BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, December 10, 2024
10:00 AM to 12:00 PM
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
1st floor Conference Rooms A&B

To Join Meeting Remotely: *https://covaconf.webex.com/covaconf/j.php?MTID=m84dcab39c35d54a04fd706b0bf1ac836*
Closed Captioning Link https://www.streamtext.net/player?event=HamiltonRelayRCC-1210-VA4119

AGENDA

#	Item	Presenter	
1	Call to order	Tim Hanold, Board Chair	10:00am
2	Introductions	Tim Hanold, Board Chair	10:00am – 10:05am
3	Approval of 09/17/2024 Meeting Minutes	Tim Hanold, Board Chair	10:05am - 10:10am
4	Director's Report Updates including: ▪ Strategic Plan ▪ Biennial Report ▪ Launch 2025 Theme	Cheryl Roberts, Agency Director	10:10am- 10:40am
5	Budget Update Including: Forecast Update	Truman Horwitz, Budget Division Director	10:40am- 11:00am
6	Member Communication	Montserrat Serra, Civil Rights Coordinator	11:00am - 11:20am
7	SMI 1115 Demonstration	Lisa Jobe-Shields Brian Campbell	11:20am - 11:40am
8	CMS Rules 2024-2026	Sarah Hatton, Deputy Director of Administration	11:40am - 11:55am
9	New Business/Old Business		
10	Public Comment		
11	Adjournment		12:00pm

Next Meeting Dates: March 11,2025, June 10,2025, September 9, 2025, December 9, 2025

BMAS DRAFT MINUTES
Tuesday, September 17, 2024
10:00 AM

A quorum of the Board of Medical Assistance Services attended the meeting at the Department of Medical Assistance Services (DMAS) offices at 600 East Broad Street, Richmond. A web-ex option was also available for members of the Board and the public to attend virtually.

Present: Tim Hanold, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Bernie Boone, Vienne Murray, Joye Moore

Present Virtually: Ashish Kachru

Absent: Basim Khan, Patricia Cook

DMAS Attendees: Cheryl Roberts-DMAS Director, Tammy Whitlock – Deputy Complex Care Services, Adrienne Fegans -Deputy for Programs, Chris Gordon-Deputy for Finance, John Kissel-Deputy for Technology & Innovation, Ivory Banks – Chief of Staff, Rich Rosendahl- Deputy for Health Economics and Economic Policy-Virtually, Lisa Price-Stevens, MD-Chief Medical Officer, Truman Horwitz, Director of Budget, Craig Markva – OSHHR Assistant Secretary, Brian McCormick- Director
Legislative and Intergovernmental Affairs, Emily McClellan-Policy Division Director, Morgan Greer- Board counsel and Brooke Barlow- Board Secretary.

Other Attendees: Margaret Kosherzenko, Center for Medicare and Medicaid Services, Nicole McKnight, Center for Medicare and Medicaid Services, Anna Garrett, Sarah Haggie, Montserrat Serra, John Stanwix.

Virtual Attendees: Alexander Macauley, Caroline Faber, Cathy Jones, Dyaln Bishop, Joy Spencer, Karin Roth, Kedra Keith, Kerdijah Mitchell, Kim Jones, Leticia Rasnick, Linda Hines, Meredith Lee, Michael Cook, Michael Haggins, Molly Dean, Steve Ford, Suzanne Gore, Vanessa Lane.

1. Call to Order

Tim Hanold, Board Chair, called for a motion by the Board to open the regular meeting of the Board of Medical Assistance Services at 10:06 am on September 17, 2024, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

Moved by Jason Brewster; 10:06 am; seconded by Margaret Roomsburg.

2. **Approval of Minutes**

The minutes from the June 18, 2024 meeting were introduced and approved.

Moved by Vienne Murray; seconded by Jennifer Clarke to Approve Motion Passed: 8 - 0
Voting For: Tim Hanold, Bernie Boone, Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None
Absent: Patricia Cook, Basim Khan
Virtual: Ashish Kachru

3. **Director's Report**

Director Roberts presented to the Board an overview of Medicaid, program updates, along with program updates for the Executive Leadership Team. Director Roberts reviewed the DMAS mission and values, who we cover, covered services, Medicaid finance update, expenditures and program updates.

4. **Enhancing Language and Disability Access in Virginia Medicaid**

This presentation was postponed to the December 10, 2025 meeting.

5. **Introduction of New Board Member**

New Board Member Joye B. Moore introduced herself and was welcomed by the Board.

6. **Member Communication**

Adrienne Fegans, Deputy Director of Programs discussed the parameters for discussion by the Board members. Two parameters were 1) What can we do with the member vs. what can we do for the member 2) You have to give feedback. There was discussion regarding social media, apps and the website.

7. **Aspirin Reveal**

Dr. Lisa Stevens, Chief Medical Officer, gave an overview of the aspirin initiative.

8. **Dashboards**

Rich Rosendahl, Deputy Director for Healthcare Analytics & Transformation, gave an overview of the HEDIS Dashboard, Nursing Facility Value-Based Purchasing Dashboard and the Waiver Services Dashboard.

9. Finance

Truman Horwitz, Budget Division Director presented on the Five-Year Expenditure comparison and the Forecast to actual for FY 2025. In summary, the financial data shows a variance from forecast due to slower unwinding/the knock-on effects of the actions taken in FY24 and this will influence the Forecast and the ultimate need outlined in the Budget Process.

10. New Business/Old Business

11. Public Comment – No public comments

12. Regulations – Regulations were presented to the Board and posted to Townhall.

13. Adjournment

Moved by Jennifer Clarke; seconded by Margaret Roomsburg to Approve Motion Passed: 8 - 0
Voting For: Tim Hanold, Bernie Boone, Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None
Absent: Patricia Cook, Basim Khan
Virtual: Ashish Kachru

Board of Medical Assistance Services Director's Update

Cheryl J. Roberts, J.D., DMAS Director

December 10, 2024

Director's Program Updates

- ❑ Financial Updates
- ❑ Upcoming CMS Changes
- ❑ Major Contracts and Procurements
- ❑ Behavioral Health
- ❑ Maternal Health
- ❑ ED Utilization
- ❑ BMAS Biennial Report
- ❑ Strategic Plan
- ❑ 2024 Wrap Up

Board of Medical Assistance Services 2023-2024 BIENNIAL REPORT

Board of Medical Assistance Services
2023-2024
BIENNIAL REPORT

Virginia Department of Medical Assistance Services
600 E. Broad Street. Richmond, VA 23219
(804) 786-7933 | www.dmas.virginia.gov

LETTER FROM THE BMAS BOARD CHAIR

I am privileged to submit this Biennial Report on behalf of the Virginia Board of Medical Assistance Services (BMAS), highlighting the work of Virginia's Department of Medical Assistance Services (DMAS).

Fiscal Year 2023 – 2024 presented multiple opportunities and initiatives to serve the Commonwealth, carried out through the tremendous leadership of Director Cheryl Roberts and the DMAS staff, in collaboration with sister agencies, the legislature and Governor's offices.

There were a multitude of member centric initiatives, and the following name only a few. We are nearing the end of more than a year-long undertaking to redetermine the eligibility of over 2.1 million people enrolled in Medicaid, which entailed significant coordination, engagement, and outreach to the populations we serve. DMAS continued to play an integral role in Governor Youngkin's Right Help Right Now to reform our current behavioral health system in Virginia and support individuals in crisis.

The agency took a bold approach in the creation of the Cardinal Care Managed Care program, consolidating two previous programs (Commonwealth Coordinated Care Plus and Medallion 4.0) and created transformational goals through the reprocurement of the managed care delivery system. Improving health outcomes for all pregnant and postpartum women remains a top priority for DMAS, with a focus on reducing racial disparities and maternal mortality. In improving access to quality care, there was extended postpartum coverage, postpartum visits, wellness checks, postpartum mental health and post-delivery care.

DMAS has been a key player in the Partnership for Petersburg, with the mission to help Petersburg become one of the best cities to live, work, and raise a family. Significant funding was approved for additional waiver slots towards the Developmental Disability (DD) Waiver system, which allows people to receive home and community care rather than in a health care institution.

The Biennial Report will go into more detail to explain initiatives and services that are the result of the hard work by DMAS staff, countless stakeholders, and advocates to bring these services to reality for many Virginians.

I would like to thank the Board, our directors and DMAS staff and the Secretary's office for your continued commitment to improve the health and well-being of Virginians through access to high-quality healthcare coverage and services.

Tim Hanold, Chair
Board of Medical Assistance Services

BMAS 2023-2024 Biennial Report is located on DMAS website

https://www.dmas.virginia.gov/about-us/boards-and-public-meetings/board-of-medical-assistance-services/

DMAS Strategic Plan 2024-2026 Approved by HHR

Our agency strives to fulfill this mission by upholding our core values of service, collaboration, trust, adaptability, and problem solving

Mission

The mission of DMAS is to improve the health and well-being of Virginians through access to high quality health care coverage and services

Vision

Values

Service, Collaboration, Trust, Adaptability, Problem Solving

DMAS Strategic Plan 2024-2026 Goals

- Goal 1: Medicaid Enrollment - Monitoring Enrollment and Understanding Potential Population Trends Post-Unwinding
- Goal 2: Behavioral Health
- Goal 3: Financial and Fiscal Stability
- Goal 4: Improve Managed Care Processes and Oversight of the Cardinal Care Program
- Goal 5: Improve Maternal and Child Health Outcomes
- Goal 6: Compliance with State and Federal Requirements

DMAS website link to strategic plan 2024-2026
https://www.dmas.virginia.gov/about-us/mission-and-values/strategic-plan/

2024 Wrap Up

DMAS Commitment

Committed to exploring, investing, and implementing best practices that fit our Virginia Medicaid members

S	O	A	R
Services for Members	Operations & Opportunities	Accountability	Results

Highlights of DMAS SOAR 2024 Achievements

Completed the unwinding/ redetermination process for 2,140,288 Medicaid members (98.8%). No CMS penalties.

Right Help, Right Now - Behavioral Health Services Redesign, Crisis Support Project, and new SMI 1115 waiver.

Notice of Intent to Award Cardinal Care Managed Care (CCMC) program contracts.

Obtained approval from CMS for 3400 DD Waiver slots. Distributing quarterly.

120 Hospitals and 268 Nursing Facility base payments rebased.

Reprocuring DMAS core IT system that manages claims, payments, and member data.

New Office of MCO Compliance and Monitoring and 360° Performance Review Process.

Increased maternal health activities including Maternal Cardiovascular Roundtables - Ask About Aspirin Campaign

Improved Medicaid member experience and engagement (redesigned website, social media etc.)

Best-in-class workforce support with HHR recognition. Current turnover for 2024 is 2% with a retention rate of 98%.

General Assembly Health and Human Services Boot Camp 101

Second successful program year of the Nursing Home Value Based Purchasing ($100M worth of incentive payments)

Only 4 findings in the FY2023 APA audit report.

Increased dental network – 2255 enrolled dentists.

THRIVE in 2025

DMAS is committed to providing quality health care coverage and services efficiently to qualified Virginians in the Commonwealth

T	H	R	I	V	E
Trust	Health	Results	Integrity	Vision	Engagement

Budget Update

Truman Horwitz, Budget Division Director

Overview

- Five-Year Expenditure comparison

- Forecast to actual for FY 2025

Expenditure Comparison

In Millions

Five Year Look-back (Through October)

Expenditures	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY24 vs. FY25	
	Actuals through October						
Cardinal Acute	1,664.9	1,903.1	2,226.5	2,089.7	2,257.1	167	8.0%
Cardinal LTSS	1,954.3	2,157.0	2,428.3	2,107.3	2,637.2	530	25.1%
Fee-For-service: General Medicaid	512.1	552.1	627.1	673.5	863.5	190	28.2%
Fee-For-service: BH & Rehabilitative	22.0	31.9	15.8	21.4	20.2	(1)	-5.8%
Fee-For-service: Long-Term Care Services	516.1	550.8	740.9	787.2	941.5	154	19.6%
Hospital Supplemental (DSH, IME/GME, Dx)	145.2	246.8	286.9	148.4	232.9	85	57.0%
Hospital Rate Assessment Payments	291.4	410.4	509.5	632.5	1,082.4	450	71.1%
Pharmacy Rebates	(444.9)	-	1.4	(0.1)	(18.7)	(19)	20532.3%
Title XIX Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**
Fund Type							
General	1,301.5	1,582.6	1,784.1	1,526.7	2,250.6	724	47.4%
Coverage Assessment	120.9	150.6	189.6	232.0	213.7	(18)	-7.9%
Rate Assessment	81.9	109.6	135.8	179.6	285.1	106	58.8%
VA Health Care Fund	100.0	195.8	215.0	248.0	125.1	(123)	-49.5%
Federal	3,056.9	3,813.6	4,511.9	4,273.5	5,141.6	868.0	20.3%
Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**

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FY24 trends lower due to the July accelerated capitation payment into FY23 (only 11 capitation payments) to save general funds at a favorable FMAP. **FY25 added one additional capitation payment** to return back to 12 normal payments in a fiscal year

Rate Assessment	81.9	109.6	135.8	179.6	285.1	106	58.8%
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This reflects the increase in **10% increase in IP/OP rates due to hospital rebasing and inflation,** growth in **tribal spending**, and **11.5% increase in Medicare Premiums ($200→$223/month per member)**, along with portion of one-time carryover costs from FY24

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY24 vs. FY25	
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Utilization of **500 DD Waiver slots** added in January plus **430 DD Waiver** slots added in Q1FY25 (part of 3,440 added in 24GA session) along with **3% DD Waiver provider rate increase**, as well as **9.6% increase in Nursing Facility per diems from rebasing and inflation**, and an increase in FFS bed days due to **return of churn** as members recycle in and out of MCOs

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Reflects **$21 million in Supplemental Payments** (physician) carried over into FY25 during the FY24 spend-down

Expenditure Comparison

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Decreasing Medicaid Expansion population leads to higher supplemental payments. Additionally, retroactive FY24 adjustments in Q1FY25 resulted higher-than-normal quarterly payment.

Expenditure Comparison

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Current Year **Pharmacy Rebates** do not typically appear until January – what you are seeing here are administrative adjustments.

Expenditure Comparison

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Fee-For-ser							%
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Hospital Su							%
Hospital Rate Assessment Payments	291.4	410.4	509.5	632.5	1,082.4	450	71.1%
Pharmacy Rebates	(444.9)	-	1.4	(0.1)	(18.7)	(19)	20532.3%
Title XIX Total	**4,661.2**	**5,852.2**	**6,8[illegible]6.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**
Fund Type							
General	1,301.5	1,582.6	1,784.1	1,526.7	2,250.6	724	47.4%
Coverage Assessment	120.9	150.6	189.6	232.0	213.7	(18)	-7.9%
Rate Assessment	81.9	109.6	135.8	179.6	285.1	106	58.8%
VA Health Care Fund	100.0	195.8	215.0	248.0	125.1	(123)	-49.5%
Federal	3,056.9	3,813.6	4,511.9	4,273.5	5,141.6	868.0	20.3%
Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**

From Earlier: FY24 trends lower due to the accelerated capitation payment into FY23 (July to June) to save general funds at a favorable FMAP. **FY25 reflects a return to normal capitation spending.**

This also reflects the carried-over supplemental payments.

Expenditure Comparison

In Millions

Five Year Look-back (Through October)

Expenditures	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY24 vs. FY25	
	Actuals through October						
Cardinal Acute	1,664.9	1,903.1	2,226.5	2,089.7	2,257.1	167	8.0%
Cardinal LTS							%
Fee-For-ser							%
Fee-For-ser							%
Fee-For-ser							%
Hospital Supplemental (DSH, IME/GME, Dx)	145.2	246.8	286.9	148.4	232.9	85	57.0%
Hospital Rate Assessment Payments	291.4	410.4	509.5	632.5	1,082.4	450	71.1%
Pharmacy Rebates	(444.9)	-	1.4	(0.1)	(18.7)	(19)	20532.3%
Title XIX Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**

Fund Type	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY24 vs. FY25	
General	1,301.5	1,582.6	1,784.1	1,526.7	2,250.6	724	47.4%
Coverage Assessment	120.9	150.6	189.6	232.0	213.7	(18)	-7.9%
Rate Assessment	81.9	109.6	135.8	179.6	285.1	106	58.8%
VA Health Care Fund	100.0	195.8	215.0	248.0	125.1	(123)	-49.5%
Federal	3,056.9	3,813.6	4,511.9	4,273.5	5,141.6	868.0	20.3%
Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**

Coverage Assessment and Rate Assessment are **inversely related.** When MedEX membership decreases, hospitals receive more supplemental rate payments. This was tilted toward Coverage Assessment during the public health emergency, now tilting back to Rate Assessment.

Expenditure Comparison

In Millions

Five Year Look-back (Through October)

Expenditures	Actuals through October					FY24 vs. FY25	
	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025		
Cardinal Acute	1,664.9	1,903.1	2,226.5	2,089.7	2,257.1	167	8.0%
Cardinal LTS							%
Fee-For-ser							%
Fee-For-service: BH & Rehabilitative	22.0	31.9	15.8	21.4	20.2	(1)	-5.8%
Fee-For-service: Long-Term Care Services	516.1	550.8	740.9	787.2	941.5	154	19.6%
Hospital Supplemental (DSH, IME/GME, Dx)	145.2	246.8	286.9	148.4	232.9	85	57.0%
Hospital Rate Assessment Payments	291.4	410.4	509.5	632.5	1,082.4	450	71.1%
Pharmacy Rebates	(444.9)	-	1.4	(0.1)	(18.7)	(19)	20532.3%
Title XIX Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**
Fund Type							
General	1,301.5	1,582.6	1,784.1	1,526.7	2,250.6	724	47.4%
Coverage Assessment	120.9	150.6	189.6	232.0	213.7	(18)	-7.9%
Rate Assessment	81.9	109.6	135.8	179.6	285.1	106	58.8%
VA Health Care Fund	100.0	195.8	215.0	248.0	125.1	(123)	-49.5%
Federal	3,056.9	3,813.6	4,511.9	4,273.5	5,141.6	868.0	20.3%
Total	**4,661.2**	**5,852.2**	**6,836.4**	**6,459.8**	**8,016.1**	**1,556.3**	**24.1%**

This is mostly a product of timing of when revenues are received and reclassified into the fund.

Expenditure Comparison – Another way to Look at the Data

In Millions

CardinalCare
Virginia's Medicaid Program

FY 2025 Compared to November 1, 2024 Forecast

Expenditures	YTD FY 2025	YTD Forecast	Variance
Cardinal Acute	2,257.1	2,262.0	-0.2%
Cardinal LTSS	2,637.2	2,616.6	0.8%
Fee-For-service: General Medicaid	863.5	913.1	-5.4%
Fee-For-service: BH & Rehabilitative	20.2	19.2	4.9%
Fee-For-service: Long-Term Care Services	941.5	942.2	-0.1%
Hospital Supplemental (DSH, IME/GME, Dx)	232.9	264.9	-12.1%
Hospital Rate Assessment Payments	1,082.4	1,082.4	0.0%
Pharmacy Rebates	(18.7)	(3.7)	401.9%
Title XIX Total	**8,016.1**	**8,096.8**	**-1.0%**
Fund Type			
General	2,250.6	2,299.4	-2.1%
Coverage Assessment	213.7	207.9	2.8%
Rate Assessment	285.1	285.1	0.0%
VA Health Care Fund	125.1	158.5	-21.0%
Federal	5,141.6	5,145.9	-0.1%
Total	**8,016.1**	**8,096.8**	**-1.0%**

This compares Year-to-date actuals against the new **November 2024 Forecast.**

This shows spending remains on track to the recently released Forecast.

DMAS will continue to monitor trends to ensure preparedness.

Summary

- The new November Forecast was released on November 1
- Spending is on track to that Forecast
- DMAS will continue to monitor trends to react as needed

Enhancing Language and Disability Access in Virginia Medicaid

December 10, 2024

Montserrat Serra
Civil Rights Coordinator
Civil Rights Unit | Appeals Division
montserrat.serra@dmas.virginia.gov | (804) 482-7269

Introduction to the DMAS Civil Rights Unit

- **Who We Are**:
  - John Stanwix, Appeals Division Director.
  - Montserrat Serra, Civil Rights Coordinator.
  - Jesus Perez, Civil Rights Compliance Specialist.
  - Teresa Roberts, Civil Rights Administrative Specialist.
- **What We Do**
  - Protect the rights of Medicaid applicants and members, ensuring equitable access to services regardless of language or disability.
  - Ensure compliance with federal and state civil rights laws across Medicaid programs and services.
  - Oversee the implementation of language and disability access programs.
  - Coordinate language and disability access services and accommodations within DMAS.
  - Handle discrimination complaints related to Medicaid.

Applicable Laws and Regulations

Title VI of the Civil Rights Act of 1964

Prohibits discrimination on the basis of race, color and national origin

Section 504 of the Rehabilitation Act of 1973:

Ensures individuals with disabilities have equal access to services.

ADA Title II

Requires state and local government to provide appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities

Affordable Care Act Section 1557

Covered entities shall take reasonable steps to ensure meaningful access to its programs or activities by limited English proficient individuals. 45 CFR 92.101

How We Currently Inform the Public of Their Rights

- **Language and Disability Access Plan:**
  - Published on the DMAS website, providing detailed information on how we support language and disability access.
- **Notices:**
  - Nondiscrimination notices and language taglines are included in all major communications, ensuring that members know their rights.
- **Appeal Documents:**
  - Information about language and disability access rights is included in all appeal-related communications.
- **DMAS Virtual Forum:**
  - Regular discussions and updates on language and disability access are provided through our forum, engaging stakeholders and the public.

Resources for Providers

- Medicaid providers are required to provide language and disability access services since they are partially paid from federal funds.
- **Guidance and Tools**:
  - Detailed resources on language and disability access obligations are available for providers.
    - DMAS Language and Disability Access Plan
    - Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
    - National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
    - ADA.Gov

Soliciting Feedback

- Questions for the Board:
  - How can we enhance awareness among Medicaid applicants and members regarding their rights to language and disability access?
  - What additional resources or training would be beneficial for Medicaid providers and stakeholders to better understand their obligations?
  - Are there any gaps in our current outreach or resources that need addressing?

1115 Demonstration Waiver for Serious Mental Illness (SMI): Amendment Application

VIRGINIA BUILDING AND TRANSFORMING COVERAGE, SERVICES, AND SUPPORTS FOR A HEALTHIER VIRGINIA

1115 Demonstration Waiver

Amending Virginia’s 1115 Demonstration Waiver

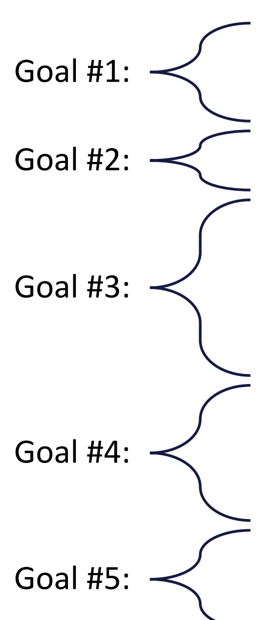
Building and Transforming Coverage, Services, and Supports for a Healthier Virginia (Number: 11-W-00297/3)

- Virginia submitted a renewal application to extend the existing Substance Use Disorder (SUD) and Former Foster Care Youth (FFCY) components to CMS August, 2024
- With this application, we are planning to add an additional amendment to seek a waiver program for Serious Mental Illness (SMI), an opportunity that was announced in 2018
- The intent of the amendment is to allow inpatient and residential crisis stabilization services for adults 21-64 in Institutions for Mental Disease (IMDs)

Overview of SMI 1115 Waiver Opportunity

The SMI demonstration opportunity allows states, upon CMS approval of their demonstrations, to receive Federal Financial Participation (FFP) for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services.

Five Required Goals for 1115 SMI Waiver Opportunity



1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

- Reduced preventable readmissions to acute care hospitals and residential settings

- Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;

- Improved access to community-based services to address the chronic mental healthcare needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care; and

- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Six Pillars of Right Help. Right Now. Plan

An aligned approach to BH that provides access to **timely, effective, and community-based care** to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families

1: We must strive to ensure **same-day care for individuals experiencing behavioral health crises**

2: We must **relieve the law enforcement communities' burden** while providing care and **reduce the criminalizatio n of behavioral health**

3: We must **develop more capacity** throughout the system, going beyond hospitals, especially to enhance community-based services

4: We must **provide targeted support for substance use disorder (SUD)** and efforts to prevent overdose

5: We must **make the behavioral health workforce a priority**, particularly in underserved communities

6: We must **identify service innovations and best practices** in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close

Source: VA HHR

Services Included in Proposed Amendment

- We do not propose adding any new services through this amendment
- However, we propose adding the excluded IMD setting to two existing services for adults 21-64:
  - Inpatient psychiatric treatment
  - Residential crisis stabilization

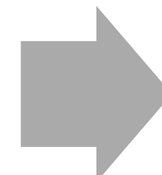
What Would Change with the Proposed Amendment?

Inpatient Psychiatric Treatment for Adults 21-64

Curren
t

Currently, medically necessary psychiatric inpatient care can be provided to adults 21-64 in psychiatric units of general acute care hospitals

Managed care health plans may cover medically necessary psychiatric inpatient care for adults 21-64 in IMDs for up to 15 days under the "in lieu of



Propose
d

Medically necessary psychiatr
inpatient care would be
available to adults 21-64 in bo
psychiatric units of general ac
care hospitals as well as up to
days in IMDs

Although up to 60 days could
covered if medically necessar
Virginia would be required to
keep average length of stay

Overview: Medicaid Final Rules

Overview

- **There are three main areas of final rule making include eligibility, managed care, and accessibility:**
  - Two Medicaid eligibility related rules
  - Two managed care related rules
  - Three accessibility rules
  - One rule related to incarcerated youth re-entry

- The timelines for state compliance with key provisions ranges from June 2024 through December of 2030

Consolidated Appropriations Act of 2023

Incarcerated Youth Re-Entry

- Applicable to young individuals in jails, prisons, or juvenile justice setting.
- Requires Medicaid agencies provide screening and diagnostic services to eligible juveniles in the 30-days prior to release and
- Requires Medicaid agencies provide targeted case management services in the 30-days prior to release and 30-days following release

Eligibility Rules

Streamlining Medicaid, Medicare Savings Program Eligibility Determination and Enrollment

- Simplifies processes for eligibility individuals to enroll and retain eligibility in the Medicare Savings Programs (MSPs)
- Aligns enrollment into the MSPs with requirements and processes for other public programs
- Reduces the complexity of applications and enrollment for eligible individuals

Eligibility Rules

Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

- Simplifies enrollment processes in Medicaid/Children's Health Insurance Program (CHIP)
- Aligns enrollment and renewal requirements for most individuals in Medicaid
- Establishes beneficiary protections related to returned mail
- Creates timeliness requirements for redeterminations of eligibility
- Probits lock out periods, benefit limitations, and waiting periods for the CHIP program
- Modernizes record keeping requirements to ensure proper documentation

Accessibility Rules

Department of Justice Rule: Nondiscrimination on the Basis of Disability, Accessibility of Web Information and Services of State and Local Government Entities

- Adopts specific technical standards for making services, program, and activities offered by state and local government entities to the public through the web and mobile applications.

1557 Rule: Nondiscrimination in Health Programs and Activities

- Designate a Section 1557 Coordinator and implement written policies and procedures to comply with new requirements
- Extend access requirements for individuals with disabilities limited English proficiency to companions
- Provide notice of availability of language assistance services and auxiliary aids and services

The 504 Rule: Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Assistance

- Ensure web content and mobile applications comply with Level A and Level AA success criteria and conformance requirements (two compliance dates depending on size of organization)
- Have at least one examination table and at least one weight scale that meet the requirements for Standards for Accessible Medical Diagnosis Equipment

Managed Care Rules

Ensuring Access to Medicaid Services

- Increases transparency and accountability
- Standardizes data and monitoring
- Promotes active beneficiary engagement in the Medicaid program

Medicaid and CHIP Managed Care Access, Finance, and Quality

- Standards for timely access to care and state's monitoring and enforcement efforts
- Reduces burden for implementing some state directed payments and certain quality reporting
- New standards for use of in lieu of services and settings to promote utilization
- Specifies medical loss ratio requirements
- Established a quality rating system for Medicaid and CHIP managed care plans.

Regulatory Activity Summary — December 10, 2024
(* Indicates Recent Activity)

2024 General Assembly

***(01) Provider Appeals Updates:** This SPA allows DMAS to update provider appeals language to align with the Department's current regulations. Specifically, this SPA will:

- Reflect a settlement proposal and review process that involves extending deadlines;
- Update the filing definition to account for use of online and other electronic means;
- Define what is considered the "last known address" of the provider;
- Clarify presumptions regarding receiving items transmitted to the last known address;
- Delineate the basis for administrative dismissals; and
- Outline the procedures for when a provider alleges that there are deficiencies with the informal appeal case summary.

Following internal and oversight agency review, the SPA was submitted to CMS for review on 11/18/24.

***(02) Repeal of Case Management Services for Recipients of Auxiliary Grants:** This regulatory action repeals the regulations associated with case management services for assisted living facility residents receiving auxiliary grants. DMAS has not provided this service for over ten years, so the regulations are outdated and need to be repealed to align with DMAS' current practices. DMAS submitted a SPA to CMS to remove the outdated case management language from the state plan. The SPA was approved on September 11, 2024, and this regulatory action will also align the Virginia Administrative Code with State Plan language. Following internal review, the reg project was submitted to the OAG for review on 11/19/24.

***(03) RAC Exemption Request:** This state plan amendment (SPA) seeks to request an exemption from CMS mandated RAC requirements. Section 1902(a)(42)(8) of the Social Security Act requires DMAS to have a Medicaid RAC program. However, 42 CFR §455.51 allows DMAS to file a request for an exemption to the RAC requirements, by submitting a written justification to CMS through the SPA process. In 2022, DMAS requested and received a temporary exemption from the RAC program, while research was conducted to procure a new RAC vendor. That exemption expired on July 1, 2024, so DMAS needs to file a request for another exemption. DMAS has transitioned to a 95% managed care program environment, such that the claims-eligible RAC review was rendered largely obsolete. A search to secure a vendor to operate an efficient RAC program, in this new environment, proved unviable. A new vendor would entail additional state funding, in conjunction with the RAC contingency fee, and represents an impractical scenario for Virginia Medicaid. Following internal and oversight agency review, the SPA was submitted to CMS on 11/8/24 and approved on 11/22/24.

***(04) Licensed Behavior Analysts — Credentialed Addiction Treatment Professionals:** The state plan is being amended to add Licensed Behavior Analysts (LBAs) to the definition of "Credentialed Addiction Treatment Professional." LBAs are not currently recognized by DMAS in the Addiction and Recovery Treatment Services (ARTS) program as practitioners because behavior analysts provide a broad spectrum of behavioral health services. Behavioral Analysis does, however, include a subspeciality directed at treating substance use disorders.

Adding LBAs to the definition of a “Credentialed Addiction Treatment Professional,” and recognizing them as a provider type under the ARTS program, helps address the shortage of available credentialed addiction treatment professionals in Virginia. Following internal and oversight agency review, the SPA was submitted to CMS on 9/4/24 and approved on 9/11/24. The corresponding regulatory project is currently circulating for internal review.

***(05) EPSDT Therapeutic Group Homes:** In accordance with the 2024 Appropriations Act, Item 288.EEEEE, this SPA establishes a per diem rate to therapeutic group homes that provide services to youth with an intellectual or developmental disability in addition to a behavioral health diagnosis. Group homes that provide this higher level of service are called “Early and Periodic Screening, Diagnosis, and Treatment” (or EPSDT) Therapeutic Group Homes. The per diem rate for these facilities shall be increased by 50%, effective July 1, 2024. Following internal and oversight agency review, the SPA was submitted to CMS on 6/18/24 and approved on 9/5/24. The corresponding regulatory project is currently circulating for internal review.

***(06) Core Set Mandatory Reporting:** This state plan amendment is needed in order to respond to a CMS State Health Official Letter requiring states to attest to compliance with mandatory annual state reporting of the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the behavioral health measures on the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). Following internal and oversight agency review, the SPA was submitted to CMS on 10/17/24 and approved on 11/1/24.

***(07) Supplemental Payments to Private Hospitals for Physician Services:** In accordance with the Item 288.OO.9.a-c of the 2024 Appropriations Act, this SPA makes supplemental payments to private hospitals and related health systems who intend to execute affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the non-federal share of the authorized payments. Virginia community colleges, Virginia public institutions of higher education, local governments, and instrumentalities of local government are public entities that are authorized to transfer funds to the department for purposes of covering the non-federal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Following internal and oversight agency review, the SPA was submitted to CMS for review on 11/8/24.

***(08) Social Security Disability Income (SSDI) Disregard:** In accordance with Virginia Senate Bill 676 and House Bill 908, DMAS is amending the state plan to disregard any Social Security Disability Insurance income above the maximum monthly federal Supplemental Security Insurance payment amount during the financial eligibility determination process for individuals who are receiving services under the Family and Individual Support Waiver, Community Living Waiver, and Building Independence Waiver. Following internal and oversight agency review, the SPA was approved by CMS on 9/13/24.

***(09) CHIP Annual SPA:**

The changes to the CHIP State Plan include:

- In accordance with House Bill 680 in the 2022 General Assembly, and the 2022 Appropriation Act, Traumatic Brain Injury-Case Management services became available for individuals who are 18 years of age and older, effective July 1, 2023. In the CHIP program, this coverage is only available to individuals who are age 18. (The CHIP program is not available to individuals above age 18.) The CHIP coverage matches the Medicaid coverage that was approved by CMS in Medicaid SPA 23-0008.
- Revision to school services coverage to allow services to be reimbursed regardless of whether the student receiving care has an individualized education program, or whether the health care service is included in a student's individualized education program. These changes are being made in accordance with 2021 Special Session, Item 313.AAAAA, and match the changes that were approved by CMS in SPA 21-0017. In accordance with CMS rules, these changes will have an effective date of July 1, 2023.

In addition, DMAS recently conducted a thorough review of the CHIP State Plan and determined that several items needed clarification. These items are:

- Revision to the wording related to dental coverage so that the meaning is clear.
- Revision to the wording related to disposable medical supplies so that the meaning is clear.
- Revision to clarify that nursing facility services are included in CHIP coverage. CHIP coverage was originally designed and approved in the year 2000 based on a "base benchmark" plan: the Key Advantage Plan. The Key Advantage plan included nursing facility coverage for up to 180 days. This coverage is being clarified in the state plan document.

DMAS also updated website addresses and removed an old reference to coverage for 60 days postpartum. (Postpartum coverage has been extended to one year.) Following internal and oversight agency review, the SPA was submitted to CMS on 6/28/24 and approved on 9/5/24.

***(10) 2024 Institutional Provider Reimbursement Changes:** In accordance with the 2024 Appropriations Act, Item 288.HH.5, the state plan is being amended to revise reimbursement methodologies for Psychiatric Residential Treatment Facilities (PRTFs) rates to implement inflation increases for each fiscal year to be effective July 1, 2024. Per Item 288.PP.2, the state plan is also being revised to make 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 equal the greater of what would have been paid to the freestanding children's hospitals under the current uncompensated care formula or $16,000,000 annually, the average due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit. This SPA also corrects language to be consistent with current DMAS policies and regulations. Following internal and oversight agency review, the SPA was submitted to CMS for review on 9/9/24. The SPA was approved by CMS on 10/9/2024.

***(11) 2024 Non-Institutional Provider Reimbursement Changes:** The 2024 Appropriations Act requires DMAS to revise the state plan to increase reimbursement rates for dental services by three percent (Item 288.BBBB.2). The state plan is also being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and the Diagnosis and Treatment (EPSDT) benefit by two percent (Item 288.GGGGG.1). (A

corresponding rate increase of two percent will be provided for these 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.) Additional revisions include updating the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale (Item 288.SSSS). Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations. Per Item 288.XXXX, the state plan is being revised to update the rates for consumer-directed facilitation services under EPSDT based on the most recent rebasing estimates. This SPA also includes a revision to set the reimbursement rate to 100 percent of the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for specific Durable Medical Equipment (DME) products, including enteral products and supplies and in the following categories in the DMAS fee schedule for Feeding Kits and Tubes and Nutrition Kits/Feeding Tubes (Item 288.YYYY). The project is currently circulating for oversight agency review. Following internal and external review, the SPA was submitted to CMS for review on 9/23/2024.

***(12) Supplemental Payments for Acute Care Hospital Chain with Level One Trauma Center:** The purpose of this SPA, in accordance with the 2024 Acts of Assembly, Item 288.OO.10, is to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, for an acute care hospital chain with a level one trauma center in the Tidewater Metropolitan Statistical Area (MSA) in 2020, upon the execution of affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the nonfederal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Public entities are authorized to use general fund dollars to accomplish this transfer. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. As part of the Interagency Agreements the department shall require the public entities to attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. Following internal and external review, the SPA was submitted to CMS for review on 11/1/2024.

(13) Adult Dental and 2024 Updates: This regulatory project (formerly entitled Adult Dental) adds language to the Virginia Administrative Code to implement a comprehensive dental benefit for adults, in accordance with a mandate from the General Assembly. Following internal review, the fast-track project was submitted to the OAG for review on 4/25/24.

(14) Substance Use Disorder: This regulatory action will align the Virginia Administrative Code (VAC) with DMAS' current practices. Specifically, this action will:

- Update the terminology of the Preferred Office Based Opioid Treatment (OBOT) to Preferred Office Based Addiction Treatment (OBAT) in 12 VAC 30-130-5020 and 12 VAC30-130-5040. In accordance with the 2021 Appropriations Act, Item 313.PPPPP, DMAS already expanded the substance use disorder service called OBOT (which had been available only to individuals with a primary diagnosis of opioid use disorder) to individuals with a substance-related or addictive disorder. DMAS updated the terminology in other

sections of the VAC in a previous regulatory action, but inadvertently missed the references in 12 VAC 30-130-5020 and 12 VAC30-130-5040.

- Clarify requirements for the Substance Use Care Coordination as well as the role of the licensed practical nurse (LPN) in the opioid treatment program (OTP) setting to align with current practices. LPNs are permitted to provide onsite medication administration treatment during the induction phase.
- Clarify the size of SUD counseling groups to align with current practice. The group size is limited to a maximum of 12 individuals, but this may be exceed based on the clinical determination of a Credentialed Addiction Treatment Professional (CATP).
- Update provider licensing references for SUD services (ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0) to reflect current DBHDS requirements and DMAS current practices.

The project is currently circulating for internal review.

2023 General Assembly

***(01) Complex Rehabilitation Technology:** The Code of Virginia, § 32.1-325 is being amended in accordance with 2023 HB 1512 to allow DMAS to reimburse for the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories for patients who reside in nursing facilities. An enactment clause authorized DMAS to promulgate emergency regulations to implement the provisions of HB 1512 within 280 days of its enactment. Following internal review, this regulatory project was submitted to the OAG on 11/8/23. The reg project was submitted to DPB for review on 8/27/24 and to HHR on 10/4/24.

(02) FAMIS Plan Update: This regulatory action is intended to make technical program updates, in addition to reducing the overall regulatory burden on the public in accordance with Executive Order 19. The primary advantage of these changes is that they update the regulations to align with current practices and remove outdated and unnecessary language from the Virginia Administrative Code (VAC). Following internal review, the project was forwarded to the OAG for review on 12/26/23.

***(03) Pharmacists as Providers:** In accordance with SB 1538 of the 2023 General Assembly, the state plan is being revised to provide reimbursement to a pharmacist, pharmacy technician, or pharmacy intern when services are (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to services and treatment in accordance with § 54.1-3303.1. Following internal review, the SPA was submitted to CMS on 10/16/23 and approved by CMS on 12/20/23. The corresponding regulatory project is circulating for internal review.

***(04) Third Party Liability:** The purpose of this state plan amendment is to add language that is needed to respond to a CMS State Medicaid Director letter (#23-002) requiring Medicaid agencies to amend their state plan to provide assurances that the state has rules in place that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. The

SPA will also provide clarity relating to lien amounts arising from the Medicaid program and asserted against personal injury claims proceeds. Following internal review, the SPA was submitted to CMS for review on 9/1/23. On 12/19/23, CMS requested that DMAS withdraw the SPA and re-file once new budget language/TPL authority is in place. The replacement SPA project is currently circulating for review.

(05) State-Based Exchange: This state plan amendment explains that The Virginia General Assembly passed legislation creating the Health Benefit Exchange Division within the State Corporation Commission to oversee Virginia's transition to a Virginia State Based Exchange (SBE). The SBE is expected to go live in November, 2023. One element of this project is that DMAS must file a SPA to reflect the presence of the SBE in Virginia.

The SPA notes that the exchange will:
"… conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the SBE. The SBE will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost sharing (if applicable) or assigning a benefit package. These functions will be performed by the single state agency. The SBE also refers individuals to the single state agency for determination if potentially eligible for non-MAGI Medicaid (e.g. ABD or limited coverage) or if potentially eligible for MAGI coverage but the exchange was unable to make a full determination. The SBE will not be handling appeals." Following internal review, the SPA was submitted to CMS for review on 5/12/23. The SPA was approved on 8/7/23. Following internal review, the project was forwarded to the OAG for review on 5/15/24.

(06) Electronic Visit Verification (EVV) for Home Health: The purpose of this SPA is to incorporate changes to the state plan text in accordance with the requirements of the Social Security *Act* (SSA) § 1903(l) regarding EVV as applicable to home health care services across all mandates of the SSA and the *Cures Act*. Virginia is in compliance with section 12006 of the 21st Century CURES Act, which required states to implement EVV for personal care services by January 1, 2020. Section 12006 of the CURES Act requires states to implement EVV for Home Health Care Services (HHCS) by January 1, 2023. Virginia applied for and received a one-year Good Faith Effort (GFE) exemption for HHCS. As a result, Virginia implemented EVV for Home Health Care Services on July 1, 2023. Following internal review, the SPA was submitted to CMS on 8/28/23 and approved on 10/26/23. The corresponding regulatory project was submitted to the OAG on 1/17/24 for review. DMAS received OAG comments on 2/13/24, 2/16/24, 3/8/24, 4/8/24, 4/24/24, and 4/26/24 and DMAS responded to all inquiries and addressed the requested edits. A conference call with the OAG was held on 4/23/24. DMAS submitted additional revisions to the OAG on 4/24/24. More OAG questions were received on 4/26/24. Revisions were sent to the OAG for review on 5/7/24 and 5/14/24. Additional OAG comments were received on 7/22/24. DMAS coordinated responses and subsequently participated in a conf. call w/ OCL staff on 8/1/24 to discuss the project. DMAS forwarded responses to the OAG for review on 8/13/24.

***(07) Case Management for Assisted Living Facility Residents:** This SPA will allow DMAS to remove outdated case management language for assisted living facility residents from the

state plan. DMAS has not provided this service for several years, so the state plan needs to be updated accordingly. Following internal review, the SPA was submitted to CMS on 7/3/23. CMS issued a RAI (request for additional information) on 9/28/23. The SPA was approved by CMS on 9/11/24. The corresponding regulatory project is forthcoming.

2022 General Assembly

(01) Post Eligibility Special Earnings: The 2022 Appropriations Act, Item 304.ZZ, requires DMAS to adjust the post eligibility special earnings allowance for individuals in the Commonwealth Coordinated Care Plus (CCC Plus), Community Living (CL), Family and Individual Support (FIS), and Building Independence (BI) waiver programs to incentivize employment for individuals receiving waiver services. The purpose of this action is to incentivize employment for individuals receiving DD waiver services by allowing a percentage of earned income to be disregarded when calculating an individual's contribution to the cost of their waiver services when earning income. This enables individuals enrolled in the DD waiver to keep more of their income, without losing financial eligibility for the waiver. This does not result in new individuals being added to the DD waiver. The project was submitted to the OAG for review on 2/7/23.

(02) Medicaid Enterprise System: The purpose of this final exempt regulatory action is to make technical updates to several of the agency's regulations to reflect the Department's transition of several key information management functions handled through the Virginia Medicaid Management Information System (VAMMIS) to a new technology platform called the Medicaid Enterprise System (MES). The MES replaced the department's VAMMIS on April 4, 2022. The reg project was posted to the Town Hall on 3/7/23 for OAG review.

***(03) Preventive Services:** Item 304.EEEE in the 2022 Appropriations Act requires DMAS to "amend the State Plan under Title XIX of the Social Security Act, and any waivers thereof as necessary to add coverage of the preventive services provided pursuant to the Patient Protection and Affordable Care Act (PPACA) for adult, full Medicaid individuals who are not enrolled pursuant to the PPACA." Following internal review, the DPB and Tribal notices were sent for review on 8/30/22. The SPA was submitted to CMS on 9/30/22 and approved by CMS on 12/7/22. Following internal review, the corresponding reg project was submitted to the OAG for review on 7/27/23. Multiple regulatory revisions have been submitted to the OAG and a conf. call was held in Nov. '23. Following internal discussions and review, DMAS re-submitted the project to the OAG on 7/31/24 and fielded questions from the OAG on 8/28/24 & 8/29/24. Additional revisions were submitted to the OAG on 8/29/24 and 9/3/24, for review. The OAG posed follow-up questions to DMAS on 11/26/24.

(04) Third Party Liability Update: This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA was submitted to CMS on 6/27/22 and approved on 7/25/22. Following internal review, the corresponding fast-track project was submitted to the OAG for review on 12/13/22. Revised regs were sent to the OAG for review

on 5/30/23. Minor revisions were made to the regs and updated regs were forwarded to the OAG for review on 10/24/23.

(05) PACE (Rates & Payment Methodology): DMAS has revised the state plan to update sections that pertain to the Program of All-Inclusive Care for the Elderly (PACE). Specifically, this SPA (1) incorporates the Rates and Payments language from the Center for Medicare & Medicaid Services' (CMS') most current PACE State Plan Amendment Pre-Print and (2) updates the PACE Medicaid capitation rate methodology to align with DMAS' current rate setting practices. DMAS has transitioned from fee-for-service data to managed care encounter data for development of the amount that would otherwise have been paid. The PACE program will continue to operate in the same way that is has based on regulations in the Virginia Administrative Code, and there will be no changes for providers as a result of this SPA. Following internal DMAS review, the SPA was submitted to CMS on 3/3/22. The SPA was approved by CMS on 4/26/22. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 6/29/22; to DPB on 10/13/22; to HHR on 11/16/22; to the Gov.'s Ofc. on 7/25/24; and to the Register on 8/6/24 (the regs were published on 8/26/24, with a comment period that will end on 9/25/24, and the regs became effective on 10/10/24).

2021 General Assembly

***(01) Mental Health and Substance Use Case Management:** These regulation changes remove the limit on substance use case management for individuals in IMDs are to comply with the Medicaid Mental Health Parity Rule. The federal Mental Health Parity regulation can be found in 42 CFR 438.910(b)(1). Specifying that reimbursement is allowed, provided two conditions are met, for mental health and substance use case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in IMDs and individuals of any age who are inmates of public institutions, aligns DMAS regulations with 42 CFR 411.18(a)(8)(vii) and documents the Department's existing practices. Clarifying ISP review timeframes and grace periods, and clarifying CSAC-Supervisees can bill for substance use case management services, document existing DMAS practices, rather than changes in practices. Following internal review, the project was submitted to the OAG on 1/13/22. DMAS received OAG inquiries on 1/19/22 and responded to those on 1/27/22. The regulatory action was approved by the OAG on 2/23/22 and was forwarded to DPB for review on 2/24/22. The project was forwarded to HHR on 4/5/22 and approved on 10/8/24; submitted to the Gov's Office and approved on 10/17/24; and submitted to the Registrar on 10/21/24, with the comment period ending on 12/18/24.

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

(03) Private Duty Nursing Services Under EPSDT: This regulatory action updates the Virginia Administrative Code to include the following items related to private duty nursing, in accordance with a mandate from the 2021 General Assembly: services covered, provider qualifications, medical necessity criteria, and rates. This regulation establishes the regulatory framework for individuals with the need for high-intensity medical care. Having regulations in place (rather than just language in Medicaid manuals) helps ensure that the rules are clear and transparent, and that they are applied equally across providers, and across members. This reg action includes a service description, a list of service components, provider qualifications, and service limits (which includes references to the documents needed to establish medical necessity). Following internal review, the regs were submitted to the OAG on 8/6/21 and then to DPB on 4/6/22. After edits were made to the regulations, the project was re-submitted to the OAG on 4/26/22 and sent to DPB on 5/18/22. The project was forwarded to the Secretary's Office for review on 6/1/22. Following additional internal revisions, the regulations were sent back to HHR on 8/1/22. The reg action was forwarded to the Gov's Ofc. on 9/25/23; to the Register on 10/5/23; and was published in the Register on 10/23/23. The 30-day public comment period ended on 11/22/23 and the emergency regulation is effective beginning 10/6/23 through 4/5/25. The corresponding fast-track project, following internal review, was submitted to the OAG on 3/18/24 for review.

(04) Consumer-Directed Attendants: This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer-directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. DMAS reached out to the OAG to re-engage this project. The OAG sent additional revisions/questions on 9/12/22. DMAS forwarded responses to the OAG on 11/9/22. The OAG sent a request for additional edits on 12/6/22. DMAS coordinated the responses and submitted them to the OAG on 12/21/22. The OAG forwarded additional questions on 1/9/23. DMAS had placed the project on hold to review General Assembly outcomes to determine if pending legislation (SB 886) would impact this regulation. Edits were made to the project and the regulatory action was re-submitted for OAG review on 7/26/23. Additional edits were sent to the OAG on 9/28/23 and 10/25/23. The project was submitted to DPB on 11/9/23. A conf. call w/ DPB was held on 12/5/23. DMAS submitted follow-up info to DPB on 12/7/23. DPB requested additional info on 12/8/23 and DMAS forwarded responses on 12/13/23, 12/15/23, and 12/18/23. The project was approved by DPB on 12/19/23. HHR is currently reviewing the regulations.

(05) School Services: The purpose of this SPA is to adhere to the 2021 Appropriations Act, Items 313.EEEE and VVVV, which require DMAS to make changes to the state plan. These changes will: 1) increase the rates for psychiatric services by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates; and 2) increase supplemental physician payments for a freestanding children's hospital serving children in Planning District 8. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by CMS and all other Virginia Medicaid fee-for-service payments. The project was submitted to CMS on 10/18/21. The request for additional information (RAI) for this project was received from CMS on 1/4/22. DMAS' RAI response was sent to CMS on 3/30/22. The SPA was approved by CMS on 9/26/23. Following internal review, the corresponding regulatory action was forwarded to the OAG on 2/29/24.

(06) Clarifications for Durable Medical Equipment and Supplies – Revisions: This state plan amendment proposes to amend a previous SPA. DMAS previously submitted SPA 20-011 entitled "Clarifications for Durable Medical Equipment and Supplies" which was approved by CMS on October 20, 2020. Following the approval of SPA 20-011, CMS discovered duplicative wording and the necessity to re-categorize a heading on multiple pages, and also requested that DMAS submit a new SPA to revise the text on those pages. There is no change to the content or meaning of the state plan text as a result of the change. Following internal review, and the submission of the DPB and Tribal Programs notifications, the SPA was forwarded to HHR for review on 3/8/21. The SPA was approved by CMS on 5/24/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 8/26/21. The project was re-submitted to the OAG for review on 8/11/22. Additional revisions were posted to the Town Hall on 4/16/24. DMAS is awaiting further direction.

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. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22. DMAS received inquiries from the OAG on 12/16/22, 1/3/23, 1/9/23, 1/25/23, 2/9/23, 2/13/23, 3/2/23, and 3/13/23. DMAS submitted responses to the multiple OAG requests for edits and is awaiting further direction. On 6/15/23, DMAS requested an emergency reg extension and notified the OSHHR of the request. On 6/20/23, the Gov.'s Ofc. approved extending the emergency regulation until 2/14/24. On 4/17/24, the OAG posed additional questions and DMAS submitted responses on

4/25/24. On 5/1/24, DMAS forwarded revised regulations and informed the OAG that the revisions are available for review.

(02) 90-Day Prescriptions: The recent Medicaid Disaster Relief SPA allowed DMAS to provide 90-day prescriptions to Medicaid members (excluding Schedule II drugs), however, that SPA will end on the last day of the federal-declared emergency period. DMAS is filing a SPA to allow for the provision of a maximum of a 90-day supply for select maintenance drugs dispensed to Medicaid members (excluding Schedule II drugs) after the end of the federal emergency period. The 90-day supply will be available to Medicaid members after the member has received two (2) fills of 34 days or less of the drug. Following internal review, the SPA was filed with CMS on 11/9/20 and approved on 12/10/20. Following internal review, the corresponding regulatory action was submitted to OAG on 1/28/21. Status inquiries were forwarded to the OAG on 7/1/21, 8/10/21, 8/24/21, 9/14/21, 1/25/22, 3/9/22, 4/13/22, and 7/12/22. The project's economic impact form was uploaded to the Town Hall on 9/30/22.

(03) 2020 Long Term Services and Supports (LTSS) Screening Changes: For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in accordance with 2020 HB/SB 902 to allow qualified nursing facility staff to complete the Long-Term Services and Supports (LTSS) screening for individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The amendments to the Code include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community based services. Following internal review, the regulations were submitted to the OAG for review on 11/18/20. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/1/21 and 4/14/21. DMAS submitted the project to DPB on 6/14/21. Questions were received on 6/21/21 and responses were sent to DPB on 6/21/21. A conf. call was held on 6/22/21 to discuss the project. The reg action was submitted to HHR on 6/23/21. The regs were forwarded to the Governor on 11/10/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21 (w/ corrections sent on 12/29/21); published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal DMAS review, the fast-track stage regs were submitted to OAG on 7/26/22. DMAS received comments from the OAG on 10/4/22. DMAS sent revisions to the OAG on 10/7/22. The project was submitted to DPB on 10/13/22 and DMAS responded to DBP questions on 10/18/22 and made additional revisions. The project's economic impact form was uploaded to the Town Hall on 10/13/22. A conference call with DPB was held on 11/7/22 to discuss the project. The reg action was submitted to HHR for review on 11/21/22. The agency response to DPB's economic impact analysis was posted to the Town Hall on 11/29/22. The Ofc. of Regulatory Management economic impact form was uploaded to the Town Hall on 10/13/22. A conf. call with HHR was held on 8/28/23 to discuss changes in reg text and to discuss implications. HHR approved DMAS proceeding with revisions to the regs on 11/2/23 and revisions were made. The project was submitted to the Gov.'s Ofc. on 7/24/24 and to the Registrar on 8/7/24.

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.