



BOARD OF MEDICAL ASSISTANCE SERVICES



Tuesday, June 14, 2022
10:00 AM BMAS Meeting

Meeting will be held both in-person and virtually

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

To Join Meeting Virtually
https://covaconf.webex.com/covaconf/j.php?MTID=mfb599ac65b398c22dc112894ae9f5fff
Meeting # (Access Code): 2434 744 3076
Dial in (Phone): US Toll Free: +1-866-692-4530 US Toll: +1-517-466-2023
Remote Conference Captioning Link: https://www.streamtext.net/player?event=HamiltonRelayRCC-0614-VA3493

AGENDA

#	Item	Presenter
1	Call to Order	Mr. Michael Cook
2	Introduction of New Board Members	Mr. Michael Cook
3	Approval of 03/08/2022 BMAS Draft Minutes	Mr. Michael Cook
4	Vote on Bylaw Amendment: 2.7 Electronic Participation in Meetings	Mr. Davis Creef, Board Counsel
5	Director's Report	Ms. Cheryl Roberts – DMAS Acting Director
6	Medicaid Public Health Emergency (PHE) Unwinding Update	Ms. Sarah Hatton – Deputy of Administration
7	MES, General Assembly and Budget – Update	Mr. Chris Gordon – Deputy of Finance and Technology
8	Medicaid Managed Care Organization & Social Determinants of Health	Ms. Tameeka Smith – Chief Executive Director – United Health Care Mr. Randy Ricker – Plan President – Optima Health
9	SUD/ SUPPORT Act Grant Update	Ms. Ashley Harrell - ARTS Senior Program Advisor

10	New Business/Old Business	Mr. Michael Cook
11	Regulations	Board Review Prior to Meeting – Questions as Needed.
12	Break for Lunch	
13	Policy Discussion (12:30 pm – 2 pm) a. Medicaid Budget 101	Ms. Ashley Gray – Subcommittee Chair Mr. Chris Gordon – Deputy of Finance and Technology
14	Adjournment	Mr. Michael Cook

DRAFT BMAS MINUTES

Tuesday March 8, 2022

10:00 AM

Present: Michael H Cook Esq., Chair; Ashley Gray; Maureen S Hollowell; Patricia T Cook, MD; Greg Peters; Kannan Srinivasan, Vice Chair; and Elizabeth Noriega

Virtual Attendance: Dr. Basim Khan, and Raziuddin Ali, MD

Absent: Elizabeth Coulter and Peter R. Kongstvedt, MD

DMAS Staff Present:

Davis Creef, Legal Counsel for the Board, Office of the Attorney General

Karen Kimsey, DMAS Director

Sarah Hatton, Deputy Director of Administration

Mariam Siddiqui, Senior Operations Advisor

Richard Traylor, Senior Finance & Technology Compliance Advisor

Brian McCormick, Director of Legislation and Intergovernmental Affairs

Rich Rosendahl, Chief Health Economist

Cheryl Roberts, Deputy Director of Programs

Christina Nuckols, Director of Strategic Communications

Chris Gordon, CFO

Will Frank, Senior Legislative Affairs Advisor

Ivory Banks, Chief of Staff

Natalie Pennywell, Outreach & Community Engagement Manager

Tammy Whitlock, Deputy Director of Complex Care

Emily McClellan, Director of Policy, Regulation, and Member Engagement

Nancy Malczewski, Public Information Officer

Dorothy Swann, Public Information Officer

Guests:

The Honorable John Littel, Secretary of Health and Human Resources

1. Call to Order

Meeting was called to order at 10:03 a.m.

2. Introductions

DMAS Director, Karen Kimsey, introduced Secretary John Littel

Then Michael Cook asked that everyone introduce themselves.

Secretary Littel spoke briefly about the 2022 legislative session, noting that human services are often subject to budget cuts, but this year there are more resources, and so HHR can begin to act on issues that they've been wanting to address for many years. He also noted that the Agency's vision for Medicaid program should include best in class services, best in class outcomes and best in class stewardship of tax payer dollars.

Michael Cook asked for a moment of silence for solidarity for the Ukrainians.

3. Approval of Minutes

Approval of November 30, 2021 Minutes

Motioned by Greg Peters; seconded by Patricia Cook, MD to approve.

Motion Passed: 7 - 0

Voting For: Michael Cook, Esq.; Maureen Hollowell; Ashley Gray; Greg Peters;
Elizabeth Noriega; Patricia Cook, MD; and Kannan Srinivisan
Voting Against: None
Unanimous approval

4. Election of Officers

For the election of officers, Brian McCormick moderated the election and had each member vote one by one signifying by saying “aye” or “nay.” Because of state “open meeting laws,” the votes of those participating virtually could not be counted since they were not physically present.

Michael Cook was nominated by Kannan Srinivasan for the Board Chair, the motion was seconded by Maureen Hollowell. Hearing no further nominations, the nominations were closed. The vote was taken.

Voting “aye,” Kannan Srinivisan; Patricia Cook, MD; Elizabeth Noriega; Greg Peters;
Maureen Hollowell; Ashley Gray; and Michael Cook
Voting Against: None
Unanimous approval (7 – 0)

Kannan Srinivisan was nominated by Michael Cook for the Board Vice Chair, the motion was seconded by Greg Peters. Hearing no further nominations, the nominations were closed. The vote was taken.

Voting “aye,” Michael Cook; Maureen Hollowell; Ashley Gray; Greg Peters; Elizabeth
Noriega; Patricia Cook, MD; and Kannan Srinivasan
Voting Against: None
Unanimous approval (7 - 0)

Even though Brooke Barlow was not at the meeting, due to a special assignment, she was nominated by Michael Cook for Board Secretary; the motion was seconded by Ashley Gray. Hearing no further nominations, the nominations were closed. The vote was taken.

Voting “aye,” Michael Cook; Maureen Hollowell; Ashley Gray; Greg Peters; Elizabeth
Noriega; Patricia Cook, MD; and Kannan Srinivasan
Voting Against: None
Unanimous approval (7 - 0)

4. Director's Report – Karen Kimsey

Medicaid Enterprise System (MES) Update:

Director Kimsey explained we were upgrading our systems from a single system to a modular system that can more easily adapt to change while supporting our Agency's mission. Additionally, an April 4th implementation is still on track for fee for service providers in Phase 1 and managed care network providers, beginning June 2022 in Phase 2.

Director Kimsey provided an overview of the various training resources available for providers, staff and stakeholders as a part of Operation Readiness.

Additionally, Director Kimsey spoke about the five-day MMIS outage, March 30th – April 3rd, necessary for execution of key pre-launch steps, reviewed the agency functions impacted and DMAS mitigation efforts relating to contingencies and COOP execution.

5. Budget Report – Chris Gordon, CFO

Chris Gordon presented a slide deck that described DMAS' key fiscal metrics:

- Prompt Pay to Medicaid Providers
- Agency Small, Women, and Minority contracts (SWAM)
- Fiscal Year 2022 Appropriations (\$17.8 billion)
- Medical Spend (through Jan. '22 - \$1,030,661,467)
- MCO Expenditures and Performance
- American Rescue Plan Act (ARPA) Va. Funding – \$1K bonus for home health care workers, 12.5% HCBS rate increases, \$5 per diem for NFs, and \$15M to address the Enrollment & Eligibility backlog
- Budget Amendments from the 2022 General Assembly (DMAS tracking 39 mandates)
- MES Schedule Performance Index – all systems go!

6. Legislative Report – Will Frank, Senior Advisor for Legislative Affairs

Will explained his role as it relates to the GA session

- Monitor legislation and review every bill
- Flag bills important to DMAS
- Review legislation, language and budget for the Secretary and Governor
- Communicate the positions of the Secretary and Governor to the General Assembly
- Provide expert testimony and technical assistance to legislators

DMAS was assigned 21 bills out of just under 3000 introduced. At the time of meeting, 11 were alive and ten had failed. Twenty three comments were made to other agencies' bills and another 82 were tracked. Other key bills discussed included HB241, HB680, HB800, HB987, SB231, SB426, SB594, SB663, HB925 and SB405.

7. Report on “Unwinding” – Sarah Hatton and Natalie Pennywell

Sarah Hatton presented a slide deck providing a thorough explanation of the federally mandated process DMAS must follow to redetermine Medicaid eligibility for all members in the year following the close of the federal COVID-19 Public Health Emergency (PHE). The key point is that states are required to maintain enrollment of all Medicaid members until the end of the PHE, including the “continuous coverage” of members requirement. In the next 12 months DMAS must redetermine every Medicaid member’s eligibility status. To prepare for this massive effort, DMAS has developed a detailed plan for the 12-month staged review, implement IT systems automation to quickly and efficiently process eligibility renewals, and significantly augmented eligibility DMAS staff to handle the several million renewals to complete the unwinding. In addition, DMAS significantly enhancing its outreach & stakeholder engagement process to ensure that the Agency has contact information for all members, in order to provide essential notice and access to eligibility staff.

Break for lunch

8. New Business/Old Business

Old Business – ByLaws Amendment – 2.7 Electronic Participation in Meetings

Michael Cook noted that we started another amendment to the Board of Medical Assistance Services (BMAS) Bylaws at the last meeting and asked Davis Creef to take over the meeting. Davis Creef noted that this was discussed generally at the last meeting.

The proposed ByLaws Amendment language of 2.7 Electronic Participation in Meetings was previously brought forth, but there was controversy of some language in item 4. The language in red was submitted to be reviewed by the Board.

This would allow remote participation under certain circumstances by board members, it basically follows language found in the Virginia Code; and there was concern at the last meeting it might require a board member to disclose medical information if they were participating remotely due to a permanent or temporary disability or another family member's medical condition.

As seen, the red text was added to make it clear. There is no requirement in the Code that the specific medical condition be disclosed, which is different than a board member is participating remotely for a personal matter. Personal matters must be disclosed with specificity. Assuming that the board is okay with this language, it will be brought up at the next meeting and be voted for official adoption into the Bylaws at that time. It is a two-step process for an amendment.

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

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

Procedure for Approval:

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

Michael Cook asked if there was any discussion on the language or if everyone approved. No one had any comments; therefore, the approved language will be voted on at the next meeting.

9. Regulations – Emily McClellan

Emily McClellan provided the BMAS members a Summary of the Agency's regulatory activity. Ms. McClellan provided an extensive list of all DMAS regulations currently in the public promulgation process, noting the following groups of regulations by General Assembly year:

2022 - 5 packages
2021 - 25 package
2020 – 5 packages
2019 – 1 package
2018 – 2 packages
2017 – 1 package
2015 – 1 package

10. Regulatory 101 – Emily McClellan

The Policy Division is charged with following and pursuing the regulatory processes to make sure DMAS gets its regulations in place. Regulations are needed when there is a "pay or no pay

decision” involved and if there is an “adverse decision” -- is a provider going to get paid for a service and is a member going to be able to benefit from services that are reimbursed by Medicaid.

We work within the Virginia framework, which applies to all state agencies and requires that: 1) regulations involve the least possible intrusion into the lives of the citizens of commonwealth; 2) regulations are necessary to protect public health, safety and welfare; and 3) that agencies actively seek input from stakeholders on planned regulatory changes.

DMAS has general authority to develop or amend regulations. DMAS does not need a specific grant of authority from the General Assembly unless there is a cost associated with the change – then a legislative mandate is needed.

The Virginia Code delegates authority to the Agency Director; the Director may sign off on regulatory packages.

There are several types of regulatory actions. There are two three-stage processes and two one-stage processes.

The “typical” three-stage processes typically take three years from beginning to end. Once the notice of intend regulatory action is signed by the DMAS Director, it goes to the Office of the Attorney General for its review; then to the Department of Planning and Budget. Then it goes to the Secretary of Health and Human Resources; then to the Governor and then it has a 30-day comment period and then it goes back to DMAS. The second part of the three-stage process goes through all those same steps again, except with a longer comment period. Then there is a third and final stage.

We try to update our Medicaid manuals quickly so those Medicaid manuals serve as our state authority until the regulations can be finalized. A budget item may direct DMAS to move forward with the changes in this budget provision based on federal authority even if the regulations have not yet been promulgated. Then we technically have legislative approval to move forward even though we don't have regulations in place.

Another three-stage process is the Emergency Regulatory process. DMAS must have authority from the General Assembly for an emergency regulation. An emergency regulation goes through all the same stages as the traditional process but the ER goes into effect after ER/NOIRA is finalized, which is typically six to nine months. There are several cautions with emergency regulations: 1) they are temporary and are not added to the Virginia Administrative Code (they last 18 months with one possible 6-month extension) and 2) there is frequently a “gap” between the end of the emergency regulation and the finalization of the permanent regulations.

The Fast Track regulatory process is a one-stage process that can be used if the regulations are not controversial. This process usually takes six to nine months. During the waiting period after publication in the Virginia Register, if there are ten or more objections to Fast Track process, the regulations must be withdrawn and the three-stage process should be initiated.

Final Exempt regulations are another one-stage process, and generally only take three to six months to take effect. A final exempt process may only be used if there is a:

- Federal statutory requirement, or
- Federal regulatory requirement, or
- State budget or statute (within 90 days of enactment) or
- Court order

AND no discretion.

Once the regulations are signed by DMAS director, they go to the OAG, and then are published in the Register. They do not become final until 45 days after publication.

To obtain the authority for a final exempt action, DMAS may submit budget language for the next General Assembly session with wording describing exactly what needs to be accomplished, with no undecided issues or discretion.

11. Adjournment

Michael Cook asked for a motion to adjourn the meeting at 2:00 p.m. Motion to adjourn was made by Kannan Srinivasan; seconded by Greg Peters

Adjourn. Motion Passed: 7 - 0

Voting For: Michael Cook; Maureen Hollowell; Ashley Gray; Greg Peters; Elizabeth Noriega; Patricia Cook, MD; and Kannan Srinivasan

Voting Against: None

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DMAS DIRECTOR'S REPORT TO BMAS

June 14, 2022

Cheryl Roberts
DMAS Acting Director

Agenda

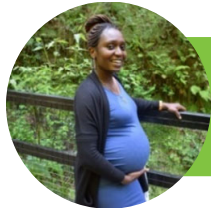
- ❑ Current Enrollment
- ❑ Agency Priorities
- ❑ DMAS returns to 600 E Broad St.

Who Does Medicaid Serve?



Children

832,324



Pregnant Individuals

28,820



Older Adults

84,580



Individuals with Disabilities

153,041



Adults (Including Expansion)

822,825

Medicaid plays a critical role in the lives of over 2 million Virginians

Agency Priorities



**Behavioral
Health**

**Maternal
& Child
Health**

**Coverage and
Redetermination**

LTSS

**Access to
Care**



Priorities

- **July 1, 2023 General Assembly Initiatives**
 - New initiatives, rate increases and studies
 - Win: we were able to quickly resolve concerns
 - Modifying forecast, trends, utilization and contracts
 - There will be program, contracts, and rate delays
- **Unwinding/Redetermination for 2.2 million**
- **Provider Enrollment Module – Hard launch in April 2022**
 - Focus to Improving productivity
 - Need to enroll 30,000 MCO providers into MES portals
- **Earned Credit Release for 4,000 inmates June-July 2022**
 - Working with DOC and DSS on transition and long term solutions

Priorities

- **Maternal and Child Health**
 - Continued work on 12 month post partum (#3 in country)
 - and Community Doula benefit (#4 in country)
- **Long Term Services and Supports**
 - Working to provide \$1,000 COVID support payments for home care aides who delivered agency-directed or consumer-directed personal care, respite care, or companion care services to Medicaid members during the first quarter of the State Fiscal Year (SFY) 2022
- **COVID-19**
 - Vaccinations- need to increase Medicaid vaccination rate beyond 54%
 - VDH/DMAS/MCO collaborative
 - Focus on increasing preventive and acute care
- **Procurements**
- **Compliance and Oversight**
 - Program and financial oversight including dashboards

HEDIS Dashboards

Virginia Medicaid Managed Care HEDIS 2020 Dashboards

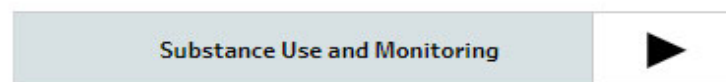
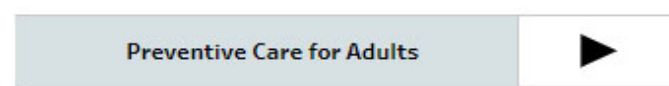
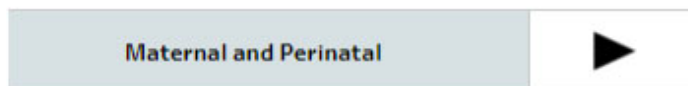
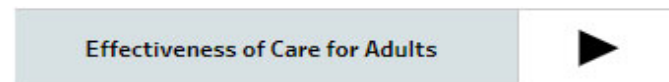
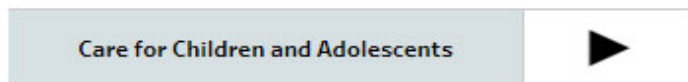
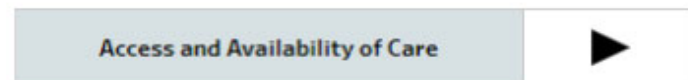
Healthcare Effectiveness Data and Information Set (HEDIS®) is a national standard that is widely used to present performance measures in the managed care industry, collected and maintained by The National Committee of Quality Assurance (NCQA). The purpose of the Virginia HEDIS dashboard is to provide transparency to Virginia Medicaid members and regulatory bodies, while demonstrating accountability to members.

The panel below consists of seven categories of HEDIS measures. Each quality measure is reported by Managed Care Organization (MCO), and includes the state average and national 50th percentile rate. The HEDIS 2020 measures reflected in this dashboard occurred in calendar year 2019.

Click on the preferred category, then choose the measure to view.

HEDIS® is a registered trademark of NCQA.

* Note: Magellan Complete Care was acquired by Molina Healthcare on July 1, 2021.



Monthly Expenditures Dashboard

Medicaid Monthly Expenditures

Selecting either Base Medicaid (Non-Expansion Members) or Medicaid Expansion Members in the Member Type filter below will display that selection only. The Member Type unselected will display None for the Month and Year below.

Member Type
All

Service Category
All

March 2022
Total Expenditures
\$1,580,944,216

March 2022
Base Medicaid Expenditures
\$1,173,927,490

March 2022
Medicaid Expansion Expenditures
\$407,016,726

Monthly Expenditures

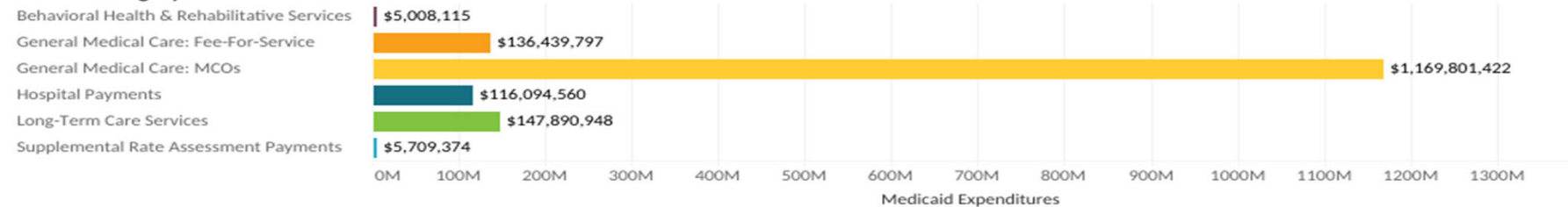
Select a month below to display additional detail



Expenditures by Service Category and Detailed Service Category

Select (+) next to Service Category to display additional details

Service Category



Behavioral Health

Medicaid is the dominate Behavioral Health payer in country

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

Return to the Office July 5, 2002

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

QUESTIONS?



MEDICAID FEDERAL PUBLIC HEALTH EMERGENCY UNWINDING PLANNING

PRESENTATION TO: BOARD OF MEDICAL
ASSISTANCE SERVICES
JUNE 14, 2022

SARAH HATTON, DEPUTY FOR ADMINISTRATION
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



VIRGINIA'S MEDICAID PROGRAM
DMAS

Medicaid and the Public Health Emergency: Background

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

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



Redetermination Processing Timeline

Closures from redeterminations may not occur prior to the month after the PHE ends. Redeterminations must be managed over a 12-month period to ensure an even distribution of overdue redeterminations combined with currently due renewals, and a sustainable workload for local agencies in future years. Assuming a PHE end date of July 15, 2022, normal Medicaid operations would resume in September 2023. As states did not receive 60 day notice for a July 15, 2022 end date, this timeline will shift based on the extension.



Medicaid Unwinding: Current Planning Efforts

Local DSS agencies face a significant increase in Medicaid workloads when the PHE ends. Increased enrollment and the redetermination of over 2 million individuals is expected to have major impacts to call centers, member appeals, and other operational areas within both agencies.

- To address the redetermination effort, DMAS and DSS are working closely to ensure readiness in three major areas:

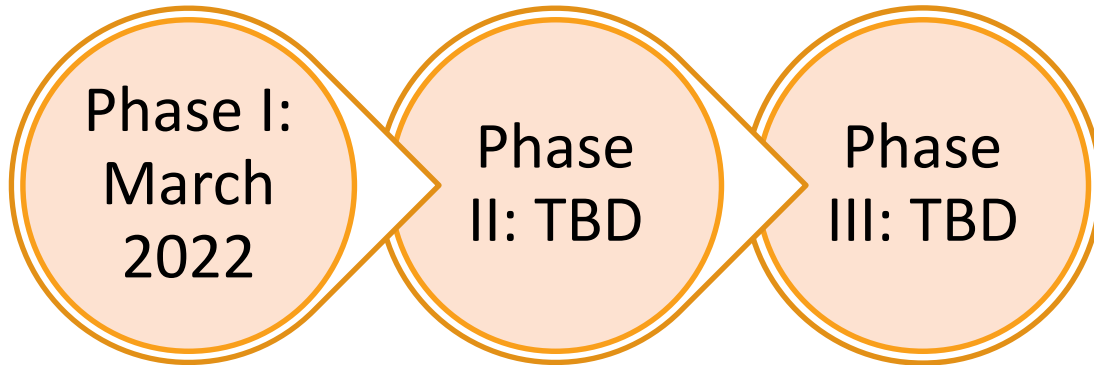
Outreach &
Communication

System
Improvements

Staffing



Community Outreach and Engagement Strategies



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 during the full unwinding period
- All stakeholder participation

Phase III Purpose:

- Encourage members who lose coverage for administrative reason to complete needed paperwork
- Campaign will run during the full unwinding period
- Primarily health plan participation & Marketplace navigators



System Strategies

System improvements to increase automation and no touch processing will be critical to ensure timely and accurate redeterminations while balancing staffing shortages, attrition rates, and training needs. DMAS has allocated American Rescue Plan Act (ARPA) funding, totaling \$1.6 million, for seven system enhancements. Improvements are expected in June 2022, with final changes in September 2022.

- The planned system enhancements include seven updates to the DSS-owned eligibility determination system and one change to the DMAS-owned Medicaid enrollment system. Of those changes:
 - Five enhancements are permanent, or ongoing, solutions which will increase accuracy and decrease worker intervention.
 - Six enhancements *may* result in cost savings for the Commonwealth, either through complete automation of a process or decreasing the need for manual work.
 - Five enhancements will result in more timely processing at application, annual redetermination, or when a change occurs, which will result in improved customer service for Virginians.
 - One enhancement provides federally required reporting during the unwinding period.



Staffing Strategies

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



Impact of Maintenance of Effort: Enhanced Match Rate

- Beginning in the third quarter of state fiscal year 2020, Virginia has received enhanced matching funds (6.2%) from the federal government, replacing state funds. To receive the enhanced match, states could not take adverse action on Medicaid members, with limited exceptions. The resulting enrollment gain has general fund costs, but those costs are small compared to the savings resulting from the enhanced match.
- Federal public health emergency has provided \$1.2 billion since the start of the pandemic (even net of MOE)

		State funds only	PHE Ending July 2022
			MOE Cost Estimate PHE Ending July 2022
SFY2020	Q3	(\$152,983,089)	\$0
	Q4	(\$152,983,089)	\$6,056,117
SFY2021	Q1	(\$167,196,657)	\$23,140,671
	Q2	(\$180,483,296)	\$30,152,432
	Q3	(\$167,855,155)	\$36,880,565
	Q4	(\$155,362,202)	\$42,997,768
SFY2022	Q1	(\$186,848,670)	\$43,673,475
	Q2	(\$193,040,514)	\$51,931,708
	Q3	(\$178,201,519)	\$55,728,950
	Q4	(\$164,766,107)	\$57,250,822
SFY2023	Q1	(\$211,408,159)	\$59,175,644
	Q2		\$49,157,136
	Q3		\$29,295,174
	Q4		\$10,340,917
SFY2024	Q1		\$8,580,729
	Total-->	(\$1,911,128,457)	\$504,362,109



QUESTIONS?





FINANCE & TECHNOLOGY UPDATE

Chris Gordon, CFO
Deputy Director of Finance
and Technology

- ❑ Key Metrics
- ❑ FY22 Appropriation
- ❑ Medical Spend
- ❑ MCO performance
- ❑ Appropriation Act
- ❑ Summary

F&T Key Metrics

Metric	Target	Current	YTD
Prompt Pay¹	95%	96%	96%
SWaM²	55%	63%	61%
Admin Spend³	\$61.8m	\$59.5m	-3.7%
Medical Spend⁴	\$15.15b	\$15.47b	+2.1%

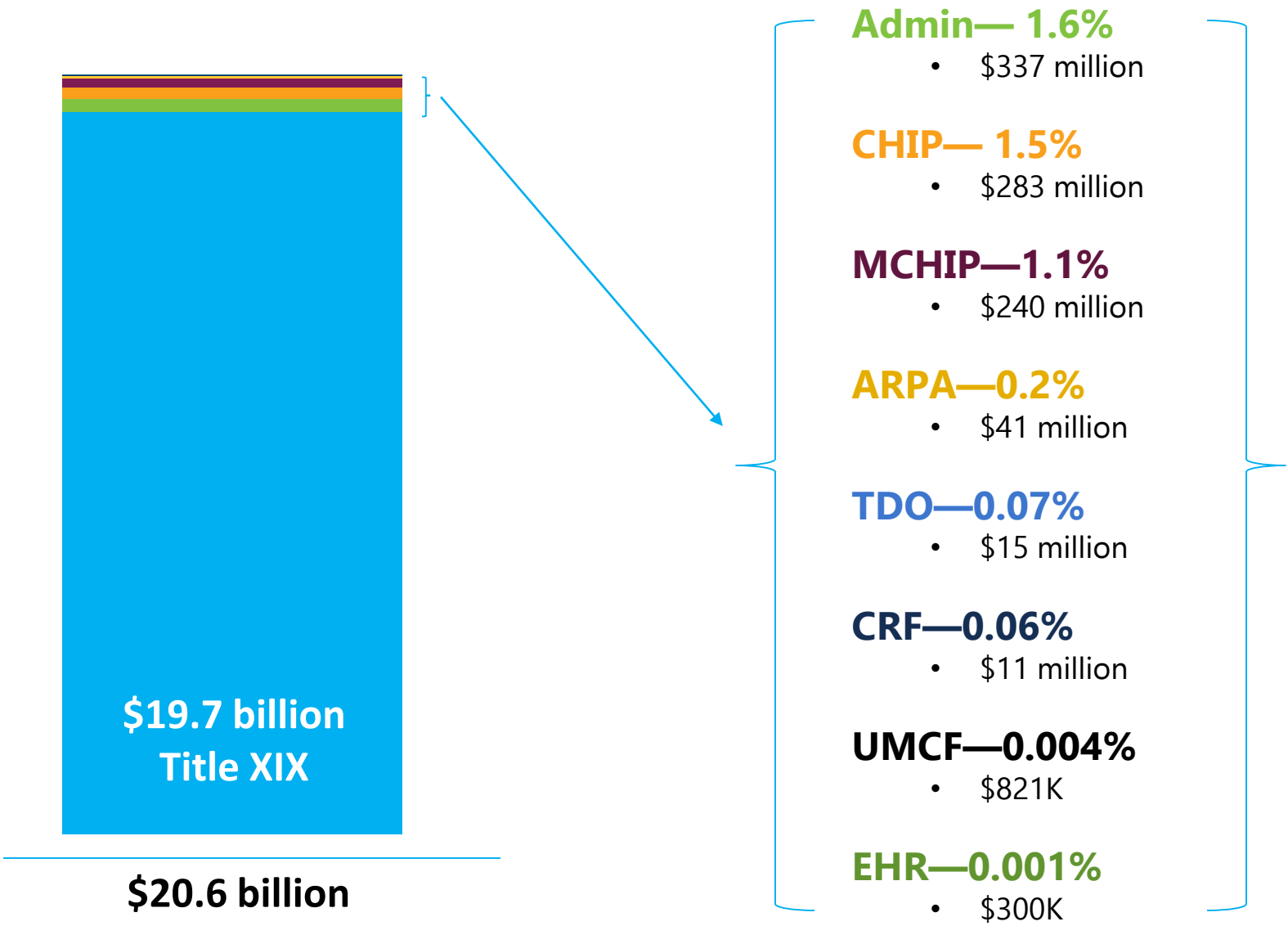
1. Prompt Pay as of May 2022

2. SWaM as of March 2022

3. Admin spend (GF) as of April 2022

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

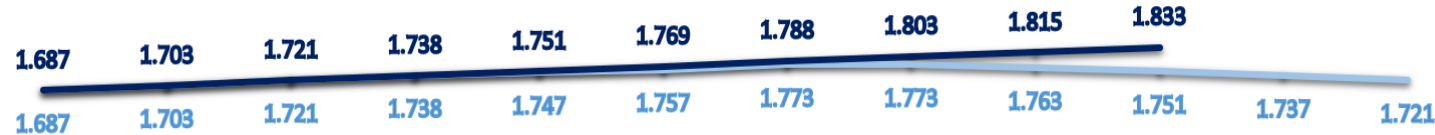
DMAS FY22 Appropriation



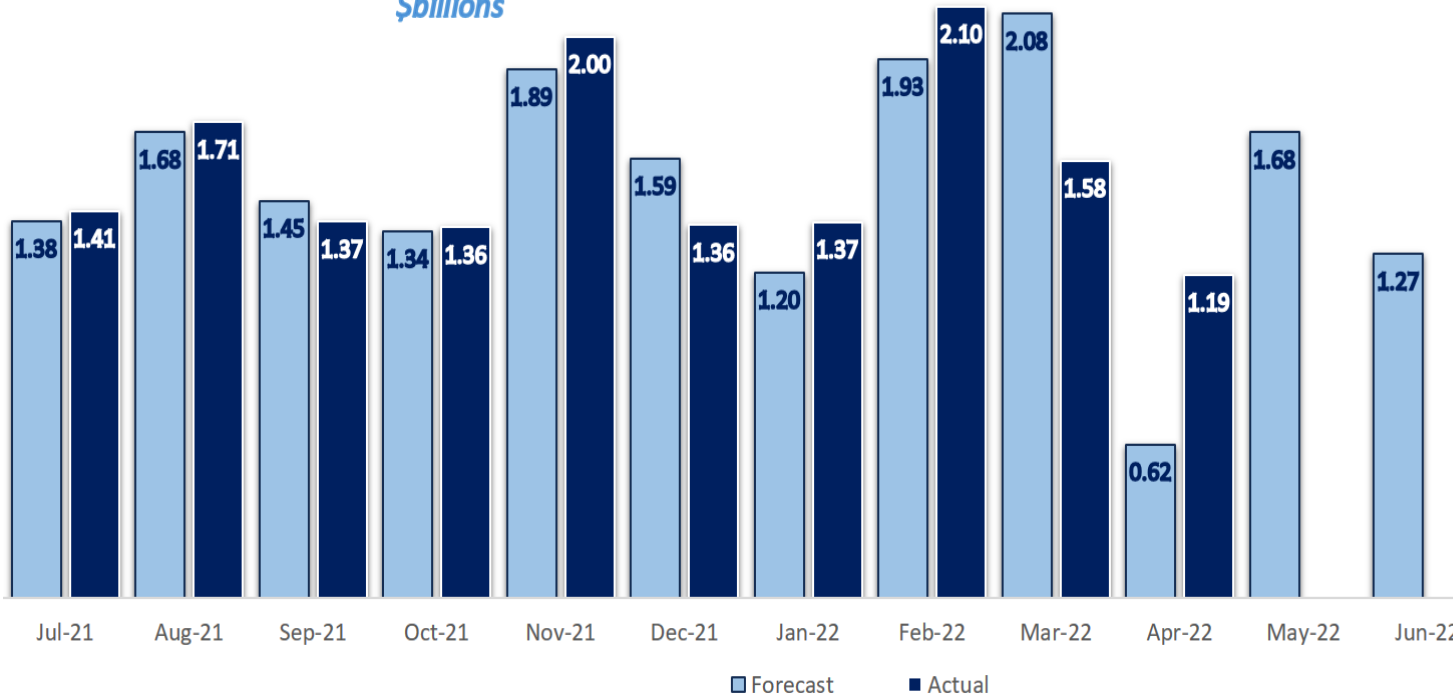
DMAS Financial & Enrollment Forecast vs. Actuals

TOTAL Medicaid

Total Medicaid Enrollment *millions*



Total Medicaid Expenditures *\$billions*



■ Forecast ■ Actual

Based on official November 2021 Forecast

April 2022



Enrollment

Forecast: 1,750,672

Actual: 1,833,339



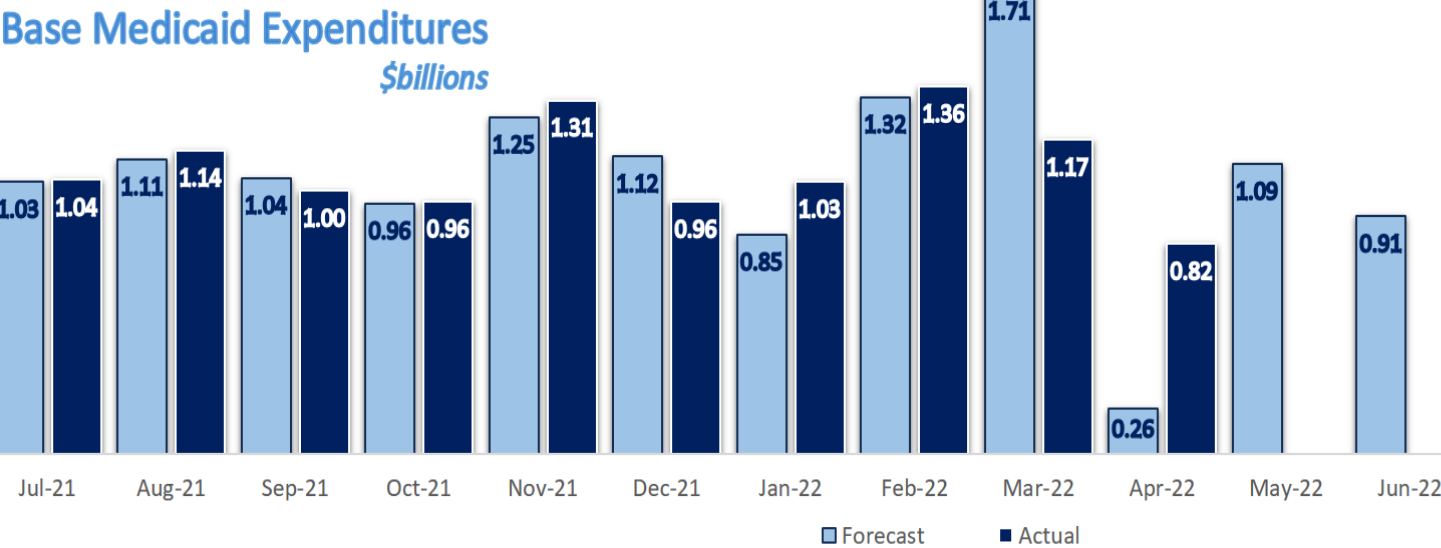
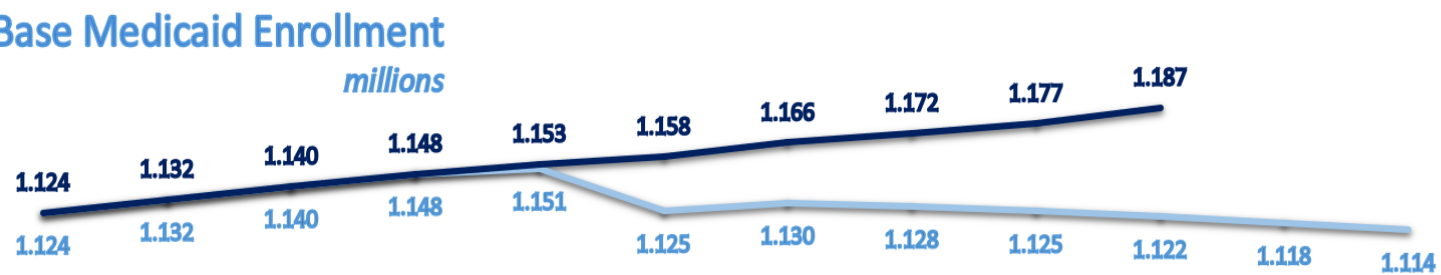
Expenditure

Forecast: \$619,883,359

Actual: \$1,193,484,648

DMAS Forecast vs. Actuals

Base Medicaid



Based on official November 2021 Forecast

April 2022

Enrollment

Forecast: 1,122,018
Actual: 1,186,479

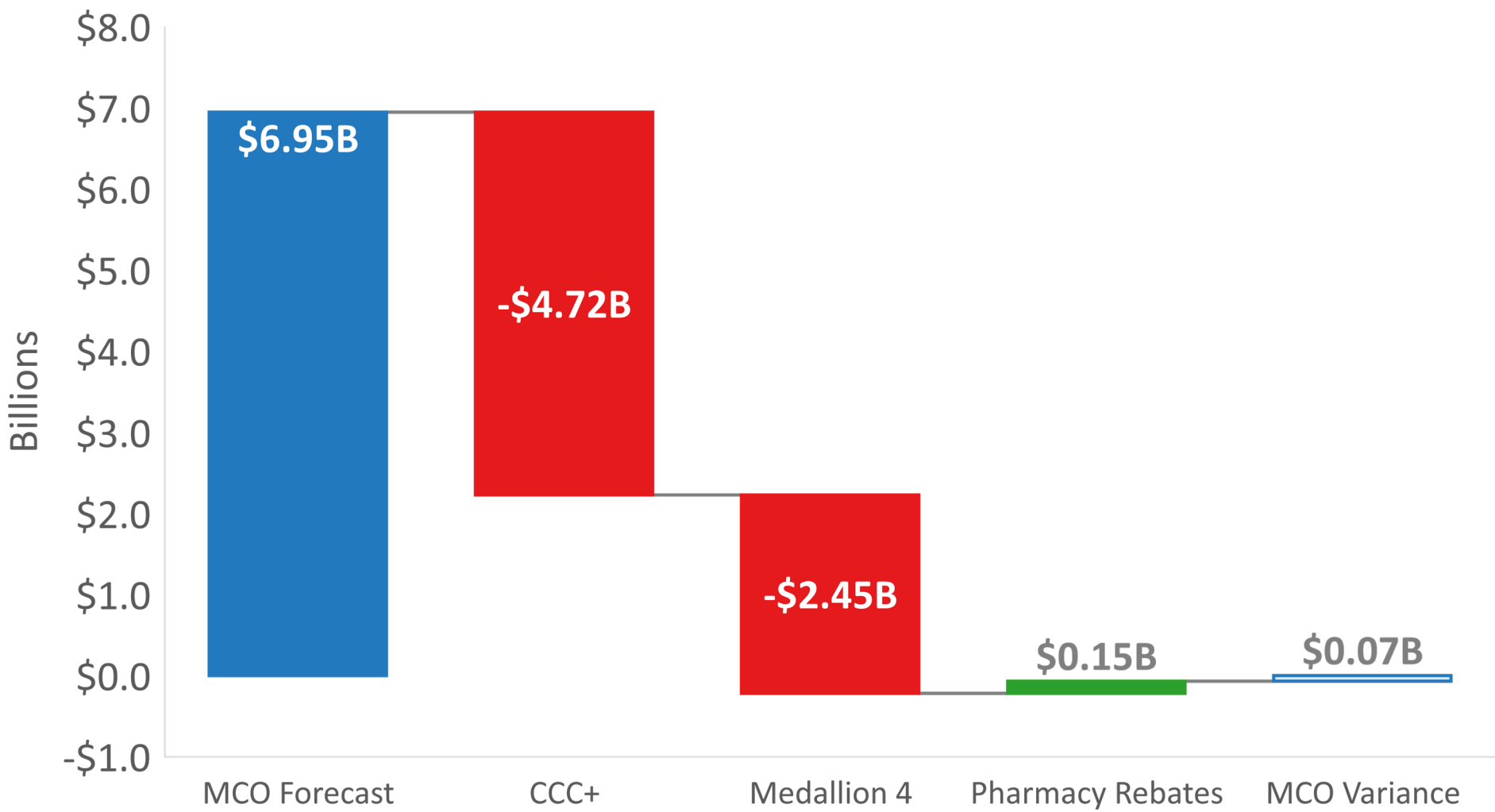


Expenditure

Forecast: \$255,265,568
Actual: \$818,566,808

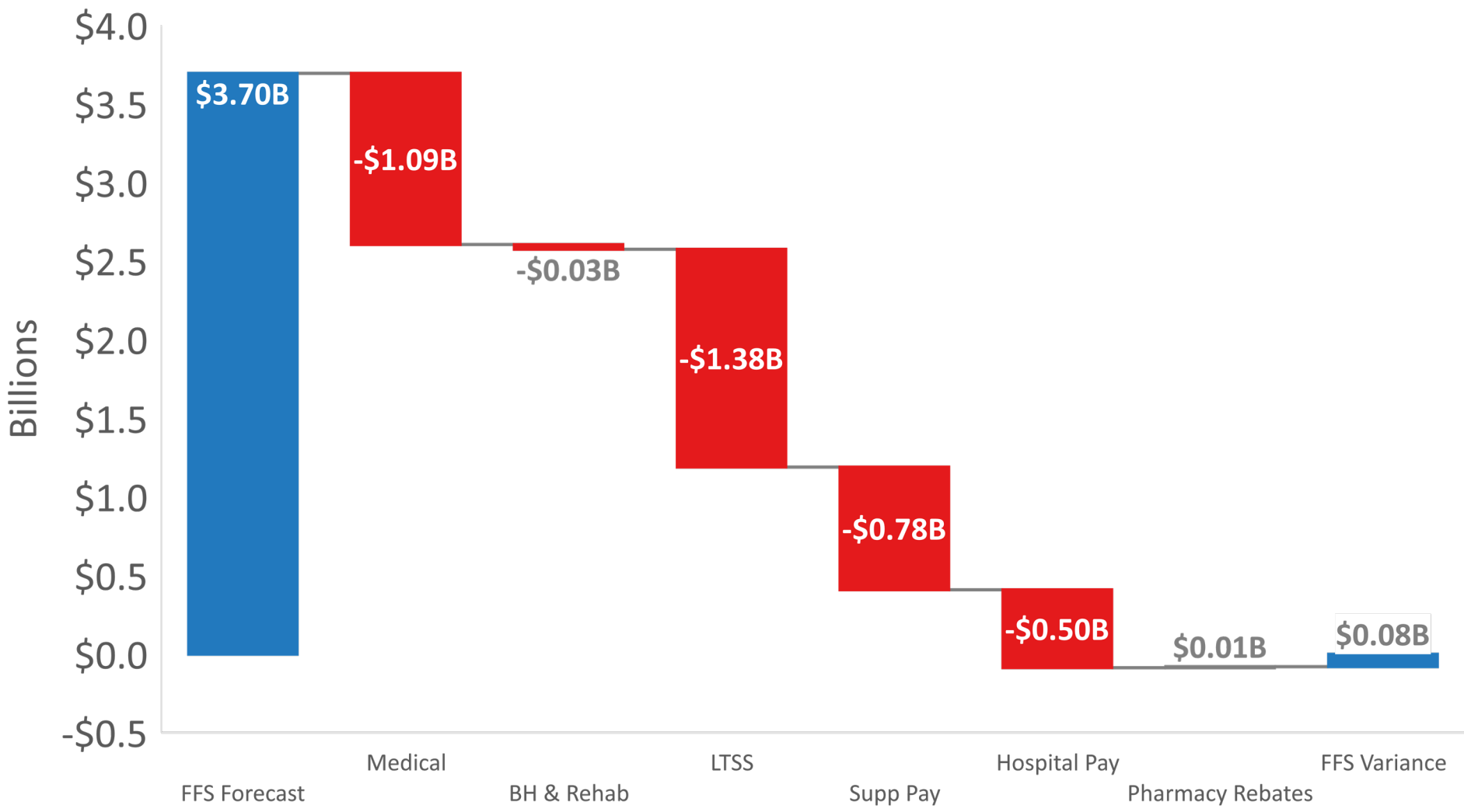
Base Medicaid: Managed Care (MCO)

FY22 Expenditures



Base Medicaid: Fee For Service (FFS)

FY22 Expenditures



DMAS Forecast vs. Actuals

Medicaid Expansion

Medicaid Expansion Enrollment
millions



Medicaid Expansion Expenditures
\$billions



Based on official November 2021 Forecast

April 2022



Enrollment

Forecast: 628,654
Actual: 646,375

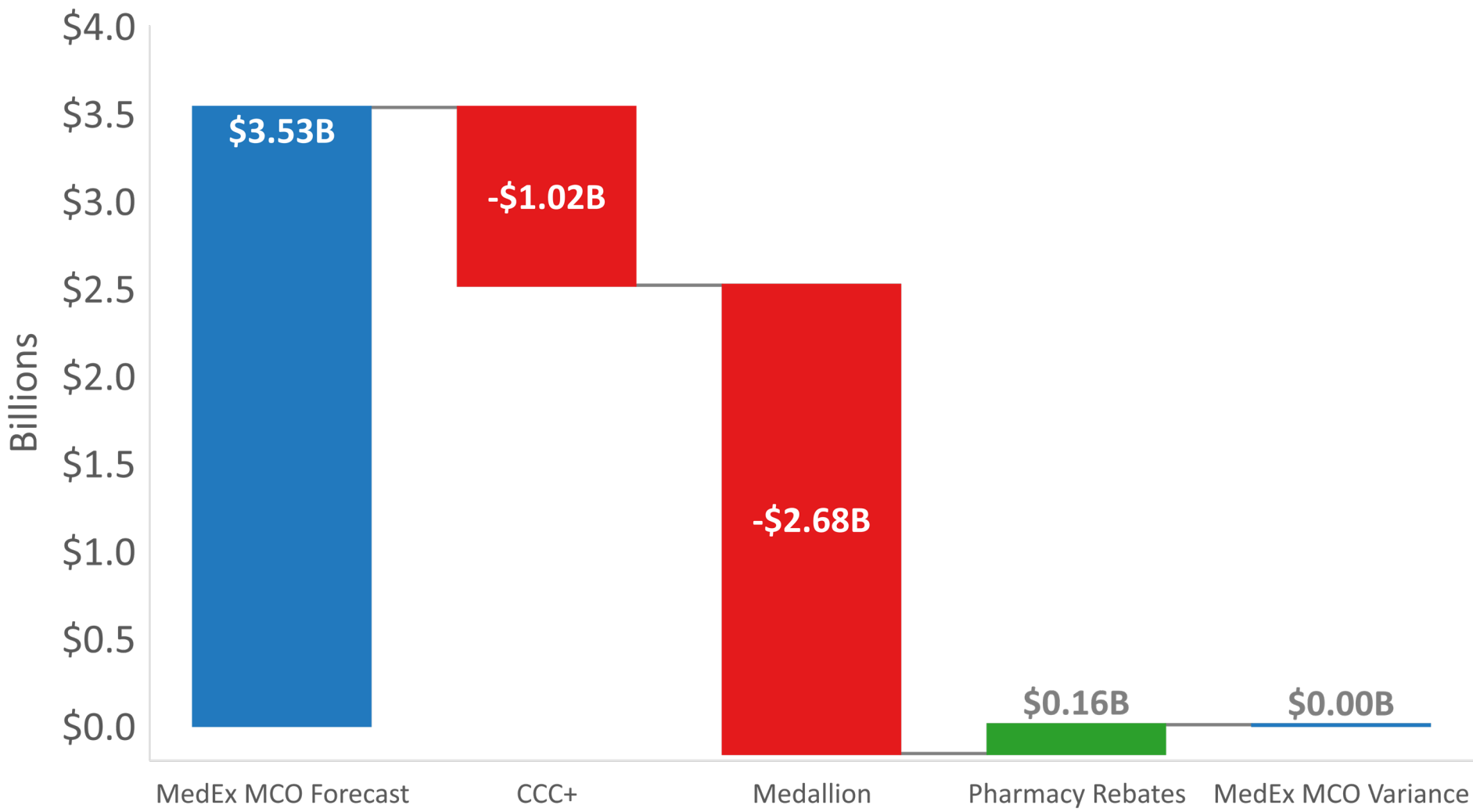


Expenditure

Forecast: \$364,617,791
Actual: \$374,917,840

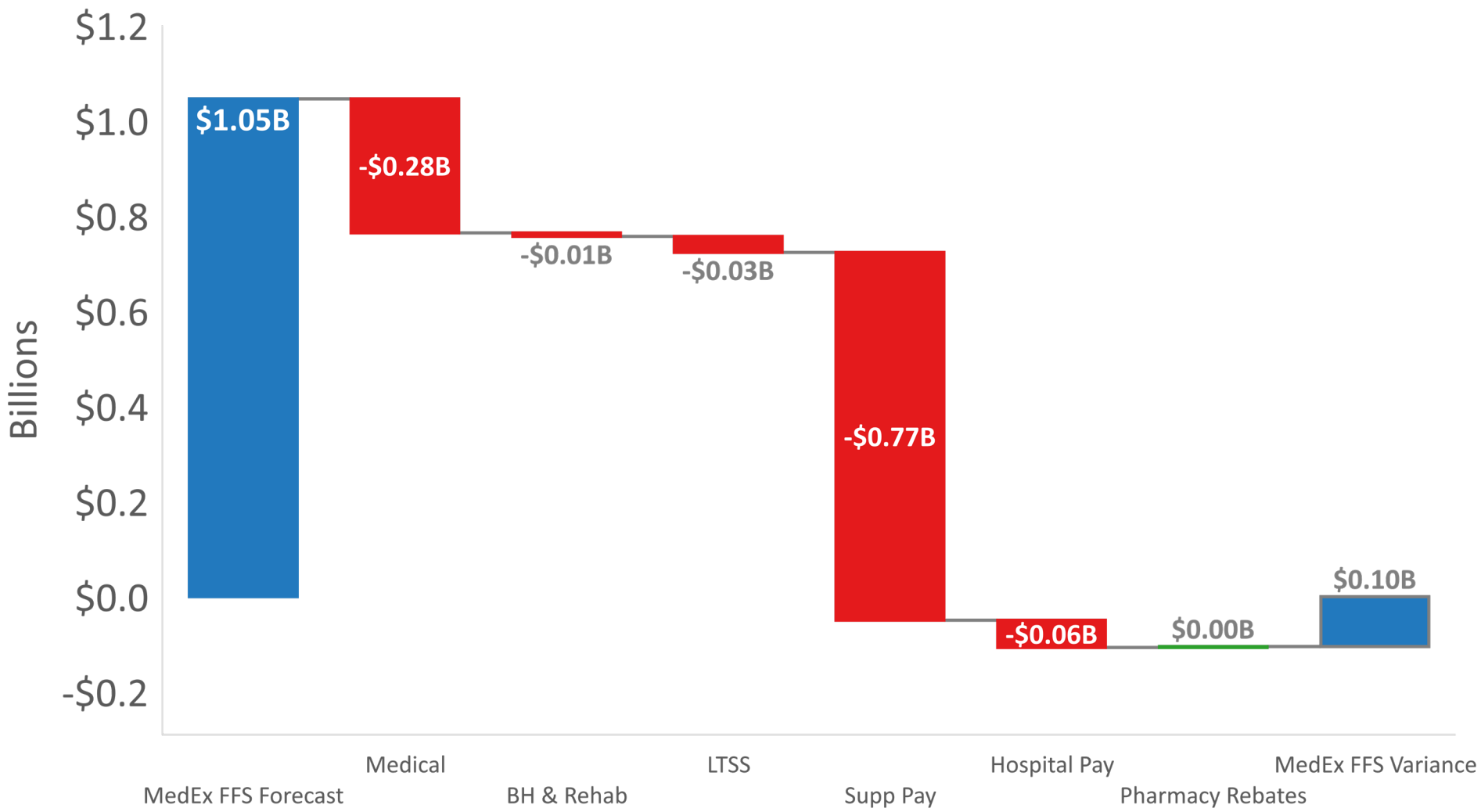
Medicaid Expansion: Managed Care

FY22 Expenditures



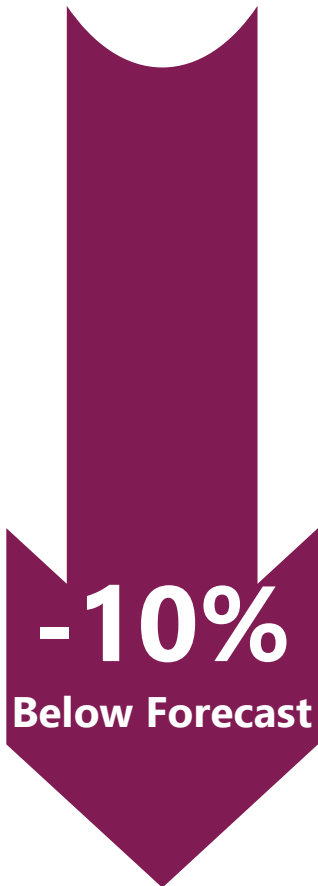
Medicaid Expansion: Fee For Service

FY22 MedEx FFS Forecast-to-Actuals (YTD)



Medicaid Accuracy Report – April 2022

Fluctuation Analysis: Base Medicaid



- MCO Pharmacy Rebates
- Outpatient Hospital
- Mental Health Residential Services
- Mental Rehabilitative Services
- Early Intervention & EPSDT-Authorization Services
- Nursing Facility
- Home and Community Based Services Waivers: Case Management & Support



- Clinic Services
- Supplemental Rate Assessment Payments

Medicaid Accuracy Report – April 2022

Fluctuation Analysis: Medicaid Expansion

- 
- MCO & FFS Pharmacy Rebates
 - Physician/Practitioner Services
 - Outpatient Hospital
 - Pharmacy (Point of Sale Only)
 - Dental
 - Transportation
 - Hospital Payments

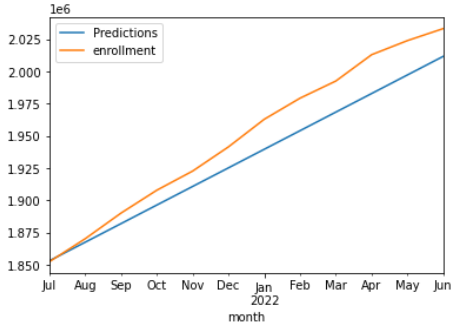
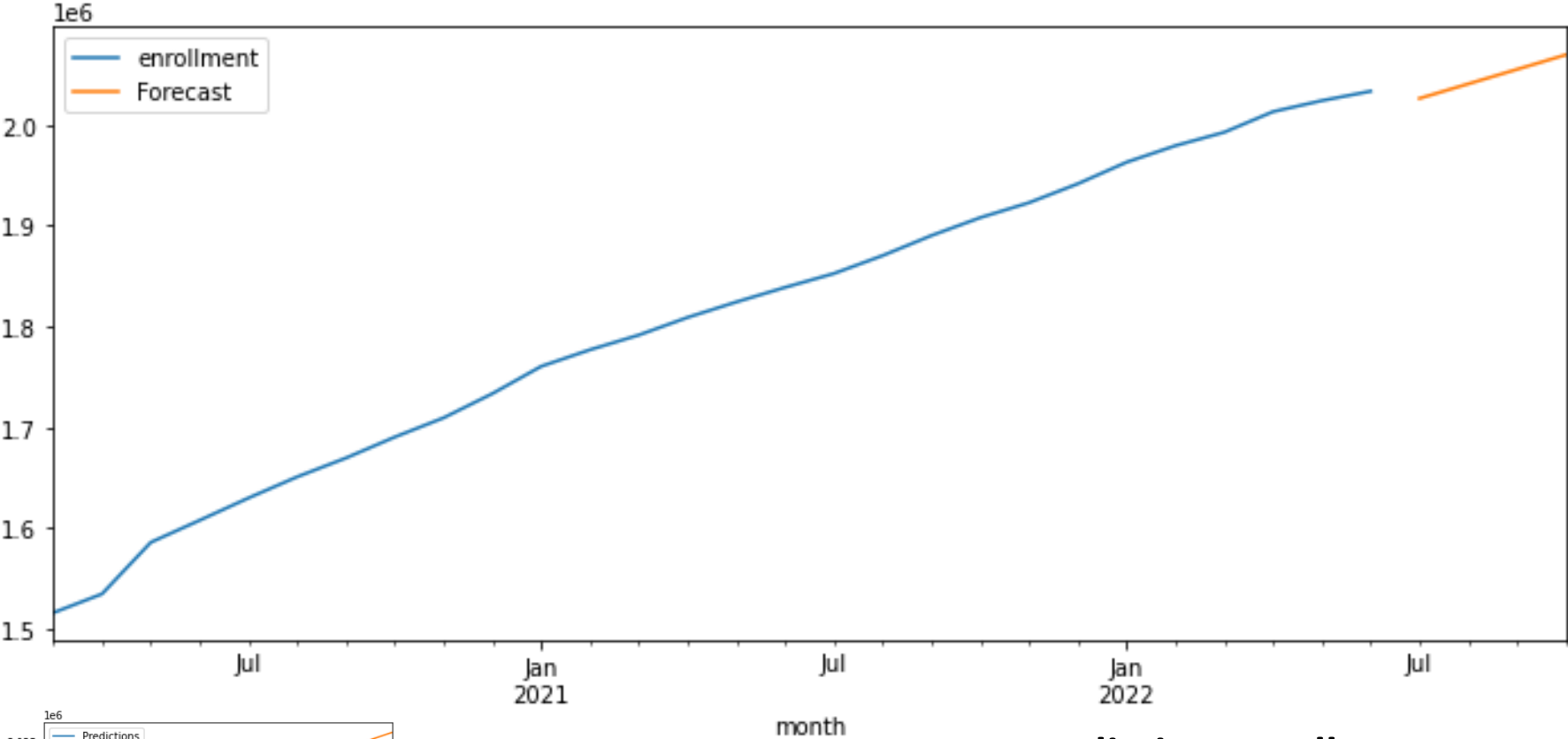


+10%
Above Forecast

- Clinic Services
- All Other
- Behavioral Health & Rehabilitative Services: Fee-For-Service
- Supplemental Rate Assessment Payments

Medicaid Total Enrollment—predicting October

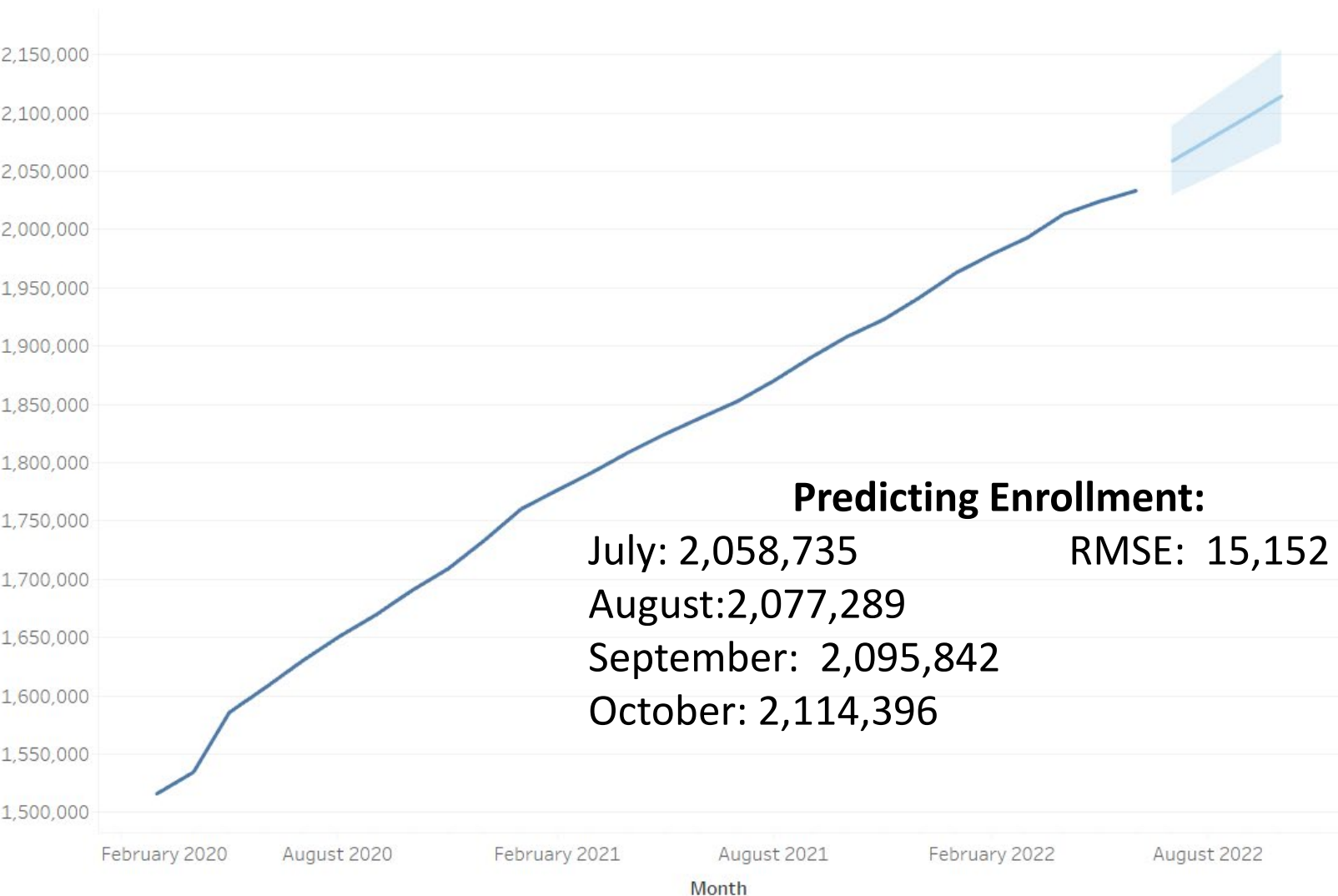
Python ARIMA analysis



Predicting Enrollment:
July: 2,036,320 RMSE: 19,272
August: 2,040,697
September: 2,055,115
October: 2,069,534

Medicaid Total enrollment—predicting October

Tableau Exponential Smoothing



Forecast indicator
■ Actual
■ Estimate

FY21 MCO MLR & UW Gains

MCO	MLR-DMAS Estimate	MLR-Actual	UW Gain- DMAS Estimate	UW Gain- Actual	Total-DMAS Estimate	Total-Actual
Aetna	\$6,176,963	\$16,919,697	\$44,786,937	\$37,383,170	\$50,963,900	\$54,302,867
Anthem	\$118,327,709	\$43,218,942	\$101,238,050	\$117,064,033	\$219,565,759	\$160,282,975
Molina	\$0	\$521,337	\$0	\$13,917,855	\$0	\$14,439,192
Optima	\$0	\$0	\$9,765,567	\$46,205,977	\$9,765,567	\$46,205,977
United	\$7,419,894	\$38,773,756	\$45,256,325	\$22,807,584	\$52,676,219	\$61,581,340
VA Premier	\$0	\$29,271,848	\$14,976,650	\$55,762,822	\$14,976,650	\$85,034,670
Total	\$131,924,566	\$128,705,580	\$216,023,529	\$293,141,441	\$347,948,095	\$421,847,021

Medical loss ratio (MLR): 85% minimum

Underwriting Gain (UWG):

- <3%: MCO retains
- 3% to 10%: MCO retains 50%, rebates 50% to DMAS
- >10%: MCO rebates 100% back to DMAS

Conference Amendments

- 31 Medicaid
- 4 American Rescue Plan Act (Sec. 9901 SLRF)
 - \$34 million to Hospitals
 - \$9.7 million to five NSGONF (Bedford, Dogwood, Birmingham Green, Lake Taylor, Lucy Corr)
 - \$4 million for Unwinding
 - \$38 million for 12.5% HCBS for behavioral health

GA22 Medicaid Conference Amendments

Amendment #	Description
304 #1c	Medicaid Mobile Vision Services
304 #2c	Rebase Medicaid DD Waiver Rates
304 #3c	Medicaid Traumatic Brain Injury Targeted Case Management Services (HB 680)
304 #4c	Supplemental Payments for Chesapeake Regional and Lake Taylor Hospitals
304 #5c	Medicaid Coverage of Anesthesia for Children's Dental Procedures
304 #6c	Add 10 Psychiatric Residency Slots
304 #7c	Delay Developmental Disability Waiver Slots
304 #8c	Modify Reentry Care Coordination and Outreach Initiative
304 #9c	Expand Remote Patient Monitoring
304 #10c	Nursing Rates inflated & not-rebased
304 #11c	Personal Care Rates
304 #12c	Supplemental Payments to Private Hospitals
304 #13c	Medicaid Peer and Family Support Rate Increase
304 #14c	Indirect Medical Education Funding for Children's Hospital of The King's Daughters
304 #15c	Capture Savings from Federal Match Rate Change

Amendment #	Description
304 # 16c	Remove Emergency Room Utilization Program Study
304 #17c	Acquisition Policy for Type One Hospitals
304 #18c	Adjust Health Care Fund Appropriation for Managed Care Repayments
304 #19c	Increase in Medicaid Dental Rates
304 #20c	Provide Inflation for Psychiatric Residential Treatment Facilities
304 #21c	Medicaid Reimbursement for Virginia Home Nursing Facility
304 #22c	Continue 12.5 Percent Rate Increase for Certain Home and Community Based Services
304 #23c	Allow Medicaid Payments for Parents to be Caregivers of Eligible Minor Children
304 #24c	Add Funding for Medicaid Value Based Purchasing Program for Nursing Homes
308 #1c	Traumatic Brain Injury Waiver Plan
308 #2c	Capture Administrative Savings from Merger of Managed Care Programs
308 #3c	Eliminate Study of Human Donated Breast Milk
308 #4c	Adjust Administrative Appropriation
308 #5c	Eliminate Medicaid Spending Target
308 #6c	Plan to Allow Direct Purchase of OTC Medications (HB 1046)
308 #7c	Nursing Home Quality Improvement Program

Summary

- Agency key F&T metrics continue to exceed targets
- Ongoing extensions of PHE continue to create enrollment and expenditure forecasting challenges
- Five MCOs did not meet MLR targets, all six made more than 3% profit in FY21
- DMAS tracking final budget



Social Determinants of Health



**United
Healthcare**

June 14, 2022

UHC Community & State Strategic Priorities

Our Differentiated Role



We Enable a
Sustainable
Care
Ecosystem



We
Empower
Consumers



Our Capabilities



Modern Tech
and Insights



Durable
Performance



Inspired
People

We embed health equity, behavioral health and the social determinants of health in all we do.

We Are United By Our Culture...

Integrity

Compassion

Relationships

Innovation

Performance

Comprehensive Solutions

Transformational Approach = Foundational + Interventional

Foundational elements – requires engagement strategy; reporting on process and outcomes

Analytics

Assessment

Referral (support)

Intervention

Monitor (follow up)

Interventional elements – requires shared investment, partnership and commitment with client and local entities



Transportation

Work with ride-share and public transportation services to provide subsidies and access



Housing

Support of local shelters & investment/partnership in temporary housing infrastructure and programs



Food

Address food insecurity: food banks, local farming, “ food local grocers



Financial

Employment support services, job programs, internships, education, financial literacy



Environmental

Enhance and create safe gathering and recreational spaces; address environmental hazards, waste, digital access and social isolation



UnitedHealthcare's Housing + Health Program

Housing + Health Program

Intentionally goes beyond traditional care to remove barriers to care — social and clinical.

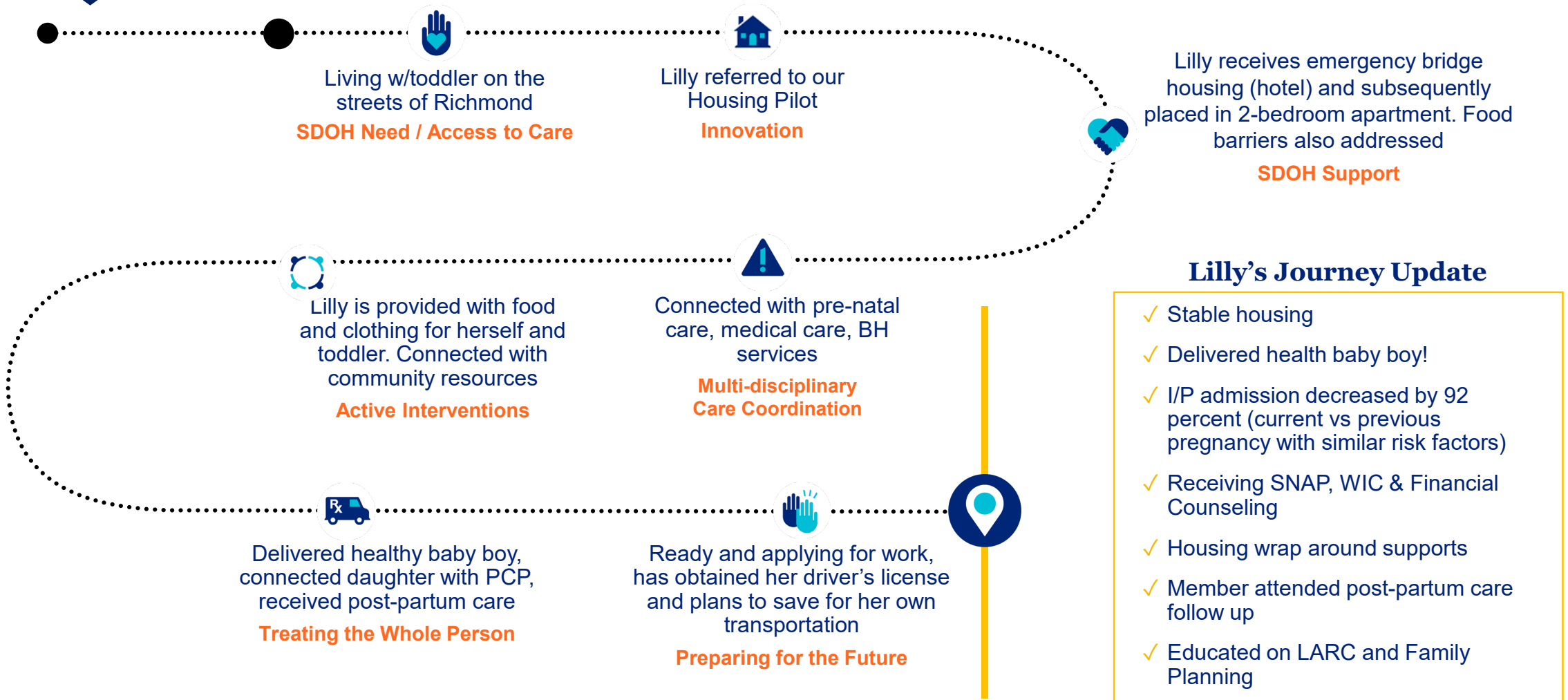
- ❑ Evidence-based solution to stabilize members with complex socio-clinical needs and improve outcomes
- ❑ Addresses the underlying issues that resulted in homelessness
- ❑ Provides transitional apartment or congregate housing
- ❑ Integrated physical and behavioral health care, and end-to-end care management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





Lilly, 25 years old

- Homeless, with a two-year old child
- Pregnant with pre-eclampsia, third trimester
- Previous high-risk pregnancy with complications
- Major depressive order, anxiety
- Asthma and seizures





Thank you!

Tameeka_Smith@uhc.com

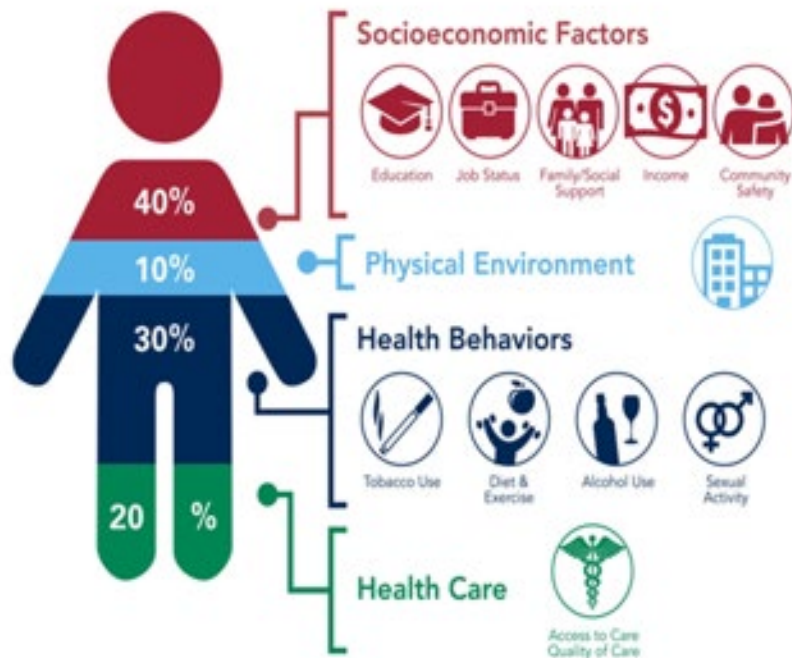


Addressing Social Determinants of Health

Randy Ricker and Traci Massie
June 14, 2022

Social Determinants of Health

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



SDOH Impact



20% of a person's health and well-being is related to access to care and quality of services



The physical environment, social determinants and behavioral factors drive **80%** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

- In the U.S. each year, 1.5 million individuals experience homelessness¹
- Housing instability may negatively impact health outcomes and increase the risk of premature death.²
- Homelessness has higher incidents of diabetes, hypertension, asthma, major depression, and a substance use disorder.²

1: Source: <http://www.rootcausecoalition.org/wp-content/uploads/2016/11/White-Paper-Housing-and-Health.pdf>

2: Source: <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability>

Access:

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

Opportunity:

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

Engagement:

- Ingrain in the community
- Trust and buy-in of our members

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

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

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

Boosting care and referral options

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



Prior to entering the housing pilot

Ms. B., an Optima Health Medicaid member, is a 47-year-old Hispanic native of Norfolk with a long history of homelessness and housing instability. She slept in a friend's car and had several stays in local shelters. Ms. B. has a history of drug addiction and was incarcerated for a felony.

After entering the housing pilot

Ms. B. entered the housing pilot program in February 2022 and has made considerable progress in just a few short months. She has obtained gainful employment as an Assistant Chef at an upscale local establishment and acquired stable housing. Ms. B. regularly attends NA groups and reports that she has not actively used substances since being housed. Ms. B. states that she now feels that she has a positive support system to foster greater independence.





Questions?



Contact Information:
Traci Massie, Director, Government Programs
TAMASSIE@sentara.com

Thank You!



The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant

SUPPORT ACT GRANT OVERVIEW

VIRGINIA BOARD OF MEDICAL ASSISTANCE SERVICES JUNE 14, 2022

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Overview of SUPPORT Act Demonstration Project

Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003

Demonstration Project to Increase Substance Use Provider Capacity

Federal Law passed October 24, 2018

State Participants



Planning Grants

The purpose of planning grants was to increase the capacity of Medicaid providers to deliver substance use disorder treatment or recovery services through:

- An ongoing assessment of the substance use disorder treatment needs of the state;
- Recruitment, training, and technical assistance for Medicaid providers that offer substance use disorder treatment or recovery services; and
- Improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers.

Overview of SUPPORT Act Demonstration Project

The purpose of Demonstration Project was to increase capacity of Medicaid providers to deliver substance use disorder treatment or recovery services through:

1. An ongoing assessment of the substance use disorder treatment needs of the state;
2. Recruitment, training, and technical assistance for Medicaid providers that offer substance use disorder treatment or recovery services; and
3. Improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers

State Participants



Virginia SUPPORT Act Grant Award

Notice of Award: September 18, 2019

Period of Performance: September 30, 2019 to
September 30, 2022

Approved Budget: \$4.9 million

Components

1. Need assessment
2. Strengths-based assessment
3. Activities to increase provider capacity

Virginia Medicaid's SUPPORT Act Grant Goals:

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

Grant Team

- Alyssa Ward, Ph.D., LCP, Director, Division of Behavioral Health
- Ashley Harrell, LCSW, Project Director & ARTS Senior Program Advisor
- Jason Lowe, MSW, CPHQ, Grant Manager
- Christine Bethune, MSW, Grant Coordinator
- Paul Brasler, MA, MSW, LCSW, Behavioral Health Addiction Specialist
- Tiarra Ross, Senior Budget Analyst
- Adam Creveling, MSW, CPRS, Grant Program Specialist
- Prabhdeep Singh, Grant Data Analyst

SUPPORT Act Grant Achievements

- Strengthened relationships with state Departments of Corrections, Health, and Social Services
- Provided policy-specific recommendations to leadership on opportunities to address gaps, barriers, and challenges for substance use disorder treatment
- Identified opportunities to improve continua of care for pregnant/parenting members and members with legal/carceral involvement
- Provided more than 225 training and technical assistance sessions (virtual and in person) to more than 11,000 professionals
- Identified and addressed challenges and opportunities for implementation and expansion of peer recovery services
- Provided trainings on race-based trauma and culturally sensitive treatment practices that were attended by more than 1,200 individuals
- Addressed challenges for Medicaid members who have substance use disorders as well as infectious diseases such as HIV and hepatitis C

SUPPORT Act Grant Overview

Highlights of Completed Contracts

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

SUPPORT Act Grant Overview

Highlights of Completed Contracts

- Manatt Health – SUD-specific Policy Landscape Review
 - Assessed SUPPORT Act and other federal and state SUD-related policy requirements and opportunities
 - Performed 44 stakeholder interviews
 - Identified key strengths and opportunities for DMAS, which were presented to agency leadership;
 - Strengths include covering full spectrum of American Society of Addiction Medicine levels of care, utilizing data to improve service provision and efficiency, and offering ongoing technical assistance
 - Opportunities include strengthening and evolving current care coordination system, increasing utilization of peer recovery services, and strengthening enrollment and linkages for members with legal/carceral experience

SUPPORT Act Grant Overview

Highlights of Completed Contracts

- Health Management Associates (HMA) – Legal/carceral system, SUD, and Medicaid
 - Completed an environmental scan of current system, including surveys of and focus groups with stakeholders
 - Conducted systems analyses with five pilot sites, including “current state” assessments and individualized site reports with “future state” goals
 - Convened two regional cross-sector stakeholder events to bring stakeholders together to identify and address opportunities for growth and collaboration
 - Presented findings to DMAS Justice-Involved Workgroup

SUPPORT Act Grant Overview

Highlights of Completed Contracts

- Carilion Clinic: Emergency Department Bridge Clinic
 - Expanded and enhanced existing Bridge Clinic services
 - Expanded Bridge Clinic staff, including licensed social worker and peer recovery specialist
 - Developed a curriculum for bridge clinic implementation based on quality improvement work done in partnership with Virginia Department of Health
 - Established Virginia Emergency Department Bridge Replication program, with an initial cohort of five non-Carilion hospitals and three Carilion expansion sites that are hoping to implement their own bridge clinic programs

SUPPORT Act Grant Overview

Highlights of Completed Contracts

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

SUPPORT Act Grant Overview

Projects Update – Contracts ending September 2022

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

DMAS/SUPPORT Website

Virginia Medicaid
Department of Medical Assistance Services

Privacy Policy Sitemap MES Portal Login

Search the site

Applicants Members Providers Appeals COVID-19 Open Data About Us

Home > For Providers > Addiction and Recovery Treatment Services > SUPPORT Act Grant

SUPPORT Act Grant

SUPPORT 101 Webinars, General Information and Monthly Stakeholder Meetings

Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

NAVIGATE

Addiction and Recovery Treatment Services

Information and Provider Map

Policy and Provider Manual

Credentialing

Authorization and Registration

SUPPORT Act Grant

External Resources

ARTS Provider Memos

DMAS Home Page: <https://www.dmas.virginia.gov/>

ARTS Home Page: <https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/>

SUPPORT Grant: <https://www.dmas.virginia.gov/#/artssupport>

Regulatory Activity Summary June 14, 2022
(* Indicates Recent Activity)

2022 General Assembly

***(01) Disaster Relief SPA:** The 2021 General Assembly, Special Session II required DMAS to make a one-time \$1,000 payment to Agency Directed personal care providers and Consumer Directed Attendants who provided personal care, attendant care, respite care, or companion care services to members who receive services via EPSDT during the first quarter of state fiscal year 2022. DMAS filed a SPA to accomplish that, but included the \$1000 figure, rather than the more specific figures that account for the taxes paid by the provider on the \$1000 payment. DMAS is submitting this Disaster Relief SPA to clarify those amounts as follows: Agency-Directed personal care providers will receive \$1,117.60, while Consumer-Directed personal care providers will receive \$1,107.60. Please note that these administrative costs have already been incorporated into the 2021 General Assembly appropriation, and that there are no costs associated with this SPA: it is a language change only. Following internal review, the SPA was submitted to CMS on 4/25/22 for review.

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

***(03) 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 is currently circulating for internal review.

***(04) Non-Emergency Medical Transportation:** This state plan amendment revises the state plan to add an attestation that DMAS meets all the minimum requirements for Non-Emergency Medical Transportation (NEMT) providers and individual drivers under Section 1902(a)(87) of the Social Security Act – also known as Section 209 of the Medicaid Coverage of Certain Medical Transportation Under the Consolidated Appropriations Act of 2021 (P.L. 116-260). The minimum requirements include: (a) each provider and individual driver is not excluded from participation in any federal health care program and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services; (b) each such individual driver has a valid driver’s license; (c) each such provider has in place a process to address any violation of a state drug law; and, (d) each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations. DMAS has policies and procedures in place that meet these requirements. Following internal review, the SPA was submitted to CMS on 2/8/22. The SPA was approved by CMS on 3/7/22.

***(05) Addiction Recovery Treatment Services:** This SPA allows DMAS to make the following changes to align with the Department’s current practices: (1) adds certified substance abuse counselors (CSACs) and CSAC-Supervisees to the list of staff that can conduct

multidimensional assessments for intensive outpatient services and partial hospitalization, pursuant to the Virginia Department of Health Professions' Board of Counseling guidance regarding CSACs' and CSAC-Supervisees' scopes of practice; (2) removes the requirement that multidimensional assessments for intensive outpatient services include a physical examination and laboratory testing, in accordance with the American Society of Addiction Medicine's (ASAM's) definition of multidimensional assessments; and, (3) incorporates assessments to determine if an individual meets the diagnostic criteria for substance-related and/or addictive disorder into the service component definitions of intensive outpatient services and partial hospitalization, in accordance with ASAM criteria, and specifies that credentialed addiction treatment professionals shall conduct these diagnostic assessments. Following internal DMAS review, the SPA was submitted to CMS on 2/14/22. The SPA was approved by CMS on 3/15/22.

***(06) 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.

***(07) Remove Limit on Mental Health & Substance Use Disorder Case Management:** This state plan amendment is necessary to align with the CMS Medicaid Mental Health Parity Rule, issued on March 30, 2016. The overall objective of the Medicaid Mental Health Parity Rule is to ensure that accessing mental health and substance use disorder services is no more difficult than accessing medical/surgical services. To comply with the Parity Rule, the Department of Medical Assistance Services (DMAS) must remove the limit of no more than two one-month periods of mental health and substance use disorder case management prior to discharge during a 12 month period for individuals in institutions of mental diseases (IMDs) (this does not include individuals between ages 22 and 64 who are served in IMDs). DMAS' Medicaid managed care plans and the Department's Behavioral Health Services Administrator (BHSA) are not currently applying the limits. For individuals served in IMDs, mental health and substance use disorder case management must be based on medical necessity and not be limited to no more than two one-month periods during a 12-month period. The citation for the federal regulation to remove the limits can be found in 42 CFR 438.910(b)(1). Following internal review, the SPA was submitted to CMS on 3/31/22 and approved on 5/16/22.

***(08) Clinical Trials:** The purpose of this SPA is to make revisions to include reimbursement for coverage for routine patient costs furnished in connection with a member's participation in a qualifying clinical trial in accordance with Section 210 of the Consolidated Appropriations Act of 2021 and the CMS State Medicaid Director (SMD) letter #21-005. Per the SMD letter, DMAS will cover any item or service provided to the individual under the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor, or treat

complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver, including a demonstration project under section 1115 of the Social Security Act. Such routine services and costs also include any item or service required to administer the investigational item or service. Following internal DMAS review, the SPA was submitted to CMS on 3/28/22 and approved on 4/7/22. The corresponding reg project was submitted to the OAG for review on 4/28/22, following internal review.

2021 General Assembly

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

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

***(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.

***(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.

(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. Changes may or may not be needed.

(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. DMAS is awaiting approval.

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

(08) Non-Institutional Provider Reimbursement Changes: In accordance with the 2021 Appropriations Act, Items 313.EEEE, UUUU, and VVVV, DMAS will be making the following changes to the state plan: (1) Increase rates for psychiatric services by 14.7 percent to the equivalent of 110 percent of Medicare rates, effective July 1, 2021. (2) Increase rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates. (3) Increase the supplemental physician payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 (Children's National Medical Center) to the maximum allowed by the Centers for Medicare and Medicaid Services (CMS) within the limit of the appropriation provided for this purpose. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by the CMS and all other Virginia Medicaid fee-for-service payments. The SPA was submitted to CMS on 6/21/21. DMAS submitted responses to informal questions on 8/11/21 and the SPA was approved on 9/15/21. The corresponding reg project is currently circulating for internal review.

***(09) Doula Services:** In accordance with the 2021 Special Session, Item 313.WWWWW, DMAS plans to revise the state plan to include coverage for doula services for Medicaid-enrolled pregnant women. Services will include up to eight prenatal/postpartum visits, and support during labor and delivery. The SPA will also provide authority for two linkage-to-care incentive payments for postpartum and newborn care. The associated PPN was posted on 7/23/21 and the Tribal Programs and DPB notifications were sent out on 7/23/21. The SPA was submitted to CMS for review on 8/24/21. DMAS received informal questions from CMS on 9/13/21 and responses were sent on 9/16/21. The SPA was approved by CMS on 10/29/21. Following internal review, the project was submitted to the OAG for review on 1/19/22. DMAS responded to OAG inquiries on 1/21/22 and made the requested revisions on 1/26/22. The project was re-submitted to the OAG for review on 2/11/22. DMAS received OAG questions on 3/4/22 and responded on 3/8/22. The regulatory project was withdrawn from the Town Hall on 4/28/22 and will be accessed for re-submission at a later date.

***(10) 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.

(11) Office-Based Opioid Treatment Changed to Office-Based Addiction Treatment: This SPA will allow DMAS to expand the substance use disorder service called "Preferred Office-Based Opioid Treatment" (which has been available only to individuals with a primary diagnosis of opioid use disorder) to individuals with a substance-related or addictive disorder. Following internal review, the SPA was submitted to CMS on 7/23/21. DMAS responded to informal questions on 8/5/21, 8/6/21, and 8/11/21. CMS approved the SPA on 10/14/21. The corresponding reg package, following internal review, was submitted to the OAG for review on 11/3/21. The OAG submitted additional questions and DMAS responded. The project was certified by the OAG on 12/10/21 and submitted to DPB on 12/13/21. DPB forwarded questions

on 12/14/21 & 12/30/21; DMAS provided responses and made revisions to the regs. Following a call with DPB on 1/7/22, DMAS responded to additional DPB questions on 1/18/22, 1/29/22, and 1/20/22. The project was sent to HHR on 1/21/22.

***(12) COVID Vaccine Administration Fee:** In the March 15, 2021 CMS toolkit entitled “Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children’s Health Insurance Program, and Basic Health Program” it states that: “States will need to submit SPAs to describe payment for the vaccine administration to the extent that the payment is different from what is otherwise approved under the state plan. DMAS has adopted the Medicare payment rate of \$40 for COVID-19 Vaccine Administration, which is different from the administration fees for other vaccines, and is filing this SPA as a result. After internal and oversight agency review, this SPA was submitted to CMS on 6/1/21. Informal questions were received from CMS on 7/7/21 and responses were forwarded to CMS on 8/3/21 and 9/17/21. This SPA was withdrawn on 3/10/22 and has been replaced by another regulatory action.

(13) 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).

***(14) COVID Vaccine for Plan First:** In accordance with Section 9811 of the American Rescue Plan Act of 2021, DMAS will be making changes to the State Plan in order to cover COVID-19 vaccines and vaccine administration fees for the limited benefit program called Plan First. (Typically, individuals in this program only receive Medicaid coverage for services that delay or prevent pregnancy.) The costs of both the vaccine and the vaccine administration fee will be covered by the federal government. This project was submitted to CMS on 6/21/21. This SPA was withdrawn on 3/10/22 and has been replaced by another regulatory action.

(15) 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.

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

2020 General Assembly

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

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

***(03) 2020 Long Term Services and Supports (LTSS) Screening Changes:** For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in accordance with 2020 HB/SB 902 to allow qualified nursing facility staff to complete the Long-Term Services and Supports (LTSS) screening for individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting

following discharge from an acute care hospital. The amendments to the Code include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community based services. Following internal review, the regulations were submitted to the OAG for review on 11/18/20. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/1/21 and 4/14/21. DMAS submitted the project to DPB on 6/14/21. Questions were received on 6/21/21 and responses were sent to DPB on 6/21/21. A conf. call was held on 6/22/21 to discuss the project. The reg action was submitted to HHR on 6/23/21. The regs were forwarded to the Governor on 11/10/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21 (w/ corrections sent on 12/29/21); published in the Register on 1/17/22; and became effective on 2/16/22. The emergency regs will be in effect until 8/15/23. The fast-track stage of the reg project is currently circulating for internal review.

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

(05) Hospital and ER Changes: The purpose of this SPA is to comply with multiple mandates. Pursuant to the General Assembly mandate in bill HB30, Item 313.AAAAA, DMAS will amend the State Plan to allow the pending, reviewing, and the reducing of fees for avoidable emergency room (ER) claims for codes 99282, 99283, and 99284, both physician and facility. (Managed Care Organizations are authorized by waivers rather than the state plan, and MCO changes related to ER claims paid by will not be part of the SPA.) Also, pursuant to the General Assembly mandate in bill HB30, Item 313.BBBBB, DMAS will amend the State Plan to modify the definition of readmissions to include cases when patients are readmitted to a hospital for the same or similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice. If the patient is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at 50 percent of the normal rate, except that a readmission within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. The SPA DPB notification was forwarded to DPB and the PPN was posted to the Town Hall on 5/19/20. Tribal notice for this SPA was sent on 5/28/20. DMAS fielded questions from CMS on a conf. call on 6/8/20. The SPA was submitted to HHR on 9/15/20 and to CMS on 9/25/20. DMAS responded to informal CMS questions on 10/30/20 and received additional inquiries on 11/6/20. Request for additional information (RAI) responses were sent to CMS on 10/6/21 and DMAS is awaiting further direction. Following internal review, the corresponding regulatory project was sent to the OAG on 9/15/20. Following OAG approval, the action was forwarded to the Register on 11/23/20; published on 12/21/20; and became effective on 1/20/21.

2017 General Assembly

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

2015 General Assembly

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

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



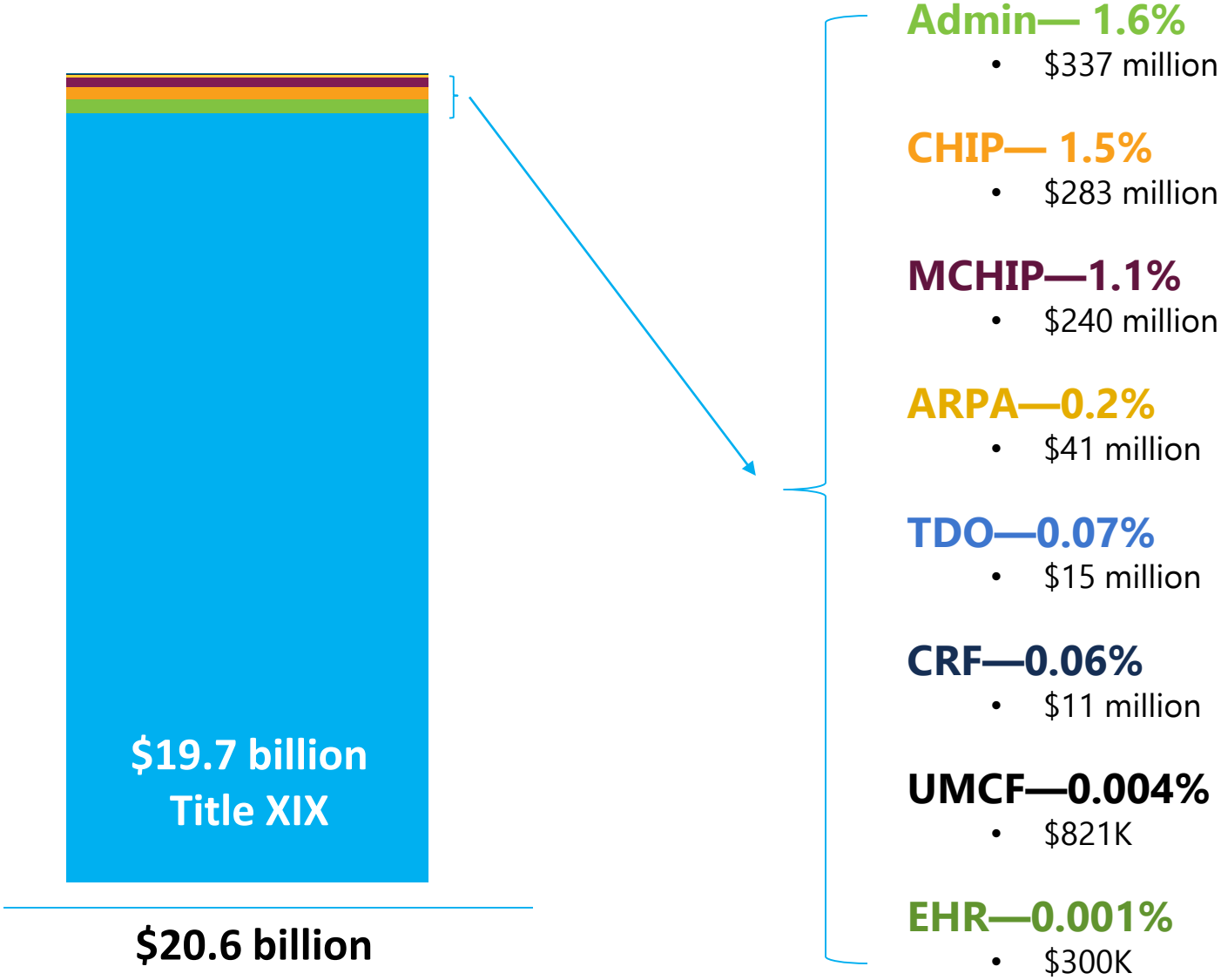
BUDGET 101

Chris Gordon, CFO
Deputy Director of Finance
and Technology

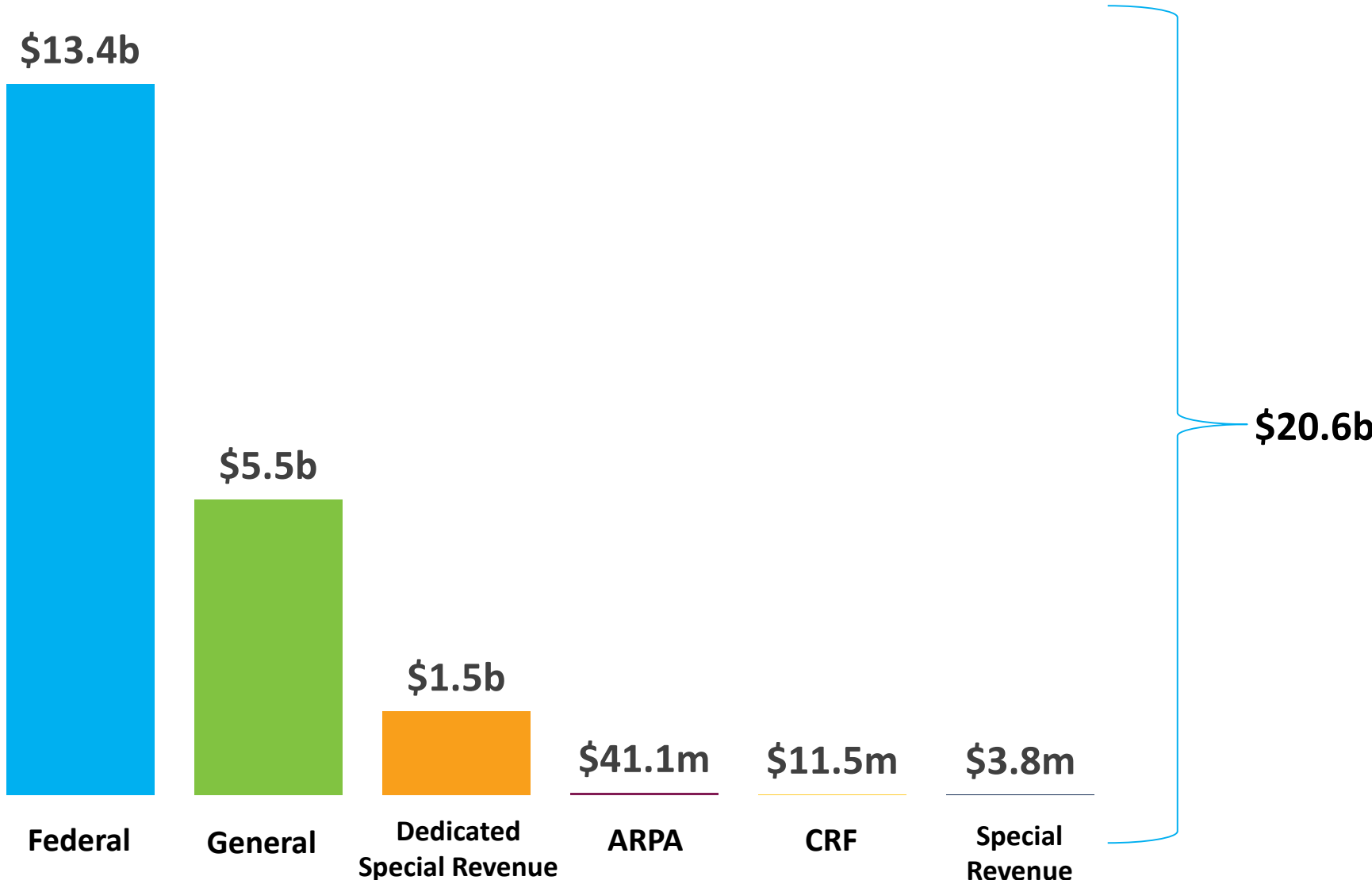
Agenda

- ❑ Overview of Medical & Admin Budget
- ❑ Appropriation & Cash Flow
- ❑ CMS Budget Development
- ❑ Virginia Budget Development
- ❑ Appropriation Act
- ❑ Summary

DMAS FY22 Program Appropriation



FY22 DMAS Fund Appropriation



Title XIX Medicaid: General Fund vs. NGF

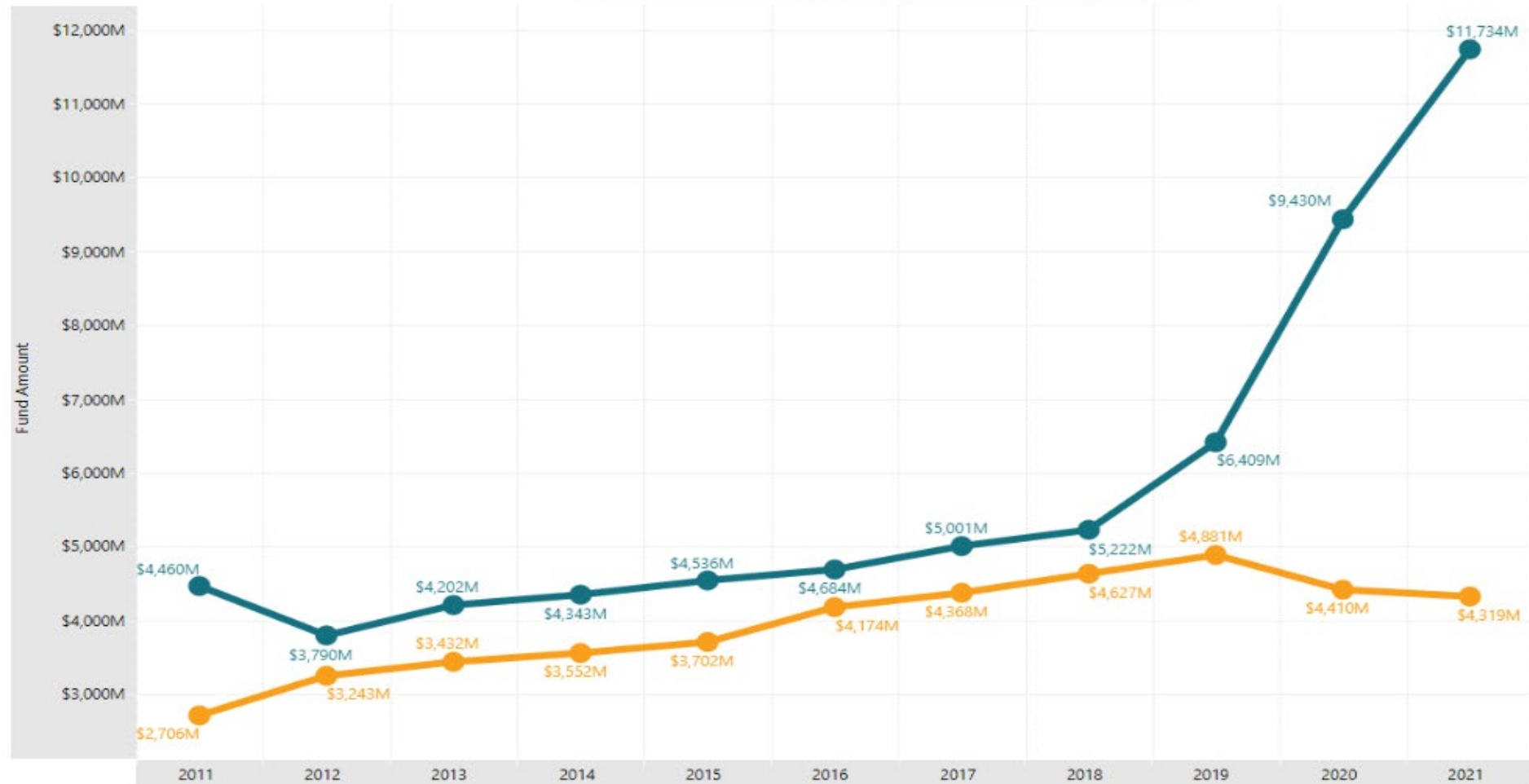
Report Type

- Title XIX Medicaid Expenditures by Fund
- Title XXI FAMIS / MCHIP Expenditures by Fund

Fund Type

- General Fund
- Non-General Fund

Annual Trends: Title XIX Medicaid Expenditures by Fund



Title XXI FAMIS/CHIP: General Fund vs. NGF

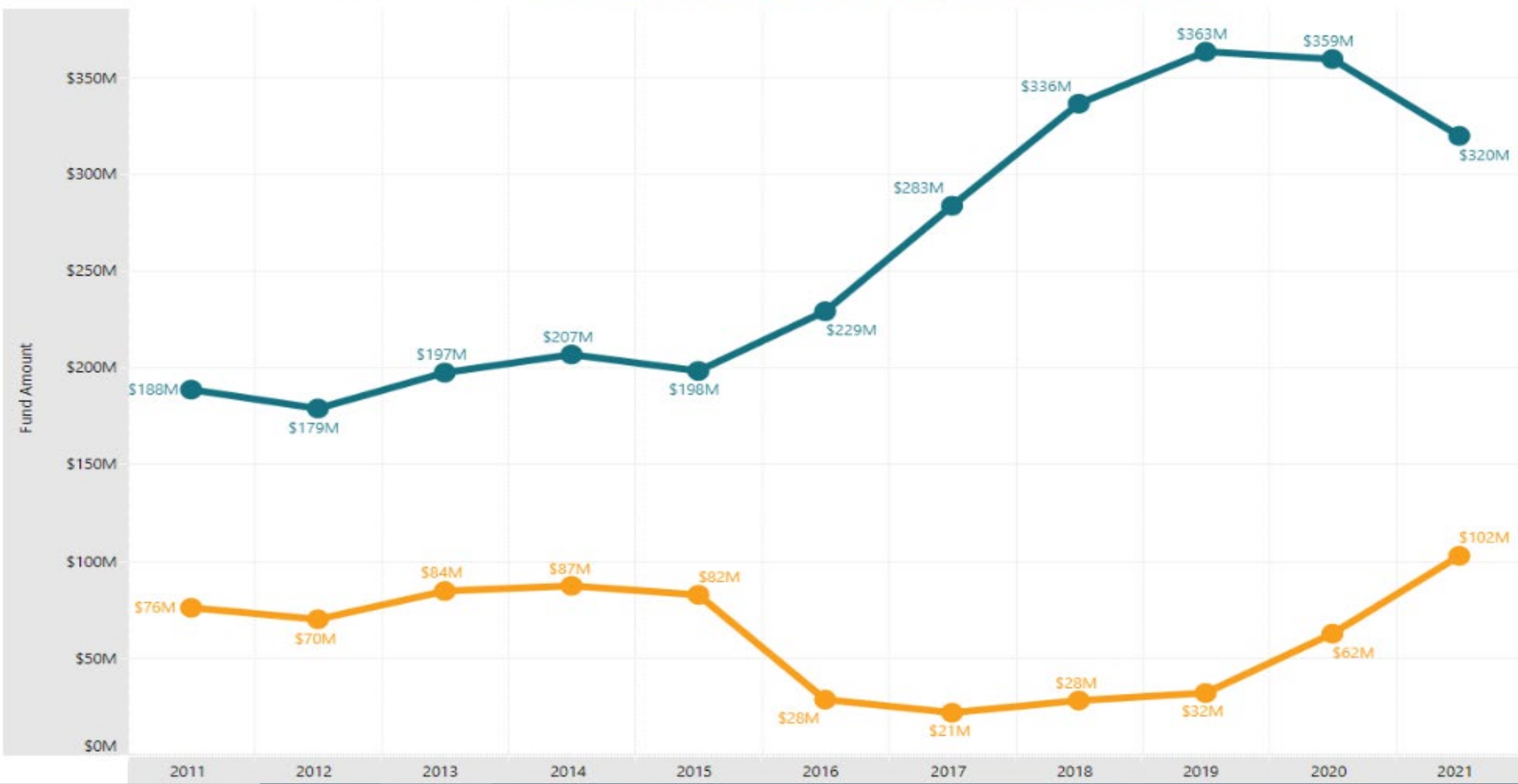
Report Type

- Title XIX Medicaid Expenditures by Fund
- Title XXI FAMIS / MCHIP Expenditures by Fund

Fund Type

- General Fund
- Non-General Fund

Annual Trends: Title XXI FAMIS / MCHIP Expenditures by Fund



DMAS Annual Cash Flow

Federal:

- October 1: $\frac{1}{4}$ annual cash
- January 1: $\frac{3}{4}$ annual cash
- Appropriation on July 1
- “Semi-annual draw”

General:

- Cash on July 1
- Appropriation on July 1

Dedicated Special Revenue:

- Cash must be earned
- Appropriation on July 1

Special Revenue:

- Cash must be earned
- Appropriation on July 1

CMS Budget Development

- ❑ Federal fiscal year: October 1 - September 30
- ❑ CMS-37: DMAS quarterly declares federal budget need for Medicaid Title XIX
- ❑ CMS-21: DMAS quarterly declares federal budget need for CHIP Title XXI

Virginia Budget Development

- ❑ State fiscal year: July 1 - June 30
- ❑ Biennial budget: but changes can be made annually
- ❑ DMAS budget has two components:
 - Medical:
 - Title XIX and XXI developed in three-year Forecast
 - Preliminary: October 15
 - Final: November 1
 - Based on projected enrollment and rates
 - Admin:
 - Forecasted
 - Non-forecasted

DMAS Budget Development: Decision Packages

□ Decision packages (DPs)

- Agency-initiated Medical & Admin operating proposals for consideration by Administration in developing GIB
 - Description of need & cost
- DMAS starts DP development in July
- In accordance with instructions from SHHR and DPB
 - IT—typically due in August
 - Non-IT—typically due in September

DMAS Budget Development: Forecast



11 Source: "Forecasting 101", <https://www.dmas.virginia.gov/data/financial-reports/>

Virginia Budget Development

1. Governor's Introduced Budget (GIB)

Mid-December



2. General Assembly (GA)

- House & Senate introduce GIB as bill
- Budget is final bill signed at end of session, supersedes everything but Virginia Constitution
- Long (60) and short (45) session

3. Member Amendments/ Fiscal Impact Statements (FIS)

- GA Members submit amendments to the GIB and introduce bills
- Bills that have a presumed FIS are cost-estimated by DMAS

4. Committee Meetings

- Both Houses hold committee meetings to review and vote on legislation and its associated FIS
- House Appropriations Committee (HAC)
- Senate Finance & Appropriation Committee (SFAC)

5. Cross Over

- Each house passes their own Budget and bills
- Each house then considers the other house's Budget and bills

8. Governor VETO session/ Adopted Budget

- Enrolled budget is received by the Governor to sign, veto, or amend



7. Enrolled Budget

- Approved and signed by both houses, and submitted to the Governor



6. Conference

- Committee members from both chambers decide on conference amendments that supersede individual house amendments
- Conference amendments and untouched GIB items roll forward
- Separately, bills that are approved by both houses are sent to the GOV for approval/veto



DMAS Budget: Monitoring & Execution

□ Weekly:

- Medical & Admin Payment Assurance Checklist:
 - Friday—load Fiscal Agent System appropriation
 - Monday—cash verification
- Revenue report
- Admin SABAR tracking

□ Monthly:

- Medical:
 - “Medical Accuracy Report”
 - “Monthly Expenditure Reports of the Medicaid Program” Tableau dashboard
 - “Visualization of Medicaid Forecast vs. Actuals” dataviz
- Admin:
 - “Administrative Budget and Expenditures” Tableau dashboard

□ Quarterly:

- Pharmacy rebates
- 4th quarter year-end spend down

□ Annually & Year-Over-Year:

- DMAS Data Book
- Official Forecast
- “Annual Trends: Title XIX & XXI Medicaid Expenditures by Fund” Tableau dashboard

DMAS Admin Budget: Monitoring & Execution

“Administrative Budget and Expenditures” Tableau dashboard

- Cover Page
- Budget & Expenditures Dashb...
- YoY Comparisons
- Detailed View
- Data Export Utility



Budget & Expenditures Dashboard

Fiscal Year: 2022

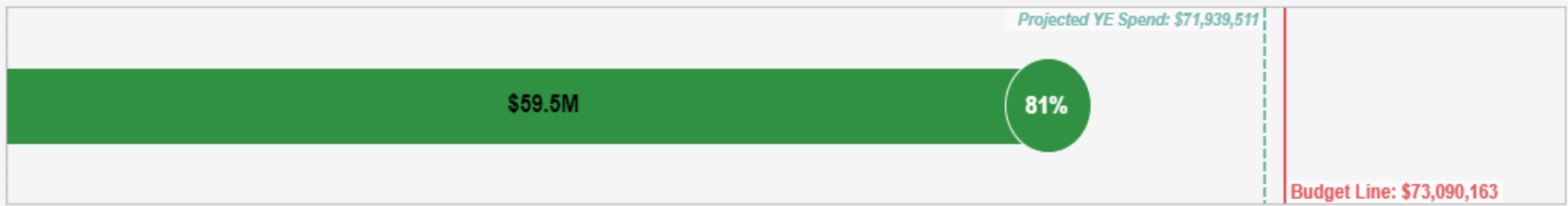
Threshold Levels:

- Actuals < 85% of the Budget
- Actuals Between 85% to 99% of Budget

View Dashboard As:

- % Total Budget
- \$ GF Actuals

2022 GF Actuals Vs GF Budget GF Actuals Through Jul-2021 to Apr-2022



Deputy Summary



DMAS Medical Budget: Monitoring & Execution

“Medical Accuracy Report” PDF

Department of Medical Assistance Services Detail Report on Medicaid Expenditures -- April FY2022

Category	Base Medicaid			Medicaid Expansion		
	FY 2022 Official Forecast ³	FY 2022 Appropriation ³	Expenditures through April FY 2022	FY 2022 Official Forecast ³	FY 2022 Appropriation ³	Expenditures through April FY 2022
General Medical Care: Managed Care	8,163,188,254	8,199,315,737	7,014,467,715	4,112,969,546	3,897,409,950	3,528,197,376
MCO Capitation Payments: Low-Income Adults & Children	2,889,601,253	2,793,206,124	2,447,722,665	3,269,911,006	3,009,177,809	2,676,516,293
MCO Capitation Payments: CCC+ Program	5,669,626,747	5,776,083,309	4,715,825,053	1,213,146,234	1,117,571,899	1,016,248,653
MCO Pharmacy Rebates (Current Year) [†]	-396,039,746	-369,973,696	-149,080,003	-370,087,694	-229,339,758	-164,567,570
General Medical Care: Fee-For-Service	1,282,947,409	1,306,316,073	1,083,847,657	323,946,536	375,578,800	279,105,087
Inpatient Hospital	135,033,056	181,042,004	121,741,738	185,308,582	219,980,218	158,797,440
Outpatient Hospital	27,698,868	32,499,573	20,546,430	34,190,630	47,239,921	25,332,973
Physician/Practitioner Services	39,361,199	40,206,644	34,073,244	28,874,504	34,788,809	18,956,635
Clinic Services	104,619,916	87,677,304	86,199,389	6,544,960	16,403,323	7,975,007
Pharmacy (Point of Sale Only)	10,092,673	9,585,495	8,308,688	7,009,684	17,457,321	5,084,708
FFS Pharmacy Rebates (Current Year POS, Hospital and Physician)	-9,802,693	-30,102,209	-6,834,538	-27,368,442	-16,959,959	-2,394,549
Medicare Premiums Part A & B	426,175,251	399,409,063	366,855,313	-	-	-
Medicare Premiums Part D	287,853,728	318,427,508	231,168,842	-	-	-
Dental	174,606,439	179,678,757	148,301,849	79,892,141	47,882,618	57,948,472
Transportation	62,273,249	53,580,482	52,782,492	5,309,152	2,371,959	3,084,318
All Other	25,035,726	34,311,452	20,704,211	4,185,325	6,414,590	4,320,083
Behavioral Health & Rehabilitative Services: Fee-For-Service	46,484,234	56,141,151	29,977,135	7,936,027	8,712,737	7,757,448

DMAS Medical Budget: Monitoring & Execution

“Monthly Expenditure Reports of the Medicaid Program” Tableau Dashboard

Monthly Expenditures
Year-to-Date Expenditures
Footnotes and Definitions

Medicaid Monthly Expenditures

Selecting either Base Medicaid (Non-Expansion Members) or Medicaid Expansion Members in the Member Type filter below will display that selection only. The Member Type unselected will display None for the Month and Year below.

Member Type: (All)
 Service Category: (All)

March 2022 Total Expenditures: **\$1,580,944,216**
 March 2022 Base Medicaid Expenditures: **\$1,173,927,490**
 March 2022 Medicaid Expansion Expenditures: **\$407,016,726**

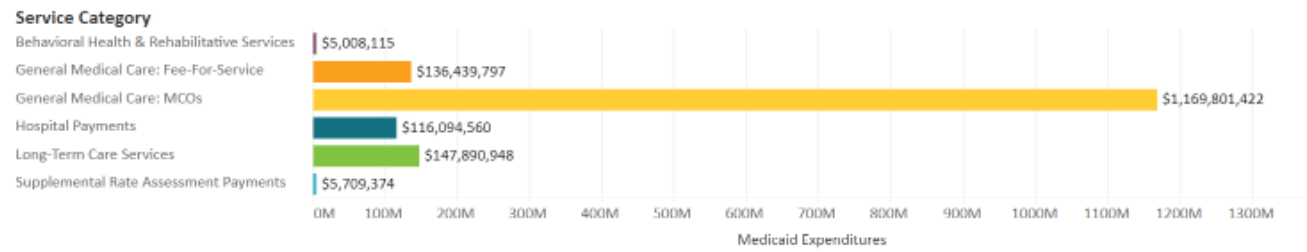
Monthly Expenditures

Select a month below to display additional detail



Expenditures by Service Category and Detailed Service Category

Select (+) next to Service Category to display additional details



DMAS Medical Budget: Monitoring & Execution

“Visualization of Medicaid Forecast vs. Actuals” dataviz

Base Medicaid Enrollment
millions



April 2022

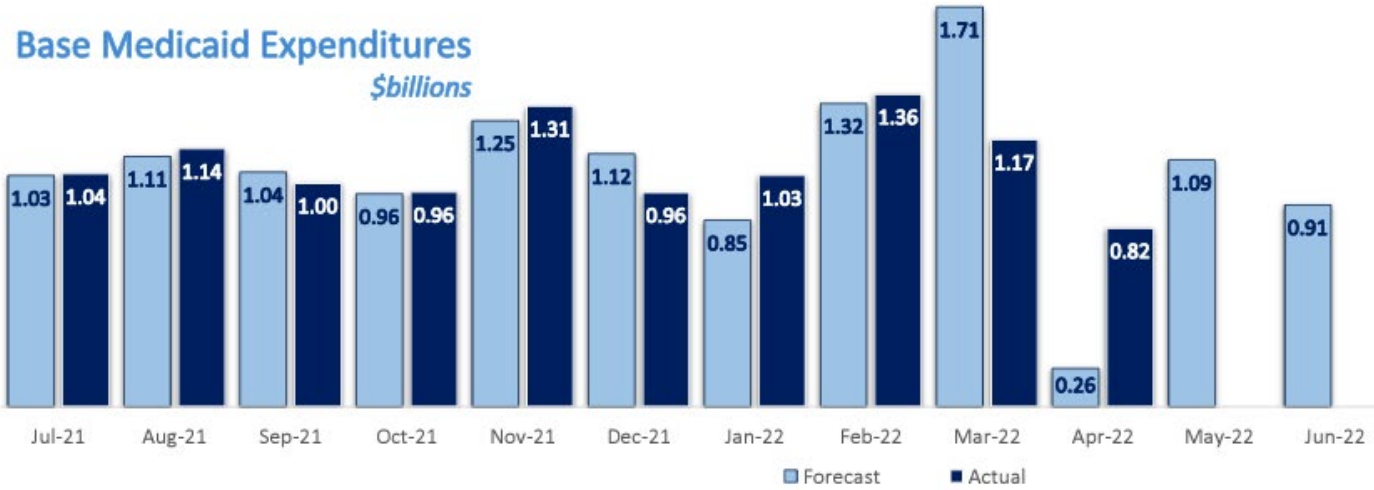
Enrollment

Forecast: 1,122,018
Actual: 1,186,479

Expenditure

Forecast: \$255,265,568
Actual: \$818,566,808

Base Medicaid Expenditures
\$billions



Based on official November 2021 Forecast

Summary

- Appropriation & Cash Flow require continuous monitoring
- Medical & Admin budget development is an ongoing annual process involving multiple agencies & branches of government
- Reporting on monitoring and execution are critical components of DMAS transparency