



Board of Medical Assistance Service – Director's Update

Cheryl Roberts, J.D., DMAS Director

March 12, 2024



Agenda

1. Medicaid overview
2. Program updates
3. Maternal health update
4. Cardinal Care Managed Care procurement update

DMAS Mission & Values

Our Mission & Values

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



Service



Collaboration



Trust



Adaptability



Problem Solving

DMAS Executive Leadership Team



Cheryl Roberts
Agency Director



Ivory Banks
Chief of Staff



Adrienne Fegans
Deputy for Programs
& Operations



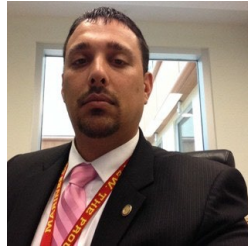
Chris Gordon
Chief Financial
Officer



Sarah Hatton
Deputy for Administration



Jeff Lunardi
Chief Deputy Director



John Kissel
Deputy for Technology
& Innovation



Rich Rosendahl
Chief Analytics
Officer



**Dr. Lisa Price-
Stevens**
Chief Medical Officer



Tammy Whitlock
Deputy for
Complex Care

Medicaid and CHIP Authority



Medicaid and CHIP (FAMIS) are joint federal and state programs authorized under Title XIX and Title XXI of the Social Security Act



Implementation requires authorization by the Governor and General Assembly, and funding through the Appropriation Act



Federal guidance and oversight is provided by the Centers for Medicare and Medicaid Services (CMS)



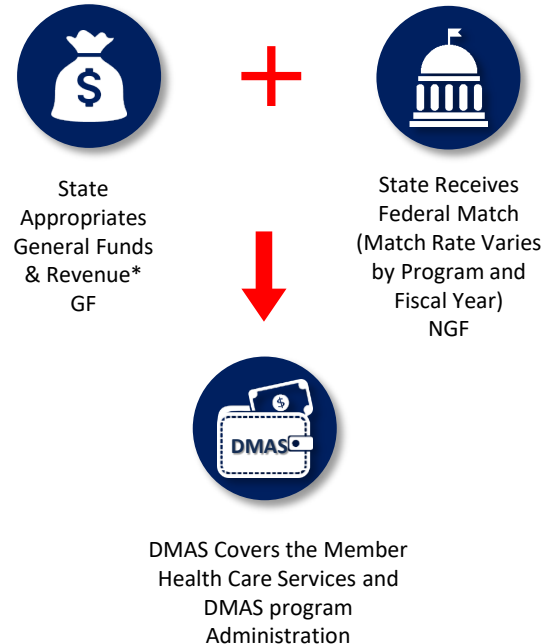
State programs are based on a CMS-approved “State Plan” and Waivers



DMAS is designated as the single state agency within the Governor’s administration to operate the Medicaid program in Virginia

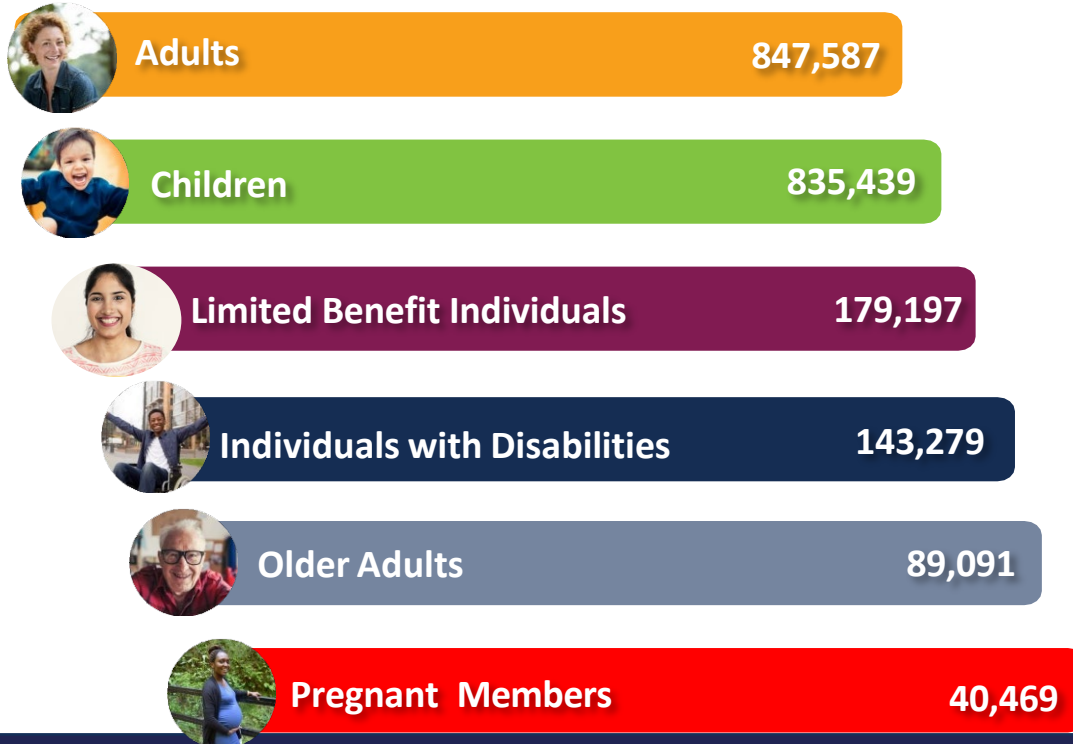
Virginia Medicaid Funding and Authority

- Current Appropriations is \$22.9 billion
- Medicaid match: 51% Non-General Funds (NGF)/ 49% General Funds (GF)
- Medicaid Expansion: 90% NGF/10% is covered by hospital coverage assessment
- Only 1.5% of the total DMAS budget is for administrative expenses



Who Do We Cover?

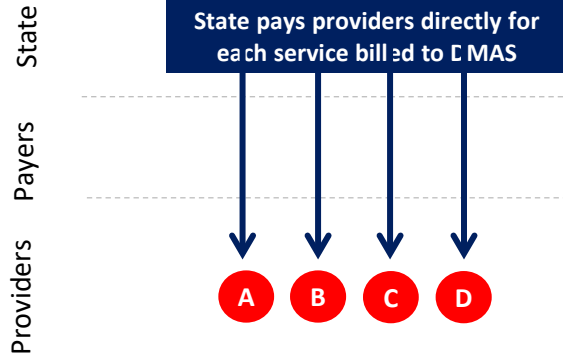
Medicaid is available to Virginians who meet specific income thresholds and other eligibility criteria



Virginia Medicaid – Delivery Systems

Fee-For-Service (FFS)

DMAS contract and pays providers directly for every Medicaid eligible service rendered to Medicaid members.



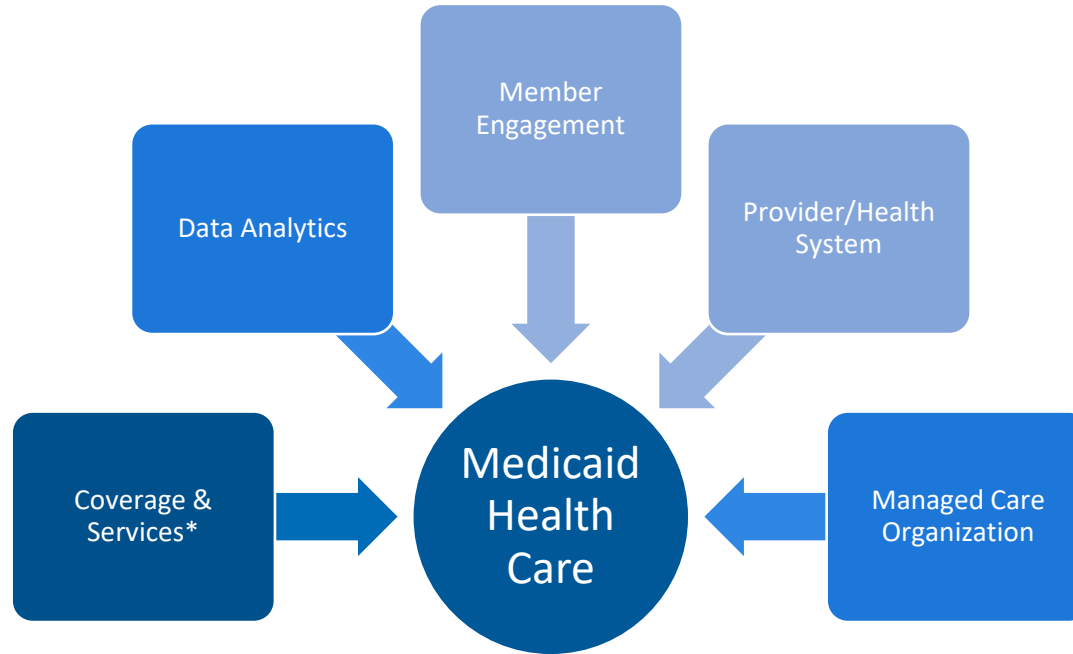
Managed Care (MCO)

96% of Medicaid members are covered through five health plans. Each MCO is responsible for delivering health benefits and related services to its Medicaid members.



Virginia Medicaid – Health Care Levers

Five levers are involved in Virginia Medicaid health care



Virginia Medicaid and FAMIS Enrollment

Reporting Period

March 1, 2024

Member Eligibility

Pregnant Members

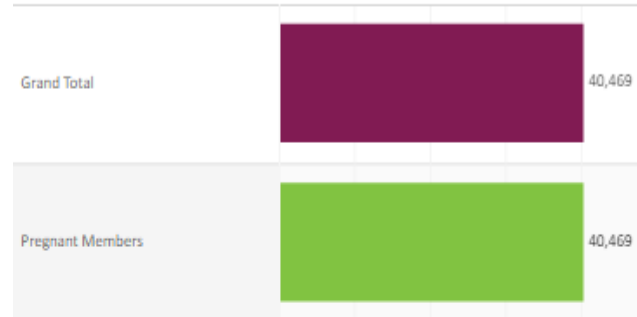
Health Plan

(All)

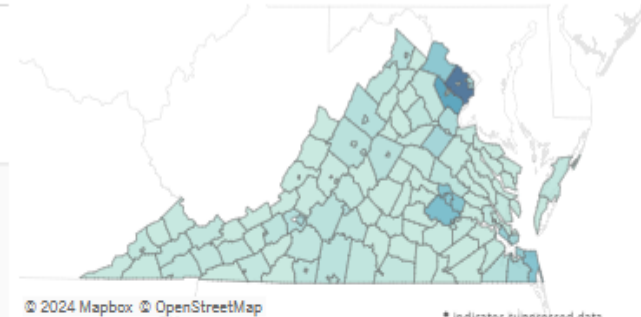
Program

(All)

Eligibility Categories

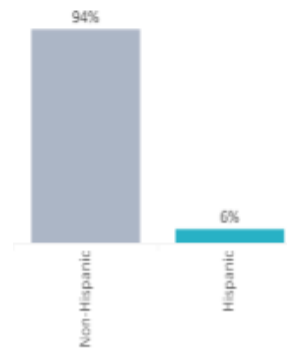


Virginia Localities

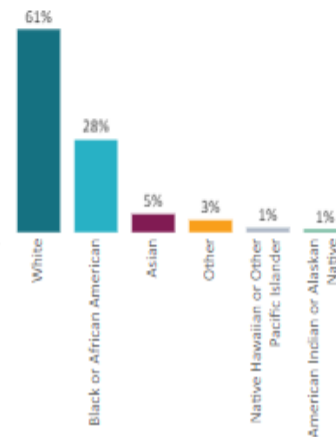


Medicaid
Maternal
Enrollment
dashboard

Ethnicity



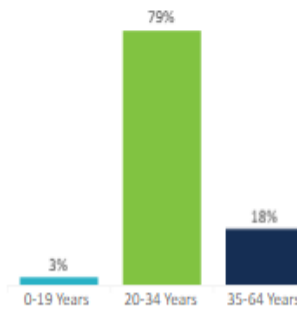
Race



Gender



Age Groups



Program Updates

Workforce

DMAS has 91% staff fill rate and first paid intern cohort started 1/24

Resume Renewal Processing - Unwinding Update

1.8M reviews completed
Auto batch closures began

Change Health Care Breach

Pharmacy Updates and
Provider Engagement

Partnership in Petersburg
Update

Legally Responsible
Individuals

Maternal Health Updates

Virginia Medicaid Maternal Health & Outcomes

Investing in Medicaid maternal health and adopting best evidence-based practices in the perinatal and postpartum period can prevent many of the common causes of pregnancy-related morbidity and improved family and community health

- Pregnancy-related morbidity disparities are greatest among African American women and women in the Tidewater, and Roanoke/ Alleghany region.
 - Highest pre-term and low-weight babies,
 - Highest Emergency Room (ER) utilization postpartum
- Clinical Focus Areas:
 - Increase Postpartum visits
 - Cardiac health for Pregnant Women
 - Reduce ER Utilization Postpartum (current rate 15%)
- Actions:
 - Maternal health Roundtable hosted by HHR Secretary
 - National Governor's Association (NGA) Rural Maternal Health Collaborative
 - Cardiovascular disease
 - DMAS maternal health internal workgroup



Virginia Medicaid Overall Birth Outcomes

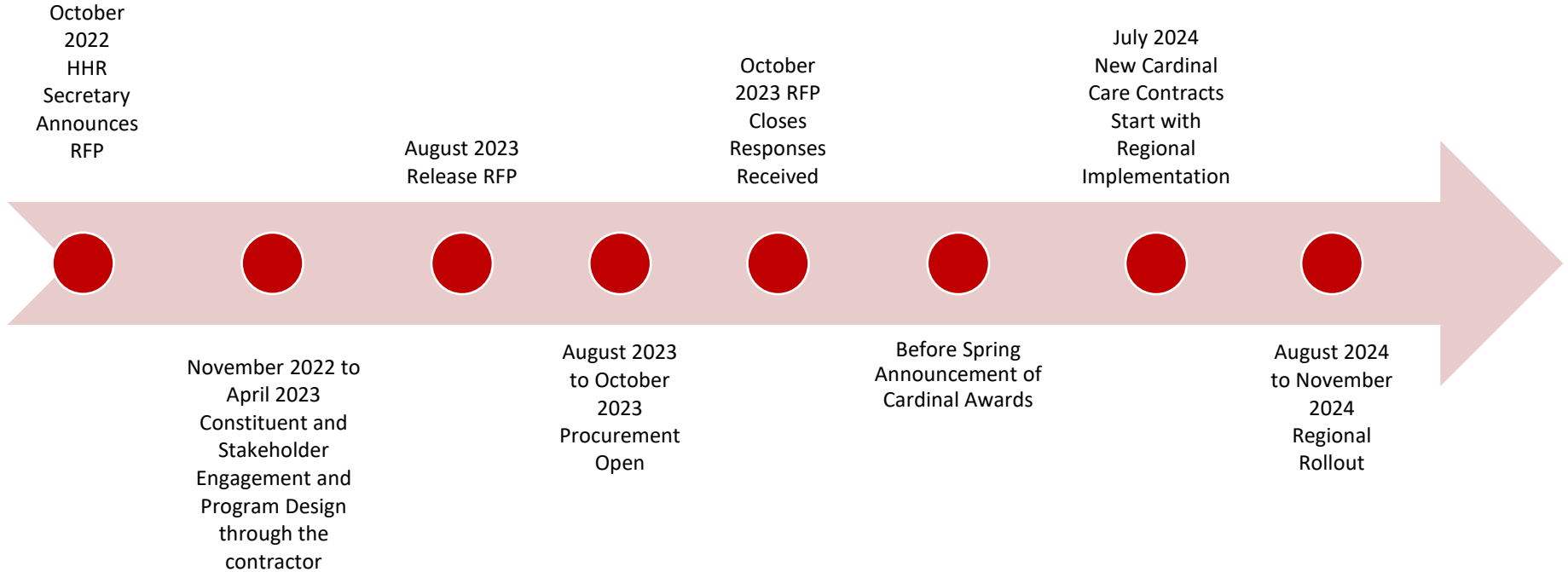
Study Indicator	National Benchmark	Calendar Year 2020		Calendar Year 2021		Calendar Year 2022		Calendar Year 2022**	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Births With Early and Adequate Prenatal Care	76.4%	22,245	71.9%	23,780	72.7%	25,535	72.1%	22,737	74.3%
Births With Inadequate Prenatal Care*	NA	4,651	15.0%	5,106	15.6%	5,454	15.4%	4,211	13.8%
Births With No Prenatal Care*	NA	534	1.7%	685	2.1%	1,072	3.0%	796	2.6%
Preterm Births (<37 Weeks Gestation)*	9.4%	3,168	9.8%	3,327	10.1%	3,446	9.6%	3,076	9.9%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	2,979	9.2%	3,074	9.3%	3,279	9.1%	2,970	9.6%

Cardinal Care Managed Care – Procurement Updates

Cardinal Care Managed Care Background

- The Cardinal Care Managed Care (CCMC) program provides comprehensive health care services for 1.8 million Virginians receiving Medicaid and CHIP through five contracted health plans.
- DMAS is taking a bold approach to improve the program with three steps:
 - Creation of Cardinal Care Managed Care – A consolidation of the two programs formerly known as Commonwealth Coordinated Care Plus and Medallion 4.0
 - Defining the transformation goals for the program
 - Reprourement of the Cardinal Care Managed Care delivery system

Cardinal Care Managed Care Procurement Milestones



Notice of Intent to Award – February 28, 2024

- The Department of Medical Assistance Services (DMAS or Department) has completed its evaluation and negotiations of the proposals received in response to RFP 13330. Records for this solicitation are available for review by participating Offerors/Suppliers.
- The Department intends to award statewide contract(s) for the Cardinal Care Managed Care (CCMC) program to *Aetna Better Health of Virginia, Anthem HealthKeepers Inc., Humana Healthy Horizons of Virginia, Sentara Health Plans, and United Healthcare of the Mid-Atlantic, Inc.*
- In addition, *Anthem HealthKeepers Inc.*, has been selected to administer the Foster Care Specialty Plan (FCSP) statewide program under same contract and the addendum for this scope of work will be incorporated into their contract.
- Requests for procurement records by participating Offerors/Suppliers shall be sent to the procurement office at RFP13330@dmas.virginia.gov.

DMAS Commitment

Committed to exploring, investing and implementing best practices that fit our Virginia Medicaid members

S
Services for
Members

O
Operations &
Opportunities

A
Accountability

R
Results



Virginia General Assembly Update

Will Frank
*Senior Advisor for Legislative,
Department of Medical
Assistance Services*



DMAS Legislative Role

1. Monitor introduced legislation
2. Review legislation and budget language for Secretary and Governor
3. Make position recommendations to Secretary and Governor
4. Communicate Governor's positions to General Assembly
5. Provide expert testimony and technical assistance to legislators on legislation

2024 GA Session Stats

- 2,852 bills introduced.
- DMAS was assigned 38 lead bills plus took an active role in key legislation led by other agencies
- These included bills with Amend, No Position, and Oppose positions.
- Major topics include:
 - New Medicaid benefits
 - Changes to rules for paid family caregivers (legally responsible adults)
 - Eligibility changes for waiver recipients
 - Pharmacy benefit changes

New Benefit Proposals

Comprehensive Children's Coverage

Community Health Workers

Violence Prevention Services

Remote Fetal Monitoring

Brain Injury Services

Human Donor Breast Milk

Adult Hearing Screenings

Fertility Preservation

PANS/PANDAS Services

Essential Hygiene Services

Legally Responsible Adults

- Legislation introduced in the House and the Senate to change specific provisions of DMAS's approved plans to continue paying Legally Responsible Individuals who provide personal care to their children
 - Allows 40 hours per member if there are two members in the household
 - LRI to provide services without proof of no other provider
 - Another parent can be employer of record
 - LRI is eligible for respite services
- HB909 and SB488, which passed the General Assembly requires DMAS to allow the above services except for respite, but study and submit a report on allowing respite.

Pharmacy Legislation

- Legislation and Budget Amendments were introduced proposing changes to drug costs and purchasing
 - State-wide centralized pharmacy purchasing
 - Pharmacy carve-out from managed care
 - Prescription Drug Affordability Board
 - Changing payment structure for long-acting injectables (LAI)
- Of these proposals, only the Prescription Drug Affordability Board passed and had funding in the budget.

Waiver and Screening Bills

- Disregard Social Security Disability Insurance when determining financial eligibility for DD waivers
- Increase the time a DD waiver slot can be retained from 150 days to up to 365 days
- Greater flexibility for nursing facilities and PACE programs to conduct LTSS screenings in specific circumstances

Other Legislation

- Bill to require timeliness of lien settlements when DMAS has a claim for reimbursement against the settlement of a member (when they are injured and the settlement covers their medical costs)
- Bill creating a new provider type – behavioral health technicians and behavioral health technician assistants – would enable DMAS to potentially include these provider types in redesigned behavioral health services

Questions

Thank you

Will Frank- will.frank@dmas.virginia.gov

Nursing Facility VBP - Overview

- The Nursing Facility Value-Based Purchasing Program (NF VBP) program incentivizes Nursing Facilities (NFs) to improve quality of care
- Established by the General Assembly in 2021, DMAS administers this program in collaboration with contracting Managed Care Organizations (MCOs)
- 265 NFs participate, serving close to 19,000 Medicaid members each month
- For the 2024-2025 period, approximately \$144M will be distributed to NFs for achievement and/or improvement on the following quality measures:

Staffing

- Days Without Minimum RN Hours
- Total Nurse Staffing (Case-Mix Adjusted)

Avoidance of Events for Long-stay Residents

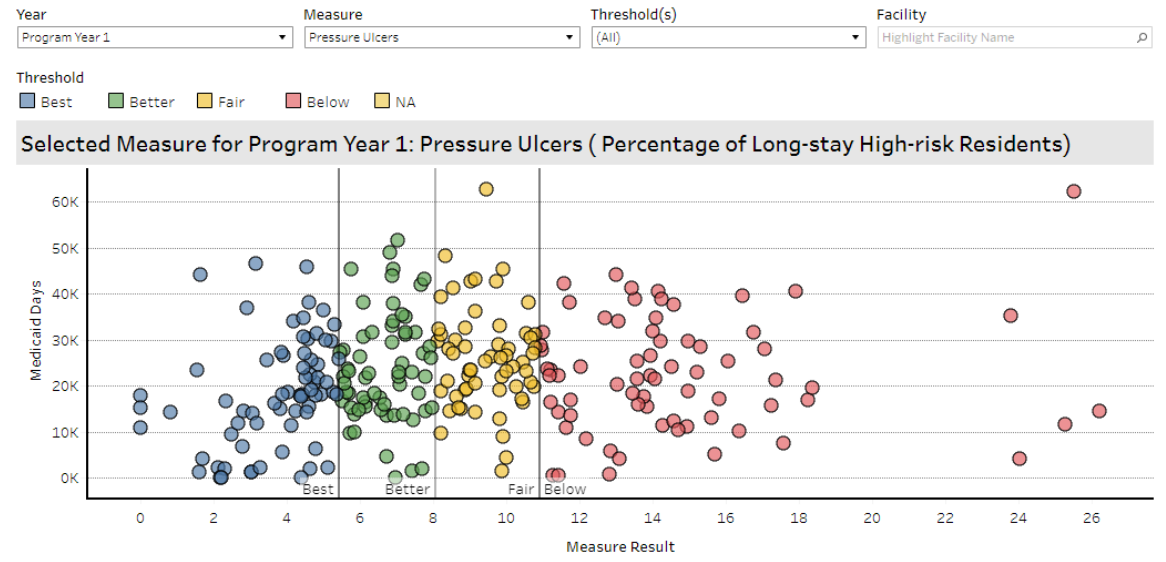
- # Hospitalizations / 1,000 Resident Days
- # ED Visits / 1,000 Resident Days
- # High-Risk Residents with Pressure Ulcers
- # Residents with a Urinary Tract Infection

Monitoring

Facility Report Card (illustrative)

Total Possible Performance Payment	Total Attainment and Improvement Payment	Performance Attainment Payment	Improvement Payment			
\$361,414	\$207,992	\$180,707	\$27,285			
Total Payment 1:		\$207,972				
Measure	Program Year Name (Baseline Year, Program Y..)	Threshold Met (Below, Fair, Better, Best)	Measure Result	Attainment Payment	Improvement Payment	Total Performance Payment
Days without 8 RN Hours	Program Year 1	Best	3.00	\$42,880	\$0	\$42,880
Pressure Ulcers	Program Year 1	Best	4.84	\$49,005	\$23,807	\$72,813
Urinary Tract Infection	Program Year 1	Fair	3.38	\$24,503	\$3,477	\$27,980
Weighted Case Mix Hours	Program Year 1	Better	3.30	\$64,320	\$0	\$64,320
Total Payment 2:		\$20				
Measure	Program Year Name (Baseline Year, Program Y..)	Threshold Met (Below, Fair, Better, Best)	Measure Result	Attainment Payment	Improvement Payment	Total Performance Payment
ED Visits	Program Year 1	Below	0.98	\$0	\$0	\$0
Hospitalizations	Program Year 1	Below	2.96	\$0	\$0	\$0

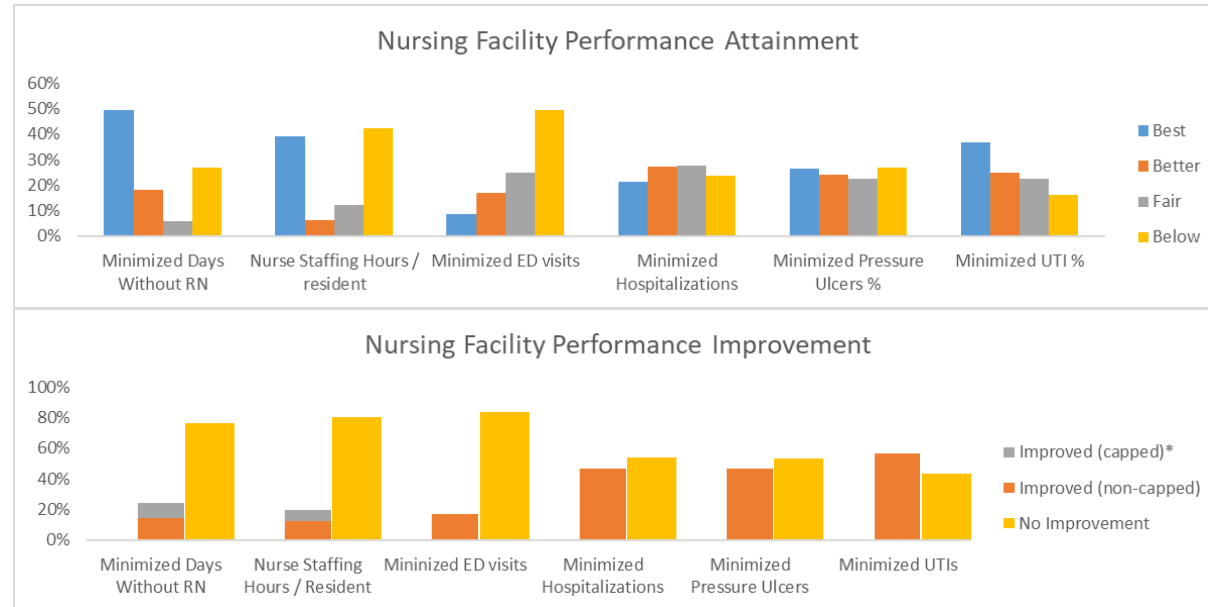
Overall achievement (example)



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

Results (2022 Measurement Year)

- 97% of NFs were awarded an attainment payment and/or improvement payment (total payments averaged \$231K / NF)
- NFs performed most strongly on minimizing days without RNs, UTIs and pressure ulcers; minimizing ED visits was most challenging to NFs



* Facilities receiving a Best designation at baseline for staffing measures were not eligible to receive an Improvement payment



Finance Update

Truman Horwitz, Budget Division Director



Overview

- Expenditure comparison
- Enrollment comparison
- Tracking to the forecast

Expenditure Comparison

In Millions

Five Year Look-back (Through January)

Expenditures	Actuals Through January					FY24 vs FY23	
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	Change	% Change
Cardinal Acute	2,474	2,949	3,482	4,003	3,885	(118)	-2.9%
Cardinal LTSS	2,985	3,516	3,929	4,371	4,120	(250)	-5.7%
Fee-For-service: General Medicare	940	890	950	1,069	1,163	94	8.8%
Fee-For-service: BH & Rehabilitative	31	33	26	24	39	15	61.8%
Fee-For-service: Long-Term Care Services	879	867	989	1,289	1,393	103	8.0%
Hospital Supplemental (DSH, IME/GME, Dx)	287	264	425	443	422	(20)	-4.6%
Hospital Rate Assessment Payments	528	747	913	1,220	1,330	110	9.0%
Pharmacy Rebates ¹	(256)	(211)	(122)	(245)	(173)	71	-29.1%
Title XIX Total	7,867	9,055	10,590	12,173	12,178	5	0.0%
Fund Type							
General	2,749	2,475	4,077	3,041	3,016	(24)	-0.8%
Coverage Assessment	116	212	269	329	397	68	20.6%
Rate Assessment	194	209	242	325	395	70	21.6%
VA Health Care Fund	211	312	365	406	406	(0)	0.0%
Federal	4,597	5,847	5,637	8,073	7,964	(109)	-1.3%
Total	7,867	9,055	10,590	12,173	12,178	5	0.0%

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Reimbursement							21.6%
VA Health							0.0%
							-1.3%
							0.0%

FY24 will continue to trend lower due to the accelerated capitation payment into FY23 (July to June) to save general funds at a favorable FMAP. **FY24 will have a total of 11 capitation payments; normal years have 12.**

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

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This FY24 number includes CSA cases that are typically not included in this report.

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Primarily driven by DD Waiver slots added in FY24.

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Accelerated Q1FY24 payments into Q4FY23 to save general funds at a favorable FMAP.

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Increased Upper Payment Limit and Medicaid Expansion population over FY23.

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Expenditures	Actuals Through January					FY24 vs FY23	
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	Change	% Change
Cardinal Acute	2,474	2,949	3,482	4,003	3,885	(118)	-2.9%
Cardinal LTSS	2,985	3,516	3,929	4,371	4,120	(250)	-5.7%
Fee-For-service: General Medicare	940	890	950	1,069	1,163	94	8.8%
Fee-For-service: BH & Rehabilitative	31	33	26	24	39	15	61.8%
Fee-For-service: Long-Term Care Services	879	867	989	1,289	1,393	103	8.0%
Hospital Supplemental (DSH, IME/GME, Dx)	287	264	425	443	422	(20)	-4.6%
Hospital Rate Assessment Payments	528	747	913	1,220	1,330	110	9.0%
Pharmacy Rebates ¹	(256)	(211)	(122)	(245)	(173)	71	-29.1%
Title XIX Total	7,867	9,055	10,590	12,173	12,178	5	0.0%
Fund Type							
General	2,749	2,475	4,077	3,041	3,016	(24)	-0.8%
Coverage Assessment							20.6%
Rate Assessment							21.6%
VA Health Care Fund	211	312	365	406	406	(0)	0.0%
Federal	4,597	5,847	5,637	8,073	7,964	(109)	-1.3%
Total	7,867	9,055	10,590	12,173	12,178	5	0.0%

Due to timing, FY24's number reflects only one month of Pharmacy Rebates.

Expenditure Comparison

In Millions

Five Year Look-back (Through January)

Expenditures	Actuals Through January					FY24 vs FY23	
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	Change	% Change
Cardinal Acute	2,474	2,949	3,482	4,003	3,885	(118)	-2.9%
Cardinal LTSS	2,985	3,516	3,929	4,371	4,120	(250)	-5.7%
Fee-For-service: General Medicare	940	890	950	1,069	1,163	94	8.8%
Fee-For-service: BH & Rehabilitative	31	33	26	24	39	15	61.8%
Fee-For-service: Long-Term Care Services					93	103	8.0%
Hospital Supplemental (DSH, IME/GME, Dx)					22	(20)	-4.6%
Hospital Rate Assessment Payments	528	747	913	1,220	1,330	110	9.0%
Pharmacy Rebates ¹	(256)	(211)	(122)	(245)	(173)	71	-29.1%
Title XIX Total	7,867	9,055	10,590	12,173	12,178	5	0.0%
Fund Type							
General	2,749	2,475	4,077	3,041	3,016	(24)	-0.8%
Coverage Assessment	116	212	269	329	397	68	20.6%
Rate Assessment	194	209	242	325	395	70	21.6%
VA Health Care Fund	211	312	365	406	406	(0)	0.0%
Federal	4,597	5,847	5,637	8,073	7,964	(109)	-1.3%
Total	7,867	9,055	10,590	12,173	12,178	5	0.0%

Increased Medicaid Expansion Enrollment and Increased UPL

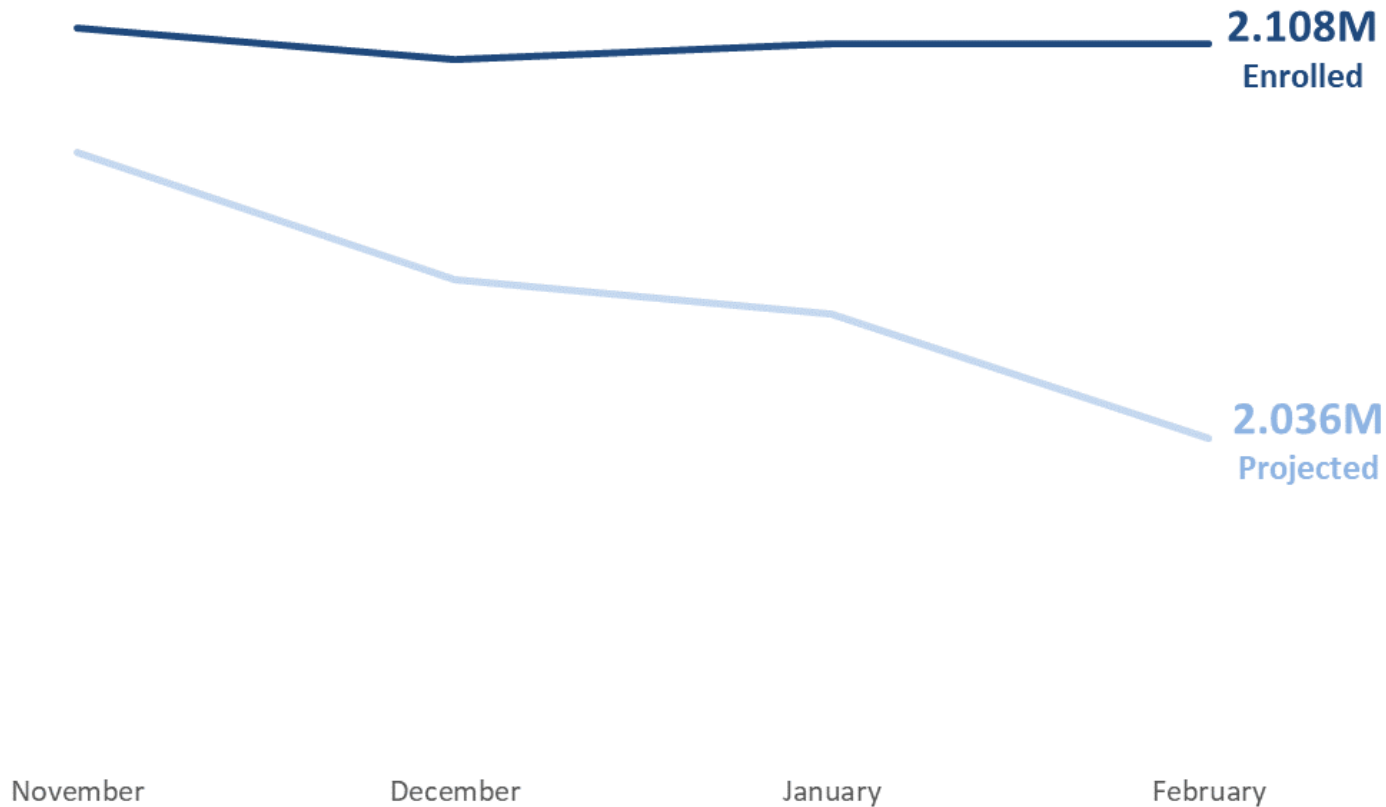
Expenditure Comparison – Another way to Look at the Data

In Millions

FY 2024 Compared Against the Forecast

Expenditures	YTD FY 2024	YTD Jan Forecast	Variance	Comments
Cardinal Acute	3,884.7	3,834.1	1.3%	On target for January
Cardinal LTSS	4,120.2	4,169.3	-1.2%	On target for January
Fee-For-service: General Medicare	1,162.8	1,161.1	0.1%	On target for January
Fee-For-service: BH & Rehabilitative	38.9	25.6	52.0%	CSA Issue from Prior Slide
Fee-For-service: Long-Term Care Services	1,392.7	1,388.5	0.3%	On target for January
Hospital Supplemental (DSH, IME/GME, Dx)	422.1	396.0	6.6%	Cost settlement for IME/GME/DSH for FY22 UVA and VCU
Hospital Rate Assessment Payments	1,329.7	1,438.9	-7.6%	Increased MedEx enrollment; More Coverage Assessment, less Rate Assessment
Pharmacy Rebates	(173.3)	(248.4)	-30.2%	Timing issue from Prior Slide
Title XIX Total	12,177.7	12,165.1	0.1%	
Fund Type				
General	3,016.5	3,100.0	-2.7%	
Coverage Assessment	396.6	382.3	3.7%	
Rate Assessment	394.8	416.4	-5.2%	
VA Health Care Fund	405.6	405.6	0.0%	
Federal	7,964.2	7,860.8	1.3%	
Total	12,177.7	12,165.1	0.1%	

One Final Note—Enrollment



- Financial data shows DMAS is ‘on track’ or ‘slightly below’ spending target
- But number of children and returning Expansion non-caretaker adults are greater than expected:
 - Children: CMS changed rules on determining household vs. individuals in September, increasing enrollment
 - Expansion Non-Caretaker adults: DMAS conducting additional research
- Capitation is paid based on the **prior month’s** enrollment, so divergence will not begin to show until February’s financial data
- DMAS is taking steps to ensure that funding is available in FY24, alerted Administration and GA that FY25 and FY26 expenditures will likely be higher due to increased enrollment

Summary

- Financial Data through January is tracking to the Forecast.
- The agency is monitoring enrollment and taking steps to ensure we are covered through the year.

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

2024 General Assembly

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

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

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

The project is currently circulating for internal review.

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

- (i) Remove the reference to ophthalmologists on this page of the state plan because these practitioners fall into the "physician services" section of the

state plan. The word “ophthalmologists” has been removed as required by CMS.

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

The SPA project is currently circulating for internal review.

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

2023 General Assembly

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

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

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

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

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

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

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

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

The SPA notes that the exchange will:

“... conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the SBE. The SBE will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a

specific eligibility group, determining cost sharing (if applicable) or assigning a benefit package. These functions will be performed by the single state agency. The SBE also refers individuals to the single state agency for determination if potentially eligible for non-MAGI Medicaid (e.g. ABD or limited coverage) or if potentially eligible for MAGI coverage but the exchange was unable to make a full determination. The SBE will not be handling appeals.” Following internal review, the SPA was submitted to CMS for review on 5/12/23. The SPA was approved on 8/7/23. The corresponding reg project is currently circulating for review.

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

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

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

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

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

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

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

2022 General Assembly

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

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

(03) Medicaid Enterprise System: The purpose of this final exempt regulatory action is to make technical updates to several of the agency's regulations to reflect the Department's transition of several key information management functions handled through the Virginia

Medicaid Management Information System (VAMMIS) to a new technology platform called the Medicaid Enterprise System (MES). The MES replaced the department's VAMMIS on April 4, 2022. The reg project was posted to the Town Hall on 3/7/23 for OAG review.

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

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

(06) PACE (Rates & Payment Methodology): DMAS has revised the state plan to update sections that pertain to the Program of All-Inclusive Care for the Elderly (PACE). Specifically, this SPA (1) incorporates the Rates and Payments language from the Center for Medicare & Medicaid Services' (CMS') most current PACE State Plan Amendment Pre-Print and (2) updates the PACE Medicaid capitation rate methodology to align with DMAS' current rate setting practices. DMAS has transitioned from fee-for-service data to managed care encounter data for development of the amount that would otherwise have been paid. The PACE program will continue to operate in the same way that is has based on regulations in the Virginia Administrative Code, and there will be no changes for providers as a result of this SPA. Following internal DMAS review, the SPA was submitted to CMS on 3/3/22. The SPA was approved by CMS on 4/26/22. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 6/29/22; to DPB on 10/13/22; and to the HHR on 11/16/22.

2021 General Assembly

(01) Mental Health and Substance Use Case Management: These regulation changes remove the limit on substance use case management for individuals in IMDs are to comply with the Medicaid Mental Health Parity Rule. The federal Mental Health Parity regulation can be found in 42 CFR 438.910(b)(1). Specifying that reimbursement is allowed, provided two conditions are met, for mental health and substance use case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in IMDs and individuals of any age who are inmates of public

institutions, aligns DMAS regulations with 42 CFR 411.18(a)(8)(vii) and documents the Department's existing practices. Clarifying ISP review timeframes and grace periods, and clarifying CSAC-Supervisees can bill for substance use case management services, document existing DMAS practices, rather than changes in practices. Following internal review, the project was submitted to the OAG on 1/13/22. DMAS received OAG inquiries on 1/19/22 and responded to those on 1/27/22. The regulatory action was approved by the OAG on 2/23/22 and was forwarded to DPB for review on 2/24/22. The project was forwarded to HHR on 4/5/22.

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

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

***(04) Consumer-Directed Attendants:** This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer-directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the

project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. DMAS reached out to the OAG to re-engage this project. The OAG sent additional revisions/questions on 9/12/22. DMAS forwarded responses to the OAG on 11/9/22. The OAG sent a request for additional edits on 12/6/22. DMAS coordinated the responses and submitted them to the OAG on 12/21/22. The OAG forwarded additional questions on 1/9/23. DMAS had placed the project on hold to review General Assembly outcomes to determine if pending legislation (SB 886) would impact this regulation. Edits were made to the project and the regulatory action was re-submitted for OAG review on 7/26/23. Additional edits were sent to the OAG on 9/28/23 and 10/25/23. The project was submitted to DPB on 11/9/23. A conf. call w/ DPB was held on 12/5/23. DMAS submitted follow-up info to DPB on 12/7/23. DPB requested additional info on 12/8/23 and DMAS forwarded responses on 12/13/23, 12/15/23, and 12/18/23. The project was approved by DPB on 12/19/23. HHR is currently reviewing the regulations.

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

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

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

action was circulated for internal review and submitted to the OAG on 8/26/21. The project was re-submitted to the OAG for review on 8/11/22.

(08) Adult Dental: The purpose of this SPA is to align with Item 313.III in the 2020 Virginia Appropriations Act, which requires DMAS to provide a comprehensive dental benefit to adults, effective July 1, 2021. The DPB and Tribal Programs notifications were forwarded on 2/22/21. The SPA was submitted to CMS on 3/25/21. The SPA was approved on 6/14/21, with an effective date of 7/1/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 6/23/21.

2020 General Assembly

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

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

(03) 2020 Long Term Services and Supports (LTSS) Screening Changes: For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in

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

2017 General Assembly

(01) CCC Plus WAIVER: DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and

additional inquiries on 2/22/18, 3/19/18, 4/10/18, and 5/16/18. The regs were approved by the OAG and forwarded to the Governor's Ofc. for review on 6/19/18. The emergency regulations were signed by Governor and became effective on 6/29/18 and published in the Register on 7/23/18. The NOIRA comment period was held between 7/23/18 - 8/22/18. An ER Extension request was submitted on 10/16/18, and the ER was extended through 6/28/20. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21; to DPB on 12/6/21; to HHR on 1/19/22; and to the Governor's Ofc. on 6/1/22. Following approval from the Gov. Ofc., the project was submitted to the Registrar on 11/2/22 and was published in the Register on 12/5/22. Following the internal review of the final stage phase of the project, the regulations were submitted to DPB on 7/18/23 and to HHR on 8/7/23.

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