BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, December 12, 2023
10:00 AM to 12:00 PM

AGENDA

#	Item	Presenter
1	Call to order	Kannan Srinivisan, Board Chair
2	Approval of 9/12/2023 Meeting Minutes	
3	Director's Report	Cheryl Roberts, Agency Director
4	Unwinding Update	Sarah Hatton, Deputy of Administration
5	Mobile Crisis and Legally Responsible Individuals (LRI)	Tammy Whitlock, Deputy of Complex Care Services
6	Budget Update	Chris Gordon, Deputy for Finance
7	New Business/Old Business	
8	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.	
9	Regulations	
10	Adjournment	

CardinalCare
Virginia's Medicaid Program

Board of Medical Assistance Services

Cheryl Roberts, J.D., DMAS Director

December 12, 2023

DMAS

DMAS Executive Leadership Team

Cheryl Roberts
Agency Director

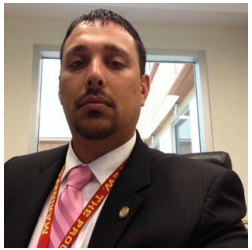
Ivory Banks
Chief of Staff

Adrienne Fegans
Deputy for Programs & Operations

Chris Gordon
Chief Financial Officer

Sarah Hatton
Deputy for Administration

Jeff Lunardi
Chief Deputy Director



John Kissel
Deputy for Technology & Innovation

Rich Rosendahl
Chief Analytics Officer

Dr. Lisa Price-Stevens
Chief Medical Officer

Tammy Whitlock
Deputy for Complex Care

Who Do We Cover?

Medicaid plays a critical role in the lives of more than 2.1 million Virginians


Adults 848,836


Children 835,767


Limited Benefit Individuals 167,176


Individuals with Disabilities 145,755


Older Adults 88,125


Pregnant Members 38,885

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Virginia's Medicaid Program

Source: November 15, 2023 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

Virginia Medicaid's Overarching Goals

Goal 1: Member-Centered
Serving members the best way possible

1. Improve maternal/child health outcomes
2. Ensure members with behavioral health needs obtain coordinated care and services
3. Support community living and independence for all older adults and people with disabilities who need help with daily activities

By

Goal 2: Innovating
To create new ways to address member and program needs

1. Explore and develop new models and services that drive outcomes
2. Foster a team of qualified and passionate public servants
3. Streamline the member journey and process from application to services to transitions
4. Use data and technology to make our program more efficient and effective

And

Goal 3: Accountable
Managing the Commonwealth's resources with integrity and measurable outcomes

1. Ensure program integrity and compliance with State and federal requirements
2. Increase accountability of contractors and partners to ensure a stable, accessible, and continuously improving program
3. Monitor fiscal integrity and accountability and manage risk

CardinalCare
Virginia's Medicaid Program

Program Updates

DMAS

Program Updates

Workforce

DMAS has 91% staff fill rate and will have first paid intern cohort January 2024

Enrollment

12-month continuous enrollment for children effective January 2024

State-Based Exchange

Virginia State-Based Exchange went live November 2023

Right Help Right Now

1-year anniversary meeting Thursday Dec 14 at State library

ID/DD Waiver Slots

CMS approved the allocated ID/DD waiver slots

OCMO Update

OCMO had well attended Pharmacist as Physician meetings as well as special P&T meeting on weight loss drugs

KePro and Magellan Service authorization services combined – Acentra November 1, 2023

- All Physical and Behavioral Health service authorizations for fee for service are being done by Acentra.
- Behavioral Health Service authorizations were transferred to Magellan for all BH services including PRTF November 1, 2023.
- All Behavioral health claims are now being paid by Conduent and provider enrollment is done via PRSS (Gainwell).
- This transition requires providers to learn new business processes associated with each of the contractors

Resources: Provider issues regarding FFS authorization should be directed to Acentra via Customer Service/Provider Issues:

Acentra DMAS Provider Email (do not include PHI): VAproviderissues@kepro.com
Local Phone: 804.622.8900
Tollfree: 888.827.2884

For questions or issues related to direct billing or clearinghouses, email Virginia.EDISupport@conduent.com

For assistance with other billing and claims (as well as member eligibility) contact the Virginia Medicaid Provider Helpline:

toll-free 800-552-8627

in-state 804-786-6273

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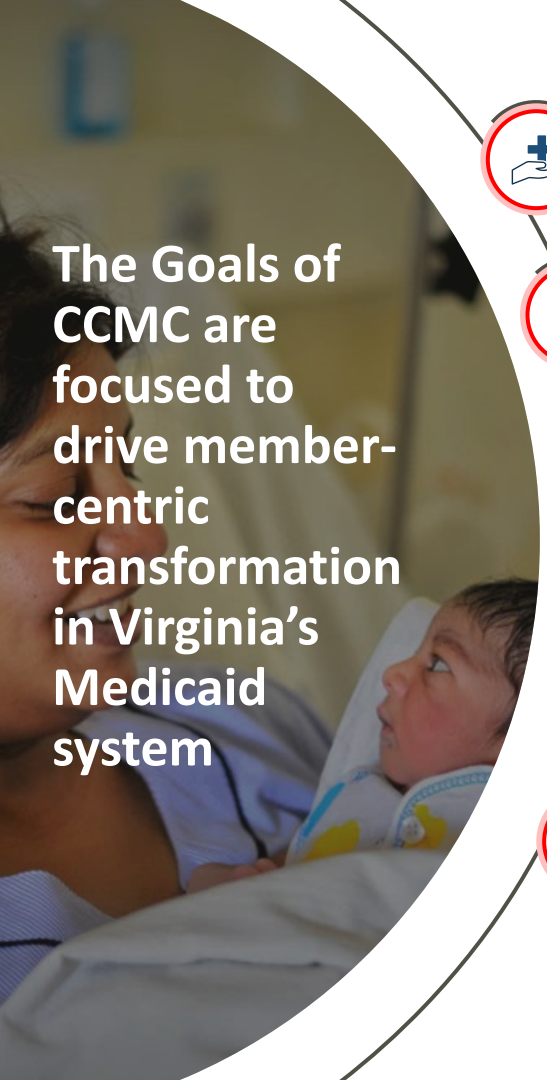
Virginia's Medicaid Program

MCO Procurement

DMAS

BACKGROUND

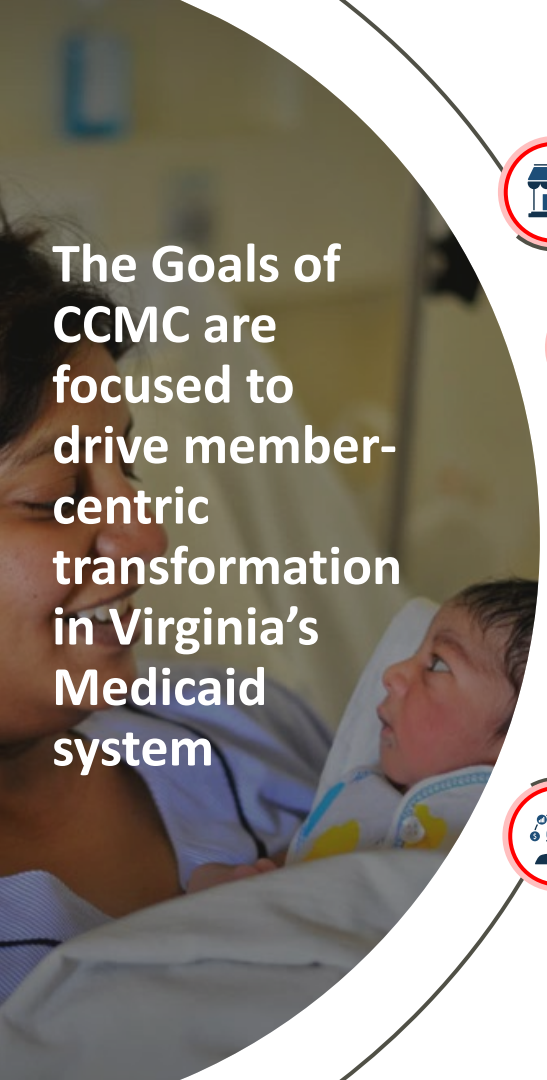
- The Department of Medical Assistance Services (DMAS) Cardinal Care Managed Care program provides comprehensive health care services for 2.0 million Virginians receiving Medicaid and CHIP coverage through five contracted health plans.
- This presentation will provide the goals and program changes that will strengthen the Cardinal Care Managed Care program
- DMAS is taking a bold approach to improve the Cardinal Care Managed Care program with three steps:
  - Defining the transformation goals for the program
  - Creation of Cardinal Care Managed Care – a consolidation of the two programs formerly known as Commonwealth Coordinated Care Plus and Medallion 4.0
  - Reprocurement of the Cardinal Care Managed Care delivery system



The Goals of CCMC are focused to drive member-centric transformation in Virginia's Medicaid system

DEFINING GOALS

1. Ensure Virginians covered by Medicaid have appropriate access to quality health care in every community.
2. Transform behavioral health services and outcomes for members through integrated health care with a focus on prevention, treatment, crisis and recovery as part of *Right Help Right Now* initiative.
3. Enhance maternal and child health outcomes through strategic initiatives that increase member engagement and provide appropriate and timely access to services across geographic and ethnic populations.
4. Strengthen provider access, adequacy, and availability through streamlined administrative and payment processes, training, and monitoring.
5. Support members with high risk factors or needs through case management and other resources to support health-related social needs in the community.



The Goals of CCMC are focused to drive member-centric transformation in Virginia's Medicaid system

DEFINING GOALS

6. Provide support to children and youth in foster care with focused and dedicated services to meet their medical and behavioral health needs.

7. Improve access to appropriate services and supports for members receiving LTSS to enable them to live in the setting of their choice and promote their wellbeing and quality of life.

8. Drive innovation and operational excellence with a focus on improved outcomes.

9. Increase value-based payment arrangements, quality driven withholds and tighter limits on MCO profits.

10. Expand the use of data analytics, compliance monitoring and oversight.

Creation of Cardinal Care Managed Care

January 1 2023 began the Cardinal Care process. October 1, 2023, DMAS received approval to consolidate the two managed care programs as a foundation for the procurement.

Single MCO Contract and Single CMS Managed Care Program

Cardinal Care Branding, Communications, and Consolidated Enrollment Broker Website (January 2023)

Preserves Continuity of Managed Care Enrollment

Responsive Model of Care

Aligned Regional Open Enrollment Effective January 1, 2023

Aligned Technical Differences

This consolidation did not disrupt services, providers, or access for members.

Cardinal Care Managed Care Procurement

In October 2022, HHR Secretary announced that DMAS would seek to reprocure Cardinal Care to drive person-centered, innovation, creativity and strengthen quality and accountability for the Virginia Medicaid Managed Care program.

DMAS solicited several hundred comments and input from major associations and the Medicaid Managed Care Advisory Committee for review.

DMAS worked with Boston Consultant Group, a national consulting firm to create a program that focused on the Administration priorities, identify emerging best practices across the nation, incorporate stakeholder input, and focus on key areas of improvement for Virginia Cardinal Care Medicaid Managed Care program.

Cardinal Care Managed Care Procurement

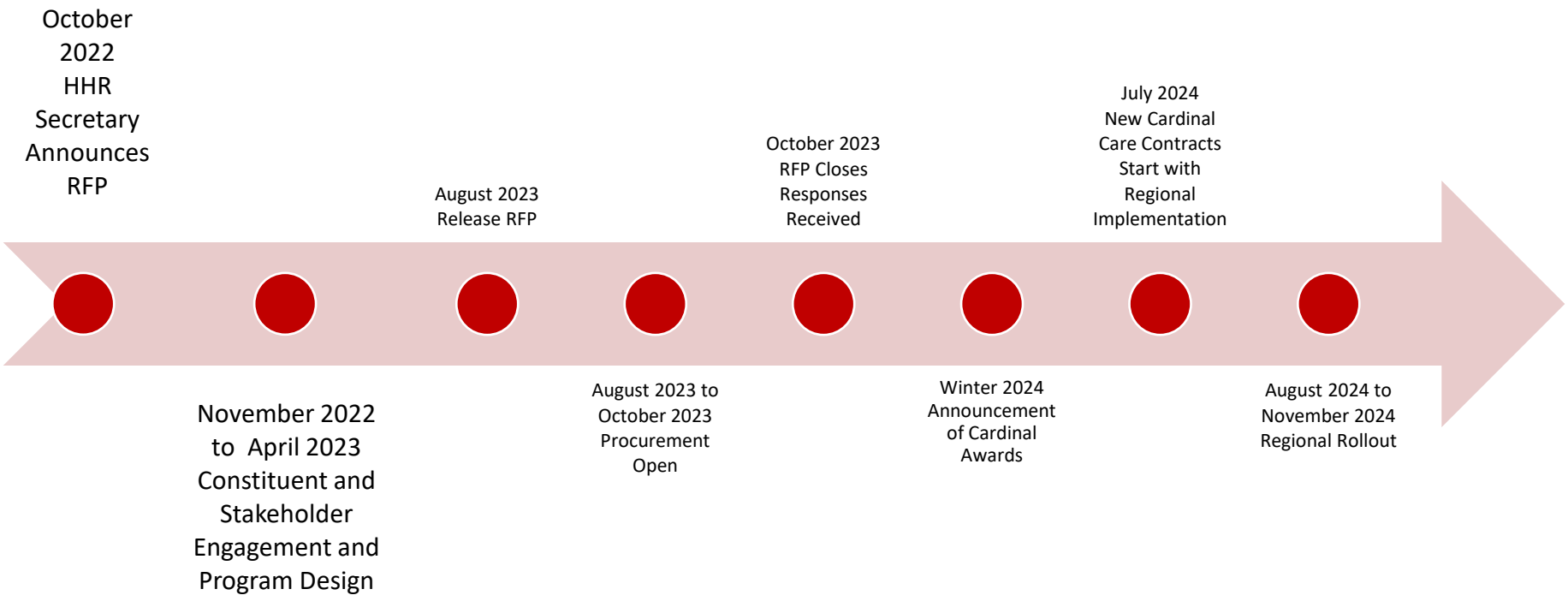
On August 31, 2023, DMAS released the Cardinal Care Managed Care Request for Proposal, model contract, and draft rates on eVA.Virginia.gov

The pre-proposal conference was held as well as providing responses to initial questions.

MCO Proposals were received on October 27, 2023, and the Department expects to award Winter 2024.

The Department acknowledged that the requirements, dates and program changes may change based on Governor and legislative directives

Cardinal Care Managed Care Milestones



Cardinal Care Managed Care – Procurement Changes

- Provider Management
  - Revise network adequacy and access standards including extended hours for appointments
  - Promote member choice
  - Work on standardizing provider credentialing
  - Add new CMS standards
  - Incorporate new payment changes
- Model of Care
  - Focus on member-centric care
  - Better use of resources and extenders
  - Members can move from one level of intensity to another
- Trends and Utilization
  - Monitoring new high-cost drugs and services
  - Review over and underutilization trends
  - Open to new innovations

Cardinal Care Managed Care – Procurement Changes

- Membership
  - Member education and choice
  - Regional implementation
  - Redistribution of members
- Behavioral Health
  - Focus on and support of the *Right Help Right Now* initiatives
  - Pre-crisis prevention services, crisis care, post-crisis treatment recovery and support
  - Members – youth and adults
  - Providers – inpatient, Community Service Boards
  - Services - new and continued community services, new waiver services, application for SMI, schools
  - Include PRTF services as a carve out service
- Maternal Child Health
  - Focus on increasing preventive care for children
  - Increase the maternal scope of programs and outcomes
  - Move HEDIS data outcomes up
  - One single plan for children and youth in foster care

Cardinal Care Managed Care – Procurement Changes

- Financials
  - Clinical efficiencies
  - Performance withholds
  - Profit margin tiers
  - Value-based purchasing arrangements
- New Compliance and Monitoring Focus
  - New compliance processes
  - Expanded reporting requirements
- Stakeholder and Evaluation Process
  - Increased transparency
  - Increased data mining and usage
  - Increased open discussions

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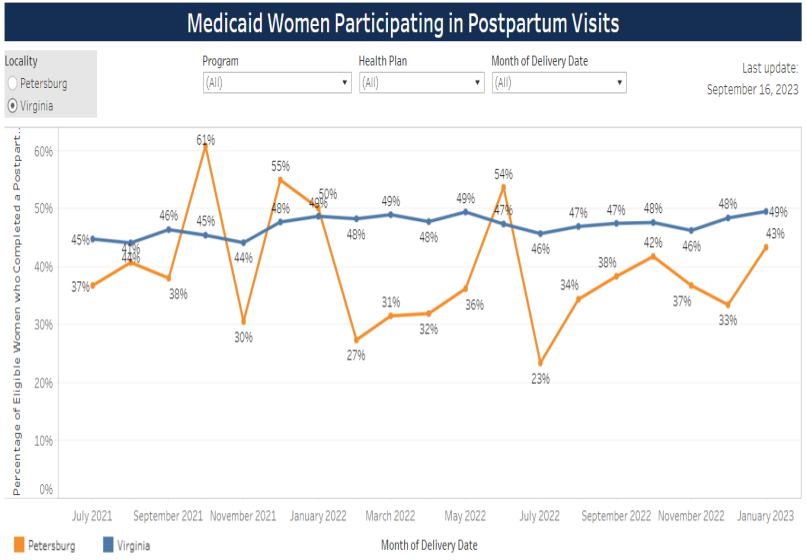
Virginia's Medicaid Program

Maternal Health Updates

DMAS

Increasing Postpartum Visits – Virginia has the 12-month postpartum continuous coverage, to improve access to care and outcomes. But the rates need to be improved



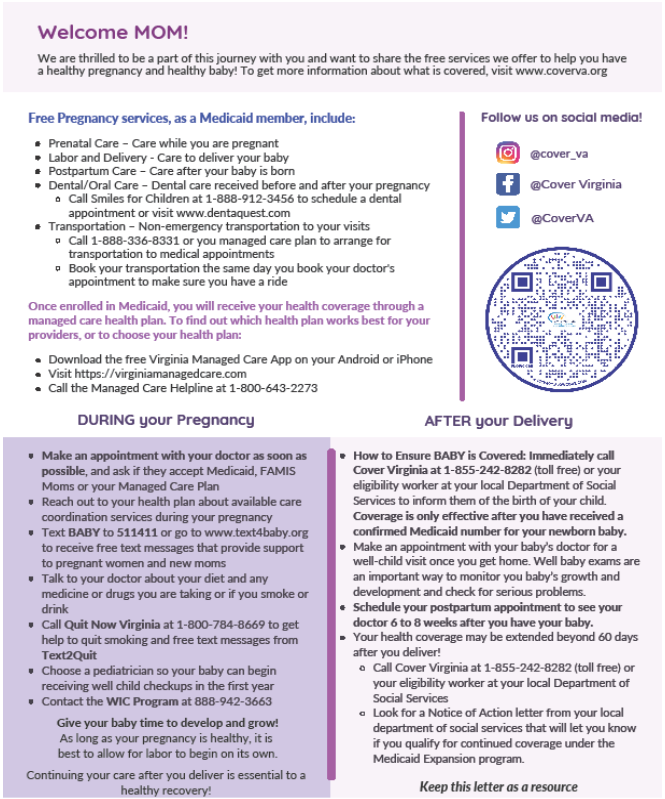
Ranking	State	Measure Rate
1	State A	83.41
2	State B	82.88
3	State C	82.60
4	State D	82.60
5	State E	82.49
6	State F	80.06
7	State G	79.41
8	State H	79.13
9	State I	78.61
10	State J	78.22
	Virginia (Medicaid)	70.40
	Virginia (Commercial*)	79.00

Footnotes:
1. Postpartum visits use unvalidated, unaudited HEDIS specified measures and follow the administrative methodology
2. Per HEDIS Specs, Postpartum visits are counted if they occur within 7-84 days of the date of birth
3. Due to claims runout and the 84 days timeframe for Postpartum visits, the data shown may be incomplete

Addressing Maternal Health in Petersburg

- Governor's initiative to "*Build Comprehensive Relationships to Foster Comprehensive Change through a Comprehensive Approach*"
- *33% of the women getting adequate maternal care and postpartum*
- A four tiered project was launched
  - Date analytics
  - Member engagement
  - MCO engagement
  - Provider engagement

Old New Mom Letter



Welcome MOM!

We are thrilled to be a part of this journey with you and want to share the free services we offer to help you have a healthy pregnancy and healthy baby! To get more information about what is covered, visit www.coverva.org

Free Pregnancy services, as a Medicaid member, include:

- Prenatal Care – Care while you are pregnant
- Labor and Delivery - Care to deliver your baby
- Postpartum Care – Care after your baby is born
- Dental/Oral Care – Dental care received before and after your pregnancy
  - Call Smiles for Children at 1-888-912-3456 to schedule a dental appointment or visit www.dentaquest.com
- Transportation – Non-emergency transportation to your visits
  - Call 1-888-336-8331 or you managed care plan to arrange for transportation to medical appointments
  - Book your transportation the same day you book your doctor's appointment to make sure you have a ride

Once enrolled in Medicaid, you will receive your health coverage through a managed care health plan. To find out which health plan works best for your providers, or to choose your health plan:

- Download the free Virginia Managed Care App on your Android or iPhone
- Visit https://virginiamanagedcare.com
- Call the Managed Care Helpline at 1-800-643-2273

Follow us on social media!

@cover_va

@Cover Virginia

@CoverVA

DURING your Pregnancy

- **Make an appointment with your doctor as soon as possible**, and ask if they accept Medicaid, FAMIS Moms or your Managed Care Plan
- Reach out to your health plan about available care coordination services during your pregnancy
- Text **BABY** to **511411** or go to www.text4baby.org to receive free text messages that provide support to pregnant women and new moms
- Talk to your doctor about your diet and any medicine or drugs you are taking or if you smoke or drink
- Call **Quit Now Virginia** at 1-800-784-8669 to get help to quit smoking and free text messages from **Text2Quit**
- Choose a pediatrician so your baby can begin receiving well child checkups in the first year
- Contact the **WIC Program** at 888-942-3663

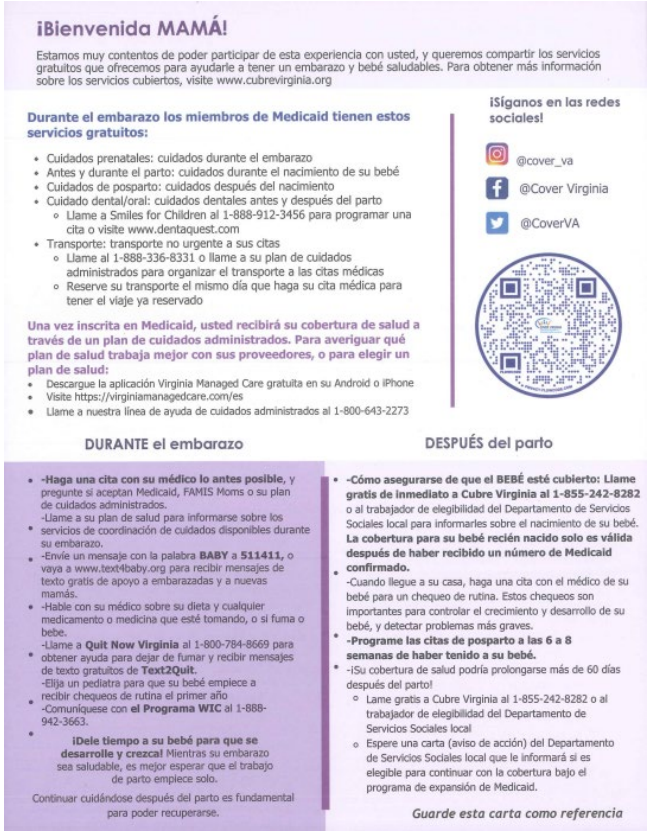
Give your baby time to develop and grow!
As long as your pregnancy is healthy, it is best to allow for labor to begin on its own.

Continuing your care after you deliver is essential to a healthy recovery!

AFTER your Delivery

- **How to Ensure BABY is Covered: Immediately call Cover Virginia at 1-855-242-8282** (toll free) or your eligibility worker at your local Department of Social Services to inform them of the birth of your child. **Coverage is only effective after you have received a confirmed Medicaid number for your newborn baby.**
- Make an appointment with your baby's doctor for a well-child visit once you get home. Well baby exams are an important way to monitor you baby's growth and development and check for serious problems.
- **Schedule your postpartum appointment to see your doctor 6 to 8 weeks after you have your baby.**
- Your health coverage may be extended beyond 60 days after you deliver!
  - Call Cover Virginia at 1-855-242-8282 (toll free) or your eligibility worker at your local Department of Social Services
  - Look for a Notice of Action letter from your local department of social services that will let you know if you qualify for continued coverage under the Medicaid Expansion program.

Keep this letter as a resource



¡Bienvenida MAMÁ!

Estamos muy contentos de poder participar de esta experiencia con usted, y queremos compartir los servicios gratuitos que ofrecemos para ayudarle a tener un embarazo y bebé saludables. Para obtener más información sobre los servicios cubiertos, visite www.cubrevirginia.org

Durante el embarazo los miembros de Medicaid tienen estos servicios gratuitos:

- Cuidados prenatales: cuidados durante el embarazo
- Antes y durante el parto: cuidados durante el nacimiento de su bebé
- Cuidados de posparto: cuidados después del nacimiento
- Cuidado dental/oral: cuidados dentales antes y después del parto
  - Llame a Smiles for Children al 1-888-912-3456 para programar una cita o visite www.dentaquest.com
- Transporte: transporte no urgente a sus citas
  - Llame al 1-888-336-8331 o llame a su plan de cuidados administrados para organizar el transporte a las citas médicas
  - Reserve su transporte el mismo día que haga su cita médica para tener el viaje ya reservado

Una vez inscrita en Medicaid, usted recibirá su cobertura de salud a través de un plan de cuidados administrados. Para averiguar qué plan de salud trabaja mejor con sus proveedores, o para elegir un plan de salud:

- Descargue la aplicación Virginia Managed Care gratuita en su Android o iPhone
- Visite https://virginiamanagedcare.com/es
- Llame a nuestra línea de ayuda de cuidados administrados al 1-800-643-2273

¡Síganos en las redes sociales!

@cover_va

@Cover Virginia

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DURANTE el embarazo

- **-Haga una cita con su médico lo antes posible**, y pregunte si aceptan Medicaid, FAMIS Moms o su plan de cuidados administrados.
  -Llame a su plan de salud para informarse sobre los servicios de coordinación de cuidados disponibles durante su embarazo.
- -Envíe un mensaje con la palabra **BABY** a **511411,** o vaya a www.text4baby.org para recibir mensajes de texto gratis de apoyo a embarazadas y a nuevas mamás.
- -Hable con su médico sobre su dieta y cualquier medicamento o medicina que esté tomando, o si fuma o bebe.
  -Llame a **Quit Now Virginia** al 1-800-784-8669 para obtener ayuda para dejar de fumar y recibir mensajes de texto gratuitos de **Text2Quit.**
  -Elija un pediatra para que su bebé empiece a recibir chequeos de rutina el primer año
  -Comuníquese con **el Programa WIC** al 1-888-942-3663.

¡Dele tiempo a su bebé para que se desarrolle y crezca! Mientras su embarazo sea saludable, es mejor esperar que el trabajo de parto empiece solo.

Continuar cuidándose después del parto es fundamental para poder recuperarse.

DESPUÉS del parto

- **-Cómo asegurarse de que el BEBÉ esté cubierto: Llame gratis de inmediato a Cubre Virginia al 1-855-242-8282** o al trabajador de elegibilidad del Departamento de Servicios Sociales local para informarles sobre el nacimiento de su bebé. **La cobertura para su bebé recién nacido solo es válida después de haber recibido un número de Medicaid confirmado.**
- -Cuando llegue a su casa, haga una cita con el médico de su bebé para un chequeo de rutina. Estos chequeos son importantes para controlar el crecimiento y desarrollo de su bebé, y detectar problemas más graves.
- **-Programe las citas de posparto a las 6 a 8 semanas de haber tenido a su bebé.**
- -¡Su cobertura de salud podría prolongarse más de 60 días después del parto!
  - Llame gratis a Cubre Virginia al 1-855-242-8282 o al trabajador de elegibilidad del Departamento de Servicios Sociales local
  - Espere una carta (aviso de acción) del Departamento de Servicios Sociales local que le informará si es elegible para continuar con la cobertura bajo el programa de expansión de Medicaid.

Guarde esta carta como referencia

Revised New Mom Letter

WELCOME, NEW PREGNANT MEMBER !

Virginia Department of Medical Assistance Services (DMAS) is thrilled to join you on this journey and to help you have a healthy pregnancy and healthy baby!

Free Pregnancy services
Once enrolled in Medicaid, you will receive your health coverage through your health plan.

Call the Virginia Managed Care Helpline **at 1-800-643-2273 (TTY: 1-800-817-6608)** for more information on your health plan.

Contact your health plan for gifts (gift cards and/or diapers) that are offered for your family!

For more information about what is covered, along with additional resources visit:

www.dmas.virginia.gov/for-members/for-pregnant-women/

DURING YOUR PREGNANCY

- **Make an appointment with your doctor as soon as possible,** and ask if they accept your health plan.
- **Contact your health plan a**bout available care coordination services during your pregnancy.
- **Talk to your doctor** about your diet and any medication you are taking, or if you smoke or drink.
- **Choose a pediatrician** so your baby can begin receiving well - child checkups in the first year.

AFTER YOUR DELIVERY

- **Schedule your postpartum appointment** to see your doctor 6-8 weeks after you have your baby. Virginia Medicaid offers continued postpartum coverage, so you will receive health coverage for 12 months (including dental) after you deliver.
- **Ensure your baby is covered:** Call Cover VA at 1-855-242-8282 (TTY: 1-888-221-1590) or your eligibility worker at the local Dept. of Social Services to inform them of your child's birth. Coverage is only effective after you have received a confirmed Medicaid number for your newborn baby.
- **Schedule a well-child visit once you get home**. Well baby exams are an important way to monitor your baby's growth and check for any problems.

CardinalCare Virginia's Medicaid Program

VIRGINIA'S MEDICAID PROGRAM DMAS

Follow us on social media!

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¡BIENVENIDA, NUEVA AFILIADA EMBARAZADA!

¡Es un placer para el Departamento de Servicios de Asistencia Médica (DMAS) acompañarla en esta etapa y ayudarla a tener un embarazo y un bebé saludables!

Servicios gratuitos para el embarazo
Una vez inscrita en Medicaid, recibirá su cobertura de salud a través de su plan de salud.

Llame a la Línea de Ayuda de Atención Administrada de Virginia **al 1-800-643-2273 (TTY: 1-800-817-6608)** para obtener más información sobre su plan de salud.

¡Póngase en contacto con su plan de salud para obtener regalos (tarjetas de regalo y/o pañales) que ofrecemos para su familia!

Para obtener más información sobre lo que está cubierto, así como recursos adicionales, visite:

www.dmas.virginia.gov/for-members/for-pregnant-women/

DURANTE SU EMBARAZO

- **Programe una cita con su médico lo antes posible**, y pregúntele si aceptan su plan de salud.
- **Pregunte a su plan de salud** sobre los servicios de coordinación de atención médica disponibles durante su embarazo.
- **Hable con su médico** sobre su dieta y cualquier medicamento que esté tomando, o si fuma o bebe.
- **Elija un pediatra** para que su bebé pueda comenzar a recibir chequeos de bienestar infantil durante el primer año.

DESPUÉS DEL PARTO

- **Programe su cita posparto** para ver a su médico entre las 6 y 9 semanas después de tener a su bebé. Medicaid de Virginia ofrece cobertura posparto continua, por lo que recibirá cobertura médica (incluyendo la dental) durante 12 meses después del parto.
- **Asegúrese de que su bebé tiene cobertura:** Llame a Cubre VA al 1-855-242-8282 (TTY: 1-888-221-1590) o a su trabajador de elegibilidad en el Departamento Local de Servicios Sociales para informarles sobre el nacimiento de su hijo. La cobertura entra en vigor únicamente después de que haya recibido un número de Medicaid confirmado para su bebé recién nacido.
- **Programe una cita de control para su bebé cuando llegue a casa.** Las revisiones de salud del bebé son importantes para supervisar el crecimiento de su bebé y detectar cualquier problema.

CardinalCare Virginia's Medicaid Program

VIRGINIA'S MEDICAID PROGRAM DMAS

¡Síganos en redes sociales!

@Cover Virginia @cover_va @CoverVA

Petersburg Update

- Member engagement – New hand addressed mailings, flyers, targeted providers
- MCO engagement – special targeted projects to address the community - including communication, a maternal hub , and community baby showers.
- Provider engagement – DMAS collaborated with VHHA and Southside Regional leadership to provide extended clinic hours for the Petersburg and surrounding area residents for OBGYN services.
- Dr. Bazille held clinic hours from 9:30 am – 12 pm on Saturday, November 11th for the Medicaid members.
- Majority of women in Petersburg are now receiving adequate care
- Dr. Brazille next clinic is in Jan. Now asking other Hospitals system to do quarterly clinics

Thank You

CardinalCare
Virginia's Medicaid Program

Virginia Medicaid:
Ending Continuous Coverage Requirements and the Return to Normal Enrollment

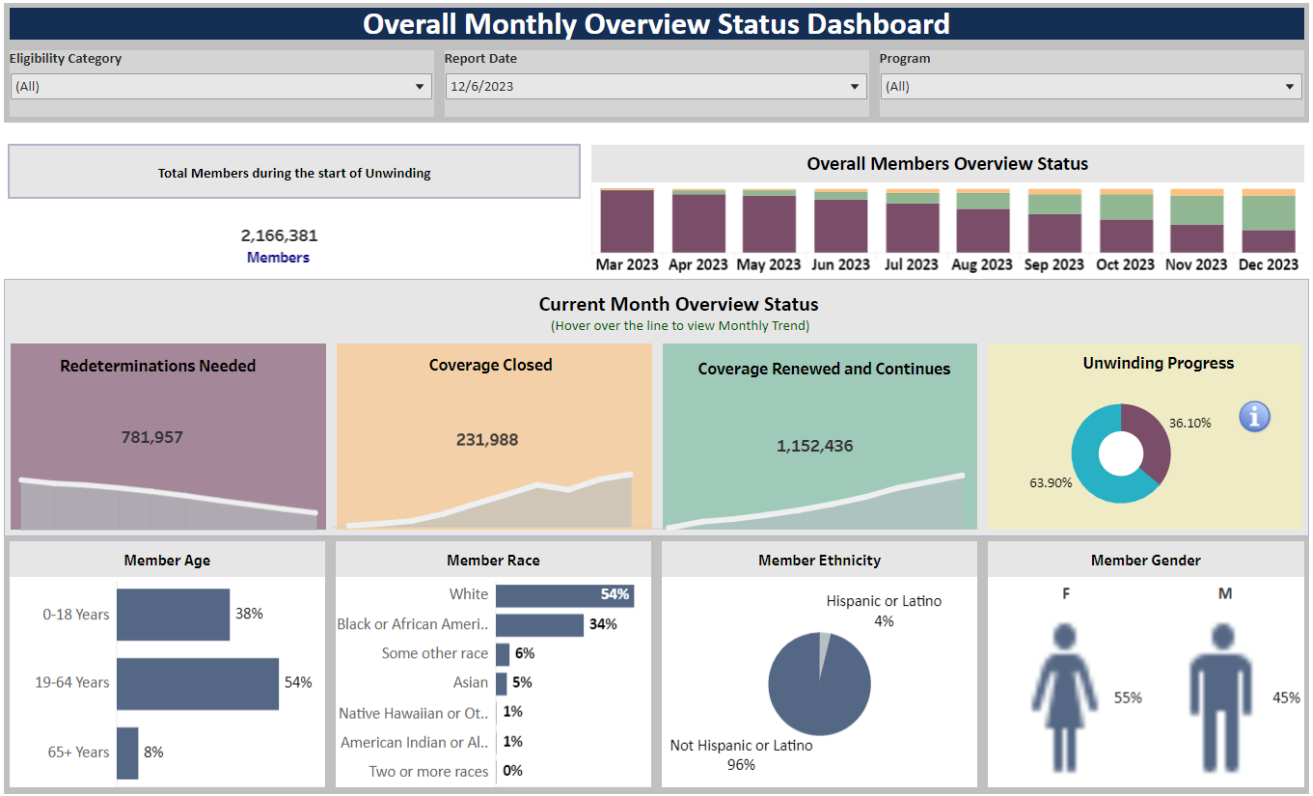
Department of Medical Assistance Services

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

COVER VIRGINIA

DMAS

Unwinding Dashboard



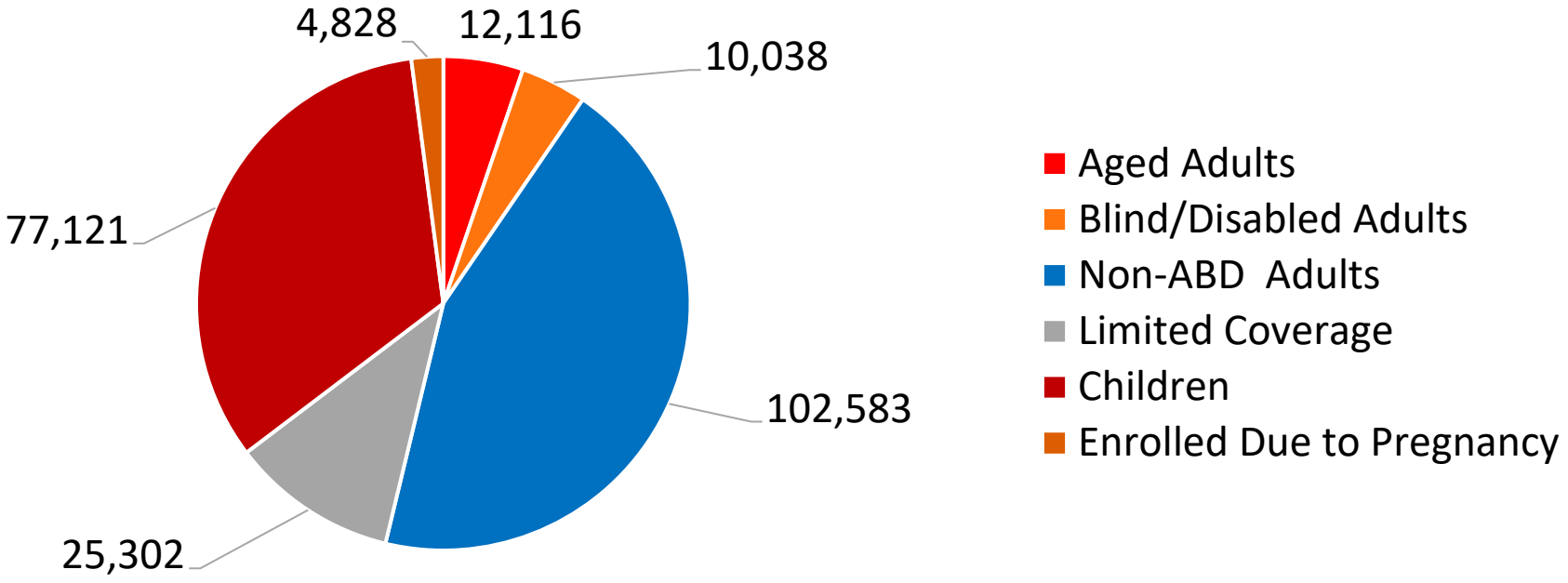
*The dashboard was refreshed on 12/06/2023 – 231,988 members were closed, and 1,152,436 members were renewed with ongoing. More than 63% of members have been determined, with 53% of members remaining enrolled.

Completed by Member
2,166,831
2,000,000
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
1,384,424*
1,200,000
1,100,000
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000

Top Closures by Eligibility Grouping:

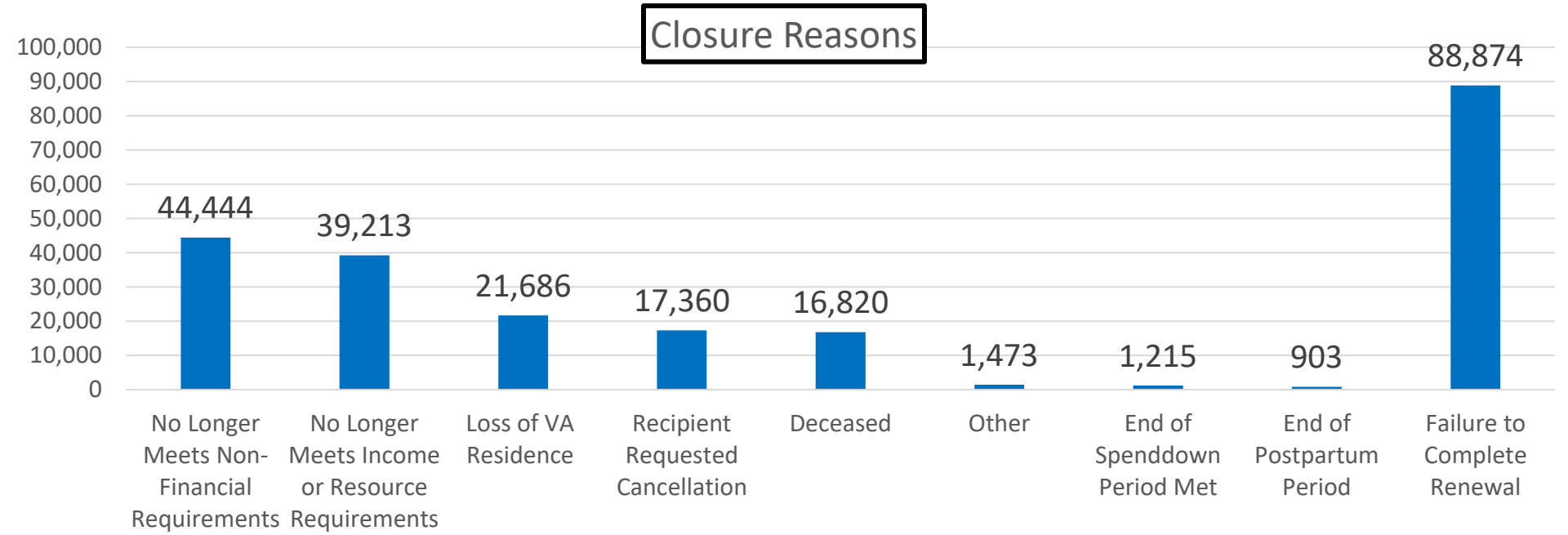
Closures through 12/06/2023

The highest closures have occurred among non-disabled adults between the ages of 19-64, followed by children, and then those enrolled in limited coverage such as Medicare Savings Plans, Plan First (family planning coverage), Incarcerated Coverage, and Emergency Medicaid.



Top Closure Reasons – Closures through 12/06/2023

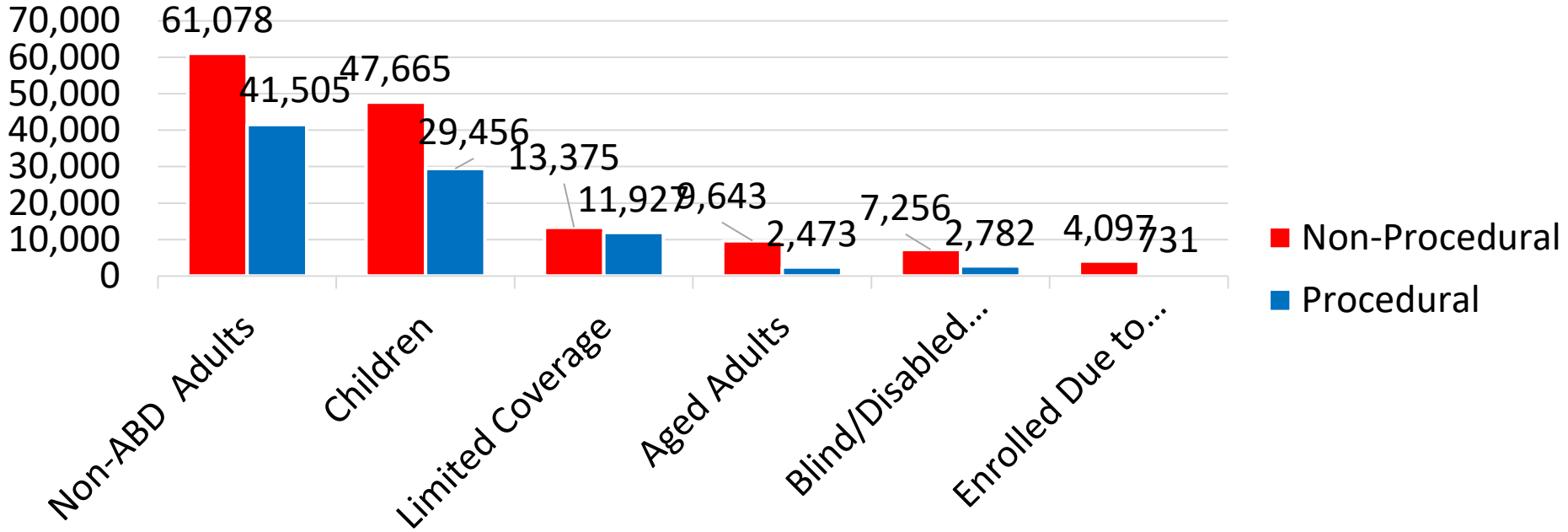
While December marks the tenth month of unwinding, the first month renewals were due in Virginia was May 2023. Redeterminations that were received in April were processed, however, April did not include closures for failure to return Medicaid renewal packets. As of 12/06/2023, 143,114 members were closed for non-procedural reasons (ineligible) and 88,874 members were closed for procedural reasons (did not return a renewal form or verifications needed to determine eligibility). This total is through unwinding out of the 2,166,381 members identified in the unwinding cohort.



Procedural vs. Non-Procedural Closures by Eligibility Grouping:

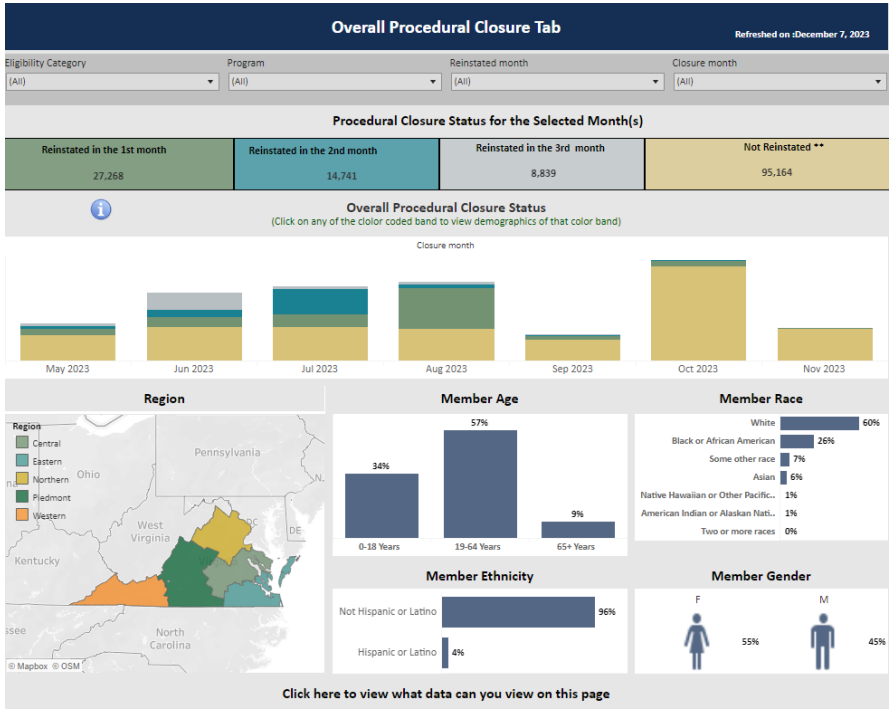
Closures through 12/06/2023

The highest closures have occurred among non-disabled adults between the ages of 19-64, followed by children, and then those enrolled in limited coverage such as Medicare Savings Plans, Plan First (family planning coverage), Incarcerated Coverage, and Emergency Medicaid.



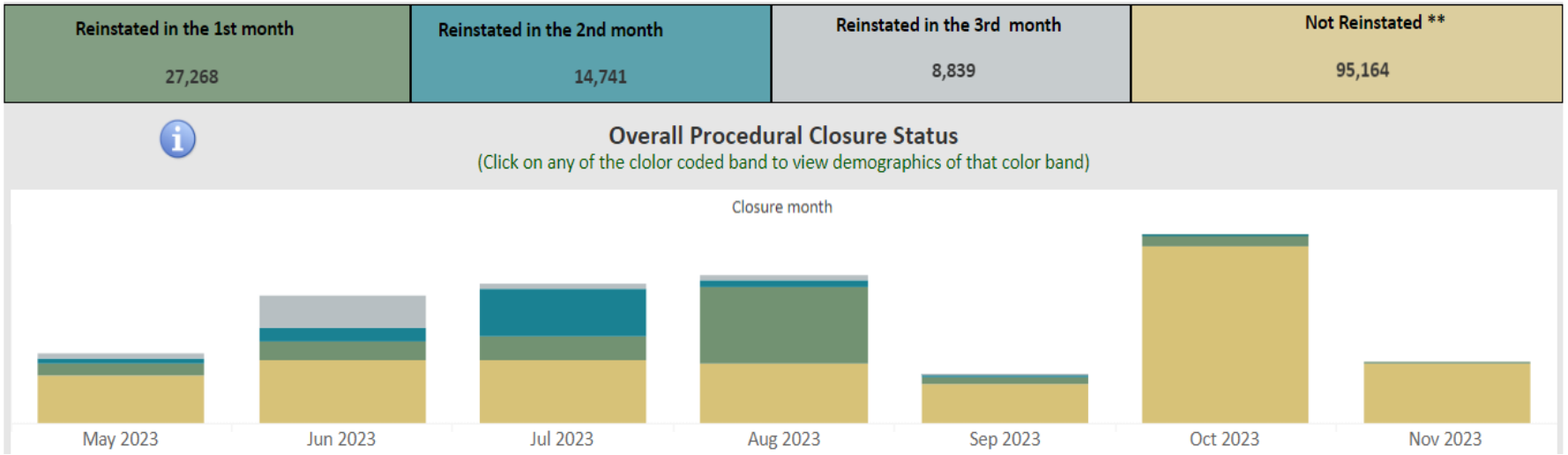
New Dashboard Tab – Procedural Churn

The procedural churn tab shows the number of members closed each month and the number of members reinstated coverage during the three-month reconsideration period.



- 27,268 individuals have returned to coverage in the first month after coverage loss.
- 14,741 individuals have returned to coverage during the second month after coverage loss.
- 8,839 individuals have returned to coverage during the third month after coverage loss.
- The procedural churn tab is located on the Eligibility Redetermination Dashboard at: https://www.dmas.virginia.gov/data/return-to-normal-enrollment/eligibility-redetermination-tracker/ by clicking on the “Overall Procedural Closure Tab.”

The procedural churn tab shows the number of members closed each month and the number of members reinstated coverage during the three-month reconsideration period.



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

Serving Medicaid Members in Behavioral Health Crisis

- In December 2021, Virginia Medicaid implemented four crisis specific services to support the implementation of a statewide Crisis Now Model for all Virginians
  - Medicaid has required providers to be under Memorandums of Understanding with regional mobile crisis hubs and use the statewide Crisis CONNECT data platform since 2022
- Beginning December 15, 2023 the Mobile Crisis Response service will be dispatched via regional mobile crisis hubs and regional 9-8-8 call centers

Reimbursing Legally Responsible Individuals (LRIs)

- DMAS received federal approval to permanently allow legally responsible individuals (parents of minors and spouses) to be paid to provide personal care services when circumstances prevent a member from being cared for by a non-LRI.
- Safeguards were developed to meet Federal and State requirements while considering the needs of the Medicaid members and the integrity of the program. The safeguards were developed in concert with stakeholders, advocates, and feedback received from public comment.
- The original pandemic-related flexibility to allow payment to LRIs was set to expire on November 10, 2023 however, DMAS received CMS approval to delay the implementation of the new safeguards until March 1, 2024.
- DMAS will continue to provide information to members, providers, and families about changes occurring on March 1, 2024. More information can be found on the DMAS Website at: https://dmas.virginia.gov/for-providers/long-term-care/waivers/legally-responsible-individuals/
- Questions can be sent to CDLRI@dmas.virginia.gov

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CardinalCare
Virginia's Medicaid Program

Finance Update

Board of Medical Assistance Services

December 12, 2023

DMAS

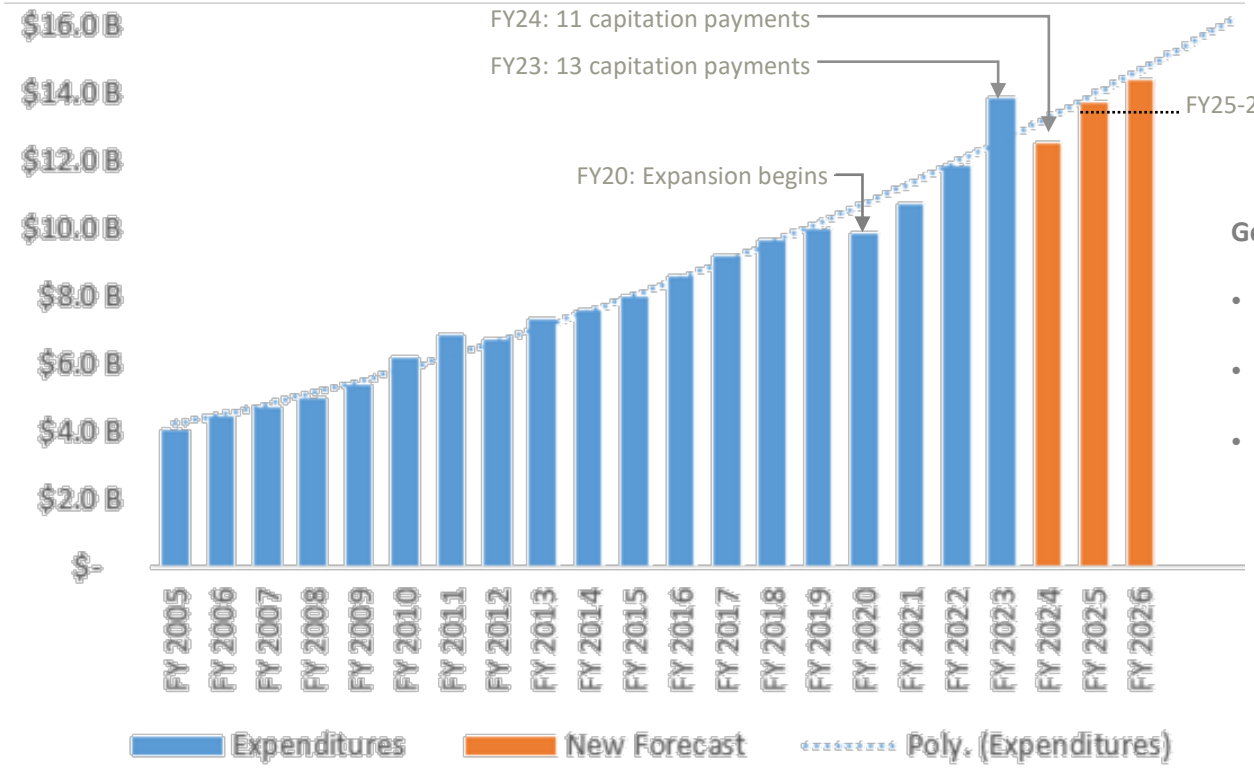
Medicaid Forecast—FY24-FY26

Cost Drivers	FY24	FY25	FY26
Enrollment	• Unwinding • Case mix	• Normal population growth • Case mix	• Normal population growth • Case mix
Rates	• 11 Base capitation payments • Increase in MCO Rates • Inflation adjustments • Enhanced FMAP Ending	• 12 Base capitation payments • Increase in MCO rates • Inflation adjustments • Lower FMAP (3 quarters)	• 12 Base capitation payments • Increase in MCO rates • Inflation adjustments • Lower FMAP (4 quarters)
Services	• Utilization increasing	• Utilization increasing	• Utilization increasing
Net GF Need (Surplus)	**($126 million)**	**$175 million**	**$539 million**
Net Cov. Assessment	**$99 million**	**$86 million**	**$147 million**

CardinalCare
Virginia's Medicaid Program

Source: DMAS Official Forecast published November 1, 2023

19 Years of Base Medicaid Total Expenditures



General fund growth:

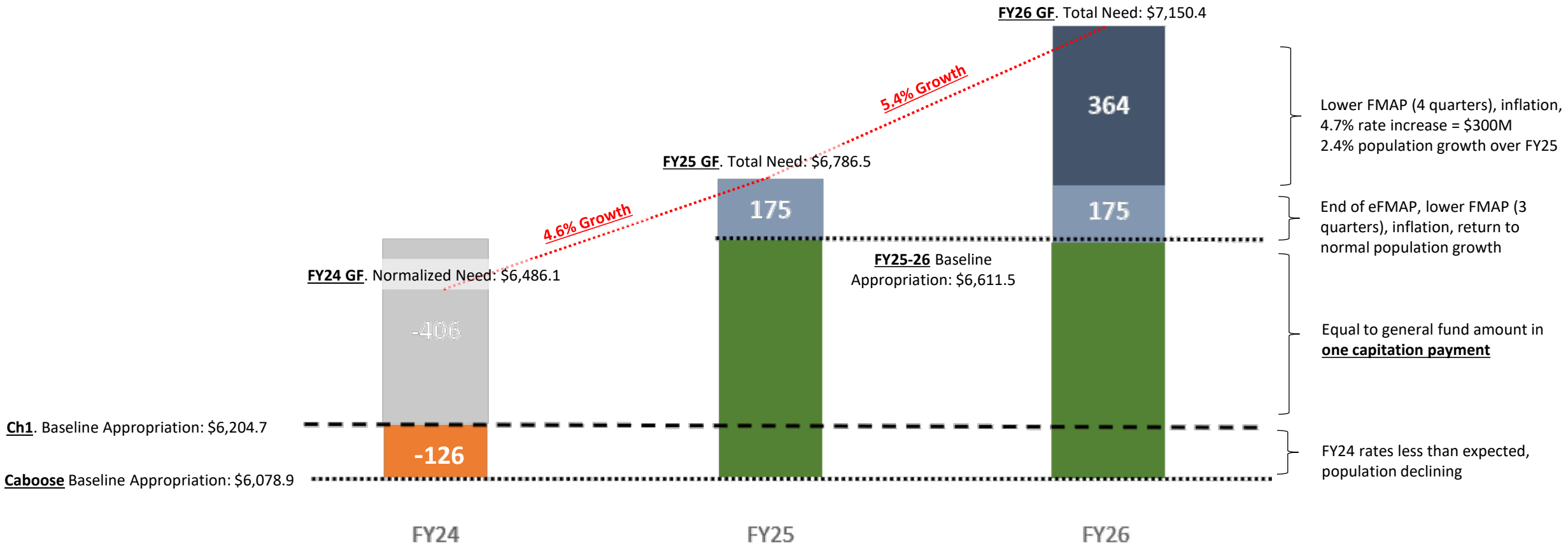
- **FY05-FY19**: 7% average increase
- **FY20-FY23**: 9% average increase
- **FY25-FY26 forecast**: 7% projected increase

Key takeaway: Medicaid is returning to normal growth

Source: DMAS Official Forecast published November 1, 2023

Final Forecast: Getting to the General Fund Need FY24-26

In Millions



Final Considerations

Beyond the Forecast

- **High-cost drug utilization and therapies**
  - Weight-loss medication,
  - Exa-cel gene therapy for Sickle-cell disease,
  - Exon-skipping gene therapy for Duchenne Muscular Dystrophy,
  - Monoclonal antibody treatment for respiratory syncytial virus (RSV)
- **2024 Governor's Introduced Budget**
- **2024 new General Assembly session**
- **Significant declines in Virginia Health Care Fund**

Source: DMAS

Regulatory Activity Summary December 12, 2023
(* Indicates Recent Activity)

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 project will do the following:

- Repeal redundant and unnecessary language in 12 VAC 30-141-50 through 12 VAC 30-141-70, 12 VAC 30-141-670, and 12 VAC 30-141-710 through 12 VAC 30-141-730. In accordance with Governor Youngkin's Executive Order #19, DMAS completed an internal review and determined that some of the content of these regulation sections already exist in other Virginia Administrative Code (VAC) sections, specifically in 12 VAC 30-110, 12 VAC 30-120, and other sections of 12 VAC 30-141.
- Make technical updates and amendments to multiple sections of Chapter 141. These updates represent current practices that are already in place.
- Update or repeal the appeals-related requirements in 12 VAC 30-141-40 through 12 VAC 30-141-70, 12 VAC 30-141-700, and 12 VAC 30-141-710 through 12 VAC 30-141-730, because they are unnecessary and duplicative.
- Make clarifications and remove obsolete and/or outdated language referencing payments and copayments in 12 VAC 30-141-50, 12 VAC 30-141-150, 12 VAC 30-141-175, 12 VAC 30-141-180, and 12 VAC 30-141-810.
- Remove outdated prior authorization language from 12 VAC 30-141-500 and 12 VAC 30-141-830.
- Repeal 12 VAC 30-141-670 because the definitions are duplicative and DMAS is merging chapter definitions into a single section at 12 VAC 30-141-10

The project is currently circulating for internal review.

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

***(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.

(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) Supplemental Payments for Freestanding Children's Hospital Physician Services:** In accordance with the Medicaid State Plan (Supplement 6 to Attachment 4.19-B) and 12VAC30-80-300, supplemental payments for services provided by physicians at freestanding children's hospitals must be calculated using the Medicare equivalent of the average commercial rate (ACR) methodology prescribed by CMS. DMAS is required to recalculate the ACR every three years. The last ACR is dated July 1, 2020, and CMS requires DMAS to submit a new ACR calculation effective July 1, 2023. After performing calculations based on data provided by the Virginia freestanding children's hospitals, DMAS determined that the ACR must be increased from 178% of Medicare to 191% of Medicare. Following internal review, this state plan amendment was submitted to CMS for review on 7/24/23 and approved on 10/19/23.

***(07) Nursing Facility Value-Based Purchasing Program:** This SPA will allow DMAS to revise the nursing facility (NF) value-based purchasing (VBP) program for year two of the program. In accordance with the 2022 Special Session, Item 304.OOO, DMAS revised the state plan in 2022 to establish a unified, value-based purchasing (VBP) program that includes enhanced funding for 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 this 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. Pursuant to the 2022 Special Session, Item 304.OOO, DMAS will revise the state plan again to reflect the second year of the nursing facility VBP program. The amount of funding devoted to nursing facility quality of care investments shall be 25 percent of available funding in the second year of the program before the program transitions to payments based solely on nursing facility performance criteria in the third year of the program. In the third year of this program, such

funds as appropriated for this purpose shall be fully disbursed according to the aforementioned unified VBP arrangement to participating nursing facilities that qualify for the enhanced funding. Following internal review, the project was submitted to CMS on 8/15/22 and approved on 10/25/22. The corresponding regulatory project is currently circulating for internal review.

***(08) 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.

***(09) 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.

***(10) 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.

***(11) 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 reg project is currently circulating for internal review.

(12) 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.

(13) 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.

(14) 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.

(15) 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.

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

(06) Non-Institutional Provider Reimbursement Changes: The 2022 Appropriations Act requires DMAS to make several changes to non-institutional provider reimbursement. Following internal review, the SPA documents were forwarded to DPB and to the Tribal Programs for review on 8/19/22. The SPA was submitted to CMS for review on 9/19/22. A request for additional information (RAI) was received from CMS on 12/14/22. Draft RAI responses were sent to CMS for review on 1/19/23 and the final RAI response was forwarded to CMS on 2/17/23. The SPA was approved on 3/14/23. The regulatory review phase of the project is currently on hold.

***(07) 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.

(08) 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.

***(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 is currently working of the responses.

(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. The corresponding regulatory action in currently circulating for internal review.

***(07) DSH Changes for Children's Hospitals:** DMAS seeks to create additional hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs, effective June 2, 2017. As part of this SPA, these new hospital supplemental payments, for freestanding children'shospitals, shall equal what would have been paid to the freestanding children's hospitals under the current disproportionate share hospital (DSH) formula without regard to the uncompensated care cost limit. These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional hospital supplemental payments authorized, accordingly. Following internal review, the DPB and Tribal notices for this SPA were submitted on 5/6/21. DPB approved the SPA on 5/10/21

and the project was submitted to HHR on 5/18/21. Following HHR approval on 5/20/21, the SPA was submitted to CMS on 6/7/21. Informal questions were received from CMS on 7/12/21 and responses were forwarded to CMS on 7/19/21. The SPA was approved by CMS on 8/24/21. The corresponding regulatory action was circulated for internal DMAS review and submitted to the OAG for review on 9/28/21. The OAG sent additional questions on 10/7/21 (DMAS response provided on 10/12/21) and 10/12/21 (DMAS response provided on 10/13/21). DMAS withdrew this regulatory action on 9/29/23.

(08) 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.

(09) 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.

***(04) Update Average Commercial Rate (ACR) for Physicians Affiliated with Type One Hospitals:** DMAS is required to recalculate the ACR every three years. The last ACR is dated April 1, 2017, and CMS requires DMAS to submit a new ACR calculation, effective April 1, 2020. After performing calculations based on data provided by Type One hospitals, DMAS

determined that the ACR must be reduced from 258% of Medicare to 236% of Medicare. The DPB notification for this SPA was sent to DPB on 4/20/20. Following internal review, the SPA binder was forwarded to HHR for review on 5/20/20 and to CMS on 5/28/20. CMS approved the SPA on 7/31/20. Following internal review, the corresponding regulatory action was submitted to the OAG on 1/27/21. After multiple discussions with the OAG since March '21, DMAS withdrew this regulatory action on 9/29/23.

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.

2015 General Assembly

***(01) Barrier Crimes Not Permitted:** This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 2/17/2017. The OAG issued inquiries on 3/21 and a conference call occurred on 4/26/17 to discuss the regs. The action had been placed on hold. Regulatory processing began again on 4/26/18 with a conf. call with the OAG. Revised text was forwarded to the OAG on 11/28/18 and an additional conf. call took place on 11/29/18. Additional revisions were sent to the OAG on 1/15/19. Another conf. call was held on 8/9/19 and revised regs were sent to the OAG on 8/16/19 for review. DMAS withdrew this regulatory action on 9/29/23.

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.