BOARD OF MEDICAL ASSISTANCE SERVICES

Wednesday, December 9, 2020
10:00 AM BMAS Meeting

Department of Medical Assistance Services
Virtual Via WebEx

AGENDA

Date of the Event	Link to Access the WebEx Event	Phone Bridge for Audio ONLY	Access Code for Audio ONLY
December 09, 2020 10:00am – 12:00pm	Click Here to Enter the Event	866-692-4530	178 018 7910

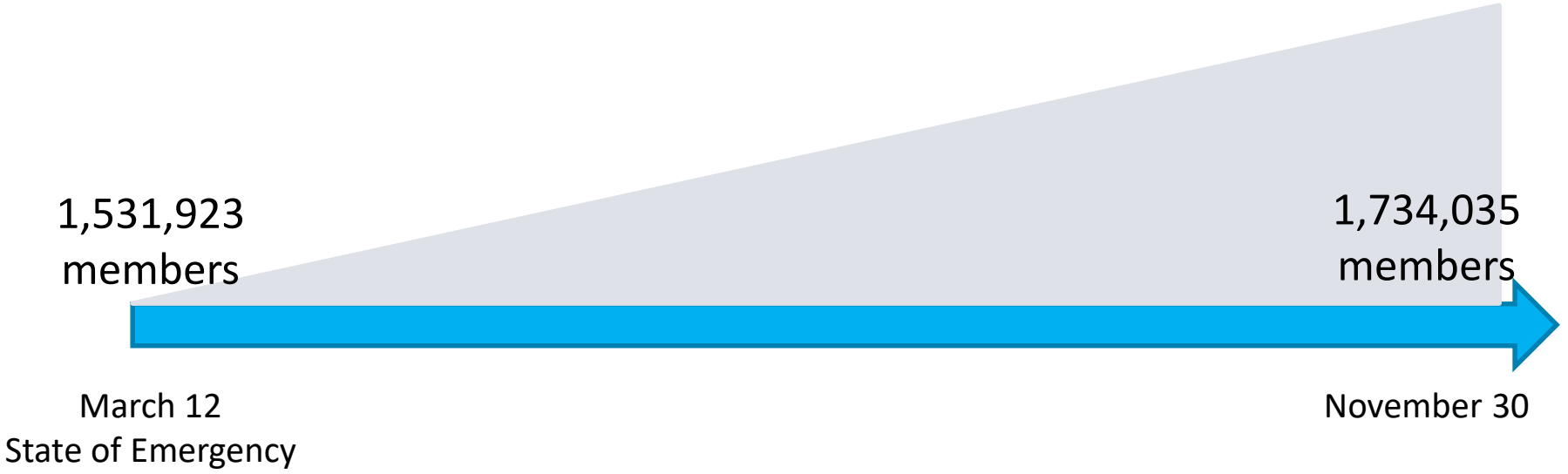
#	ITEM	PRESENTER
1.	Call to Order	Chair, Michael Cook Board
2.	Roll Call	
3.	Approval of Minutes	
4.	Discussion of BMAS Retreat	
5.	Director's Report 4.A. Director's Report: Project Cardinal Care Medicaid Expansion Update Upcoming 2021 initiatives	Karen Kimsey, Director
5.	Health Equity/DEI Update 5.A. Health Equity/DEI Update	Corey Pleasants, Mariam Siddiqui and Michael Palmer
6.	Legislative Session Update 6.A. Legislative Session Update Upcoming Session	Rachel Pryor
7.	2022 Budget Update/Forecast 7.A. 2022 Budget Update/Forecast	Chris Gordon, CFO
8.	New Business/Old Business	
9.	Public Comment	
10.	Regulation Update	
11.	Adjournment	

BMAS
DIRECTOR'S REPORT

Karen Kimsey
Director

December 9, 2020

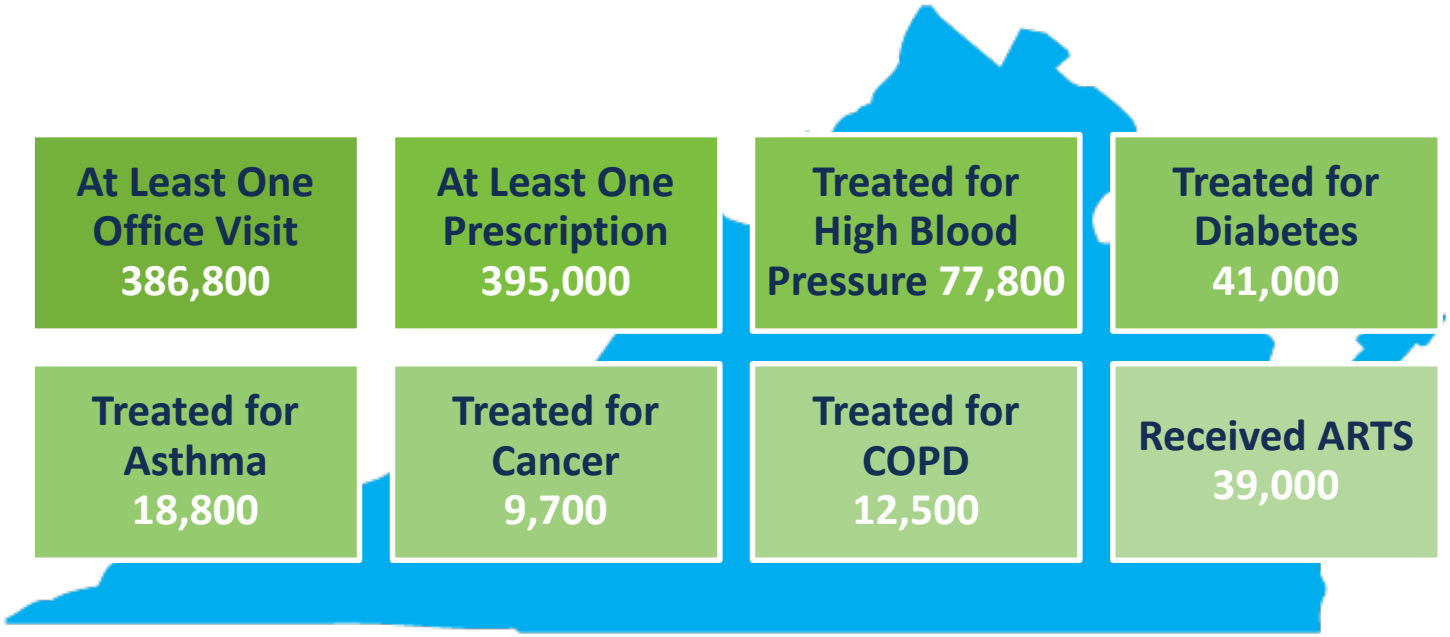
Medicaid Enrollment



- Since the State of Emergency was declared, Medicaid has gained **200,758 new members**
  - 99,874 are in Medicaid Expansion
  - 64,706 are children
- On average, Medicaid gains **4,700 new members each week**

Medicaid Expansion Update

- During the COVID-19 public health emergency, DMAS has implemented a number of policy and procedural changes to **improve coverage**, enable **new flexibilities to expedite enrollment**, ensure members **maintain health care coverage**, and to provide an even greater level of support.
- Medicaid expansion is providing health and economic security to **nearly 486,900 Virginians**.



Data from DMAS online public dashboard 11/15/20

Project Cardinal: Value Proposition

- **The ultimate goal of Project Cardinal is to effectuate a single, streamlined managed care program that links seamlessly with our fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to our members and adds value for our providers and the Commonwealth**

  - **Adds value for members**
    - Moving to one managed care delivery system streamlines the process for members, eliminating the need for unnecessary transitions between the two managed care systems, avoids confusion for members with family members in both programs, and drives equity in a fully integrated, well-coordinated system of care
    - Allows for improved continuous care management and quality oversight based on population-specific needs
  - **Adds value for providers**
    - Streamlines the contracting, credentialing, and billing processes for providers
  - **Adds value for DMAS, its MCOs and the Commonwealth**
    - Merges the two managed care contracts, two managed care waivers, and streamlines the rate development and CMS approval processes. Moving to one streamlined contract, and combining our internal processes for contract oversight, will allow DMAS to operate with greater efficiency and effectiveness and provides enhanced opportunity for value-based payment activities to promote improved health outcomes

2021 Priorities from Special Session

CARES Act

- Ongoing distribution of funding including funding for long-term care facilities, PPE for personal care attendants, hazard pay for personal care workers, hospital reimbursements for COVID-19 costs, and retainer payments for DD waiver day support providers

Behavioral Health Enhancement

- To ensure that services provided through Medicaid are evidence-based and provide a continuum of community rehabilitation behavioral health services

Extending Coverage to Pregnant Women

- Up to 205% of the federal poverty level for one year postpartum

2021 Priorities from Special Session

Eliminate 40-Quarter Work Requirement

- Ends requirement that lawful permanent residents have 10 years of work history to qualify for Medicaid in Virginia.

Adding a Comprehensive Adult Dental Benefit

- Approved for July 2021
- Begin working on contract modifications
- Goal: provide wide access

Increasing Rates for Certain Providers

- Including anesthesiologists, mental health providers, skilled and private duty nursing services and DD waiver providers

Value of Medicaid

ADDRESSING HEALTH EQUITY & DISPARITIES FOR MEDICAID MEMBERS & PROVIDERS

Mariam Siddiqui

Corey Pleasants

Sarah Hatton

December 9, 2020

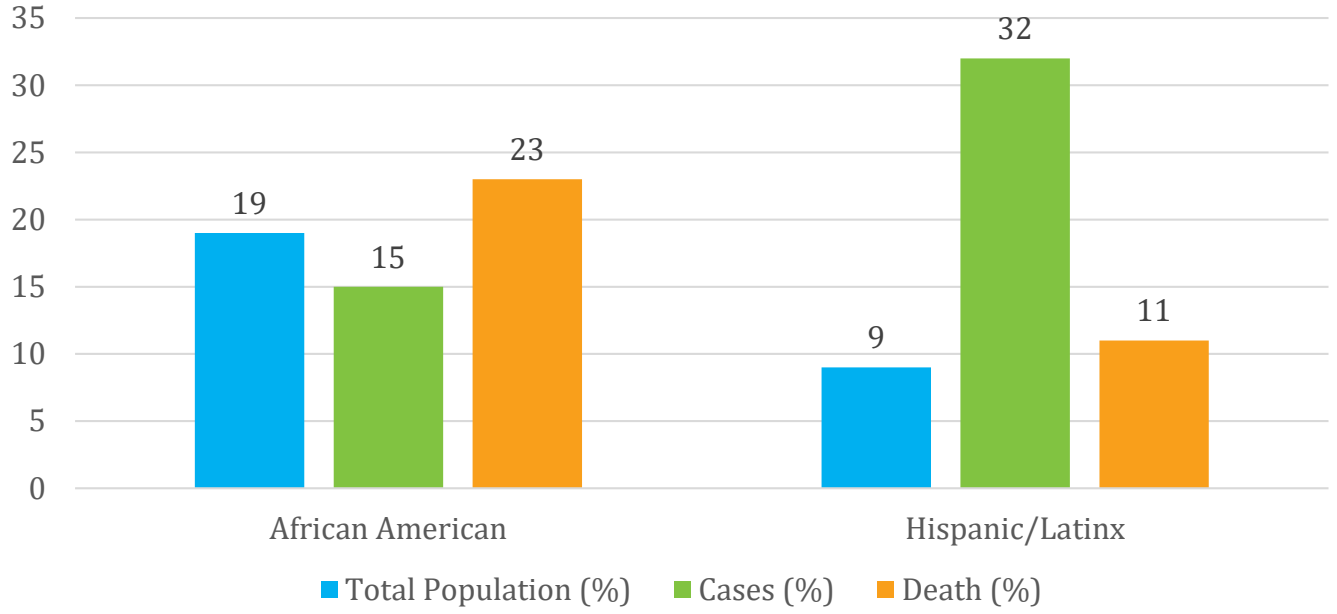
Background

- Health equity is the principle underlying a commitment to reduce—and, ultimately, *eliminate*—disparities in health and in its determinants, including social determinants.
- Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged).
- Health disparities are the metrics we use to measure progress toward achieving health equity.

https://www.cdc.gov/healthyyouth/disparities/index.htm
https://www.who.int/topics/health_equity/en/

COVID-19 & Racial Inequity in Virginia

- The COVID-19 pandemic has had a disproportionate impact on vulnerable communities (especially, communities of color--Black, Indigenous and People of Color [BIPOC]) across the Commonwealth.



Source: VDH COVID Daily Dashboard 07/14/20; 2018 American Community Survey five-year estimates from the U.S. Census Bureau

Eligibility & Enrollment Changes

Continuing flexibilities to assist members during the COVID-19 crisis.

Continuation of Coverage

- ✓ Delayed acting on most changes affecting eligibility
- ✓ Expanded redetermination timelines
- ✓ Waive out-of-pocket costs to member for duration of state emergency.

Additional Member Flexibilities

- ✓ Waive public notice and comment period requirements related to SPAs and modify tribal consultation timeframes.
- ✓ Suspend integration requirement for incarcerated individuals
- ✓ Accept attestation of medical expenses

Organization Framework to Achieve Health Equity

1. Make health equity a strategic priority
2. Develop structure and processes to support health equity work
3. Deploy specific strategies to address the multiple SDOH for direct impact
4. Develop partnerships with community and managed care organizations

http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx

Framework of the Workgroup

In order to develop an agency strategy, the work group will address the following questions –

1. What is DMAS currently doing to reduce and *eliminate* health disparities?
2. What does health equity look like in Virginia in terms of access to care, coverage of care and quality of services?
3. What are the key equity issues that affect Medicaid members and providers?
4. How should DMAS address those key equity issues?
5. What is DMAS doing to address health equity disparities in its response to the COVID-19 pandemic, given that the crisis is disproportionately impacting African American and Hispanic communities?
6. What can DMAS learn from other state Medicaid agencies, federal efforts, community leaders, advocacy groups and others to address health equity issues?

Eliminate is used here as an objective for the agency to work toward in its year-to-year strategic planning.

Short-Term Goals/Initiatives

Member Engagement & Communications	Engage Member Advisory Committee and other stakeholders on a regular basis to receive feedback on health disparity issues, in trying to access care, request coverage for care or receive quality services
Policies & Services	Create an inventory of projects to catalog current projects focused on equity
	Identify current SDOH projects/initiatives
	Conduct state research to learn and understand how other states are addressing health disparities
	Review Medicaid language access plan
	Review any cultural competency trainings provided by DMAS & MCO
	Evaluate Managed Care Organization contracts to assess for health equity concerns and areas of improvement
Data, Quality & Measurement	Develop an inventory of all available SDOH data
	Evaluate system capabilities to update or add new data elements
	Review and standardize MCO annual health equity report
	Review quality measures for health equity (e.g. HEDIS)

Long-Term Goals/Initiatives

Member Engagement & Communications	Develop a comprehensive outreach and communication strategy to engage community members and leaders, advocacy groups and other stakeholders to gather feedback and disseminate program information
Policies & Services	Develop a framework for health equity with social determinants of health factors that can be used to improve health and eliminate health disparities
	Develop strategies to promote health equity above regulatory requirements for MCOs and DMAS policy developments
	Implementation of language access plan
Data, Quality & Measurement	Develop Medicaid enrollment dashboard with demographic information such as age, race, ethnicity, gender, sexual orientation, disability and other sociodemographic characteristics
	Develop health equity performance measure for Medicaid program
	Establish long-term, annual metrics to assess changes in health disparity issues (e.g., access to care, quality of services, use of coverage, etc.)

Topic Area Initiatives

Behavioral Health	Assess community based behavioral health network capacity and cultural competency for African American, Latinx, and Asian individuals, as well as other people of color traditionally underrepresented.
	Address the disproportionate number of African American and Latinx individuals residing in state psychiatric facilities.
Maternal Mortality	Develop a strategy to leverage Medicaid to improve maternal health outcomes for African American and Latinx women (e.g., extending post-partum coverage for 12 months, early elective deliveries, maternal home visiting benefit etc.)

Topic Area Initiatives (Continues)

Eligibility & Enrollment	Align SNAP/TANF/ WIC flexibilities to further integrate with Medicaid
	Reduce churn for individuals transitioning between care delivery systems
	Identify strategies to promote access to coverage/care for immigrants
	Ensure coverage for justice-involved individuals prior to release
Coordination & Integration	Coordinate and further integrate health equity initiatives with the Governor's office, VDH and Virginia Bureau of Insurance

Questions?

DMAS LEGISLATIVE PROCESS: OVERVIEW

As a state agency, DMAS has a unique role of proposing ideas for budget and legislative actions to the Governor.

- A majority of DMAS work during session is in the budget with some legislation
- In December, the Governor's budget is announced; as the GA decides what amendments to include, DMAS provides support to legislators and staff
- DMAS provides expert review of any legislation assigned by the Governor
- DMAS works to implement all budget and legislative requirements.

2020 REGULAR SESSION

The General Assembly met for its long session (60 days) starting on January 8th and adjourned on March 12th.

- The GA passed a biennial budget that made investments in key DMAS initiatives advancing equity and access to healthcare:
  - Extending FAMIS MOMS postpartum coverage to 12 months postpartum
  - Eliminating the 40 Quarters Work Requirement for Lawful Permanent Residents
  - Study to evaluate costs and benefits for the Medicaid payment of services provided by doulas to help reduce maternal and infant mortality in Virginia
  - Enhancements to Behavioral Health services
  - Adding a comprehensive adult dental benefit

- Due to COVID and the uncertainty of the economy, all of these items were “un-allotted” or put on hold until later in the summer.

2020 REGULAR SESSION (CONT.)

The General Assembly also passed legislation impacting DMAS.

- **HB902 and SB902:** provides more access to Long Term Services and Supports screenings and alternate tools to be used for screenings.

- **HB1291 and SB568:** requires DMAS to ensure that Managed Care Organizations' contracts with Pharmacy Benefits Managers prohibits using spread pricing while providing pharmacy benefits.

- **Other legislation included:**
  - **HB826 and HB213:** convening workgroups to study adding a doula benefit and evaluation of the current Personal Maintenance Allowance.
  - **HB925:** requires development of a process to transition between the HCBS waiver to Medicaid Works.
  - **HB806, HB807, and SB949:** these bills deal with compensation and EOB receipt for sexual assault victims, and potentially moving the program to DMAS.

2020 SPECIAL SESSION

Special Session began on August 18th; with a focus on the budget and legislation on COVID and justice issues.

- The GA adjourned on Monday November 9th making this special session last longer then a regular “long” session.

- Key legislation for DMAS was related telehealth:
  - **HB5046 and SB5080**: allows telehealth flexibilities implemented during the public health emergency to continue
  - Extend flexibilities granted under COVID-19 until July, 2021

2020 SPECIAL SESSION

The GA passed a budget that included those budget items that were previously “un-allotted” due to the economic impact of COVID.

- Including Elimination of 40 quarters work requirement
- Extending FAMIS MOMS coverage to 12 months postpartum
- Providing an adult dental benefit
- Funding for advancing the enhancement of behavioral health services

2021 REGULAR SESSION

The 2021 Regular Session begins on January 13th 2021. This session is a short session and is set to last 45 days.

- Key DMAS topics will likely be those focused on COVID including:
  - Telehealth
  - Long-term care facilities
  - Access to healthcare

- DMAS is in the process of developing budget priorities for the Governor who will announce his budget on December 16th.

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

FORECAST AND BUDGET UPDATE

December 9, 2020

Summary of Medicaid Forecast

Chapter 1289

	FY21 Surplus/ (Need)	FY22 Surplus/ (Need)	FY23 Surplus/ (Need)
General Funds	$532.6*	$51.8	($234.8)

Dollars in Millions

2020 Special Session I Amendments to the 2020 Appropriation Act.

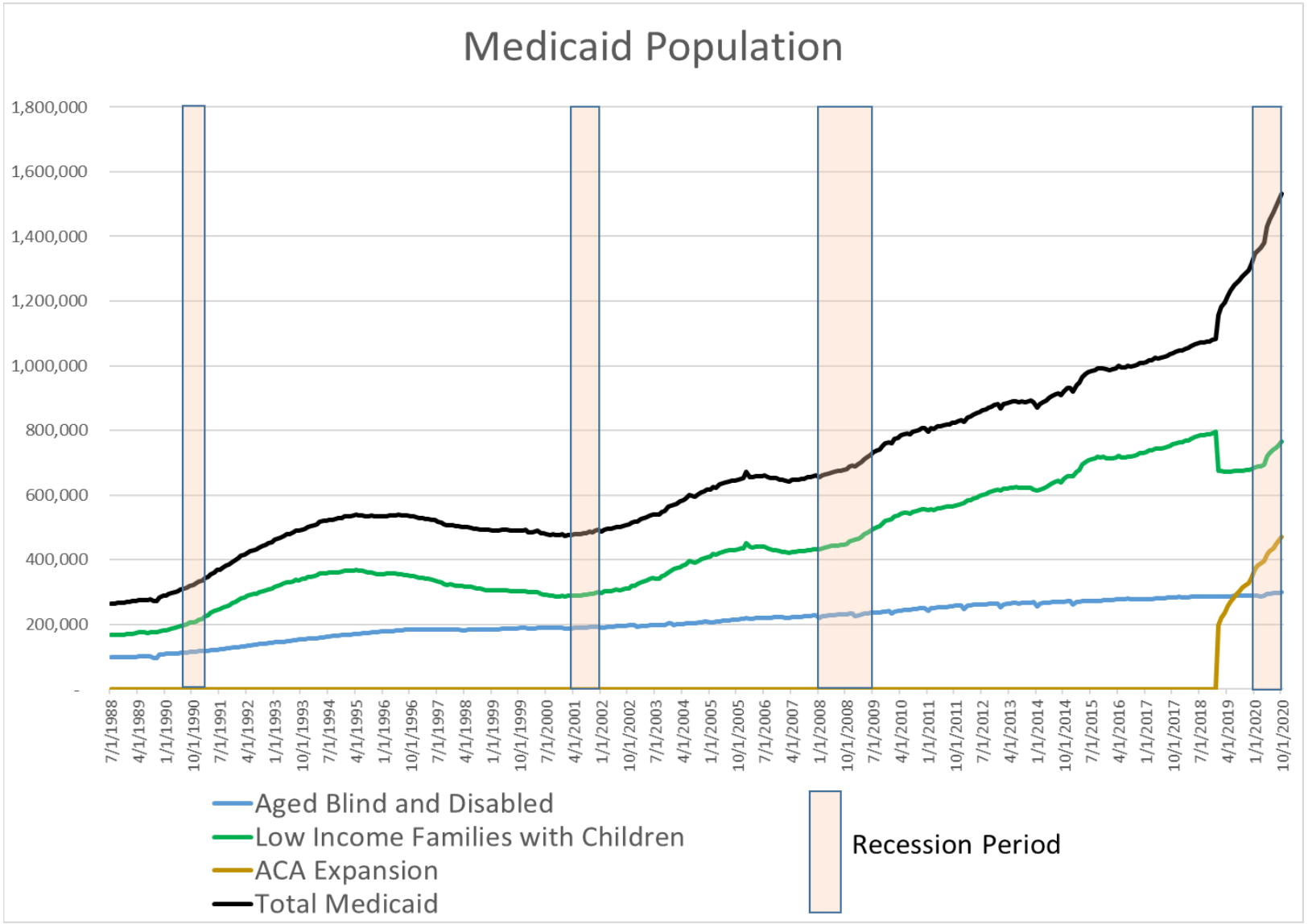
	FY21 Surplus/ (Need)	FY22 Surplus/ (Need)	FY23 Surplus/ (Need)
General Funds	$244.1**	($22.3)	($343.7)

Dollars in Millions

*Includes: Based on 2019 Forecast eFMAP Q1: $121.8M, Q2: $108.9M. The 2020 Forecast restates eFMAP Q1 and Q2, rolling new numbers into Q3: $204.4M. After eFMAP unallottment, net surplus is $97.4M.

**Includes: The 2020 Forecast restates eFMAP Q1 and Q2, rolling new numbers into Q3: $203.8M net of MOE. After eFMAP unallottment, net surplus is $40.3M.

Key Forecast Driver: Population Growth



Managed Care Rate Changes

Base Medicaid*

Dollars in Millions

	FY 2022	FY 2022	FY 2023	FY 2023
Medallion 4.0 Weighted Average	**4.8%**	**$115.6**	**3.4%**	**$214.6**
CCC+ Weighted Average	**5.5%**	**$266.4**	**4.7%**	**$537.9**

Medicaid Expansion

	FY 2022*	FY 2023*
Medallion 4.0 Weighted Average	**5.3%**	**3.7%**
CCC+ Weighted Average	**7.1%**	**6.0%**

*Notes:

1. Rate forecast based on CY2018 financial experience
2. Rates drawn against Ch.1289. Any new actions in GA20 Special Session I, or GA21 Regular Session will change rates

Managed Care: COVID-19 Vaccines

Reimbursement Schedule				
Fiscal Year	**Total Funds**	**General**	**Federal**	**Special**
FY21	$12,250,167	$2,526,389	$9,044,653	$679,125
FY22	$38,303,780	$14,185,121	$23,292,755	$825,904

- Administration: 1st dose: $16.94, 2nd dose: $28.39, full-treatment: $45.33
- No costing in FY21 for pregnant women and children (no vax studies yet)
- Includes transportation cost ($43 roundtrip, assumes 8% utilize NEMT)
- Utilization: 75%
- No cost for vaccine, purely administration
- Vaccines do not have rebates like other Medicaid pharmaceuticals
- Duals expected to be covered 100% by Medicare
- Children expected to be covered for Vaccines for Children (VDH)

Budget Submissions for 2021 Session

Decision Packages Submitted to DPB

21GA Decision Package Title	FY 2021 Total Funds	FY 2021 General Funds	FY 2021 MEL	FY 2022 Total Funds	FY 2022 General Funds	FY 2022 MEL
Accelerate Managed Care Profit Rebate	$0	$0	0.0	$0	$0	0.0
Add DBHDS licenses to ASAM Level 4.0	$0	$0	0.0	$0	$0	0.0
Allow FAMIS MOMS to utilize Substance Use Disorder Treatment	$0	$0	0.0	$38,564	$13,497	0.0
Allow Medicaid 90-Day Pharmacy Supply	$0	$0	0.0	$0	$0	0.0
Allow Pharmacy Immunizations for Covered Services	$0	$0	0.0	$0	$0	0.0
Authorize Post-Public Health Emergency Telehealth	$0	$0	0.0	$0	$0	0.0
Expand Addiction Treatment Beyond Opioid Use Disorder	$208,498	$84,383	0.0	$2,177,560	$881,306	0.0
Extend Medicaid/FAMIS MOMS prenatal coverage to otherwise-eligible expectant mothers whose children will be citizens at birth	$0	$0	0.0	$4,961,518	($2,292,083)	0.0
Fund COVID-19 Vaccine Coverage for Non-Expansion Medicaid Adults	$0	$0	0.0	$8,731,888	$4,365,944	0.0
Fund Doula Services for Pregnant Women	$0	$0	0.0	$2,411,402	$1,168,371	0.0
Fund Durable Medical Equipment (DME) Federal Mandate	$144,160	$68,014	0.0	$576,635	$272,050	0.0
Fund HITECH Interoperability and Patient Access	$0	$0	0.0	$12,857,001	$2,431,879	0.0
Fund Home Visiting Benefit Workgroup	$0	$0	0.0	$750,000	$375,000	0.0
Fund Managed Care Operational Changes – Federally Mandated	$0	$0	0.0	$7,001,000	$2,196,012	0.0
Fund Post-Public Health Emergency Remote Patient Monitoring	$0	$0	0.0	$5,687,528	$2,256,633	0.0
Implement Client Appeals Process Changes	$742,985	$240,673	10.0	$1,998,992	$868,364	10.0
Implement the Virginia Facilitated Enrollment Program	$0	$0	0.0	$8,125,391	$1,166,180	4.0
Increase Appropriation for Civil Monetary Penalty (CMP) Funds	$0	$0	0.0	$3,265,000	$0	0.0
Standardize Outpatient Rehabilitation Reimbursement Methodology	$0	$0	0.0	$0	$0	0.0
Totals	**$1,095,643**	**$393,070**	**10.0**	**$58,582,479**	**$13,703,153**	**14.0**

Public Comment December 9, 2020

Good morning DMAS Board Members,

I am Brittney Lee and I live in Henrico. I am asking that Assistive Technology be funded without a medical prescriber. Assistive Tech would greatly improve my life by allowing me the ability to stay connected with friends, family and support. It would also provide the ability to be more self-sufficient when completing every day tasks. For example, I serve as a co-chair for an Alliance, my level of involvement is limited because typing is hard with only one finger. I have had to pay over $300 for a computer and over $50 for a printer. I am also trying to save for additional home assistive tech that would help ensure my safety and independence including Dragon Naturally Speaking, Alexa and a Ring Doorbell. Saving is difficult with a $120/month budget that is u sed to purchase all of my personal care items, clothes and activities. Thank you for your attention.

To: DMAS Board Members and Director Kimsey
From: Jesse Monroe
RE: DMAS Board Public Comment on December 9, 2020

Good morning DMAS Board members. My name is Jesse Monroe, and I live in Norfolk, Virginia. I am here today to ask that there be increased funding for assistive technology for those of us with disabilities. I'm also requesting that certain barriers be removed from AT funding that already exists.

I have a disorder called Arthrogryposis. Though I have sensation, I have no movement of my limbs and need full physical support. I utilize AT such as Google Home and Amazon Echo to live more independently in my apartment. Between the two of them, I can open and close the front door, turn on and off all the lights, and operate my television without any assistance, simply using my voice. This technology is vital for my freedom and safety, especially opening the door. I have a Medicaid waiver and when I looked into utilizing the AT funding that was available through my waiver, I was informed no one in my area was certified by Medicaid to either sell or modify my devices as I needed them.

I know I am not alone in this struggle. I have several disabled friends who had been unable to get the AT they need to live an inclusive life. The approval process for AT funding must be me made less burdensome, and there should be more funding available. By doing this, those of us with disabilities can live more fulfilling lives.

Thank you.

JB/12.8.2020

Regulatory Activity Summary December 9, 2020
(* Indicates Recent Activity)

2020 General Assembly

***(01) Repeal to GAP-SMI Regulations:** The Governor's Access Plan (GAP) was a Medicaid program implemented in 2015 to provide low-income individuals with a serious mental illness (SMI) access to medical and behavioral health care. Individuals enrolled in the GAP-SMI program were covered for limited mental health benefits. However, the vast majority were able to move into the Medicaid Expansion program, which allowed members to be covered for all Medicaid-covered services. This fast-track regulatory action was initiated to remove outdated reg text, which is no longer needed due to the January 2019 implementation of Medicaid Expansion. The GAP-SMI program closed due to the Expansion, and these regulations can now be repealed. The draft regulatory text is currently being created.

***(02) 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. The project is currently circulating for internal review.

***(03) 2020 Provider Reimbursement Changes:** This regulatory action implements three mandates from the 2020 General Assembly. These relate to specialized care operating rates, personal care rates, and a supplemental DSH payment for non-state government public acute care hospitals. Following internal review, which began on 6/22/20, the regs were submitted to the OAG for review on 8/26/20; published in the Register on 11/23/20; and will become final on 12/23/20. The corresponding State Plan Amendments (SPAs), for institutional and non-institutional reimbursement, were submitted to CMS on 9/25/20; and the SPAs were approved on 11/22/20 and on 12/2/20, respectively.

***(04) Update of Dental Fee Schedule:** The purpose of this state plan amendment, as it relates to reimbursement of dental services, is to reflect the inclusion of updated dental procedure codes in the agency fee schedule. Following internal review, HHR approved the SPA on 7/16/20. The SPA was submitted to CMS for review on 7/27/20. CMS approved the action on 9/2/20.

***(05) 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.

***(06) 2020 Program of All-Inclusive Care for the Elderly (PACE) Changes:** These regulatory amendments are being made pursuant to HB/SB902, passed by the 2020 General Assembly, which make the following changes to § 32.1-330.3 of the Code of Virginia: (1) remove the definition of and references to Pre-PACE; (2) update references to the U.S. Health Care Financing Administration with references to the Centers for Medicare and Medicaid Services; and (3) change "preadmission screening" to "long term services and supports screening." Following internal review, these final exempt regulations were submitted to the OAG for review on 11/4/20.

***(07) 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.

(08) Update of the DMAS-225 Form: This reg project is designed to clarify that the DMAS-122 Form (Adjustment Process) has been updated and re-numbered as the DMAS-225 Form (Long-Term Care Communication) in the regulations. This action conforms with current DMAS practice, as the DMAS-225 is currently in use to administer payments and adjustments. The DMAS-122 is no longer in use. Two definitions and multiple regulatory references to the DMAS-122 form are being updated to reflect that the form is now the DMAS-225 form. Following internal review, the regulatory action was submitted to the OAG on 2/10/20 for review.

***(09) 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. The corresponding fast-track regulations are currently circulating for internal review.

***(10) 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. Following internal review, the corresponding regulatory project was sent to the OAG on 9/15/20.

***(11) Home Health Changes Due to Federal Regulatory Change:** DMAS intends to file a SPA with CMS in order to comply with new federal regulations that allow nurse practitioners, clinical nurse specialists, and physician assistants to order and certify home health services. (Previously, only physicians could order or certify these services.) CMS amended its regulations for Home Health on May 8, 2020 (in 85 Federal Register 27626) to allow practitioners other than physicians to order and certify home health services. DMAS is amending the state plan in order to comply with the new federal requirements. Following internal DMAS review, the DPB SPA notification and tribal notification letters were submitted on 7/16/20. The SPA was sent to CMS on 8/17/20 and approved on 10/29/20. The corresponding reg package, following internal DMAS review, was submitted to the OAG on 6/22/20. Following approval, the regs were sent to the Registrar, with an effective date of 8/19/20.

2019 General Assembly

(01) Federal Changes to PACE: The purpose of this regulatory action is to amend three sections of 12VAC30-50-335, General PACE Plan Requirements, in order to align the regulation with the federal PACE regulations. On May 28, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized a rule to update and modernize the Programs of All-Inclusive Care for the Elderly (PACE) program. This rule enforces best practices regarding the care for frail and elderly individuals. The first major proposed update to PACE since 2006, this action allows PACE organizations to operate with greater efficiency, while ensuring they continue to meet the needs and preferences of participants. More than 45,000 older adults are currently enrolled in more than 100 PACE organizations in 31 states, and enrollment in PACE has increased by over 120 percent since 2011. With the increased demand for PACE services, the federal updates are timely and will provide greater operational flexibility, remove redundancies and outdated information, and codify existing practice. The project was circulated for internal review on 10/30/19 and forwarded to the OAG for review on 1/16/20. Following a conf. call with the OAG on 6/2/20, DMAS submitted the requested edits on 6/26/20, and the reg action was approved by the OAG on 7/15/20. The regs were submitted to the Registrar on 7/16/20 for the 8/17/20 Issue, with an effective date of 9/16/20.

(02) Pooling of State Supplemental Drug Rebates: Currently, Virginia Medicaid enters into state-specific contracts with pharmaceutical manufacturers. The purpose of this State Plan

Amendment is to allow Virginia to participate in multi-state purchasing pools to enable Virginia to enter into value based purchasing agreements for high cost drugs. DMAS sent the DPB notification of the SPA on 9/24/19. Following internal review, the SPA was submitted to HHR on 10/25/19; forwarded to CMS on 11/1/19; and approved by CMS on 1/3/20. The corresponding regulatory action began circulating for internal review on 1/8/20. The regs were forwarded to DPB on 3/11/20 and submitted to HHR on 4/17/20.

***(03) Processing Medicaid Applications Using SNAP Income:** This SPA will enable DMAS to use gross income determined by SNAP to support Medicaid eligibility determinations at the tme of Medicaid application. Currently, DMAS uses a similar strategy at the time of annual Medicaid renewals. Medicaid eligibility criteria will remain the same, and there will be no change in the number or outcome of eligibility determinations made as a result of this change. The SPA notification was submitted to DPB on 9/24/19. Following internal DMAS review, he SPA was sent to HHR on 11/12/19 and forwarded to CMS on 12/5/19. CMS approved the SPA on 3/12/20. Following internal review, the corresponding regs were submitted to the OAG on 12/2/20. DMAS is awaiting OAG review and certification.

***(04) Revisions to Drug Utilization Review Program:** DMAS is implementing changes to the state plan text related to the Drug Utilization Review Program in accordance with the requirements of the Support Act (Public Law No. 115-271). The changes include Support Act provisions related to: claims review limitations; a program to monitor antipsychotic medications by children; fraud and abuse identification; and Medicaid managed care organizations requirements. The SPA notification was submitted to DPB on 10/22/19. Following internal review, the SPA was forwarded to HHR on 12/10/19; submitted to CMS on 12/17/19; and CMS approved the SPA on 3/4/2020. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 8/13/20. The regs were revised and re-submitted to the OAG on 12/2/20, as requested.

(05) Third Party Liability – Payment of Claims: Under current law, Medicaid is generally the "payer of last resort," meaning that Medicaid only pays for covered care and services if there are no other sources of payment available. Section 1902(a)(25) of the Social Security Act (the Act) requires that states take "all reasonable measures to ascertain the legal liability of third parties." The Act further defines third party payers to include, among others, health insurers, managed care organizations (MCOs), and group health plans, as well as any other parties that are legally responsible by statute, contract, or agreement to pay for care and services. This final exempt regulatory action mirrors this definition of third parties at 42 CFR 433.136. The Bipartisan Budget Act of 2018, which was signed into law on February 9, 2018, includes several provisions which modify third party liability (TPL) rules. This new law makes changes to the special treatment of certain types of care and payment, delays the implementation changes to the time period for payment of claims, repeals a provision regarding recoveries from settlements, and applies TPL to CHIP. Following internal DMAS review, the project was submitted to the OAG on 12/30/19.

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

controls of these providers will remain the same. The SPA folder began circulating for internal review on 8/22/19 and was sent to HHR on 10/22/19. The SPA was approved by CMS on 11/5/19. The corresponding fast track project was sent for review on 8/22/19. The reg action was submitted to the OAG on 9/27/19. DMAS responded to OAG inquiries on 12/2/19; the regs were certified by the OAG on 12/30/19; and then forwarded to DPB on 1/7/20. The project was sent to HHR on 2/13/20, and forwarded to the Governor's Ofc. on 11/24/20 for review.

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

***(08) ARTS Updates:** This fast-track regulatory package seeks to streamline, simplify, and clarify existing requirements for ARTS services and ARTS providers. The Addiction and Recovery Treatment Services (ARTS) program regulations became effective on April 1, 2017. Now, the regulations need minor modifications to address program needs as well as to answer questions that have been raised by providers. Following internal DMAS review and coordination, the reg project was forwarded to the OAG on 8/13/19. A conf. call was held on 9/18/19 to discuss the regs. The OAG requested revisions and corrections were sent on 9/25/19. Additional requested changes were sent to the OAG on 10/8/19. The OAG certified the regulations on 10/11/19; the project was submitted to DPB on 10/15/19; and forwarded to HHR for review on 11/22/19. The regs were submitted to the Registrar on 12/18/19; published in the Register on 1/20/20; and became final on 3/5/20. The corresponding SPA began circulating for internal review on 4/28/20. The SPA was submitted to CMS on 10/6/20 and approved on 11/10/20.

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

edits were made. The project was submitted to DPB on 12/12/19 and forwarded to HHR on 1/21/2020. The reg action was forwarded to the Governor's Ofc. on 11/24/20 for review.

2018 General Assembly

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

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

(03) Medicaid Expansion — Determination State (Medicaid): This state plan amendment is designed to allow Virginia to change from the Assessment Model of eligibility determination to the Determination Model of eligibility determination. In the Assessment Model, which Virginia currently follows, the Federally Facilitated Marketplace (FFM) makes an initial assessment of eligibility and the State Medicaid agency must then re-determine eligibility to make a final decision. In the Determination Model, the FFM makes the final Modified Adjusted Gross Income (MAGI) or CHIP determination and transmits the determination to the State Medicaid agency. The state must then accept the FFM determination as final. The Virginia General Assembly has directed DMAS to expand Medicaid eligibility to individuals age 19 or

older and under age 65, who have household income at or below 138% of the federal poverty level, effective January 1, 2019. As a result of Medicaid expansion, many more FFM applicants will now qualify for Virginia Medicaid and the application determination backlog that is currently experienced during open enrollment is expected to increase. Movement to the Determination Model will significantly reduce the number of applications forwarded from the FFM that require a Medicaid determination by state/local/contractor staff. This change is particularly important due to the anticipated increase in applications from all sources due to interest in Medicaid expansion coverage combined with the 2019 Open Enrollment Period. Following internal DMAS review, the SPA was submitted to HHR, and then forwarded to CMS on 7/23/18. A conf. call with CMS was held on 8/2/18 and CMS requested edits on 8/7/18. Additional follow-up questions from CMS were received and responses were returned to CMS on 8/20/18. The SPA was approved 10/9/18. The corresponding reg package was forwarded to the OAG on 11/9/18. OAG comments were forwarded to DMAS on 2/28/19. Responses were returned on 3/7/19 and 3/19/19. The regs were submitted to DPB on 4/4/19; to HHR on 4/16/19; and to the Governor on 5/27/19. The project was sent to the Registrar on 7/3/19. The regs were published in the Register on 8/5/19, with an ER effective date of 8/19/19. The NOIRA comment period extended from 8/5/19 through 9/4/19, with one comment received. The corresponding fast-track began circulating for internal review on 9/6/19 and was submitted to the OAG on 10/10/19. DMAS requested an ER extension on 2/19/20 that will expire on 9/17/21.

(04) Settlement Agreement Discussion Process: This regulatory action establishes a more formalized process by which to address administrative settlement agreements, in a timely fashion. The proposed new regulation, 12 VAC 30-20-550, describes the process for settlement agreement discussions between a Medicaid provider and DMAS and how it affects the time periods currently set forth in the existing informal and formal appeal regulations at 12 VAC 30-20-500 et. seq. The proposed amendments to 12 VAC 30-20-540 and 12 VAC 30-20-560 are necessary for these sections to be consistent with the proposed new regulation, 12 VAC 30-20-550. The amendments affect the timelines for issuing either the informal decision in an informal administrative appeal or recommended decision of the hearing officer in a formal administrative appeal when the proposed new regulation 12 VAC 30-20-550 pertaining to the settlement agreement process is used. Following internal review, the project was submitted to the OAG for review on 10/16/18. DMAS received questions from the OAG on 4/29/19. Responses were forwarded to the OAG on 5/8/19. The project was sent to DPB on 7/9/19; to HHR on 7/23/19; to the Gov. Ofc. on 9/10/19; approved by the Gov. on 9/18/19; and submitted to the Registrar on 9/18/19. The reg publication date was 10/14/19, with a comment period though 11/13/19, an effective date of 11/14/19, and an expiration date of 5/13/21. The corresponding fast-track package was circulated for internal review on 10/9/19 and submitted to the OAG on 11/14/19.

***(05) Removal of the 21 Out of 60 Day Limit:** This fast-track regulatory action is necessary to comply with the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Rule, issued on March 30, 2016. The overall objective of the Medicaid Mental Health Parity Rule is to ensure that accessing mental health and substance use disorder services is no more difficult than accessing medical/surgical services. To comply with the Medicaid Mental Health Parity Rule, DMAS must remove the limit of 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan for psychiatric inpatient hospitalization, as this limit for coverage of non-psychiatric admissions was removed on July 1, 1998. (Medicaid managed care plans do not apply the limit of 21 out of 60 days, and both the limit and the change

only apply to fee for service.) Psychiatric inpatient hospitalizations must be service authorized based on medical necessity and not be limited to 21 days per admission in a 60 day period. The citation for the federal regulation to remove the "21 out of 60 day limit" can be found in 42 CFR 438.910(b)(1). Following internal DMAS review and coordination, beginning on 6/20/18, the project was submitted to the OAG on 7/1/19. A conf. call w/ the OAG and SMEs to discuss the regs was held on 7/24/19. The OAG sent additional questions on 8/12/19, and DMAS responded on 8/21/19. The regs were certified by the OAG on 9/12/19 and submitted to DPB on 9/13/19. DMAS responded to DPB inquiries the week of 9/16/19 and to additional DBP inquiries following a conf. call on 10/1/19. DPB forwarded the regs to HHR on 10/21/19 and the action was sent to the Gov. Ofc. on 11/17/19. The Gov. Ofc. approved the regs on 8/12/20. The regulatory action was submitted to the Registrar on 8/20/20, with an issue date of 9/14/20. The comment period ended 10/15/20, with an effective date of 10/30/20. The corresponding SPA is currently being developed, in preparation for internal review.

***(06) Electronic Visit Verification (EVV):** This NOIRA action intends to amend regulations in order to include provisions related to Electronic Visit Verification (EVV) as required by the 21st Century CURES Act, 114 U.S.C. 255, enacted December 13, 2016 (the CURES Act) and the 2017 Appropriations Act Chapter 836, Item 306. YYYY. The CURES Act requires states to implement an EVV system for personal care services by January 1, 2019 and home health care services by January 1, 2023. The 2017 Appropriations Act authorizes DMAS to require EVV for personal care, respite care and companion services. The CURES Act requires that the EVV system must verify: 1) The type of service(s) performed; 2) The individual receiving the service(s); 3) The date of the service; 4) The location of service delivery; 5) The individual providing the service, and 6) The time the service begins and ends. DMAS sought input regarding the EVV system from individuals receiving services, family caregivers, providers of personal, respite and companion care services, home health care services, provider associations, managed care organizations, health plans and other stakeholders. DMAS also sought input on the current use of EVV in the Commonwealth and the impact of EVV implementation. The NOIRA was circulated for internal DMAS review and submitted to DPB on 4/30/18. The NOIRA was approved by DPB on 5/11/18 and forwarded to the Gov. Ofc. The Gov. approved the regs on 8/22/18. The regs were filed with the Registrar's Ofc. on 8/23/18, with the comment period ending on 10/17/18. With no comments received, the proposed phase review began on 10/25/18. The regs were forwarded to the OAG for review on 1/17/19. The OAG forwarded regulatory questions on 4/23/19, and DMAS sent responses back on 4/29/19. Additional changes were sent to the OAG on 6/7/19. The OAG forwarded inquiries on 7/19/19 and DMAS responded. The regs were sent to DPB for review on 7/29/19. A conf. call w/ DBP was held on 8/20/19, and DMAS sent additional responses/revisions on 8/21/19. DMAS fielded several DPB questions the weeks of 9/9/19 and 9/16/19. The reg action was submitted to HHR, approved on 9/15/19, and sent to the Governor on 9/15/19. The EIA response was posted to the TH on 9/18/19. The Gov. Ofc. completed its review on 12/17/19. The project was submitted to the Registrar on 12/18/19, with a publication date of 1/20/20. The 60-day public comment period expired on 3/21/20. The Town Hall proposed stage comment review was complete/categorized on 4/10/20 and a notification e-mail was submitted to commenters. The final stage phase of the reg action was sent to the OAG for review on 9/14/20. On 11/10/20, revisions were made and the project was sent back to the OAG. DMAS is awaiting further feedback. The SPA DBP notification was submitted to DPB on 11/4/19. Following internal review, the SPA was submitted to HHR on 3/2/20 and HHR approval was received on 3/26/20. The Tribal notification was sent on 6/11/20. The SPA was submitted to CMS for review on 9/1/20 and approved on 10/6/20.

2017 General Assembly

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

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

***(03) Clarifications for Durable Medical Equipment and Supplies:** This NOIRA regulatory action will serve to update coverage and documentation requirements to better align them with best practices and Centers for Medicare and Medicaid (CMS) guidance, and to eliminate unnecessary elements that create confusion among DME providers. Specifically, these proposed changes include elements around: enteral nutrition, implantable pumps, delivery ticket components, and replacement DME after a natural disaster. It is expected that these changes will clarify coverage of DME and supplies for DME providers and Medicaid beneficiaries, and reduce unnecessary documentation elements for DME providers. Further, the changes will improve coverage by permitting newer and better forms of service delivery that have evolved in recent years and align Virginia's coverage with recent guidance from CMS for enteral nutrition. Following an internal DMAS review, the package was submitted to DPB on 3/13/17. DPB moved the regs to the Governor's Office for review/approval on 3/27/17. The Governor signed the regulatory action on 4/14; and the regs were published on 5/15, with the comment period ending on 6/14/17. The Proposed Stage regs were drafted on 6/16 and submitted to the OAG on 10/25. The OAG submitted questions on 12/11 and DMAS coordinated and submitted responses on 1/3/18. Additional revisions were forwarded to the OAG on 2/13/18. The regs were certified by the OAG on 3/8/18 and submitted to DPB on 3/9/18. A conf. call w/ DPB was held on 4/17/18 to discuss the regs. Revisions were made and DMAS revised text and resubmitted the regulatory action. DPB approved the project on 4/26/18 and it was also moved to the Secretary Ofc. for review on 4/26/18. The EIA was posted on 4/26 and the Agency response to EIA was posted on 4/27/18. HHR completed its review on 10/24/18, and the regs were forwarded to the Gov. Ofc. on 10/24/18. The Proposed Stage regs were approved by the Gov. on 2/5/19 and submitted to the Registrar on 2/6/19. The regs were published in the Register on 3/4/19, with a 60-day comment period, ending on 5/3/19. The Final Stage reg package was circulated internally for review on 5/13/19. The regs were submitted to DPB on 7/26/19. DMAS received and fielded DPB questions to SMEs on 8/7/19. The Agency submitted responses to DPB's inquiries on 8/13/19 and 8/21/19. A conf. call w/ DPB was held on 9/4/19, resulting in additional edits. The reg action was submitted to the Gov. on 9/10/19 for review. The reg action was approved by the Gov. on 12/09/19, with a 30-day public comment that expired on 2/06/20. The regs became effective on 2/21/20. The corresponding SPA began circulating for internal review on 5/27/20. After HHR approval on 7/22/20, the SPA was submitted to CMS on 7/27/20. Following a conf. call with CMS on 8/3/20, DMAS coordinated responses to additional CMS inquiries. CMS requested additional edits on 10/7/20 and the revised plan pages were sent back. CMS approved the SPA on 10/20/20.

2016 General Assembly

***(01) CCC Plus (MCOs - B Waiver) – formerly known as 'Managed Long Term Care Services and Supports (MLTSS)':** This emergency regulatory action is required by 2016 budget language. The regulation changes will transition the majority of the remaining Medicaid fee-for-service populations into an integrated, managed long-term services and supports (MLTSS) program. DMAS intends to launch an MLTSS program that provides a coordinated system of care that focuses on improving quality, access, and efficiency. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 3/9/2017. DMAS received requests for revisions from the OAG on 3/16, 3/20 and 3/21. Following conference calls on 4/7 and 4/11 and a meeting on 5/1, the action was certified on 5/12 and then submitted to the DPB. The regs were forwarded to HHR on 5/22/17 and on to the Governor on 5/29. The Gov. signed the action on 6/16/17, with an effective date between 6/16 and 12/15/2018. The regs were published in the Register on 7/10, with a comment period through 8/9 (three comments were submitted). DMAS drafted the next stage of the regulatory review. The regs were submitted to the OAG on 1/9/18. DMAS received inquiries from the OAG and responded on 2/26/18. Following internal edits, DMAS sent additional revisions to the OAG on 3/5/18, 3/21/18, 4/9/18, and 4/23/18. The regs were sent to DPB for review on 5/7/18. The EIA for this project was posted on 7/16/18, in addition to the corresponding DMAS response. The regs were forwarded to HHR on 7/16/18 and they were certified on 7/17/18. The Proposed Stage regs were signed by the Gov. on 12/18/18 and published in the Registrar on 1/21/19; with a public comment period through 3/22/19. The Final Stage reg package was circulated internally for review on 5/7/19. The regs were submitted to the OAG on 7/19/19. DMAS received inquiries from the OAG on 8/14/19 and forward responses on 8/20/19. Additional revisions were sent to the OAG on 9/3/19. The project was submitted to DPB on 1/7/20 and forwarded to HHR for review on 1/27/20. The project was submitted to the Gov.'s Ofc. on 11/24/20.

2015 General Assembly

***(01) Three Waiver Redesign:** This emergency regulatory action is required by 2016 budget language. The Individual and Family Developmental Disabilities Support Waiver is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver is changing to the Community Living Waiver (CL), and; the Day Support Waiver for Individuals with Mental Retardation is changing to the Building Independence Waiver (BI). This redesign effort, ongoing between DMAS, DBHDS, consultants, and stakeholders for the last two years, combines the target populations of individuals with both intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. The regulatory action was OAG-certified on 8/18/2016 and DPB and the Secretary's Office approved the regulations on 8/22/16. The action was approved by the Governor on 8/24 and published in the Register on 9/19/16, with a public comment period through 10/24 (1 comment submitted). The Proposed Stage regs were drafted on 12/2016 and following internal DMAS review, submitted to the OAG on 7/31/17, and re-submitted on 9/7/17. Following a conference call on 9/18/17, DMAS coordinated revisions and submitted changes on 11/1/17. DMAS submitted an ER extension request for this project on 12/8/17. The ER had been extended until 8/30/18. The regs were forwarded to DPB on 5/23/18; certified by HHR on 7/16/18; and the Proposed Stage regs were approved by the Gov. on 12/18/18. The regs were published on 2/4/19, with a public comment that ended on 4/5/19. Following the public comment review, the Final Stage reg package was circulated for internal review on 6/4/19. The regs were submitted to the OAG on 9/17/19 for review. DMAS held a meeting with the OAG on 10/15/19 to discuss the project, and awaited additional feedback. The reg action was forwarded to the Governor for review on 11/24/20.

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

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

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

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