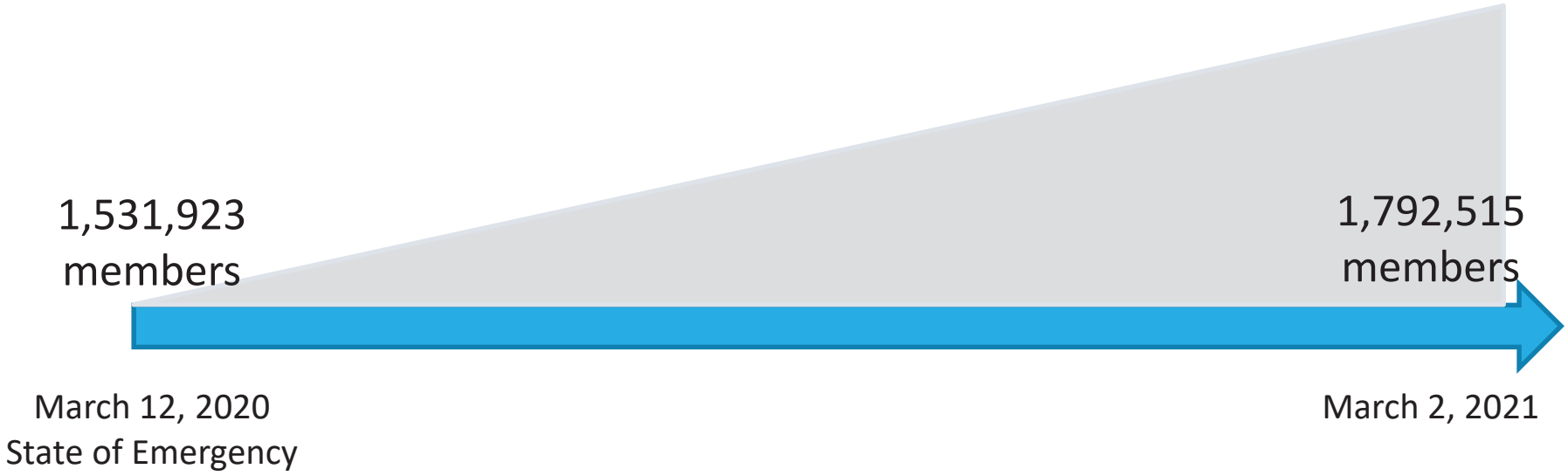
BMAS
DIRECTOR'S REPORT

Karen Kimsey
Director

March 10, 2021

- Enrollment update
- COVID-19 vaccine information
- Project Cardinal
- Diversity, equity and inclusion initiatives

Medicaid Enrollment



- Since the State of Emergency was declared, Medicaid has gained **259,496 new members**
  - 136,526 are in Medicaid Expansion
  - 79,574 are children
- Medicaid gained **2,000 new members in the last week**

COVID-19 Vaccine in Virginia: Overview

Who is currently eligible for vaccination in Virginia?

More information on each group can be found by clicking on each piece of the above infographic at this link:
https://www.vdh.virginia.gov/covid-19-vaccine/#phase1b

COVID-19 Vaccine in Virginia: Overview

How is the vaccination roll-out going in Virginia?

- The Vaccine Summary Dashboard continues to show Virginia's significant progress in vaccinations, with more than **2 million doses** administered. (https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary/)
- **More than 9 in 10 available first doses have been administered**.
- Vaccine supply continues to increase on a weekly basis.

- **In mid-February, VDH deployed a centralized sign-up tool (vaccinate.virginia.gov) and call center (877-VAX-IN-VA)**

Overview: Eligible Medicaid Member Counts Phase 1a and Phase 1b (65+ and Department of Corrections)

Category Description	Eligible Members
Skilled Nursing Facility/ Intermediate Care Facility	17,782
State Hospital	701
PACE	1,504
Group Residential	7,217
Day Support	8,230
Respite	16,813
Personal Care Services	23,039
Hospice	1,051
Long-Term Care Hospitals	69
Private Duty Nursing	245
HCBS	55,829
Aged 75+	55,544
Department of Corrections	19,940
Aged 64-74	81,433
Dual Eligible	206,282
TOTAL Unique members	281,182

Note: Members may be eligible in multiple categories. Does not include members 16-64 with “high risk” conditions or frontline essential workers.

DMAS COVID-19 Vaccination Strategies: Focus Areas

DMAS, as the insurer of one in five Virginians, has a critical role to play in the state's vaccine roll-out strategy

- Data Acquisition + Reporting
- Communications
- Care Coordination
- Specialized Strategies

Example of DMAS COVID vaccine communication

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

#CoverVA

Answers to Your COVID-19 Vaccine Questions

Virginia Medicaid is here for you during the COVID-19 public health crisis. We want to make sure you have the information you need to answer your questions about the new COVID-19 vaccine.

Will it work? There are two vaccines available now. They are both highly effective at preventing serious illness and hospital admissions from COVID-19.

When can I get a vaccine? Supplies are currently limited but will increase in the coming months. Virginia is in Phase 1b of vaccine distribution. This includes:

- frontline workers,
- those aged 65 and older,
- people living in correctional facilities, homeless shelters and migrant labor camps,
- and people aged 16 - 64 with a high-risk medical condition.

You can pre-register for a vaccine on the Virginia Department of Health's vaccine website. Help your friends and family register by sharing the tool with them. You can also call the vaccine hotline at 877-829-4682 if you prefer to speak with someone by phone.

Fairfax County is using its own registration site. If you live in Fairfax County, you can use the county's website to pre-register for a vaccine.

How do I get a vaccine? Once you pre-register, you will receive updates when you are able to receive a vaccine. You will be required to make an appointment.

What should I expect when I get a vaccine? There is no cost for anyone to receive a vaccine. You will need 2 doses to ensure you are protected from COVID-19. You do not need to bring a government-issued ID and cannot be turned away for not having ID. However, you should bring some form of ID if possible to make sure the right person receives the vaccine.

Pre-register Today

Not a Medicaid member? Virginia Medicaid offers quality, low-cost and no-cost coverage for Virginians. Learn more about how to apply.

Project Cardinal: Value Proposition

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

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

2021 Special Session Appropriations Act: Authorization for Project Cardinal

- *[DMAS] shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to merge the CCC Plus and Medallion 4.0 managed care programs, effective July 1, 2022, into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth.*

- Budget language also directs DMAS to
  - Deliver legislative report on impact of merging the children's programs -- FAMIS and children's Medicaid -- by November 1.
  - Conduct analysis of current contracts and staffing and determine operational savings from merging the managed care programs. Report on administrative cost savings and merger-related costs by October 1.

Project Cardinal: Phases

July – Nov 2020
****Laying eggs****

Convened initial work groups to develop high-level implementation plan and report for the General Assembly: https://rga.lis.virginia.gov/Published/2020/RD567/PDF

Nov 2020 – Feb 2021
****Baby birds!****

Pre-implementation phase:

- **Contract alignment work begins**
- **Convening key work groups**
- **Rebranding planning work commences**
- **Calls with other states to gather best practices**

Feb – Apr 2021
****Leaving the nest****

Implementation planning phase so that by April 2021, full implementation structure is in place

Apr 2021 – July 2022
****Taking flight****

Project in full implementation mode, including stakeholder engagement, for July 1, 2022 implementation date

Key Focus Areas: Project Cardinal

- ✓ **Align MCO administrative tasks, such as reporting requirements and compliance and oversight responsibilities**
- ✓ **Strategically align care management and models of care**
  - ✓ Maintain high-touch care coordination, assessments, and interdisciplinary care planning for vulnerable/complex populations based on member need
- ✓ **Streamline managed care enrollment at initial enrollment, open enrollment and renewal**
  - ✓ Leverage upcoming systems updates and procurements to expedite initial managed care enrollment, keep eligible members enrolled with the health plan of their choice, and avoid disruptions in care management
- ✓ **Streamline benefit enrollment for all populations**
- ✓ **Implement MCO and provider-level quality and value based purchasing contract requirements that incentivize appropriate member health and program cost outcomes**
- ✓ **Set rates based on population characteristics as opposed to program**
- ✓ **Rebrand the fee-for-service and managed care programs under a single name: Cardinal Care Virginia to achieve a more cohesive agency voice and member experience**

Internal Diversity, Equity and Inclusion Efforts

Human Capital and Development

- **Diversity and Inclusion Officer**
- Review and update DMAS HR policies (ethics, hiring, etc.)
- **New recruiting initiatives & increased partnerships with colleges and universities for diverse workforce,**
- Review of Agency Workforce Planning (Hiring Stats & Demographics)
- Compensation Study and Analysis.
- Added DEI inclusion statement to all job postings.

Employee Engagement

- **Conducted several surveys**
- **Fostered meaningful discussions surrounding events within the Commonwealth and Nation**
- Greater visibility of efforts and initiatives via internal newsletter, SharePoint, and Blogs.
- Celebrating Diversity, i.e. Juneteenth, Disability Freedom, Pride, and Hispanic Heritage

Training

- **Leadership trainings on diversity, unconscious bias, and microaggressions**
- **Agency-wide mandatory trainings**: Sensitivity and Cultural Awareness and History; Subconscious Biases and Institutional Racism.

External Initiatives

- **DMAS leads the monthly State Agency Partnership Meeting with other Agencies interested in standing up their own councils**
- Collaborate our efforts to support Governor's Chief Diversity Officer's "One Virginia" Plan
- Actively participates in the Commonwealth State Health Equity Group.

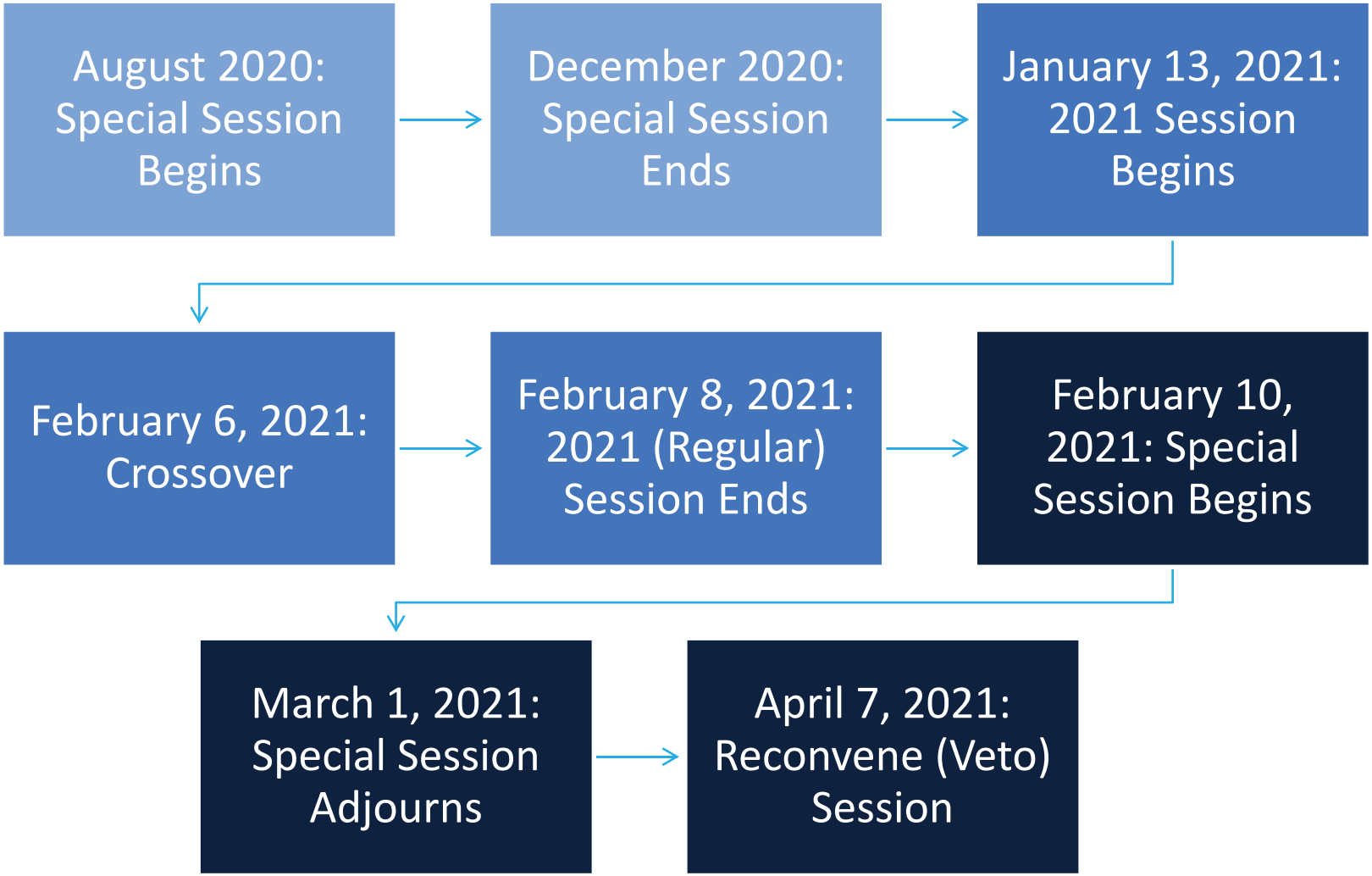
2021 VIRGINIA GENERAL ASSEMBLY SESSION

March 10, 2021

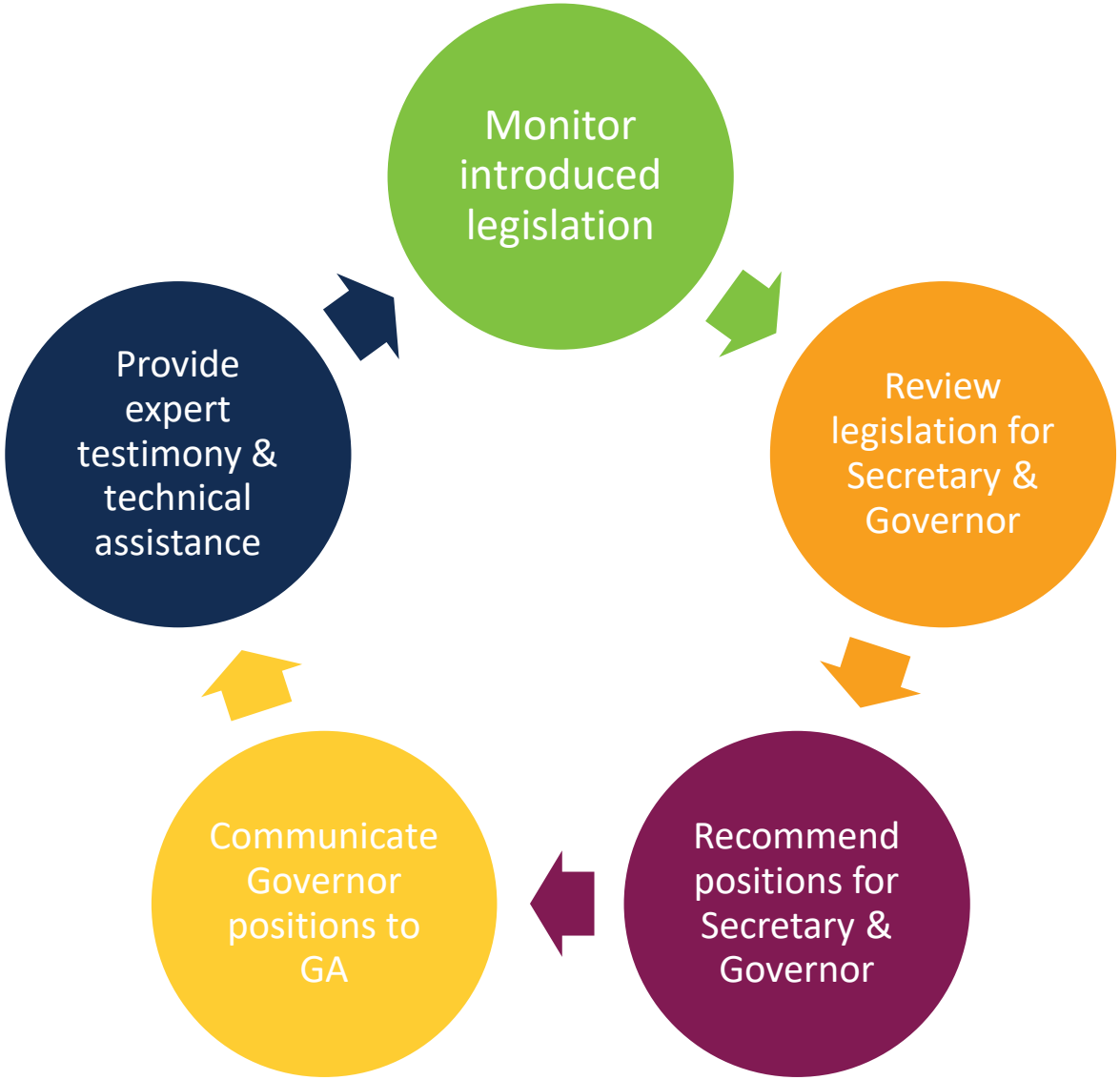
Sarah Hatton

Acting Deputy Director, Administration, Department of Medical Assistance Services

2021 Session Overview



DMAS Legislative Role



Governor's Introduced Budget

Better Access to Coverage and Services

	FY2021		FY2022	
	GF	NGF	GF	NGF
Implement the Virginia Facilitated Enrollment Program (Item 317 HH)	$0	$0	$1,166,180	$6,959,211
Allow FAMIS MOMS to utilize Substance Abuse Disorder Treatment (Item 312 G)	$0	$0	$13,497	$25,067
Fund Doula Services for Pregnant Moms (Item 313 WWWWW)	$0	$0	$1,168,371	$1,243,031

Governor's Introduced Budget

Better Access to Coverage and Services

	FY2021		FY2022	
	GF	NGF	GF	NGF
Expand Addiction Treatment Beyond Opioids (Item 313 PPPPP)	$0	$0	$881,306	$1,296,254
Affirm Medicaid Coverage of Gender Dysphoria Related Services (Item 313 ZZZZZ)	$0	$0	$0	$0
Fund Durable Medical Equipment (DME) Federal Mandate (Item 313 QQQQQ)	$68,014	$76,146	$272,050	$304,585
Authorize Post-Public Health Emergency Telehealth (Item 313 VVVVV)	$0	$0	$0	$0

Governor's Introduced Budget

Better Access to Coverage and Services

	FY2021		FY2022	
	GF	NGF	GF	NGF
Move funds to cover the cost of implementing a live-in caretaker exemption (Item 313 HHH)	$0	$0	$0	$0
Authorize 12-month prescriptions of contraceptives for Medicaid Members (Item 313 YYYYY)	$0	$0	$136,533	$1,380,694
Fund COVID-19 Vaccine Coverage for Non-Expansion Medicaid Adults (Item 313 XXXXX)	$0	$0	$995,742	$995,742
Allow Pharmacy Immunizations for Covered Services (Item 313 UUUUU)	$0	$0	$0	$0

Governor's Introduced Budget

Administrative and Technical Changes

	FY2021		FY2022	
	GF	NGF	GF	NGF
Implement Federal Client Appeals Requirements (Item 317 GG 1)	$34,135	$34,135	$598,763	$823,476
Federally Mandated MCO Contract Changes (Item 313 E)	$0	$0	$2,196,012	$4,804,988
Increase Appropriation for Civil Monetary Penalty (CMP) Funds (Item 317 R1.,2. & 7)	$0	$225,000	$0	$225,000
Provide support for federal interoperability and patient access requirements (Item 313 SSSSS)	$0	$0	$1,739,306	$3,805,694

Governor's Introduced Budget

Administrative and Technical Changes

	FY2021		FY2022	
	GF	NGF	GF	NGF
Account for third quarter of enhanced federal Medicaid match in facility budget (Item 313 A.)	-$808,764	$1,617,528	$0	$0
Authorize the transfer of funds between CCCA and DMAS to account for cost shifts (Item 313 A. 2.)	$0	$0	$0	$0
Make required adjustments to the graduate medical residency program (Item 313 BBB. 1.)	$0	$0	$0	$0
Increase Medicaid reimbursements for Veteran Care Centers (Item 313 RRRRR.)	$0	$0	$0	$0

Governor's Introduced Budget

Administrative and Technical Changes

	FY2021		FY2022	
	GF	NGF	GF	NGF
Move Reductions to Agency Budget (Various Items)	-$63,443,772	-$1,522,168	-$28,302,522	-$1,167,598
Transfer funds to cover Medicaid related system modifications	-$300,000	-$2,700,000	-$300,000	-$2,700,000
Transfer assisted living screening funds to DSS (DARS Item 344 F)	-$641,050	$0	-$641,050	$0
Add DBHDS licenses to ASAM Level 4.0 (Item 313 TTTTT.)	$0	$0	$0	$0

Key Budget Amendments

- Prenatal Coverage for Undocumented Women
- Retainer payments for DD waiver day support providers
- Continuing telehealth services
- Child and maternal health initiatives
- Home visiting
- Mobile vision clinics for kids

Key Bills

SB1307	•Directs DMAS to expand Medicaid coverage of school health services in public schools beyond special education services provided under a student's IEP
HB1987 and SB1338	•Mandates Medicaid coverage of remote patient monitoring through telehealth
SB1102	• Requires DMAS to establish an annual training and orientation program for all personal care aides who provide Medicaid self-directed services
HB2124	• Directs DMAS to, during a public health emergency related to COVID-19, deem testing for, treatment of, and vaccination against COVID-19 to be emergency services for which payment may be made pursuant to federal law for certain noncitizens not lawfully admitted for permanent residence

Other Legislation

COVID-19 response including vaccination distribution and equity

Paid sick leave for personal care attendants

Establishing a reinsurance program

Creating a plan to implement a three year pilot Produce Rx Program

Removal of 40 Quarter Work Requirement

Virginia was one of six states to require that lawful permanent residents (LPRs) to have 40 quarters of work history in order to qualify for Medicaid coverage. Historically, this has been a major hindrance to eligible LPR adults who would otherwise be eligible, exacerbating health disparities for LPRs across the Commonwealth.

- Beginning April 1, lawful permanent residents with five years of US residency will now meet immigration requirements for health care coverage from Virginia Medicaid.
- The DMAS outreach team is working directly with community partners, religious organizations, and clinics. Communications staff have developed a social media strategy which will include additional messaging through Facebook and Twitter.
- Policy and Eligibility and Enrollment Services teams are working through the State Plan Amendment process, implementation of system changes, and policy updates and training for eligibility workers.

Questions?

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

FINANCE UPDATE

March 10, 2021

Finance Update

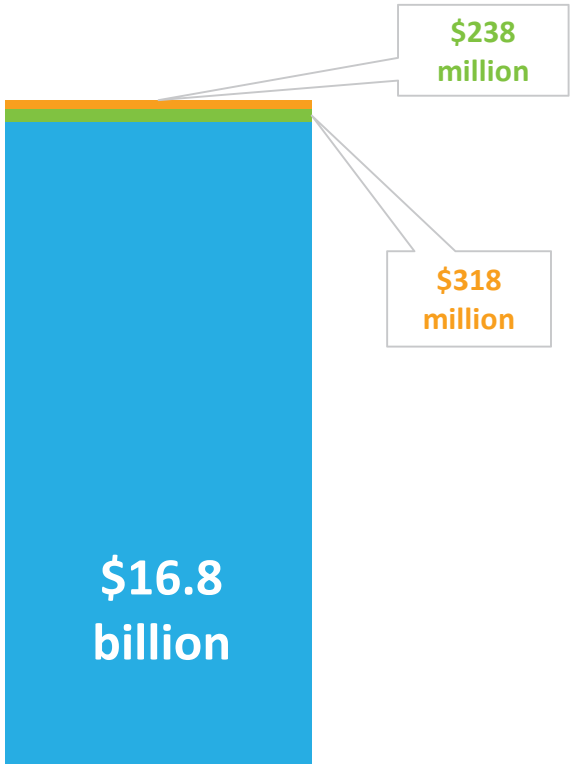
- Finance 101
- DMAS Expenditures
- General Assembly Actions on Budget
- Coronavirus Relief Fund Update

Finance 101 Video

- YouTube Link:
  - https://www.youtube.com/watch?v=tqDozcKiF-o

DMAS Total Budget Mix - $17.4 Billion

State Fiscal Year 2021



Coronavirus Relief Funds– 1.4%

$238 Million

Administration– 1.8%

$318 Million

Medical Services – 96.8%

$16.8 Billion

DMAS Administrative Budget - $318 Million

State Fiscal Year 2021

48%
CONTRACTUAL SERVICES

31%
INFORMATION TECHNOLOGY

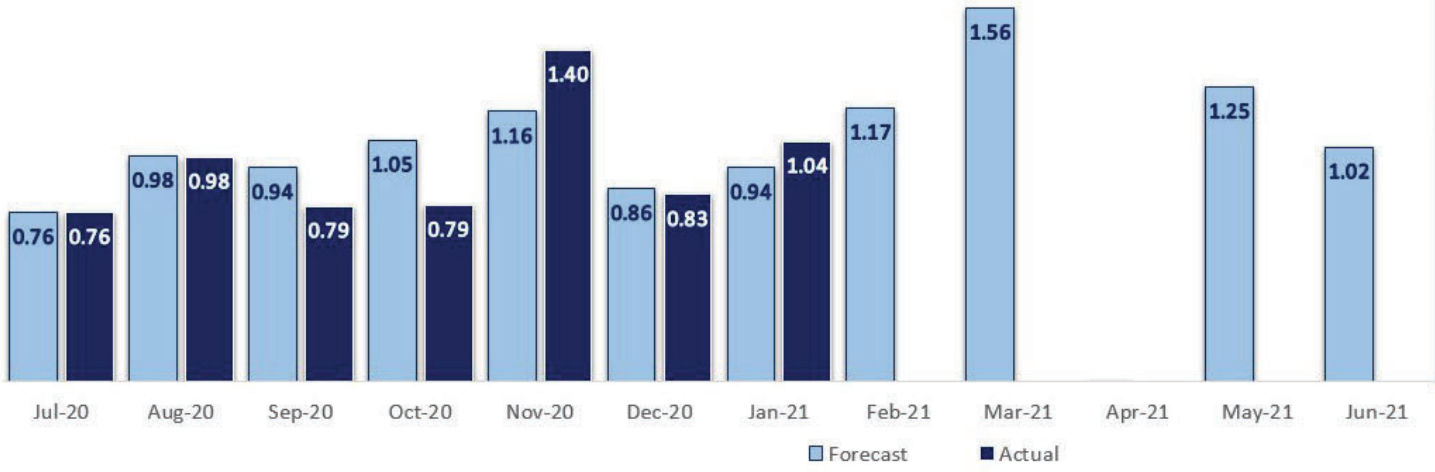
19%
SALARIES & BENEFITS

2%
AGENCY OPERATIONS

Base Medicaid

Base Medicaid Enrollment
millions

Base Medicaid Expenditures
$billions



Based on November 2020 official forecast

Note: The peak in March and drop in April can be explained by the accelerated capitation cycle. DMAS plans to make April's capitation payments in March.

January 2021

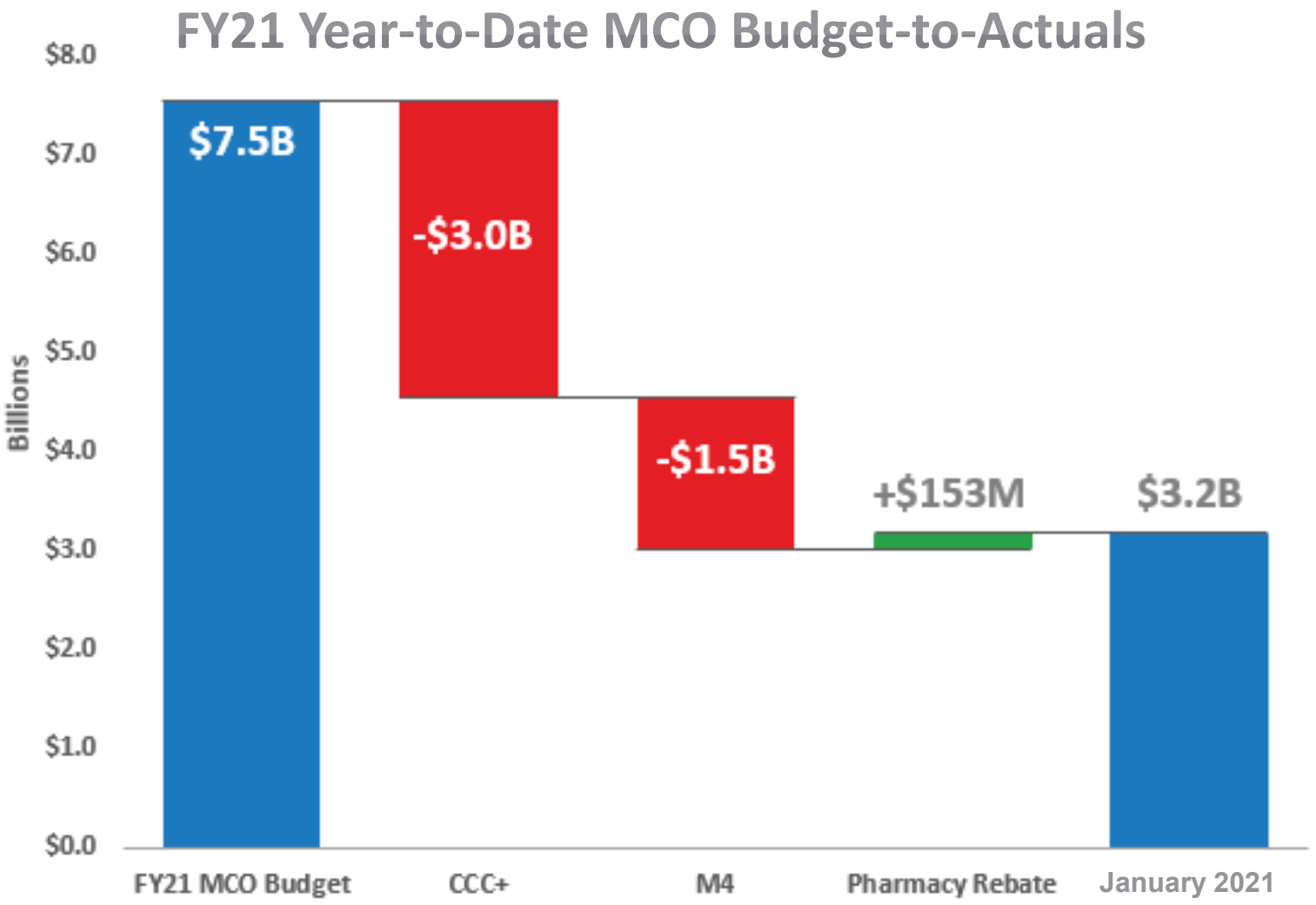
Enrollment

Forecast: 1,090,777
Actual: 1,088,228

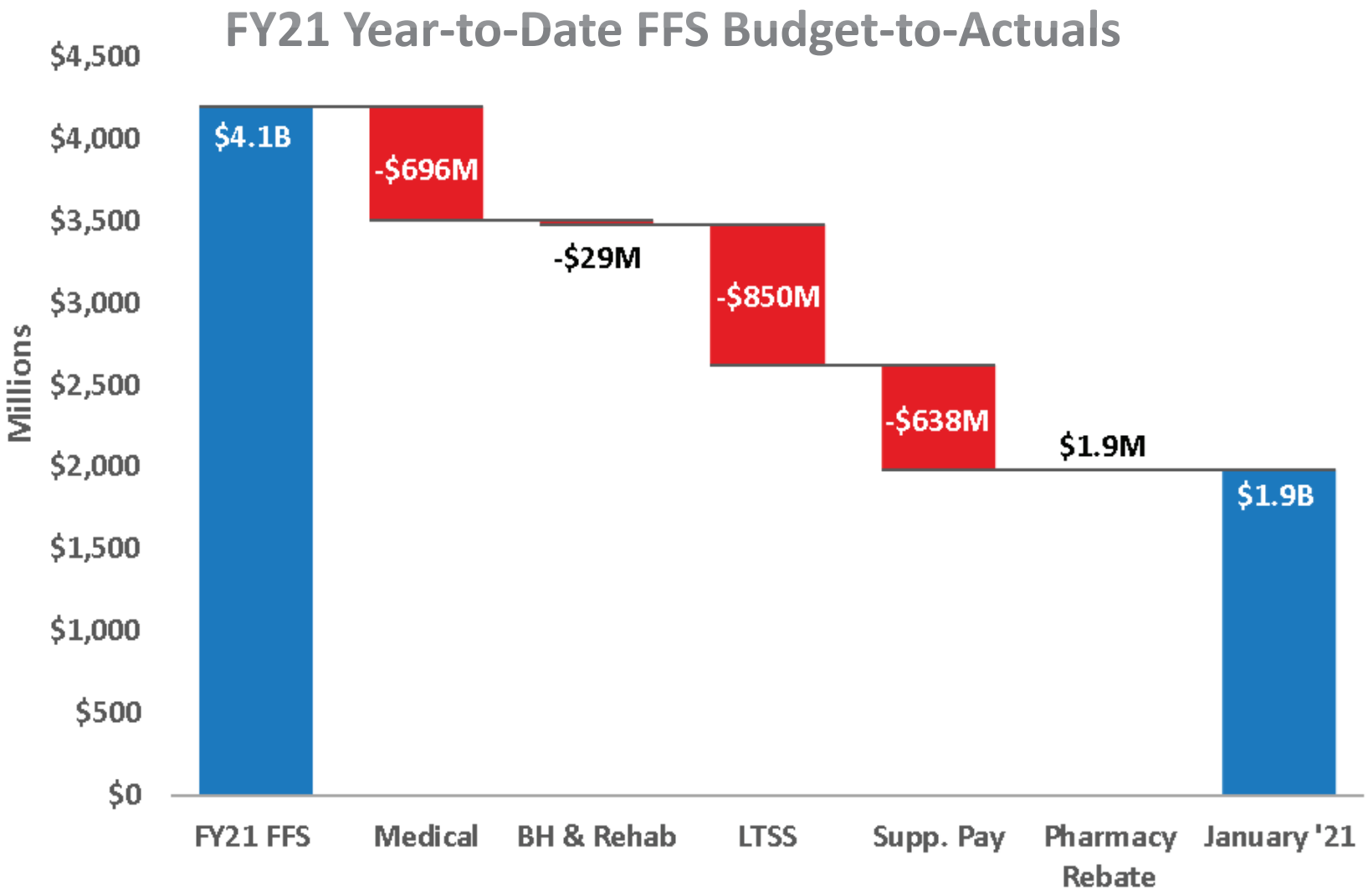
Expenditure

Forecast: $937,373,872
Actual: $1,040,314,940

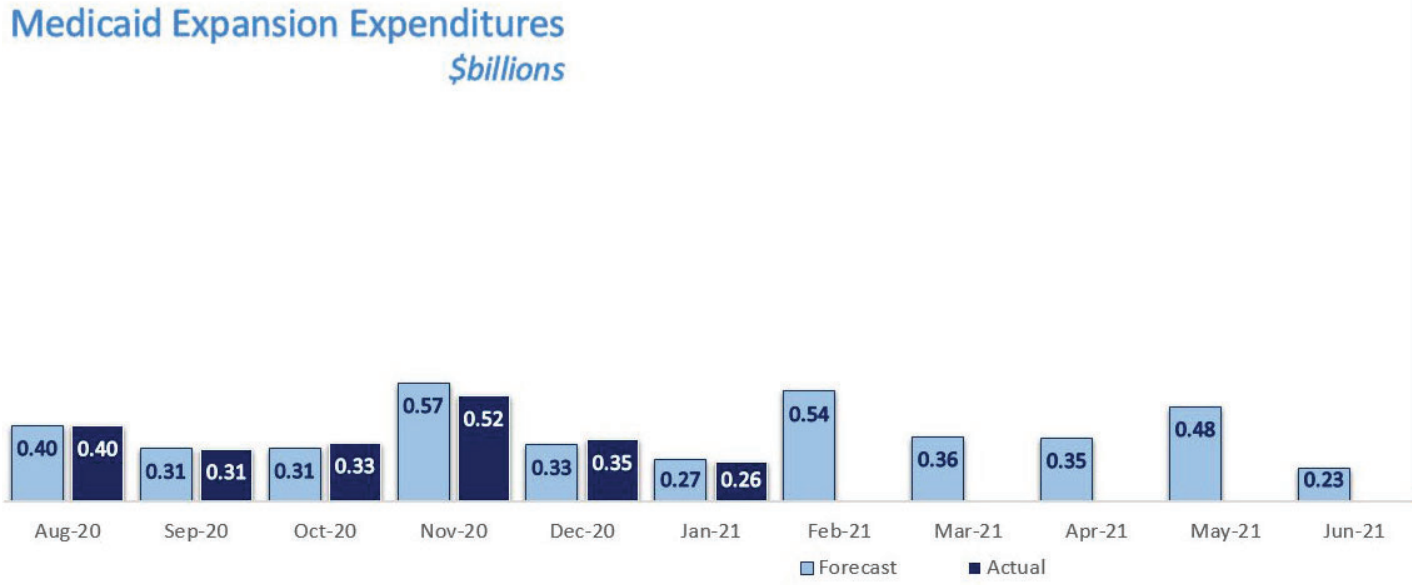
Base Medicaid: MCO



Base Medicaid: Fee-for-Service



Medicaid Expansion (MedEX)



January 2021

Enrollment

Forecast: 562,132
Actual: 511,119

Expenditure

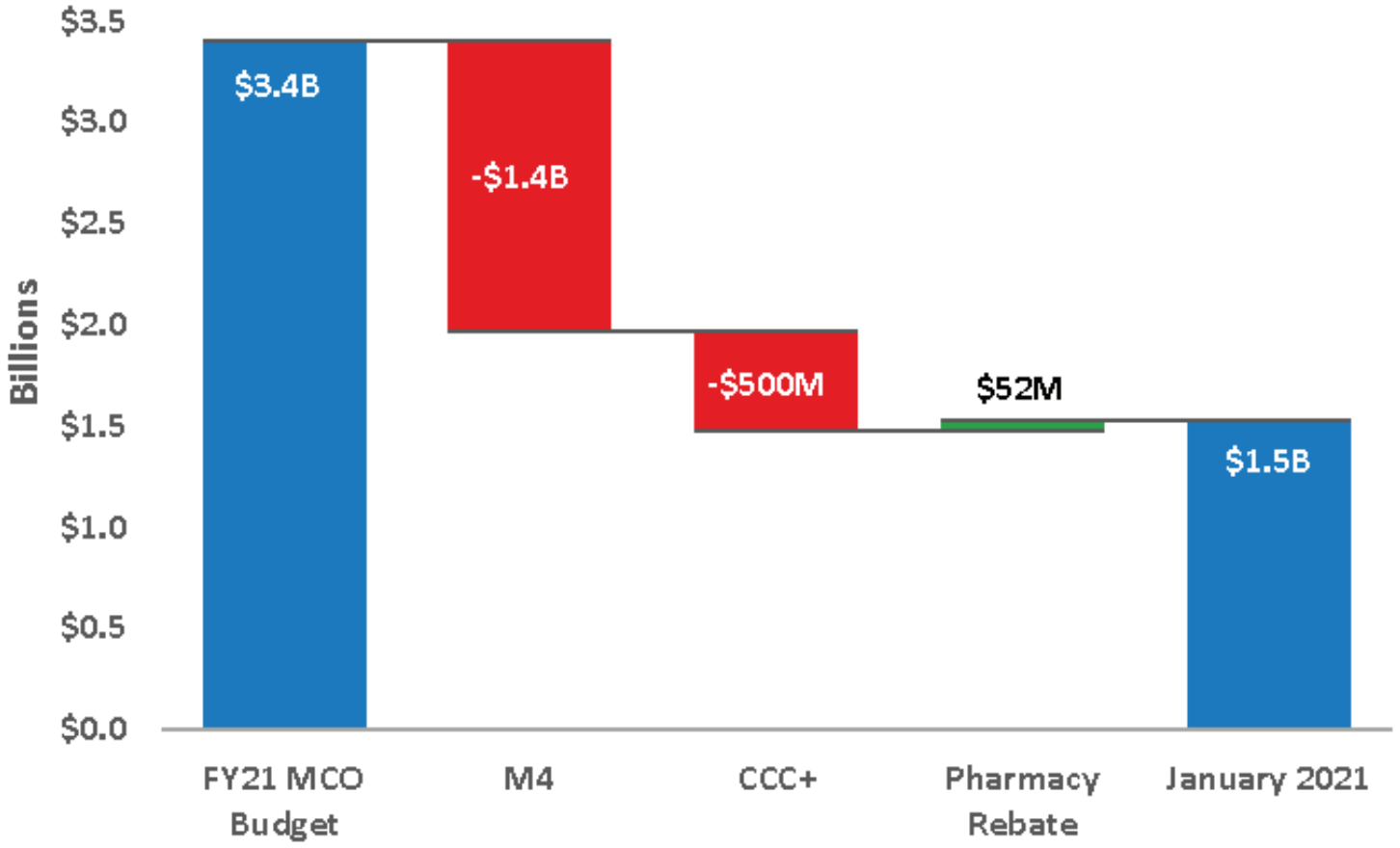
Forecast: $265,571,202
Actual: $258,630,816

Based on November 2020 official forecast

Note: The peak in March and drop in April can be explained by the accelerated capitation cycle. DMAS plans to make April's capitation payments in March.

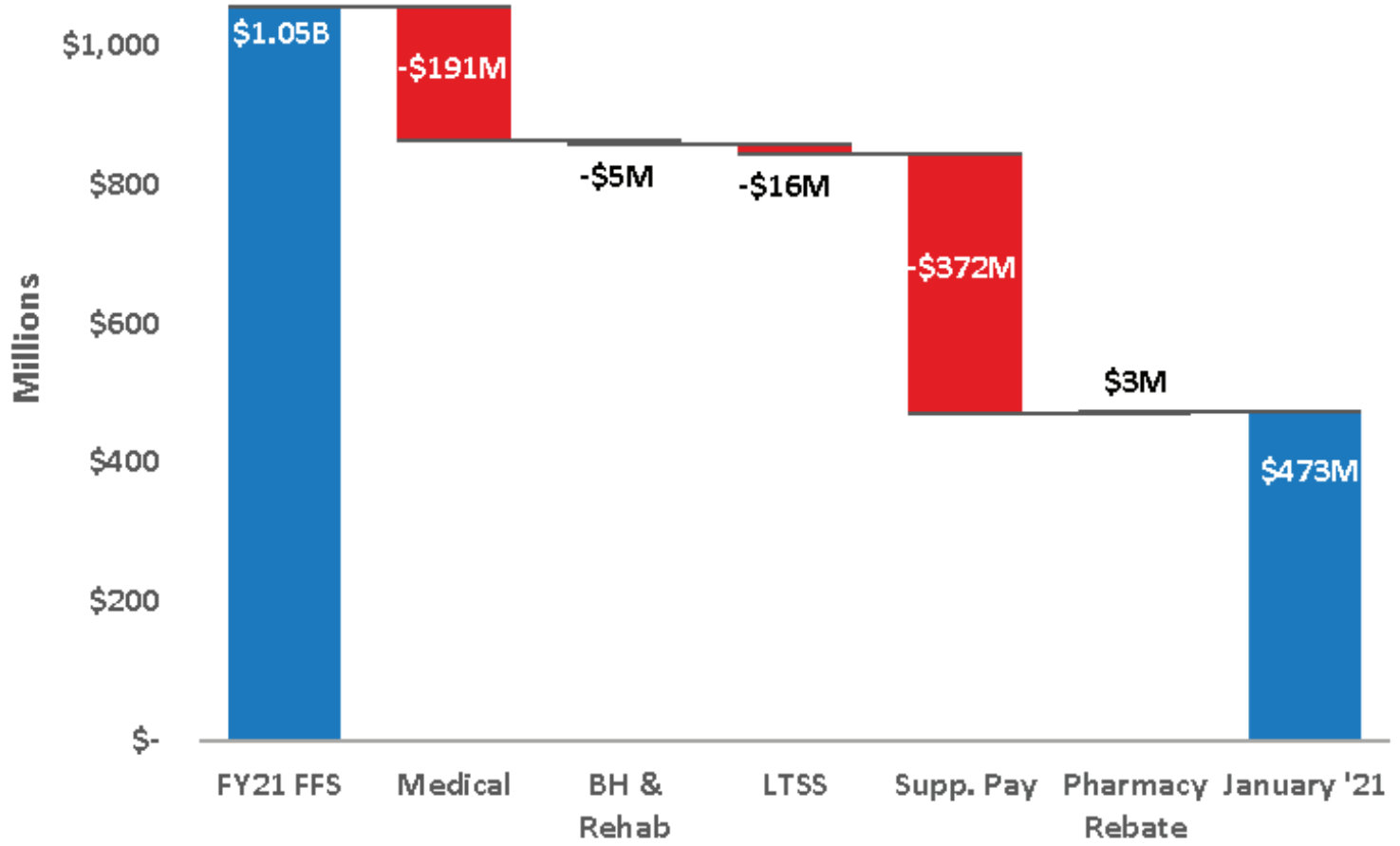
MedEX: MCO

FY21 Year-to-Date MCO Budget-to-Actuals



MedEX: FFS

FY21 Year-to-Date FFS Budget-to-Actuals



GA Actions on DMAS Budget

Amendment #	Description	GF Dollars FY2021	GF Dollars FY2022	NGF Dollars FY2021	NGF Dollars FY2022
312 #1c	Capture Savings from Enhanced Federal Matching Funds	($1,834,183)	($5,378,570)	$1,834,183	$5,378,570
312 #2c	Coverage of Prenatal Care Services		$11,136,631		$20,682,315
313 #10c	Adjust Health Care Fund and Clarify Repayment Provisions	($39,410,177)		$39,410,177	
313 #11c	Supplemental Payments for Lake Taylor				$5,437,276
313 #12c	Capture Enhanced Federal Match Savings	($114,851,105)	($191,551,022)	$114,851,105	$191,551,022
313 #13c	Continue Workgroup On Emergency Department Utilization				
313 #14c	Coverage for Applied Behavioral Analysis Services				
313 #15c	Merger of the Medicaid Managed Care Programs		$1,017,162		$1,502,838
313 #16c	Permanent Continuation of DD Waiver Telehealth/Virtual Services				
313 #17c	Increase Rates for Personal, Respite and Companion Care	$3,021,843	$60,695,492	$3,137,694	$63,014,845
313 #18c	Plan for Home Visiting Medicaid Benefit				
313 #19c	Add 435 Waiver Slots to Address the Priority One Waitlist		$7,093,086		$7,093,086
313 #1c	Restore Funds for Nursing Homes with Special Populations		$506,903		$506,903
313 #20c	Provider Terminations Reporting				
313 #21c	Expand Remote Patient Monitoring Services		$2,682,089		$4,186,201
313 #22c	Modify Medicaid Costs for Commonwealth Center for Children and Adolescents	($590,206)		($742,208)	
313 #23c	Pharmacy Vaccine Administration Fee for COVID-19				
313 #24c	Support Payments for Medicaid Developmental Disability Waiver Providers				
313 #25c	Deferral of Nursing Home Rebasing				
313 #26c	Medicaid Non-Emergency Transportation				
313 #27c	Continue Nursing Home Per Diem Payment & Begin Value-based Purchasing Program		$46,723,014		$46,723,014
313 #28c	Indirect Medical Education Funding for Children's Hospital of the King's Daughters		$2,250,000		$2,250,000
313 #29c	Plan Pilot Program for Medicaid Support for Mobile Vision Clinics for Kids				
313 #2c	Restore Funding for Medicaid Works for Individuals with Disabilities		$57,210		$57,210

GA Actions on DMAS Budget

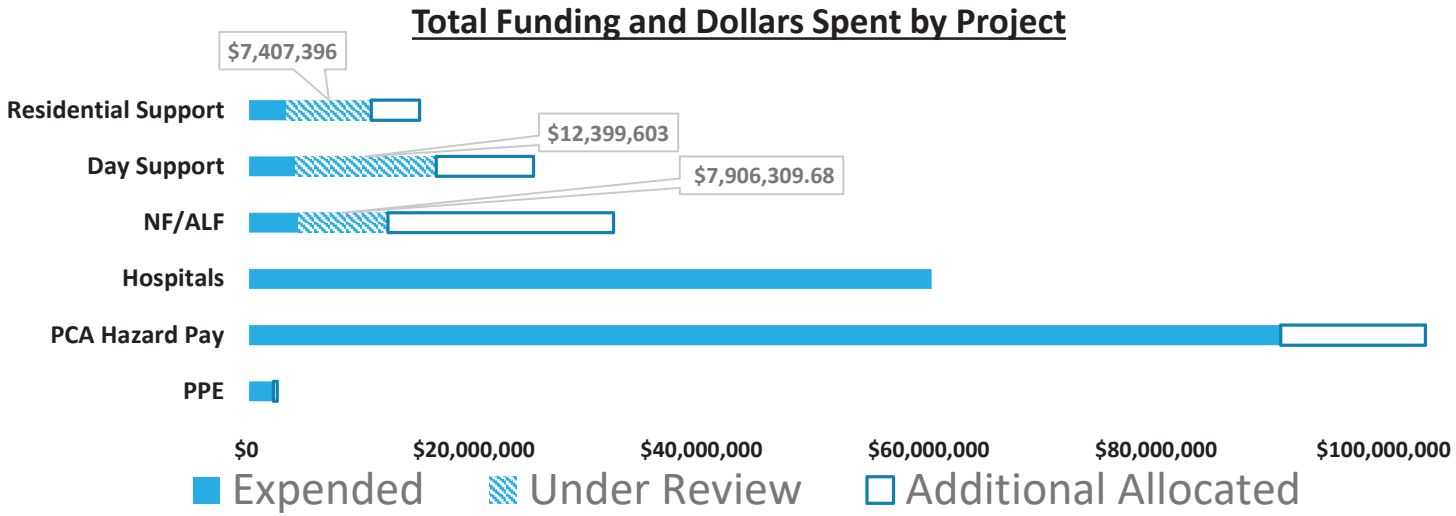
Amendment #	Description	GF Dollars FY2021	GF Dollars FY2022	NGF Dollars FY2021	NGF Dollars FY2022
313 #30c	Review Medicaid Eligibility Requirements for SSI Recipients				
313 #3c	Shift Coverage of Certain Prenatal Care Services to FAMIS Program		($13,428,714)		($13,428,714)
313 #4c	Restore Supplemental Payments for Children's National Medical Center		$354,766		$354,766
313 #5c	Expand Tobacco Cessation Coverage		$34,718		$34,718
313 #6c	Improving Reimbursement for School-Based Services		($104,168)		$2,314,798
313 #7c	Modify Capital Reimbursement for Certain Nursing Facilities		$119,955		$119,955
313 #8c	Paid Sick Leave for Personal Care Attendants		$3,443,865		$3,443,865
313 #9c	Capture Savings from Delay in Behavioral Health Redesign		($10,062,988)		($38,332)
315 #1c	Capture Savings from Enhanced Federal Match	($1,762,463)	($5,250,333)	$1,762,463	$5,250,333
317 #1c	Capture Savings from Enhanced Federal Match	($742,622)	($427,900)	$742,622	$427,900
317 #2c	Analysis of Medicaid/FAMIS Coverage on Maternal & Child Health Outcomes		$250,000		$250,000
317 #3c	Emergency Department Care Coordination Program		$1,319,515		$3,798,129
317 #4c	Reduce Funding for Managed Care Operational Changes		($500,000)		($500,000)
317 #5c	Publish Medicaid State Plan and Other Information on Website				
317 #6c	Personal Care Attendant Orientation Training		$53,247		$103,361
317 #7c	Medicaid Doula Provider Training and Resources		$67,660		$67,660
3-5.15 #1c	Provider Coverage Assessment				
3-5.16 #1c	Modify Methodology for Hospital Provider Payments				
479.10 #2c	Adjustments to Federal CRF Allocations				
	Total Impact	($156,168,913)	($88,898,382)	$160,996,036	$350,581,719

Coronavirus Relief Fund – Project Summary

- Modifications to CRF funding included in the enrolled Budget are not reflected here.

Program	Estimated Expenses Through 12/31/20	Appropriated	Approved Spending	Total Expended to Date
PPE*	$2,470,552.00	$9,256,178	$2,470,552	$2,128,568
Hazard Pay	$103,446,513.00	$73,056,734	$103,446,513	$90,734,028
Hospitals	$60,000,000.00	$60,000,000	$60,000,000	$60,000,000
NF + ALF	$12,202,280.00	$55,640,872	$32,036,718	$4,295,971
Day Support	$16,444,265.24	$25,000,000	$25,000,000	$4,044,662
Group Residential	$10,726,537.40	$15,000,000	$15,000,000	$3,319,141
TOTAL	**$205,290,147.63**	**237,953,784**	**$237,953,784**	$164,522,370

- Total dollars spent to date for each program



Regulatory Activity Summary March 10, 2021
(* Indicates Recent Activity)

2021 General Assembly

***(01) Removal of 40 Quarters Requirements:** The purpose of this SPA is to align with the 2020 Appropriations Act, Item 313.XXX, which states: "Effective upon federal approval but no earlier than April 1, 2021, the Department of Medical Assistance Services shall amend the State Plan under Title XIX of the Social Security Act to eliminate the 40 quarter work requirement for Lawful Permanent Residents who otherwise meet all Medicaid eligibility requirements. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this Act." Following internal review, this SPA was submitted to CMS on 1/20/21. DMAS is currently awaiting feedback from CMS.

***(02) Repeal of CCC Program:** This regulatory action repeals the regulations associated with the Commonwealth Coordinated Care (CCC) Program, a managed-care program launched in 2014 to improve quality, access, and health care experiences for dual-eligible recipients of Medicare and Medicaid. The program reduced Medicare and Medicaid costs by streamlining benefits into one plan and provided individuals with services that are more coordinated and person-centered. DMAS, with support from the Governor and the General Assembly, implemented a new managed long-term services and supports (LTSS) initiative, known as CCC Plus in 2017. CCC Plus operates statewide across six regions as a mandatory Medicaid managed care program, and serves individuals (adults and children) with disabilities and complex care needs. Nearly half of the CCC Plus participants are dually eligible for Medicare and Medicaid and many individuals (dual and non-dual) receive care through nursing facilities or through one of the DMAS home and community based services. Once the CCC Plus program was implemented, all members who had been served by the old CCC program were transitioned into the new program, and the CCC program ended on December 31, 2017. As a result, the CCC regulations are no longer in effect, and are being repealed. Following internal DMAS review, this reg project was submitted to the OAG on 3/5/21.

***(03) 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.

***(04) 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 have been forwarded and this amendment is currently circulating for internal review.

***(05) Tribal Health Clinic:** This SPA includes language allowing the Upper Mattaponi Tribe to collect Medicaid payment for health care services provided through a new Tribal Health Clinic (THC). The Upper Mattaponi Tribe has established a THC to meet the primary care health needs of Tribal members, including those enrolled in Virginia Medicaid. Federal law requires DMAS to file a SPA to recognize and reimburse THCs as Medicaid providers. The THC will be enrolled as a Federally Qualified Health Center and will be reimbursed for services to Medicaid members at a rate set annually by the federal government. CMS will cover 100% of DMAS' payments to the Upper Mattaponi THC for services to Medicaid members. The DPB and Tribal Programs notifications were forwarded on 2/17/21; the prior public notice was posted on 2/23/21; and this amendment is currently circulating for internal review.

***(06) Coverage of Mandatory MAT Drugs:** DMAS currently has robust coverage of all three FDA approved medications for the treatment of opioid use disorder (OUD): Buprenorphine; Methadone; and Naltrexone. DMAS also covers behavioral therapies for the treatment of OUD per requirements of 1905(ee)(1). Current coverage includes all three forms and over 130 FDA approved medications of opioid use disorder (MOUD), all of which have a federal rebate with the Secretary of Health and Human Services (HHS). DMAS does not cover pharmaceuticals which do not have a federal rebate with the HHS Secretariat per the rebate requirements in section 1927. The change in law per the SUPPORT Act amends this section, requiring Medicaid state agencies to begin covering these non-rebatable medications effective October 1, 2020. This results in DMAS covering an additional 11 medications for the treatment of OUD from five pharmaceutical repackaging manufacturers. Since DMAS currently covers all varieties of MOUD and the non-rebatable medications covered by these additional manufacturers offer no variety in ingredients, thus DMAS does not estimate a cost impact. Thus, DMAS must submit this SPA to allow for coverage of all medications for MOUD to include those that do not have a federal rebate agreement with the HHS Secretariat. This SPA is currently circulating for internal review.

***(07) Tribal Consultation:** This state plan amendment proposes to amend the section dedicated to the *State Medical Care Advisory Committee*. The changes for this regulatory section are intended to meet the requirements of Section 1902(a)(73) of the Social Security Act §1902. Section 1902(a)(73) mandates that states that have Indian Health Programs: (1) develop and file a Tribal Consultation SPA and (2) solicit advice from Tribes and from Indian Health Programs prior to submitting any SPA or waiver amendment. Prior to the start of Virginia's Pamunkey Tribe Indian Health Program, DMAS was only required to solicit advice for 1915 and 1115 waiver applications/renewals. The DPB and Tribal Programs notifications were forwarded on 2/23/21 for review.

***(08) Behavioral Health Enhancement – Part 1:** In accordance with the 2020 Special Session, DMAS intends to make the following Behavioral Health Enhancement changes by amending the state plan: (1) Assertive Community Treatment, which will replace and serve as an "enhancement" of the current Intensive Community Treatment Service. This will continue to be a service for adults; (2) Mental Health Intensive Outpatient Programs, a new service for youth and adults; and (3) Mental Health Partial Hospitalization Programs for Youth and Adults, which will replace the current Partial Hospitalization Program for adults. The DPB and Tribal

Programs notifications and the PPN were submitted on 2/22/21 and this amendment is currently circulating for internal review.

2020 General Assembly

***(01) Repeal to GAP-SMI Regulations:** The Governor's Access Plan (GAP) was a Medicaid program implemented in 2015 to provide low-income individuals with a serious mental illness (SMI) access to medical and behavioral health care. Individuals enrolled in the GAP-SMI program were covered for limited mental health benefits. However, the vast majority were able to move into the Medicaid Expansion program, which allowed members to be covered for all Medicaid-covered services. This fast-track regulatory action was initiated to remove outdated reg text, which is no longer needed due to the January 2019 implementation of Medicaid Expansion. The GAP-SMI program closed due to the Expansion, and these regulations can now be repealed. Following internal review and coordination, the project was submitted to the OAG for review on 2/2/21 and certified on 2/23/21. The regs were submitted to DPB on 2/24/21.

***(02) Preadmission Screening and Resident Review (PASRR) Update:** In responding to the legislative mandate of the General Assembly, the purpose of this regulatory action is to establish regulatory requirements for (i) allowing qualified nursing facility staff to complete the LTSS screening for an individual who applies for or requests LTSS, and who is receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital; and (ii) protecting an individual's choice for institutional or community based services and choice of provider. Following internal review, the project was submitted to the OAG for review on 1/5/21.

***(03) 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.

(04) 2020 Program of All-Inclusive Care for the Elderly (PACE) Changes: These regulatory amendments are being made pursuant to HB/SB902, passed by the 2020 General Assembly, which make the following changes to § 32.1-330.3 of the Code of Virginia: (1) remove the definition of and references to Pre-PACE; (2) update references to the U.S. Health Care Financing Administration with references to the Centers for Medicare and Medicaid Services; and (3) change "preadmission screening" to "long term services and supports screening." Following internal review, these final exempt regulations were submitted to the OAG for review on 11/4/20.

(05) 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.

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

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

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

to the OAG on 9/15/20. Following OAG approval, the action was forwarded to the Register on 11/23/20; published on 12/21/20; and became effective on 1/20/21.

2019 General Assembly

***(01) Pooling of State Supplemental Drug Rebates:** Currently, Virginia Medicaid enters into state-specific contracts with pharmaceutical manufacturers. The purpose of this State Plan Amendment is to allow Virginia to participate in multi-state purchasing pools to enable Virginia to enter into value based purchasing agreements for high cost drugs. DMAS sent the DPB notification of the SPA on 9/24/19. Following internal review, the SPA was submitted to HHR on 10/25/19; forwarded to CMS on 11/1/19; and approved by CMS on 1/3/20. The corresponding regulatory action began circulating for internal review on 1/8/20. The regs were forwarded to the OAG on 2/14/20; to DPB on 3/11/20; and submitted to HHR on 4/17/20. Following submission to the Gov. Office on 12/7/20, the regs were forwarded to the Register on 1/19/21; will be published on 2/15/21; and will become final on 4/4/21.

***(02) Processing Medicaid Applications Using SNAP Income:** This SPA will enable DMAS to use gross income determined by SNAP to support Medicaid eligibility determinations at the tme of Medicaid application. Currently, DMAS uses a similar strategy at the time of annual Medicaid renewals. Medicaid eligibility criteria will remain the same, and there will be no change in the number or outcome of eligibility determinations made as a result of this change. The SPA notification was submitted to DPB on 9/24/19. Following internal DMAS review, he SPA was sent to HHR on 11/12/19 and forwarded to CMS on 12/5/19. CMS approved the SPA on 3/12/20. Following internal review, the corresponding regs were submitted to the OAG on 12/2/20. While awaiting OAG review and certification, DMAS responded to a request for additional information on 2/10/21.

***(03) Revisions to Drug Utilization Review Program:** DMAS is implementing changes to the state plan text related to the Drug Utilization Review Program in accordance with the requirements of the Support Act (Public Law No. 115-271). The changes include Support Act provisions related to: claims review limitations; a program to monitor antipsychotic medications by children; fraud and abuse identification; and Medicaid managed care organizations requirements. The SPA notification was submitted to DPB on 10/22/19. Following internal review, the SPA was forwarded to HHR on 12/10/19; submitted to CMS on 12/17/19; and CMS approved the SPA on 3/4/2020. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 8/13/20. The regs were revised and re-submitted to the OAG on 12/2/20, as requested. The reg project was submitted to DPB on 3/3/21 for review.

(04) Third Party Liability – Payment of Claims: Under current law, Medicaid is generally the "payer of last resort," meaning that Medicaid only pays for covered care and services if there are no other sources of payment available. Section 1902(a)(25) of the Social Security Act (the Act) requires that states take "all reasonable measures to ascertain the legal liability of third parties." The Act further defines third party payers to include, among others, health insurers, managed care organizations (MCOs), and group health plans, as well as any other parties that are legally responsible by statute, contract, or agreement to pay for care and services. This final exempt regulatory action mirrors this definition of third parties at 42 CFR 433.136. The Bipartisan Budget Act of 2018, which was signed into law on February 9, 2018, includes several

provisions which modify third party liability (TPL) rules. This new law makes changes to the special treatment of certain types of care and payment, delays the implementation changes to the time period for payment of claims, repeals a provision regarding recoveries from settlements, and applies TPL to CHIP. Following internal DMAS review, the project was submitted to the OAG on 12/30/19.

***(05) Incontinence Supplies:** The purpose of this State Plan Amendment (and corresponding fast-track action) is to remove a sentence that indicates that DMAS reimburses incontinence supplies based on a selective contract with one vendor. When the contract ends on December 31, 2019, DMAS will allow multiple vendors to provide incontinence supplies to Medicaid members. The rate and pricing for incontinence supplies will not change, and the oversight and controls of these providers will remain the same. The SPA folder began circulating for internal review on 8/22/19 and was sent to HHR on 10/22/19. The SPA was approved by CMS on 11/5/19. The corresponding fast track project was sent for review on 8/22/19. The reg action was submitted to the OAG on 9/27/19. DMAS responded to OAG inquiries on 12/2/19; the regs were certified by the OAG on 12/30/19; and then forwarded to DPB on 1/7/20. The project was sent to HHR on 2/13/20, forwarded to the Governor's Ofc. on 11/24/20 for review, and approved by the Gov. on 1/30/21. The regulatory action was sent to the Register on 2/1/21; will be published on 3/1/21; and will be finalized on 4/14/21.

***(06) Fair Rental Value for New and Renovated Nursing Facilities:** This State Plan Amendment revises the state plan to clarify payment rules for new nursing homes or renovations that qualify for mid-year rate adjustments, effective July 1, 2019. The 2019 Appropriations Act, Item 303.VVV, requires DMAS to take this action. Following internal review, the SPA was sent to CMS on 11/1/19 for review and approved by CMS on 11/26/19. The corresponding regulatory action circulated for review on 1/7/20 and was submitted to the OAG on 2/25/20, and certified on 3/30/20. The project was submitted to DPB on 3/31/20 and forwarded to HHR on 5/4/20. The project was submitted to the Gov. Ofc. on 12/7/20 and approved on 1/30/21. The regulatory action was published in the Register on 3/1/21 and will become effective on 4/14/21.

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

edits were made. The project was submitted to DPB on 12/12/19 and forwarded to HHR on 1/21/20. The reg action was forwarded to the Governor's Ofc. on 11/24/20 for review and signed on 1/30/21. The project was submitted to the Register on 2/1/21; published in the Register on 3/1/21; and will become effective on 4/14/21.

2018 General Assembly

***(01) Service Authorization:** This emergency regulatory action clarifies the documentation requirements for service authorization for Community Mental Health and Rehabilitative Services (CMHRS). This regulation is essential to protect the health, safety, or welfare of citizens in that it ensures that Medicaid members receive appropriate behavioral health services based on their documented needs. The regulatory changes reflect the transfer of community mental health rehabilitative services from the behavioral health services administrator (BHSA) to DMAS managed care contractors. Following internal DMAS review and coordination, the regs were forwarded to the OAG on 10/29/18 for review. Responses to OAG inquiries were forwarded on 4/29/19. The OAG sent additional comments on 7/9/19 and DMAS forwarded a revision on 7/10/19. More changes were requested on 7/12/19 and additional revisions were forwarded to the OAG on 7/16/19 and 7/29/19. More change requests were received and revisions were sent on 9/10/19. Following a conf. call on 10/31, revised text was sent to the OAG on 11/1/19 and additional revisions were sent on 11/25/19. The regulatory action was forwarded to DPB on 12/4/19; sent to HHR on 12/12/19; and forwarded to the Governor on 3/24/20. The project was submitted to the Register on 2/8/21; published in the Register on 3/1/21; and will become effective on 4/1/21.

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

(03) Medicaid Expansion — Determination State (Medicaid): This state plan amendment is designed to allow Virginia to change from the Assessment Model of eligibility determination to the Determination Model of eligibility determination. In the Assessment Model, which Virginia currently follows, the Federally Facilitated Marketplace (FFM) makes an initial assessment of eligibility and the State Medicaid agency must then re-determine eligibility to make a final decision. In the Determination Model, the FFM makes the final Modified Adjusted

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

***(04) Settlement Agreement Discussion Process:** This regulatory action establishes a more formalized process by which to address administrative settlement agreements, in a timely fashion. The proposed new regulation, 12 VAC 30-20-550, describes the process for settlement agreement discussions between a Medicaid provider and DMAS and how it affects the time periods currently set forth in the existing informal and formal appeal regulations at 12 VAC 30-20-500 et. seq. The proposed amendments to 12 VAC 30-20-540 and 12 VAC 30-20-560 are necessary for these sections to be consistent with the proposed new regulation, 12 VAC 30-20-550. The amendments affect the timelines for issuing either the informal decision in an informal administrative appeal or recommended decision of the hearing officer in a formal administrative appeal when the proposed new regulation 12 VAC 30-20-550 pertaining to the settlement agreement process is used. Following internal review, the project was submitted to the OAG for review on 10/16/18. DMAS received questions from the OAG on 4/29/19. Responses were forwarded to the OAG on 5/8/19. The project was sent to DPB on 7/9/19; to HHR on 7/23/19; to the Gov. Ofc. on 9/10/19; approved by the Gov. on 9/18/19; and submitted to the Registrar on 9/18/19. The reg publication date was 10/14/19, with a comment period though 11/13/19, an effective date of 11/14/19, and an expiration date of 5/13/21. The corresponding fast-track package was circulated for internal review on 10/9/19 and submitted to the OAG on 11/14/19. The OAG approved the fast-track phase on 2/26/21 and the reg action was sent to DPB for review on 3/1/21.

***(05) Removal of the 21 Out of 60 Day Limit:** This fast-track regulatory action is necessary to comply with the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Rule, issued on March 30, 2016. The overall objective of the Medicaid Mental Health Parity Rule is to ensure that accessing mental health and substance use disorder services is no

more difficult than accessing medical/surgical services. To comply with the Medicaid Mental Health Parity Rule, DMAS must remove the limit of 21 days per admission in a 60 day period for the same or similar diagnosis or treatment plan for psychiatric inpatient hospitalization, as this limit for coverage of non-psychiatric admissions was removed on July 1, 1998. (Medicaid managed care plans do not apply the limit of 21 out of 60 days, and both the limit and the change only apply to fee for service.) Psychiatric inpatient hospitalizations must be service authorized based on medical necessity and not be limited to 21 days per admission in a 60 day period. The citation for the federal regulation to remove the "21 out of 60 day limit" can be found in 42 CFR 438.910(b)(1). Following internal DMAS review and coordination, beginning on 6/20/18, the project was submitted to the OAG on 7/1/19. A conf. call w/ the OAG and SMEs to discuss the regs was held on 7/24/19. The OAG sent additional questions on 8/12/19, and DMAS responded on 8/21/19. The regs were certified by the OAG on 9/12/19 and submitted to DPB on 9/13/19. DMAS responded to DPB inquiries the week of 9/16/19 and to additional DBP inquiries following a conf. call on 10/1/19. DPB forwarded the regs to HHR on 10/21/19 and the action was sent to the Gov. Ofc. on 11/17/19. The Gov. Ofc. approved the regs on 8/12/20. The regulatory action was submitted to the Registrar on 8/20/20, with an issue date of 9/14/20. The comment period ended 10/15/20, with an effective date of 10/30/20. The corresponding SPA is currently circulating through internal review.

***(06) Electronic Visit Verification (EVV):** This NOIRA action intends to amend regulations in order to include provisions related to Electronic Visit Verification (EVV) as required by the 21st Century CURES Act, 114 U.S.C. 255, enacted December 13, 2016 (the CURES Act) and the 2017 Appropriations Act Chapter 836, Item 306. YYYY. The CURES Act requires states to implement an EVV system for personal care services by January 1, 2019 and home health care services by January 1, 2023. The 2017 Appropriations Act authorizes DMAS to require EVV for personal care, respite care and companion services. The CURES Act requires that the EVV system must verify: 1) The type of service(s) performed; 2) The individual receiving the service(s); 3) The date of the service; 4) The location of service delivery; 5) The individual providing the service, and 6) The time the service begins and ends. DMAS sought input regarding the EVV system from individuals receiving services, family caregivers, providers of personal, respite and companion care services, home health care services, provider associations, managed care organizations, health plans and other stakeholders. DMAS also sought input on the current use of EVV in the Commonwealth and the impact of EVV implementation. The NOIRA was circulated for internal DMAS review and submitted to DPB on 4/30/18. The NOIRA was approved by DPB on 5/11/18 and forwarded to the Gov. Ofc. The Gov. approved the regs on 8/22/18. The regs were filed with the Registrar's Ofc. on 8/23/18, with the comment period ending on 10/17/18. With no comments received, the proposed phase review began on 10/25/18. The regs were forwarded to the OAG for review on 1/17/19. The OAG forwarded regulatory questions on 4/23/19, and DMAS sent responses back on 4/29/19. Additional changes were sent to the OAG on 6/7/19. The OAG forwarded inquiries on 7/19/19 and DMAS responded. The regs were sent to DPB for review on 7/29/19. A conf. call w/ DBP was held on 8/20/19, and DMAS sent additional responses/revisions on 8/21/19. DMAS fielded several DPB questions the weeks of 9/9/19 and 9/16/19. The reg action was submitted to HHR, approved on 9/15/19, and sent to the Governor on 9/15/19. The EIA response was posted to the TH on 9/18/19. The Gov. Ofc. completed its review on 12/17/19. The project was submitted to the Registrar on 12/18/19, with a publication date of 1/20/20. The 60-day public comment period expired on 3/21/20. The Town Hall proposed stage comment review was complete/categorized on 4/10/20 and a notification e-mail was submitted to commenters. The final stage phase of the reg action was sent to the OAG for review on 9/14/20. On 11/10/20, revisions were made and the project was sent back to the OAG. Additional reg changes were brought about by the GA 2020 Special Session and revisions were sent to the OAG on 11/10/20. DMAS is awaiting further feedback. The SPA DBP notification was submitted to DPB on 11/4/19. Following internal review, the SPA was submitted to HHR on 3/2/20 and HHR approval was received on 3/26/20. The Tribal notification was sent on 6/11/20. The SPA was submitted to CMS for review on 9/1/20 and approved on 10/6/20.

2017 General Assembly

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

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

2016 General Assembly

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

2015 General Assembly

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

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

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

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.