BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, March 14, 2023
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
Teams Meeting Link

AGENDA

#	Item	Presenter
1	Call to order	Brian McCormick
2	Welcome New Board Members	Cheryl Roberts, Director
3	Election of New Board Officers • Chair • Co-Chair • Secretary of the BMAS	
4	Appoint Board member to Managed Care Advisory Committee (MMCAC)	
5	Approval of 12/13/2022 Meeting Minutes	
6	Director's Report	Cheryl Roberts, Director
7	Legislative Update	Brian McCormick Will Frank
8	CFO Updates • Budget Amendments • Financials	Chris Gordon, CFO
9	Unwinding Update	Sarah Hatton, Deputy of Administration
10	New Business/Old Business	
11	Public Comment - Public comments limited to a total of 15 minutes. Public should send their request in writing to BMAS Board Secretary, speaker's name and subject.	1. Maureen Hollowell
12	Regulations	
13	Adjournment	

BOARD OF MEDICAL ASSISTANCE SERVICES

DRAFT MINUTES
Tuesday, December 13, 2022
10:00 AM

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

Virtual Attendees: Ashley Gray, Elizabeth Noriega, Ashish Kachru
Absent: Patricia T. Cook, MD

1. Call to Order

Michael Cook, Board Chair called to order the regular meeting of the Board of Medical Assistance Services at 10:09 am on December 13, 2022, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219. The meeting was also held virtually via Microsoft Teams.

2. Approval of Minutes

The minutes from the September 20, 2022 meeting were introduced and approved.

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

3. Director's Report

Director Roberts reported to the Board on the Delivery System and as of August 15, 2022, Managed care serves more than 91% of all populations; over 97% full benefit populations. The highlights of 2022 were: Rate and Payment changes, Safe and Sound, Early Release, Doulas, COVID vaccinations, Cardinal Care, Nursing Home Quality Project, Crisis Services, Early and Periodic Screening Diagnostic and Treatment (EPSDT) and getting back to “Normal”.

Partnership for Petersburg was introduced in August. Governor Youngkin and state agency partners made a public commitment to work toward improving the City of Petersburg

Managed Care Organizations joined Secretary Littel in the Governor's commitment and have so far contributed the following toward our goals of improving healthcare outcomes and access to maternity, pediatric, and primary care:

- 40+ community and health events, many including screenings and vaccinations
- More than $3M invested into projects directly serving Petersburg, including support of a maternity hub, partnership with Conexus for glasses for all students, as well as donations of necessities, such as toothbrushes, cribettes, diapers, and food

Next Steps: Sustainability, provider engagement

- Our MCO partners are also actively engaged in the Petersburg community through participation in over 40 community and health events since August, many of these events including mobile screenings, vaccinations, and preventive health care services.
- To date, MCOs have invested more than $3M into projects directly serving Petersburg, including support of a maternity hub, partnership with Conexus for glasses for all students, and donations of necessities, such as toothbrushes, cribettes, diapers, and food.

Next Steps:

1. Engaging Petersburg-area providers on community needs and sustainable strategies to increase health care outcomes:
    - •Meeting with Pathways ED on December 16th
    - •Maternity Provider meeting on January 4th at the Petersburg Library
    - •Collaboration with CVHS
    - •Ongoing discussions with VDH, DSS, VHHA
2. Focus on access and utilization, tracking data to evaluate the impact of Partnership for Petersburg engagement

Director Roberts spoke on the Governor's Budget and General Assembly, Behavioral Health System Transformation which Governor Youngkin is committed to enhancing and transforming the Behavioral Health System, the end of the Federal Public Health Emergency, State-Based Exchange, Post-Partum and Infant Care, Community Doula Implementation, Long-Term Services and Supports, Brain Injury Services and Procurement.

4. CFO Report

Chris Gordon, CFO, provided the Board with updates on the FY23 Appropriation, FY23 Appropriation to Actuals by Program and Fiscal Month, and Enrollment and Expenditures.

In Summary, Medicaid Title XIX Expenditures increased nearly 17% over the last year. Medicaid population is still growing at 12.5K per month and ACA childless adults on trend, accounting for over half of Medicaid growth in the first 5 months.

5. Unwinding

Deputy of Administration, Sarah Hatton, provided updates on unwinding.

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). Since the beginning of the PHE, Virginia has received $2,001,653,414 in increased funding through Q4 FY22.

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, states will be required to redetermine eligibility for nearly all Medicaid enrollees.

While states are still required to initiate all renewals within 12 months, CMS granted an additional two months for states to complete clean-up actions to come into compliance with Federal requirements for a total of 14 months.

HHS has committed to providing a 60-day PHE final end date notice to CMS/states

- Current PHE expiration date is January 11, 2023, a 60-day notice would have been due on November 12, 2022, for January expiration.
- Another extension of the PHE is expected prior to the January expiration date – it is anticipated this extension will last for a full 90 days.
    - If this extension is the final PHE, the 60-day notice would be given on February 10, 2023, with a new assumed end date of April 11, 2023.
    - First-month coverage termination could begin May 1, 2023.
    - 6.2% FMAP would end June 30, 2023.

As a result of the continuous coverage requirement, the Commonwealth has not experienced the typical churn of Medicaid enrollees. As such, the Commonwealth, like almost all states, is experiencing enrollment growth. Over 2.0 million individuals are enrolled in Virginia Medicaid. At the end of the continuous coverage requirements, almost all of these individuals will require a redetermination.

Preparations to resume normal operations include system updates, Training, Clean Up and Pre-Unwinding Processes, Policy Flexibilities, Stakeholder Outreach, Unwinding Waivers, Member Outreach, and Temporary Flexibilities.

6. Service Recognition

Director Roberts two long-standing board members whose terms will expire in March 2023. Board Chair Michael Cook and member Maureen Hollowell were commended on their participation on the board and valued service to the Medicaid members. Director Roberts recognized both for their time and service to the Board.

7. Regulations

8. New Business/Old Business

9. Adjournment

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

BMAS
MARCH 2023

Cheryl Roberts, *DMAS Director*

& ELT

- Director’s Updates
- ELT Updates

Director's Updates

Change of key staff	Unwinding	Behavioral Health Transformation
Eclipse-Procurement	EAPG	Dashboards
Partnership for Petersburg	PRSS Certification	Budget

Chief of Staff Update

Workforce Updates

Workforce Stats

- **543 allotted** MEL positions for FY23.
- Of these, **478 filled** (3/2/23)
- Leaving **65 vacant** positions (12% vacancy rate)
  - 48 positions in active recruitment
  - 6 positions filled for 3/10
  - 3 positions filled for 3/25

Critical Recruitments

- Chief Information Officer starting 3/25
- Chief Medical Officer - recruiting
- Behavioral Health Director - recruiting
- Budget Director - recruiting
- Provider Reimbursement Director – recruiting
- Eligibility and Enrollment Director - recruiting

Retention Strategies

- Staff appreciation events (February, April, June)
- Public Service Week events (May)
- Non-monetary peer recognition – DMAS Heroes
- Recognition award monitoring and dashboard
- Service opportunities (CVC, blood drive, etc)
- Planning affinity groups (book groups, working parents)
- Quarterly all-leadership meetings
- Enhanced New Employee Onboarding
- New employee check-ins through first year

Chief of Staff Update

Audits

APA Audit

The APA noted 3 findings in the FY2021 audit and 4 issues in the FY2022

PERM Audit

- PERM errors mostly declined from RY19 to RY22, with error rates decreasing from 32% to 4.9% for eligibility and from 21% to 1.4% for data processing, with a slight increase from 1.3% to 1.6% for the medical record review.

Improper Payment Rates (IPRs)

- Overall IPR CHIP & Medicaid (includes DP, MR, & Eligibility): RY19 28.56% and 9.13% for RY22 ae 5.80% and 5.34%

Eligibility CHIP & Medicaid

- RY19 are 17.72% & 3.51% and for RY22 are 5.47 & 4.78%
- FFS CHIP & Medicaid: RY19 is 37.24% & 12.77% and for RY22 are 2.59% and 2.46%.
- No managed care errors/IPR for either year ry19 or ry22

Total Open Audit Issues

Auditor	Number of Open Audit Issues
APA Annual Audit	5
External Audits	11
Internal Audit	17
Internal IT Audits	50
Grand Total	83

Number of Open Audit issues by Division	Number of Open Audit Issues
Budget	1
CIO	1
CLIA	1
COS	1
DADS	1
DADS and PCM	1
PI	1
ODA and IS	2
CFO	2
E&E	2
Fiscal	2
IC	2
IM and ISO	2
PCM and IS	2
OCL	4
IS	5
PCM	6
ODA	10
ISO	17
IM	20

Chief Analytics Officer Update

Data, Quality and Nursing Homes Project

- Office of Data Analytics- published ARTS dashboard in December 2022 to show the utilization of Medicaid's ARTS services
- Office of Quality and Population Health- submitted 2023-2025 Virginia Medicaid Quality Strategy to CMS and posted on DMAS website
- Office of Value-Based Purchasing- Nursing Facility VBP program: anticipating distributing the first round of payments to MCOs in the next two weeks. Once first-round payments are received from DMAS, MCOs will have one month to send funds to Nursing Facilities. VBP will prepare for round two payments in April 2023.

Deputy of Technology and Innovation Update

Information Management and Enterprise PMO

- 7 procurements
- 6 projects
- Strengthening relationship with VITA (Customer Account Manager now onsite 1 day a week)
- Reducing overall VITA infrastructure and telecommunication bill
- Hired CIO
- Looking at innovation post MES implementation
  - Division automation (i.e. Robotic Process Automation (RPA))
  - Updates to MES modules

Upcoming Projects

DMAS PMO
ENTERPRISE PROJECT
MANAGEMENT OFFICE

Active Project	Status
Prescription Monitoring Program (PMP)	•Waiting for feedback from ODA, VITA, and DHP
T-MSIS Mandated System Changes	•In Planning. PARF being submitted.
MCO Re-Procurement (Eclipse)	•In Planning. Project schedule under review. •PGR submitted, under VITA review.
Postpartum Extension	•Initial Review with Hope Richardson & VCU CM Neil Mccrray in progress
Optima/VAP Merger	•Work in Progress adding DMAS IM/Systems tasks and Rx Rebate tasks to the work plan •Merger date is moved to 1/1/2024
Enrollment Broker	• Restarting RFP process

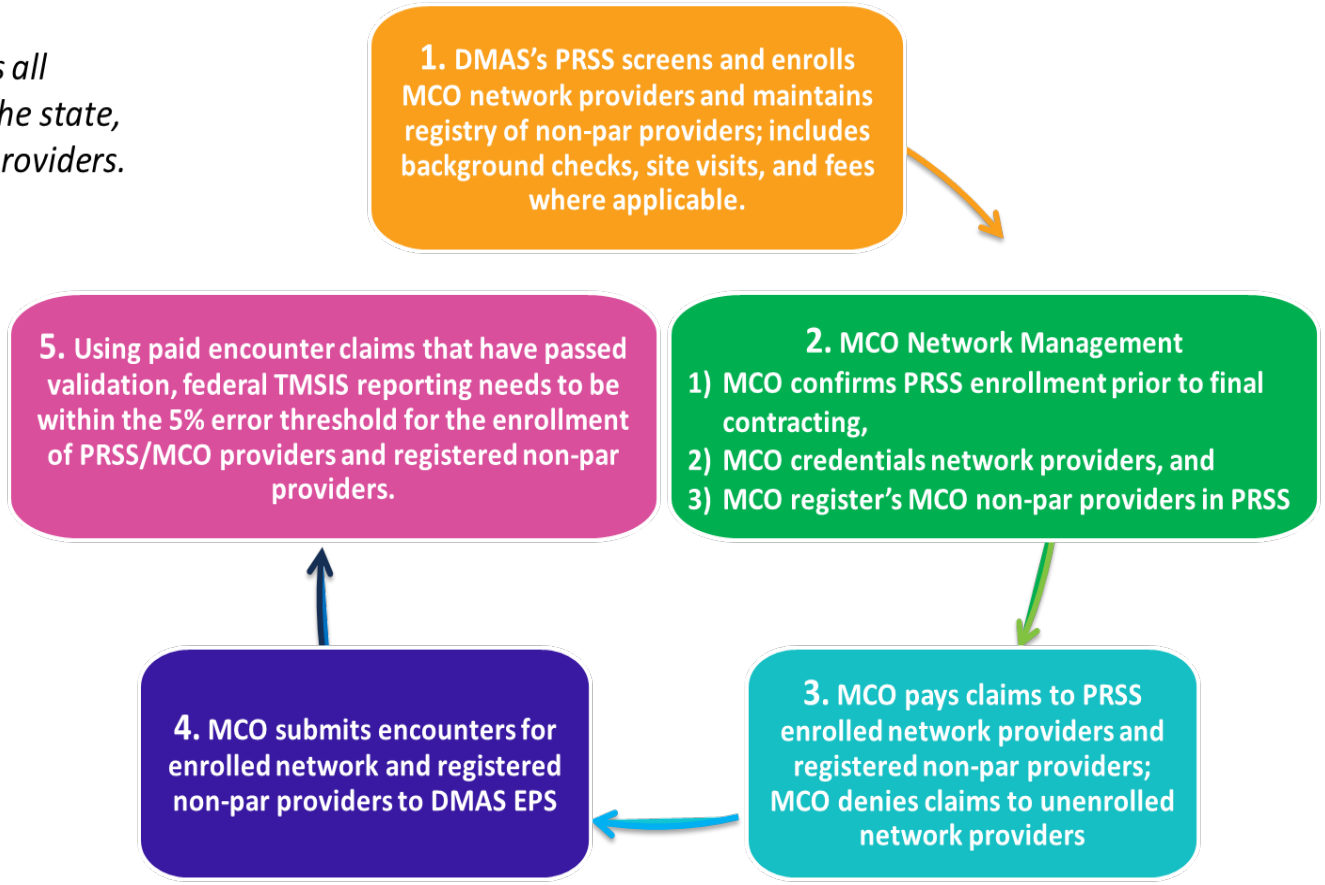
Deputy of Programs and Operations Update

Five Dimensions of MCO Provider Enrollment

The 21st Century Cures Act requires all Medicaid providers to enroll with the state, including managed care network providers.

As we move to comply with Cures Act requirements, our goal is to 1) ensure network access, 2) mitigate member disruption, and 3) avoid any unnecessary provider abrasion.

MCO provider enrollment is needed to satisfy a variety of state and federal requirements, including network adequacy, claims payment, encounter processing, and TMSIS federal reporting.



Represents the fully-operational system

Deputy of Programs and Operations Update

Proposed Phases of Network Provider Terminations/Payment Suspension *For providers who are not PRSS pending or enrolled*	March	April	May	June	July
Phase 1 - Providers with no claims in the past 2+ years and provider is not needed for network adequacy. ***Terminations set to begin 3/31 and will be completed by 4/30/2023.***					
Phase 2 - Providers with no claims in the last 1+ year and provider is not needed for network adequacy. ***Terminations to be effective on 4/30/2023.***					
Phase 3 - Providers with recent claims but not needed for network adequacy. ***Terminations to be effective on 5/31/2023.*** • *Requires MCO member transition plans and care management to ensure access.*					
Phase 4 - Providers needed for network adequacy. ***Terminations would not be effective before 6/1/2023. Terminations will follow a phased process in June and July 2023.*** • *Network adequacy exception process applies. If the non-enrolled provider is a critical provider, for example, the only pediatric oncologist in the region, MCO must consider out of network agreement.*					

Deputy of Programs and Operations Update

- Doulas - We now have 94 state certified doulas – recruitment strategy for statewide coverage
- Partnership for Petersburg – meeting with hospital and providers – mailings to members
- NASHP MCH PIP – finishing up 2 year project focused on postpartum and doulas
- Strategic Plan and MCO Improvement Plans to increase prenatal and postpartum utilization
- DMAS OKR focused on increasing postpartum care
- Baby Steps VA meetings bi-monthly

Deputy of Complex Care Update

Behavioral Health Transformation

- On December 14, 2022, Governor Youngkin announced his three-year plan to transform Virginia's behavioral health system, entitled "Right Help, Right Now."
  - The Governor proposed additional spend and budget language amendments for the first year totaling over $230M

- **An aligned approach to Behavioral Health** 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.

Deputy of Complex Care Update

Behavioral Health Transformation

- The Commonwealth's Behavioral Health Plan is founded on 6 Workstreams
  1. **Ensure same-day care for individuals experiencing behavioral health crises**
  2. **Relieve law enforcement burdens and reduce criminalization of mental health**
  3. **Develop more capacity throughout the system**
  4. **Targeted support for substance use disorder (SUD) and efforts to prevent overdose**
  5. **Make the behavioral health workforce a priority**
  6. **Identify service innovations and best practices to close capacity gaps**
- January – March 2023: Implementation Phase
  - 6 Workstream teams developing detailed implementation plans
- March 2023- December 2025: Execution Phase

VIRGINIA GENERAL ASSEMBLY UPDATE

March 2, 2023

Brian McCormick

Director,

Legislative and

Intergovernmental Affairs

Will Frank

Senior Advisor for Legislative Affairs

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.

2023 GA Session Stats

- 2,858 bills introduced.
- DMAS was assigned as the Lead Agency for 31 bills.
- 13 lead bills passed.
- 18 lead bills failed.
  - These included bills with Amend, No Position, and Oppose positions.
- DMAS commented on another 26 bills assigned to other agencies.
- DMAS Tracked another 107 bills.

Key Bills 2023

HB1681/SB1457	• Provides that if an individual is admitted to a skilled nursing facility for skilled nursing services and such individual was not screened but is subsequently determined to have been required to be screened prior to admission to the skilled nursing facility, then the screening may be conducted after admission.
HB1446/SB1339	• Sets nursing staffing requirements for certified nursing facilities, imposes administrative sanctions on a certified nursing facility if it does not comply with the staffing requirements, provides for exemptions to the administrative sanctions under certain circumstances, and directs the promulgation of regulations consistent with the bill.
HB1963/SB945	• Directs DMAS to take steps to amend the Family and Individual Supports, Community Living, and Building Independence waivers to provide greater financial flexibility to individuals with developmental disabilities who are receiving waiver services.

Key Bills 2023

HB2190/SB1270

- Requires DMAS to collect data for each fiscal year from fiscal year 2018 through fiscal year 2022 regarding (i) the number of claims submitted to MCOs that were denied and the reasons for such denials and (ii) the number of claims submitted to MCOs that required resubmission prior to payment and the reasons for such resubmissions and to examine such data.

HB2262/SB1154

- Requires a health insurance carrier that credentials the physicians, mental health professionals, or other providers in its network to establish reasonable protocols and procedures for processing of new provider credentialing applications. This includes online notification application is received through online system, timeline for notification if not online system, and timelines for approval and denial of applications.

Other Bills 2023

HB1512	• Directs DMAS to amend the state plan for medical assistance services to include a provision for payment of medical assistance for the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories.
HB2158	• Directs DMAS to evaluate its ability to comply with certain federal requirements regarding the Commonwealth's right of recovery from insurance carriers for items or services for which payment was made under the state plan for medical assistance services by the effective compliance date of July 1, 2024.
SB1538	• Requires DMAS to provide reimbursement when the services provided for by the state plan are services by a pharmacist, pharmacy technician, or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in relevant law 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 relevant law.

Questions????

Thank you

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

FINANCE UPDATE

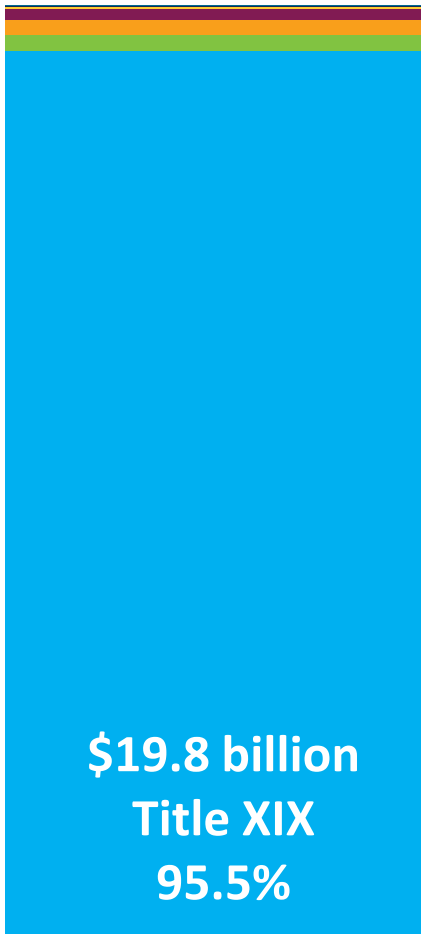
Chris Gordon, CFO

Deputy Director of Finance

Agenda

- FY23 Appropriation
- FY23 Actuals by Program & Fiscal Month
- Enrollment
- Capitation Decomposition
- Summary

DMAS FY23 Appropriation



$20.8 billion

Admin— 1.7%
- $345 million

CHIP— 1.5%
- $316 million

MCHIP—1.2%
- $249 million

ARPA—0.07%
- $14 million

TDO—0.08%
- $15 million

UMCF—0.004%
- $822K

Source: Department of Planning & Budget Operating Plan; https://pbreporting.virginia.gov/rdPage.aspx

Comparing: FY20-23 first seven months

In Millions

	Actuals				FM7 FY22 vs.FM7 FY23	
Expenditures	**FM7 FY20**	**FM7 FY21**	**FM7 FY22**	**FM7 FY23**	**Change**	**% Change**
Managed Care: Medallion 4	2,418.0	2,892.3	3,481.6	4,002.0	520.4	14.9%
Managed Care: CCC+	3,040.7	3,573.5	3,928.6	4,370.0	441.4	11.2%
Fee-For-Service: General Medical Care	919.1	884.9	994.3	1,062.5	68.2	6.9%
Fee-For-Service: Behavioral Health & Rehabilitative Svcs	30.8	33.4	25.8	24.0	(1.8)	-7.0%
Fee-For-Service: Long-Term Care Services	879.2	866.7	989.4	1,289.4	300.0	30.3%
Hospital Payments	286.7	263.8	424.6	442.6	18.0	4.2%
Supplemental Rate Assessment Payments	527.8	746.7	912.5	1,219.7	307.2	33.7%
Total Title XIX	**$ 8,102.3**	**$ 9,261.3**	**$ 10,756.8**	**$ 12,410.2**	**$ 1,653.4**	**15.4%**
Total GF Expenditures (Title XIX)	**$ 2,748.9**	**$ 2,475.3**	**$ 4,076.8**	**$ 3,040.7**		

Source: Department of Medical Assistance Services Monthly Accuracy Reports for FM1 through FM7 FY20 through FY23, https://www.dmas.virginia.gov/data/financial-reports/

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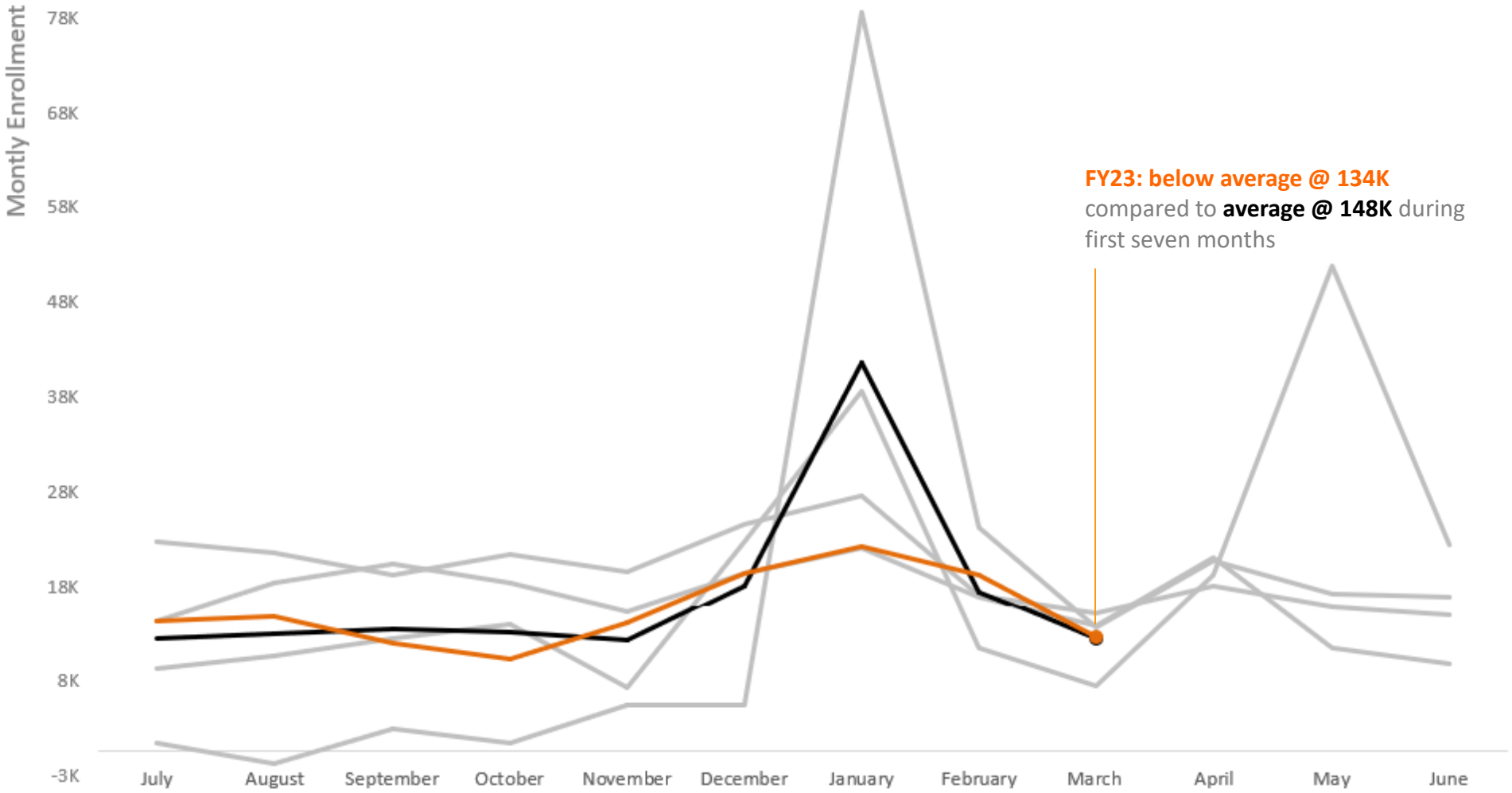
Monthly Enrollment in Medicaid

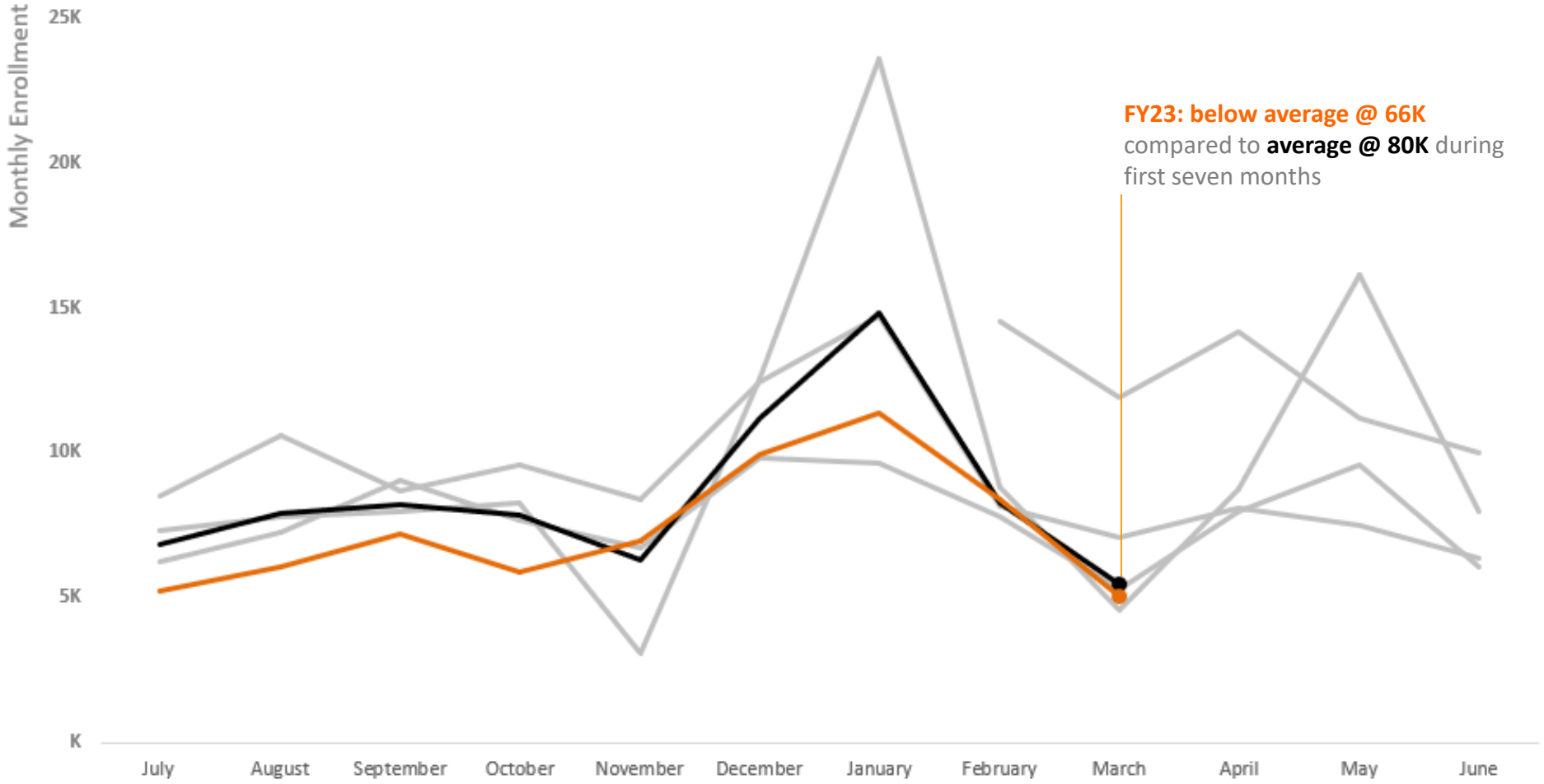
FY23 Monthly Enrollment: **below average** compared to last four years



Source: DMAS Enrollment Report retrieved March 2, 2023

ACA Childless Adult Enrollment

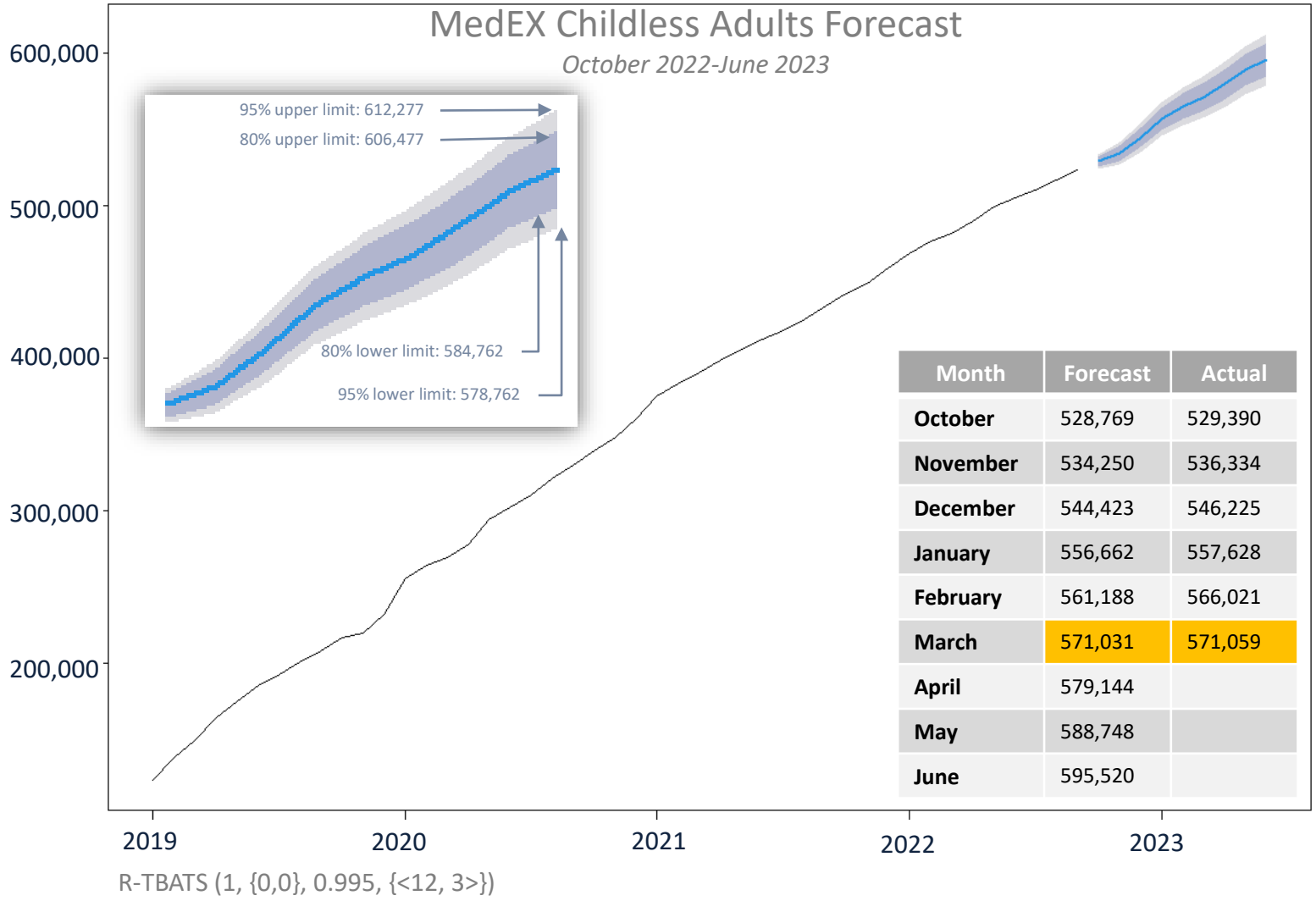
FY23 Childless Adult Enrollment: **below average** compared to last four years



 Source: DMAS Enrollment Report retrieved March 2, 2023

ACA Childless Adult Forecast

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

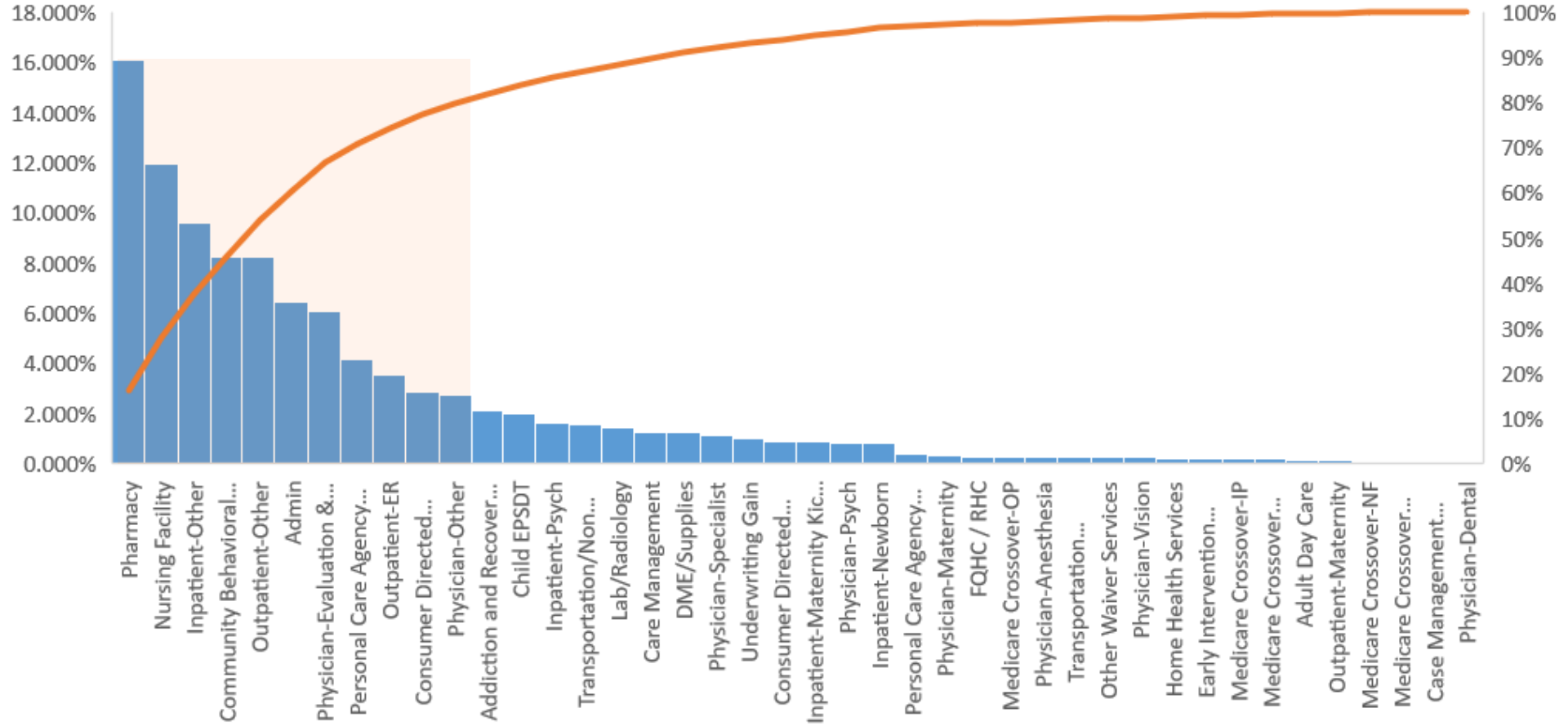


Month	Forecast	Actual
October	528,769	529,390
November	534,250	536,334
December	544,423	546,225
January	556,662	557,628
February	561,188	566,021
March	571,031	571,059
April	579,144	
May	588,748	
June	595,520	

Source: DMAS Enrollment Report retrieved September 2, 2022 and March 2, 2023, and R-TBATS Forecasting

FY23 Capitation decomposition

- 80% of $14 billion capitation represents spending in just 11 categories of service



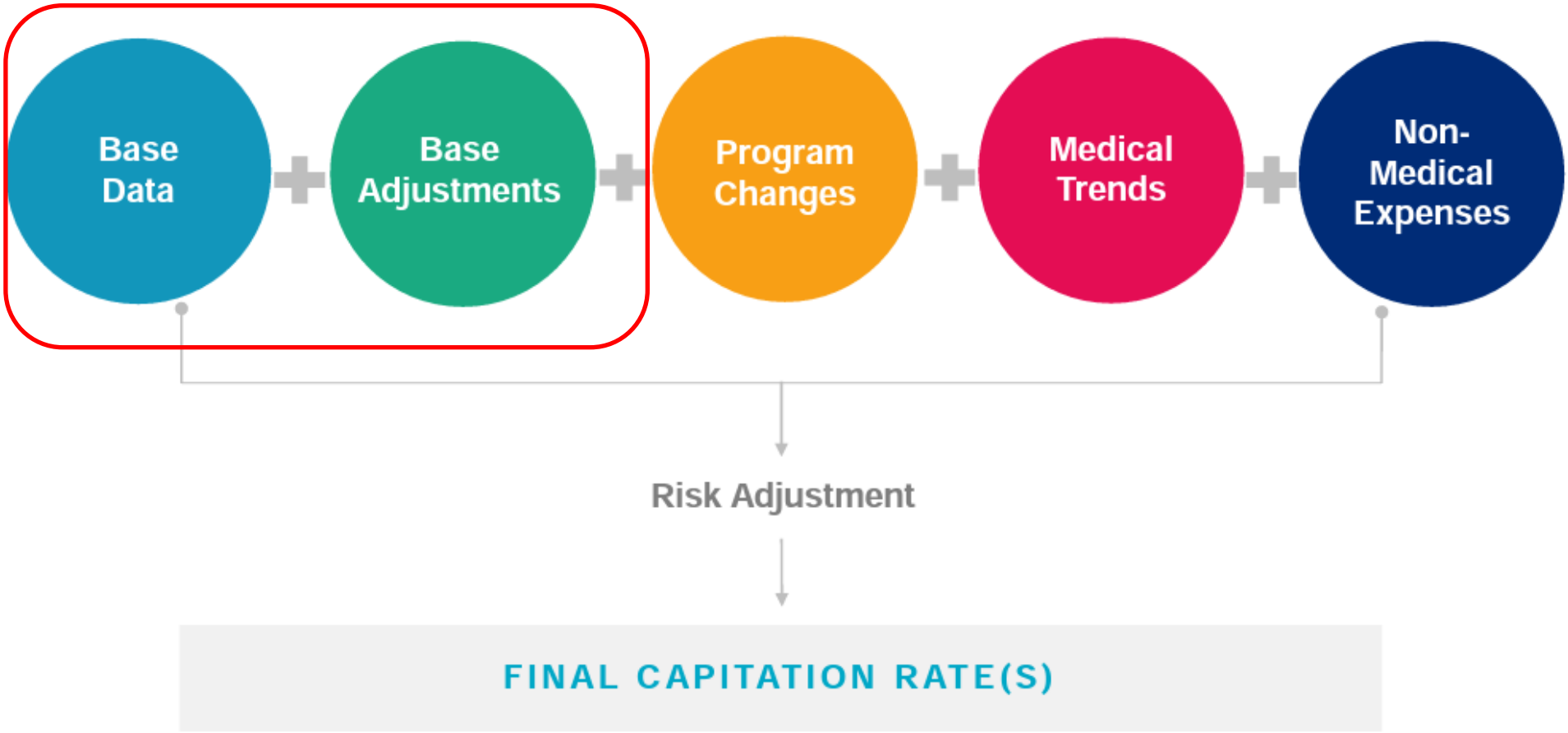
 Source: Mercer FY23 capitation categories of service, retrieved March 2, 2023

FY23 Capitation decomposition

Category of Service	CCC Plus	Medallion and FAMIS	Total Projected FY2023 Dollars	Percent
Pharmacy	$ 917,658,755	$ 1,337,383,197	$ 2,255,041,952	16.08%
Nursing Facility	$ 1,672,234,002	$ -	$ 1,672,234,002	11.93%
Inpatient-Other	$ 594,855,794	$ 750,356,208	$ 1,345,212,002	9.60%
Community Behavioral Health	$ 567,797,725	$ 590,056,968	$ 1,157,854,693	8.26%
Outpatient-Other	$ 400,210,242	$ 755,754,658	$ 1,155,964,899	8.25%
Admin	$ 362,339,871	$ 543,860,906	$ 906,200,776	6.46%
Physician-Evaluation & Management	$ 191,936,442	$ 662,344,058	$ 854,280,500	6.09%
Personal Care Agency-Personal Care	$ 579,029,822	$ -	$ 579,029,822	4.13%
Outpatient-ER	$ 108,480,464	$ 390,965,038	$ 499,445,501	3.56%
Consumer Directed-Personal Care	$ 397,306,862	$ -	$ 397,306,862	2.83%
Physician-Other	$ 133,621,903	$ 245,754,413	$ 379,376,316	2.71%

 Source: Mercer FY23 capitation categories of service, retrieved March 2, 2023

Capitation Development



Source: Actuarial Rate Setting 101 from March 1, 2019, https://www.dmas.virginia.gov/media/1864/actuarial-rate-setting-101.pdf

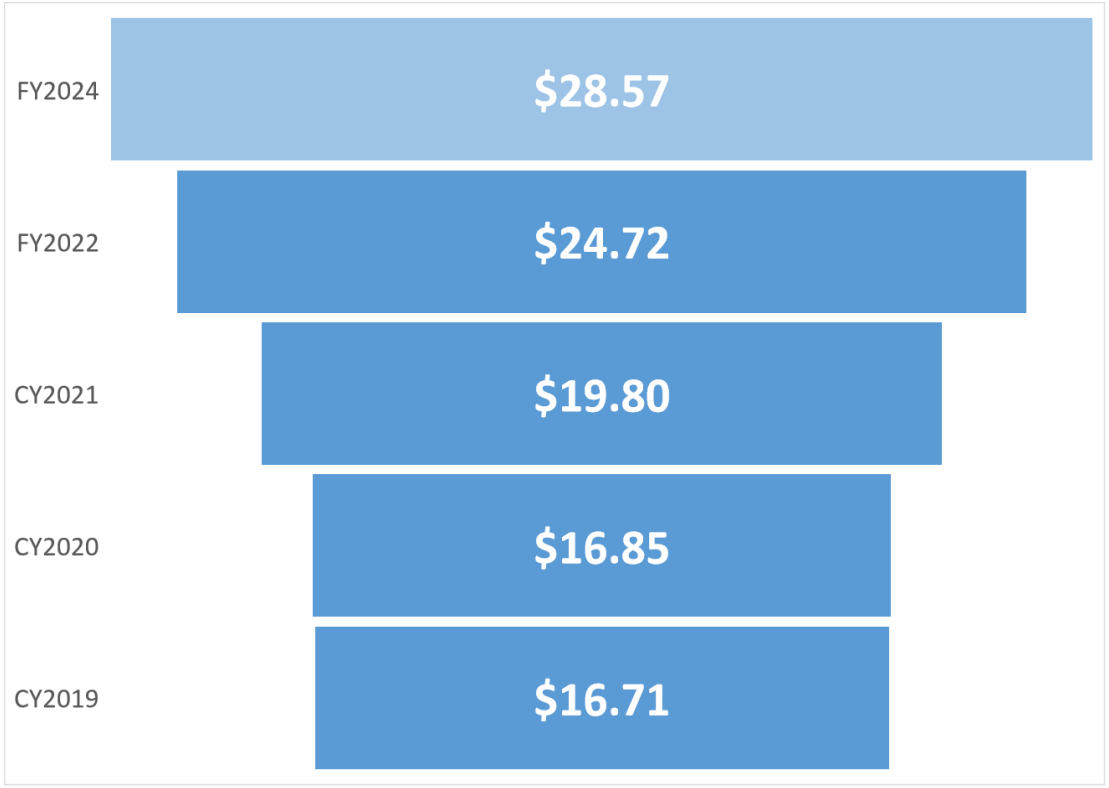
FY24 Capitation Development

- Measurement period:
  - January 1, 2021 through June 30, 2022
  - 1st time since Covid19 that DMAS utilizing claims data within pandemic for base, not just trending

- Key initial base data observations:
  - Significant reduction in community behavioral health: child, adult, expansion
  - Cardinal Care Acute: overall drop of 8.7% PMPM
  - Cardinal Care LTSS: overall increase of 3.2% PMPM

 Source: Mercer FY24 Base Data retrieved February 8, 2023

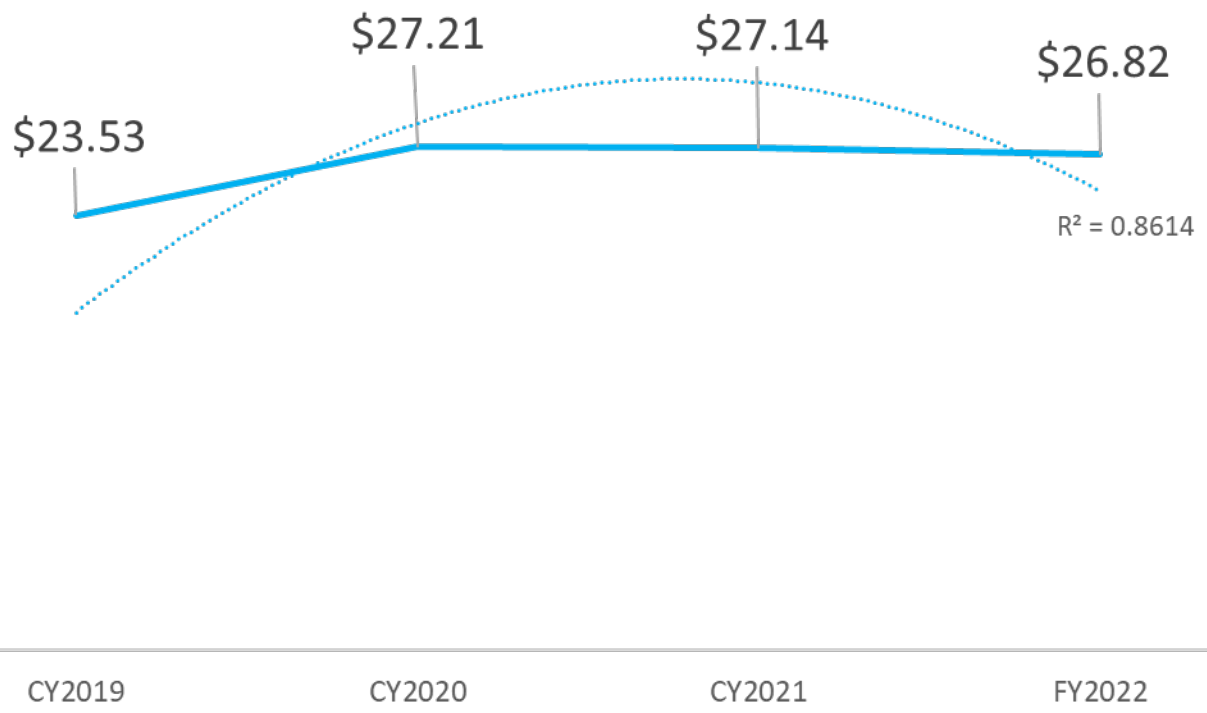
FY24 Trending select data—Base Child



Base Child “Other Professional”

 Source: Mercer FY24 Trending Base Data retrieved March 1, 2023

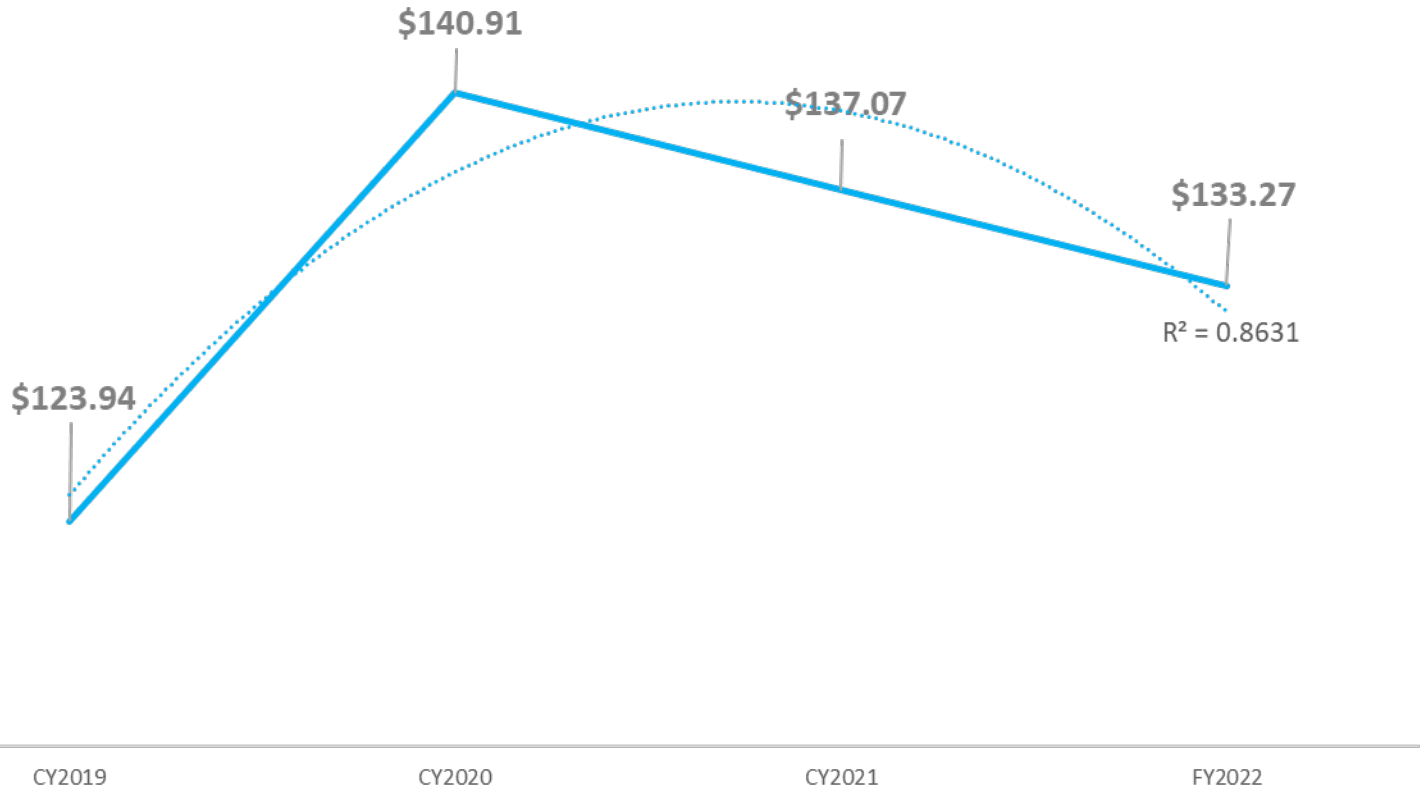
FY24 Trending select data—Base Adult



Base Adult “ARTS”

 Source: Mercer FY24 Trending Base Data retrieved March 1, 2023

FY24 Trending select data—Expansion



Expansion “Pharmacy”

 Source: Mercer FY24 Trending Base Data retrieved March 1, 2023

CY23 Capitation Payment Timing

Capitation Payments

Remit Schedule During eFMAP Quarterly Step-Down

Typical Capitation Process	Accelerated Base, FAMIS & MCHIP Cap Pmt
03/03/23	
04/07/23 →	03/31/23
05/05/23	
06/02/23	
07/07/23 →	06/30/23
09/01/23	
10/06/23 →	09/29/23
11/03/23	
12/01/23	
01/05/24 →	12/29/23

$29M cost

$129M savings

~$100M savings in general fund to Commonwealth

 Source: 2023 Amendments to the 2022 Appropriation Act (*proposed*)

Summary

- Medicaid Title XIX Expenditures **increased 15%** over last year
- Overall Medicaid enrollment **slowing by 1,560 less members** each month compared to average growth over last four years
- ACA Childless Adults on forecast, **slowing by 1,607 less members** each month compared to average growth over last four years
- FY24 capitation rate work under development—draft initial rates to DMAS by end of March

VIRGINIA MEDICAID UNWINDING:
ENDING CONTINUOUS COVERAGE REQUIREMENTS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DEPARTMENT OF SOCIAL SERVICES

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

VIRGINIA'S MEDICAID PROGRAM DMAS

CardinalCare Virginia's Medicaid Program

COVER VIRGINIA

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

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.

- On December 23rd, 2022, the 2023 Consolidated Appropriations Act was passed (an omnibus spending bill to fund the federal government for FY 2023). The legislation included the decoupling of the continuous coverage requirements for Medicaid from the COVID-19 federal PHE.

- **Starting April 1st, 2023, states will be required to redetermine eligibility for nearly all Medicaid enrollees.** As of 01/05/2023, Virginia will be responsible for redetermining 2,137,977 members within 1,231,705 cases – one third of all cases are expected to be redetermined automatically, with the remaining cases to be redetermined by local Departments of Social Services.
  - DMAS is working to obtain vendor support to supplement local agency efforts.

Source: FFCRA §6008(b)(3); SHVS, Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates.

Financial Elements Related to the PHE and Unwinding

- With the Federal omnibus bill passage, the enhanced Federal Medical Assistance Percentage (FMAP) would be ramped down as follows –

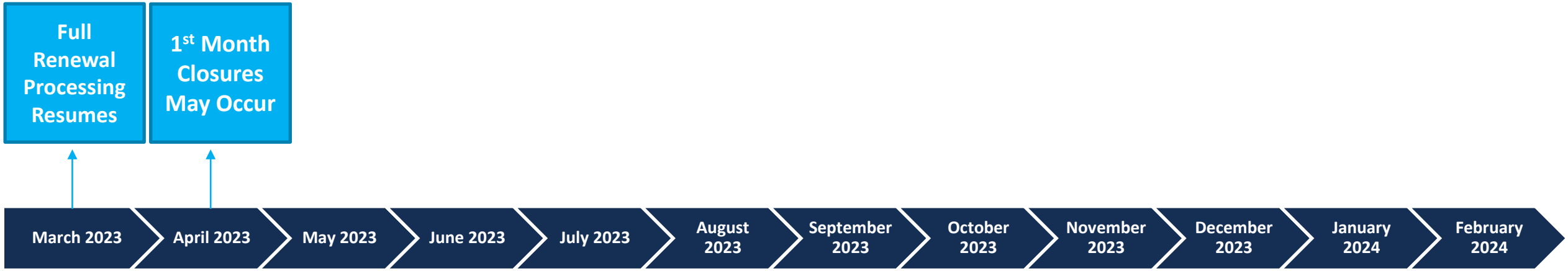
Calendar Year Quarter	Medicaid Enhanced FMAP
Q1 2023 (January – March)	6.2%
Q2 2023 (April – June)	5%
Q3 2023 (July – Sept)	2.5%
Q4 2023 (October – December)	1.5%

- Virginia has received nearly $2.5 billion in additional federal funds throughout the pandemic.

- DMAS also received $15 million in American Rescue Plan Act (ARPA) funding to assist with unwinding related work, including but not limited to system enhancements, temporary staffing, and communications/outreach. DMAS has requested an additional $20 million in ARPA funding and $3.3 million in general funds approval from the General Assembly in the 2023 session to assist with redetermination efforts through the Cover Virginia vendor.

Redetermination Processing Timeline

Closures from redeterminations may not occur prior to the month after the continuous coverage requirement ends. Redeterminations will be initiated over a 12-month period to ensure an even distribution of overdue renewals combined with currently due renewals, and a sustainable workload for local agencies in future years. In addition, CMS allows states an additional two months for all clean up work in order to align with federal processing requirements.



March 2024: Month 13

Clean-up & Complete Outstanding Unwinding Issues

April 2024: Month 14

Clean-up & Complete Outstanding Unwinding Issues

May 2024

Regular Work Resumes

Preparations to Resume Normal Operations

In mid-2020, shortly after the PHE declaration, preparations for resuming normal operations began. Much of this work will require teams to pivot to finalize the changes and undo temporary policies and procedures to revert to normal operations.

System Updates – Increased Automation (VaCMS & MES)

20 Changes Implemented

3 Changes in Progress

Clean Up & Pre-Unwinding Processes

5 New or Updated Processes Implemented

Stakeholder Outreach/Engagement

4 Toolkits
18 Outreach Templates
65 Provider Memos Issued
2 PHE Website Pages

Member Outreach/Engagement

1 million + Letters Mailed
1 Social Media Campaign
Radio Campaign in 5 Regions
3 PHE Website Page
1 Television Campaign

Training

7 Trainings Developed

Policy Flexibilities

9 Flexibilities Made Permanent

Unwinding Waivers

7 Waivers Submitted & Approved

Temporary Flexibilities

116 Total Implemented
(74: Ended, 42: in Progress)

Community Outreach and Engagement Strategies

Phase I: March 2022

Phase II: Feb 2023

Phase III: April 2023

Phase I Purpose:

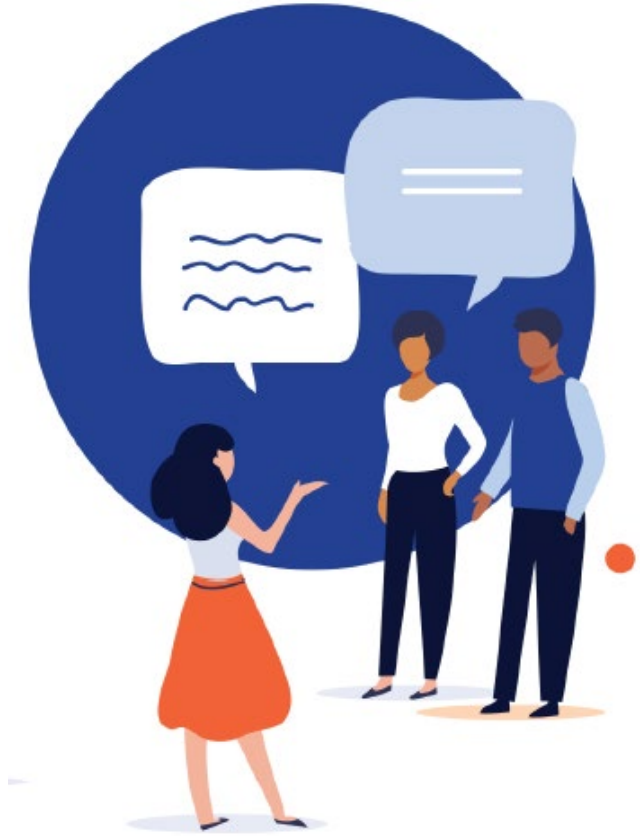
- Encourage members to update contact information
- Campaign began in March will run throughout unwinding
- All stakeholder participation

Phase II Purpose:

- Encourage members to complete needed paperwork
- Campaign will run Feb 2023- Jan 2024
- All stakeholder participation

Phase III Purpose:

- Encourage members who lose coverage for administrative reason to complete needed paperwork
- Campaign will run April 2023-June 2024
- Primarily health plan participation & Marketplace navigators



January – March 2023: What to Expect

DMAS and DSS have been working for almost 3 years to prepare for unwinding, which is considered the biggest health care related event since the implementation of the Affordable Care Act. With the April 1st start date approaching, DMAS and VDSS will now begin to implement the planned activities in order to support members, local agencies, providers, and other stakeholders both before and throughout the unwinding period.

- Systems: Turning off processes designed to continue coverage and turning on regular processes such as sending paper renewal forms. In addition, several new automated processes will be turned on to allow additional no-touch renewals and/or applications.
- Communications/Outreach: Phase II and III toolkits are available on the Cover Virginia/Cubre Virginia website and have been distributed to health plans to prepare for outreach.
  - Health plans will assist in outreach when the automated ex parte is unsuccessful and if members are closed for administrative reasons to attempt to decrease instances of churn.
  - Note: Certain provider flexibilities not related to eligibility processes remain in effect until the end of the PHE on May 11, 2023.
- Contractor Support: DMAS has developed a new scope of work to supplement local agencies with vendor support through Cover Virginia. DMAS is currently working to implement this solution.

Questions?

Thank you to all partners across the Commonwealth who are working to support the efforts to ensure a smooth transition back to normal processing.

APPENDIX: TOWN HALLS & PHE FLEXIBILITIES

Virginia Medicaid Unwinding Town Halls/ Listening Sessions: What You Need To Know

The Families First Coronavirus Response Act directed states to maintain Medicaid health coverage for individuals enrolled on or after March 18, 2020, regardless of changes in their circumstances through the end of the COVID-19 Public Health Emergency. Recent federal guidance in the 2023 Consolidated Appropriations Act ends this continuous coverage requirement on March 31, 2023. In March of 2023, the Department of Medical Assistance Services and the Department of Social Services will resume full redeterminations of Medicaid eligibility, with the first closures occurring on April 30, 2023. Over the course of 12 months, redeterminations will be initiated for all 2.2 million Virginians enrolled in Medicaid. We invite all of our community partners, stakeholders, and community members to join us as we share information about how resuming to normal operations will impact members and how Medicaid partners can assist during the transition.

SESSION (BY AUDIENCE)	DATE	TIME
Medical Providers and Medical Advocates	2/28/2023	7:30 AM
Senior Programs	3/2/2023	9:00 AM
Advocates and Community Leaders	3/6/2023	6:00 PM
Home Health Associations	3/7/2023	6:00 PM
Nursing Facilities	3/13/2023	12:00 PM
General Session - Everyone	3/13/2023	6:00 PM

SCAN FOR MORE INFO

VIRGINIA'S MEDICAID PROGRAM DMAS

Public Health Emergency (PHE): Impact to Other Flexibilities

The Commonwealth implemented a variety of policies in 2020 in response to the needs of members and providers as they confronted the COVID-19 pandemic. The remaining flexibilities will end on one of two dates, depending on the vehicle used to obtain federal authority.

- **Expiration of Flexibilities:**
  - 18 flexibilities ending on May 11, 2023, at midnight.
  - Four flexibilities ending November 10, 2023 (six months after the end of the PHE)

- **A full list of the flexibilities and their end date can be found on the DMAS website at: COVID-19 Public Health Emergency Flexibilities, Updated February 13, 2023 (virginia.gov).**

Regulatory Activity Summary March 14, 2023
(* Indicates Recent Activity)

2023 General Assembly

***(01) Provider Appeals:** The purpose of this regulatory action is to clarify when documents are considered filed and adds the Appeals Information Management System (AIMS) to the Virginia Administrative Code in accordance with the DMAS current provider appeals practices. Following internal review, this project was submitted to the OAG on 2/1/23.

***(02) Former Foster Care Youth:** The state plan is being revised to change eligibility requirements for former foster care children in accordance with section 1 002(a) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act") and the Centers for Medicare and Medicaid Services (CMS) State Health Official (SHO) letter #22-003. Per the SUPPORT Act and the SHO letter, states must modify eligibility requirements for former foster care children under age 26 who were in foster care when they transitioned to independence as adults, or "aged out" of foster care. This SPA, following internal review, was submitted to CMS for review on 3/9/23.

***(03) Resource Disregard:** DMAS did not increase the patient pay amount for individuals receiving long-term care services during the federal public health emergency in accordance with the "Maintenance of Effort" rules. Some individuals who are receiving long-term care services may have had increases in income during the PHE, and these normally would have resulted in an increase in patient pay amounts. Since DMAS did not increase the patient pay, some members may have retained this income increase during the PHE. When the PHE is over, some of these individuals could lose Medicaid eligibility due to their increases in income as the accumulated resources could put them over the applicable limit if DMAS does not make any changes to eligibility rules. DMAS is filing this SPA with CMS to officially notify CMS of the non-collection of increased patient pay, retroactive to the start of the federal public health emergency. This SPA is being submitted in accordance with the 2022 Appropriations Act, Item GGGG, which instructs DMAS to file a SPA to "exclude excess resources accumulated by individuals receiving long-term supports and services (LTSS) during the federal Public Health Emergency (PHE) …". Following DPB approval on 1/4/23, the SPA was forwarded to HHR and approved on 1/12/23. The SPA was submitted to CMS on 2/6/23.

***(04) Repeal of Out-of-Date and Unnecessary Regulations:** This regulatory action is required in accordance with Governor Youngkin's Executive Order #19. DMAS has completed an internal review of these regulations and has determined that all of the content already exists in the DMAS Eligibility and Enrollment Manual on the DMAS webpage, and that these regulations are redundant and unnecessary, and should be repealed. Following internal review, the project was submitted to the OAG for review on 1/30/23.

***(05) OTC Drugs:** This SPA is required based on the CMS' request for Virginia to change the language related to over-the-counter (OTC) drugs. CMS asked DMAS to include the following sentence in order to indicate where a list of OTC drugs could be located: "A list of specific covered drug categories is published in Chapter 4 of the Pharmacy Provider Manual." With

this new language, DMAS no longer needs, and proposes deleting the following language: "2. Non-legend drugs shall be covered by Medicaid in the following situations: a. Insulin, syringes, and needles for diabetic patients; b. Diabetic test strips for Medicaid recipients under 21 years of age; c. Family planning supplies; d. Designated categories of non-legend drugs for Medicaid recipients in nursing homes…" (These items will remain covered, but they will be stated with specificity in the Pharmacy Manual and do not need to be repeated in the state plan.) CMS also asked that Virginia remove language related to home infusion therapy from the pharmacy section of the state plan. That language is already in the durable medical equipment section of the state plan, so removing the language from the pharmacy section has no practical effect. The project is currently circulating for internal review.

***(06) Average Commercial Rate for Physicians Affiliated with Type 1 Hospitals:** In accordance with the 2022 Appropriations Act, Item 304.B(4), DMAS "… shall have the authority to amend the State Plan for Medical Assistance to increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate [ACR] as demonstrated by University of Virginia Health System and Virginia Commonwealth University Health System…". In addition, this SPA will satisfy the DMAS requirement to recalculate the ACR every three years. The last ACR is dated April 1, 2020, and CMS requires DMAS to submit a new ACR calculation effective April 1, 2023. The SPA is currently circulating for internal DMAS review.

2022 General Assembly

(01) Removal of Cost Sharing: The purpose of this regulatory action is to remove co-payments for Medicaid and FAMIS enrollees in accordance with a General Assembly mandate. The 2022 Appropriations Act, Item 304.FFFF, required DMAS to remove co-payments for Medicaid and FAMIS enrollees effective, April 1, 2022. DMAS has not been imposing co-payments on Medicaid and FAMIS members during the federal public health emergency (PHE) related to the Coronavirus Disease 2019 (COVID-19) pandemic. However, as of a result of 2022 Appropriations Act, Item 304.FFFF, co-payments have been permanently removed and they will not be reinstated after the federal PHE ends. The project is currently circulating for internal review.

***(02) 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.

***(03) Medicaid Works:** In accordance with Item 313.WWWW of the 2020 Appropriations Act, this state plan amendment will allow DMAS to increase the income eligibility for participation in the Medicaid Works program to 138 percent of the Federal Poverty Level. Medicaid Works is a program that offers individuals with a disability who are employed, or who want to go to work, the ability to earn more income and save more of their earnings than otherwise allowed by Medicaid rules. Medicaid Works allows individuals to keep their health coverage from Virginia Medicaid while they work and gain greater independence. Following internal review, the SPA was submitted to CMS on 1/17/23 and was subsequently withdrawn on 2/28/23.

***(04) 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.

(05) Program of All-Inclusive Care for the Elderly II: This SPA will allow DMAS to update sections of the state plan that pertain to the Program of All-Inclusive Care for the Elderly (PACE) to align with the Department's current practices pursuant to the Code of Virginia, state regulations, and federal regulations. This project is currently circulating for internal review.

(06) Application Update: CMS requires state Medicaid agencies to submit the full set of their Medicaid application materials for review whenever there are changes to the application. DMAS is submitting a SPA to CMS to request approval for two changes to the Medicaid application: 1) update the pregnancy related question from 60 days to 12 months to align with Virginia's postpartum extension; 2) add language for MCO pre-selection for those that are found eligible for FAMIS. These changes will allow the Medicaid application to reflect current DMAS procedures and Virginia eligibility policy. Following internal review, the SPA was submitted to CMS on 12/13/22 and approved on 1/9/23.

***(07) 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. The corresponding reg project began circulating for internal review on 1/25/23.

(08) Institutional Provider Reimbursement Changes: The 2022 Appropriations Act requires DMAS to make several institutional (inpatient and long-term care) changes to the state plan. Following internal review, the SPA was submitted to CMS for review on 9/2/22. The SPA was approved by CMS on 11/23/22. The regulatory review phase of the project is currently underway.

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

Programs for review on 8/19/22. The SPA was submitted to CMS for review on 9/19/22. A request for additional information (RAI) was received from CMS on 12/14/22. Draft RAI responses were sent to CMS for review on 1/19/23 and the final RAI response was forwarded to CMS on 2/17/23. DMAS is awaiting further direction.

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

(11) 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; and to HHR on 11/16/22.

2021 General Assembly

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

(02) Personal Care Rate Increase: This state plan amendment updates the date of the personal care fee schedule on January 1, 2022, in accordance with Item 313.SSSS.3 of the 2021 Appropriations Act. (A corresponding rate increase of 12.5% will be provided for personal care services and for companion and respite services provided under home and community-based

waivers, however, the increase is not included in a state plan amendment but via waiver documentation.) Following internal review, the SPA was submitted to CMS on 12/13/21 and approved on 4/28/22. The corresponding regulatory 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.

(04) Update to Outpatient Practitioners: The purpose of this action is to add licensed school psychologists to the list of allowed providers of outpatient psychiatric services. Several of Virginia's Child Development Clinics have identified the need to allow licensed school psychologists to bill for outpatient psychiatric services provided in their clinics to increase access to the number of children that they serve. Following internal review, the project was submitted to the OAG on 8/27/21. OAG questions were received on 11/10/21 and DMAS submitted responses to the OAG on 11/12/21. DMAS made Town Hall corrections on 11/16/21. DMAS responded to additional OAG questions on 2/7/22 and 2/8/22 and made project revisions on 2/11/22. The regulatory action was approved by the OAG on 2/22/22 and submitted to DPB on 2/23/22. DPB inquiries were received on 2/24/22 and DMAS sent responses to DPB on 3/2/22, 3/15/22, and 3/15/22. The regs were certified by DPB on 4/5/22. The project was submitted to the Secretary's Ofc. on 4/6/22. An Agency response to the Economic Impact Analysis (EIA) was posted on 4/12/22. The project was forwarded to the Gov. Ofc. for review on 6/17/22. The Gov. Ofc. approved the project on 9/21/22. The project was submitted to Registrar on 9/21/22, with a public comment forum from 10/24/22 thru 11/23/22. The regulations became effective on 12/8/22.

***(05) Consumer-Directed Attendants:** This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer-directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed

model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. DMAS reached out to the OAG to re-engage this project. The OAG sent additional revisions/questions on 9/12/22. DMAS 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 has placed the project on hold to review General Assembly outcomes to determine if pending legislation (SB 886) would impact this regulation.

***(06) Client Appeals Update:** This regulatory action seeks to comply with a 2021 General Assembly mandate that requires DMAS to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of documents and decision deadlines for de novo client hearings. Following internal DMAS review, the reg action was submitted to the OAG on 7/23/21; to DPB on 1/14/22; and to HHR on 1/27/22. The project moved the Gov. Ofc. on 7/13/22 and was approved by the Governor on 9/2/22. The regulations were sent to the Registrar on 9/6/22; were published in the Register on 9/26/22, and will be in effect until 3/7/24.

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

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

to the OAG for review on 9/28/21. The OAG sent additional question on 10/7/21 (DMAS response provided on 10/12/21) and 10/12/21 (DMAS response provided on 10/13/21). These regulations are currently on hold.

(09) 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.

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

2020 General Assembly

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

***(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.

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

2017 General Assembly

(01) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory

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

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. The project has again been placed on hold.

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.