backlogs and unwinding efforts resulting from the pandemic. In partnership with the Department of Social Services (DSS), DMAS has planned a three pronged approach to address these efforts.

Systems:
Increased
Automation

Staff
Augmentation

Outreach &
Stakeholder
Engagement

Outreach & Communications



- **Outreach Partners:**
 - Health Plans
 - Community Partners to include:
 - Non-profit
 - Local Government
 - Faith Based
 - Navigators
 - Advocates
 - Sister Agencies
 - Department of Education
 - Call Centers
 - Providers
- **Toolkits**
 - Stakeholders
 - Health Plans
 - Legislators
 - Department of Social Services

Open Discussion



thank you!

The Department of Medical Assistance Services (DMAS) will update this resource and add materials as new federal guidance and additional insights are available. Information about the federal public health emergency can be found on the [Cover Virginia website](https://www.covervirginia.gov). Reach out to us at covervirginia@dmas.virginia.gov if you have any questions.

Appendix A

Resuming Normal Operations, AKA “Unwinding” Policies

- HHS Secretary Becerra has the authority to extend the federal Public Health Emergency (PHE).
- The current federal PHE expires **04/16/2022**.
- If unwinding is based around the PHE expiration, normal operations can resume in the month in which the PHE ends.
- The enhanced FMAP would end in the quarter in which the PHE ends.
- States have 12 months to initiate all redeterminations and an additional two months to complete all unwinding work and come into compliance with all timeliness standards, however no member can be terminated without a full re-determination.

Federal Public Health Emergency Unwinding Toolkit

Normal Medicaid Enrollment Processes Will Start Soon



Federal Public Health Emergency Unwinding Toolkit: *Normal Medicaid Enrollment Processes Will Start Soon*

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Toolkit Introduction Letter

Outreach and Communications Timeline

**Federal Medicaid Continuous Coverage Requirement: Resuming Normal Operations
PowerPoint Presentation**

Messaging Samples

- ENewsletter Blurb
- ENewsletter Text
- Text Messages
- Email Text
- Website Text
- Social Media Posts

Stakeholder Outreach Materials

- Factsheet
- Frequently Asked Questions (FAQs)
- Stakeholder Flier
- Poster (11x17)

Member Outreach Materials

- Factsheet
- Frequently Asked Questions (FAQs)
- Member Flier

Outreach Templates

- Post Card/Front and Back (4x6 and 5x7)
- Folded Mailer
- Event A-Frame
- Window Cling (5x7 and 8x10)
- Rack Card
- Bi-Fold Brochure

Additional Resources

- Virginia Association of Free and Charitable Clinics (VAFCC)
- Virginia Health Care Foundation (VHCF)
- Virginia Poverty Law Center (VPLC)



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

804-786-7933
www.dmas.virginia.gov

DATE: FEBRUARY 01, 2022

TO: COMMUNITY PARTNERS, STAKEHOLDERS, & ADVOCATES

SUBJECT: DMAS RETURN TO NORMAL MEDICAID ENROLLMENT PROCESS TOOLKIT

The purpose of this toolkit is to provide our community partners, stakeholders, and advocates with messaging and resources to support local and state agencies as Virginia prepares to return to normal Medicaid enrollment processes, also known as unwinding. The goal of the outreach messaging and templates is to encourage members to provide updated contact information. The Department of Medical Assistance Services (DMAS) will update this resource and add materials as new federal guidance and additional insights are available.

The outreach resources include messaging and templates that can be used in various forms of outreach, including print, telephonic communications, and digital media. DMAS worked with our many partners to ensure this toolkit contains the messaging and resources needed to engage members immediately. We encourage partners to use this messaging and integrate it into their outreach and social media campaigns. Partners may modify the outreach language to meet any business need; however, the language in these resources must remain the same to ensure consistency in messaging.

DMAS is sharing the outreach language and templates broadly for use by health plans, other state agencies, providers, and other community partners in their outreach activities. Due to this outreach effort, the Medicaid call centers, to include the Cover Virginia Call Center, the CommonHelp portal, and local Department of Social Services offices may experience an increase in activity as Medicaid members provide updated contact information.

If you have any questions or require additional information regarding DMAS's plans for resuming normal Medicaid enrollment operations or outreach efforts, please visit the [Cover Virginia website](https://www.covervirginia.org) or email our team at covervirginia@dmas.virginia.gov.

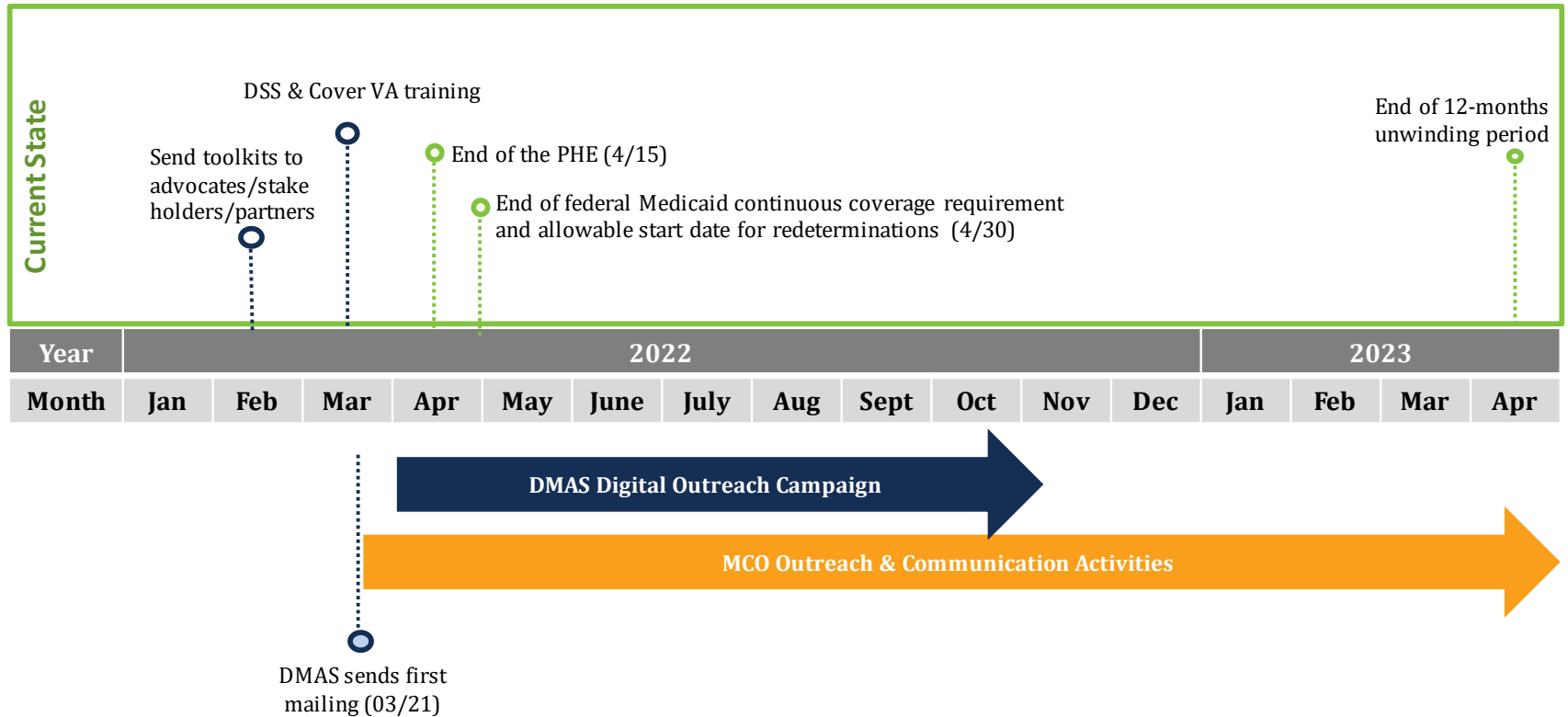
Sarah Hatton, MHSA
Deputy of Administration
Director's Office
Virginia Department of Medical Assistance Services

CC: Jessica Anecchini, Senior Advisor, Administration
Natalie Pennywell, MPH, CHES, Outreach and Community Engagement Manager
Mariam Siddiqui, MS, Senior Operations Advisor, Administration

Enclosure



Outreach & Communication Timeline



NOTE: Dates are subject to change, based on federal guidance and extensions of the Public Health Emergency.

Federal Medicaid Continuous Coverage Requirement: Resuming Normal Operations

PowerPoint Presentation

If you would like someone from DMAS to present to your organization/agency please email us at covervirginia@dmas.virginia.gov.



Federal Medicaid Continuous Coverage Requirement: Resuming Normal Operations

If requested, the presentation will include information on the following topics:

- Overview and purpose of information
- Background and continuous coverage
- Federal expectations of states related to “unwinding” continuous coverage
- Continuous coverage in the commonwealth
- Outreach, Engagement and Communications
- Open discussion



Messaging Samples

No changes should be made to the DMAS standard language set in the samples and templates.

Our outreach and communications goals are to:

- **Educate** - Raise awareness of actions members need to take and when they need to take them to maintain coverage.
- **Engage** - Engage stakeholders, partners, and advocates to align messaging, create “surround sound,” and leverage and build partnerships with trusted messengers.
- **Establish** - Establish feedback loop with stakeholders, partners, and advocates to share input for planning, and to identify and address issues as implementation takes place.

DMAS’ outreach and communications will be focused around three specific areas:

- **Updating contact information**
- **Completing the renewal process**
- **Losing coverage – next steps (the reconsideration period)**

Ultimately, the goals and objectives of our outreach and communications effort is to align with operational planning and ensure that information reaches Medicaid members to maximize continuity of coverage and effectively communicate how to maintain it.

Citation: GMMB. (n.d.). Planning for the End of the Continuous Coverage Requirement: A Communications Toolkit for States. Resources for states on unwinding the Medicaid continuous coverage requirement. Retrieved January 19, 2022, from <https://www.shvs.org/resource/phe-unwinding-resources-for-states/>

Messaging Samples

ENewsletter Blurb

- Normal Medicaid Enrollment Processes Will Start Soon! Virginia Department of Medical Assistance Services (DMAS) will soon start to review Medicaid members' health coverage. They will not cancel or reduce coverage for members without asking for updated information, but they need your help to make this a smooth process. You can take steps now to make sure you receive information you will need to renew your coverage. Update your contact information today online at commonhelp.virginia.gov, by calling Cover Virginia at 1-855-242-8282, or by calling your [local Department of Social Services](#).

ENewsletter Text

- If you have Medicaid/FAMIS/CHIP health insurance, make sure your current mailing address, email, and phone numbers are up to date so that important information about your coverage gets to you. Visit the [Cover Virginia website](#) for more information or call 1-855-242-8282 to update your contact information today.

Text Messages

- This is [AGENCY/ORGANIZATION] with a reminder to make sure your current address, email, and phone number is in our records. It is important to keep your contact information up to date so we can reach you about any changes to your [MEDICAID/FAMIS/CHIP] coverage. Visit the [Cover Virginia website](#) for more information or call 1-855-242-8282 to update your contact information today.

Email Text

- **Re: Make Sure [AGENCY/ORGANIZATION] Can Reach You**

Have you moved in the past three years? Has your address or contact information changed? It is important to make sure your health insurance moves with you.

Moving can be overwhelming—take a moment today to confirm that [AGENCY/ORGANIZATION] has the correct mailing address, phone numbers, and email address on file so we can reach you in case of any changes to your health coverage. You may be notified of steps you need to take to keep your coverage.

Visit the [Cover Virginia website](#) for more information or call 1-855-242-8282 to update your contact information today.

Website Text

- Have you moved in the past three years? Has your address or contact information changed? Please make sure [MEDICAID/FAMIS] has your current mobile phone number, email, and mailing address so our records are up to date. It's important to make sure we can reach you with information about changes to your health insurance. There may be steps you need to take to keep your coverage. Visit the [Cover Virginia website](#) for more information or call 1-855-242-8282 to update your contact information today.

Social Media Posts

- **Message 1:**

Don't miss out on important health coverage information from Virginia Medicaid! It's time for Medicaid members to update their contact information. Take action today!

(computer emoji) Visit commonhelp.virginia.gov

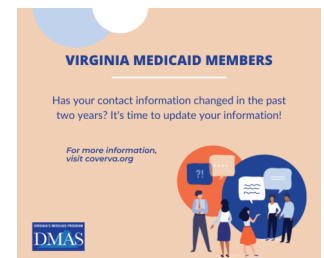
(phone emoji) Call 1-855-242-8282 (TDD: 1-888-221-1590)

(building emoji) Call your local Department of Social Services



- **Message 2:**

Did your contact information change over the past two years? Let us know! It's important that we are able to reach you with information about your coverage, such as reminders to renew your coverage. Visit <https://coverva.org/en/phe-planning> to learn how to update your information today!



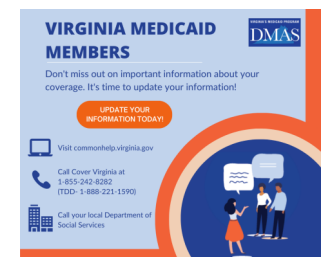
- **Message 3:**

It's important that Virginia Medicaid has your most current mailing address, phone number and email address so we can reach you with information about your health coverage. Don't miss out on any updates!

(computer emoji) Visit commonhelp.virginia.gov

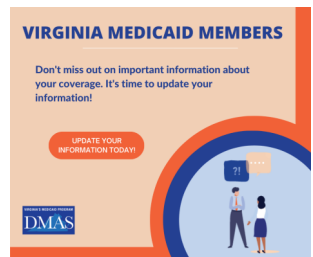
(phone emoji) Call 1-855-242-8282 (TDD: 1-888-221-1590)

(building emoji) Call your local Department of Social Services



- **Message 4:**

Updating your contact information for Virginia Medicaid is easy! Visit commonhelp.virginia.gov to report any changes and make sure we can reach you with important information about your health coverage.



- **Message 5:**

Attention Virginia Medicaid members: it's time to update your contact information! Make sure we can reach you with important updates about your health coverage.

(computer emoji) Visit commonhelp.virginia.gov

(phone emoji) Call 1-855-242-8282 (TDD: 1-888-221-1590)

(building emoji) Call your local Department of Social Services



Stakeholder Outreach Materials

- Factsheet
- Frequently Asked Questions (FAQs)
- Flier
- Poster



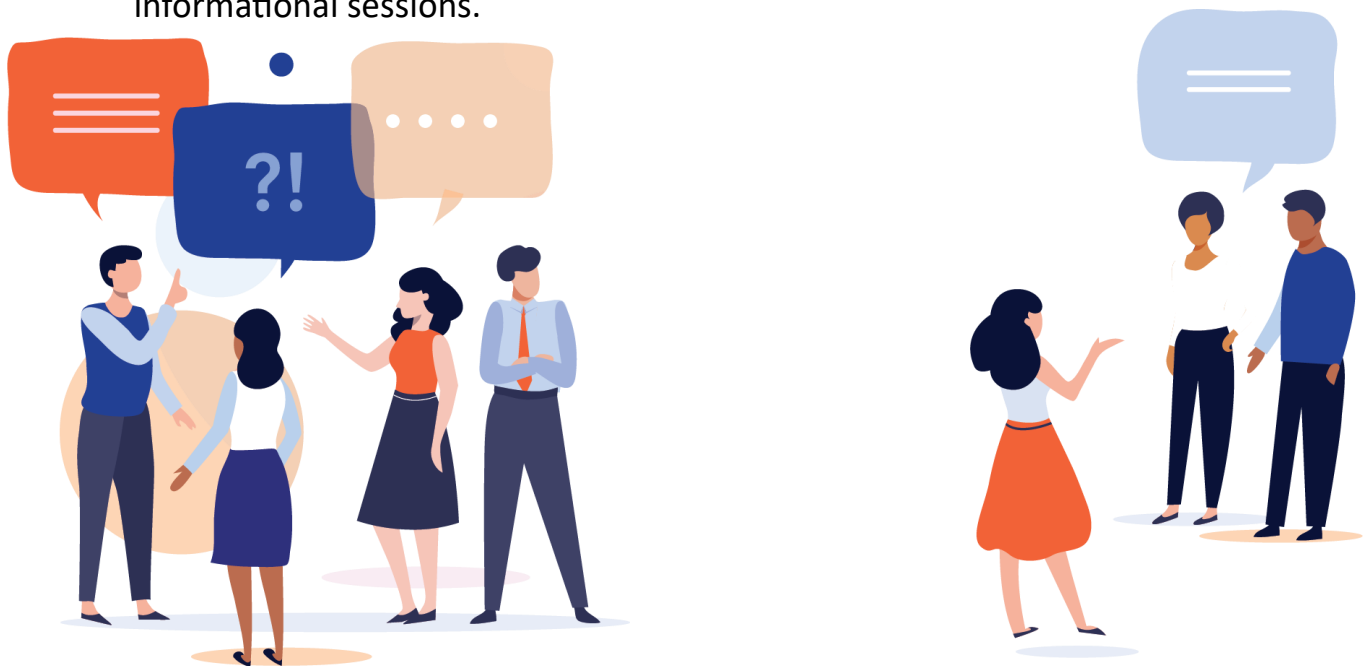
Help Us Return to Normal Medicaid Enrollment Processes

Since the start of the COVID-19 pandemic, Medicaid members have been able to keep their health coverage even if their eligibility status changed. Soon Virginia and all other states will begin re-evaluating eligibility for Medicaid members. This process will be a heavy lift, and the Virginia Medicaid agency is committed to working in partnership with community partners to ensure our members have the information they need to complete their renewal documents. We need to prepare now!

Federal officials plan to give states 12 months to review Medicaid coverage for all members, but they have not yet announced the start date for this process. We want all eligible Virginians to keep their health coverage. We will need the support of our health care advocates and stakeholders to achieve this goal.

What Stakeholders/Advocates/Partners Can Do:

- Get as much information as possible on Virginia's plan for re-evaluating and renewing coverage.
- <https://coverva.org/en/phe-planning> Engage in Virginia's planning process
 - Sign up to receive current information on Virginia's planning process via the Medicaid Outreach team's [Bi-Monthly Stakeholder Meeting](#) and [our Partner Points newsletter](#).
 - Identify Medicaid members and partners in your existing system, coalitions or networks, encourage them to access our resources, and invite them to join informational sessions.



- **Coordinate communications**

- Engage your Medicaid members and your partner networks to read and share messages and resources from Virginia Medicaid about the renewal process.
- Plan your member and partner messaging to coordinate with Virginia’s outreach and communication plan.
- Plan member communications to coincide with coordinated calls to action to:
 - ◆ Update contact information (mailing addresses and phone numbers) to make sure members receive important paperwork.
 - ◆ Respond to notices/renewals and provide needed eligibility verifications. Inform individuals who lose Medicaid coverage about the 90-day reconsideration period for re-enrollment without a new application if they did not return their administrative renewal form or associated verifications.
 - ◆ Use Medicaid coverage to catch up on preventive or delayed care.

- **Help our members take steps now to get ready. Members can make updates to their information:**

- Online at commonhelp.virginia.gov,
- By calling Cover Virginia at **1-855-242-8282**, or
- By calling their local [Department of Social Services](#).

We will continue to share information for stakeholders, partners and advocates on [Cover Virginia](#) and the [DMAS COVID-19 Response](#) websites.



Frequently Asked Questions for Stakeholders and Advocates

What is the federal public health emergency and how does it affect members?

The federal government declared a public health emergency when the COVID-19 pandemic began in March 2020. Since then, state Medicaid agencies have continued health care coverage for all medical assistance programs, even if an individual's eligibility changed.

When will normal Medicaid enrollment requirements resume?

We do not know exactly when federal officials will instruct states to return to normal enrollment practices, but we need to prepare now. Here is what we know now:

- States must re-determine coverage for all Medicaid members over a 12-month period, although we do not yet have a start date for this process.
- Virginia will not take any negative action to cancel or reduce coverage for our members without completing a full redetermination of benefits.

What if members lose their coverage?

We want all eligible Virginians to get and stay covered. If a member no longer qualifies for health coverage from Virginia Medicaid, they will get:

- Notice of when their Medicaid coverage will end,
- Information on how to file an appeal if the member thinks the cancellation decision was incorrect,
- A referral to the Federal Marketplace and information about buying other health care coverage.

What can members do now?

Members can:

- Update their contact information online at commonhelp.virginia.gov, or by calling Cover Virginia at 1-855-242-8282. We must have current contact information on file, such as a mailing address and phone number(s), so members receive important notices and so we can reach out if we need more information.
- [Sign up](#) for our electronic newsletter and follow us on social media to get updates.
- **Watch for and respond quickly to notices about their coverage.**

We will post information, resources and tools online:

- For members, partners, and stakeholders at coverva.org and facebook.com/coverva/
- For providers at dmas.virginia.gov/covid-19-response/



What are the other health care coverage choices?

Virginians who do not qualify for Virginia Medicaid can buy health insurance through [Enroll Virginia](#), a network of community-based organizations committed to helping Virginians get high-quality, affordable health coverage. Individuals can sign up for insurance on the Federal Marketplace:

- Within 60 days of losing their health coverage or
- Anytime during the annual open enrollment period from November 1 through December 15

Individuals who do **not** qualify for health coverage from Virginia Medicaid may be able to get financial help to lower the cost of private health insurance through [HealthCare.gov](#). The amount of financial help is based on the cost of the premiums where the applicants live, how many people are in their household and their estimated yearly income.

Learn more at [enrollva.org](#) or 888-392-5132:

- Get help from trained and certified navigators and enrollment experts to sign up for health coverage online or in person.
- Browse plans and costs with an easy, anonymous online tool.
- Find out how much financial help an individual may qualify to receive.

How will DMAS work with its partners?

- We will work closely with our providers and eligibility partners to redetermine members' eligibility, and only disenroll those who are no longer eligible.
- We will give appropriate notice to all members whose eligibility ends or changes, including appeal information.
- We will work closely with Enroll Virginia and its network to connect Virginians to other health coverage options.



How can I get more information?

Virginia Medicaid will continue to inform members and stakeholders through our [Partner Points newsletter](#), [Bi-Monthly Stakeholder Meeting](#), [coverva.org](#), [commonhelp.virginia.gov](#), emails, text messages and social media.

Where can I submit outstanding questions or provide additional insight?

Members and stakeholders are always encouraged to contact us via covervirginia@dmas.virginia.gov

We will also provide policy and operational information to our partners through stakeholder meetings, at [dmas.virginia.gov/covid-19-response/](#) and through [our Partner Points newsletter](#).

Normal Medicaid enrollment processes will return soon, and we want all eligible Virginians to keep their health coverage.

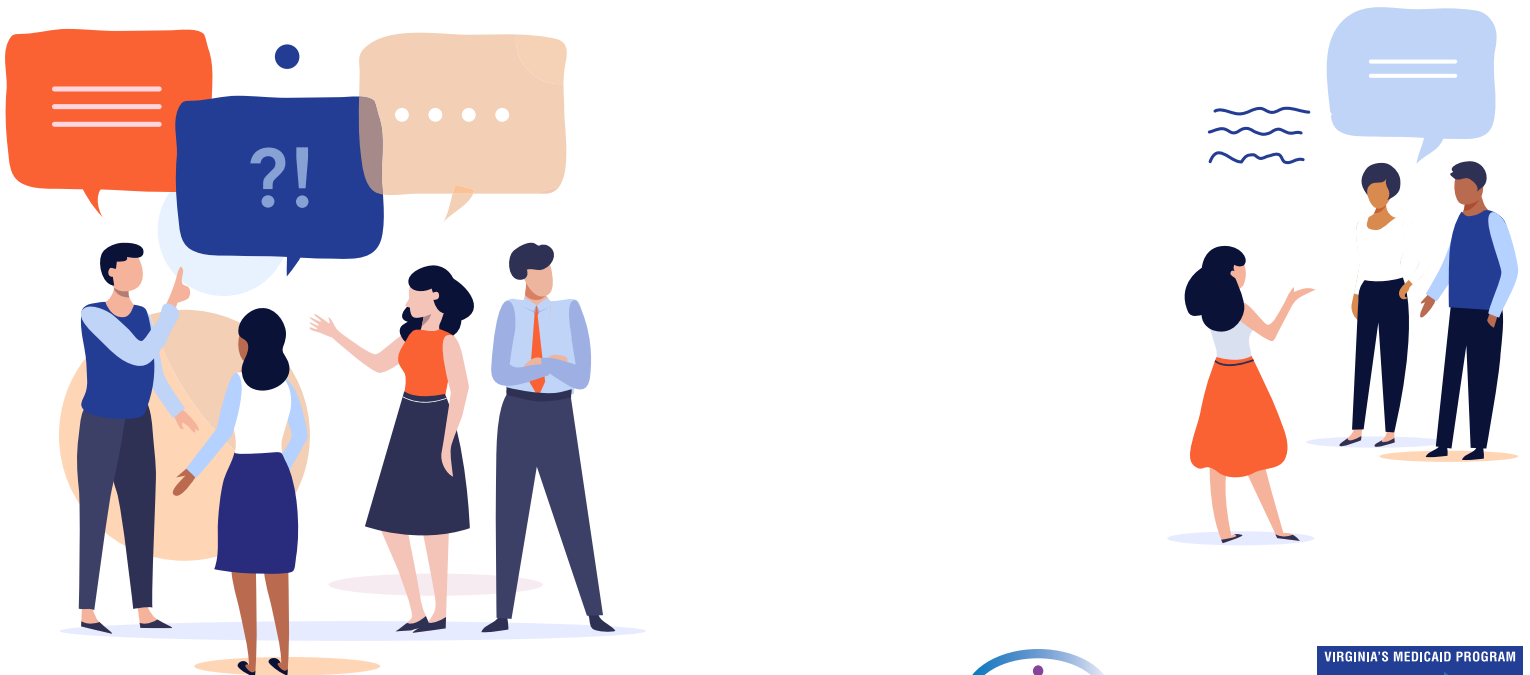
We need the most up-to-date **mailing address and phone number** to make sure members receive important paperwork.

Members can make updates:

- Online at commonhelp.virginia.gov
- By calling Cover Virginia at 1-855-242-8282, or
- By calling their [local Department of Social Services](#)

Spread the word to community members, patients, family, friends, neighbors and anyone else who might be enrolled in Medicaid to keep our communities covered!

Visit the [Cover Virginia](#) and [DMAS COVID-19 Response](#) websites to learn more.



Normal Medicaid enrollment processes will return soon, and we want all eligible Virginians to keep their health coverage.

We need the most up-to-date mailing address and phone number to make sure members receive important paperwork.

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Visit the [Cover Virginia](#) and [DMAS COVID-19 Response](#) websites to learn more.



Member Outreach Materials

- Factsheet
- Frequently Asked Questions (FAQs)
- Flier



Normal Medicaid Enrollment Processes Will Start Soon

Virginia and other states will soon start to review Medicaid members' health coverage. We will not cancel or reduce coverage for our members without asking for updated information, but we need your help to make this a smooth process. **You can take steps now to make sure you receive information you will need to renew your coverage.**

What Medicaid Members Can Do:

- Update your contact information. You can make updates:
 - Online at commonhelp.virginia.gov
 - By calling Cover Virginia at 1-855-242-8282, **or**
 - By calling your [local Department of Social Services](#)
- Take action when you get official notices from Virginia Medicaid, other state agencies, community groups, and health care providers asking you to:
 - Update contact information (mailing addresses and phone numbers)
 - Respond to notices/renewals to confirm that you are eligible
 - Use your coverage to catch up on preventive or delayed care
- Learn more about Virginia's plans
 - Visit the [Cover Virginia](#) website for updates
- Read the Medicaid [Members Frequently Asked Questions](#) and [updated COVID-19 Medicaid Information Eligibility, Enrollment, and Appeals](#) fact sheets.
 - [Sign up](#) for email and text updates, and follow us on social media.

Visit the [Cover Virginia](#) website for more information



Frequently Asked Questions for Medicaid Members

What is the federal public health emergency and how does it affect Medicaid members?

The federal government declared a public health emergency when the COVID-19 pandemic began. Since then, state agencies have continued health care coverage for all medical assistance programs, even for people who are no longer eligible.

When will normal Medicaid processes begin again?

- States will have 12 months to make sure Medicaid members are still eligible for coverage. We do not yet know when this process will start. We will not cancel or reduce coverage for our members without asking them for updated information.

What if members lose their coverage?

We want all eligible Virginians to get and stay covered. If a member no longer qualifies for health coverage from Virginia Medicaid, they will get:

- Notice of when their Medicaid coverage will end,
- Information on how to file an appeal if the member thinks the cancellation decision was incorrect, **and**
- A referral to the Federal Marketplace and information about buying other health care coverage.

What can members do now?

Members can:

- Update their contact information online at commonhelp.virginia.gov or by calling Cover Virginia at 1-855-242-8282. We must have current contact information on file, such as a mailing address and phone number(s), so members receive important notices and so we can reach out if we need more information.
- Watch for and respond quickly to notices about their coverage.
- [Sign up](#) for email and text updates, follow us on social media and visit us at coverva.org and facebook.com/coverva/



- Continued on other side -

What are the other health care coverage choices?

Virginians who do not qualify for Virginia Medicaid can buy health insurance through [Enroll Virginia](#). Enroll Virginia has offices in communities across the state to helping Virginians get high quality, affordable health coverage. You can sign up for insurance on the Federal Marketplace on [HealthCare.gov](#):

- Within 60 days after losing health coverage or
- Anytime during the annual open enrollment period from November 1 through December 15

Virginians who do **not** qualify for health coverage from Medicaid may be able to get financial help to lower the cost of private health insurance through [HealthCare.gov](#). The amount of financial help is based on the cost of insurance where the applicants live, how many people are in their household, and their estimated yearly income.

Learn more at [enrollva.org](#) or 888-392-5132:

- Get help from trained assisters, called navigators, to sign up for health coverage online or in person.
- Compare plans and cost with an easy, anonymous online tool
- Find out how much financial help you may qualify to receive
- Get enrolled!

How can I get more information?

Virginia Medicaid will keep members up to date through [coverva.org](#), [commonhelp.virginia.gov](#), emails, text messages and social media.

Where can I send questions or share my views?

Members can reach us at covervirginia@dmas.virginia.gov.

Visit the [Cover Virginia](#) website for more information.



Normal Medicaid enrollment processes will return soon, and we want all eligible Virginians to keep their health coverage.

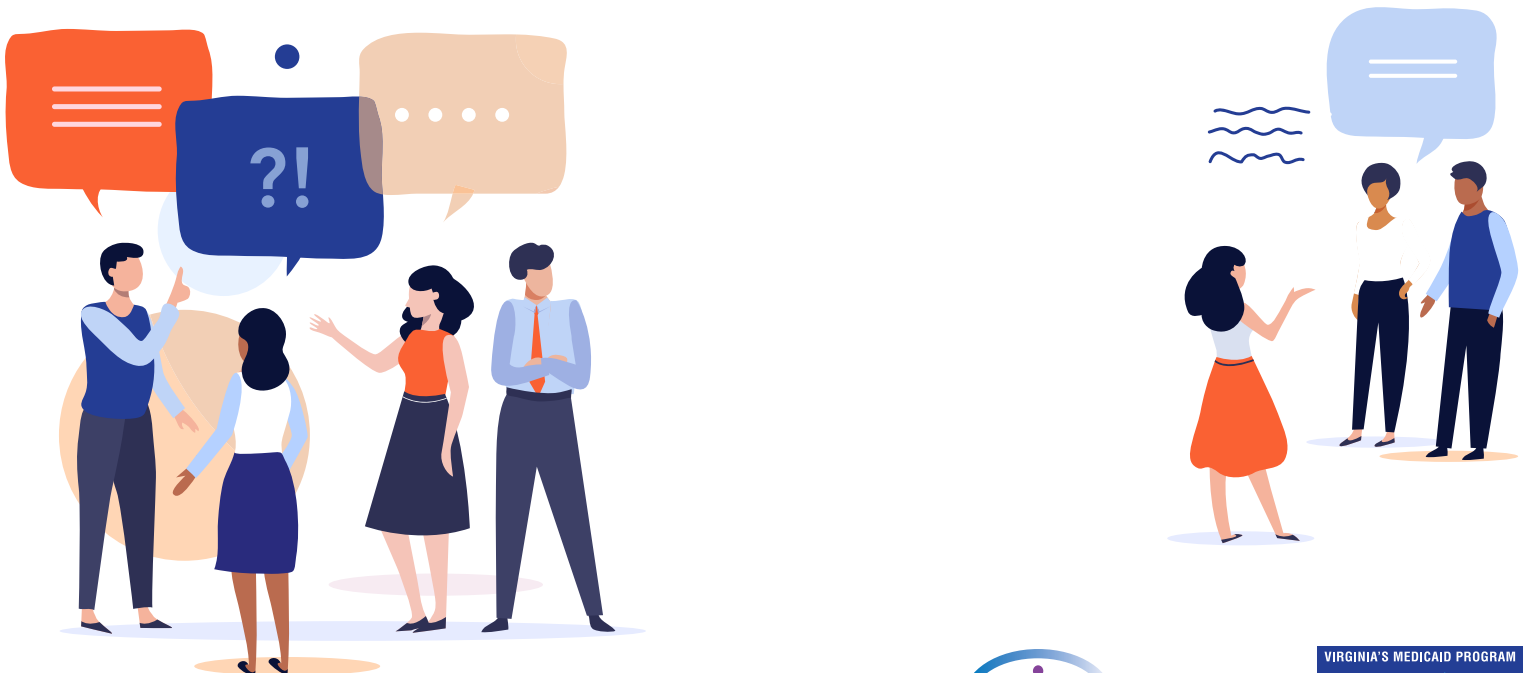
We need the most up-to-date **mailing address and phone number** to make sure members receive important paperwork.

Members can make updates:

- Online at commonhelp.virginia.gov
- By calling Cover Virginia at 1-855-242-8282, or
- By calling their [local Department of Social Services](#)

Spread the word to community members, patients, family, friends, neighbors and anyone else who might be enrolled in Medicaid to keep our communities covered!

Visit the [Cover Virginia](#) and [DMAS COVID-19 Response](#) websites to learn more.



Outreach Templates

No changes should be made to the DMAS standard language set in the samples and templates.

Full scale templates will be located on the [Cover Virginia website](https://www.covervirginia.org). Reach out to us at covervirginia@dmas.virginia.gov if you have any questions.

- Post card (front & back) Sizes: 4x6 and 5x7
- Folded Mailer
- Event A-Frame
- Window Cling Sizes: 5x7 and 8x10
- Bi-Fold Brochure
- Rack card



PHE A-Frame

Normal Medicaid Enrollment Processes Will Start Soon!

Sub-header

We need the most up-to-date *mailing address, phone number, and email address* to make sure Medicaid members get important paperwork.

Members can make updates:

- Online at commonhelp.virginia.gov
- By calling Cover Virginia at 1-855-242-8282
- By calling their local Department of Social Services



Take action quickly when you get a notice from the Virginia Department of Medical Assistance Services (Medicaid), other state agencies, community groups, and health care providers.



PHE A-Frame Evergreen



Keep Your Medicaid Information Current

We need the most up-to-date *mailing address, phone number, and email address*.

SUB HEADER TEXT

Members can make updates:

- Online at commonhelp.virginia.gov
- By calling Cover Virginia at 1-855-242-8282
- By calling their local Department of Social Services



PHE Window Cling 8 x 10



Keep your Medicaid Information Current

We need the most up-to-date *mailing address, phone number, and email address*.

Members can make updates:

- Online at commonhelp.virginia.gov
- By calling Cover Virginia at 1-855-242-8282
- By calling their local Department of Social Services



PHE Window Cling 5 x 7



Keep your Medicaid Information Current

We need the most up-to-date *mailing address, phone number, and email address*.

Members can make updates:

- Online at commonhelp.virginia.gov
- By calling Cover Virginia at 1-855-242-8282
- By calling their local Department of Social Services



Additional Resources

- [Virginia Association of Free and Charitable Clinics \(VAFCC\)](#)
- [Virginia Health Care Foundation \(VHCF\)](#)
- [Virginia Poverty Law Center \(VPLC\)](#)
- [CommonHelp Virginia](#)



FREE CLINICS CARE FOR VIRGINIA

www.vafreeclinics.org

www.freeclinicscare.org

VAFCC MEMBER CLINICS REPORTED IN CY20:



60+ FREE CLINICS
ENGAGED **6,900+**
VOLUNTEERS



PROVIDED
\$117 MILLION
WORTH OF CARE



TO **74,000+**
VULNERABLE PATIENTS
IN **193,000+**
PATIENT VISITS

PRIMARY CARE SERVICES:



94% have
on-site medical



92% offer
pharmacy services



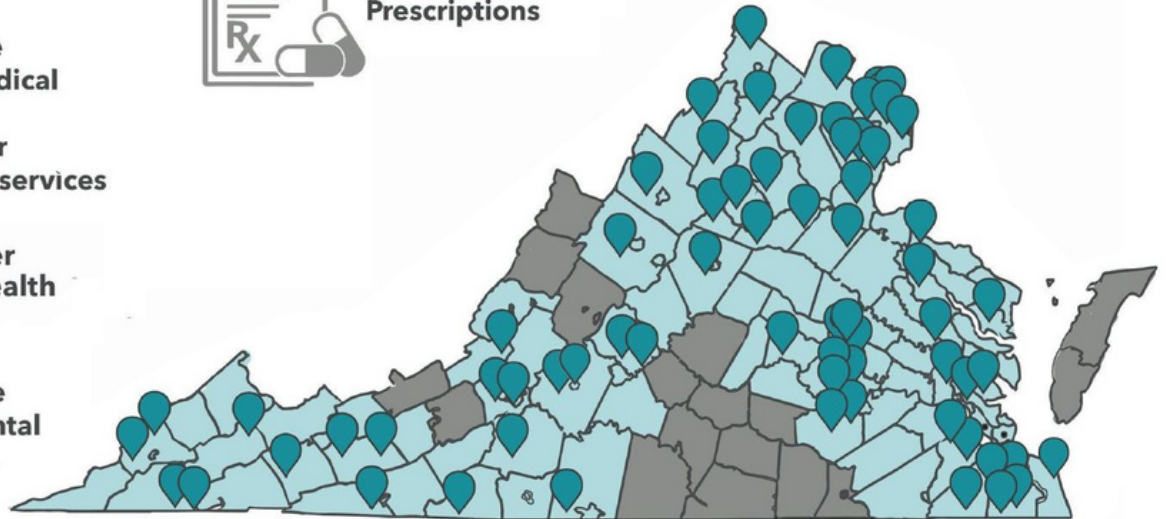
60% offer
mental health
services



54% have
on-site dental



353,000+
Prescriptions



Ensuring Equitable Access to Comprehensive, Quality Health Care

Virginia's free and charitable clinics are safety-net, not-for-profit, health care organizations that utilize a volunteer-driven, staff-supported model to provide a range of inclusive, high-quality health care services that can include medical, dental, pharmacy, vision, and/or behavioral health in addition to a variety of support services focused on social determinants of health. Often, free and charitable clinic patients are working individuals and families who do not qualify for Medicare or Medicaid yet can't afford the high cost of private insurance and are simply struggling to make ends meet. Clinics offer services at no cost to patients suffering economic hardship however, patients who can afford to invest in their own health and wellbeing are asked to make a nominal contribution towards their care. In this way, clinics are an affordable option for those who lack insurance. Clinics serve as an efficient and high-quality medical home for individuals in need and are here to provide an essential safety net to care for those who might otherwise go without it.



VAFCC

VIRGINIA ASSOCIATION OF FREE AND CHARITABLE CLINICS



***Project Connect* Application Assisters**

What is *Project Connect*?

Since 1999, Application Assisters (AA) from the Virginia Health Care Foundation's (VHCF) *Project Connect* initiative have helped more than 129,000 Virginians enroll in or renew their eligibility for Medicaid or FAMIS coverage.

These specially trained AAs are located in areas of the state with high numbers of uninsured Virginians. They work closely with local schools, medical providers, health departments, childcare providers, faith-based organizations, and businesses to identify those who are eligible for coverage. They provide 1:1 help completing applications and coordinate with the state call center or the applicant's local Department of Social Services to solve problems, as necessary.

In addition, *Project Connect* AAs contact members they've helped, to remind them to renew their Medicaid/FAMIS each year.

Project Connect Application Assisters also:

- Conduct public awareness and outreach campaigns/activities in their communities;
- Develop and sustain referral partnerships with community organizations;
- Present information about the Medicaid/FAMIS programs to individuals and small groups;
- Educate individuals and families about Medicaid/FAMIS; and
- Assist with and participate in community outreach events.

How do I find my local *Project Connect* Application Assister?

A coverage map, including *Project Connect* Application Assisters' contact information, is attached. For updated contact information for *Project Connect* Application Assisters, please go to vhcf.org/who-and-how-we-help/medicaid-famis-outreach-enrollment/project-connect/.

What is the best way to contact a *Project Connect* Application Assister?

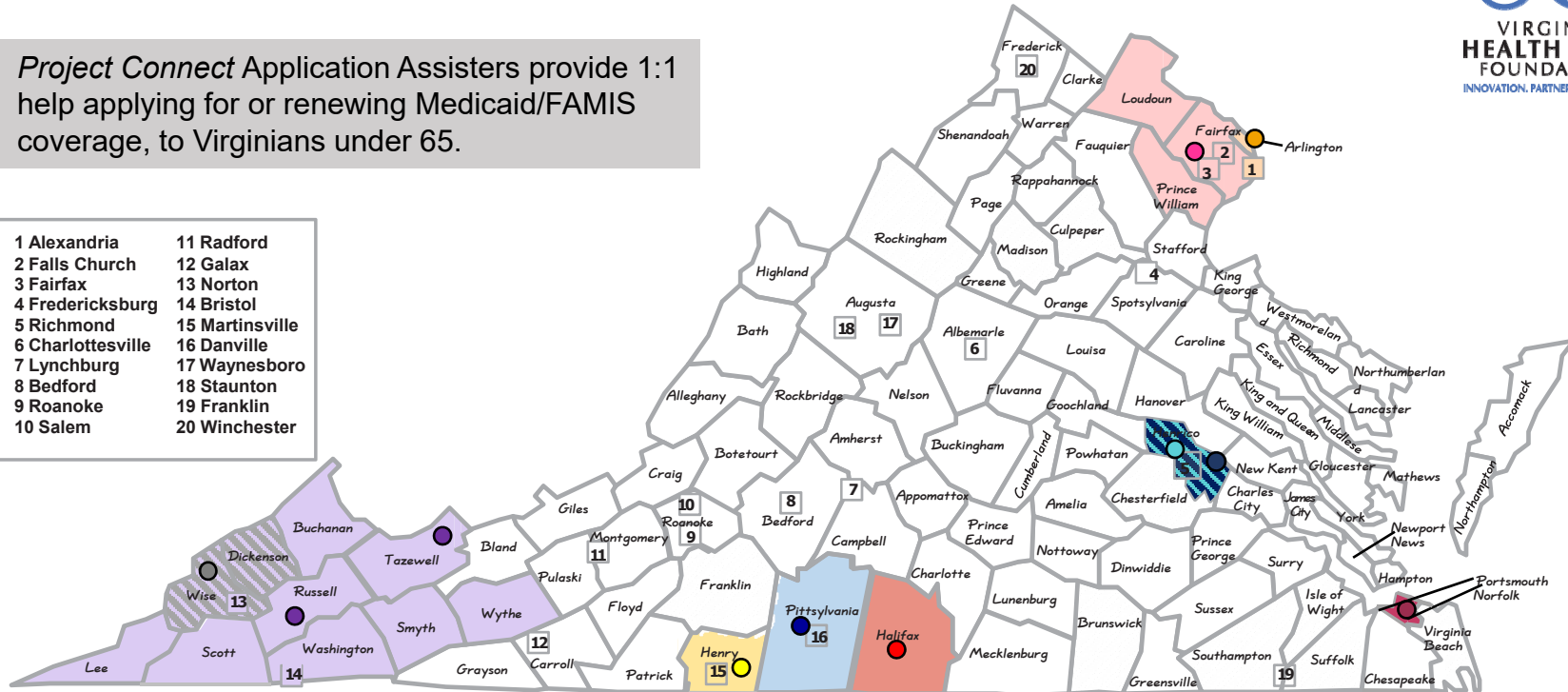
Assisters are available by phone or email. You can also call VHCF at 804-828-6062, or email signupnow@vhcf.org, for help connecting with your local *Project Connect* Application Assister.

Project Connect Application Assisters



Project Connect Application Assisters provide 1:1 help applying for or renewing Medicaid/FAMIS coverage, to Virginians under 65.

- | | |
|-------------------|-----------------|
| 1 Alexandria | 11 Radford |
| 2 Falls Church | 12 Galax |
| 3 Fairfax | 13 Norton |
| 4 Fredericksburg | 14 Bristol |
| 5 Richmond | 15 Martinsville |
| 6 Charlottesville | 16 Danville |
| 7 Lynchburg | 17 Waynesboro |
| 8 Bedford | 18 Staunton |
| 9 Roanoke | 19 Franklin |
| 10 Salem | 20 Winchester |



Program	Service Area	Contact Information
Cumberland Plateau Health District	Buchanan, Dickenson, Lee, Russell, Scott, Tazewell, Washington, and Wythe Counties; Bristol & Norton Cities	Pat McGlothlin: (276) 415-3337
Danville-Pittsylvania Community Services	Danville City, Pittsylvania County	Francina Jones: (434) 799-0456, ext. 3810
M-HC Coalition for Health & Wellness	Henry County, Martinsville City	Ann Walker: (276) 732-0509
The Health Wagon	Dickenson and Wise Counties	Donna Crabtree: (276) 328-8850, ext. 120
Virginia Legal Aid Society	Halifax County	Liz Cunningham: (434) 515-0497
Neighborhood Health	Alexandria City, Southern Fairfax, Arlington County	Eduardo Mantilla-Torres (703) 535-5568, ext. 2410
Norfolk Department of Public Health	Norfolk City	Denise Parker: (757) 285-7841 or Ester DeJesus-Melvin: (757) 683-8774
Partnership for Healthier Kids	Fairfax, Loudoun, and Prince William Counties	Team of CareLink Specialists: Fairfax County: (703) 698-2550; Loudoun County: (703) 579-7161; Prince William County: (703) 967-3772
Richmond City Health District	Richmond City, Henrico County	Richmond City: Jasmine Hawkins (804) 664-4759; Henrico County: Lyric Shipp (804) 807-1873
Virginia Health Care Foundation	Richmond City, Chesterfield & Henrico Counties	Norma Ryan: (804) 955-9578

Get covered. Stay covered.

Have peace of mind and find affordable, high-quality health coverage with the Marketplace or Medicaid!

Key Things to Remember

- More financial assistance is available now than ever before on the Marketplace.
- Outside of Open Enrollment, you can enroll in Marketplace coverage **ONLY IF** you qualify for a "Special Enrollment Period" due to certain life changes (e.g. loss of other coverage, permanent move, change of income, marriage).
- Unlike the Marketplace, Medicaid accepts applications year-round.
- There is no tax penalty if you don't have health insurance in 2022, but staying covered is **SMART!** You never know when you might get sick or have an accident.
- Marketplace and Medicaid enrollees need to shop for the right plan that fits their budget and includes their doctors, hospital, and medicines.
- Local help is available in your community!

Who Can Help

Enroll Virginia can help you apply, compare plans, and enroll in Marketplace or Medicaid coverage. We can answer your questions, see if you can get help paying for coverage, and more! Navigators are trained to give assistance that's free and unbiased.

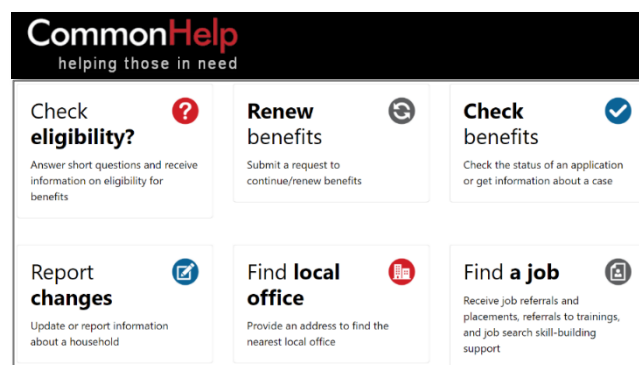


Where to Find Help

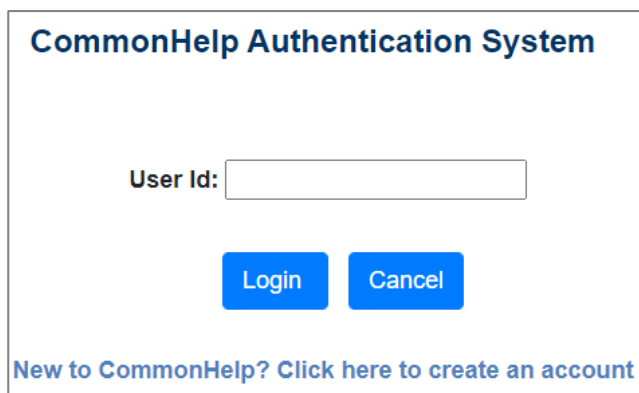
- Website: **enrollva.org**
- Statewide Toll-free Hotline: **1-888-392-5132**
- E-mail: **info@enroll-virginia.com**
- Schedule an Appointment with an Assister Near You: **enrollva.org/get-help**
- Find a community event in your area: **enrollva.org/events**
- Apply online: **healthcare.gov**
- Marketplace Call Center: **1-800-318-2596** (TTY users 1-855-889-4325)
- Virginia Medicaid and FAMIS insurance programs: **coverva.org** or call 1-855-242-8282; online application at **commonhelp.virginia.gov**
- Facebook: **facebook.com/enrollva** & Twitter: **@enrollvirginia**

Updating Your Contact Information Online: CommonHelp - www.commonhelp.virginia.gov

You may have used CommonHelp to apply for health care coverage or other benefits, but did you know you can report changes and submit your renewal online? To make sure we can reach out to you during your annual renewal for health care coverage, we need your contact information. You can check your current information and make updates by associating your case to your CommonHelp account!



If you've applied in the past you may already have an account, but if you don't remember or don't have an account you can navigate to [Check benefits](#) on the CommonHelp homepage. You can then click a link to create an account. Once you create your account, you can use the Manage function to associate your case to your account using your VaCMS case and client numbers found on your most recent notice you were sent about your health care coverage.



CommonHelp has a number of guides and videos that can walk you through several processes during and after applying. Navigate to the [New to CommonHelp?](#) link on the main page in the [About Benefits](#) section!



No changes should be made to the DMAS standard language set in the samples and templates.

The Department of Medical Assistance Services (DMAS) will update this resource and add materials as new federal guidance and additional insights are available. Information about the federal public health emergency can be found on the [Cover Virginia website](https://www.covervirginia.org).

Reach out to us at covervirginia@dmas.virginia.gov if you have any questions.

This document is for use by Community Stakeholders, Health Plans, and Government Agencies.

DMAS-PHE1 0222



Improving the health and well-being of Virginians through access to high-quality health care coverage.



Proposed Revision to Proposed Amendment to BMAS Bylaws

2.7 Electronic Participation in Meetings – An individual member may participate in a meeting of the Board or a public meeting of any committee established by the Board through electronic communication from a remote location for the following reasons, as permitted by § 2.2-3708.2 of the Code of Virginia:

1. A temporary or permanent disability or other medical condition prevents the member's physical attendance;
2. A family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance; or
3. A personal matter prevents the member's physical attendance.

Procedure for Approval:

1. **Notification:** The member requesting to participate through electronic communication from a remote location must notify the Board or committee chair on or before the day of the meeting.
2. **Quorum:** A quorum of the Board, or a simple majority of the committee, must be physically assembled at the primary or central meeting location identified in the public notice required for the meeting.
3. **Technological Arrangements:** Arrangements must be made for the voice of the remote participant to be heard by all persons at the primary or central meeting location.
4. **Documentation:** The specific reason the member is unable to attend the meeting, and the remote location from which the member participates, shall be recorded in the meeting minutes; **notwithstanding this disclosure requirement, the specific medical condition(s) or related clinical information affecting the member requesting virtual participation shall not be publicly disclosed but will instead be treated as consistent with Protected Health Information.**
The nature of the personal matter shall also be included in the minutes. Pursuant to Va. Code § 2.2-3708.2(A)(2), the remote location from which the member participates need not be open to the public.
5. **Limitation:** Members may only participate through electronic communication due to personal matters for no more than two meetings of the Board or committee per calendar year. This limitation shall not apply to electronic participation due to a member's disability or medical condition, or to a family member's medical condition that prevents the member's physical attendance.
6. **Approval Process:** A member's participation from a remote location shall be approved by a vote of the other members of the Board or committee, unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act (FOIA). If the other members of the Board or committee vote to disapprove the member's electronic participation from a remote location, such disapproval shall be recorded in the minutes.

Regulatory Activity Summary March 8, 2022
(* Indicates Recent Activity)

2022 General Assembly

***(01) Non-Emergency Medical Transportation:** This state plan amendment revises the state plan to add an attestation that DMAS meets all the minimum requirements for Non-Emergency Medical Transportation (NEMT) providers and individual drivers under Section 1902(a)(87) of the Social Security Act – also known as Section 209 of the Medicaid Coverage of Certain Medical Transportation Under the Consolidated Appropriations Act of 2021 (P.L. 116-260). The minimum requirements include: (a) each provider and individual driver is not excluded from participation in any federal health care program and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services; (b) each such individual driver has a valid driver’s license; (c) each such provider has in place a process to address any violation of a state drug law; and, (d) each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations. DMAS has policies and procedures in place that meet these requirements. Following internal review, the SPA was submitted to CMS on 2/8/22.

***(02) Addiction Recovery Treatment Services:** This SPA allows DMAS to make the following changes to align with the Department’s current practices: (1) adds certified substance abuse counselors (CSACs) and CSAC-Supervisees to the list of staff that can conduct multidimensional assessments for intensive outpatient services and partial hospitalization, pursuant to the Virginia Department of Health Professions’ Board of Counseling guidance regarding CSACs’ and CSAC-Supervisees’ scopes of practice; (2) removes the requirement that multidimensional assessments for intensive outpatient services include a physical examination and laboratory testing, in accordance with the American Society of Addiction Medicine’s (ASAM’s) definition of multidimensional assessments; and, (3) incorporates assessments to determine if an individual meets the diagnostic criteria for substance-related and/or addictive disorder into the service component definitions of intensive outpatient services and partial hospitalization, in accordance with ASAM criteria, and specifies that credentialed addiction treatment professionals shall conduct these diagnostic assessments. Following internal DMAS review, the SPA was submitted to CMS on 2/14/22.

***(03) 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.

***(04) Remove Limit on Mental Health & Substance Use Disorder Case Management:** This state plan amendment is necessary to align with the 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 Parity Rule, the Department of Medical Assistance Services (DMAS) must remove the limit of no more than two one-month periods of mental health and substance use disorder case management prior to discharge during a 12 month period for individuals in institutions of mental diseases (IMDs) (this does not include individuals between ages 22 and 64 who are served in IMDs). DMAS' Medicaid managed care plans and the Department's Behavioral Health Services Administrator (BHSA) are not currently applying the limits. For individuals served in IMDs, mental health and substance use disorder case management must be based on medical necessity and not be limited to no more than two one-month periods during a 12-month period. The citation for the federal regulation to remove the limits can be found in 42 CFR 438.910(b)(1). The project is currently circulating for internal DMAS review.

***(05) 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. The project is currently circulating for internal DMAS 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.

***(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.

***(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 regulation 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.

***(04) Sick Leave, Overtime, Private Duty Nursing Rate Increase:** This SPA contains amendments implementing three mandates from the Virginia General Assembly and removes the words “and respite”. (1) Item 313.YYYY states that DMAS “shall increase rates for skilled and private duty nursing services to 80 percent of the benchmark rate developed by the department and consistent with the appropriation available for this purpose.” (2) Item 313.ZZZZ states that DMAS “shall amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any necessary waivers, to authorize time and a half up to eight hours and effective July 1, 2021, up to 16 hours for a single attendant who works more than 40 hours per week for attendants providing Medicaid-reimbursed consumer directed (CD) personal assistance, respite and companion services.” (3) Item 313.BBBBBB states that DMAS “shall seek federal authority through waiver and State Plan amendments under Title XIX of the Social Security Act to provide sick leave to providers of consumer-directed personal, respite or companion care.” Following internal review, the SPA was filed with CMS on 9/16/21 and approved on 12/8/21.

***(05) 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.

***(06) 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. Changes may or may not be needed.

***(07) Repeal of Alzheimer's Assisted Living (AAL) Waiver:** This regulatory action repeals the regulations associated with the Alzheimer's Assisted Living (AAL) Waiver, which was developed to provide care and supports to help aging Virginia residents who have been diagnosed with Alzheimer's disease or other related memory disorders. Due to lack of utilization and the implementation of the Centers for Medicare & Medicaid Services (CMS) home- and community-based services (HCBS) Final Rule, AAL was ended, effective June 30, 2017. The HCBS Final Rule established new reimbursement criteria with the goal of enabling Medicaid members to receive services in settings that are integrated into the community rather than in skilled nursing facilities. Following internal review, the project was submitted to the OAG on 8/6/21. OAG questions were received on 8/17/21 and DMAS submitted responses to the OAG on 8/18/21 and 8/19/21. The project was submitted to DPB on 9/16/21 and DMAS responded to DPB inquiries on 10/12/21. The regulatory action was sent to HHR on 10/22/21; to the Governor on 12/3/21; and approved by the Gov.'s Ofc. on 12/21/21. The project was submitted to the Registrar on 12/22/21 and corrections were sent on 12/29/21. The actions was published in the Register on 1/17/22 and became effective on 3/4/22.

***(08) 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. DMAS is awaiting approval.

***(09) Institutional Provider Reimbursement Changes:** This SPA will include all of the institutional (inpatient and long-term care) changes arising out of the 2021 Appropriations Act. Following internal review, the SPA was submitted to CMS on 6/26/21. The SPA was approved by CMS on 9/24/21. The corresponding regulatory action is currently being reviewed internally.

(10) Non-Institutional Provider Reimbursement Changes: In accordance with the 2021 Appropriations Act, Items 313.EEEE, UUUU, and VVVV, DMAS will be making the following changes to the state plan: (1) Increase rates for psychiatric services by 14.7 percent to the

equivalent of 110 percent of Medicare rates, effective July 1, 2021. (2) Increase rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates. (3) Increase the supplemental physician payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 (Children's National Medical Center) to the maximum allowed by the Centers for Medicare and Medicaid Services (CMS) within the limit of the appropriation provided for this purpose. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by the CMS and all other Virginia Medicaid fee-for-service payments. The SPA was submitted to CMS on 6/21/21. DMAS submitted responses to informal questions on 8/11/21 and the SPA was approved on 9/15/21. The corresponding reg project is currently circulating for internal review.

***(11) Doula Services:** In accordance with the 2021 Special Session, Item 313.WWWWW, DMAS plans to revise the state plan to include coverage for doula services for Medicaid-enrolled pregnant women. Services will include up to eight prenatal/postpartum visits, and support during labor and delivery. The SPA will also provide authority for two linkage-to-care incentive payments for postpartum and newborn care. The associated PPN was posted on 7/23/21 and the Tribal Programs and DPB notifications were sent out on 7/23/21. The SPA was submitted to CMS for review on 8/24/21. DMAS received informal questions from CMS on 9/13/21 and responses were sent on 9/16/21. The SPA was approved by CMS on 10/29/21. Following internal review, the project was submitted to the OAG for review on 1/19/22. DMAS responded to OAG inquiries on 1/21/22 and made requested revisions on 1/26/22.

***(12) EVMS Supplemental Payments:** The purpose of this SPA is to update the state plan text related to supplemental payments made to physicians affiliated with Eastern Virginia Medical School (EVMS). The first change is to remove old text dating back to 2012. The second change makes the language more general so that DMAS does not have to update the state plan every time the average commercial rate percentage changes. Partner agency notification letters were submitted and the PPN was posted on 8/24/21. DPB approved the SPA on 9/7/21. Following internal DMAS review, the SPA was filed with CMS on 9/27/21 and approved on 12/14/21. The corresponding regulatory project is currently circulating for internal review.

***(13) Pharmacy-Administered Vaccines:** In accordance with the 2021 Special Session, Item 313.UUUUU, DMAS has initiated state plan changes to authorize reimbursement, using a budget neutral methodology, of pharmacy-administered immunizations for all vaccinations covered under the medical benefit for Medicaid members. Reimbursement for fee-for-service members will be the cost of the vaccine plus an administration fee not to exceed \$16. Reimbursement for pharmacy-administered vaccinations for pediatric Medicaid members eligible for free vaccinations through the Vaccines For Children (VFC) program shall include only the administration fee. The SPA was submitted to CMS for review on 9/2/21. Following a conference call on 9/13/21, changes were requested, and revised SPA pages were sent to CMS on 9/14/21. The SPA was approved on 11/23/21. The corresponding regulatory project is currently circulating for internal DMAS review.

***(14) Behavioral Health Enhancement – Part 2:** In accordance with the 2021 Special Session, Items 313.YYYY and CCCCC, DMAS will be revising the state plan to implement programmatic changes and reimbursement rates for the following: multisystemic therapy, functional family therapy, crisis intervention services, crisis stabilization services, and

behavioral therapy. The DPB and Tribal Programs notifications were submitted on 9/9/21 and the corresponding PPN was also posted on 9/9/21. DPB approved the SPA on 9/16/21. The SPA was submitted to CMS for review on 10/8/21 and approved on 12/15/21.

(15) 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.

***(16) 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.

***(17) COVID Vaccine Administration Fee:** In the March 15, 2021 CMS toolkit entitled "Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program" it states that: "States will need to submit SPAs to describe payment for the vaccine administration to the extent that the payment is different from what is otherwise approved under the state plan. DMAS has adopted the Medicare payment rate of \$40 for COVID-19 Vaccine Administration, which is different from the administration fees for other vaccines, and is filing this SPA as a result. After internal and oversight agency review, this SPA was submitted to CMS on 6/1/21. Informal questions were received from CMS on 7/7/21 and responses were forwarded to CMS on 8/3/21 and 9/17/21. DMAS is awaiting further direction.

(18) 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).

(19) COVID Vaccine for Plan First: In accordance with Section 9811 of the American Rescue Plan Act of 2021, DMAS will be making changes to the State Plan in order to cover COVID-19 vaccines and vaccine administration fees for the limited benefit program called Plan First. (Typically, individuals in this program only receive Medicaid coverage for services that delay or prevent pregnancy.) The costs of both the vaccine and the vaccine administration fee will be covered by the federal government. This project was submitted to CMS on 6/21/21 and DMAS is awaiting further directive.

(20) 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.

(21) Adult Dental: The purpose of this SPA is to align with Item 313.III 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 7/1/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 6/23/21.

***(22) Tribal Health Clinic:** This SPA includes language allowing the Upper Mattaponi Tribe to collect Medicaid payment for health care services provided through a new Tribal Health Clinic (THC). The Upper Mattaponi Tribe has established a THC to meet the primary care health needs of Tribal members, including those enrolled in Virginia Medicaid. Federal law requires DMAS to file a SPA to recognize and reimburse THCs as Medicaid providers. The THC will be enrolled as a Federally Qualified Health Center and will be reimbursed for services to Medicaid members at a rate set annually by the federal government. CMS will cover 100% of DMAS' payments to the Upper Mattaponi THC for services to Medicaid members. The DPB and Tribal Programs notifications were forwarded on 2/17/21 and the prior public notice was posted on 2/23/21. The SPA was submitted to CMS for review on 3/26/21. The SPA was approved by CMS on 6/22/21. The associated fast-track reg project was submitted to the OAG on 7/21/21; to DPB on 8/17/21; and to HHR on 9/25/21. The Gov.'s Ofc. approved the project

on 12/21/21. The regulatory action was published in the Register on 1/17/22 and became effective on 3/3/22.

***(23) Tribal Consultation:** This state plan amendment proposes to amend the section dedicated to the *State Medical Care Advisory Committee*. The changes for this regulatory section are intended to meet the requirements of Section 1902(a)(73) of the Social Security Act §1902. Section 1902(a)(73) mandates that states that have Indian Health Programs: (1) develop and file a Tribal Consultation SPA and (2) solicit advice from Tribes and from Indian Health Programs prior to submitting any SPA or waiver amendment. Prior to the start of Virginia's Pamunkey Tribe Indian Health Program, DMAS was only required to solicit advice for 1915 and 1115 waiver applications/renewals. The DPB and Tribal Programs notifications were forwarded on 2/23/21 for review; to HHR on 3/17/21; and to CMS on 4/7/21. DMAS received CMS' informal questions on 5/7/21 and responses were submitted on 5/18/21, and additional responses were sent on 5/26/21. The SPA was approved on 6/7/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 7/7/21. DMAS responded to OAG inquiries on 7/23/21 and 7/27/21. The package was approved by the OAG on 8/24/21. The action was submitted to the Registrar on 9/13/21 and DMAS responded to Registrar inquiries and made regulatory corrections on 9/20/21. DMAS responded to additional Registrar questions and made RIS corrections on 9/22/21, 9/23/21, and 9/24/21. Responded to additional Registrar questions and made RIS corrections on 9/22/21, 9/23/21, 9/24/21. The regs were published on 10/11/21 and became effective on 11/11/21.

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.

(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.

(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.

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

on a conf. call on 6/8/20. The SPA was submitted to HHR on 9/15/20 and to CMS on 9/25/20. DMAS responded to informal CMS questions on 10/30/20 and received additional inquiries on 11/6/20. Request for additional information (RAI) responses were sent to CMS on 10/6/21 and DMAS is awaiting further direction. Following internal review, the corresponding regulatory project was sent to the OAG on 9/15/20. Following OAG approval, the action was forwarded to the Register on 11/23/20; published on 12/21/20; and became effective on 1/20/21.

2019 General Assembly

(01) 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. DMAS submitted additional responses to OAG questions in July, 2021 and is awaiting further direction.

2018 General Assembly

***(01) Expansion – Alternative Benefit Plan:** This regulatory action incorporates changes made to the Virginia State Plan in order to implement Medicaid expansion. Specifically, this action includes the alternative benefit plan (ABP) that is available to individuals who are covered by Medicaid expansion. The Centers for Medicare and Medicaid Services (CMS) requires state Medicaid agencies to create an ABP for expansion populations. The purpose of this regulation is to incorporate the CMS-approved Medicaid expansion ABP into the Virginia Administrative Code. This regulation is essential to protect the health, safety, and welfare of citizens in that it implements the General Assembly mandate to expand Medicaid coverage to new populations. Following internal DMAS review and coordination, the regs were forwarded to the OAG on 11/9/18 for review. The OAG forwarded comments on 3/1/19 and DMAS sent responses back on 3/6/19. The regs were submitted to DBP for review on 4/4/19. The regs were forwarded to HHR on 4/16/19; to the Gov.’s Ofc. on 5/27/19; and to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with no comments received. The corresponding fast-track began circulating for review on 9/5/19. The regulatory action was forwarded to the OAG on 10/30/19; to DPB on 3/24/21; to HHR on 5/3/21; and to the Governor’s Ofc. on 5/20/21. The fast-track phase of the reg project was submitted to DPB on 6/24/21; to HHR on 7/13/21; to the Governor on 10/26/21; and signed on 12/2/21. The regs were published in the Register on 1/3/22 and became effective on 2/17/22.

***(02) Medicaid Expansion — Determination State (Medicaid):** This state plan amendment is designed to allow Virginia to change from the Assessment Model of eligibility determination to the Determination Model of eligibility determination. In the Assessment Model, which Virginia currently follows, the Federally Facilitated Marketplace (FFM) makes an initial assessment of eligibility and the State Medicaid agency must then re-determine eligibility to make a final decision. In the Determination Model, the FFM makes the final Modified Adjusted Gross Income (MAGI) or CHIP determination and transmits the determination to the State Medicaid agency. The state must then accept the FFM determination as final. The Virginia General Assembly has directed DMAS to expand Medicaid eligibility to individuals age 19 or older and under age 65, who have household income at or below 138% of the federal poverty level, effective January 1, 2019. As a result of Medicaid expansion, many more FFM applicants will now qualify for Virginia Medicaid and the application determination backlog that is currently experienced during open enrollment is expected to increase. Movement to the Determination Model will significantly reduce the number of applications forwarded from the FFM that require a Medicaid determination by state/local/contractor staff. This change is particularly important due to the anticipated increase in applications from all sources due to interest in Medicaid expansion coverage combined with the 2019 Open Enrollment Period. Following internal DMAS review, the SPA was submitted to HHR, and then forwarded to CMS on 7/23/18. A conf. call with CMS was held on 8/2/18 and CMS requested edits on 8/7/18. Additional follow-up questions from CMS were received and responses were returned to CMS on 8/20/18. The SPA was approved 10/9/18. The corresponding reg package was forwarded to the OAG on 11/9/18. OAG comments were forwarded to DMAS on 2/28/19. Responses were returned on 3/7/19 and 3/19/19. The regs were submitted to DPB on 4/4/19; to HHR on 4/16/19; and to the Governor on 5/27/19. The project was sent to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with one comment received. The corresponding fast-track began circulating for internal review on 9/6/19 and was submitted to the OAG on 10/10/19. DMAS requested an ER extension on 2/19/20 that expired on 9/17/21. Following the internal review, the fast-track phase of the reg project was submitted to DPB on 5/28/21; to HHR on 7/6/21; to the Governor on 12/3/21; and to the Register on 1/10/22. The regs were published on 1/31/22 and will become effective on 3/17/22.

2017 General Assembly

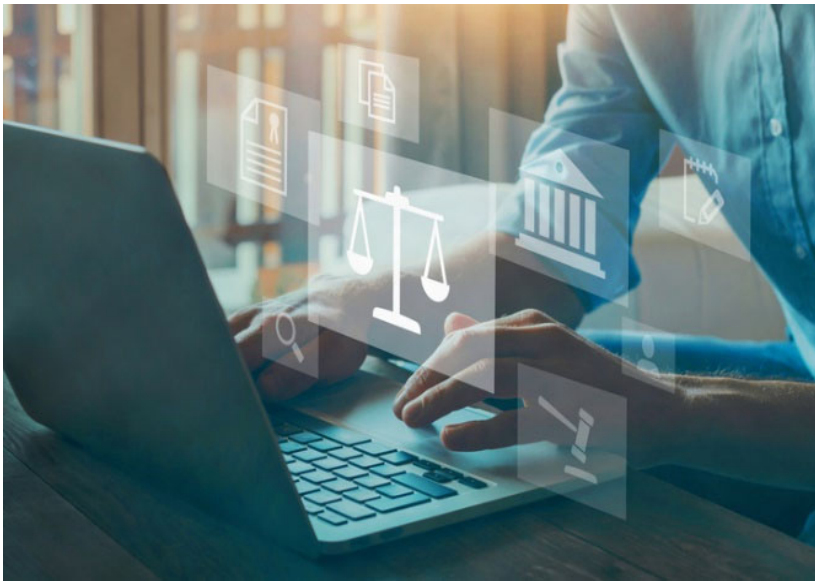
(01) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration 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; and to HHR on 1/19/22.

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.



POLICY SUBCOMMITTEE DMAS REGULATORY PROCESS

Emily McClellan

*Policy, Regulation, and Member
Engagement Division*

When Are Regulations Needed?

- ❑ Regulations needed when “pay or no pay decision” is involved
 - Member eligibility for Medicaid
 - Whether a provider is entitled to reimbursement: proper staff providing service, all components provided, documentation requirements met
 - What type of reimbursement – how much, how is it calculated

- ❑ “Adverse decision” to member or provider

Virginia Regulatory Principles

- ✓ Least possible intrusion into the lives of citizens of the Commonwealth
- ✓ Necessary to protect public health, safety, and welfare
- ✓ Agencies should actively seek input from stakeholders on planned regulatory changes



Things that make the DMAS Regulatory Process different

- DMAS has general authority to develop or amend regulations. DMAS does not need a specific grant of authority from the General Assembly unless there is a cost associated with the change – then a legislative mandate is needed.
- The Virginia Code delegates authority to the Agency Director ... the Director may sign off on regulatory packages.



Types of Regulatory Actions

- Three-stage processes:
 - “Normal” process
 - Notice of Intended Regulatory Action
 - Proposed Stage
 - Final Stage
 - Emergency regulation
 - ER/NOIRA
 - Proposed Stage
 - Final Stage
- One-stage processes:
 - Fast Track
 - Final Exempt

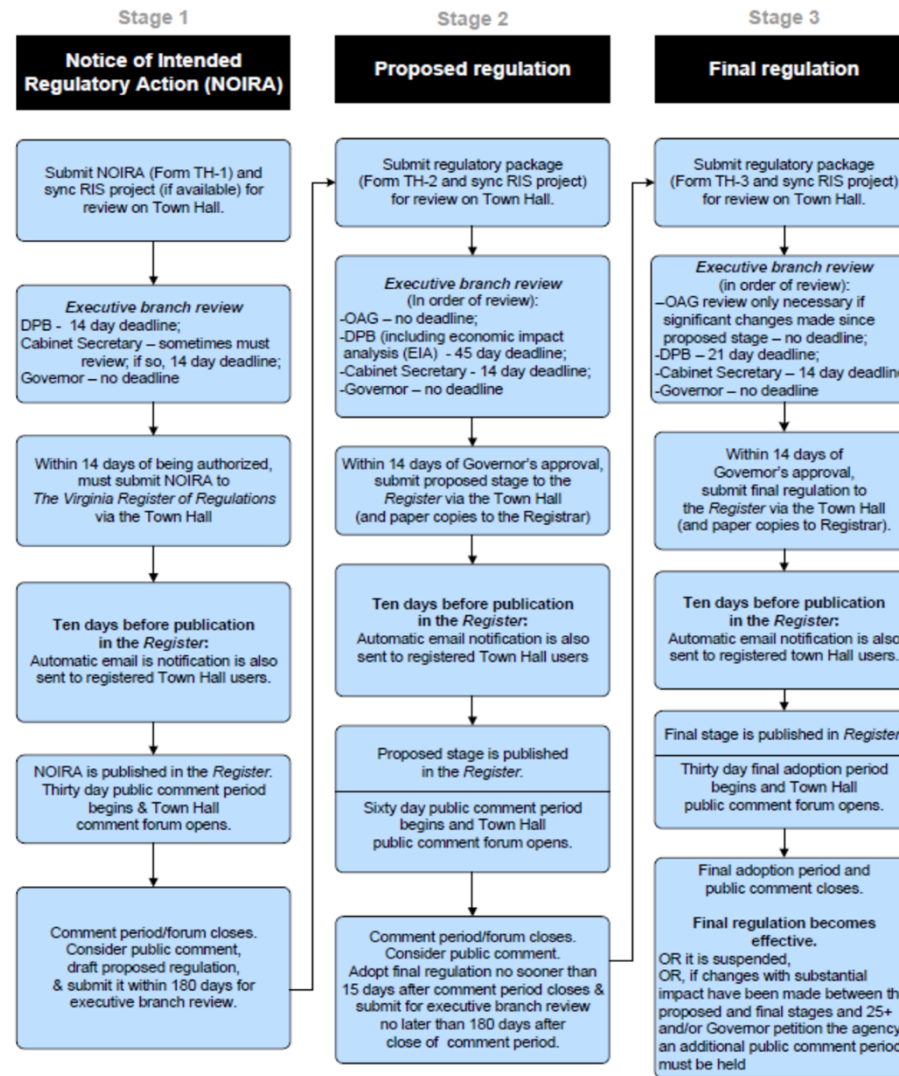




Three-Stage Process: NOIRA-Proposed-Final

Worst Case Scenario

Standard regulatory process: Guide for state agencies



For more information, visit the Virginia Regulatory Town Hall at townhall.virginia.gov

NOIRA-Proposed-Final

- NOIRA – once signed by DMAS director, goes to:
 - OAG, then
 - Dept. of Planning and Budget, then
 - Secretary of Health and Human Resources, then
 - Governor, then
 - 30-day comment period, then
 - Back to DMAS for changes
- Proposed – new regulatory text and background doc
 - Repeats all steps except this is a 60-day comment period
- Final
 - Repeats all steps but after Governor signs, is published in Register. Won't be final until 30 days after publication.

NOIRA-Proposed-Final

- Used for: actions that could be considered controversial or that have some decisions to be made, and no emergency regulatory authority
- Typically 3 years from beginning to end
- How can this be avoided? Advance planning – get ER authority in the budget for controversial projects that have some decisions left to be made.



Three-Stage Process:
ER/NOIRA- Proposed-Final

Emergency Regulatory Process

- DMAS must have authority from the General Assembly for an emergency regulation.
- All the same stages as the traditional process but ER goes into effect after ER/NOIRA is finalized, typically six to nine months
- Cautions
 - Emergency regulations are temporary and are not added to the Virginia Administrative Code: 18 months with possibility for one 6-month extension.
 - Frequently a “gap” between the end of the emergency regulation and the finalization of the permanent regulations.



One-Stage Process: Fast Track Regulation

Fast Track Process

- Must be non-controversial.
- Takes 9-12 months to go into effect
- Once signed by DMAS director, goes to:
 - ① → OAG, then
 - ② → Dept. of Planning and Budget, then
 - ③ → Secretary of Health and Human Resources, then
 - ④ → Governor, then
 - ⑤ → Published in Register – doesn't become final until 45 days after publication
- During waiting period after publication, if 10 or more objections to Fast Track process, must be withdrawn





One-Stage Process: Final Exempt Regulation

Final Exempt Process

- Must have:
 - Federal Statutory requirement, or
 - Federal regulatory requirement, or
 - State budget or statute (within 90 days of enactment) or
 - Court order

AND no discretion

- Takes 3-6 months to go into effect
- Once signed by DMAS director, goes to:
 - OAG, then
 - Published in Register – doesn't become final until 45 days after publication

How to Get a Final Exempt

- Submit budget language for the next General Assembly session with wording describing exactly what needs to be accomplished – no undecided issues or discretion.
- Sometimes used for Provider Reimbursement changes such as updates to rate methodology.

BMAS Regulatory Report



- Provided to Board members for each meeting
- Shows all open regulations that are in some stage of the process
- Includes any updates since the last board meeting.

Questions?

