BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, June 18, 2024
10:00 AM to 12:00 PM
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
1st floor Conference Rooms A&B

To Join Meeting Remotely: *https://covaconf.webex.com/covaconf/j.php?MTID=meb731f1f86a9f1a4b9b1d6dc375aaf72*
Closed Captioning Link https://www.streamtext.net/player?event=HamiltonRelayRCC-0611-VA4121

AGENDA

#	Item	Presenter
1	Call to order	Tim Hanold, Board Chair
2	Approval of 03/12/2024 Meeting Minutes	Tim Hanold, Board Chair
3	Director's Report	Cheryl Roberts, Agency Director
4	ARTS/Former Foster Care 1115 Renewal	Jason Lowe, Behavioral Health Integration Advisor Christine Minnick, MSW, Child Welfare Program Specialist
5	Board Discussion – How do we encourage member engagement in care and coverage	Adrienne Fegans, Deputy of Programs
6	GA Updates	Jeff Lunardi, Chief Deputy
7	Budget Updates	Chris Gordon, CFO
8	Virtual Option: Bylaws Review	Morgan Greer, Board Counsel
9	New Business/Old Business	
10	Public Comment - Public comments limited to a total of 15 minutes. Public should send their request in writing to BMAS Board Secretary, speaker's name and subject 10 days before the scheduled meeting.	
11	Regulations	
12	Adjournment	

Next Meeting Dates: September 17th and December 10th

DRAFT MINUTES
Tuesday, March 12, 2024
10:00 AM

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

Present: Tim Hanold, Patricia Cook, Basim Khan, Elwood Boone, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan

Present Virtually: Ashish Kachru

Absent: Dr. Vienne Murray

DMAS Attendees: Cheryl Roberts-DMAS Director, Jeff Lunardi - Chief Deputy, Tammy Whitlock – Deputy Complex Care Services, Adrienne Fegans -Deputy for Programs, Sarah Hatton – Deputy for Administration, Chris Gordon-Deputy for Finance, John Kissel-Deputy for Technology & Innovation, Ivory Banks – Chief of Staff, Rich Rosendahl- Deputy for Health Economics and Economic Policy, Will Frank, Senior Advisor for Legislative Affairs, Truman Horwitz, Director of Budget, Brian McCormick, Emily McClellan, Beth Guggenheim, Board counsel and Brooke Barlow, Board Secretary.

1. **Call to Order**

Brooke Barlow, Board Secretary, called for a motion by the Board to open the regular meeting of the Board of Medical Assistance Services at 10:10 am on January 12, 2024, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

Moved by Brooke Barlow; 10:06 am.

2. **Introduction of New Board Members**

Cheryl Roberts, Director, welcomed new members Jennifer Clarke, Margaret Roomsburg and Dr. Vienne Murray to the Board. Dr. Vienne Murray was not present for this meeting.

3. **Elect Chair Pro Tem and Election of Officers**

The Board Secretary, called for the Board to nominate a Chair Pro Tem due to the current board not having a Chair or Co-Chair.

Tim Hanold moved to nominate Paul Hogan as Pro Tem; seconded by Elwood Boone.
Motion 8-0

Voting for: Tim Hanold, Patricia Cook, Basim Khan, Elwood Boone, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan
Voting Against: None

Paul Hogan as Pro Tem motioned the Board to take nominations for the position of Chair.
Jason Brewster nominated himself and Tim Hanold nominated himself. There were no other nominations for Board Chair. Oral votes were taken from the members.
Voting for Jason Brewster: Patricia Cook, Elwood Boone and Jason Brewster
Voting for Tim Hanold: Basim Khan, Tim Hanold, Paul Hogan, Jennifer Clarke and Margaret Roomsburg
By a 4-3 vote, Tim Hanold is elected to the Board Chair position.
Motion 8-0

Paul Hogan as Pro Tem motioned the Board to take nominations for the position of Co-Chair and Paul Hogan moved that Jason Brewster be nominated as Co-Chair; seconded by Elwood Boone.
Motion 8-0
Voting For: Tim Hanold, Patricia Cook, Basim Khan, Elwood Boone, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan
Voting Against: None

Paul Hogan as Pro Tem motioned the Board to take nominations for the position of Board Secretary.
Paul Hogan as Pro Tem nominated Brooke Barlow as Board Secretary.
Moved by Patricia Cook; seconded by Jason Brewster
Motion 8-0
Voting For: Tim Hanold, Patricia Cook, Basim Khan, Elwood Boone, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan
Voting Against: None

4. Amending the Bylaws

After some discussion and question from the Board to Beth Guggenheim, Board Counsel, the Board motioned to table the issue of Amending the Bylaws.

5. Approval of Minutes

The minutes from the December 12, 2023, meeting were introduced and approved.

Moved by Tim Hanold; seconded by Elwood B Boone to Approve Motion Passed: 8 - 0
Voting For: Tim Hanold, Patricia Cook, Basim Khan, Elwood Boone, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan
Voting Against: None

6. Director's Report

Director Roberts presented to the Board an overview of Medicaid, program updates, maternal health and the Cardinal Care Managed Care procurement. Medicaid and CHIP (FAMIS) are joint federal and state programs authorized under Title XIX and Title XXI of the Social Security Act. Implementation requires authorization by the Governor and General Assembly, and funding through the Appropriation Act. Federal guidance and oversight is provided by the Centers for Medicare and Medicaid Services (CMS). State programs are based on a CMS-approved "State Plan" and Waivers. DMAS is designated as the single state agency within the Governor's administration to operate the Medicaid program in Virginia.

Current appropriations is $22.9 billion with a match of 51% non-general funds (NGF) and 49% general funds (GF). Medicaid expansion is 90% NGF/10% is covered by hospital coverage assessment. Only 1.5% of the total DMAS budget is for administrative expenses. Medicaid covers adults, children, limited benefit individuals, individuals with disabilities, older adults and pregnant members.

The delivery systems for Virginia Medicaid are Fee-For-Service (FFS), where DMAS contract and pays providers directly for every Medicaid eligible service rendered to Medicaid members and Managed Care (MCO) where 96% of Medicaid members are covered through five health plans. Each MCO is responsible for delivering health benefits and related services to its Medicaid members.

There are five levers involved in Virginia Medicaid health care: Coverage & Services (requires federal and state authority and funding), Data Analytics, Member Engagement, Provider/Health System, Managed Care Organization.

The Virginia Medicaid and FAMIS enrollment dashboard reflects the Medicaid Maternal Enrollment. As of March 1, 2024 there was a total of 40,469 pregnant members covered under Virginia Medicaid. Investing in Medicaid maternal health and adopting best evidence-based practices in the perinatal and postpartum period can prevent many of the common causes of pregnancy-related morbidity and improved family and community health.

Pregnancy-related morbidity disparities are greatest among African American women and women in the Tidewater, and Roanoke/ Alleghany region.

•Highest pre-term and low-weight babies,

•Highest Emergency Room (ER) utilization postpartum

Clinical Focus Areas:

•Increase Postpartum visits

•Cardiac health for Pregnant Women

•Reduce ER Utilization Postpartum (current rate 15%)

Actions:

•Maternal health Roundtable hosted by HHR Secretary

•National Governor's Association (NGA) Rural Maternal Health Collaborative

•Cardiovascular disease

•DMAS maternal health internal workgroup

Cardinal Care Managed Care Background

•The Cardinal Care Managed Care (CCMC) program provides comprehensive health care services for 1.8 million Virginians receiving Medicaid and CHIP through five contracted health plans.

•DMAS is taking a bold approach to improve the program with three steps:

•Creation of Cardinal Care Managed Care – A consolidation of the two programs formerly known as Commonwealth Coordinated Care Plus and Medallion 4.0

•Defining the transformation goals for the program

• Reprocurement of the Cardinal Care Managed Care delivery system

7. Legislation Update

Will Frank, Senior Advisor for Legislative Affairs, presented an update on the Virginia General Assembly. DMAS' legislative role is to monitor introduced legislation, review legislation and budget language for Secretary and Governor, make position recommendations to Secretary and Governor, communicate Governor's positions to General Assembly, provide expert testimony and technical assistance to legislators on legislation.

The 2024 General Assembly session had 2,852 bills introduced, DMAS was assigned 38 lead bills plus took an active role in key legislation led by other agencies. These included bills with Amend, No Position and Oppose positions.

The major topics included:
•New Medicaid benefits

•Changes to rules for paid family caregivers (legally responsible adults)

•Eligibility changes for waiver recipients

•Pharmacy benefit changes

Legally Responsible Adults

•Legislation introduced in the House and the Senate to change specific provisions of DMAS's approved plans to continue paying Legally Responsible Individuals who provide personal care to their children

•Allows 40 hours per member if there are two members in the household

•LRI to provide services without proof of no other provider

•Another parent can be employer of record

•LRI is eligible for respite services

•HB909 and SB488, which passed the General Assembly requires DMAS to allow the above services except for respite, but study and submit a report on allowing respite.

Pharmacy Legislation

•Legislation and Budget Amendments were introduced proposing changes to drug costs and purchasing

•State-wide centralized pharmacy purchasing

•Pharmacy carve-out from managed care

•Prescription Drug Affordability Board

•Changing payment structure for long-acting injectables (LAI)

•Of these proposals, only the Prescription Drug Affordability Board passed and had funding in the budget.

Wavier and Screening Bills

•Disregard Social Security Disability Insurance when determining financial eligibility for DD waivers

•Increase the time a DD waiver slot can be retained from 150 days to up to 365 days

•Greater flexibility for nursing facilities and PACE programs to conduct LTSS screenings in specific circumstances

Other Legislation

•Bill to require timeliness of lien settlements when DMAS has a claim for reimbursement against the settlement of a member (when they are injured and the settlement covers their medical costs)

•Bill creating a new provider type – behavioral health technicians and behavioral health technician assistants – would enable DMAS to potentially include these provider types in redesigned behavioral health services

8. Budget Update

Truman Horwitz, Budget Division Director, provided an overview of expenditure comparison, enrollment comparison and tracking to the forecast.

Starting with the MCO categories, FY24 is trending lower than FY23. This is anticipated to continue to be the case because of the accelerated capitation payment at the start of the Fiscal Year – July's capitation payment was made in June to take advantage of a more favorable FMAP, saving general funds.

Beginning in January of 2023, Medicare Part D premiums could be paid for the Medicaid Expansion population. Additionally, approximately 4.7% year over year enrollment growth in expansion.

Looking next at Fee for Service Behavioral Health - The FY24 number is reporting higher than it should be; this includes CSA cases that are typically not included in the accuracy report. On November 1, DMAS had a contractor turnover the reporting of CSA cases to another contractor and staff is working through the new contractor to get a new report live so that the cases can be identified. All that's to say is that this number is overreported and is likely closer to the FY22/23 numbers based on historical trends. This is expected to be fixed within the month.

This change is driven by the increases in slots in FY24:
170 CL
500 FIS

Looking next at hospital supplemental payments – in addition to capitation, DMAS also accelerated several DSH, GME, and IME payments from FY24 into FY23 to save general funds.

The Upper Payment Limit has increased, as has utilization, year–over-year, primarily explaining this change. As a reminder, UPL is defined as a reasonable estimate of the amount that would have been paid for the same service under Medicare payment principles.

This data represents only one month of data in current year rebates. Looking ahead to next month's data, we are anticipating getting closer to the FY23 number in February's data.

Comparing it to the latest FY24 forecast. Many of the items we discussed on earlier slides impact the variance here, specifically the CSA reporting, the timing of the rate assessment payments, and the pharmacy rebates. Hospital Supplemental payments is higher than forecast due to an unanticipated cost settlement with UVA and VCU. Increased MedEx enrollment is resulting in higher collections of coverage assessment and lower rate assessment payments.

Summary:

•Financial Data through January is tracking to the Forecast.

•The agency is monitoring enrollment and taking steps to ensure we are covered through the year.

9. Nursing Facility Value-Based Purchasing Program Update

Rich Rosendahl, Deputy for Healthcare Analytics & Transformation presented an overview of the Nursing Facility Value Based Purchasing.

•The Nursing Facility Value-Based Purchasing Program (NF VBP) program incentivizes Nursing Facilities (NFs) to improve quality of care

•Established by the General Assembly in 2021, DMAS administers this program in collaboration with contracting Managed Care Organizations (MCOs)

•265 NFs participate, serving close to 19,000 Medicaid members each month

•For the 2024-2025 period, approximately $144M will be distributed to NFs for achievement and/or improvement on the following quality measures:

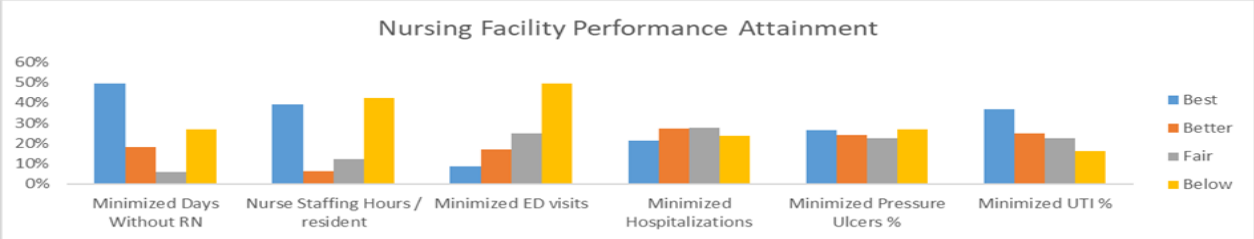
https://www.dmas.virginia.gov/data/value-based-purchasing/nursing-facility-value-based-purchasing-program/

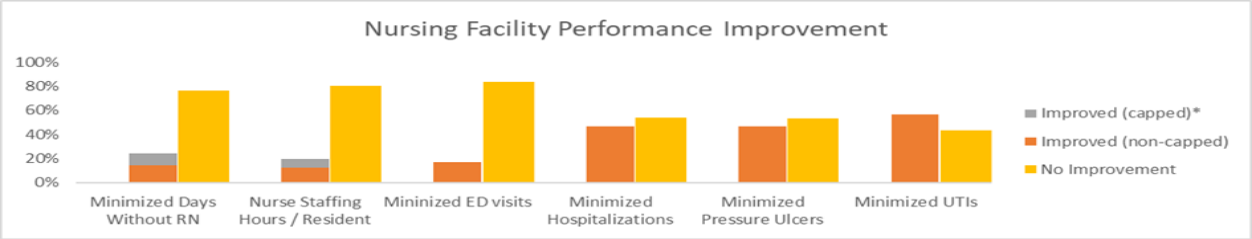
Staffing	Avoidance of Events for Long-stay Residents
•Days Without Minimum RN Hours •Total Nurse Staffing (Case-Mix Adjusted)	•# Hospitalizations / 1,000 Resident Days •# ED Visits / 1,000 Resident Days •# High-Risk Residents with Pressure Ulcers •# Residents with a Urinary Tract Infection

Results (2022 Measurement Year)

•97% of NFs were awarded an attainment payment and/or improvement payment (total payments averaged $231K / NF)

•NFs performed most strongly on minimizing days without RNs, UTIs and pressure ulcers; minimizing ED visits was most challenging to NFs





10. New Business/Old Business – No New Business or Old Business

11. Public Comment – No public comments

12. Regulations

Regulatory Activity Summary March 12, 2024
(* Indicates Recent Activity)

2024 General Assembly

***(01) 12-Months Continuous Coverage (Medicaid):** The purpose of this state plan amendment is to follow a mandate, requiring state Medicaid agencies to cover children for a continuous 12-month period from the date of enrollment, regardless of changes in the child's circumstances. This coverage will improve access to health care and health care outcomes for individuals under the age of 19. These changes became effective January 1, 2024. This SPA also makes a technical change to note that DMAS processes the eligibility applications of individuals who are returning to the community after a period of incarceration. This change reflects current DMAS processes and does not have a cost impact; instead, it provides a more detailed description so that CMS is aware of the role that DMAS plays with regard to these specific applications. Following internal review, the SPA was submitted to CMS on 1/20/24.

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

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

Clarify requirements for the Substance Use Care Coordination as well as the role of the licensed practical nurse (LPN) in the opioid treatment program (OTP) setting to align with current practices. LPNs are permitted to provide onsite medication administration treatment during the induction phase.

Clarify the size of SUD counseling groups to align with current practice. The group size is limited to a maximum of 12 individuals, but this may be exceed based on the clinical determination of a Credentialed Addiction Treatment Professional (CATP).

Update provider licensing references for SUD services (ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0) to reflect current DBHDS requirements and DMAS current practices.

The project is currently circulating for internal review.

***(03) Other Licensed Practitioners:** DMAS recently received approval from CMS of SPA 23-0014, entitled "Pharmacists as Practitioners." CMS sent a "companion letter" with the SPA approval requesting additional changes to one of the state plan pages. These changes are wording changes only and do not reflect any change in coverage or in program rules. This SPA will incorporate the following changes based on CMS' request:

(i) Remove the reference to ophthalmologists on this page of the state plan because these practitioners fall into the "physician services" section of the state plan. The word "ophthalmologists" has been removed as required by CMS.
(ii) Clarify whether DMAS reimburses licensed optometrists and opticians or also reimburses unlicensed practitioners. Wording changes have been made to clarify that only licensed practitioners are covered.
(iii) Clarify whether DMAS reimburses unlicensed providers for behavioral health services. Wording changes have been made to clarify that reimbursement is only made to licensed mental health professionals and certified pre-screeners.

The SPA project is currently circulating for internal review.

***(04) Removal Duplicative Language:** DMAS is amending the State Plan to remove redundant and unnecessary language. DMAS submitted a previous SPA related to School Services (SPA 21-0017), which was approved by CMS on September 26, 2023. In that SPA, DMAS inadvertently did not remove some of the old school services text. Consequently, this SPA will repeal the outdated language which is duplicative and unnecessary. The project is currently circulating for internal review.

2023 General Assembly

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

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

***(03) Dental Updates:** The purpose of this state plan amendment, in accordance with the 2023 Virginia Acts of Assembly Item 304.XXXX, is to (1) extend the age limitation for children receiving fluoride varnish from non-dental providers from "through age 3" to "through age 5"; (2)

remove the current limitation on the number of times a dentist can bill the behavioral management code when treating adults with disabilities; (3) provide payment for crowns for patients who received root canal therapy prior to becoming a Medicaid beneficiary; and (4) provide reimbursement for pre-treatment evaluations performed by dentists treating patients requiring deep sedation or general anesthesia to mirror the Centers for Medicare and Medicaid Services (CMS) guidelines. Following internal review, the project was submitted to CMS for review on 1/10/24.

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

(05) Third Party Liability: The purpose of this state plan amendment is to add language that is needed to respond to a CMS State Medicaid Director letter (#23-002) requiring Medicaid agencies to amend their state plan to provide assurances that the state has rules in place that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. The SPA will also provide clarity relating to lien amounts arising from the Medicaid program and asserted against personal injury claims proceeds. Following internal review, the SPA was submitted to CMS for review on 9/1/23.

(06) Removal of DATA Waiver (X-Waiver): Section 1262 of the Consolidated Appropriations Act, 2023, removed the federal requirement that practitioners obtain a DATA-Waiver or X-Waiver to prescribe medications, like buprenorphine, to treat patients with opioid use disorder. Accordingly, the state plan is being revised to allow providers who have a current license to practice and a Drug Enforcement Administration (DEA) registration authorizing the prescribing of Schedule III drugs to prescribe buprenorphine for the treatment of opioid use disorder or pain management. Following internal review, the SPA was submitted to CMS for review on 6/30/23 and approved on 9/22/23.

***(07) Targeted Case Management for Individuals with Traumatic Brain Injury:** In accordance with **House Bill 680** of the 2022 legislative session and the **2022 Appropriations Act,** DMAS is revising the state plan to include a provision for the payment of targeted case management for individuals with severe brain injury. The project is currently circulating for internal review. Implementation planning is underway to begin provider enrollment activities and service delivery in state fiscal year 2023. Following internal review, the project was submitted to CMS for review on 8/30/23 and approved by CMS on 11/22/23. The corresponding regulatory action is forthcoming.

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

The SPA notes that the exchange will:

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

***(09) Electronic Visit Verification (EVV) for Home Health:** The purpose of this SPA is to incorporate changes to the state plan text in accordance with the requirements of the Social Security *Act* (SSA) § 1903(l) regarding EVV as applicable to home health care services across all mandates of the SSA and the *Cures Act*. Virginia is in compliance with section 12006 of the 21st Century CURES Act, which required states to implement EVV for personal care services by January 1, 2020. Section 12006 of the CURES Act requires states to implement EVV for Home Health Care Services (HHCS) by January 1, 2023. Virginia applied for and received a one-year Good Faith Effort (GFE) exemption for HHCS. As a result, Virginia implemented EVV for Home Health Care Services on July 1, 2023. Following internal review, the SPA was submitted to CMS on 8/28/23 and approved on 10/26/23. The corresponding regulatory project was submitted to the OAG on 1/17/24 for review.

(10) Case Management for Assisted Living Facility Residents: This SPA will allow DMAS to remove outdated case management language for assisted living facility residents from the state plan. DMAS has not provided this service for several years, so the state plan needs to be updated accordingly. Following internal review, the SPA was submitted to CMS on 7/3/23.

(11) Repeal of Documents Incorporated by Reference (Chapter 60): This regulatory action is being carried out in accordance with Governor Youngkin's Executive Order #19. DMAS completed an internal review of 12VAC30-60 and determined that all of the documents incorporated by reference are either outdated or already exist on the DMAS Medicaid Enterprise System (MES) Web Portal or via other sources that are not owned by DMAS (e.g., the DSM). Therefore, referencing them in the Virginia Administrative Code is unnecessary and they should be repealed. This regulatory action is being promulgated to repeal out-of-date and unnecessary regulations. Following internal review, this regulatory action was submitted to the OAG on 7/19/23.

(12) Provider Appeals: The purpose of this regulatory action is to clarify when documents are considered filed and adds the Appeals Information Management System (AIMS) to the Virginia Administrative Code in accordance with the DMAS current provider appeals practices. Following internal review, this project was submitted to the OAG on 2/1/23 and certified by the OAG on 6/12/23. The reg project was submitted to DPB on 6/22/23 and to HHR on 7/25/23.

(13) Repeal of Out-of-Date and Unnecessary Regulations: This regulatory action is required in accordance with Governor Youngkin's Executive Order #19. DMAS has completed an internal review of these regulations and has determined that all of the content already exists in the DMAS Eligibility and Enrollment Manual on the DMAS webpage, and that these regulations are

redundant and unnecessary, and should be repealed. Following internal review, the project was submitted to the OAG for review on 1/30/23.

(14) OTC Drugs: This SPA is required based on the CMS' request for Virginia to change the language related to over-the-counter (OTC) drugs. CMS asked DMAS to include the following sentence in order to indicate where a list of OTC drugs could be located: "A list of specific covered drug categories is published in Chapter 4 of the Pharmacy Provider Manual." With this new language, DMAS no longer needs, and proposes deleting the following language: "2. Non-legend drugs shall be covered by Medicaid in the following situations: a. Insulin, syringes, and needles for diabetic patients; b. Diabetic test strips for Medicaid recipients under 21 years of age; c. Family planning supplies; d. Designated categories of non-legend drugs for Medicaid recipients in nursing homes…" (These items will remain covered, but they will be stated with specificity in the Pharmacy Manual and do not need to be repeated in the state plan.) CMS also asked that Virginia remove language related to home infusion therapy from the pharmacy section of the state plan. That language is already in the durable medical equipment section of the state plan, so removing the language from the pharmacy section has no practical effect. Following internal review, the SPA was submitted to CMS on 4/24/23 and approved on 5/18/23. The corresponding regulatory project was submitted to the OAG for review on 7/31/23.

2022 General Assembly

(01) Removal of Cost Sharing: The purpose of this regulatory action is to remove co-payments for Medicaid and FAMIS enrollees in accordance with a General Assembly mandate. The 2022 Appropriations Act, Item 304.FFFF, required DMAS to remove co-payments for Medicaid and FAMIS enrollees effective, April 1, 2022. DMAS has not been imposing co-payments on Medicaid and FAMIS members during the federal public health emergency (PHE) related to the Coronavirus Disease 2019 (COVID-19) pandemic. However, as of a result of 2022 Appropriations Act, Item 304.FFFF, co-payments have been permanently removed and they will not be reinstated after the federal PHE ends. Following internal review, the reg project was submitted to the OAG for review on 3/21/23.

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

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

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

(05) Third Party Liability Update: This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA was submitted to CMS on 6/27/22 and approved on 7/25/22. Following internal review, the corresponding fast-track project was submitted to the OAG for review on 12/13/22. Revised regs were sent to the OAG for review on 5/30/23. Minor revisions were made to the regs and updated regs were forwarded to the OAG for review on 10/24/23.

(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. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 6/29/22; to DPB on 10/13/22; and to the HHR on 11/16/22.

2021 General Assembly

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

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

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

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

additional info on 12/8/23 and DMAS forwarded responses on 12/13/23, 12/15/23, and 12/18/23. The project was approved by DPB on 12/19/23. HHR is currently reviewing the regulations.

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

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

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

(08) Adult Dental: The purpose of this SPA is to align with Item 313.IIII in the 2020 Virginia Appropriations Act, which requires DMAS to provide a comprehensive dental benefit to adults, effective July 1, 2021. The DPB and Tribal Programs notifications were forwarded on 2/22/21. The SPA was submitted to CMS on 3/25/21. The SPA was approved on 6/14/21, with an 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. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22. DMAS received inquiries from the OAG on 12/16/22, 1/3/23, 1/9/23, 1/25/23, 2/9/23, 2/13/23, 3/2/23, and 3/13/23. DMAS submitted responses to the multiple OAG requests for edits and is awaiting further direction. On 6/15/23, DMAS requested an emergency reg extension and notified the OSHHR of the request. On 6/20/23, the Gov. Ofc. approved extending the emergency regulation until 2/14/24.

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

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

Management economic impact form was uploaded to the Town Hall on 10/13/22. A conf. call with HHR was held on 8/28/23 to discuss changes in reg text and to discuss implications. HHR approved DMAS proceeding with revisions to the regs on 11/2/23 and revisions were made. DMAS is currently awaiting the project's submission for the Gov's signature.

2017 General Assembly

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

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.

13. Adjournment

Moved by Patricia Cook; seconded by Jennifer Clarke to Adjourn 12:03pm.
Motion: 8 - 0

Voting For: Tim Hanold, Patricia Cook, Basim Khan, Elwood Boone, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan
Voting Against: None

Board of Medical Assistance Service – Director's Update

Cheryl Roberts, J.D., DMAS Director

June 18, 2024

1

Agenda

- Medicaid Overview
- Director's Program Updates
- ELT Program Updates

2

DMAS Mission & Values

Our Mission & Values

To improve the health and well-being of Virginians through access to high-quality health care coverage and services

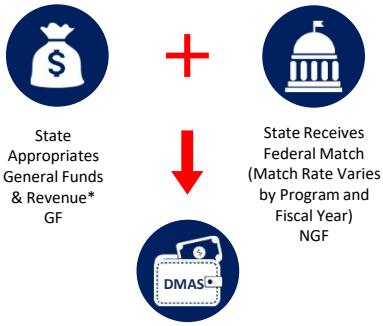
- Service
- Collaboration
- Trust
- Adaptability
- Problem Solving

Medicaid and CHIP Authority

- Medicaid and CHIP (FAMIS) are joint federal and state programs authorized under Title XIX and Title XXI of the Social Security Act
- Implementation requires authorization by the Governor and General Assembly, and funding through the Appropriation Act
- Federal guidance and oversight is provided by the Centers for Medicare and Medicaid Services (CMS)
- State programs are based on a CMS-approved "State Plan" and Waivers
- DMAS is designated as the single state agency within the Governor's administration to operate the Medicaid program in Virginia

Virginia Medicaid Funding and Authority

- Current Appropriations is $24.6 billion
- Medicaid match: 51% Non-General Funds (NGF)/49% General Funds (GF)
- Medicaid Expansion: 90% NGF/10% is covered by hospital coverage assessment
- Only 1.5% of the total DMAS budget is for administrative expenses



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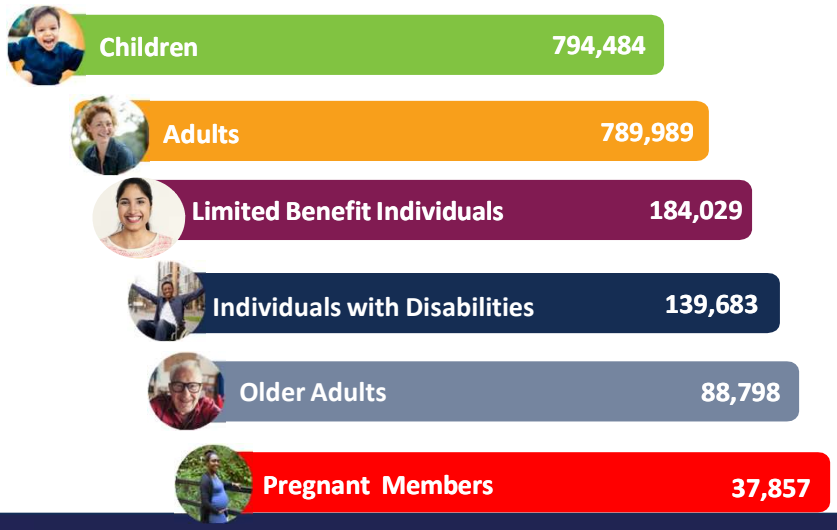
Who Do We Cover?

Medicaid is available to Virginians who meet specific income thresholds and other eligibility criteria



Source: June 1, 2024 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

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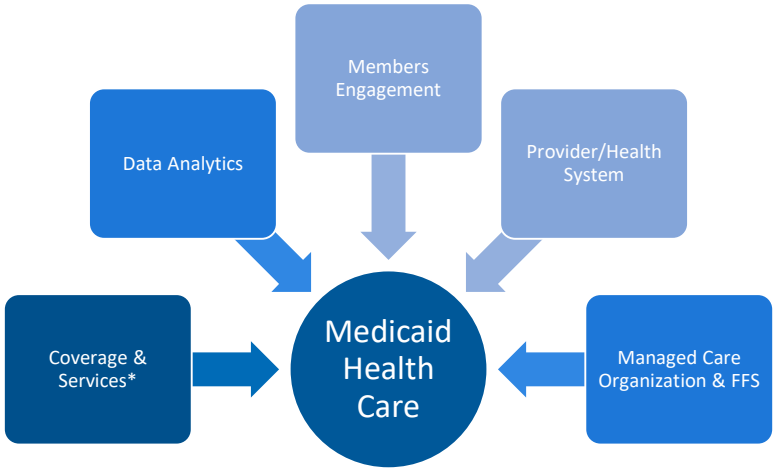
Virginia Medicaid – Health Care Levers

Five levers are involved in Virginia Medicaid health care



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* Requires Federal and state authority and funding

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SOAR in 2024

Reinforces DMAS' Commitment to Provide Health Insurance Coverage and Services to Qualified Low Income Members in the Commonwealth Efficiently

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

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8

8

Director's Program Updates

Managed Care
Contracts and rates
Procurement update
360 compliance review

CMS Final Rules
Eligibility;
Managed Care;
Access

Maternal Health
HHR Round table; lunch and learn;
NGA technical assistance
VHHA hospital discharge project
Podcast

Communication
Stakeholders
Other

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ELT Program Updates

Workforce
94% staff fill rate
Best in class - HR series
2nd paid intern cohort 5/24

Unwinding Update
92.99% completed

Systems
Fiscal Agent Solution (FAS) RFP

OCMO Update
Maternity and cardiac care
P&T Committee

Special Projects
Massey breast cancer project
Care coordination for RTC

Complex Care Updates
Legally responsible Individuals
BH Redesign activities

Nursing Facilities - VBP update

Dental Update

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Cardinal Care

Thank You!

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

1115 Demonstration Waiver Renewal Application:
Addiction and Recovery Treatment Services (ARTS)
and Former Foster Care Youth (FFCY)

DMAS

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Current 1115 Demonstration Expires 12/31/2024

With this renewal application, Virginia seeks to extend the SUD and Former Foster Care Youth (FFCY) components the Commonwealth's current 1115 demonstration to build upon Medicaid delivery system reforms already in place under Virginia's State Plan and Medicaid managed care program. Specifically, this demonstration extension, Virginia's demonstration "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" will:

1. Continue to provide essential SUD services to all Medicaid enrollees through the ARTS benefit;
2. Maintain authority for coverage of FFCY who aged out of foster care in another state and turned 18 prior to January 1, 2023; and
3. Sunset the High Needs Supports components of the demonstration until such time that the General Assembly signals funding authority to renew these or similar efforts to implement certain housing and employment supports to eligible high needs Medicaid members.

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Renewing Virginia's 1115 Demonstration Waiver

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

Virginia seeks to extend the Substance Use Disorder (SUD) and Former Foster Care Youth (FFCY) components the Commonwealth's current 1115 demonstration to build upon Medicaid delivery system reforms already in place under Virginia's State Plan and Medicaid managed care program.

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Former Foster Care Youth (FFCY) - Overview

Demonstration Overview

- Youth who age out of foster care services are at a higher risk for negative outcomes, including homelessness, incarceration, and substance abuse.
- This expenditure authority allows individuals who turn 18 while in foster care in any state to continue receiving Medicaid coverage up to age 26.
  - Goal: increase and strengthen overall coverage and improve health outcomes
- DMAS, Departments of Social Services (DSS), and Managed Care Organizations (MCOs) coordinate efforts to effectively transition these members to adulthood:
  - FFCY members can select and change their MCO at any time
  - Contract and reporting requirements for MCOs & DMAS oversight
  - DMAS External Quality Review: Annual Child Welfare Focus Study includes analysis of health care utilization of FFCY members

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Former Foster Care Youth (FFCY) - Outcomes

Demonstration Outcomes

- Since the FFCY demonstration was implemented, **enrollment** has steadily **increased**.
  - Specifically, enrollment has increased by 40%--from 65 members in 2019 to 91 members in 2022.
- Prior evaluation reports documented the following impacts of the demonstration on **service utilization** among out-of-state FFCY:
  - Among outpatient medical visits, outpatient behavioral health visits, emergency room visits, and inpatient stays,
    - Emergency Room (ER) visits were consistently the highest utilized service, while
    - Inpatient stays were the least utilized service.

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Former Foster Care Youth (FFCY) - Changes

Demonstration Changes

- Effective January 1, 2023, changes made by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act expanded eligibility under state plans to individuals who were in foster care from another states.
  - These changes were effective for individuals who reach age 18 on or after January 1, 2023.
- Virginia continues to seek 1115 demonstration authority to enroll individuals who received foster care in another state, and needs to **update** the authority to indicate that the demonstration will cover only out-of-state FFCY who turned 18 years of age prior to January 1, 2023.

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High Needs Supports (HNS)

- The High Needs Supports (HNS) program would provide critical housing and employment support services to the Commonwealth's high need Medicaid members who are enrolled in the managed care delivery system.
- **Please note: This program requires General Assembly authority in order to implement and continue development of the benefit.**
- This program will be sunsetted and removed from the 1115 demonstration waiver.

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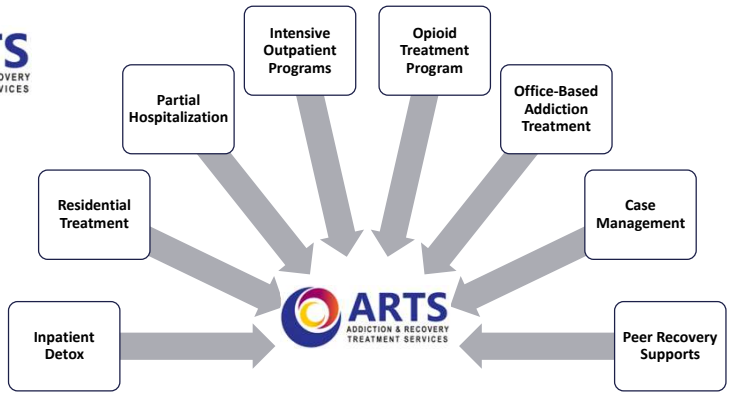
Virginia Medicaid SUD Benefit: Addiction & Recovery Treatment Services (ARTS)

ARTS ADDICTION & RECOVERY TREATMENT SERVICES



Goal is to ensure that members are matched to the right level of care to meet their evolving needs as they enter and progress through treatment.

ARTS offers a fully integrated physical and behavioral health continuum of care.

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Addiction and Recovery Treatment Services

- Due to the federal 1115 program requirements ARTS was built based on the American Society for Addiction Medicine (ASAM) continuum of care
  - ASAM is a model of comprehensive addictions treatment services
- This expenditure authority allows individuals who are aged 21 or older to receive high intensity treatment in behavioral health facility settings including psych hospitals and residential treatment centers.
- This facet of the program is essential to managing hospital discharges effectively for individuals who demonstrate a higher level of support need after a crisis or overdose emergency.

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Prevalence of SUD – Identifying more members in need

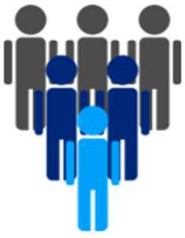
The **supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit** and has continued through Medicaid expansion and the COVID-19 pandemic.

In addition, ARTS is administered through the Medicaid Managed Care Organizations (MCOs) to fully integrate physical and behavioral health continuum of care for members.

 # Medicaid Members where SUD was identified - 2016

48,341

 # Medicaid Members where SUD was identified - 2023



267,528

ARTS ADDICTION & RECOVERY TREATMENT SERVICES

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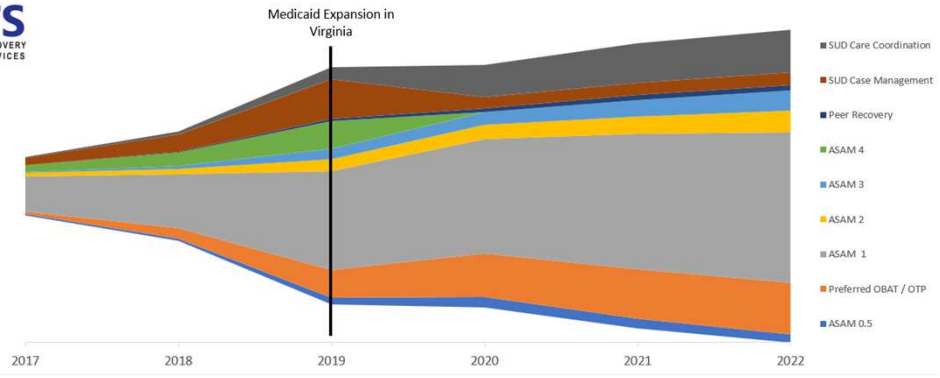
Treatment Rates Increased Substantially with ARTS



Treatment rates increasing substantially since ARTS implemented, specifically for members with OUD - **as of July 2021, more than 69 percent of members with OUD have received treatment, 26 percent more than members with any SUD diagnosis.**

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What action items should DMAS and other state agencies consider to:

a. support former foster care youth?

b. address the overdose crisis?

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12

What do you see as the greatest challenge to addressing care issues for:

- Former foster care youth?
- For members with substance use disorders?

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Virginia's Medicaid Program

13

13

Stay Connected to the ARTS

The new edition of the American Society of Addiction Medicine's Criteria has been released, and the ARTS team is looking at incorporating changes to the Criteria in ARTS policies and procedures.

Please email the SUD inbox (SUD@dmas.virginia.gov) if you have thoughts or ideas about things the team should be considering as we are preparing to make these changes.

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Virginia's Medicaid Program

14

14

Questions?

Jason Lowe, MSW
SUD@dmas.virginia.gov
804-659-8732

Christine Minnick, MSW
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804-255-4710

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15

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Encouraging Member Engagement in Coverage and Care

DMAS

1

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Open Discussion

- Member facing information
  - Social Media
  - Apps
  - Websites
- How do we encourage members to be more actively engaged?

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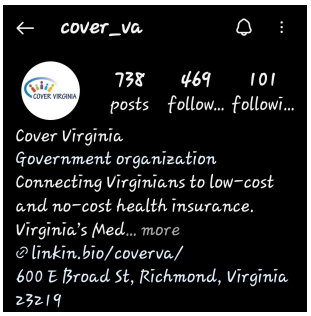

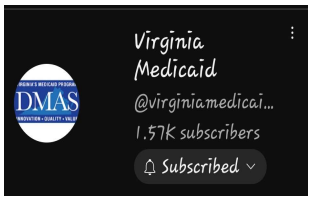

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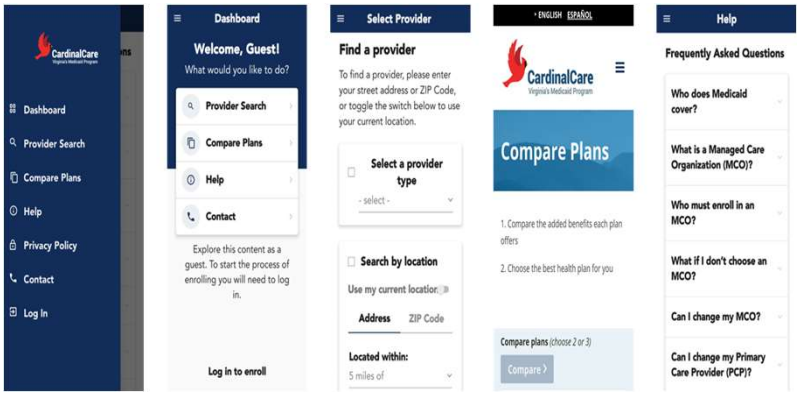

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Questions?

- **Enrollment Broker Website:** https://virginiamanagedcare.com/
- **Enrollment Broker Phone Number:**
  - **Toll-free number:**
    - 1-800-643-2273
    - **TTY:** 1-800-817-6608
  - **Hours of operation**:

    Monday – Friday

    8:30 a.m. – 6:00 p.m.

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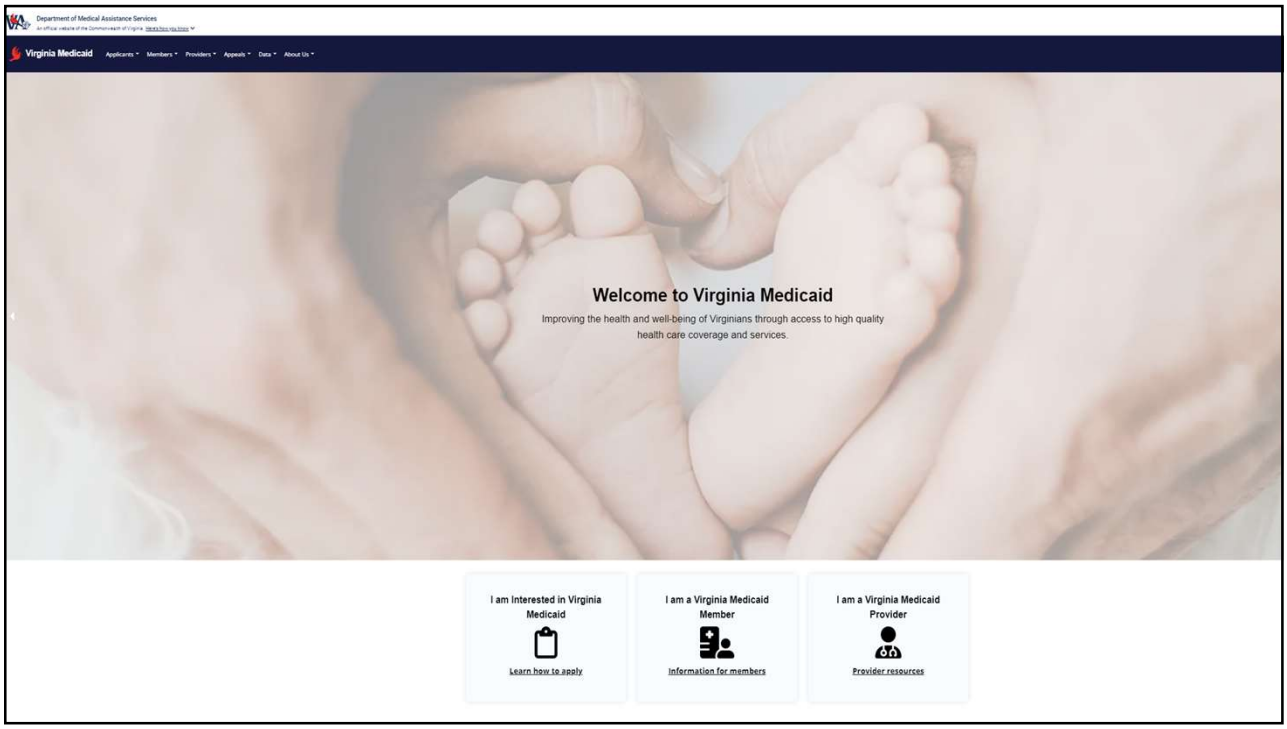
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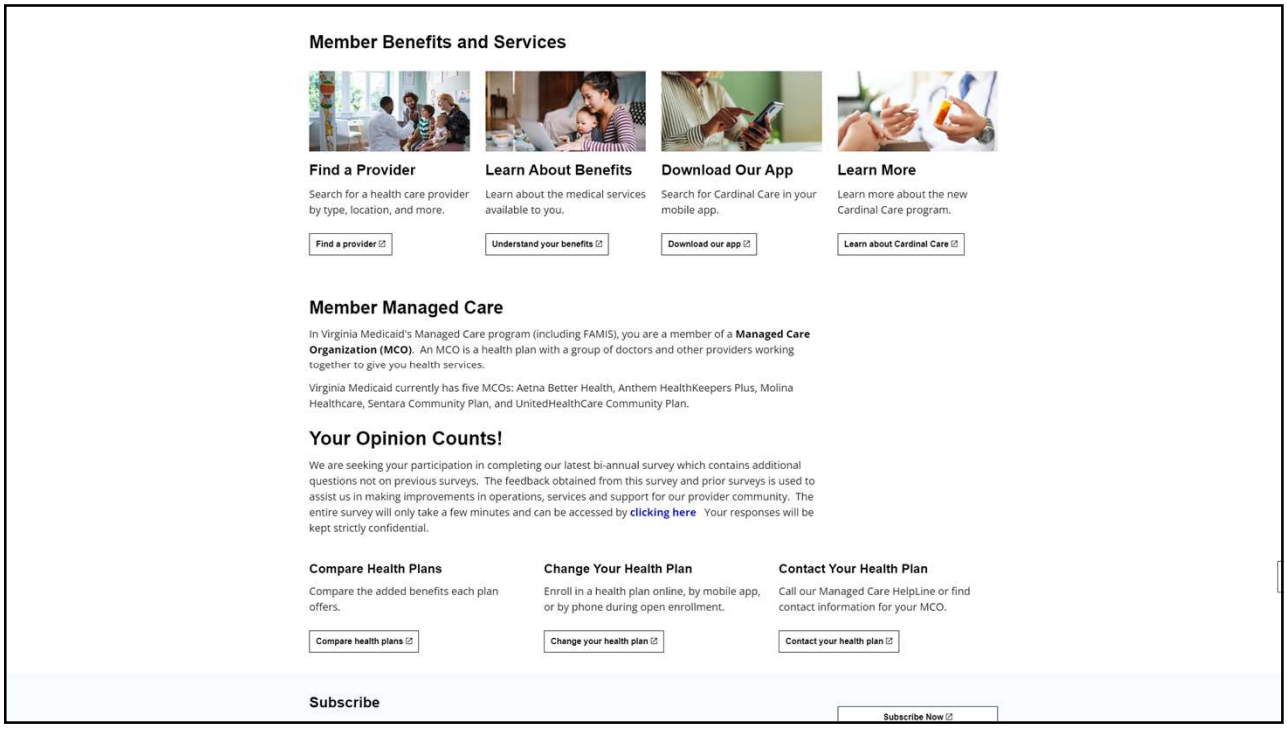
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In Virginia Medicaid's Managed Care program (including FAMIS), you are a member of a Managed Care Organization (MCO). An MCO is a health plan with a group of doctors and other providers working together to give you health services.
Virginia Medicaid currently has five MCOs: Aetna Better Health, Anthem HealthKeepers Plus, Molina Healthcare, Sentara Community Plan, and UnitedHealthCare Community Plan.
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We are seeking your participation in completing our latest bi-annual survey which contains additional questions not on previous surveys. The feedback obtained from this survey and prior surveys is used to assist us in making improvements in operations, services and support for our provider community. The entire survey will only take a few minutes and can be accessed by clicking here Your responses will be kept strictly confidential.
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Brainstorming Session

- What methods work?
- What methods don't work?
- What new ideas can we try?

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Virginia General Assembly Update

Jeff Lunardi
Chief Deputy
Department of Medical Assistance Services

1

Final Legislative Summary

- ID/DD waiver slots
- Behavioral health redesign
- Long-term care services and eligibility changes
- Provider rate increases
- Operational efficiencies
- System modernization

2

Interim Work 2024

DMAS is monitoring or involved in several studies by legislative committees

- Disability Commission is monitoring implementation of several policy changes from the 2024 GA
- Joint Commission on Health Care is conducting studies on access to health care and the health care workforce
- The Behavioral Health Commission is studying crisis services
- The Speaker created the House Select Committee on Advancing Rural and Small Town Health Care which is meeting this year
- The Joint Subcommittee on Health and Human Resources Oversight is planning to meet this year

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Budget Update

Truman Horwitz, Budget Division Director

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Overview

- Expenditure comparison
- Tracking to the forecast
- Signed Budget Update

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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

	Actuals Through April					FY24 vs FY23	
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Fee-For-service: Long-Term Care Services	1,241	1,236	1,418	1,850	2,026	176	9.5%
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Discussed Last Meeting: FY24 trends lower due to the accelerated capitation payment into FY23 (July to June) to save general funds at a favorable FMAP. **FY24 will have a total of 11 capitation payments; normal years have 12.** From accelerations in FY24, **approximately $34m in GF was saved through the acceleration of capitation payments alone in FY24.**

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Expenditure Comparison
In Millions

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Discussed Last Meeting: Primarily related to Medicaid Expansion: Year-over-year population growth as well as Medicare Part D payments beginning in January 2023.

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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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Issue from prior months has been resolved; trend is returning to pre-FY22 levels.

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Expenditure Comparison
In Millions

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Discussed Last Meeting: Primarily driven by DD Waiver slots added in FY24.

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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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Discussed Last Meeting: Increased Upper Payment Limit and Medicaid Expansion population over FY23.

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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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Total	**11,194**	**13,127**	**15,468**	**17,592**	**17,952**	**360**	**2.0%**

Discussed Last Meeting: Pharmacy Rebates have been trending lower. A few months forward has closed the gap slightly.

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Expenditure Comparison
In Millions

Five Year Look-back (Through April)

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Discussed Last Meeting: Increased Medicaid Expansion Enrollment in short term and Increased UPL.

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Expenditure Comparison – Another way to Look at the Data

In Millions

FY 2024 Compared Against the Forecast

Expenditures	YTD FY 2024	YTD Apr Forecast	Variance	Comments
Cardinal Acute	5,611.5	5,493.7	2.1%	Slower unwinding than forecasted
Cardinal LTSS	6,221.3	6,187.8	0.5%	Slower unwinding than forecasted
Fee-For-service: General Medicaid	1,789.4	1,654.7	8.1%	Slower unwinding than forecasted
Fee-For-service: BH & Rehabilitative	48.7	35.7	36.3%	Slower unwinding than forecasted
Fee-For-service: Long-Term Care Services	2,025.7	1,998.4	1.4%	Slower unwinding than forecasted
Hospital Supplemental (DSH, IME/GME, Dx)	606.1	594.6	1.9%	Timing and Cost Settlement
Hospital Rate Assessment Payments	2,109.9	2,249.3	-6.2%	Timing
Pharmacy Rebates	(460.5)	(503.2)	-8.5%	Lower Pharmacy Rebates
Title XIX Total	**17,952.1**	**17,711.0**	**1.4%**	
Fund Type				
General	4,738.1	4,545.8	4.2%	
Coverage Assessment	574.6	532.1	8.0%	
Rate Assessment	635.0	660.9	-3.9%	
VA Health Care Fund	415.1	405.6	2.3%	
Federal	11,589.3	11,566.6	0.2%	
Total	**17,952.1**	**17,711.0**	**1.4%**	

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Signed Budget Highlights

- Signed biennial budget included impacts to many of DMAS' levers.
- Some highlights include:
  - Rate increases: Dental, CD/AD PCAs, DD, DME Rates.
  - Slots: DD, GME.
  - Changes to rules around weight loss drugs.
  - New FTEs to support: Cardinal Care, TPL, E&E.
- See the appendix slides for the full list.

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Summary

- Financial data shows a variance from forecast due to slower unwinding.
- Lessons from FY24 will be incorporated into FY25/26 forecast

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Appendix Slides

- Full summary of Budget Changes

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Caboose Budget Changes

Item	Summary
Aligning Virginia TPL with CMS requirements	Aligns Virginia Medicaid with new CMS requirements prohibiting TPL providers from denying claim because it did not receive prior-approval with the TPL provider's rules.
MCO Re-procurement	Document all changes, legal authority, and fiscal impact by June 1, 2024
Adds $2.8M coverage assessment appropriation	Allows DMAS to increase cost allocation for Dentaquest, Acentra, FAS to MedEX
Adds $1.7M coverage assessment appropriation	Allows DMAS to cost allocate MES modules (AIMS, EDWS, ISS, PRSS) to MedEX

Biennium Budget Changes

Item	Summary
Removes $500K each year from TDO fund	GA is removing TDO GF for other priorities since it is underused
Remove obsolete supplemental payment language	PRD will review supplemental payments with Mercer to remove unnecessary language
Develop change-in-scope policy for FQHCs	Complete by January 1, 2025, allow providers to submit CIS by October 1, 2024
Supplemental Payments (many)	Adds 5 FTEs, adds specific requirements for quality measures (DMAS approval, quarterly and annual reporting to DMAS), requires analysis of all supplemental payment quality measures and report to GA by November 15, 2024.
Adds $1M for 10 OBGYN GME slots	$1M for 10 OBGYN GME residency slots each year

Biennium Budget Changes

Item	Summary
Increase CD facilitation service rate	Adds $10.9M each year to increase CD management training, initial comprehensive visit, routine visit, and reassessment visit
Increase DME rate for enteral products ONLY (no resp.)	Increase to 100% of Medicare rural or non-rural if rural does not exist
Increase peer mentoring service rate	Adds $17K each year to increase rate for peer mentoring services
Increase dental rates 3%	3% rate increase for dental services
50% rate increase to Grafton	Provides $1.8M annually to Grafton for rate increase

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Biennium Budget Changes

Item	Summary
2% rate increase for CD/AD PCAs	FY25: authorizes 2% rate increase for CD/AD PCAs FY26: authorizes ANOTHER 2% increase for CD/AD PCAs (cumulative 4% raise)
MCO re-procurement	Allows implementation by July 1, 2024
Collaborative Care Guidelines	Deliver BH in primary care practices
Weight loss Rx—PA required	Requires PA for weight loss drugs
Weight loss Rx—restriction	Restricted to: • BMI>40, or • BMI>37 plus at least one comorbidity: hypertension, Type 2 diabetes, or dyslipidemia, or Traditional weight-loss drug excluding GLP-1s

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Biennium Budget Changes

Item	Summary
Medicaid Forecast Contingency	Provides $95M in FY25 in case there are more Medicaid members than expected based on Nov.1 forecast.
Permanently implements telehealth delivery for DD waivers	Permanently enshrine telehealth services for DD waivers
DD Waiver SLOTS: 3,440	FY25: • 387 each quarter FIS, 43 each quarter CL • total = 1,548 FIS, 172 CL FY26: • Additional 387 each quarter FIS, additional 43 each quarter CL • total = 1,548 FIS, 172 CL Total over biennium: 3,096 FIS, 344 CL for 3,440 total

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Biennium Budget Changes

Item	Summary
DD Waiver RATES: 3% each year	FY25: 3% rate increase to DD waiver providers FY26: ANOTHER 3% increase to DD waiver providers (cumulative 6% increase in FY26)
Requirements for Medicaid CD Facilitators	Removes Associate/Bachelor degree requirements for CD services facilitators
NF VBP	Adds $40M in FY25 and $40M in FY26 to inflate NF VBP program
NSGONF supplemental payments	Adds $3.7M to five NSGONFs supplemental payments
Annual inflation for PRTFs	Annually inflates rate
CHKD supplemental payment	Adds $16M annually to CHKD supplemental payment

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Biennium Budget Changes

Item	Summary
DMAS to report to DSS if TPL available for child	The Department of Medical Assistance Services, in cooperation with the Department of Social Services' Division of Child Support Enforcement (DSCE), shall identify and report third party coverage where a medical support order has required a custodial or noncustodial parent to enroll a child in a health insurance plan. The Department of Medical Assistance Services shall also report to the DCSE third party information that has been identified through their third party identification processes for children handled by DCSE.

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Biennium Budget Changes

Item	Summary
Align outpatient rehab reimbursement with industry standards	Updates reimbursement for outpatient rehab to RBRVS
Bravo 2.0	
USPTF Prevention Services for Adults	
Modify EFRC	Removes December meeting, adds focus on enrollment trends
TPL Activities	17 FTE to execute TPL, create TPL dashboard
Transfer 1 FTE from DBHDS to DMAS	Implement DD waiver rates review and changes
Add 3 FTEs to replace E&E contractors	No additional funding, need to attrition wage/contractors in E&E to fund
Fiscal Agent Services (MMIS) replacement	Un-allots funding until DMAS provides DPB with itemized documentation of cost for replacement

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Biennium Budget Changes

Item	Summary
Add 3 FTE for Cardinal Care Oversight	FY25 & 26: 3 FTE with 590K GF, 590K NGF
Improve eligibility determination	Improve efforts to determine if individuals applying to Medicaid and CHIP are eligible for alternate healthcare coverage. No funding, report due October 1.
DSH Workgroup	Workgroup evaluate how DSH needs to change in response to MedEX 2019. Report due October 1, 2024.
Evaluate Medicaid Eligibility Determination Process	Hire vendor to do a comprehensive analysis of current and proposed Medicaid eligibility determination process
Increase Medicaid Eligibility Determination	
Centralize Mail Operations	

CardinalCare
Virginia's Medicaid Program

VIRGINA STATE BOARD OF MEDICAL ASSISTANCE SERVICES POLICY FOR THE REMOTE PARTICIPATION OF MEMBERS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2-3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700-3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2. This policy also does not apply to an all-virtual public meeting.

2. DEFINITIONS

a. "Board" means the Virginia State Board of Medical Assistance Services or any committee, subcommittee, or other entity of the Virginia State Board of Medical Assistance Services.

b. "Member" means any member of the Virginia State Board of Medical Assistance Services.

c. "Remote Participation" means participation by an individual member of the Board by electronic communication means in a public meeting where a quorum of the Board is physically assembled, as defined by Va. Code § 2.2-3701.

d. "Meeting" means a meeting as defined by Va. Code 2.2-3701.

e. "Notify" or "notifies," for purposes of this policy, means written notice, such as email or letter. Notice does not include text messages or communications via social media.

3. MANDATORY REQUIREMENTS

Regardless of the reasons why the member is participating in a meeting from a remote location by electronic communication means, the following conditions must be met for the member to participate remotely:

a. A quorum of the Board must be physically assembled at the primary or central meeting location; and

b. Arrangements have been made for the voice of the remotely participating member to be heard by all persons at the primary or central meeting location. If at any point during the meeting the voice of the remotely participating member is no longer able to be heard by all persons at the meeting location, the remotely participating member shall no longer be permitted to participate remotely.

4. PROCESS TO REQUEST REMOTE PARTICIPATION

a. On or before the day of the meeting, and at any point before the meeting begins, the requesting member must notify the Board Chair (or the Vice-Chair if the requesting member is the Chair) that they are unable to physically attend the meeting due to (i) a temporary or permanent disability or other medical condition that prevents the member's physical attendance, (ii) a family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance, (iii) their principal residence location is more than 60 miles from the meeting location, or (iv) a personal matter and identifies with specificity the nature of the personal matter.
b. The requesting member shall also notify the Board staff liaison of their request, but their failure to do so shall not affect their ability to remotely participate.
c. If the requesting member is unable to physically attend the meeting due to a personal matter, the requesting member must state with specificity the nature of the personal matter. Remote participation due to a personal matter is limited each calendar year to two meetings or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. There is no limit to the number of times that a member may participate remotely for the other authorized purposes listed in (i)-(iii) above.
d. The requesting member is not obligated to provide independent verification regarding the reason for their nonattendance, including the temporary or permanent disability or other medical condition or the family member's medical condition that prevents their physical attendance at the meeting.
e. The Chair (or the Vice-Chair if the requesting member is the Chair) shall promptly notify the requesting member whether their request is in conformance with this policy, and therefore approved or disapproved.

5. PROCESS TO CONFIRM APPROVAL OR DISAPPROVAL OF PARTICIPATION FROM A REMOTE LOCATION

When a quorum of the Board has assembled for the meeting, the Board shall vote to determine whether:

a. The Chair's decision to approve or disapprove the requesting member's request to participate from a remote location was in conformance with this policy; and
b. The voice of the remotely participating member can be heard by all persons at the primary or central meeting location.

6. RECORDING IN MINUTES

a. If the member is allowed to participate remotely due to a temporary or permanent disability or other medical condition, a family member's medical condition that requires the member to provide care to the family member, or because their principal residence is located more than 60 miles from the meeting location the Board shall record in its minutes (1) the Board's

approval of the member's remote participation; and (2) a general description of the remote location from which the member participated.

b. If the member is allowed to participate remotely due to a personal matter, such matter shall be cited in the minutes with specificity, as well as how many times the member has attended remotely due to a personal matter, and a general description of the remote location from which the member participated.
c. If a member's request to participate remotely is disapproved, the disapproval, including the grounds upon which the requested participation violates this policy or VFOIA, shall be recorded in the minutes with specificity.

7. CLOSED SESSION

If the Board goes into closed session, the member participating remotely shall ensure that no third party is able to hear or otherwise observe the closed meeting.

8. STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

The Chair (or Vice-Chair) shall maintain the member's written request to participate remotely and the written response for a period of one year, or other such time required by records retention laws, regulations, and policies.

VIRGINA STATE BOARD OF MEDICAL ASSISTANCE SERVICES POLICY FOR ALL-VIRTUAL MEETINGS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2-3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700-3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2.

2. DEFINITIONS

a. "Board" means the Virginia State Board of Medical Assistance Services or any committee, subcommittee, or other entity of the Virginia State Board of Medical Assistance Services .

b. "Member" means any member of the Virginia State Board of Medical Assistance Services.

c. "All-virtual public meeting" means a public meeting conducted by the Board using electronic communication means during which all members of the public body who participate do so remotely rather than being assembled in one physical location, and to which public access is provided through electronic communication means, as defined by Va. Code § 2.2-3701.

d. "Meeting" means a meeting as defined by Va. Code 2.2-3701.

e. "Notify" or "notifies," for purposes of this policy, means written notice, including but not limited to, email or letter. Notice does not include text messages or communications via social media.

3. WHEN AN ALL-VIRTUAL MEETING MAY BE AUTHORIZED

An all-virtual public meeting may be held under the following circumstances:

a. It is impracticable or unsafe to assemble a quorum of the Board in a single location, but a state of emergency has not been declared by the Governor; or

b. Other circumstances warrant the holding of an all-virtual public meeting, including, but not limited to, the convenience of an all-virtual meeting; and

c. The Board has not had more than two all-virtual public meetings, or more than 25 percent of its meetings rounded up to the next whole number, whichever is greater, during the calendar year; and

d. The Board's last meeting was not an all-virtual public meeting.

4. PROCESS TO AUTHORIZE AN ALL-VIRTUAL PUBLIC MEETING

a. The Board may schedule its all-virtual public meetings at the same time and using the same procedures used by the Board to set its meetings calendar for the calendar year; or

b. If the Board wishes to have an all-virtual public meeting on a date not scheduled in advance on its meetings calendar, and an all-virtual public meeting is authorized under Section 3 above, the Board Chair may schedule an all-virtual public meeting provided than any such meeting comports with VFOIA notice requirements.

5. ALL-VIRTUAL PUBLIC MEETING REQUIREMENTS

The following applies to any all-virtual public meeting of the Board that is scheduled in conformance with this Policy:

a. The meeting notice indicates that the public meeting will be all-virtual and the Board will not change the method by which the Board chooses to meet without providing a new meeting notice that comports with VFOIA;
b. Public access is provided by electronic communication means that allows the public to hear all participating members of the Board;
c. Audio-visual technology, if available, is used to allow the public to see the members of the Board;
d. A phone number, email address, or other live contact information is provided to the public to alert the Board if electronic transmission of the meeting fails for the public, and if such transmission fails, the Board takes a recess until public access is restored;
e. A copy of the proposed agenda and all agenda packets (unless exempt) are made available to the public electronically at the same time such materials are provided to the Board;
f. The public is afforded the opportunity to comment through electronic means, including written comments, at meetings where public comment is customarily received; and
g. There are no more than two members of the Board together in one physical location.

6. RECORDING IN MINUTES

Meetings are taken as required by VFOIA and must include the fact that the meeting was held by electronic communication means and the type of electronic communication means used.

7. CLOSED SESSION

If the Board goes into closed session, transmission of the meeting will be suspended until the public body resumes to certify the closed meeting in open session.

STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

Appendix B

BOARD OF MEDICAL ASSISTANCE SERVICES

BYLAWS

ARTICLE I

Board Structure

1.1 Name - This body shall be known as the State Board of Medical Assistance Services, hereinafter referred to as "the Board."

1.2 Composition - The Board shall consist of eleven residents of the Commonwealth, five of whom are health care providers and six of whom are not, all to be appointed by the Governor. Any vacancy on the Board, other than by expiration of term, shall be filled by the Governor for the unexpired portion of the term. The Director of the Department of Medical Assistance Services ("the Director") shall be the executive officer of the Board but shall not be a member thereof.

1.3 Term of Office - Board members shall be appointed for four year terms. No person shall be eligible to serve on the Board for more than two full consecutive terms. Should any Board member be unable to fulfill his/her term on the Board, that member shall provide written notice to the Chairperson of the Board at least 30 days prior to resignation, and shall also provide written notice to the Governor.

1.4 Orientation of New Members - When a new member is appointed to the Board, the Board Chairperson shall assign responsibility for orientation of the new member to one veteran member of the Board. New Board members shall be expected to spend time at the office of the Department of Medical Assistance Services ("the Department") for program orientation provided by Department staff, and to become familiar with issues requiring Board action.

ARTICLE II

Board Meetings

2.1 Regular Meetings - The Board shall hold regular meetings at least quarterly at such times and places as it shall determine.

2.2 Special Meetings - The Board may meet at such other times and places as it determines to be necessary and appropriate. Special meetings of the Board may be called by the Chairperson of the Board or by any three (3) members of the Board. Reasonable effort must be made by the Chairperson to personally notify each Board member of the meeting.

2.3 Meeting Notice - Each member shall file with the Director the address and/or telephone number at which such notice is to be given.

Written notice of all regular meetings shall be sent to the Board at least ten (10) days in advance of the time and place of the meeting. Notice of all regular meetings shall also be announced in advance by publication in the Virginia Register, and a proposed agenda sent to persons on the public participation list.

2.4 Quorum - Six (6) members of the Board shall constitute a quorum.

2.5 Executive Session - Prior to meeting in an executive session, the Board must vote affirmatively to do so and must announce the purpose of the session. This purpose shall consist of one or more of the purposes for which executive or closed meetings are permitted in accordance with §2.2-3711 of the Code of Virginia, the pertinent portion of the Virginia Freedom of Information Act.

Discussion in the executive session must be limited to the subject or subjects stated in the motion. No final action may be taken in executive session. Upon return to open session, any action taken or motion adopted must be re-stated, voted upon, and placed in the minutes in order to become effective.

2.6 Conduct of Business - The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Board in all cases to which they are applicable, to the extent that they are not inconsistent with the laws of Virginia, these Bylaws, or any special rule which the Board may adopt.

2.7 Electronic Participation in Meetings –

2.7.1 Remote Participation of Members - An individual member may participate in a meeting of the Board or a public meeting of any committee established by the State Board through electronic communication from a remote location, as permitted by § 2.2-3708.3 of the Code of Virginia, by following the procedures outlined in Appendix A. During a state of emergency declared by the Governor, the procedures outlined in § 2.2-3708.2 shall be followed.

2.7.2 All-virtual Meetings – The Board may, in its discretion but only as permitted by § 2.2-3708.3, conduct a public meeting using electronic communication means during which all members of the public body who participate do so remotely rather than being assembled in one physical location, and to which public access is provided through electronic means, as defined in § 2.2-3701. The Board shall follow the procedures outlined in Appendix B to conduct all-virtual meetings.

ARTICLE III

Board Authority

3.1 Powers and Duties - The Board shall have the powers and duties as prescribed in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia. (See memorandum of April 13, 2004, from the Office of the Attorney General.)

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided. The Board shall also initiate such cost containment or other measures as are set forth in the Appropriations Act.

The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provision of this chapter.

The Board shall submit biannually a written report to the Governor and the General Assembly.

3.2 Representation of the Board - Individual members of the Board shall represent official positions of the Board only upon action of the Board. When the Board is requested to appear before the General Assembly, legislative committees, study committees, etc., the Board shall be represented by duly designated member(s) who are nominated by the Chairperson and, when practicable, confirmed by the Board.

Individual members of the Board are free to make comments to the media, individual legislators, local boards of health members, legislative committees, etc. Any comments made shall be identified as their personal views and not the position of the Board unless they have been authorized by the Board to express the Board's official position or unless the position they express is a position that has been officially taken by the Board.

3.3 Authority of the Director - The Director shall be vested with the authority of the Board as set forth in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia.

ARTICLE IV

Board Officers

4.1 Term of Office - At the first meeting of the Board after March 1 of each year, the Board shall elect officers from its membership for the coming year. Those elected shall assume their offices at the meeting following their election and shall serve, unless sooner removed, until their successors are elected.

4.2 Type of Officers - The Board shall have a Chairperson and a Vice Chairperson.

4.3 Duties of Officers

4.3.1 The Chairperson of the Board shall preside, when present, at all meetings of the Board; appoint members to committees of the Board; serve as ex-officio member of all committees; act for the Board in executing resolutions of the Board and communicating the actions of the Board to others; call such special meetings as may be deemed necessary; vote as any other member of the Board on any issue; perform other duties which may be delegated by the Board; and delegate to the Vice Chairperson such duties as may be appropriate.

The Chairperson shall work closely with the Director of the Department, or his/her designee, in determining the type of Board meetings, agenda, reports, communications and involvement that will enable Board members to carry out the responsibilities imposed on the Board by Acts of the General Assembly.

4.3.2 The Vice Chairperson shall assume all the powers and duties of the Chairperson in the absence of the Chairperson at any meeting or in the event that the Chairperson is disabled or of a vacancy in the office. The Vice Chairperson shall also perform such other duties as requested by the Board or by the Chairperson.

4.3.3 The Secretary shall be selected by the Board, but shall not be a member of the Board. The Secretary shall assist the Board in carrying out its administrative duties including the maintenance of minutes and records. The Secretary shall be a member of the Director's staff within the Department.

ARTICLE V

Board Committees

5.1 Special Committees - Special Committees may be constituted at any time by action of the full Board or the Chairperson. Such committees shall be formed when necessary for the efficient functioning of the Board. Members of a special committee and its chairperson shall be appointed by the Chairperson from among the membership of the Board. At the time a special committee is created, its mission shall be specifically established by action of the Board or by the Chairperson. In creating such special committees, the Chairperson shall specify the time within which the Committee is to make its report(s) to the Board.

5.2 Advisory Groups - The Board may, from time to time, seek the advice of various advisory groups, committees or individuals other than members of the Board on issues of concern to the Board and may form a group of such individuals for such purpose. Any member of the Board or the Director may request that such advice be sought. Selection of individuals to serve in such capacity shall be made by the Board with the advice of the Director.

Since the Board possesses legal powers which cannot be delegated or surrendered, all recommendations for action by such individual or group must be submitted to the Board for decision.

5.3 Participation in Various Department Workgroups and Committees – In order to facilitate involvement of Board members in key policy issues and activities of the Department, the Chairperson and Director shall identify and recommend, from time-to-time, Department workgroups or committees to which Board members should be appointed as full and active participants. In addition, Board members also may identify and recommend Department workgroups or committees for which they believe Board participation would be appropriate. Such participation in Department workgroups or committees shall not conflict with any pertinent statutory or regulatory requirements that may exist regarding the composition of such workgroups or committees. Members selected to serve on a Department workgroup or committee shall be appointed by the Chairperson from among the membership of the Board.

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

ARTICLE VI

Board Documents

6.1 Official Papers - All official records of the Board shall be kept on file at the Department and shall be open to inspection. All files shall be maintained for five years. Minutes of Board meetings shall be permanently retained.

ARTICLE VII

Public Participation

7.1 Public Participation - Citizens may attend all Board meetings, except executive sessions as defined by the Freedom of Information Act, and may record the proceedings in writing or by using a recording device. The Board may make and enforce reasonable rules regarding the conduct of persons attending its meetings.

7.2 Presentations to the Board - Opportunities shall be provided for individuals or citizens representing a group or groups to appear on the agenda of a regular meeting of the Board. Requests to appear before the Board should be made in writing 10 days before a scheduled meeting of the Board in order that they may be included on the agenda. The 10 days may be waived by the Board Chairperson. The request must include the subject to be discussed and the name of the speaker. In honoring such requests, the Board will limit presentations to five (5) minutes, unless an extension is granted by the Board Chairperson.

ARTICLE VIII

Revision and Compliance

8.1 Amendments - The Bylaws of the Board may be amended at any regular meeting of the Board by a majority vote, provided that the proposed amendment was submitted in writing at the previous regular meeting of the Board and is included in the notice of the meeting at which a vote is to be taken.

8.2 Review - The Bylaws shall be reviewed in total at least every two years, with a limited annual review for compliance with the Code of Virginia. Revisions shall be made as necessary, and the Bylaws signed and dated to indicate the time of the last review.

8.3 Effective Date - The foregoing Bylaws shall go into effect on the ____ day of_____ 2024. .

Approved:

_____
Chairperson, Board of Medical Assistance Services

_____
Director, Department of Medical Assistance Services

Regulatory Activity Summary June 18, 2024
(* Indicates Recent Activity)

2024 General Assembly

***(01) Core Set Mandatory Reporting:** This state plan amendment (SPA) is needed in order to respond to a CMS State Health Official Letter requiring states to attest to compliance with mandatory annual state reporting of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the behavioral health measures on the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). The project is currently circulating for internal review.

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

***(03) Brain Injury Services Targeted Case Management:** This SPA will allow entities licensed by the Department of Behavioral Health and Developmental Services as providers of case management services, specifically community services boards, to provide services under the brain injury services targeted case management (BIS TCM) program. DMAS implemented the BIS TCM program in January 2024 pursuant to House Bill 680 of the 2022 legislative session and the 2022 Appropriations Act. Allowing CSBs to become BIS TCM providers will help facilitate the BIS TCM program's implementation. Following internal and external (partner and oversight agencies) review, this SPA was submitted to CMS on 5/6/24 and approved on 5/17/24.

***(04) Social Security Disability Income (SSDI) Disregard:** In accordance with Virginia Senate Bill 676 and House Bill 908, DMAS is amending the state plan to disregard any Social Security Disability Insurance income above the maximum monthly federal Supplemental Security Insurance payment amount during the financial eligibility determination process for individuals who are receiving services under the Family and Individual Support Waiver, Community Living Waiver, and Building Independence Waiver. The project is currently circulating for internal review.

***(05) CHIP Annual SPA:**

The changes to the CHIP State Plan include:

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

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

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

DMAS also updated website addresses and removed an old reference to coverage for 60 days postpartum. (Postpartum coverage has been extended to one year.) The project is currently circulating for internal review.

***(06) Nursing Facility Value-Based Purchasing Program:** This SPA will allow DMAS to revise the nursing facility (NF) value-based purchasing (VBP) program for year three of the program. In accordance with the General Assembly, DMAS revised the state plan in 2022 and 2023 to establish a unified, value-based purchasing (VBP) program that includes enhanced funding for nursing facilities that meet or exceed performance and/or improvement thresholds as developed, reported, and consistently measured by DMAS in cooperation with participating facilities. During the first year of the program, half of the available funding was distributed to participating nursing facilities to be invested in functions, staffing, and other efforts necessary to build their capacity to enhance the quality of care furnished to Medicaid members. This funding was administered as a Medicaid rate add-on. The remaining funding was allocated based on performance criteria as designated under the nursing facility VBP program. During the second year of the program, the amount of funding devoted to nursing facility quality of care investments was 25 percent of available funding. In accordance with Item 288.QQQ.2.b of the 2024 Appropriations Act, DMAS is amending the state plan for the third year of the nursing facility VBP program. During the third year of the program, 100 percent of payments will be disbursed to participating nursing facilities that qualify for the enhanced funding based on performance criteria. This SPA project is currently circulating for internal review.

***(07) 2024 Institutional Provider Reimbursement Changes:** In accordance with the 2024 Appropriations Act, Item 288.HH.5, the state plan is being amended to revise reimbursement methodologies for Psychiatric Residential Treatment Facilities (PRTFs) rates to implement inflation increases for each fiscal year to be effective July 1, 2024. Per Item 288.PP.2, the state plan is also being revised to make hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs effective June 2, 2017 equal the greater of what would have been paid to the freestanding children's hospitals under the current uncompensated care formula or $16,000,000 annually, the average due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit. This SPA also corrects language to be consistent with current DMAS policies and regulations. The project is currently circulating for internal review.

***(08) 2024 Non-Institutional Provider Reimbursement Changes:** The 2024 Appropriations Act requires DMAS to revise the state plan to increase reimbursement rates for dental services by three percent (Item 288.BBBB.2). The state plan is also being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and the Diagnosis and Treatment (EPSDT) benefit by two percent (Item 288.GGGGG.1). (A corresponding rate increase of two percent will be provided for these services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.) Additional revisions include updating the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale (Item 288.SSSS). Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations. Per Item 288.XXXX, the state plan is being revised to update the rates for consumer-directed facilitation services under EPSDT based on the most recent rebasing estimates. This SPA also includes a revision to set the reimbursement rate to 100 percent of the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for specific Durable Medical Equipment (DME) products, including enteral products and supplies and in the following categories in the DMAS fee schedule for Feeding Kits and Tubes and Nutrition Kits/Feeding Tubes (Item 288.YYYY). The project is currently circulating for internal review.

***(09) Disproportionate Share Hospital Pool:** This SPA will implement, in accordance with Item 288.MM of the 2024 Appropriations Act, a supplemental disproportionate share hospital (DSH) redistribution methodology for DSH funds that allows the redistribution of excess DSH payments to other eligible DSH hospitals that have not met their uncompensated care costs. This supplemental redistribution shall be budget neutral and not use state funds in excess of those already appropriated for DSH payments. The SPA is currently circulating for internal review.

***(10) Supplemental Payments for Acute Care Hospital Chain with Level One Trauma Center:** The purpose of this SPA, in accordance with the 2024 Acts of Assembly, Item 288.OO.10, is to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, for an acute care hospital chain with a level one trauma center in the Tidewater Metropolitan Statistical Area (MSA) in 2020, upon the execution of affiliation agreements with public entities that are

capable of transferring funds to the department for purposes of covering the nonfederal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Public entities are authorized to use general fund dollars to accomplish this transfer. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. As part of the Interagency Agreements the department shall require the public entities to attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. The SPA is currently circulating for internal review.

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

***(12) 12-Months Continuous Coverage (Medicaid):** The purpose of this state plan amendment is to follow a mandate, requiring state Medicaid agencies to cover children for a continuous 12-month period from the date of enrollment, regardless of changes in the child's circumstances. This coverage will improve access to health care and health care outcomes for individuals under the age of 19. These changes became effective January 1, 2024. This SPA also makes a technical change to note that DMAS processes the eligibility applications of individuals who are returning to the community after a period of incarceration. This change reflects current DMAS processes and does not have a cost impact; instead, it provides a more detailed description so that CMS is aware of the role that DMAS plays with regard to these specific applications. Following internal review, the SPA was submitted to CMS on 1/20/24. The SPA was subsequently approved on 4/19/24.

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

- Update the terminology of the Preferred Office Based Opioid Treatment (OBOT) to Preferred Office Based Addiction Treatment (OBAT) in 12 VAC 30-130-5020 and 12 VAC30-130-5040. In accordance with the 2021 Appropriations Act, Item 313.PPPPP, DMAS already expanded the substance use disorder service called OBOT (which had been available only to individuals with a primary diagnosis of opioid use disorder) to individuals with a substance-related or addictive disorder. DMAS updated the terminology in other sections of the VAC in a previous regulatory action, but inadvertently missed the references in 12 VAC 30-130-5020 and 12 VAC30-130-5040.
- Clarify requirements for the Substance Use Care Coordination as well as the role of the licensed practical nurse (LPN) in the opioid treatment program (OTP) setting to align with current practices. LPNs are permitted to provide onsite medication administration treatment during the induction phase.
- Clarify the size of SUD counseling groups to align with current practice. The group size is limited to a maximum of 12 individuals, but this may be exceed based on the clinical determination of a Credentialed Addiction Treatment Professional (CATP).
- Update provider licensing references for SUD services (ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0) to reflect current DBHDS requirements and DMAS current practices.

The project is currently circulating for internal review.

***(14) Other Licensed Practitioners:** DMAS recently received approval from CMS of SPA 23-0014, entitled "Pharmacists as Practitioners." CMS sent a "companion letter" with the SPA approval requesting additional changes to one of the state plan pages. These changes are wording changes only and do not reflect any change in coverage or in program rules. This SPA will incorporate the following changes based on CMS' request:

(i) Remove the reference to ophthalmologists on this page of the state plan because these practitioners fall into the "physician services" section of the state plan. The word "ophthalmologists" has been removed as required by CMS.

(ii) Clarify whether DMAS reimburses licensed optometrists and opticians or also reimburses unlicensed practitioners. Wording changes have been made to clarify that only licensed practitioners are covered.

(iii) Clarify whether DMAS reimburses unlicensed providers for behavioral health services. Wording changes have been made to clarify that reimbursement is only made to licensed mental health professionals and certified pre-screeners.

Following internal review, the SPA project was submitted to CMS on 3/18/24 and approved on 5/14/24.

***(15) Removal Duplicative Language:** DMAS is amending the State Plan to remove redundant and unnecessary language. DMAS submitted a previous SPA related to School Services (SPA 21-0017), which was approved by CMS on September 26, 2023. In that SPA, DMAS inadvertently did not remove some of the old school services text. Consequently, this SPA will repeal the outdated language which is duplicative and unnecessary. Following internal review, the SPA project was approved by HHR on 4/23/24 and submitted to CMS for review on 4/29/24.

2023 General Assembly

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

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

***(03) Dental Updates:** The purpose of this state plan amendment, in accordance with the 2023 Virginia Acts of Assembly Item 304.XXXX, is to (1) extend the age limitation for children receiving fluoride varnish from non-dental providers from "through age 3" to "through age 5"; (2) remove the current limitation on the number of times a dentist can bill the behavioral management code when treating adults with disabilities; (3) provide payment for crowns for patients who received root canal therapy prior to becoming a Medicaid beneficiary; and (4) provide reimbursement for pre-treatment evaluations performed by dentists treating patients requiring deep sedation or general anesthesia to mirror the Centers for Medicare and Medicaid Services (CMS) guidelines. Following internal review, the project was submitted to CMS for review on 1/10/24. CMS approved the SPA on 4/3/24.

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

***(05) Third Party Liability:** The purpose of this state plan amendment is to add language that is needed to respond to a CMS State Medicaid Director letter (#23-002) requiring Medicaid agencies to amend their state plan to provide assurances that the state has rules in place that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. The SPA will also provide clarity relating to lien amounts arising from the Medicaid program and asserted against personal injury claims proceeds. Following internal review, the SPA was submitted to CMS for review on 9/1/23. On 12/19/23, CMS requested that DMAS withdraw the SPA and re-file once new budget language/TPL authority is in place. DMAS is currently coordinating a replacement SPA project.

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

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

Following internal review, the SPA was submitted to CMS for review on 5/12/23. The SPA was approved on 8/7/23. Following internal review, the project was forwarded to the OAG for review on 5/15/24.

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

(08) Case Management for Assisted Living Facility Residents: This SPA will allow DMAS to remove outdated case management language for assisted living facility residents from the state plan. DMAS has not provided this service for several years, so the state plan needs to be updated accordingly. Following internal review, the SPA was submitted to CMS on 7/3/23. CMS issued a RAI (request for additional information) on 9/28/23 and the project remains open, pending guidance from CMS.

***(09) Repeal of Documents Incorporated by Reference (Chapter 60):** This regulatory action is being carried out in accordance with Governor Youngkin's Executive Order #19. DMAS completed an internal review of 12VAC30-60 and determined that all of the documents incorporated by reference are either outdated or already exist on the DMAS Medicaid Enterprise System (MES) Web Portal or via other sources that are not owned by DMAS (e.g., the DSM). Therefore, referencing them in the Virginia Administrative Code is unnecessary and they should be repealed. This regulatory action is being promulgated to repeal out-of-date and unnecessary regulations. Following internal review, this regulatory action was submitted to the OAG on 7/19/23. The regs were submitted to DPB on 4/17/24.

***(10) Provider Appeals:** The purpose of this regulatory action is to clarify when documents are considered filed and adds the Appeals Information Management System (AIMS) to the Virginia Administrative Code in accordance with the DMAS current provider appeals practices. Following internal review, this project was submitted to the OAG on 2/1/23 and certified by the OAG on 6/12/23. The reg project was submitted to DPB on 6/22/23 and to HHR on 7/25/23. The project was forwarded to the Governor's Ofc. on 5/22/24 and to the Registrar's Ofc. on 5/28/24, following the Governor's approval. The project was published in the Register on 6/17/24.

***(11) Repeal of Out-of-Date and Unnecessary Regulations:** This regulatory action is required in accordance with Governor Youngkin's Executive Order #19. DMAS has completed

an internal review of these regulations and has determined that all of the content already exists in the DMAS Eligibility and Enrollment Manual on the DMAS webpage, and that these regulations are redundant and unnecessary, and should be repealed. Following internal review, the project was submitted to the OAG for review on 1/30/23. On 4/10/24, at the request of the OAG, DMAS withdrew this reg package.

***(12) OTC Drugs:** This SPA is required based on the CMS' request for Virginia to change the language related to over-the-counter (OTC) drugs. CMS asked DMAS to include the following sentence in order to indicate where a list of OTC drugs could be located: "A list of specific covered drug categories is published in Chapter 4 of the Pharmacy Provider Manual." With this new language, DMAS no longer needs, and proposes deleting the following language: "2. Non-legend drugs shall be covered by Medicaid in the following situations: a. Insulin, syringes, and needles for diabetic patients; b. Diabetic test strips for Medicaid recipients under 21 years of age; c. Family planning supplies; d. Designated categories of non-legend drugs for Medicaid recipients in nursing homes…" (These items will remain covered, but they will be stated with specificity in the Pharmacy Manual and do not need to be repeated in the state plan.) CMS also asked that Virginia remove language related to home infusion therapy from the pharmacy section of the state plan. That language is already in the durable medical equipment section of the state plan, so removing the language from the pharmacy section has no practical effect. Following internal review, the SPA was submitted to CMS on 4/24/23 and approved on 5/18/23. The corresponding regulatory project was submitted to the OAG for review on 7/31/23. On 4/10/24, DMAS withdrew this reg package.

2022 General Assembly

***(01) Removal of Cost Sharing:** The purpose of this regulatory action is to remove co-payments for Medicaid and FAMIS enrollees in accordance with a General Assembly mandate. The 2022 Appropriations Act, Item 304.FFFF, required DMAS to remove co-payments for Medicaid and FAMIS enrollees effective, April 1, 2022. DMAS has not been imposing co-payments on Medicaid and FAMIS members during the federal public health emergency (PHE) related to the Coronavirus Disease 2019 (COVID-19) pandemic. However, as of a result of 2022 Appropriations Act, Item 304.FFFF, co-payments have been permanently removed and they will not be reinstated after the federal PHE ends. Following internal review, the reg project was submitted to the OAG for review on 3/21/23. On 4/25/24, the reg package was withdrawn. Once additional budget authority is established, during the next budget cycle, DMAS will submit another reg package.

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

result in new individuals being added to the DD waiver. The project was submitted to the OAG for review on 2/7/23.

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

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

(05) Third Party Liability Update: This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA was submitted to CMS on 6/27/22 and approved on 7/25/22. Following internal review, the corresponding fast-track project was submitted to the OAG for review on 12/13/22. Revised regs were sent to the OAG for review on 5/30/23. Minor revisions were made to the regs and updated regs were forwarded to the OAG for review on 10/24/23.

(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. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 6/29/22; to DPB on 10/13/22; and to the HHR on 11/16/22.

2021 General Assembly

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

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

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

(04) Consumer-Directed Attendants: This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to

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

***(05) Client Appeals Update:** This regulatory action seeks to comply with a 2021 General Assembly mandate that requires DMAS to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of documents and decision deadlines for de novo client hearings. Following internal DMAS review, the reg action was submitted to the OAG on 7/23/21; to DPB on 1/14/22; and to HHR on 1/27/22. The project moved the Gov. Ofc. on 7/13/22 and was approved by the Governor on 9/2/22. The emergency regulations were sent to the Registrar on 9/6/22; were published in the Register on 9/26/22; and were in effect until 3/7/24. An extension request for the emergency regs was filed on 1/9/24 and the emergency regs were extended through 9/6/24. The fast-track phase of this project, following internal review, was submitted to the OAG on 3/27/23. The OAG certified the project on 4/2/24; the reg package was submitted to the DPB on 4/9/24; submitted to HHR on 5/16/24; submitted to the Gov.'s Office on 5/22/24; submitted to the Register on 5/28/24; and was published in the Register on 6/17/24.

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

was received from CMS on 1/4/22. DMAS' RAI response was sent to CMS on 3/30/22. The SPA was approved by CMS on 9/26/23. Following internal review, the corresponding regulatory action was forwarded to the OAG on 2/29/24.

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

2020 General Assembly

***(01) Preadmission Screening and Resident Review (PASRR) Update:** In responding to the legislative mandate of the General Assembly, the purpose of this regulatory action is to establish regulatory requirements for (i) allowing qualified nursing facility staff to complete the LTSS screening for an individual who applies for or requests LTSS, and who is receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital; and (ii) protecting an individual's choice for institutional or community based services and choice of provider. Following internal review, the project was submitted to the OAG for review on 1/5/21. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/14/21. Additional revisions were submitted on 4/28/21. The project was submitted to DPB for review on 6/16/21 and to HHR on 6/29/21. The regs were forwarded to the Governor on 11/20/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21; published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22. DMAS received inquiries from the OAG on 12/16/22, 1/3/23, 1/9/23, 1/25/23, 2/9/23, 2/13/23, 3/2/23, and 3/13/23. DMAS submitted responses to the multiple OAG requests for edits and is awaiting further direction. On 6/15/23, DMAS requested an emergency reg extension and notified the OSHHR of the request. On 6/20/23, the Gov.'s Ofc. approved extending the emergency regulation until 2/14/24. On 4/17/24, the OAG posed additional questions and DMAS submitted responses on 4/25/24. DMAS is awaiting additional feedback.

(02) 90-Day Prescriptions: The recent Medicaid Disaster Relief SPA allowed DMAS to provide 90-day prescriptions to Medicaid members (excluding Schedule II drugs), however, that SPA will end on the last day of the federal-declared emergency period. DMAS is filing a SPA to allow for the provision of a maximum of a 90-day supply for select maintenance drugs dispensed to Medicaid members (excluding Schedule II drugs) after the end of the federal emergency period. The 90-day supply will be available to Medicaid members after the member has received two (2) fills of 34 days or less of the drug. Following internal review, the SPA was

filed with CMS on 11/9/20 and approved on 12/10/20. Following internal review, the corresponding regulatory action was submitted to OAG on 1/28/21. Status inquiries were forwarded to the OAG on 7/1/21, 8/10/21, 8/24/21, 9/14/21, 1/25/22, 3/9/22, 4/13/22, and 7/12/22. The project's economic impact form was uploaded to the Town Hall on 9/30/22.

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

2017 General Assembly

(01) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care

planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and additional inquiries on 2/22/18, 3/19/18, 4/10/18, and 5/16/18. The regs were approved by the OAG and forwarded to the Governor's Ofc. for review on 6/19/18. The emergency regulations were signed by Governor and became effective on 6/29/18 and published in the Register on 7/23/18. The NOIRA comment period was held between 7/23/18 - 8/22/18. An ER Extension request was submitted on 10/16/18, and the ER was extended through 6/28/20. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21; to DPB on 12/6/21; to HHR on 1/19/22; and to the Governor's Ofc. on 6/1/22. Following approval from the Gov. Ofc., the project was submitted to the Registrar on 11/2/22 and was published in the Register on 12/5/22. Following the internal review of the final stage phase of the project, the regulations were submitted to DPB on 7/18/23 and to HHR on 8/7/23.

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.