DRAFT MINUTES
Tuesday, March 11, 2025
10:00 AM

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

Present: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore

Present Virtually: Ashish Kachru, Dr. Jeffrey Rich

DMAS Attendees: Cheryl Roberts-DMAS Director, Jeff Lunardi - Chief Deputy, Adrienne Fegans -Deputy for Programs, Sarah Hatton – Deputy for Administration, Chris Gordon-Deputy for Finance, Ivory Banks – Chief of Staff, Rich Rosendahl- Deputy for Health Economics and Economic Policy, Truman Horwitz, Director of Budget, Emily McClellan, Morgan Greer, Board counsel and Brooke Barlow, Board Secretary.

Other In-Person Attendees: Scott Johnson, Alan Fowler, Beth Frank, Dan Plain, Latimat Laatey, Divya Balaji, Ethan Johnson, Emily Roller, Jason Rachel.

Virtual Attendees: John Kissel-Deputy for Technology & Innovation , Charlotte Arbogast, Jesse Bea, Dan Blitz, Cindi Jones, Dominique McKenzie, Karen Dunaway, Gaynor Ferrell, Karla Hrobowski, Terry Hurley, Karen Cameron, Karen Kimsey, Katie Boyle, Emily Lafon, Nicole Lawter, Meredith Lee, LeVar Bowers, Roshni Manjunatha, Maureen Hollowell, Fatima McCasland, Michael Cook, Mike Tweedy, Sevda Nixon, Patrick Finnerty, Cat Pelletier, William Phipps, Rima Forrest, Karin Roth, Sarah Craddock, Aylin Shamp, Steve Ford, Katrina Stokes, Vanessa Lane, Justin Zakia.

1. Call to Order

Jason Brewster, Co-Chair, called to open the regular meeting of the Board of Medical Assistance Services at 10:02 am on March 111, 2025, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

2. Introduction of New Board Members

Cheryl Roberts, Director, welcomed new member Dr. Jeffrey Rich to the Board. Dr. Rich was present virtually and introduced himself to the Board.

3. Election of Officers

Morgan Greer, Board Counsel, called for the Board to nominate a Chair.

Jason Brewster moved to nominate himself as Chair.
Motion 8-0
Voting for: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None

Morgan Greer, Board Counsel, called for the Board to nominate a Co-Chair.

Basim Khan moved to nominate himself as Co-Chair.
Motion 8-0
Voting For: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None

Morgan Greer, Board Counsel, called for the Board to nominate a Secretary.
Jason Brewster nominated Brooke Barlow as Board Secretary.
Motion 8-0
Voting For: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None

4. Approval of Minutes

The minutes from the December 10, 2024, meeting were introduced and approved.

Moved by Bernie Boone; seconded by Jennifer Clarke to Approve Motion Passed: 8 - 0
Voting For: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None

5. Director's Report

Director Roberts presented to the Board an overview of Medicaid program updates which included updates on Dental (Cardinal Care Smiles), Behavioral Health (Governor's Right Help, Right Now), Department of Justice Settlement update, Maternal and Child Health updates and Program Integrity update.

Director Roberts also notified the Board of upcoming meetings at DMAS and encouraged all Board members to attend the meetings.

6. Virginia General Assembly Update

Chief Deputy Jeff Lunardi provided the Board with an overview of DMAS Legislative Role, 2025 GA Statistics and a recap of the 2025 Legislation and Budget Amendments.

7. Budget Update

Truman Horwitz, Budget Division Director presented Budget updates. A summary was provided that spending is on track to that Forecast and DMAS has several dates to anticipate, March 14 and May 30th.

8. Regulations

The Board was provided with updated Regulatory activity.

9. Adjournment

Moved by Vienne Murray; seconded by Jennifer Clarke to Adjourn 11:13 am.
Motion: 8 - 0
Voting For: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jennifer Clarke, Jason Brewster, Margaret Roomsburg, Paul Hogan, Joye Moore
Voting Against: None

CardinalCare
Virginia's Medicaid Program

Board of Medical Assistance Services Director's Update

Cheryl J. Roberts, J.D., DMAS Director

September 30, 2025

DMAS

Who do we cover?

1,841,200 Virginians

Base (~50/50)

Children
523,692

Adults
- Older Adults: *150,860*
- Caretaker: *116,808*

Individuals with Disabilities
90,171

Pregnant Women
30,120

FAMIS/ CHIP (~67/33)

Children
183,994

Pregnant Women
10,263

Expansion (90/10)

Parent Adults
119,936

Adults
485,529

Plus 179,294 with Limited Benefits

How We Care for Virginians

Cardinal Care Managed Care (CCMC) is DMAS's program name for the managed care delivery system.

aetna®
Aetna Better Health® of Virginia

Anthem
HealthKeepers Plus
Offered by HealthKeepers, Inc.

Humana®

Sentara® Health Plans

United Healthcare

CELEBRATING 60 YEARS OF MEDICAID: A LEGACY OF CARE!

Celebrating 60 Years of Medicaid

EST. 1965

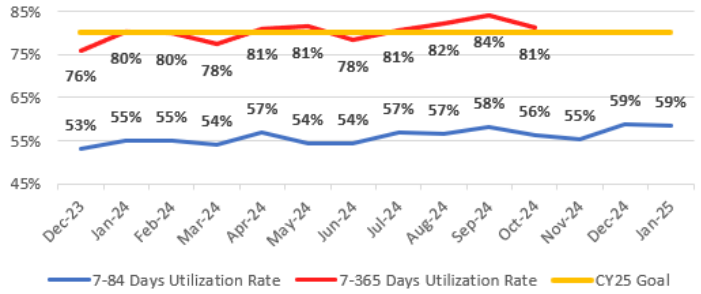
CardinalCare
Virginia's Medicaid Program

Our mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

Celebrating 60 Years of Medicaid!!!

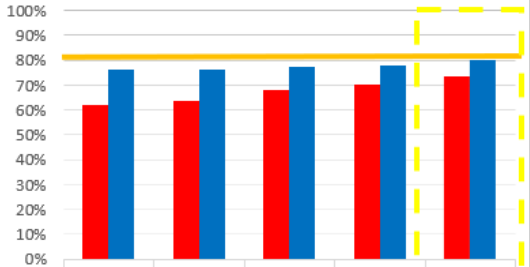
Objectives and Key Results – October 2025

Monthly Postpartum Rates



- Percent of women delivering a live birth who receive postpartum care (DMAS's internal metric)
- Medical claim lag on 12-month postpartum data results in delayed results for 7–365-day rate

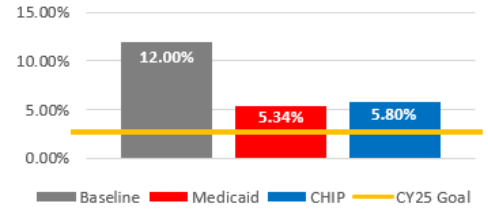
Postpartum Rates by HEDIS Measurement Year



	MY19	MY20	MY21	MY22	MY23
Virginia	61.8%	63.4%	68.1%	70.4%	73.7%
National 50th Percentile	76.4%	76.4%	77.4%	78.1%	80.2%

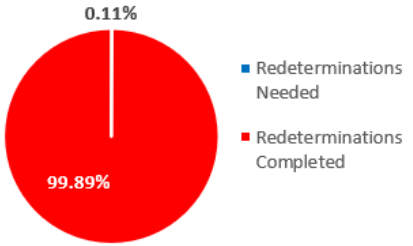
- Percent of women delivering a live birth who receive postpartum care (CMS's annual metric; includes medical record audit)
- Virginia's increase from MY19 to MY23 much greater than national average change
- Increased nearly 12 percentage points since MY19

Payment Error Rate for Medicaid (PERM) and CHIP Due to Eligibility Component of Audit

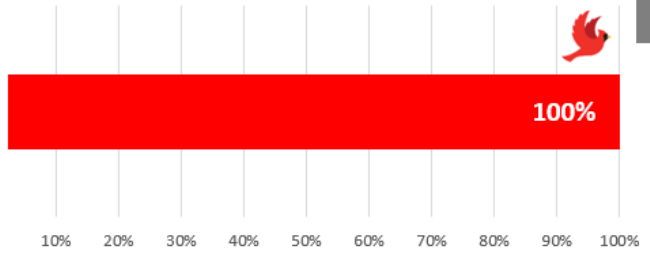


Next PERM audit report to be released November 2025

Unwinding Progress



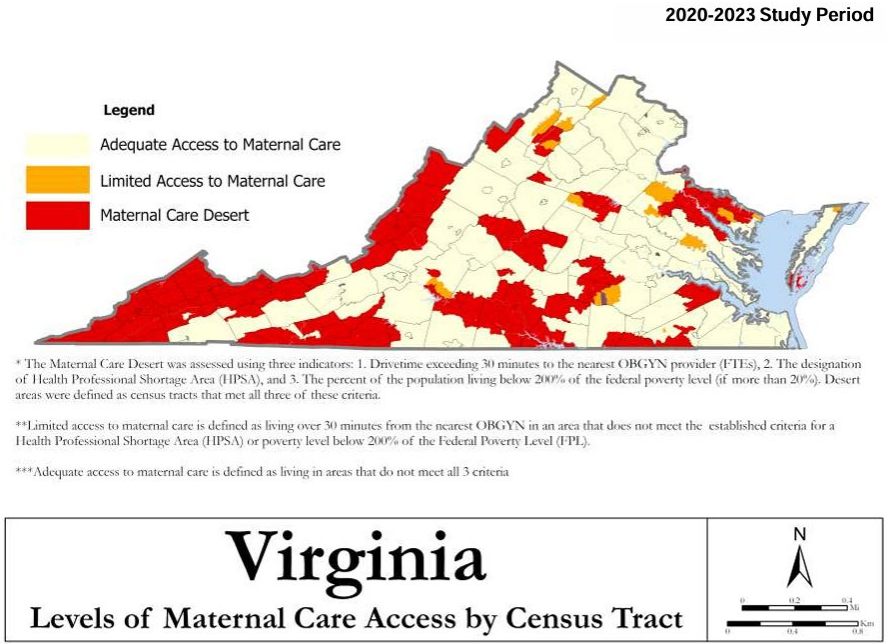
Medicaid Managed Care Procurement



- Successful Go Live on 7/1
- All implementation work is complete

Maternity Care Deserts

- Maternity care deserts are typically defined as counties where there are no hospitals or birth centers offering obstetric care and no obstetric providers.
- DMAS/MCO Maternal workgroup as part of Governor's Executive Directive 11.
- HHR Maternal Health Data Task Force met on August 22 and September 24, 2025
- DMAS established Medicaid Maternity Council and MCO task force
- DMAS and VDH were selected to participate in a technical assistance opportunity from the National Association of State Health Policymakers (NASHP) to address the issue of maternity care deserts in Virginia
- Approved Budget Item 292.UU Maternal Mobile Clinics Pilot Program



CardinalCare
Virginia's Medicaid Program

Cardinal Care

DMAS


Cheryl Roberts
For Leading Team DMAS
to a Cardinal Care Win

WE ARE LIVE!


CardinalCare
CardinalCare

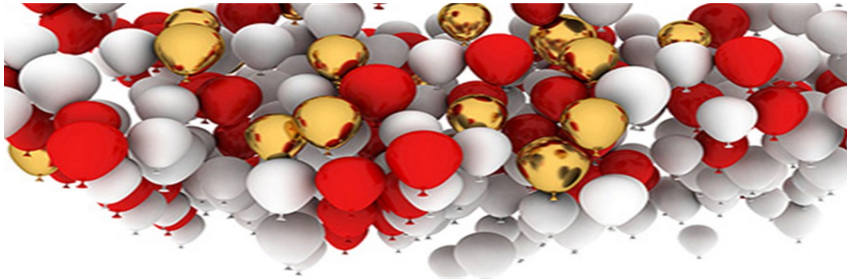
Top Goals of Cardinal Care Managed Care program

At the heart of Virginia's Medicaid system, Cardinal Care Managed Care empowers a member-first approach – ensuring care is not only accessible, but personalized and connected.

1. Ensure Medicaid members have appropriate access to quality health care through the contracted managed care plans
2. Focus on expanding behavioral health services and improving access as part of the *Right Help, Right Now* initiative
3. Improve maternal and child health outcomes through targeted initiatives across Commonwealth
4. Provide children and youth in foster care with a dedicated health plan
5. Enhance access to appropriate services, supports and settings for members receiving Long Term Services and supports (LTSS)
6. Drive innovation and operational excellence with a focus on data analytics
7. Increase MCO reporting , compliance and oversight

Virginia launched Cardinal Care Managed Care on July 1, 2025, advancing its Medicaid program.

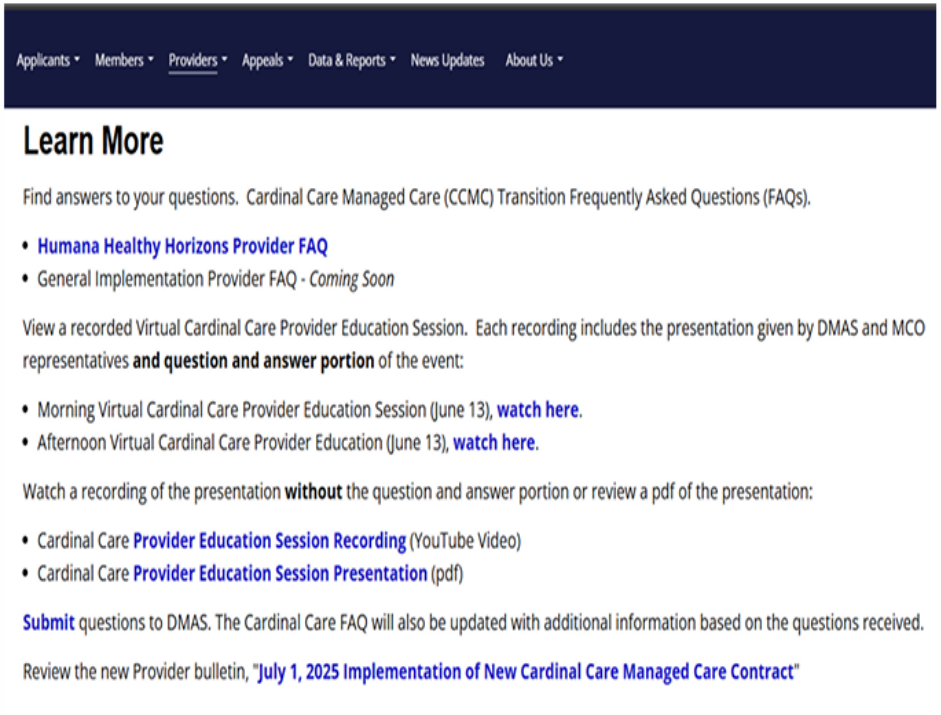
- Transitioned 1.7 million members into the program
- CCMC provided new plan initiatives and enhanced services
- Humana Healthy Horizons of Virginia is CCMC's new MCO.
- Molina members were automatically transitioned to Humana Healthy Horizons of Virginia on July 1, 2025
- Children and Youth in foster care are served in a single statewide Foster Care Specialty Plan (FCSP) through Anthem HealthKeepers Plus
- Members may change their health plan for any reason until September 30,2025. Then begins regional open enrollment

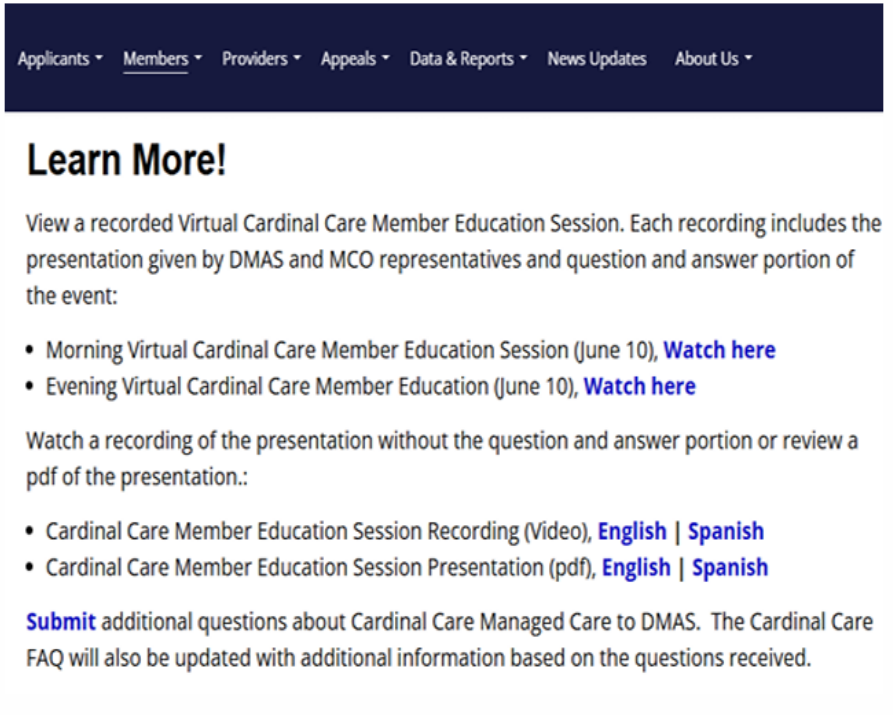


CardinalCare
Virginia's Medicaid Program

aetna Aetna Better Health® of Virginia | Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. | Humana Healthy Horizons | Sentara Health Plans | United Healthcare

New CCMC Implementation – Provider and Member Supports





Cardinal Care Managed Care

Cardinal Care Managed Care serves as the platform for a more person-centered, efficient, and accountable Medicaid delivery system in Virginia

CardinalCare
Virginia's Medicaid Program

Federal Policy Actions
H.R.1 – One Big Beautiful Bill Act (OBBBA)

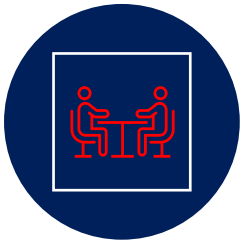
DMAS

H.R.1 – One Big Beautiful Bill Act (OBBBA)

H.R. 1, the "One Big Beautiful Bill Act (OBBBA)", became law on July 4, 2025.

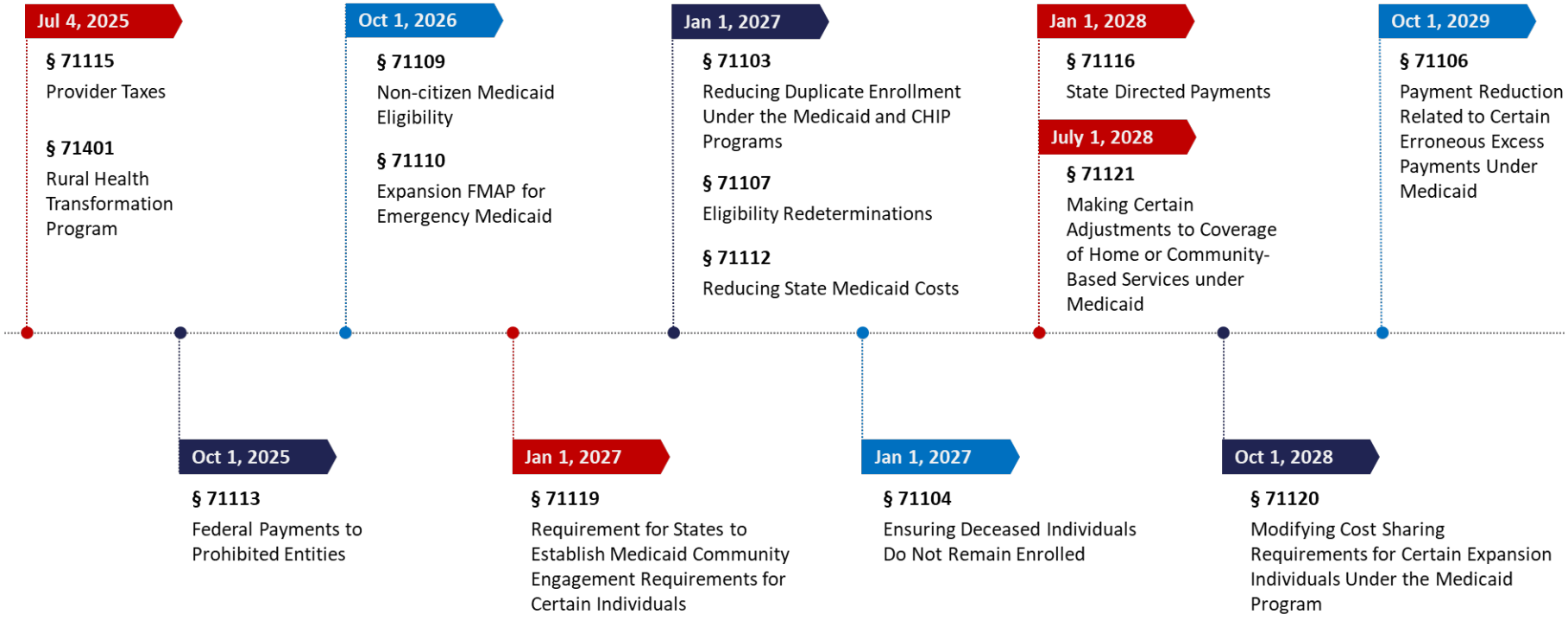
CMS implementation guidance will be forthcoming; Virginia-specific impacts will depend on guidance and directives.

Implementation of Medicaid provisions will be a collaboration with input from the Governor's Office, the General Assembly, and federal partners.



Multiple collaborations will be needed to meet HR1 requirements.

H.R.1 – OBBBA Timeline



Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Subpart A Reducing Fraud and Improving Enrollment Process

Criteria for Expansion Only, and All Populations

- **Frequency of Expansion Eligibility Redeterminations** (Section 71107)
  - Effective January 1, 2027
  - Requires a redetermination for Expansion enrolled individuals to occur every six months; currently redeterminations occur on an annual basis
  - Governor's Executive Directive directs Secretary of HHR to work with stakeholders and leverage best practices in implementation

- **Concurrent Enrollment & Deceased Individuals** (Section 71104, 71105)
  - Effective January 1, 2027/January 1, 2028
  - Requires states to obtain enrollee address information using reliable data sources
  - Requires states to review the Death Master File quarterly to identify deceased individuals

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Subpart A Reducing Fraud and Improving Enrollment Process

All Populations

- **Immigrant Eligibility and Federal Match** (Section 71109-77110)
  - Effective October 1, 2026
  - Narrows the definition of qualified alien from current law
  - Payments for services for an emergency medical condition furnished to an individual eligible for Expansion except for their citizenship status shall be limited to 50% federal match; currently 90%
  - Operational impacts to systems and general fund impact due to match reduction

- **Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid** (Section 71109-77110)
  - Effective October 1, 2029
  - Pending CMS guidance, intent is to allow recoupment of erroneous payments beyond current Payment Error Rate Measure (PERM)
  - Errors include payments made on behalf of ineligible individuals and when there is insufficient documentation to support eligibility
  - The 3% error rate threshold applies to any audits conducted by the federal Secretary of Health and Human Services (HHS) and, at the Secretary's option, audits conducted by the state

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Subpart B Preventing Wasteful Spending and Subpart C Stopping Abusive Financing Practices

- **Retroactive Coverage** (Section 71120)
  - Effective January 1, 2027
  - Limits retroactive coverage to one month for Expansion and two months for all other individuals; current limits are three months for all populations except for CHIP/FAMIS

- **Provider Taxes** (Section 71115)
  - Begins July 1, 2027
  - No impact to Medicaid expansion funding levels in Virginia
  - Virginia will retain three existing provider taxes
    - Coverage assessment (funds state share of Medicaid expansion)
    - Rate assessment (funds hospital supplemental payments)
    - Intermediate Care Facility assessment (funds ICF supplemental payments)
  - Moratorium on submission of new provider taxes effective July, 2025
  - Gradual decline in allowable provider assessments starting July 1, 2027 (from current 6% down to 3.5%)

- **State Directed Payments** (Section 71116)
  - Effective January 1, 2028
  - Supplemental payments above Medicare will be lowered to 100% of Medicare

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Subpart D Increasing Personal Accountability
Expansion Only

- **Community Engagement and Work Requirements** (Section 71119)
  - Effective December 31, 2026
  - Requires individuals applying for or enrolled in Expansion to participate in a qualifying activity at least 80 hours per month to be eligible
  - Exempts major groups such as parents and individuals with disabilities
  - Qualifying activities: work, community service, education, or any combination of the above
  - States must verify compliance at application for Medicaid and every six months thereafter

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Subpart D Increasing Personal Accountability

Expansion Only

- **CMS is beginning to work on getting states the guidance that they need**
  - Developing guidance
  - Convening a workgroup of Medicaid directors and staff on implementation (Virginia is engaged)
  - Working with IT vendors on modules that states can use for implementation

- **States have options to consider when planning implementation**
  - Statute provides flexibility for what additional circumstances will temporarily exempt members from the requirements
  - States will make policy decisions, assess verification processes, and plan outreach
  - CMS may entertain implementation delays for good cause (up to one year)

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Subpart D Increasing Personal Accountability (*Expansion Only*) *and* Subchapter E Expanding Access to Care

- **Cost Sharing**
  - Effective October 1, 2028
  - *Requires cost sharing greater than zero for Expansion mem*bers with incomes above 100% of the Federal Poverty Level up to $35 per service
  - Exceptions for: primary care, substance use disorder and mental health, services provided by FQHCs, rural and behavioral health clinics

- **Adjustments to Home or Community Based Services** (Section 71121)
  - Effective July 1, 2028
  - Creates a new standalone 1915(c) waiver that does not require participants to be subject to a determination that, but for the provision of home and community-based services (HCBS), those individuals would require nursing facility or ICF/IDD level of care
  - Payments may not be made under the waiver to third parties for benefits such as health insurance, skills training, and other benefits customary for employees

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

H.R. 1 - Rural Health Transformation Program

Rural Health Transformation Program

- Effective July 4, 2025, Between FY2026 and FY2030, the program will distribute $50 billion, with Virginia eligible for up to $500 million in direct allocations and access to additional competitive grants.

- Governor Glenn Youngkin issued **Executive Directive 12**, requiring Virginia health agencies and partners to **organize a coordinated effort to prepare for these investments** and ensure they are aligned with community priorities while maximizing long-term impact for rural families and providers.

- Virginia's one-time application detailing rural transformation plan to be approved or denied by CMS by December 31, 2025, makes the state eligible for all funding years.

Source: H.R.1 (One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text)

Rural Health Transformation Program *(continued)*

5 strategic goals prioritized by CMS with focus on ***transformation*** and ***innovation*** to improve rural health outcomes

Strategic goals	Activities for funding deployment
"Make Rural America Healthy Again"	Prevention / chronic disease care Behavioral health (mental health, substance abuse disorders)
Sustainable Access	Appropriate care availability Provider payments[1]
Workforce Development	Workforce development
Innovative Care	Innovative care models / payment systems
Tech Innovation	Consumer tech solutions (e.g., AI) Training & technical assistance IT Advances

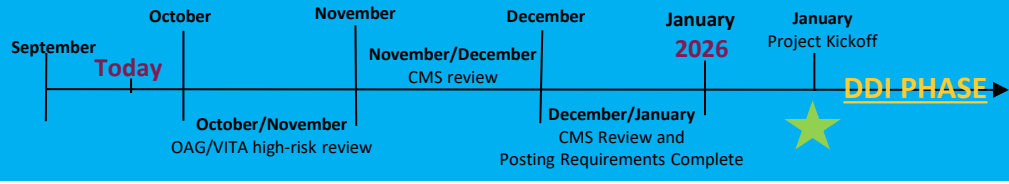
The Secretary of Health and Human Resources facilitated rapid, broad, stakeholder outreach efforts that include:

- 12 On-site listening sessions in rural areas across Virginia.
- Outreach to members of the General Assembly on the development of the Rural Health Transformation Plan.
- A central email address has been established take questions and accept additional input.

RuralTransformation@governor.virginia.gov

Thank You!

Update on FAS



Key Near Term Milestones – Procurement

- **Negotiations:** Over the course of the last several months, DMAS has engaged in negotiations with multiple Suppliers. The Notice of Intent to Award (NOIA) is forthcoming; upon release, information in the procurement file becomes available to participating Suppliers. The procurement file will become available to the public after the Notice of Award (NOA) is posted.
- **High Risk Review:** During the negotiation phase, and after DMAS has made its selection for award, the final Contract will be sent to OAG and VITA in parallel for the required high-risk review. Statutorily, the timeline to complete the review is 30-business days. Any adopted changes to the contract terms from the reviewers must be accepted by both DMAS and the selected Supplier prior to moving forward.
- **CMS Review:** Once the OAG/VITA review is complete and any changes are agreed to by all parties, the final version is sent to CMS for their official review. This is a 60-calendar day review timeline.
- **Project Kickoff:** Upon CMS approval, award posting/notification requirements, and contract signatures by authorized approvers, PMO will begin project kickoff ceremonies and begin executing the project management plan. Estimated to occur by mid-January 2026..

Project Sponsors include Chris Gordon, Adrienne Fegans, and John Kissel.

*PMO estimates a 2.5-year project duration, putting go-live at approximately **July 2028**.*

Design, Development, and Implementation (DDI)

- 90:10 FFP has been used throughout the project's procurement and pre-initiation phases. 90:10 funding will continue until go-live stabilization is achieved.
- PMO has already begun its pre-kickoff processes, including making the required compliance entries in VITA's Commonwealth Technology Portfolio, and authoring the Project Charter. A notional implementation schedule is available and being reviewed. Scope, schedule, cost, risk, and quality management plans are being readied. A communications plan is also being drafted, which incorporates internal and external stakeholder communications, including modality, frequency, and stakeholder influence.
- The Interagency Oversight Committee (IAOC) will be enacted for this project per the Code of Virginia and Commonwealth Project Management Standard. The IAOC includes all business and functional stakeholders of the project, including stakeholders in other agencies, who provide an additional layer of oversight to the project. In addition, CMS and VITA require Independent Verification & Validation (IV&V) support for the project through a third-party (in procurement at 90:10).
- The new FAS will need to be certified by CMS, to occur 6 months after go-live.

CardinalCare
Virginia's Medicaid Program

Redesign of Medicaid Behavioral Health Rehabilitative Services

BMAS September 30, 2025

DBHDS
Virginia Department of Behavioral Health and Developmental Services

RIGHT HELP. RIGHT NOW.
Transforming Behavioral Health Care for Virginians

DMAS

Project Overview

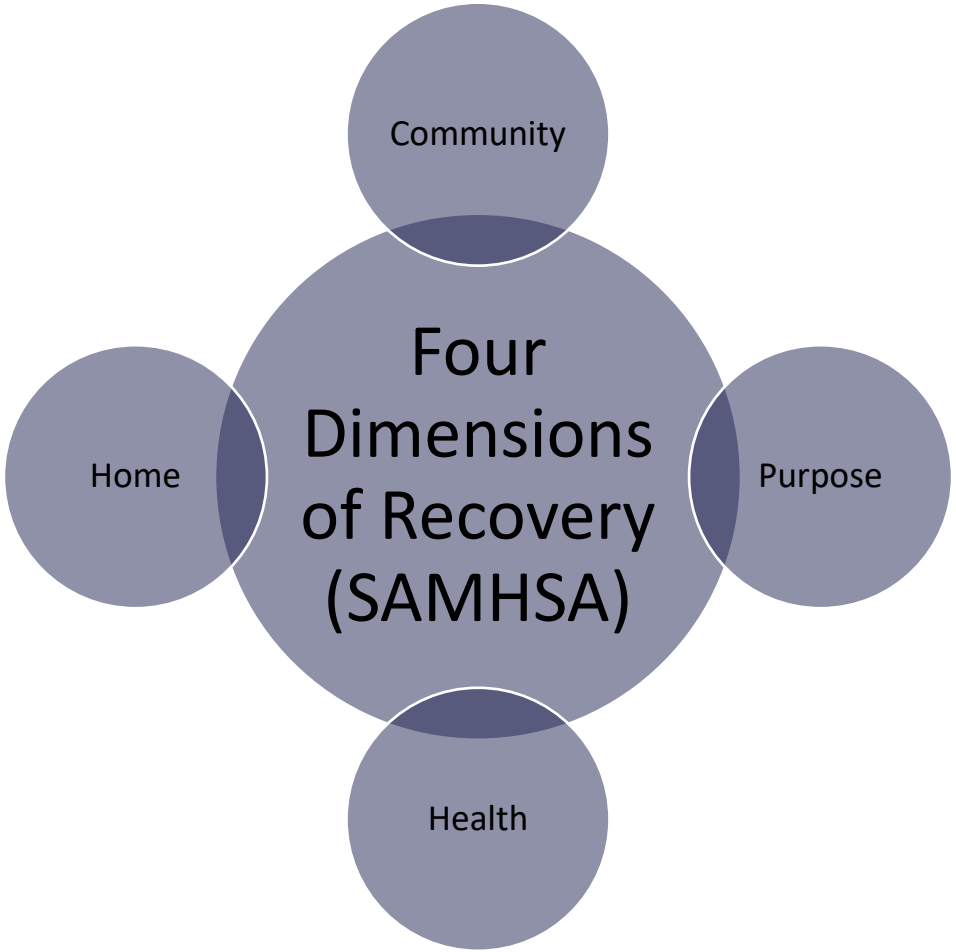
DMAS, in coordination with DBHDS, DHP and DMAS health plans, is employing an integrated and comprehensive approach to address rate, service, and workforce/provider roles for Medicaid over the next two years.

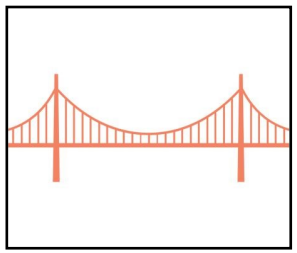
The project seeks to redesign DMAS' youth and adult legacy services: Intensive In-home Services (IIHS), Therapeutic Day Treatment (TDT), Mental Health Skill Building (MHSS), Psychosocial Rehabilitation (PSR), and Mental Health Case Management (MHCM).

The budget language authorizes DMAS to move forward with budget neutral changes to replace the legacy services with evidence-based, trauma-informed services.

XX. 1. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, Intensive In Home Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management- Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services. All new and modified services shall be evidence based and trauma informed. To facilitate this transition, DMAS shall have the authority to implement programmatic changes to service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the legacy and redesigned services identified in this paragraph. DMAS shall only proceed with the provisions of this paragraph if the authorized Medicaid behavioral health modifications and programmatic changes can be implemented in a budget neutral manner within appropriation provided in this Act for the identified legacy services. Moreover, any new or modified services shall be designed such that out-year costs are in line with the current legacy service spending projections. No new Medicaid behavioral health services or rates shall be implemented until corresponding legacy services have ended. Implementation of the redesigned services authorized in this paragraph shall be completed no later than June 30, 2026.

Medicaid Behavioral Health Services Redesign Priorities





Strengthen the evidence-based, trauma-informed service continuum for youth and adults

Promote earlier intervention and increase access through tiered service design

Design services for Virginia's managed care service delivery system and multipayer system

Integrate workforce priorities and workforce supports into service design and implementation

<u>Evidence Base Highlights</u>

- Mental health disorders are complex and include genetic, environmental, biological, and social factors
- Treatments include medication, therapy, and support services
- Duration of untreated mental illness is primary predictor of long-term functional impairment; recovery is a process
- Early, coordinated intervention during sensitive periods improves long-term outcomes
- Mental health treatment system is paradoxical if not constrained: over-treatment (mild) and under-recognition (severe)
- Financial incentives are often misaligned for both providers and payers

Medicaid Behavioral Health Redesign Timeline
July 2024-June 2026

Year 1

July 2024-June 2025

- Service research, stakeholder input, contractor support to develop service requirements
- Develop service definitions and requirements
- Develop FFS rates for each proposed new service
- Estimate utilization, cost and budget impact for redesigned services

Year 2

July 2025-June 2026

- Operationalize new services through licensure, regulatory, and policy manual changes
- Prepare providers to transition to new services
- Ensure MCO readiness to implement new services
- New Services Go Live
  Potential phased in approach of service implementation

Project Updates

We are here!

June, 2025

Fiscal impact study completed

Implementation plan developed

July, 2025

Phase 2 (Implementation) Launch!

Rates Posted

August, 2025

Provider Readiness Survey Completed

MAP Training Application

DMAS/DBHDS Regs and Policy Development

FFS/MCO Implementation Launch

September 2025

Informal public comment begins

Provider office hours begins

Provider Letter of Intent Developed

October 2025

Informal Public Comment continues

Provider Letter of Intent Due to DBHDS

Cross Walk of Current Community Rehabilitative Mental Health Services (CMHRS) and New Service Array

Current Services	New Service Replacement
Mental Health Skill Building (H0046) Psychosocial Rehabilitation (H2017)	Community Psychiatric Support and Treatment (Adult) - Community
	Coordinated Specialty Care (CSC)
	Mental Health Clubhouse Services (Clubhouse International Model)
Intensive In-Home Services (H2012)	Community Psychiatric Support and Treatment (Youth) - Community
Therapeutic Day Treatment (H2016)	Community Psychiatric Support and Treatment (Youth) - School Setting
Mental Health Case Management (H0032)	Remaining Mental Health Case Management with policy changes

Rates for BH Redesign July 2026 Implementation

Setting and Professional - Individual	Rate Type	Rate
CPST — Licensed Mental Health Professional (LMHP), Community	Per 15 Minutes	$33.24
CPST — LMHP, School Setting	Per 15 Minutes	$25.81
CPST — Qualified Mental Health Professional (QMHP), Community	Per 15 Minutes	$25.66
CPST — QMHP, School Setting	Per 15 Minutes	$19.41
CPST — Behavioral Health Technician (BHT), Community	Per 15 Minutes	$20.49
CPST — BHT, School Setting	Per 15 Minutes	$14.69

Setting and Professional – Group; (Adult max of 10); (Youth max of 6)	Rate Type	Rate
CPST — LMHP, Community Youth Group	Per 15 Minutes	$8.31
CPST — LMHP, School Setting Youth Group	Per 15 Minutes	$6.45
CPST — LMHP, Community Adult Group	Per 15 Minutes	$5.54
CPST — QMHP, Community Youth Group	Per 15 Minutes	$6.41
CPST — QMHP, School Setting Youth Group	Per 15 Minutes	$4.85
CPST — QMHP, Community Adult Group	Per 15 Minutes	$4.28

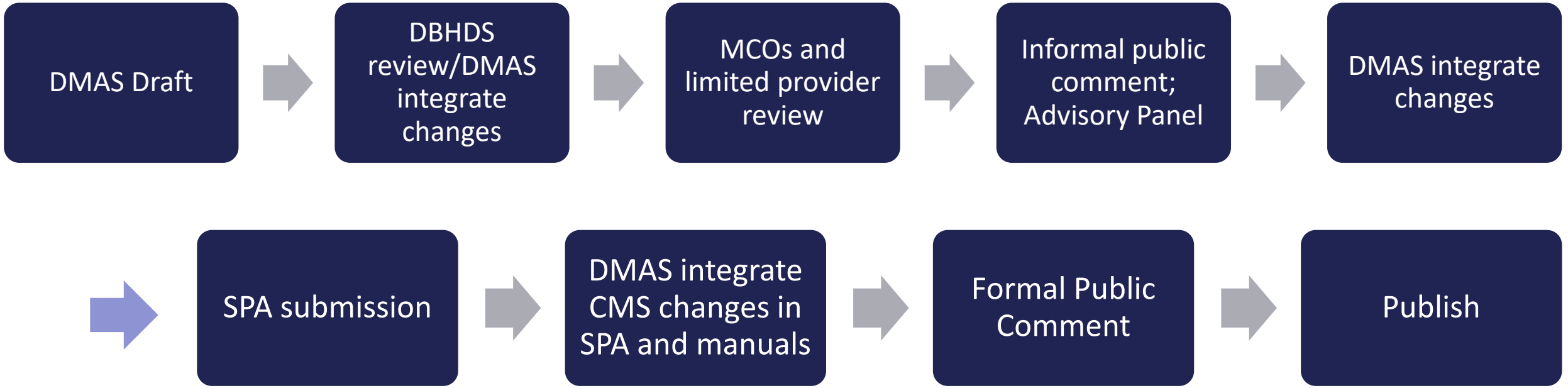
Rates for July, 2026 Implementation- Cont'd.

Service	Rate Type	Rate
Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)	Flat Rate	$323.42
Clubhouse International Model of Psychosocial Rehabilitation	Per Diem	$72.41
Coordinated Specialty Care for First Episode Psychosis	Monthly Rate	$2,308.00
Coordinated Specialty Care for First Episode Psychosis	Encounter Rate	$381.00
Mental Health Case Management for SMI and SED	Monthly Rate	$374.09

Policy and Licensing Updates

- DBHDS Licensing Regulations- Draft of CPST was submitted and reviewed at DBHDS Board meeting on Sept 23rd
  - DBHDS Board approval in September, would be public and undergoing executive branch review
  - DBHDS Board review and posting of Coordinated Specialty Care and Clubhouse in December
- DMAS policy manuals- Goal is to post for informal public comment in September/October; followed by submission of SPA to CMS; followed by formal posting in Spring
- Meeting with a group of community-based providers to hear feedback about draft policies.

Policy Review Process



FFS/MCO Implementation

- All service codes have been assigned, systems changes are currently being drafted
- MCOs are currently providing feedback on drafts, technical specifications
- MCOs began conducting review and subsequent outreach to youth providers started in September
  - IIH and TDT providers cross referenced with survey respondents and claims history, by region
  - Need to retain all/increase providers in multiple regions
- Contractor System Testing: January-March, with readiness reviews in late Spring.

Provider Readiness Survey

- Survey completed by 158 providers by deadline
  - 31 CSBs
  - 127 private providers

Services currently provided by respondents:

Current Service	Number
Intensive In-Home	93
Therapeutic Day Treatment	13
Mental Health Skill Building	127
Psychosocial Rehabilitation	42

Number of Providers interested in the new services:

New Service	Provider Count
Clubhouse	68
CSC	51
CPST-Adult	142
CPST Youth Community	127
CPST Youth School	69

Representativeness

- Providers completing survey represented about 1/3 of current providers (based on number served and claims history)
- More than half of PSR provider responded
- Respondents from smaller agencies were less likely to respond
  - Example: For intensive in home, 30% of providers serving 20-49 and 50+ members per year completed the survey but 17% of providers serving 0-8 and 8-19 members per year completed the survey

Current Service	Members Served in 2024	Paid Claims 2024 (Survey Respondents)	Total Annual Spend (All Providers)
Intensive In-Home	2928	$27,336,876	$97,874,805
Therapeutic Day Treatment	5463	$10,959,452	$30,809,629
Mental Health Skill Building	2434	$60,738,892	$194,760,307
Psychosocial Rehabilitation	1794	$16,850,408	$25,308,172

Clinical Director and Accreditation Readiness

CPST Agencies will be required to have a fully licensed, full time LMHP clinical director. Which statement describes your agency's readiness?

Readiness (Clinical Director)	Provider Count
We already have a clinical director who is fully licensed	129
We have at least one fully licensed staff who is full time. They are not currently in the role of "clinical director" but we can easily meet the criteria by 7/1/2025	17
We have no fully licensed staff who are full time and are not prepared to do so.	1
We have no fully licensed staff who are full time currently, but are prepared to hire a clinical director in order to become licensed for the service transition 7/1/2026	12
Grand Total	159

Eventually, CPST Agencies will be required to be accredited by one of the following entities: The Joint Commission, Council on Accreditation (COA), CARF. Is your agency currently accredited?

Accredited?	Provider Count
No	120
Yes	39
Grand Total	159

- 28 CARF
- 7 TJC
- 6 COA

Additional Outreach/Engagement

- Recorded information videos by DMAS/DBHDS teams are posted on DMAS Youtube Channel
- Working with Clubhouse International on Clubhouse policy draft.
- Working with Praed Foundation on the development of CANS Lifetime Assessment
- DMAS/DOE and are working on strategic communication to school admin and school-based MH staff about CPST-School and TDT ending.
- DMAS joined an OCS led workgroup (Sept 19th) on redesign to provide support for CSA planning/implementation.
- Presenting at:
  - VACSB: Oct 1st
  - VNPP: Oct 15th
  - CSA Conference: Oct 15th
  - VACBP: Oct 28th

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Virginia's Medicaid Program

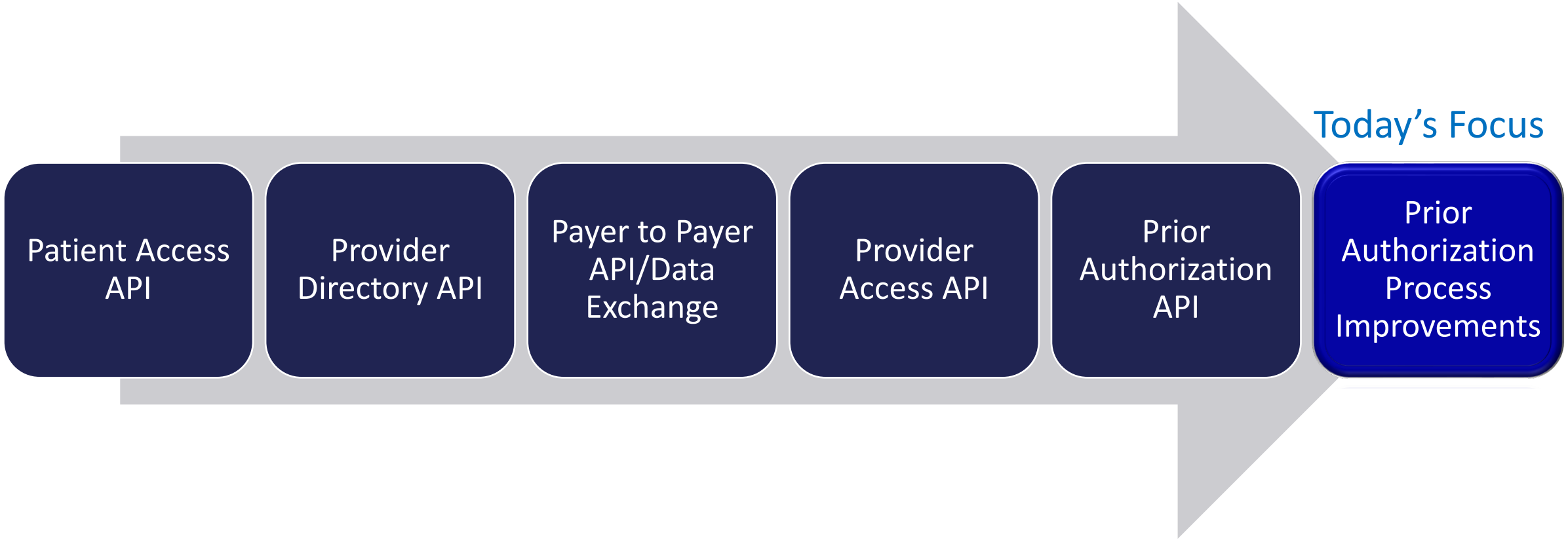
Interoperability & Prior Authorization Final Rule

September 30, 2025

DMAS

Major Provisions (Interoperability, Patient Access & Prior Authorization*)

Interoperability and Prior Authorization Final Rule (CMS-0057-F)



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*CMS term "Prior Authorization" = DMAS "Service Authorization"

Improving Prior Authorization Processes

CardinalCare
Virginia's Medicaid Program

Service Authorization Decision Timeframes- Implementation

Beginning January 1, 2026

Category	FFS Population/MCO	Standard	Expedited	Member/Provider Requested Extensions Permitted
Fee-for-Service	**Acentra Health:** Limited Benefit and Spenddown Enrollees (Medicaid & CHIP)	January 1, 2026	January 1, 2026	14 calendar days Standard Requests Only
	DBHDS: DD Waiver Participants (Medicaid only)	July 1, 2026	July 1, 2026	14 calendar days Standard Requests Only
	DMAS MSU: (Transplant Authorizations) Medically Needy Spenddown Enrollees (Medicaid & CHIP)	July 1, 2026 (Standard)	October 1, 2026 (Expedited)	14 calendar days Standard Requests Only
	Dental (DentaQuest)	January 1, 2026	January 1, 2026	14 calendar days Standard Requests Only
	Transportation (Modivcare)	January 1, 2026	January 1, 2026	14 calendar days Standard Requests Only
Managed Care	**All Plans**	January 1, 2026	January 1, 2026	14 calendar days Standard & Expedited

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Service Authorization Annual Metrics

By March 31, 2026, each MCO will need to report its own data on its website, and DMAS will need to report total (combined) MCO/FFS info on its website:

- A list of all items and services that require prior authorization (excluding drugs).
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the payer, plan, or issuer, for expedited prior authorizations, aggregated for all items and services.

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Nursing Facility Updates

September 30, 2025

DMAS

DMAS Role in Supporting NF Quality

- DMAS framework for ensuring quality
  - Quality Assurance
    - Provider enrollment/credentialing (DMAS and MCOs)
    - Billing/reimbursement standards
  - Quality Incentives: Nursing Facility Value-Based Purchasing program
  - Quality Improvement: Nursing Facility Quality Improvement program

Virginia Medicaid Nursing Home Facts

DATA SUMMARY

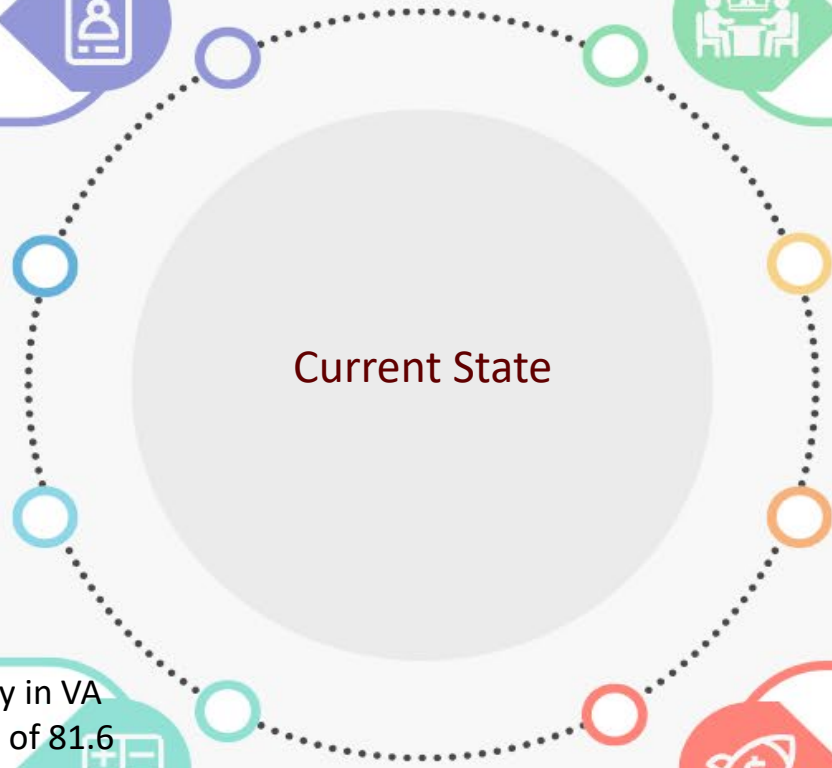
Who do we serve?

~17K Virginia Medicaid members are in NFs.
These members are primarily served in ~290 NFs across VA.

Top Resource Utilization Group (RUG) for members from claims are mostly related to Rehab and Reduced Physical function (RAC, RAD, RAB, PC1, RAA)

Top RUG Case Mix group reported for State Medicaid in MDS assessments are Reduced physical function, Behavioral and Clinically complex. (PB1, BA1, CC1, CC2, CA2)

Average Number of Residents per Day in VA is 96.6 compared to national average of 81.6
78% Percentage of short stay residents who made improvements in function & 22% were re-hospitalized after a nursing home admission



Who are the providers?

There are 290 NFs providing services to Medicaid and Medicare members across VA. One third of NFs are across 10 major cities

~50% of NFs with 1- or 2-star rating
73% of the NFs with a star rating of 1 and 2 have # certified beds of 100 to 200

~32% of NFs with 3-star & 4-star rating
70% NFs with a star rating of 3 and 4 have # certified beds of 50 to 150

~18% NFs with 5 Star rating
90% of the NFs with # certified beds of 50 or less have a star rating of 4 or 5

Nursing Facility Quality Improvement Program (NFQIP)

2022 budget item **308 Q.1.4:** DMAS to create and administer a Nursing Facility Quality Improvement Program with Civil Money Penalty (CMP) reinvestment funds.

DMAS partnering with VCU Gerontology to provide trainings, conferences, technical assistance, and other supports to NFs.

The first launched August 13, 2025, as a live workshop open to all NFs in the Commonwealth.

DMAS and VCU Outreach: targeted email blasts, social media, and networks (i.e. Long-Term Care Clinicians Network and the NF Associations)
https://www.dmas.virginia.gov/for-providers/benefits-services-for-providers/long-term-care/programs-and-initiatives/nursing-facility-quality-improvement-program-nfqip/

Evaluating: NF participation, change in participant knowledge, competence, & confidence

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NFQIP Training Topics

Current

Deepening Your Person-Centered, Dementia Care Practice: A Learning and Relearning Journey

- 12 Virtual workshops over 3 years. Live "Huddle Up" session one month after each workshop.

Person-Centered Trauma-Informed Care Training Series

- 15 self-paced training courses bundled into 3 badge levels.

Upcoming

Staff Training on Value Based Purchasing Quality Metrics

- In development. Will support NF attainment and improvement in Virginia VBP PMs.
- Anticipated start October 2025

Agreement with VCU for at least 2 more NFQIP project applications

- Anticipated start dates: Jan 2026 and June 2026

Civil Money Penalty Reinvestment Program (CMPRP)

- Reinvests penalties assessed on noncompliant NFs back into facilities
- Projects that directly improve the quality of life and care of residents
- DMAS administers the program, and CMS makes the final funding determination
- FY25- 16 Projects. 43% NFs in Virginia participated (n=124)

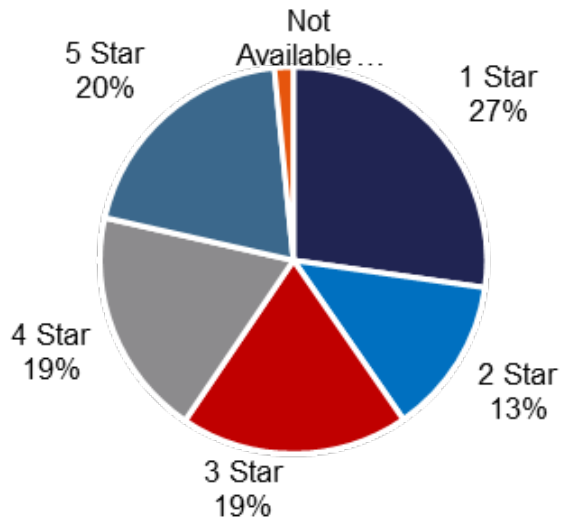
Total CMPRP Impact FY19 – FY25

$7.7 Million reinvested

33 Unique Projects

Over 75% of NFs have participated

Star Rating Breakdown of NFs Participating in CMPRP Projects in FY25



How Nursing Facility Value-Based Payments Work – Program Performance Measures

Domain	Measure	Description	Weight
Staffing 	**Minimum RN Staffing**	Meet 8 Hours/Day of RN care	20%
	Composite Nurse Staffing	Registered Nurse + Licensed Practical Nurse + Certified Nurse Assistant staffing time, case mix adjusted	20%
Quality (avoidance of events) 	**Hospitalizations**	Number of hospitalizations per 1,000 long-stay resident days	15%
	Emergency Department (ED) Visits	Number of outpatient ED visits per 1,000 long-stay resident days.	15%
	Pressure Ulcers	Percentage of high-risk long-stay residents with pressure ulcers	15%
	Urinary Tract Infections	Percentage of long-stay residents with a urinary tract infection within the past 30 days	15%

Where We're Going

- Modify how DMAS makes attainment payments to nursing facilities that decline in performance (SFY26)
- Modify program measures to recognize program-wide improvements in performance and introduce new areas requiring improvement (SFY27)
- Use improved data from licensure and certification oversight to strengthen program eligibility requirements (SFY27 and beyond)

Other NF Programs and Initiatives

Currently Underway

More frequent exchange of MDS data from VDH including Section Q data.

PDPM reimbursement methodology "Go live" 10/1/2025

Portal Entry, HRA & DME monitoring plan being carried out with the MCOs

Meetings and public hearings

Scheduled for

Future

Agency

All Agencies

Regulatory Board

Board of Medical Assistance Services

Meeting Title Partial Match

Submit

Meeting Scope

H Public hearing to discuss a proposed change to regulation

R Discuss particular regulations / chapters

G General business of the board

28 meetings scheduled for the future relating to Board of Medical Assistance Services

Date and Time		Meeting Title	Board	Scope
Sep-30 2025 (Tue)	10:00 am	**Board of Medical Assistance Services** Agenda Electronic Access	Board of Medical Assistance Services	G
Oct-16 2025 (Thu)	11:00 am	**Community Stakeholders Meeting** Electronic Access Canceled	Board of Medical Assistance Services	G
Oct-16 2025 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing** Agenda	Board of Medical Assistance Services	G
Oct-17 2025 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** Agenda Electronic Access	Board of Medical Assistance Services	G
Oct-20 2025 (Mon)	10:00 am	**Medicaid Member Advisory Committee (MAC) Meeting** Electronic Access	Board of Medical Assistance Services	G
Oct-29 2025 (Wed)	1:00 pm	**EFRC Quarterly Meeting** Agenda Electronic Access	Board of Medical Assistance Services	G
Nov-18 2025 (Tue)	3:00 pm	**Medicaid Physician and Managed Care Liaison Committee (MPMCLC)** Electronic Access	Board of Medical Assistance Services	G
Dec-09 2025 (Tue)	10:00 am	**Board of Medical Assistance Services** Electronic Access	Board of Medical Assistance Services	G
Dec-11 2025 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Dec-11 2025 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** Electronic Access	Board of Medical Assistance Services	G
Dec-19 2025 (Fri)	10:00 am	**Pharmacy Liaison Committee Meeting**	Board of Medical Assistance Services	G

Jan-16 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** Electronic Access	Board of Medical Assistance Services	G
Jan-29 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Mar-05 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** Electronic Access	Board of Medical Assistance Services	G
Mar-10 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** Electronic Access	Board of Medical Assistance Services	G
Apr-16 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Apr-17 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** Electronic Access	Board of Medical Assistance Services	G
Jun-04 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** Electronic Access	Board of Medical Assistance Services	G
Jun-09 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** Electronic Access	Board of Medical Assistance Services	G
Jul-16 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Jul-17 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** Electronic Access	Board of Medical Assistance Services	G
Sep-08 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** Electronic Access	Board of Medical Assistance Services	G
Sep-10 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** Electronic Access	Board of Medical Assistance Services	G
Oct-15 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Oct-16 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** Electronic Access	Board of Medical Assistance Services	G
Dec-08 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** Electronic Access	Board of Medical Assistance Services	G
Dec-10 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** Electronic Access	Board of Medical Assistance Services	G
Sep-09 9999 (Thu)	12:00 am	**Medicaid Physician and Managed Care Liaison Committee (MPMCLC)** Electronic Access Canceled	Board of Medical Assistance Services	G

Regulatory Activity Summary — September 30, 2025
(* Indicates Recent Activity)

2025 General Assembly

***(01) Provider Appeals AIMS Filing:** This regulatory action amends existing regulations to streamline the provider appeal process in accordance with Item 292 QQ of the 2025 Appropriations Act. The amendments require providers to file appeal notices and other appeals-related documents through the Appeals Information Management System (AIMS), an online appeals portal. Following internal review, the reg project was submitted to the OAG for review on 8/28/25.

***(02) Reentry Targeted Case Management:** In accordance with Item 288.GGGG.2 of the 2025 Appropriations Act, this SPA provides coverage of targeted case management, in the 30 days pre-release and immediately post-release to eligible incarcerated youth and young adults to comply with section 5121 of the federal Consolidated Appropriations Act of 2023. Following the internal and external reviews, the SPA was submitted to CMS on 9/8/25.

***(03) 2025 Non-Institutional Provider Reimbursement Changes:** The state plan is being amended in order to comply with the 2025 Appropriations Act. Specifically:

- Item 288.FFFFF.2: The state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit by three percent. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning provided under home and community-based waivers. These increases are not included in the state plan amendment but via waiver documentation.)

- Item 288.GGGGG.2: The state plan is being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and Diagnosis and Treatment (EPSDT) benefit by two percent. (A corresponding rate increase of two percent will be provided for these services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

- Item 288.MMMMM: The state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital emergency department. This payment shall be unbundled from the hospital rate.

- Item 288.PPPPP: The state plan is being revised to ensure the reimbursement for a service provided by a licensed certified midwife or licensed midwife shall be in the same amount as the Medicaid reimbursement paid a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

- Item 288.UUUUU: The state plan is being revised to increase the rates for Office Based Addiction Treatment, Opioid Treatment Services, Partial Hospitalization Services, and Intensive Outpatient Services by 6.5 percent.

- Item 288.WWWWW: The state plan is being revised to provide supplemental payments for dentists employed by or contracted with Virginia Commonwealth University's School of Dentistry. The total

supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. DMAS shall enter into a transfer agreement with Virginia Commonwealth University for such supplemental payments, in which the University shall provide the non-federal share in order to match federal Medicaid funds for the supplemental payments.

- Item 3-5.15: the state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for outpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

Following the internal and external reviews, the SPA was submitted to CMS on 9/8/25.

***(04) 2025 Institutional Provider Reimbursement Changes:** The state plan is being amended in order to comply with the 2025 Appropriations Act. Specifically:

- Item 288.MMMMM: The state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital inpatient setting. This payment shall be unbundled from the hospital rate.

- Item 288.RRRRR: The state plan is being revised to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, not to exceed $30,000,000 total computable for teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The public entity shall transfer the non-federal share of the authorized supplemental payments. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. Such funds may not be paid from any private agreements with Virginia Tech Carilion School of Medicine that are in excess of fair market value or that alleviate pre-existing financial burdens of the school. The Virginia Tech Carilion School of Medicine is authorized to use general fund dollars to accomplish this transfer. The Virginia Tech Carilion School of Medicine would enter into an Interagency Agreement with the department for this purpose and must attest to compliance with applicable CMS criteria.

- Item 3-5.15: The state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for inpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

Following the internal and external reviews, the SPA was submitted to CMS on 9/12/25.

***(05) 2025 Third Party Liability:** The purpose of this state plan amendment is twofold:

- 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 assurance 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.

- Provide clarity relating to lien amounts arising from the Medicaid program and asserted against personal injury claims proceeds.

In 2023, DMAS submitted a third party liability SPA to CMS to incorporate the above changes. However, CMS asked DMAS to withdraw the SPA, because the agency did not have a law in place that barred liable third-party payers from refusing payment for an item or service on the basis that such item or service did not receive prior authorization under the third-party payer's rules. Item 288.KKKKK of the 2025 Appropriations Act provides such authority; therefore, DMAS can now resubmit the SPA to CMS. Following internal review, the project was approved by DPB on 7/21/25; approved by HHR on 7/23/25; and submitted to CMS on 8/12/25.

***(06) Applicability of the OMB Outpatient All-Inclusive Rate:** This state plan amendment will comply with the requirements of the 2025 Virginia Appropriations Act, Item 288.TTTTT, which requires DMAS to seek approval from CMS to amend the State Plan to reflect that services provided by IHS or tribal clinics or tribal FQHCs that are not eligible for the federal medical assistance percentage of 100 percent (services provided to individuals who are not American Indians or Alaska Natives) shall be reimbursed at standard Medicaid rates (the rates otherwise paid to non-tribal facilities for the same services). Following the internal and external reviews, the SPA was submitted to CMS on 7/7/25.

***(07) Nursing Facility Reimbursement Methodology:** In accordance with the 2025 Appropriations Act, Item 288.IIIII, this SPA modifies the nursing facility reimbursement methodology to the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG). This change shall be implemented in a budget neutral manner. RUGs was developed and used by CMS to classify nursing facility residents into payment groups based on their resource utilization. RUGs expired on September 30, 2023. Between October 1, 2023, and September 30, 2025, CMS allowed state Medicaid agencies to use the Optional State Assessment to extend the use of RUGs IV. CMS will no longer support Medicare RUGs systems after October 1, 2025. PDPM will replace RUGs for classifying Skilled Nursing Facility (SNF) patients in a covered Medicare Part A stay. This shift aims to modernize payment systems and align reimbursement more closely with resident care needs. The project is currently circulating for internal review.

***(08) Repeal of Nursing Facility-Specific Drug Utilization Review and Updates to Nursing Facility Survey and Certification:** The purpose of this SPA is to:

- Delete language related to nursing facility-specific drug utilization review (DUR) in section 4.14g of the state plan. This text is obsolete and the requirement for this text was repealed by the Centers for Medicare & Medicaid Services in 1994. The DMAS DUR Board monitors nursing facilities according to the requirements in 42 CFR 456.703. 42 CFR 456.703(b) stipulates that prospective drug review and retrospective drug use review (including interventions and education) under the DUR program are not required for drugs dispensed to residents of nursing facilities that are in compliance with the drug regimen review procedures set forth in 42 CFR 483.45 (the Virginia Department of Health is responsible for evaluating nursing facilities' compliance with 42 CFR 483.45).

- Update the nursing facility state survey language to reflect that the Division of Licensure and Certification within the Virginia Department of Health has changed its name to the Office of Licensure and Certification (OLC) and OLC no longer contracts with the State Fire Marshall's Office.

Following internal review, the SPA was submitted to DBP and the Tribal Programs for review on 9/18/25.

***(09) Pharmacy and Therapeutics Committee:** The state plan is being amended to update the quorum that is needed for the Pharmacy and Therapeutics Committee (P&T Committee) to take action. Item 288.CC.2.a of the 2025 Appropriations Act amended the composition of the P&T Committee such that the Committee must be composed of up to 16 members (the Committee is currently composed of 12 members and a quorum is seven members). Amending the composition to 16 members means a quorum of nine members will be needed for the P&T Committee to take action, so the state plan needs to be updated accordingly. Following the internal and external reviews, the SPA was submitted to CMS on 9/18/25. The corresponding regulatory project is currently circulating for internal review.

***(10) Clinic Services:** *The state plan is being amended* in order to comply with a CMS notice indicating that: "The completion of the [SPA] template is mandatory only for states that both cover the clinic services benefit and cover tribal clinics to allow clinic services to be provided outside of the clinic under the clinic services benefit …"

DMAS covers the optional clinic services benefit, and covers tribal clinics, including the "outside of the clinic" benefit, and as a result, is required to file this SPA. The CMS notice was accompanied by a draft template. CMS provided a final version of the template for the SPA on March 10, 2025. CMS has indicated that state Medicaid agencies must file a blank SPA by March 31, 2025 to preserve the option for a January 1, 2025 effective date, while allowing for a tribal consultation period before the completed SPA template is submitted. DMAS submitted a blank SPA template to CMS by March 31, 2025, and submitted a completed template after tribal consultation occurred.

Virginia Medicaid covers:

- Medical and Behavioral Health Clinics;
- IHS and Tribal Clinics;
- Renal Dialysis Clinics; and
- Other Clinics, which include health department clinics, ambulatory surgery clinics, and family planning clinics.

The SPA template requires DMAS to list any limitations on clinic services. DMAS does not intend to make any changes to its practices regarding the scope of clinic services, but to clarify that clinic services provided under 42 CFR 440.90 do not include the following services: dental, pharmacy, home health, hospice, physical therapy, occupational therapy, speech language pathology, transportation, 1915(c) waiver services, and community mental health services. To provide those services, clinics must enroll as that provider type and abide by the state plan requirements for those services. These limitations match current DMAS practice.

In the completed SPA template, DMAS is required to define the scope of tribal clinic services and to confirm that clinic services can be provided outside of the four walls of the clinic. DMAS intends to clarify that the scope of tribal clinic services is the same as for non-tribal clinics. DMAS will also confirm in the completed SPA template that IHS and tribal clinic services can be provided outside of the clinic. Following internal and oversight agency review, the SPA was submitted to CMS on 5/15/25. CMS requested additional information on 6/20/25. DMAS is currently coordinating a response.

(11) MR Removal and Updates: This regulatory action removes the highly offensive term, "mentally retarded" from DMAS regulations and replaces it with either "individuals with developmental disabilities" or, when required to match federal regulations, the more narrow term "individuals with intellectual disabilities". These replacement terms are currently used in DMAS regulations. The reg project also removes references to the Department of Mental Health, Mental Retardation and Substance Abuse Services of the Commonwealth of Virginia (DMHMRSAS), as the agency is now called the Department of Behavioral Health and Developmental Services (DBHDS). The project is currently circulating for internal review.

***(12) Requirements for Medicaid Consumer-Directed Facilitators:** The state plan is being amended to modify requirements for Consumer-Directed (CD) Services Facilitators to eliminate the requirement that individuals providing these services have an Associate's or Bachelor's Degree in order to provide services. Work experience shall be listed as sufficient in the list of requirements. CD Facilitators provide practical skills training (such as providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication, and problem-solving) to enable families and individuals to independently direct and manage their consumer-directed services. Serving as the agent of the individual or family, the facilitator is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the individual/family to be the employer. Following internal review, the SPA was approved by DPB on 6/9/25; approved by HHR on 6/10/25; and submitted to CMS on 7/11/25 and approved on 8/5/25.

***(13) Youth Reentry:** To meet a federal mandate, DMAS is submitting this SPA on a CMS template in accordance with a CMS State Health Official letter (#24-004) indicating that:

"To comply with the amendments made by section 5121 of the CAA [Consolidated Appropriations Act], 2023, states must submit a Medicaid SPA attesting that the state has developed an internal operation plan, and in accordance with such plan, will provide coverage during the statutory pre- and post-release period of screening, diagnostic, and targeted case management (TCM) services for eligible juveniles who are within 30 days of release post adjudication. For Medicaid, a state must submit a SPA no later than March 31, 2025, to have an effective date of no later than January 1, 2025."

Coverage of pre-release services is a new exception to the longstanding Medicaid inmate payment exclusion that otherwise restricts Medicaid coverage of services for individuals while incarcerated. Section 5121 of the CAA, 2023 requires states to cover screenings and diagnostic services for eligible juveniles, as well as TCM services during this transitional period out of incarceration. Services must be provided to Medicaid-eligible individuals under age 21, CHIP (FAMIS) enrolled children, and individuals up to age 26 in the Medicaid former foster youth eligibility group.

Given the complexity associated with implementing Section 5121, CMS has stated that the attestation SPA review framework will aim to balance CMS' regulatory requirements, general oversight requirements, and the statutory effective date of January 1, 2025. The framework for reviewing SPAs will be based on states' readiness to fully implement Section 5121. States will be determined as either fully ready, partially ready, or not ready to implement Section 5121. States determined partially ready or not ready to implement will be given additional time to work toward

full readiness. In the interim, states determined partially ready will be allowed to claim for services in carceral facilities that are ready to participate.

Following internal review, the project was sent to DPB and the Tribal Programs for review on 2/25/25. The SPA was submitted to CMS for review on 3/28/25. CMS issued an RAI (request for additional information) on 6/16/25 and DMAS submitted responses on 7/11/25. The SPA was approved by CMS on 7/21/25.

***(14) Tribal Provider Reimbursement:** The state plan is being amended to make the following changes to tribal provider reimbursement:

• Clarify that tribal clinics cannot be reimbursed at the facility rate (all inclusive rate, or AIR) for non-clinic services, including pharmacy, dental, transportation, and 1915(c) waiver services.
• Clarify that tribal FQHCs cannot be reimbursed at the AIR for pharmacy, transportation, and 1915(c) waiver services. Dental services provided by Tribal FQHCs are reimbursed through the Alternative Payment Methodology (APM) established in the Medicaid State Plan at Att. 4.19-B, pages 4.6-4.7.
• Clarify the definition of the per visit rate for purposes of reimbursement at the AIR, specifying that it is a bundled, all-inclusive encounter rate and must not be unbundled and billed as separate encounter claims.
• Specify that an Indian Health Service, tribal or urban Indian organization, including a Tribal 638 facility that operates a retail pharmacy, must enroll separately as a pharmacy provider, and that payment for pharmacy services shall align with an existing pharmacy payment methodology and shall not be at the AIR. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.

The state plan is also being amended to make a change needed to reflect new federal requirements for Medicaid reimbursement to tribal clinics, clarifying that these services include professional services furnished at the clinic by or under the direction of a physician, or services furnished outside the clinic, by clinic personnel under the direction of a physician. Following internal review, the project was sent to DPB and the Tribal Programs for review on 12/20/24. The SPA was submitted to CMS for review on 5/15/25. CMS issued DMAS on RAI on 8/4/25 and DMAS is currently coordinating responses.

***(15) Update to Non-Covered Drugs:** This SPA will align state plan language related to covered outpatient drugs with current law (Section 1927 of the Social Security Act) and current DMAS practice. Following internal review, the project was sent to DPB and the Tribal Programs for review on 2/26/25. DPB approved the SPA on 3/5/25; the SPA was submitted to HHR for review on 3/13/25 and subsequently approved; and the project was submitted to CMS for review on 3/28/25. DMAS held a conf. call with CMS on 4/17/25 to discuss the project. CMS forwarded recommended changes to the state plan page on 4/23/25. Following internal review, DMAS submitted SPA page revisions to CMS on 5/22/25. The SPA was approved by CMS on 6/11/25.

2024 General Assembly

(01) Repeal of Case Management Services for Recipients of Auxiliary Grants: This regulatory action repeals the regulations associated with case management services for assisted living facility

residents receiving auxiliary grants. DMAS has not provided this service for over ten years, so the regulations are outdated and need to be repealed to align with DMAS' current practices. DMAS submitted a SPA to CMS to remove the outdated case management language from the state plan. The SPA was approved on September 11, 2024, and this regulatory action will also align the Virginia Administrative Code with State Plan language. Following internal review, the reg project was submitted to the OAG for review on 11/19/24. The OAG approved the project on 2/21/25 and subsequently, the project was submitted to DPB for review on 2/24/25.

(02) Licensed Behavior Analysts — Credentialed Addiction Treatment Professionals: The state plan is being amended to add Licensed Behavior Analysts (LBAs) to the definition of "Credentialed Addiction Treatment Professional." LBAs are not currently recognized by DMAS in the Addiction and Recovery Treatment Services (ARTS) program as practitioners because behavior analysts provide a broad spectrum of behavioral health services. Behavioral Analysis does, however, include a subspeciality directed at treating substance use disorders. Adding LBAs to the definition of a "Credentialed Addiction Treatment Professional," and recognizing them as a provider type under the ARTS program, helps address the shortage of available credentialed addiction treatment professionals in Virginia. Following internal and oversight agency review, the SPA was submitted to CMS on 9/4/24 and approved on 9/11/24. The corresponding regulatory project was reviewed/approved internally and submitted to the OAG on 2/6/25. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(03) EPSDT Therapeutic Group Homes: In accordance with the 2024 Appropriations Act, Item 288.EEEEE, this SPA establishes a per diem rate to therapeutic group homes that provide services to youth with an intellectual or developmental disability in addition to a behavioral health diagnosis. Group homes that provide this higher level of service are called "Early and Periodic Screening, Diagnosis, and Treatment" (or EPSDT) Therapeutic Group Homes. The per diem rate for these facilities shall be increased by 50%, effective July 1, 2024. Following internal and oversight agency review, the SPA was submitted to CMS on 6/18/24 and approved on 9/5/24. The corresponding regulatory project is forthcoming.

(04) Supplemental Payments to Private Hospitals for Physician Services: In accordance with the Item 288.OO.9.a-c of the 2024 Appropriations Act, this SPA makes supplemental payments to private hospitals and related health systems who intend to execute affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the non-federal share of the authorized payments. Virginia community colleges, Virginia public institutions of higher education, local governments, and instrumentalities of local government are public entities that are authorized to transfer funds to the department for purposes of covering the non-federal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Following internal and oversight agency review, the SPA was submitted to CMS for review on 11/8/24. CMS placed the SPA in a RAI (request for additional information) status on 1/15/25. DMAS forwarded a draft response to CMS on 1/22/25.

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

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

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

The project is currently circulating for internal review.

2023 General Assembly

(01) 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. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(02) 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. Following internal review, the corresponding regulatory project was submitted to the OAG for review on 4/25/25.

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

(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 implemented EVV for Home Health Care Services on July 1, 2023. Following internal review, the SPA was submitted to CMS on 8/28/23 and approved on 10/26/23. The corresponding regulatory project was submitted to the OAG on 1/17/24 for review. DMAS received OAG comments on 2/13/24, 2/16/24, 3/8/24, 4/8/24, 4/24/24, and 4/26/24 and DMAS responded to all inquiries and addressed the requested edits. A conference call with the OAG was held on 4/23/24. DMAS submitted additional revisions to the OAG on 4/24/24. More OAG questions were received on 4/26/24. Revisions were sent to the OAG for review on 5/7/24 and 5/14/24. Additional OAG comments were received on 7/22/24. DMAS coordinated responses and subsequently participated in a conf. call w/ OCL staff on 8/1/24 to discuss the project. DMAS forwarded responses to the OAG for review on 8/13/24. DMAS requested a project status update on 9/19/24. The OAG forwarded questions and requested edits on 2/19/25. DMAS is coordinating a response.

2022 General Assembly

(01) 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. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(02) 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.

***(03) 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. Following internal discussions and review, DMAS re-submitted the project to the OAG on 7/31/24 and fielded questions from the OAG on 8/28/24 & 8/29/24. Additional revisions were submitted to the OAG on 8/29/24 and 9/3/24, for review. The OAG posed follow-up questions to DMAS on 11/26/24. The OAG approved the project on 2/26/25 and the project was submitted to DPB for review 3/4/25 and approved on 3/26/25. HHR granted approval on 7/9/25. The project was submitted to the Governor's Office on 7/9/25; approved by ORM and the Governor's Ofc. on 7/22/25; and submitted to the Registrar on 7/22/25.

(04) 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. The project was approved by the OAG on 12/27/24 and submitted to DPB for review. DPB approved the project on 2/5/25 and the regs were also submitted to HHR for review on 2/5/25.

2021 General Assembly

(01) Private Duty Nursing Services Under EPSDT: This regulatory action updates the Virginia Administrative Code to include the following items related to private duty nursing, in accordance with a mandate from the 2021 General Assembly: services covered, provider qualifications, medical necessity criteria**,** and rates. This regulation establishes the regulatory framework for individuals with the need for high-intensity medical care. Having regulations in place (rather than

just language in Medicaid manuals) helps ensure that the rules are clear and transparent, and that they are applied equally across providers, and across members. This reg action includes a service description, a list of service components, provider qualifications, and service limits (which includes references to the documents needed to establish medical necessity). Following internal review, the regs were submitted to the OAG on 8/6/21 and then to DPB on 4/6/22. After edits were made to the regulations, the project was re-submitted to the OAG on 4/26/22 and sent to DPB on 5/18/22. The project was forwarded to the Secretary's Office for review on 6/1/22. Following additional internal revisions, the regulations were sent back to HHR on 8/1/22. The reg action was forwarded to the Gov's Ofc. on 9/25/23; to the Register on 10/5/23; and was published in the Register on 10/23/23. The 30-day public comment period ended on 11/22/23 and the emergency regulation is effective beginning 10/6/23 through 4/5/25. The corresponding fast-track project, following internal review, was submitted to the OAG on 3/18/24 for review. On 5/16/25, the OAG requested minor edits. DMAS submitted those revisions, via the Town Hall, to the OAG on 5/29/25.

***(02) 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. DMAS received comments/questions from the OAG and forwarded responses on 9/16/25.

(03) Clarifications for Durable Medical Equipment and Supplies – Revisions: This state plan amendment proposes to amend a previous SPA. DMAS previously submitted SPA 20-011 entitled "Clarifications for Durable Medical Equipment and Supplies" which was approved by CMS on October 20, 2020. Following the approval of SPA 20-011, CMS discovered duplicative wording and the necessity to re-categorize a heading on multiple pages, and also requested that DMAS submit a new SPA to revise the text on those pages. There is no change to the content or meaning of the state plan text as a result of the change. Following internal review, and the submission of the DPB and Tribal Programs notifications, the SPA was forwarded to HHR for review on 3/8/21. 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. Additional revisions were posted to the Town Hall on 4/16/24. DMAS is awaiting further direction.

2020 General Assembly

(01) Preadmission Screening and Resident Review (PASRR) Update: In responding to the legislative mandate of the General Assembly, the purpose of this regulatory action is to establish regulatory requirements for (i) allowing qualified nursing facility staff to complete the LTSS

screening for an individual who applies for or requests LTSS, and who is receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital; and (ii) protecting an individual's choice for institutional or community based services and choice of provider. Following internal review, the project was submitted to the OAG for review on 1/5/21. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/14/21. Additional revisions were submitted on 4/28/21. The project was submitted to DPB for review on 6/16/21 and to HHR on 6/29/21. The regs were forwarded to the Governor on 11/20/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21; published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22. DMAS received inquiries from the OAG on 12/16/22, 1/3/23, 1/9/23, 1/25/23, 2/9/23, 2/13/23, 3/2/23, and 3/13/23. DMAS submitted responses to the multiple OAG requests for edits and is awaiting further direction. On 6/15/23, DMAS requested an emergency reg extension and notified the OSHHR of the request. On 6/20/23, the Gov.'s Ofc. approved extending the emergency regulation until 2/14/24. On 4/17/24, the OAG posed additional questions and DMAS submitted responses on 4/25/24. On 5/1/24, DMAS forwarded revised regulations and informed the OAG that the revisions are available for review. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(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.

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.