BOARD OF MEDICAL ASSISTANCE SERVICES

Tuesday, June 13, 2023
12:00 PM to 2:00 PM

Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
1st floor Conference Rooms A&B

DRAFT AGENDA

#	Item	Presenter
1	Call to order	Kannan Srinivisan, Board Chair
2	Welcome New Board Members – Tentative	
3	Approval of 3/14/2023 Meeting Minutes	
4	Director's Report	Cheryl Roberts, Agency Director
5	Data & Dashboards	Rich Rosendahl, Deputy for Healthcare Analytics & Transformation
6	Behavioral Health Transformation	Tammy Whitlock, Deputy for Complex Care Services
7	Unwinding Update	Sarah Hatton, Deputy of Administration
8	Budget Update	Chris Gordon, Deputy for Finance
9	Round Robin with the Board	
10	New Business/Old Business	
11	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.	
12	Regulations	
13	Adjournment	

BOARD OF MEDICAL ASSISTANCE SERVICES

DRAFT MINUTES
Tuesday, March 14, 2023
10:00 AM

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

Present: Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster

Virtual Attendees: Ashley Gray, Paul Hogan, Ashish Kachru
Absent:

DMAS Attendees: Beth Guggenheim- Office of the Attorney General – BMAS Board Counsel, Cheryl Roberts-DMAS Director, Tammy Whitlock – Deputy Complex Care Services, Adrienne Fegans -Deputy for Programs, Sarah Hatton – Deputy for Administration, Chris Gordon-Deputy for Finance, John Kissel-Deputy for Technology & Innovation, Ivory Banks – Chief of Staff, Katie Linkenauger, Will Frank, Brian McCormick, Emily McClellan & Brooke Barlow- Board Secretary.

Virtual Attendees: Adrienne Fegans (DMAS), Alexander Shekhdar, Amy Peak, Andrew Mitchell (DMAS), Anne Leigh Kerr, Armando Sanchez-Aballi, Ashish Kachru, Ashley Gray, Bea, Jesse (DARS), Ben Barber (VA Health Cataalyst), Benoit, Sara (DMAS), Bob Kreps (Guest), Brandenburg, Mary, Brooke Barlow (DMAS), Caroline Faber [JANUS], Casey Clarke, Cat Pelletier (DMAS), Chuck Smith, Chuck Smith, Cindi Jones, Connors, Craig, Driscoll, Tammy (DMAS), Evan Lawson, Faber, Caroline [JANUS], Heidi Dix, Hope Richardson (DMAS), Ivan N Nunez, J Linkenhoker , Jesse Bea (DARS), Johanna Linkenhoker, Karen Kimsey, Karin Roth (DARS), Kassie Schroth, Katie Boyle, Kenneth Mccabe (Virginia), Kross Kaai (DMAS), Lanette Walker (GOV), Lello, Angela M, Leticia Rasnick (DARS), LeVar Bowers, Lisa Robertson (DARS), Mark Hickman, Mark Hickman, Mary Brandenburg, Matthew Ranbarger (DMAS), Michael Fotinos, Moira Holden, Moms In Motion, Natalie Pennywell (DMAS), Pat Finnerty (Guest), Patrick Gernert, Rashim Gupta (DMAS), Rebecca Dooley (DMAS), Rich Rosendahl (DMAS), Richard Johnston, Sara Benoit (DMAS), Steve Ford, Steve W, Susan Smith (DMAS), Tammy Driscoll (DMAS), TB, Timothy E. Carpenter , Tina Weatherford (DMAS), Vanessa Lane.

1. **Call to Order**

Brian McCormick, Director of Legislative & Intergovernmental Affairs, called for a motion by the Board to open the regular meeting of the Board of Medical Assistance Services at 10:05 am on March 14, 2023, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

Kannan Srinivisan moved to open the meeting; seconded by Greg Peters.
Motion: 8-0
Voting For: Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster
Voting Against: None
Virtual Attendee votes were not counted but all "ayes": Ashley Gray, Paul Hogan, Ashish Kachru

2. **Welcome New BMAS Board Members**

Director Roberts welcomed new Board members Lisa Price Stevens and Jason Brewster.

Lisa Price Stevens introduced herself to the Board. Lisa is a primary care physician and Regional Chief Medical Office at JenCare. Lisa was born and raised in Norfolk and trained in Richmond and practiced with the Daily Planet for years. Lisa works with vulnerable populations.

Jason Brewster introduced himself to the Board. Jason's focus is on startup ventures, innovations, and technology. Jason is the co-founder of Nimbus Law and is also involved with an autism sanctuary. The sanctuary is for those on the moderate end of the spectrum and is a working farm. Jason is also the parent of an autistic child who is a Medicaid recipient.

3. **Election of Officers**

Kannan Srinivisan was nominated by Greg Peters for the Board Chair; the motion was seconded by Patricia Cook. Hearing no further nominations, the nominations were closed. The vote was taken.
Voting "aye," Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster
Voting Against: None
Unanimous approval (8 – 0)
Virtual Attendee votes were not counted but all "ayes": Ashley Gray, Paul Hogan, Ashish Kachru

Ashley Gray, who was present virtually, was nominated by Kannan Srinivisan for the Board Vice Chair, the motion was seconded by Greg Peters. Hearing no further nominations, the nominations were closed. The vote was taken.

Voting “aye,” Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster
Voting Against: None
Unanimous approval (8 - 0)
Virtual Attendee votes were not counted but all “ayes”: Ashley Gray, Paul Hogan, Ashish Kachru

Brooke Barlow was nominated by Kannan Srinivisan for Board Secretary; the motion was seconded by Greg Peters. Hearing no further nominations, the nominations were closed. The vote was taken.
Voting “aye,” Greg Peters; Elizabeth Noriega; Patricia Cook, MD; and Kannan Srinivasan, Tim Hanold, Dr. Lisa Price Stevens, Jason Brewster
Voting Against: None
Unanimous approval (8- 0)
Virtual Attendee votes were not counted but all “ayes”: Ashley Gray, Paul Hogan, Ashish Kachru

Because of state “open meeting laws,” the votes of those participating virtually could not be counted since they were not physically present.

4. Managed Care Advisory Committee (MMCAC)

Tim Hanold expressed a desire to hold a seat on the MMCAC committee. Kannan Srinivisan nominated Tim Hanold.
Moved by Kannan Srinivisan; seconded by Elizabeth Noriega to approve.
Motion: 8 - 0
Voting For: Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster
Voting Against: None
Virtual Attendee votes were not counted but all “ayes”: Ashley Gray, Paul Hogan, Ashish Kachru

5. Approval of Minutes

The minutes from the December 13, 2022, meeting were introduced and approved.

Moved by Kannan Srinivisan; seconded by Greg Peters to approve.
Motion: 8 - 0
Voting For: Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster
Voting Against: None
Virtual Attendee votes were not counted but all “ayes”: Ashley Gray, Paul Hogan, Ashish Kachru

6. Director's Report

DMAS Director, Cheryl Roberts, provided updates for nine items.

1. Change in key staff - Our workforce is the most valuable thing we have; we can't do anything without them. I have a team that's very extremely talented, probably off the scale in terms of talent and scale and ability. We have two new deputies; Adrienne is now head of programs and operations. So, she has what was Medallion 4. She has program operations, and she has program integrity. John Kissel, the head of the Department of Technology and Innovation. He has both the information management, and the project management pieces and anything that has to do with technology.

We had a loss. We lost our chief medical officer. So, we'll be looking for a chief medical officer. So, if you have an interest or know someone looking let me know.

2. Second one is unwinding. For those who don't understand it, its good news, and bad news. During the pandemic, there was a commitment across the country to make sure people did not lose coverage. That's a wonderful thing. We're all very, very grateful. To do that, the federal government gave us extra money, but they also said that we would not take anyone off the eligibility roll unless they died.

The good news is people had coverage through the pandemic. They didn't have to worry about paperwork. We didn't do any redeterminations for three years. Because we were just doing the Medicaid expansion, most people in the Medicaid expansion never went through redetermination. Numbers increased more than we would normally see. We didn't take anyone off.

It's time now to do the redetermination. So, as of April 1st, we'll begin to start redeterminations. We're looking at both the localities, working with contractors, working with managed care. It's to, one, educate people, and two, get them to do the renewal. Sarah will spend a lot of time on that when she gets to her section.

There's a component that's not talked about. Most people are talking about the outreach effort. And, by the way, Sarah did a fabulous job. She did a summit, and it was a good snapshot of all the people involved, the Department of Social Services, advocates, navigators, providers in the community, the MCOs, a good, good snapshot of all the people involved, including the state exchange. Redeterminations, what we hope, I'm hoping that some people got great jobs with great health insurance, and they were going to tell us healthy and happy stories. That's what we hope; right? We hope people open their envelopes and do the work that they have to get done. We also hope that if they don't have health insurance but they're above the income is that they would then join the state exchange and get those kinds of services. We work very, very hard to make that alliance, the plans will be doing that. We had a meeting with the commercial carriers.

CMS is asking us to see our plan. They want to make sure we have a plan of action. Lucky us, Sarah and everyone on our team, we've been working on this. This includes the General Assembly.

3. Behavioral health transformation, that's the Governor's main project. Did you listen to him talk on CNN about education? What is the name of the program? Right Help Right Now. There are six pillars of Right Help Right Now. The first is same-day care for people. The second is relieve law enforcement burdens & reduce criminalization of mental health. The third is capacity and access. The fourth is substance abuse. Five is making workforce a priority. The sixth one is services and innovation.

We've been working with HHR. It's a multiagency, multidisciplinary group. It's a huge group. Tammy is going to spend time talking about it. If you have interest in hearing more information after Tammy speaks, we can talk about that. I think it's really critical. We have made a commitment to HHR that we'll integrate all the decisions into the agency. That's what we're working on.

4. In 2016 and 2017, we re-procured managed care. The first one was called CCC Plus. Those people who were here, you remember that; right? The next year, we did Medallion. We moved it from three to four. Those programs are strong. There's not a big issue in terms of their strengths and what they're doing. Happy with what's going on. However, it's time to look at it a little differently. Two things we're doing. One is combining the programs and making them one. That's something we hope to have done by July 1st. The second thing is to reprocure it all. It's a 14-billion-dollar re-procurement. It's the biggest one in the Commonwealth. Clearly, we're looking at playing a role there. That means that procurement will cover everyone from prenatal to nursing home. That's probably the biggest project in terms of depth and width. We hired a contractor. We've never done that before. That's going along well. We have a group that's always looking at it. HHR is very much involved in the process in terms of what we're doing.

It's been announced. The secretary announced it, and it's in the press release. A formal notice will be put out in the summer of this year. The date is out. We're hoping to encourage MCOs not just in Virginia. At the next meeting, we'll be able to talk about it in great detail.

5. In 2014 we started doing Enhanced Ambulatory Patient Grouping (EAPG) for the outpatient services, and we made an agreement in 2014 that every three years we would rebase, meaning looking at all pieces together. So just like DRGs, it has a 3M component, right before the grouping, and then you have a base rate. What happened was last year, we had those base rates done by a contractor, right, and then those rates obviously get put into managed care. We've estimated that it will be about 17% increase after three years, which is fair. So, what happened was that 17% was put into the capitation rate. And that was fine. What happened was the contractor made an error. As a result of that, the rate that we gave to the health plans were 20% higher than the 17%, and, therefore, the hospitals were paid accordingly.

So we're working through that process, as you can imagine. We changed the rates since March 1st. They've been published. If you have not seen it yet, it has posted. It says the revised rates

are to correct calculation errors by our vendor. We're all working through that, the MCOs, the hospitals, as well as ourselves. We're working on correcting the process for next time. We're all in the middle of the process. We'll be able to give you more information the next meeting but did not want you to not know that there's been a discussion. It leads up to about a 164-million-dollar difference. That's what we're trying to talk about. It's both fee for service and managed care. The next meeting, we'll have more information.

6. Dashboards- Once a month, put on your list, look at DMAS website.
Katie Linkenauger will provide an overview.

[Katie Linkenauger speaking] Some of our other dashboards that we have publicly posted on our website, you can see during the pandemic where, like Cheryl said, you had the continuous coverage. We had a huge increase in that enrollment, around 600,000 additional individuals. So, if you're interested, as we go through this unwinding process that Sarah is going to talk more about. You will be able to see how to enrollment numbers change as people continue to stay on or lose eligibility. So, we have our behavioral health services, enrollment data, financial information for Medicaid, and also for our managed care organizations. As Cheryl said, we're posting new things. If there's something you're interested in, you can reach out the myself or Cheryl or any of the members, and they can get it.

7. Partnership for Petersburg- Petersburg health numbers are atrocious. They are. Sadly, we did not notice it because they're in the Richmond region. When you looked at the Richmond region, you see things are not so bad. When you take Petersburg, you see the numbers are very bad. That made us change the way we look at things. Even though we're looking at regions, we're also now looking at communities. We realize that looking at the community gives you all sorts of dynamics that we probably didn't do. That's when we're glad for Rich's team. We're talking about asking for what you're doing in the community, not just what you're doing for the region. So, we learned some lessons. Good news for Petersburg. We've been doing fabulous things. We have had mobile clinics, reading for kids, and a lot of support for the community. In fact, we're having an event next week, opening up the urban babies' hub. If you're interested in what we're doing every month and may want to attend, we're happy to send those to some of you. If you're interested, tell Brooke. We're happy to be involved.

We did a project ourselves on maternity. Maternity in Petersburg. Most of the women in Petersburg have their babies at Johnson Willis. They're willing to drive an hour away. So, we're spending some energy. We found that our maternity numbers were low. Only 20% of the women were doing prenatal care. Even though we had the plans involved, we took the initiative and made a new letter and flyer that talked about maternity and only limited to two PCPs, trying to make it simple for the person. Call these two numbers. Believe it or not, between that and making follow-up calls with the plan, we went from 20% to 80%. So, we're trying to ask ourselves if that is replicable. So, Petersburg is going to be a good thing for us all across the board. My hope and I can say this now, I want the Daily Planet there. Yes, yes, yes, we want Anita there.

8. PRSS Certification- Many years ago, we decided to have modules for our IT system. It was little Lego sets, a piece for accounting data, piece for claims. The last piece was the provider

enrollment. It came up in March of 2022. Chris Gordon led that effort. Chris gets the yay for that. That was the untangling of many things. It was not just the IT piece. It was providers getting to use it and then figure out the holes. The good news is it's working very well, but now we need CMS to certify it. The certification means that's how much money we get for it because the match rate changes based on the certification. We had our meeting two weeks ago. We did very, very well. We got lots of credit for all of the work that we have done for that as well as the unwinding, which is good. So, I know that John will probably talk about it, and Adrian is going to talk about another piece, but I wanted to tell you that's going well.

9. Budget – Last, but not least, we do not have a budget. I guess you know that. Why that's a problem? In General Assembly, we have two pieces, bills, and budget. Normally, Chris will talk about the budget, but we don't have a budget to talk about. Now, that's a problem because we live and die by the budget. It's not just the fact that we have enough money to survive. All those line items, because that's where most of that comes up, affects us in a big way, in terms of operation. So, when we come back next time and we don't still have a budget, that may be the number one thing we talk about. Okay? Because then we'll have to talk about telling you what we think is going to happen.

Chief of Staff, Ivory Banks, provided an update on Workforce.
One of the things that's on the radar is business continuity. That includes having the right people doing the things and then seeing how well they're doing it, making sure they're doing it correctly. We have had some retirements. We've also had a new online recruitment system come up in the Commonwealth called Page Up.

We had a meeting with the Department of Human Resource Management (DHRM) who rolled out the new system, to talk about the challenges we're seeing. We're not getting big pools of folks. We have a shift to the private sector as well. We are trying to update our job ads to reflect the culture at DMAS. We're going to have a DMAS career day where we try to help folks, say, hey, come look at our job postings and do the best to show Page Up. We're trying to get with staffing agencies to see if they can push to our website and jobs. Collaborating with some of the colleges and universities to see if we can get the name out there. We had a big event where the secretary joined us. We had food from women and minority vendors. It was a big success there.

We are also working on employee retention. We are allowing people to nominate each other for recognition. We are also focusing on 30 / 60 / 90-day interviews. With telework, we're flexible. We have out-of-state workers that are full-time telework. We have three days, four days, it's a mixture based on your job duties. We're seeing the shift. There are folks in the private sector that have full-time, in general. Some of the job responsibilities just don't allow for it. It changed a lot after COVID. After 2020, just realizing this is our new normal and what it looks like now.

The second piece is our accountability part. Now, do we have the right people? Are we doing the right work? How well are we doing it? I will say that we've done a lot of great work in the APA audit. We had less audit items than before, but one of the ones I want to point out to is our

PERM rate. The number of audit items has gone down tremendously in that area. The next year for PERM is review year 25.

Another big part, too, is you can see a lot of the audits we have open are internal audits. The biggest part is to find it before they find us. I do want to shout out. The internal audit director, we've done a great job with finding these things so that they can be corrected.

The biggest areas of improvement are our systems and making sure that we're secure. I always like to say that we have this big, pretty house. Now it's time to make sure we have the locks and the doors correctly in our security system there. So that's one thing we're putting a greater focus on.

Rich Rosendahl & Katie Linkenauger provided an update on the Data, Quality and the Nursing Home Project.
We're working on creating and publishing dashboards externally and internally. They show services across the entire Commonwealth. It's been helpful and useful for our internal teams to monitor trends and understand how those services are being utilized.

Our Office of Quality and Population Health submitted the Virginia Medicaid quality strategy to CMS. That's also published on our website. If anybody is interested in finding it and having trouble, let us know. Our Office of Value-based Purchasing is distributing the first round of payments to the MCOs. Once those payments are received by the MCOs, they turn around and have one month to forward those payments over to the nursing facilities. Then we will start preparing for round two of payments in April.

From that program, what did we learn? What does it look like in regard to the outcomes? We're still evaluating different aspects. Right now, the payments we're putting out there are related to staffing. We're learning that nursing facilities are trying hard to make sure that they're meeting their staffing ratio obligation. The money that they will be receiving on behalf of this program will go a long way toward helping with that. That, in turn, should create better care outcomes when we start looking at the medical claims in a month or so. Due to the claim lag, we're trying to give a little bit more time for those to come in. Early indicators are that the program is accomplishing what it was set out to do. We're targeting, almost to the letter, different aspects that the Biden Administration wanted to see nursing facilities making improvements in when we released some information about this in the summer.
So, Virginia is well ahead of the curve, and we look forward to seeing the full impact of this program in the coming months and really in the coming year, too, as nursing facilities are able to take this additional money and put that into enhancing the care that its residents can receive whether it be staffing or facilities et cetera.

The quality metrics for the nursing facility, such as hospitalizations, urinary tract infections is on a different payment schedule. It will be in the secondary payment. The first payment was to try to get money in the hands of the facilities a little faster going off metrics like staffing that we would know ahead of time. The things related to a medical claim, like bed sores, and urinary tract infections can take longer to get into our system. So we didn't want to hold up the

entire payment train on those claims. One payment is going out in the next week or so related to staffing. The second payment will be made in about a month or two related to those medical claim's outcomes.

John Kissel provided an update on Information Management and Enterprise PMO.
. I can provide a list of procurements after the meeting in an appendix if you have questions.

We're strengthening our relationship with VITA because everything that has an IT component has to go through VITA for oversight. You can imagine how many they get. So, strengthening that relationship helps speed some of those reviews back from VITA. So now we have our customer account manager that is a VITA employee assigned to us. She's onsite once a week now. Anytime we have these projects coming up, we're able to reach out to her and streamline that process.

We're also working to reduce the telecommunications bill. That's also through VITA to help save DMAS some money.

Mike Jones starts on the 25th. He's the former CIO at DMAS. We're excited to have him come back because he understands the environment.

We're looking at post-implementations. MES involved taking different modules and combining them, and it went live in April 2022. We are looking at what is next.

So now we're looking at innovative and streamlining processes here at DMAS, such as with automation of tasks that currently require a manual effort. We've got a robot we're going to use now, with a little human intervention to reduce the error.

We are also looking at updating the MES modules. One of the MES modules that was not part of the rollout is our fiscal agent. We're looking at modernizing that now.
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Adrian Fegans updated the BMAS Board on the five dimensions of MCO provider enrollment, doulas (we had 94 state-certified doulas and now have one hundred) Partnership for Petersburg, a two-year project focused on postpartum and doulas, the Strategic Plan and MCO improvement plans to increase prenatal and postpartum utilization, and a focus on increasing postpartum care and Baby Steps.

Tammy Whitlock provided the BMAS Board with an update on Behavioral Health. Right Help Right Now is quite a large undertaking that the Governor's office is leading and working on with every agency that touches behavioral health. When we talk about the pillars, I think it's touching just about every aspect of behavioral health that would be thought of.

1. First, we must strive to ensure same-day care for individuals experiencing behavioral health crises.

2. Second, we must relieve the law enforcement community's burden and reduce the criminalization of mental health.

3. Third, we must develop more capacity throughout the system, going beyond hospitals, especially community-based services.

4. Fourth, we must provide targeted support for substance use disorder and efforts to prevent overdose.

5. Fifth, we must make the behavioral health workforce a priority, particularly in underserved communities.

6. Sixth, we must identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps.

January -March 2023 will be the implementation Phase and March 2023-December 2025 is the execution phase.

7. Legislative Update– Will Frank, Senior Advisor for Legislative Affairs,

DMAS staff, Brian McCormick, Director Legislative & Intergovernmental Affairs

DMAS's role includes the following:

- Monitoring legislation that is introduced
- Reviewing legislation and budget language for Secretary and Governor
- Making position recommendations to Secretary and Governor
- Communicating the Governor's positions to General Assembly
- Providing expert testimony and technical assistance to legislators on legislation

Will Frank, Senior Advisor for Legislative Affairs, provided an overview of legislation tracked by DMAS during the 2023 General Assembly Session. DMAS was assigned 31 bills and, of these, 13 bills passed and 18 bills failed. These included bills with Amend, No Position and Oppose positions. In addition, DMAS commented on 26 bills assigned to other agencies and tracked another 107 bills. Frank described several bills monitored by DMAS during session.

8. CFO Report

Chris Gordon, CFO, provided the BMAS Board with a finance update. Chris focused on FY23 appropriation, FY23 Actuals by Program and Fiscal Month, Enrollment, and Capitation Decomposition.

FY24 Capitation Development

Measurement period:
January 1, 2021 through June 30, 2022

1st time since Covid-19 that DMAS utilized claims data within pandemic for base, not just trending

Key initial base data observations:
Significant reduction in community behavioral health: child, adult, expansion
Cardinal Care Acute: overall drop of 8.7% PMPM
Cardinal Care LTSS: overall increase of 3.2% PMPM

Medicaid Title XIX Expenditures increased 15% over last year.

Overall Medicaid enrollment slowing by 1,560 less members each month compared to average growth over the last four years

ACA Childless Adults on forecast, slowing by 1,607 less members each month compared to average growth over last four years.

FY24 capitation rate work under development—draft initial rates to DMAS by end of March

9. Unwinding

Sarah Hatton, Deputy Director of Administration provided the BMAS Board with an update on the return to normal enrollment.

Medicaid Continuous Coverage Requirements Under the Families First Coronavirus Response Act (FFCRA) and Unwinding Policies:

As one of several conditions of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase under FFCRA, states are required to maintain enrollment of individuals in Medicaid until the end of the month in which the Public Health Emergency (PHE) ends (the "continuous coverage" requirement).

The continuous coverage requirement applies to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date and has allowed people to retain Medicaid coverage and get needed care during the pandemic.

On December 23rd, 2022, the 2023 Consolidated Appropriations Act was passed (an omnibus spending bill to fund the federal government for FY 2023). The legislation included the decoupling of the continuous coverage requirements for Medicaid from the COVID-19 federal PHE.

Starting April 1st, 2023, states will be required to redetermine eligibility for nearly all Medicaid enrollees. As of 01/05/2023, Virginia will be responsible for redetermining 2,137,977 members within 1,231,705 cases – one-third of all cases are expected to be redetermined automatically, with the remaining cases to be redetermined by local Departments of Social Services. DMAS is working to obtain vendor support to supplement local agency efforts.

With the Federal omnibus bill passage, the enhanced Federal Medical Assistance Percentage (FMAP) would be ramped down as follows –

Calendar Year Quarter	Medicaid Enhanced FMAP
Q1 2023 (January – March)	6.2%
Q2 2023 (April – June)	5%
Q3 2023 (July – Sept)	2.5%
Q4 2023 (October – December)	1.5%

Virginia has received nearly $2.5 billion in additional federal funds throughout the pandemic.

DMAS also received $15 million in American Rescue Plan Act (ARPA) funding to assist with unwinding related work, including but not limited to system enhancements, temporary staffing, and communications/outreach. DMAS has requested an additional $20 million in ARPA funding and $3.3 million in general funds approval from the General Assembly in the 2023 session to assist with redetermination efforts through the Cover Virginia vendor.

January – March 2023: What to Expect
DMAS and DSS have been working for almost 3 years to prepare for unwinding, which is considered the biggest healthcare-related event since the implementation of the Affordable Care Act. With the April 1st start date approaching, DMAS and VDSS will now begin to implement the planned activities in order to support members, local agencies, providers, and other stakeholders both before and throughout the unwinding period.

Systems: Turning off processes designed to continue coverage and turning on regular processes such as sending paper renewal forms. In addition, several new automated processes will be turned on to allow additional no-touch renewals and/or applications.

Communications/Outreach: Phase II and III toolkits are available on the Cover Virginia/Cubre Virginia website and have been distributed to health plans to prepare for outreach. Health plans will assist in outreach when the automated ex parte is unsuccessful and if members are closed for administrative reasons to attempt to decrease instances of churn.

Note: Certain provider flexibilities not related to eligibility processes remain in effect until the end of the PHE on May 11, 2023.

Contractor Support: DMAS has developed a new scope of work to supplement local agencies with vendor support through Cover Virginia. DMAS is currently working to implement this solution.

10. Regulations

11. New Business/Old Business

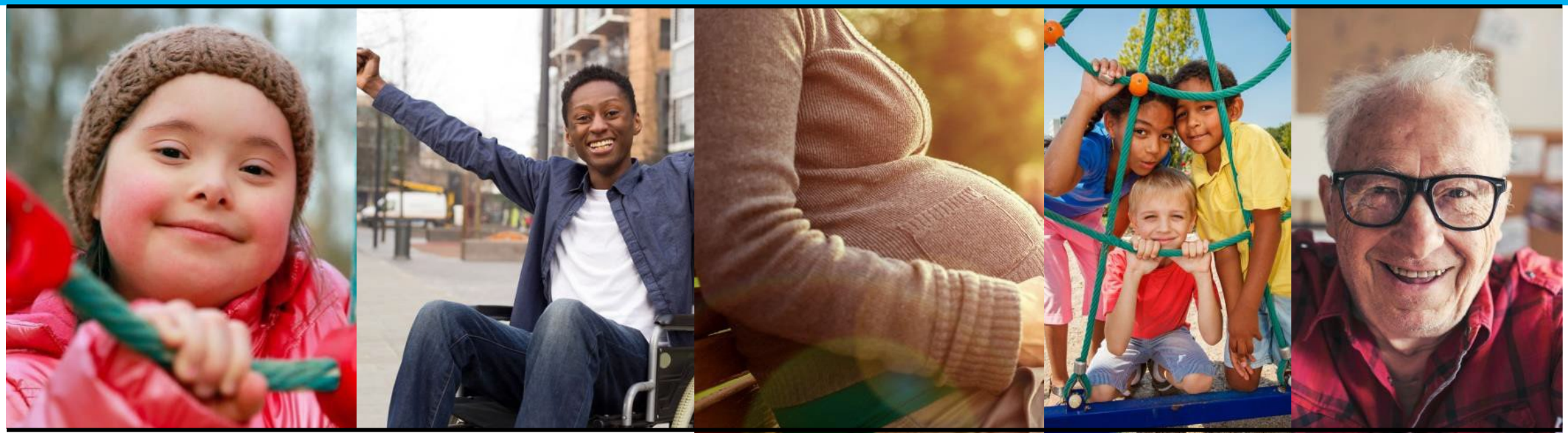
12. Public Comment –

Maureen Hollowell provided a public comment covering two subjects:

1. Process for Minimum Data Set Section Q referrals
2. Access to CCC Plus Waiver environmental modification services

13. Adjournment

Moved by Patricia Cook; seconded by Tim Hanold to adjourn @ 12:53 pm
Motion: 8 - 0
Voting For: Kannan Srinivasan, Greg Peters, Dr. Basim Khan, Tim Hanold, Patricia T. Cook, MD, Dr. Lisa Price Stevens, Elizabeth Noriega, Jason Brewster
Voting Against: None
Virtual Attendee votes not counted but all "ayes": Ashley Gray, Paul Hogan, Ashish Kachru



BOARD OF MEDICAID ASSISTANCE SERVICES
JUNE 2023

Cheryl Roberts, JD
Director, Department of Medical Assistance Services

Agenda

- DMAS Overview
- DMAS Agency Priorities “3 for 2023”
  - Unwinding
  - Right Help Right Now
  - Managed Care Procurement
- Director Updates

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

Who Do We Cover?

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

Children 877,463

Pregnant Members 37,356

Older Adults 87,555

Individuals with Disabilities 153,127

Adults 899,525

Limited Benefit Individuals 153,245

Source: May 1, 2023 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

DMAS Priorities: “3 for 2023”

1. **Unwinding:** Return to Normal Medicaid Redetermination Processing
2. **Right Help, Right Now:** Behavioral Health Transformation
3. **Procurement:** Medicaid Managed Care Delivery System Re-procurement

Impact of “Unwinding” and End of PHE

As of March 2023, Virginia is responsible for redetermining Medicaid eligibility for over 2.1 million members.

Preparations for this work began in 2022 through a joint HHR effort in close collaboration with the Department of Social Services (DSS).

DMAS expects approximately 14% of members to transition off the Medicaid program due to no longer meeting program requirements.

Asking for everyone’s assistance to assist members with completing renewal packets prior to redetermination deadlines!

RHRN: DMAS Engaged Across Six Workstreams

An aligned approach to BH that provides access to **timely, effective, and community-based care** to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families.

1: We must strive to ensure **same-day care for individuals experiencing behavioral health crises**

2: We must **relieve the law enforcement communities' burden** while providing care and **reduce the criminalization of behavioral health**

3: We must **develop more capacity** throughout the system, going beyond hospitals, especially to enhance community-based services

4: We must **provide targeted support for substance use disorder (SUD)** and efforts to prevent overdose

5: We must **make the behavioral health workforce a priority**, particularly in underserved communities

6: We must **identify service innovations and best practices** in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps

Source: VA HHR

Current Activities for 3 Year RHRN Plan

DMAS is…

- **Listening to feedback** provided in forums such as the MCO Resolution Panel, Medicaid Managed Care Advisory Committee, Member Advisory Committee, and Children's Health Insurance Program Advisory Committee.
- **Strategizing solutions** through RHRN workgroups to strengthen and enhance access to high quality BH and SUD services for children and adults.
- **Seeking opportunities** to leverage upcoming managed care procurement to drive innovation, identify and implement process and program improvements, and to emphasize BH as top priority.
- **Focusing on meaningful and sustained collaboration** with sister state agencies, MCOs, and community partners.

Source: Governor Youngkin's "Right Help, Right Now" Behavioral Health Transformation Plan, published December 14, 2022

Managed Care Procurement

To continue to build on the foundation and strengths of Virginia's Medicaid managed care, and maximize program enhancements for members and providers, DMAS is seeking to re-procure its managed care delivery system in 2023.

In October 2022 it was announced that DMAS is seeking to use this procurement to drive innovation and strengthen quality and accountability in its managed care program.

DMAS is currently working with a nationally recognized consultant to translate the priorities of this administration and emerging best practices into a targeted RFP that aims to move the needle in key areas, such as behavioral health.

A Medicaid managed care re-procurement process is an important and rare opportunity to leverage state purchasing power to improve the value that MCOs provide to the state and its members and provider networks.

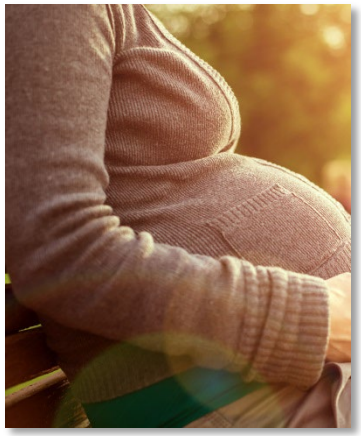
Targeting a Summer 2023 RFP release date for Summer 2024 implementation.

Source: Governor's Introduced Budget, 2023 Appropriation Act Item 308 (GG)

Director Updates

- Workforce
- Partnership for Petersburg
- Cardinal and Provider Enrollment
- Plan Merger
- EAPG correction
- New Ke Pro contract
- Doulas
- Hospital Emergency Room Services
- PI – Auto death file
- Parents and Caregiver
- Nursing Home – VBP





DMAS SPOTLIGHT:

Healthcare Analytics & Transformation

Rich Rosendahl

Chief Analytics Officer

Healthcare Analytics & Transformation

- Healthcare Analytics and Transformation (HAT)
  - Healthcare Analytics Division
  - Incentive Coordination and Economic Research Division
    - Includes Value Based Purchasing Unit
  - Quality and Population Health Division

Recent Accomplishments – Overall and Data

- DMAS's Quality and Population Health Division received positive feedback on recent submission of Virginia's External Quality Review (EQR) technical reports for the 2022-2023 EQR reporting cycle
- Data Trust – initiated and implemented Commonwealth's first Agency to Agency data transfer through the Office of Data Governance and Analytics Data Trust to support DBHDS's mandated reporting
- Research and Data Sharing Partnerships with 15 other agencies/research institutions for 21 projects to monitor and improve health outcomes for Virginians and ensure compliance with State and Federal regulations
- Submitted data and participated in 2023 Datathon on "*Unmasking Maternal Mortality*" which was led by the Office of Data Governance and Analytics in the Governor's Office
- Objectives and Key Results (OKRs) – developed and update measures for Administration's OKRs each month

Recent Accomplishments - Dashboards

- Dashboards
  - Behavioral Health Utilization
  - Cost/Utilization
  - HEDIS Measures
  - Legislative District Statistics
  - Value Based Purchasing Nursing Facility

  - Coming soon
    - Unwinding
    - Telehealth

Behavioral Health Utilization

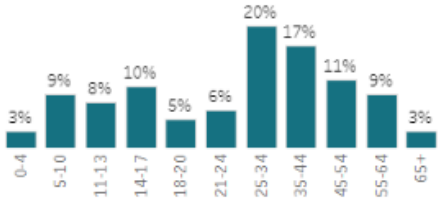
Profile of Medicaid Members Receiving Behavioral Health Services

State Fiscal Year 2023 — Last update: April 30, 2023

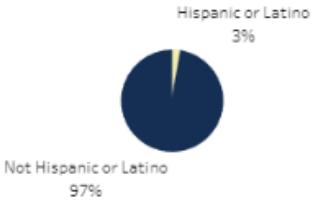
Select Period of Service: State Fiscal Year 2023 | Select Program: (All) | Select Behavioral Health Service: (All) | Select Member Age Group: (All)

Total Amount Paid	Average Amount Paid Per Member Receiving Services	Total Members Receiving Services
$1,003,136,982	$3,474	288,781

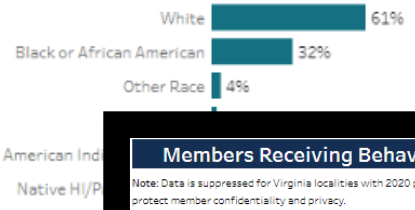
Percent of Members Receiving Services by Age Group



Percent of Members Receiving Services by Ethnicity

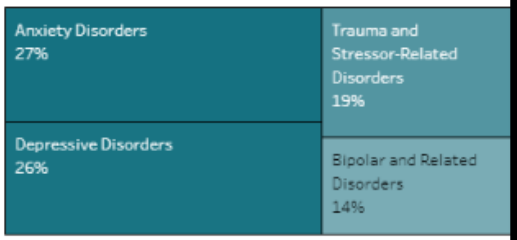


Percent of Members Receiving Services by Race



Percent of Members Receiving Services by Gender

Percent of Members Receiving Services b

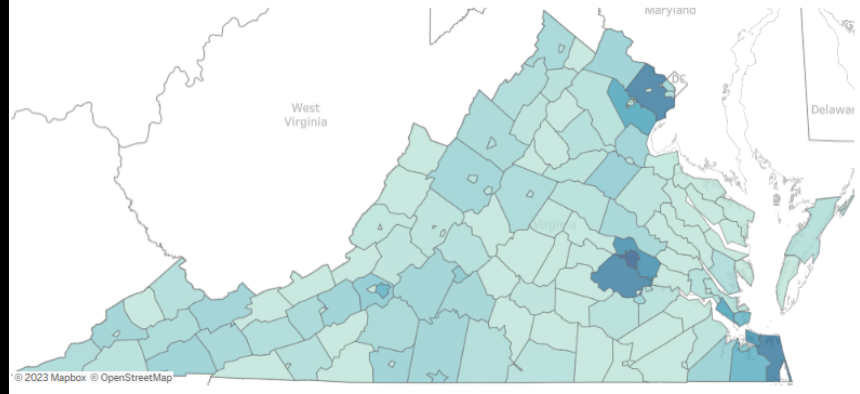


Note: Data is suppressed for values where member count is less than 10. Suppressed data will appear as 'Null', or blank, in this visu
Member confidentiality and privacy.

Members Receiving Behavioral Health Services and Total Amount Paid by County

Note: Data is suppressed for Virginia localities with 2020 population less than 20,000. Suppressed data will appear as 'Null', or blank, in the map. Data is suppressed to protect member confidentiality and privacy.

Select Period of Service: State Fiscal Year 2023 | Select Behavioral Health Service: (All)



Cost/Utilization

Big 3 By Cost Category

Program: MEDALLION4 | Healthplan: (All) | Eligibility Category: (All)

		SFY2021	SFY2022	SFY2023	% Difference
Grand Total	PMPM	$283	$289	$306	5.8%▲
	Cost Per Claim	$168	$165	$172	4.1%▲
	Claims Per 12K Members	20,241	21,052	21,387	1.6%▲
ER	PMPM	$14	$16	$21	35.8%▲
	Cost Per Claim	$124	$124	$162	31.2%▲
	Claims Per 12K Members	1,322	1,513	1,566	3.5%▲
In-Patient	PMPM	$58	$57	$52	-9.3%▼
	Cost Per Claim	$8,913	$8,645	$7,824	-9.5%▼
	Claims Per 12K Members	78	79	79	0.3%▲
Nursing Facility	PMPM	$0	$0	$0	54.8%▲
	Cost Per Claim	$2,879	$2,474	$3,178	28.5%▲
	Claims Per 12K Members	0	0	0	20.5%▲
Other Facility	PMPM	$5	$4	$5	20.7%▲
	Cost Per Claim	$1,145	$1,070	$1,279	19.6%▲
	Claims Per 12K Members	49	48	49	0.9%▲
Out-Patient	PMPM	$34	$33	$43	32.1%▲
	Cost Per Claim	$408	$390	$576	47.8%▲
	Claims Per 12K Members	996	1,013	906	-10.6%▼
Pharmacy	PMPM	$72	$73	$78	6.7%▲
	Cost Per Claim	$109	$107	$108	1.0%▲
	Claims Per 12K Members	7,965	8,235	8,698	5.6%▲
Physician Services	PMPM	$100	$106	$106	0.0%▲
	Cost Per Claim	$122	$125	$126	0.7%▲
	Claims Per 12K Members	9,832	10,163	10,089	-0.7%▼

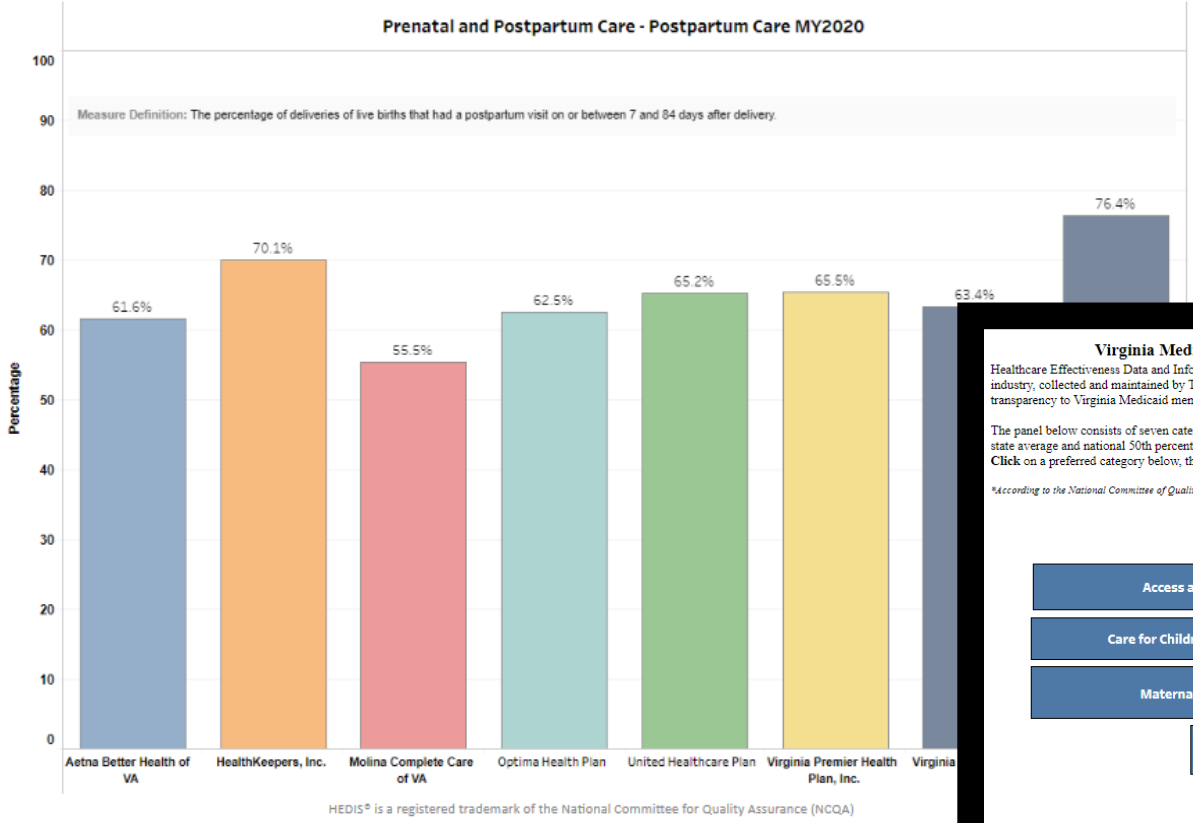
Last Update: 5/4/2023 9:23:07 AM

HEDIS Measures

Measure Name (Select from the dropdown below)

Prenatal and Postpartum Care - Postpartum Care MY2020

Category: Maternal and Perinatal



HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Virginia Medicaid Managed Care HEDIS: Measurement Year (MY) 2020 Dashboards

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

The panel below consists of seven categories of HEDIS® measures. Each quality measure is reported by Managed Care Organization (MCO) and includes the state average and national 50th percentile rate. The measurement year (MY) 2020 measures reflected in this dashboard occurred in calendar year 2020.
Click on a preferred category below, then choose a measure from the dropdown to view.

**According to the National Committee of Quality Assurance Quality Compass® , caution is advised when using MY2020 data for trending.*

- Access and Availability
- Behavioral Health
- Care for Children and Adolescents
- Effectiveness of Care
- Maternal and Perinatal
- Preventive Care for Adults
- Substance Use and Monitoring

Defined HEDIS categories:
Accessibility and Availability: This category includes measures based on the necessary resources and location of the provider to meet the needs of the member.
Behavioral Health: This category includes measures based on the connection between behaviors and the health and well-being of members.
Care for Children and Adolescents: This category includes measures focused on the health of children and adolescents.
Effectiveness of Care: This category includes measures based on how medical interventions have an effect on medical conditions.
Maternal and Perinatal Care: This category includes measures based on the health of women during pregnancy, childbirth and the post-partum period.
Preventive Care for Adults: This category includes measures based on the routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems for adults.
Substance Use and Monitoring: This category includes measures based on the initiation period, continued use and monitoring of members using alcohol and drugs.

Legislative District Statistics

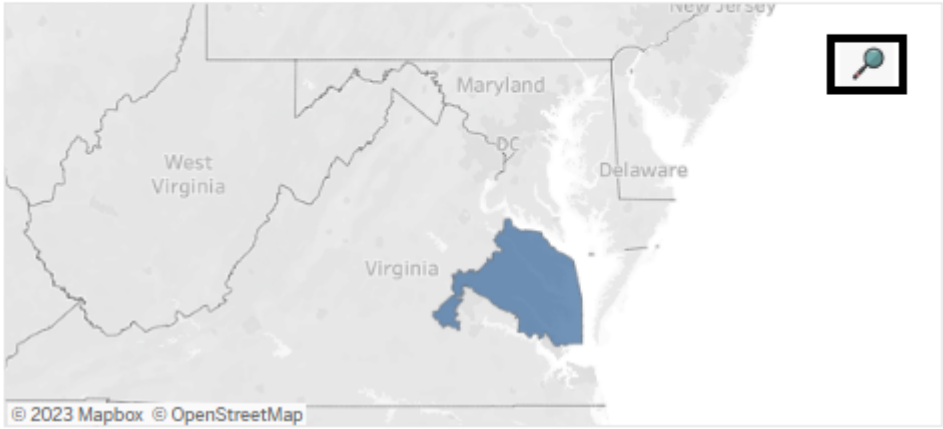
MEDICAID AT A GLANCE BY DISTRICT

updated on: 03/20/2023

Congress District Number

1

Total District Population :	784,672
Medicaid/FAMIS Member Count in District :	124,583
Medicaid/FAMIS Member Percentage in District:	15.88%



Covered Population	Member count	Percent of District Population
Low Income Children	49,385	6.29
Medicaid Expansion Childless Adults	33,026	4.21
Medicaid Expansion Parent / Caretaker Adults	11,202	1.43
Non-ABD Adults	9,633	1.23
Blind / Disabled Individuals	7,630	0.97
Limited Benefit Individuals	6,848	0.87
Aged Adults	4,440	0.57
Enrolled Due to Pregnancy	1,919	0.24
Medicaid Expansion Emergency Services Only	401	0.05
Medicaid Expansion Department of Corrections Adults	99	0.01

Value Based Purchasing Nursing Facility

Nursing Facility Report Card

NF VBP performance payments are adjusted for the size of the facility using Medicaid residents days. For facility comparisons, please see the threshold met variable to identify the performance tier (Best, Better, Fair, or Below) or the measure result variable. See https://www.dmas.virginia.gov/about-us/value-based-purchasing/ for more information . For the baseline year, performance information is provided for illustrative purposes; payment variables will reflect $0 because no payments were distributed based on baseline data performance. For Program Year 1, the Weighted Case Mix Hours measure is paid out during Payment 2.

Year: Program Year 1 | Measure(s): (All) | Facility: ABINGDON HEALTH CARE LLC

ABINGDON HEALTH CARE LLC

Attributed MCO to Make Payment	Program Year	Medicaid Days
VA PREMIER	Program Year 1	22,960

Total Possible Performance Payment	Total Attainment and Improvement Payment	Performance Attainment Payment	Improvement Payment
$132,020	$123,791	$120,540	$3,251

Total Payment 1: $123,791

Measure	Program Year Name (Baseline Year, Program Y..	Threshold Met (Below, Fair, Better, Best)	Measure Result	Attainment Payment	Improvement Payment
Days without 8 RN Hours	Program Year 1	Best	0.00	$40,180	$
Pressure Ulcers	Program Year 1	Better	7.05	$34,440	$
Urinary Tract Infection	Program Year 1	Best	0.73	$45,920	$3,25
Weighted Case Mix Hours	Program Year 1	Null	Null		

Total Payment 2: $0

Measure	Program Year Name (Baseline Year, Program Y..	Threshold Met (Below, Fair, Better, Best)	Measure Result	Attainment Payment	Improvement Payment

Distribution of Nursing Facility Sites based on Medicaid Days and Measure Result

The Scatterplot depicts each facility's performance (colored dot) in the NF VBP measures along the x-axis and the number of Medicaid Days for the facility along the y-axis. Comparing facilities vertically shows facilities performing similarly based on the measure result. Comparing facilities horizontally shows the range of performance of facilities with similar Medicaid Days.

Medicaid Days are calculated based on Medicaid Managed Care Days for all facilities participating in Managed Care, and are calculated based on Medicaid FFS days for select facilities that do not participate in Managed Care but are still eligible for the NF VBP program.

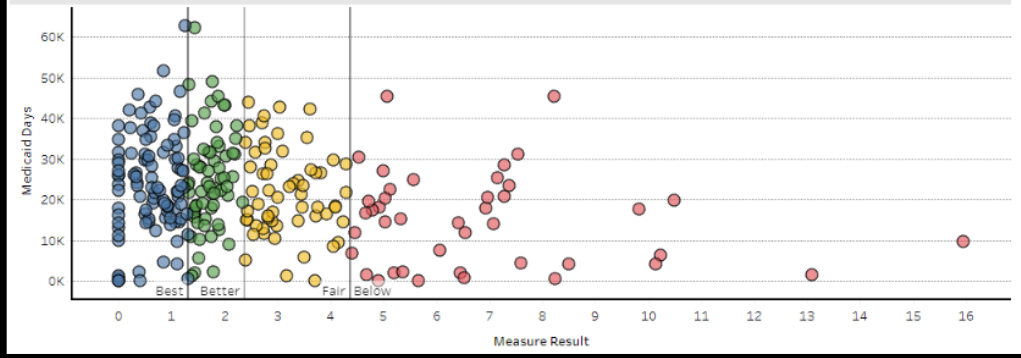
The baseline year data refers to data from CY2020 for ED Visits, Hospitalizations, Pressure Ulcers, and Weighted Case Mix Hours, and refers to CY2019 for Days without 8 RN hours.

For Program Year 1, the Weighted Case Mix Hours measure is paid out during Payment 2.

Year: Program Year 1 | Measure: Urinary Tract Infection | Threshold(s): (All) | Facility: Highlight Facility Name

Threshold: Best | Better | Fair | Below

Selected Measure for Program Year 1: Urinary Tract Infection (Percentage of Long-stay High-risk Residents)



VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

VIRGINIA MEDICAID UNWINDING:
ENDING CONTINUOUS COVERAGE REQUIREMENTS AND THE RETURN TO NORMAL ENROLLMENT

SARAH HATTON
DEPUTY OF ADMINISTRATION
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

JUNE 13, 2023

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

VIRGINIA'S MEDICAID PROGRAM DMAS

CardinalCare Virginia's Medicaid Program

COVER VIRGINIA

Medicaid Continuous Coverage Requirements: Background, Preparation and Partnerships

- States were required to maintain enrollment of Medicaid members (enrolled as of March 18, 2020) to receive the additional 6. 2 % increase until the end of the month in which the federal Public Health Emergency (PHE) ends.
- Since March of 2020, DMAS and DSS have closely collaborated to implement flexibilities and protect needed coverage during the PHE to allow access to services. In a parallel effort, the DMAS and DSS began planning in mid-2020 for the eventual unwinding. This close partnership has continued throughout the PHE to ensure all efforts were made to utilize available resources throughout the return to normal transition
- Unwinding Taskforce: Secretary Littel convened a monthly unwinding taskforce beginning in January 2022 to include DMAS and DSS leaders and the Office of the Attorney General.
  - In July 2022, the taskforce was expanded to include Senate and House finance staff and the Department of Planning and Budget per a General Assembly mandate.
- In December 2022, the Consolidated Appropriations Act (CAA) was signed into effect decoupling the PHE from the continuous coverage requirement effective March 31, 2023:
  - Stepped down the enhanced FMAP beginning April 1ST, phasing out the enhanced match December 31, 2023.
  - CMS requires that states have an approved mitigation plan – or approval not to submit a mitigation plan by March 31, 2023. States that did not receive this approval face the loss of enhanced FMAP, restrictions on taking actions to close enrollments, and delayed redetermination timelines.
  - Virginia was one of 44 states required to submit a mitigation plan. DMAS received CMS approval on March 29, 2023.

Medicaid Renewals Monthly Update

Data as of June 7, 2023

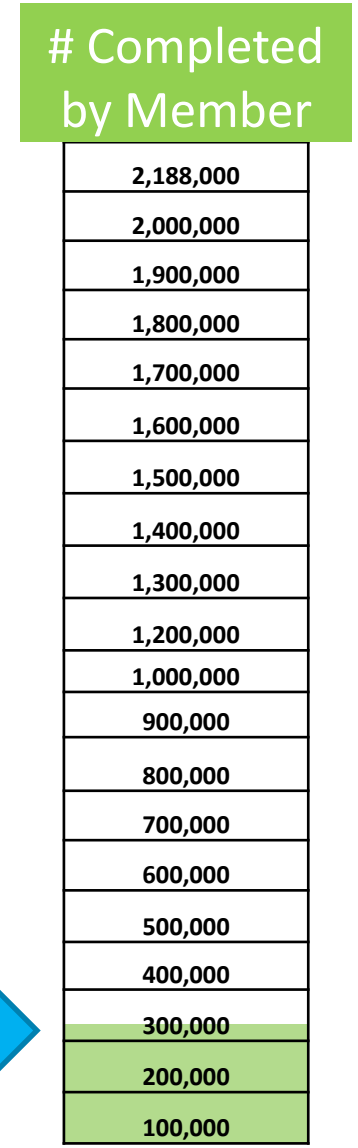
Next Automated Run: June 17th
Next mailing: June 19th

Renewals Counts by Case

Month	Total Cases Due	Automatic Renewals Completed	Paper Packets Mailed
March (Due: May)	121,604	83,776 68.9 % Success	36,488
April (Due: June)	96,521	25,541 26.5% Success	68,377
May (Due: July)	115,260	29,493 26% Success	82,872

- Per federal guidance, April 30th, 2023, was the first month states were permitted to close eligibility.
- Renewals that are unable to be completed through the automated process are mailed two months prior to the month in which the renewal is due.
- Prior to the COVID-19 Public Health Emergency, on average:
  - 64,000 cases were due each month
  - 32,000 or 50% were completed through the automated process
  - 32,000 cases were manually processed across 120 local agencies.

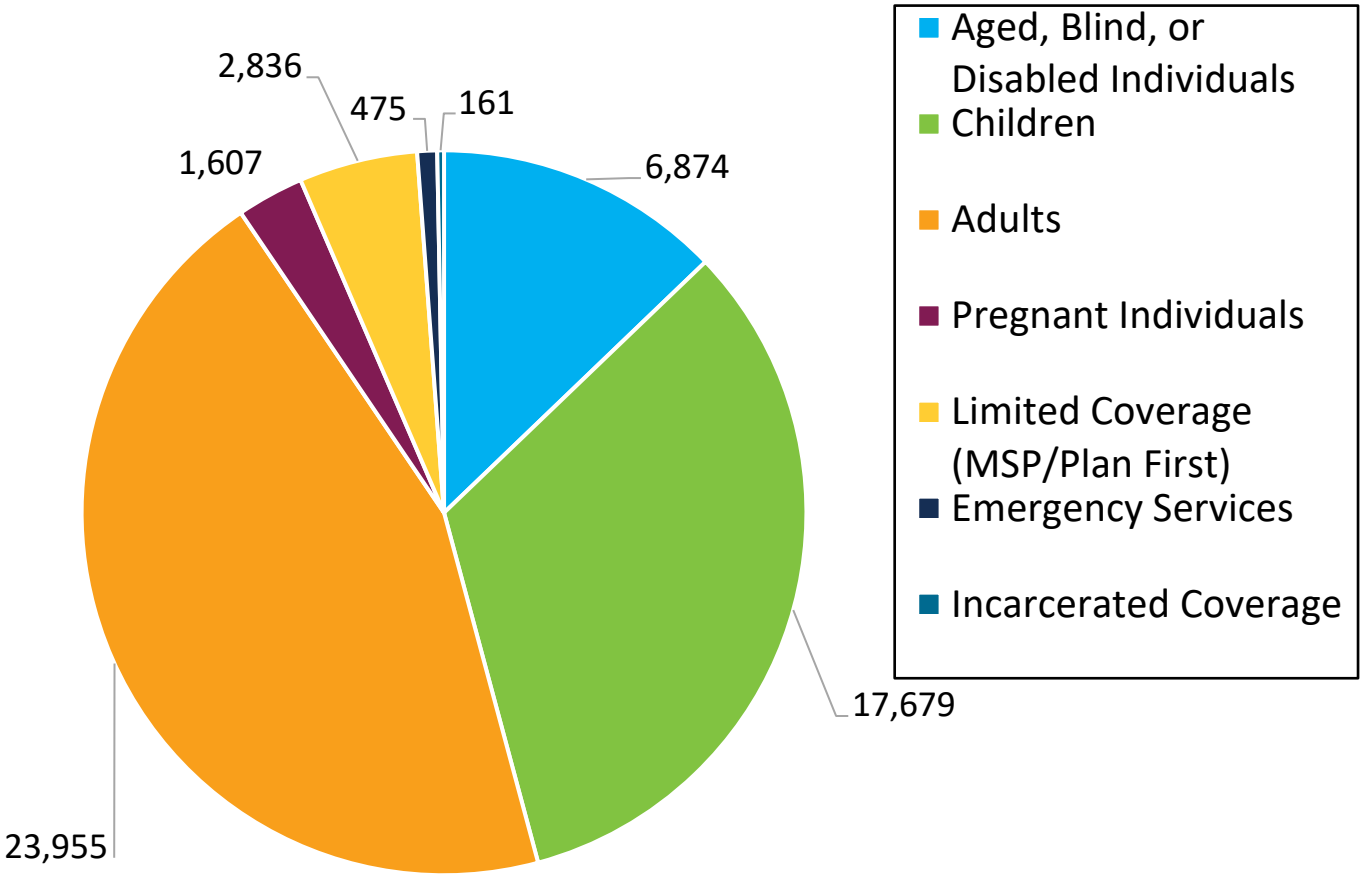
341,813 Renewals Completed



VIRGINIA'S MEDICAID PROGRAM DMAS

Closures by Eligibility Grouping

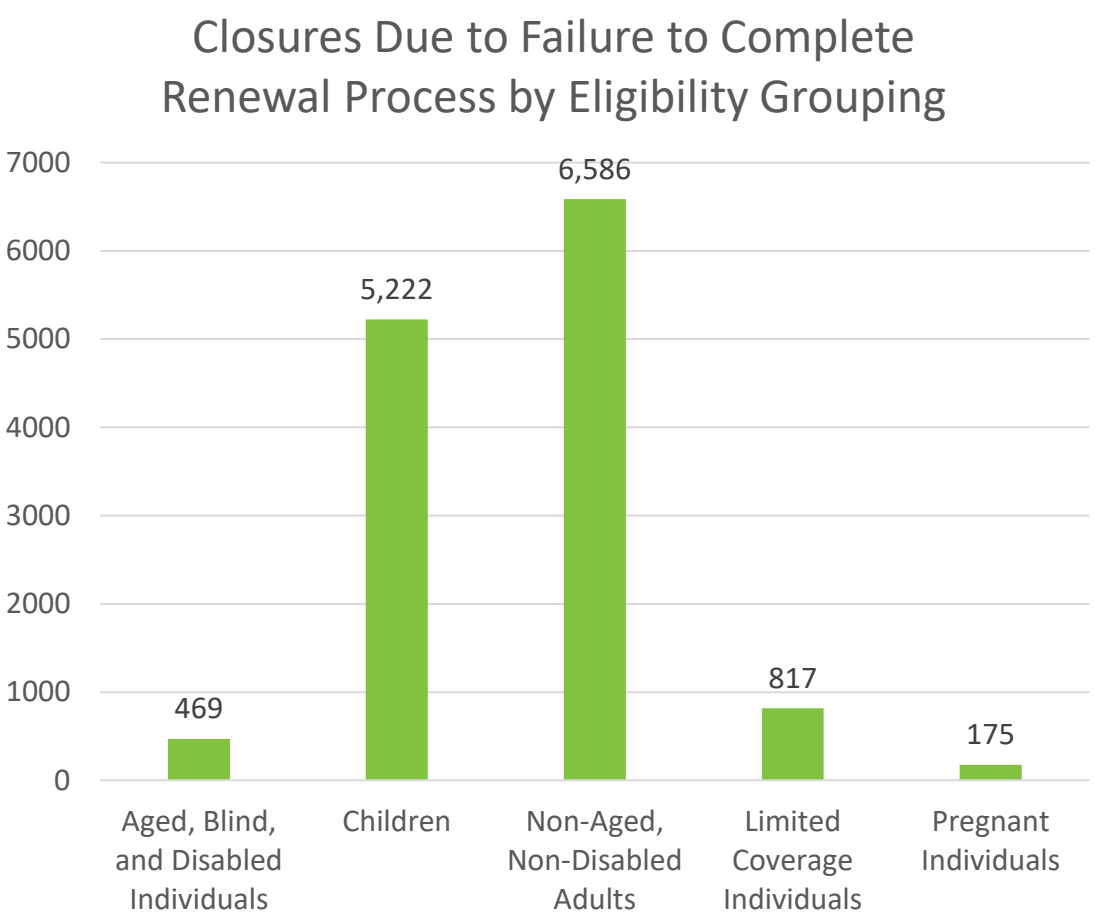
53,587 closures have occurred through May 31, 2023.



- 39% (21,054) of all closures to date occurred due to a deceased status, loss of Virginia residency, or due to the member's request for closure.
- 72% of the 6,874 aged, blind, and disabled adults with coverage closed to date occurred due to a deceased status (4,160) or a loss of Virginia residency (780).
  - 682 closures occurred due to the end of an income spenddown
  - 469 closures occurred due to failure to complete the renewal process.
- 32% of children with coverage closed to date occurred due to a loss of Virginia residency (3,471) or a cancellation of coverage was requested by the case head (2,231).
  - (27%) 4,869 closures occurred due to no longer met non-financial requirements. This typically occurs when an individual turns age 19 and does not meet eligibility for other coverage groups.
  - (30%) 5,222 closures occurred due to failure to complete the renewal process.
- 39% of non-disabled/non-aged adults with coverage closed to date occurred due to loss of Virginia residence (3,314), deceased status (1,961), and cancellation of coverage requested by the recipient (4,043).
  - 37% (6,586) closures occurred due to failure to complete the renewal process.
  - (17%) 3,063 closures occurred due to excess income.

Closures due to Failure to Complete the Renewal Process

To date, 13,269 or 25% of closures have occurred due to the individual failing to complete the renewal process. DMAS has partnered with the six Medicaid managed care plans and implemented an internal process for fee-for-service members to help prevent loss of coverage due to not completing the renewal process. The state is unable to refer individuals to the Federally Facilitated Marketplace for an evaluation in a subsidized plan when the renewal process is not completed.



Efforts to Prevent Procedural Closures

- ✓ Outreach to all individuals through all modalities (email, text, phone, and mail) each month to notify households with a renewal due that the renewal form has been mailed.
- ✓ Outreach to all individuals that have not completed their renewal through all modalities warning of coverage loss if renewal is not completed.
- ✓ Outreach to all individuals closed due to failure to complete the renewal packet to offer assistance with completing renewal and notifying individuals of 90-day grace period.
- ✓ Outreach to all individuals scheduled to closed for a non-procedural reason (excess income) offering assistance with transitioning to a qualified health plan.
- ✓ An additional layer of outreach occurs to aged, blind, and disabled individuals by phone to offer additional assistance with completing the renewal process.
- ✓ Data exchange with the Department of Blind and Visually Impaired/DMAS/health plans to ensure resources are in place to provide assistance.
- ✓ DMAS implemented a system change to allow providers to view an individual's renewal date to help remind those who present in person of the importance of completing the process.
- ✓ DMAS stood up a dedicated unit for Application Assisters and Authorized Representatives at Cover Virginia to provide a dedicated call center and email option to advocates and care takers.

Language and Disability Access:
Effective Communication During Medicaid Unwinding

- Unwinding online toolkits and materials
  - Available in English, Spanish, Arabic, Amharic, Urdu, Vietnamese, Dari, Pashto
  - Accessible to screen readers
  - Include notices informing individuals of the availability of free language assistance services and auxiliary aids and services, and how to request those services
- Return to Normal Enrollment Town Halls / Listening Sessions
  - Communication Access Real-Time Translation (CART) services available
  - Include notices informing individuals of the availability of free language assistance services and auxiliary aids and services, and how to request those services

Language and Disability Access:
Effective Communication During Medicaid Unwinding

- Call Centers
  - Equipped to take teletypewriters (TTY) calls
  - Interpreting services available in all languages
- Fee for service renewal reminders messaging
  - Through text messages, emails, and robocalls
  - Available in non-English languages
- Recently updated eligibility notices
  - Automated translation into top five languages spoken by Medicaid recipients accounting for 99.2% of members
  - Available in non-English languages: Spanish, Arabic, Amharic, Urdu, Vietnamese
  - Include a notice supplement with language taglines accounting for top 17 languages spoken in the Commonwealth and a non-discrimination notice

Information and Resources

- **Member and Stakeholder Resources and Material** can be found on the Cover Virginia, Cubre Virginia, and DMAS websites. The Return to Normal Enrollment page on each site contains toolkits, information, and resources for members, providers, and other stakeholders. to learn more about Virginia's preparation and important updates.
  - DMAS Website: https://www.dmas.virginia.gov/covid-19-response/
  - Cover Virginia Website: https://coverva.dmas.virginia.gov/return-to-normal-enrollment/
  - Cubre Virginia Website: https://cubrevirginia.dmas.virginia.gov/return-to-normal-enrollment/

- **The Renewal Status Dashboard** can be found on the DMAS site under the Data tab that tracks the progress toward redetermining Virginia's Medicaid population on a monthly basis.
  - The dashboard can be found at https://www.dmas.virginia.gov/data/return-to-normal-enrollment/eligibility-redetermination-tracker/

- **Legislator Resources and Information** can be found on the DMAS website at: https://www.dmas.virginia.gov/about-us/legislative-office-resources/
  - New dashboards are available which provide enrollment data by Virginia State House and Senate districts as well as Congressional districts.

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

FINANCE UPDATE

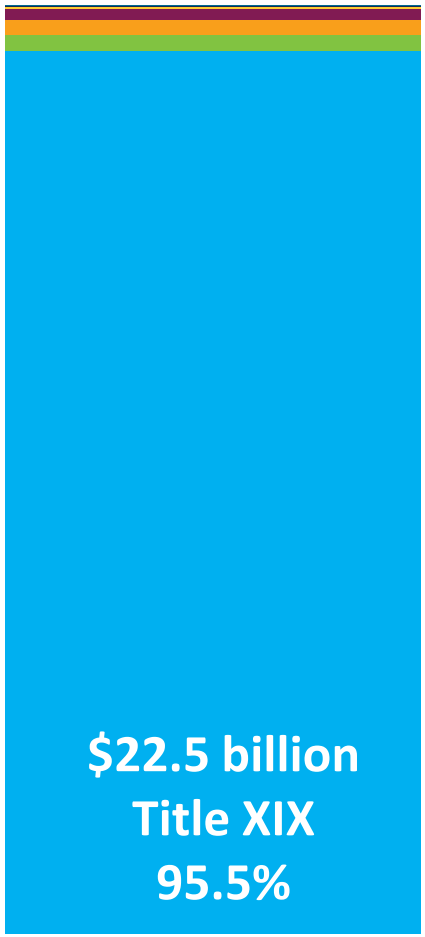
Chris Gordon, CFO

Deputy Director of Finance

Agenda

- FY23 Appropriation
- FY23 Actuals by Program & Fiscal Month
- Enrollment
- Summary

DMAS FY23 Appropriation



$23.5 billion

Admin— 1.5%
- $350 million

CHIP— 1.5%
- $343 million

MCHIP—1.2%
- $280 million

ARPA—0.24%
- $56 million

TDO—0.067%
- $15 million

UMCF—0.003%
- $822K

 Source: Department of Planning & Budget Operating Plan; https://pbreporting.virginia.gov/rdPage.aspx retrieved June 7, 2023

Comparing: FY20-23—the first 11 months

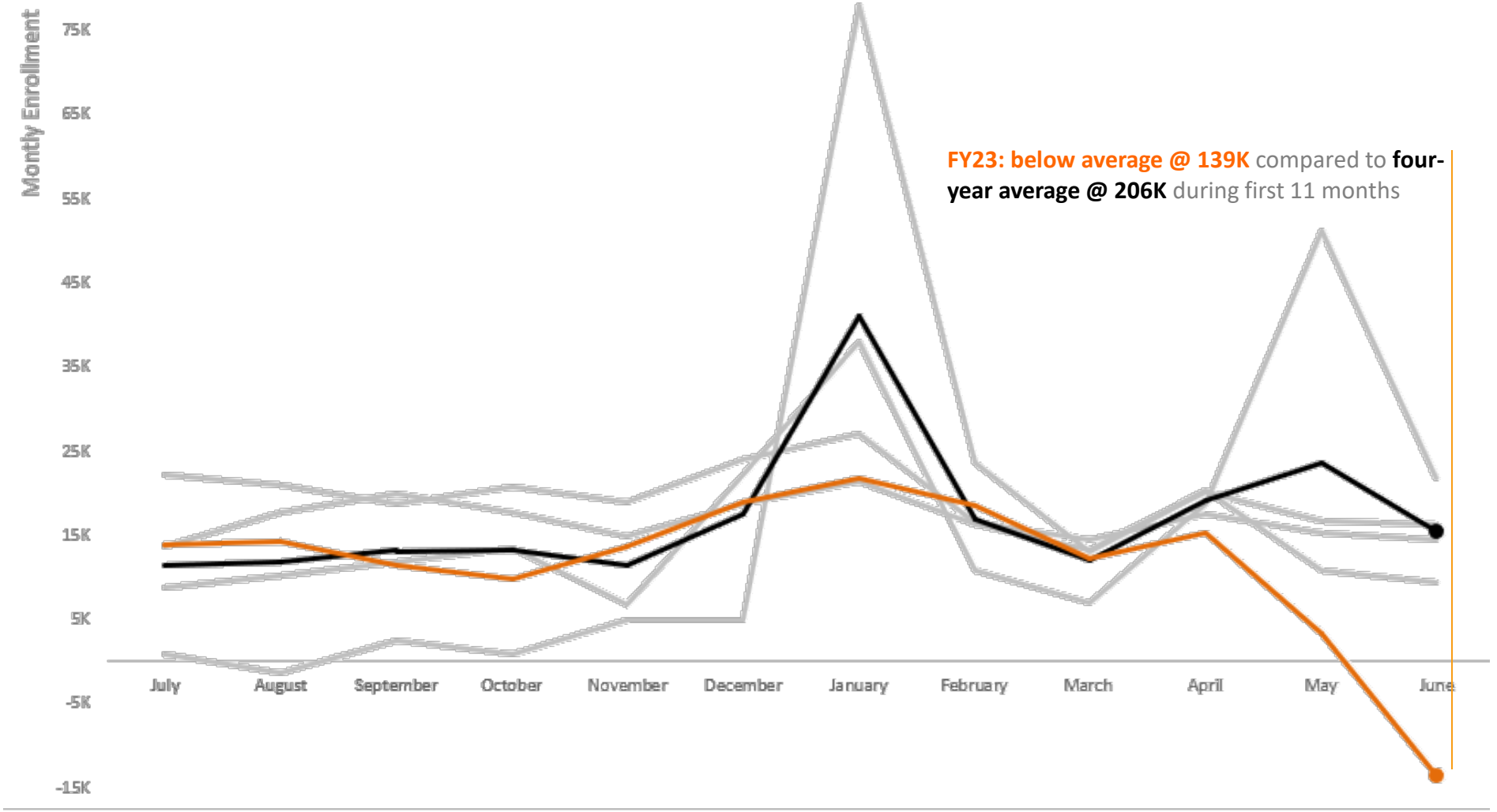
In Millions

Expenditures	Actuals FM11 FY20	Actuals FM11 FY21	Actuals FM11 FY22	Actuals FM11 FY23	FM11 FY22 vs.FM11 FY23 Change	FM11 FY22 vs.FM11 FY23 % Change
Managed Care: Medallion 4	3,891.9	4,869.5	5,660.0	6,997.2	1,337.2	23.6%
Managed Care: CCC+	4,845.7	5,608.3	5,179.5	7,607.7	2,428.2	46.9%
Fee-For-Service: General Medical Care	1,411.8	1,370.7	1,480.7	1,590.7	110.0	7.4%
Fee-For-Service: Behavioral Health & Rehabilitative Svcs	43.6	48.0	39.8	38.8	(1.0)	-2.5%
Fee-For-Service: Long-Term Care Services	1,388.7	1,349.6	1,568.3	2,032.2	463.9	29.6%
Hospital Payments	476.9	441.5	556.0	656.2	100.2	18.0%
Supplemental Rate Assessment Payments	1,035.5	1,539.1	2,111.2	2,824.0	712.8	33.8%
Total Title XIX	**$ 13,094.1**	**$ 15,226.7**	**$ 16,595.5**	**$ 21,746.8**	**$ 5,151.3**	**31.0%**
Total GF Expenditures (Title XIX)	**$ 3,989.6**	**$ 3,945.5**	**$ 4,238.4**	**$ 5,195.1**	**$ 956.7**	**22.6%**

Source: Department of Medical Assistance Services Monthly Accuracy Reports for FM1 through FM11 FY20 through FY23, https://www.dmas.virginia.gov/data/financial-reports/

Monthly Enrollment in Medicaid

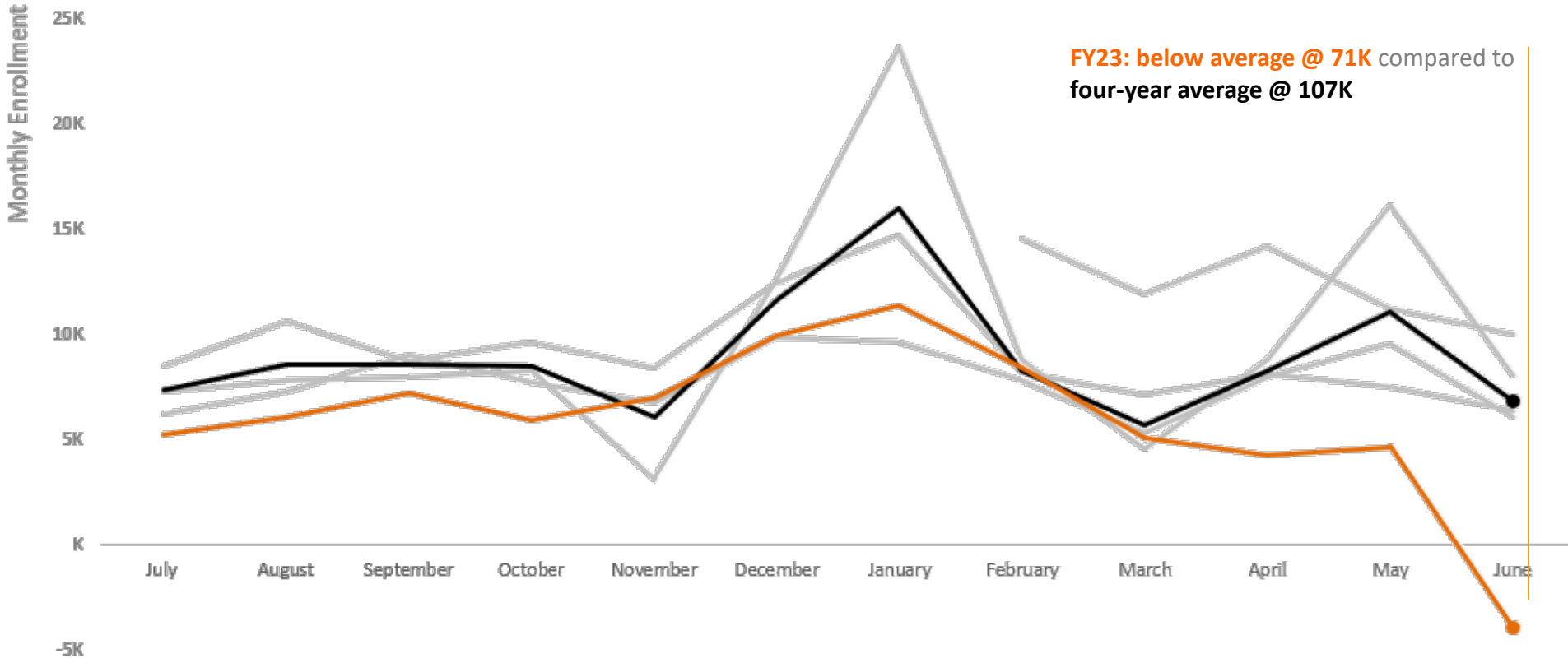
FY23 Monthly Enrollment: **May is first month since 2019 with negative enrollment**



Source: DMAS Enrollment Report retrieved June 7, 2023 https://www.dmas.virginia.gov/data/enrollment-reports/

ACA Childless Adult Enrollment

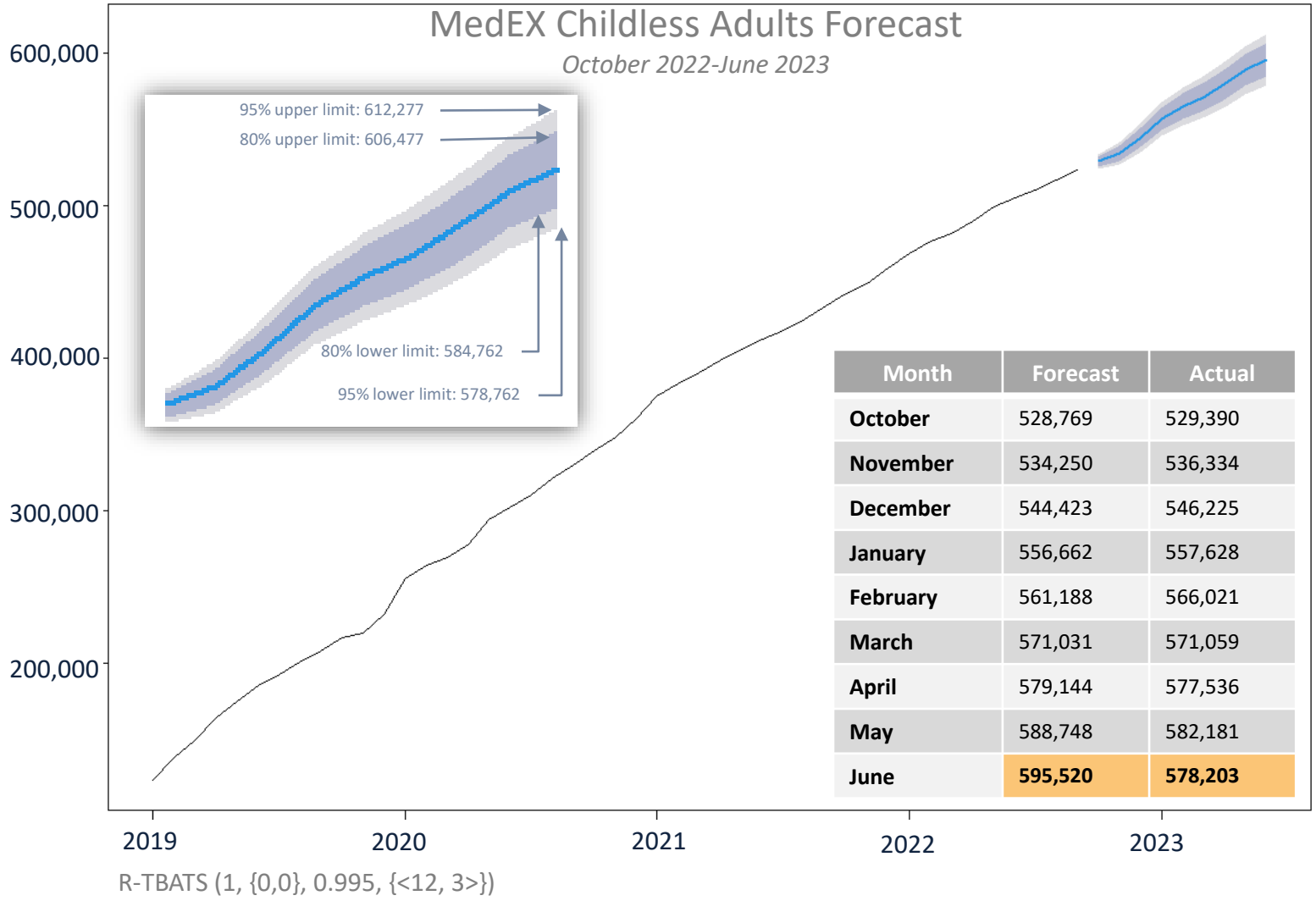
FY23 Childless Adult: June is first month since 2019 with negative enrollment



Source: DMAS Enrollment Report retrieved March 2, 2023

ACA Childless Adult Forecast

9-month Forecast for MedEX Childless Adults: October 2022 –June 2023



Month	Forecast	Actual
October	528,769	529,390
November	534,250	536,334
December	544,423	546,225
January	556,662	557,628
February	561,188	566,021
March	571,031	571,059
April	579,144	577,536
May	588,748	582,181
June	**595,520**	**578,203**

Source: DMAS Enrollment Report retrieved September 2, 2022 , R-TBATS Forecast created September 2022

Summary

- Medicaid Title XIX Expenditures **increased 8.7%** over last year
- Overall Medicaid had **negative enrollment in May** for first time since 2019
- ACA Childless Adults **negative enrollment lagged one-month** behind starting in June
- DMAS monitoring ACA enrollment closely to **implement staggered drawdown** of hospital taxes

Regulatory Activity Summary June 13, 2023
(* Indicates Recent Activity)

2023 General Assembly

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

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

***(03) 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.

***(04) 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 plans to implement EVV for Home Health Care Services on July 1, 2023. The project is currently circulating for internal review.

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

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

(07) 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.

***(08) Former Foster Care Youth:** The state plan is being revised to change eligibility requirements for former foster care children in accordance with section 1 002(a) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act") and the Centers for Medicare and Medicaid Services (CMS) State Health Official (SHO) letter #22-003. Per the SUPPORT Act and the SHO letter, states must modify eligibility requirements for former foster care children under age 26 who were in foster care when they transitioned to independence as adults, or "aged out" of foster care. This SPA, following internal review, was submitted to CMS for review on 3/9/23. The SPA was approved by CMS on 5/31/23.

***(09) Resource Disregard:** DMAS did not increase the patient pay amount for individuals receiving long-term care services during the federal public health emergency in accordance with the "Maintenance of Effort" rules. Some individuals who are receiving long-term care services may have had increases in income during the PHE, and these normally would have resulted in an increase in patient pay amounts. Since DMAS did not increase the patient pay, some members may have retained this income increase during the PHE. When the PHE is over, some of these individuals could lose Medicaid eligibility due to their increases in income as the accumulated resources could put them over the applicable limit if DMAS does not make any changes to eligibility rules. DMAS is filing this SPA with CMS to officially notify CMS of the non-collection of increased patient pay, retroactive to the start of the federal public health emergency. This SPA is being submitted in accordance with the 2022 Appropriations Act, Item GGGG, which instructs DMAS to file a SPA to "exclude excess resources accumulated by

individuals receiving long-term supports and services (LTSS) during the federal Public Health Emergency (PHE) …". Following DPB approval on 1/4/23, the SPA was forwarded to HHR and approved on 1/12/23. The SPA was submitted to CMS on 2/6/23. DMAS held a conf. call with CMS on 2/28/23 to discuss the project. The SPA was approved on 5/2/23.

(10) 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.

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

***(12) Average Commercial Rate for Physicians Affiliated with Type 1 Hospitals:** In accordance with the 2022 Appropriations Act, Item 304.B(4), DMAS "… shall have the authority to amend the State Plan for Medical Assistance to increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate [ACR] as demonstrated by University of Virginia Health System and Virginia Commonwealth University Health System…". In addition, this SPA will satisfy the DMAS requirement to recalculate the ACR every three years. The last ACR is dated April 1, 2020, and CMS requires DMAS to submit a new ACR calculation effective April 1, 2023. Following internal review, the SPA was submitted to CMS on 4/14/23 and approved on 5/19/23.

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) Program of All-Inclusive Care for the Elderly II:** This SPA will allow DMAS to update sections of the state plan that pertain to the Program of All-Inclusive Care for the Elderly (PACE) to align with the Department's current practices pursuant to the Code of Virginia, state regulations, and federal regulations. Following internal review, the SPA was submitted to CMS for review and approved on 4/27/23.

(05) 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. The corresponding reg project began circulating for internal review on 1/25/23.

(06) 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 underway.

***(07) 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.

***(08) Third Party Liability:** This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA 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.

(09) 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 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.

(04) Update to Outpatient Practitioners: The purpose of this action is to add licensed school psychologists to the list of allowed providers of outpatient psychiatric services. Several of Virginia's Child Development Clinics have identified the need to allow licensed school psychologists to bill for outpatient psychiatric services provided in their clinics to increase access to the number of children that they serve. Following internal review, the project was submitted to the OAG on 8/27/21. OAG questions were received on 11/10/21 and DMAS submitted responses to the OAG on 11/12/21. DMAS made Town Hall corrections on 11/16/21. DMAS responded to additional OAG questions on 2/7/22 and 2/8/22 and made project revisions on 2/11/22. The regulatory action was approved by the OAG on 2/22/22 and submitted to DPB on 2/23/22. DPB inquiries were received on 2/24/22 and DMAS sent responses to DPB on 3/2/22, 3/15/22, and 3/15/22. The regs were certified by DPB on 4/5/22. The project was submitted to the Secretary's Ofc. on 4/6/22. An Agency response to the Economic Impact Analysis (EIA) was posted on 4/12/22. The project was forwarded to the Gov. Ofc. for review on 6/17/22. The Gov. Ofc. approved the project on 9/21/22. The project was submitted to Registrar on 9/21/22, with a public comment forum from 10/24/22 thru 11/23/22. The regulations became effective on 12/8/22.

(05) Consumer-Directed Attendants: This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer-directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed

model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. 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 has placed the project on hold to review General Assembly outcomes to determine if pending legislation (SB 886) would impact this regulation.

***(06) Client Appeals Update:** This regulatory action seeks to comply with a 2021 General Assembly mandate that requires DMAS to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of documents and decision deadlines for de novo client hearings. Following internal DMAS review, the reg action was submitted to the OAG on 7/23/21; to DPB on 1/14/22; and to HHR on 1/27/22. 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.

(07) 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. DMAS withdrew the RAI response and continues to work with CMS "off the clock" on this project.

(08) DSH Changes for Children's Hospitals: DMAS seeks to create additional hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs, effective June 2, 2017. As part of this SPA, these new hospital supplemental payments, for freestanding children's hospitals, shall equal what would have been paid to the freestanding children's hospitals under the current disproportionate share hospital (DSH) formula without regard to the uncompensated care cost limit. These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional hospital supplemental payments authorized, accordingly. Following internal review, the DPB and Tribal notices for this SPA were submitted on 5/6/21. DPB approved the SPA on 5/10/21 and the project was submitted to HHR on 5/18/21. Following HHR approval on 5/20/21, the SPA was submitted to CMS on 6/7/21. Informal questions were received from CMS on 7/12/21 and responses were forwarded to CMS on 7/19/21. The SPA was approved by CMS on 8/24/21.

The corresponding regulatory action was circulated for internal DMAS review and submitted to the OAG for review on 9/28/21. The OAG sent additional question on 10/7/21 (DMAS response provided on 10/12/21) and 10/12/21 (DMAS response provided on 10/13/21). These regulations are currently on hold.

(09) 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.

(10) 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 7/121. 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.

(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.

(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. These regulations are currently on hold.

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. The final stage phase of the project is currently circulating for internal review.

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. The project has again been placed on hold.

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.