FINAL MINUTES
Tuesday, December 12, 2023
10:00 AM

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

Present: Kannan Srinivasan, Jason Brewster, Paul Hogan, Elwood B. Boone, Patricia Cook, MD, Ashish Kachru, Ashley Gray, Greg Peters

Present Virtually: Elizabeth Noriega, Tim Hanold and Basim Khan

DMAS Attendees: Cheryl Roberts-DMAS Director, Jeff Lunardi - Chief Deputy, Tammy Whitlock – Deputy Complex Care Services, Adrienne Fegans -Deputy for Programs, Sarah Hatton – Deputy for Administration, Chris Gordon-Deputy for Finance, John Kissel-Deputy for Technology & Innovation, Ivory Banks – Chief of Staff, Rich Rosendahl- Deputy for Health Economics and Economic Policy, Brian McCormick and Emily McClellan.

1. Call to Order

Kannan Srinivisan-Board Chair, called for a motion by the Board to open the regular meeting of the Board of Medical Assistance Services at 10:10 am on December 12, 2023, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

Moved by Kannan Srinivasan; 10:10 am.

2. Approval of Minutes

The minutes from the September 12, 2023, meeting were introduced and approved.

Moved by Ashley Gray; seconded by Elwood B Boone to
Approve Motion Passed: 8 - 0
Voting For: Patricia T Cook MD, Ashley Gray, Kannan Srinivasan, Greg Peters Dr, Paul Hogan, Ashish Kachru, Elwood B Boone, Jason Brewster
Voting Against: None

3. Director's Report

Director Roberts provided the Board with an overview of Virginia Medicaid's Overarching Goals, Agency priorities and updates.

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

Enrollment
- 12-month continuous enrollment for children effective January 2024

State-Based Exchange
- Virginia State-Based Exchange went live November 2023

Right Help Right Now
- 1-year anniversary meeting Thursday Dec 14 at State library

ID/DD Waiver Slots
- CMS approved the allocated ID/DD waiver slots.

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

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

Resources: Provider issues regarding FFS authorization should be directed to Acentra via Customer Service/Provider Issues:
Acentra DMAS Provider Email (do not include PHI): VAproviderissues@kepro.com
Local Phone: 804.622.8900
Tollfree: 888.827.2884
For questions or issues related to direct billing or clearinghouses, email Virginia.EDISupport@conduent.com
For assistance with other billing and claims (as well as member eligibility) contact the Virginia Medicaid Provider Helpline:
toll-free 800-552-8627
in-state 804-786-6273

MCO Procurement

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

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

- Ensure Virginians covered by Medicaid have appropriate access to quality health care in every community.

- Transform behavioral health services and outcomes for members through integrated health care with a focus on prevention, treatment, crisis, and recovery as part of *Right Help Right Now* initiative.

- Enhance maternal and child health outcomes through strategic initiatives that increase member engagement and provide appropriate and timely access to services across geographic and ethnic populations.

- Strengthen provider access, adequacy, and availability through streamlined administrative and payment processes, training, and monitoring.

- Support members with high risk factors or needs through case management and other resources to support health-related social needs in the community.

- Provide support to children and youth in foster care with focused and dedicated services to meet their medical and behavioral health needs.
- Improve access to appropriate services and supports for members receiving LTSS to enable them to live in the setting of their choice and promote their wellbeing and quality of life.
- Drive innovation and operational excellence with a focus on improved outcomes.
- Increase value-based payment arrangements, quality driven withholds and tighter limits on MCO profits.
- Expand the use of data analytics, compliance monitoring and oversight.

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

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

DMAS worked with Boston Consultant Group, a national consulting firm to create a program that focused on the Administration priorities, identify emerging best practices across the nation, incorporate stakeholder input, and focus on key areas of improvement for Virginia Cardinal Care Medicaid Managed Care program.
On August 31, 2023, DMAS released the Cardinal Care Managed Care Request for Proposal, model contract, and draft rates on eVA.Virginia.gov.

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

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

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

Cardinal Care Managed Care – Procurement Changes

- Provider Management
    - Revise network adequacy and access standards including extended hours for appointments.
    - Promote member choice.
    - Work on standardizing provider credentialing.
    - Add new CMS standards.
    - Incorporate new payment changes.
- Model of Care
    - Focus on member-centric care.
    - Better use of resources and extenders.
    - Members can move from one level of intensity to another.
- Trends and Utilization
    - Monitoring new high-cost drugs and services.
    - Review over and underutilization trends.
    - Open to new innovations.
- Membership
    - Member education and choice.
    - Regional implementation.
    - Redistribution of members.
- Behavioral Health
    - Focus on and support of the *Right Help Right Now* initiatives.
    - Pre-crisis prevention services, crisis care, post-crisis treatment recovery and support
    - Members – youth and adults.
    - Providers – inpatient, Community Service Boards.

    - Services - new and continued community services, new waiver services, application for SMI, schools.
    - Include PRTF services as a carve out service.
- Maternal Child Health
    - Focus on increasing preventive care for children.
    - Increase the maternal scope of programs and outcomes.
    - Move HEDIS data outcomes up.
    - One single plan for children and youth in foster care.
- Financials
    - Clinical efficiencies
    - Performance withholds.
    - Profit margin tiers.
    - Value-based purchasing arrangements.
- New Compliance and Monitoring Focus
    - New compliance processes.
    - Expanded reporting requirements.
- Stakeholder and Evaluation Process
    - Increased transparency.
    - Increased data mining and usage.
    - Increased open discussions.

Maternal Health Updates

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

Virginia HEDIS dashboards (on website) include timeliness of prenatal and postpartum care by MCO.

Addressing Maternal Health in Petersburg

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

Petersburg Update

- Member engagement – New hand addressed mailings, flyers, targeted providers
- MCO engagement – special targeted projects to address the community - including communication, a maternal hub, and community baby showers.

- Provider engagement – DMAS collaborated with VHHA and Southside Regional leadership to provide extended clinic hours for the Petersburg and surrounding area residents for OBGYN services.
- Dr. Bazille held clinic hours from 9:30 am – 12 pm on Saturday, November 11th for the Medicaid members.
- Majority of women in Petersburg are now receiving adequate care.
- Dr. Brazille next clinic is in Jan. Now asking other Hospitals system to do quarterly clinics.

4. Unwinding Update

Deputy Sarah Hatton provided the Board with an update on Unwinding.

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

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

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

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

5. Mobile Crisis and Legally Responsible Individuals (LRI)

Deputy Tammy Whitlock provided an update on Mobile Crisis and Legally Responsible Individuals.

Serving Medicaid Members in Behavioral Health Crisis

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

Reimbursing Legally Responsible Individuals (LRIs)

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

6. Finance Update

CFO Chris Gordon provided the board with update on the Medicaid Forecast and Expenditures.

In DMAS, Medicaid cost drivers, there are three key ones that drive all costs: right? Enrollment, number of payments, rates, what we pay to providers, and services we have in Medicaid.

Those are the three cost drivers. At the bottom there, what we have is how much general fund does DMAS think it's going to need this year or give back this year and the next two years as part of the biennium, and then below that, how much money are we going to have to tax hospitals additionally compared to what we do now for Medicaid expansion, again, for this year and the next two years.

So that's what the left-hand column is, cost drivers. Let's go back up to the top and go down. FY 24, that's the fiscal year that we are in. What's going to affect enrollment? You already heard from Deputy Hatton about unwinding. What you probably may not have thought about, what does that mean for the case mix? Alot of healthy people that got employment didn't know they were still on

Medicaid, have third-party health insurance, those people are enrolled, and yes, they are increasing contributing capitation payments that we make, but they also reduce the cost of Medicaid because they have TPL. Those people are the majority of the folks that are being unwound and leaving, which means the remaining population doesn't necessarily have as much TPL or any at all. And they basically are in, in many cases, unlikely are unable to work, so they have increased health care needs, which means the cost is going to increase. So even though we are shedding folks, there are folks leaving Medicaid, the case mix is changing this year, and that will set the table for 25 and 26.

Also, this year in terms of rates, we made -- Deputy Hatton talked about -- she asked about what's the slide for the FMAP? What's the decrement? Well, we are in the last 1.5% this quarter. It ends in, like, 15 days. We are accelerating capitation payments. We are moving January into December to take advantage of that and reduce the cost on general fund. We have saved about $126 million this year in general fund just by accelerating them to try and take advantage of those waterfall step-downs. We have been very proactive about that. All of that to say we have only made 11 base capitation payments this year, and we made 13 last year because we did that acceleration bump into the last fiscal year.

We are seeing an increase in MCO rates. Why? Because of the people that are leaving. Right? The people that remain, really, are the ones that are driving up increase. We also have inflation adjustments. Hospitals got 11.65% inflation this year. They are seeing the result and impact, and you are seeing this nationally, not just Virginia, because of COVID, and its labor costs are driving that, as most folks know. That's not just hospitals, but that's just the highest one we had. And as you noted, Ashish, the FMAP is ending in ten days.

Deputy Rosenthal talks about that every single time, so people are going back to the doctor, going back to the physician, inpatient, outpatient. All of that to say this year in '24, we are giving back $126 million in general fund that the agency did not need that we forecasted we would. Again, not knowing when we do these forecasts a year ahead of time, we don't know necessarily what the landscape is going to look like.

That said, we are expecting an increase in the coverage assessment. Again, that population is the one that is seeing the most influx of people still, even though we are shedding, there are more new people that are coming in.

Leavers are now starting to overtake the new folks coming in, but for a while it was inverted.

For '25 and '26, I am going to pretty much say the same thing for both of them. It's the normal population group. That's not just what Virginia thinks but United States Society of Actuaries, folks at CMS, they are basically saying you are going to shed these folks and return to normal growth. In Virginia it's been about 7% financial wise in terms of general fund year offer year. Case mix, again, leaving all the folks that left are healthier or expect to be healthier, so the acuity is going to increase, which increases costs. Right? They have higher health care needs. Also, we are going to be just returning to normal, making the 12 monthly capitation payments that we make compared to this year. Again, seeing increase in MCO rates. Inflation adjustments are still there. They are going to be less. Right now, we are forecasting about 3% to 4% inflation for hospitals and nursing facilities. We get our data from S&P Global, S&P 500 Global, and we just got the latest statistics out, and we shared that with our hospital partner, VHHA, because they are watching that too.

Along with just the ending of the enhanced FMAP, we are seeing an increase or a decrease in our federal FMAP, our regular one, so you are like why is Virginia FMAP dropping? For about ten years, it was 50/50. And then it changed the last two years. They started giving us more money, the Feds did, and they only give you more money if the personal income, average personal income, in Virginians is dropping. So, it was for the last two years. So, the question is are you doing better now

than you were a year ago? In Virginia, the data is showing that, so our average personal income is increasing. The average personal income over a three-year moving average period is increasing. So, the Feds go aha, you don't need as much money from us. So, they are going to retract it back, which is equal to $60 million in general fund more that the Commonwealth will have to contribute to Medicaid.

Utilization, the same. What you see there, the 175 and the 539, that's how much more general fund we are going to need. A key point, again, that's membership, acuity, inflation rates that we talked about. The second year, a lot of people blink, 539, wow, that's more than twice the 175. Because it's a biennial budget, I have asked for the 175 again, right, so it's baked in. So, it's not really that, like, you know, almost 2.5 times increase. It's just essentially a doubling.

And then on the coverage assessment as well, a little bit of drop there. Again, catching up with the fact that we are shedding a lot of people off, but that return to normal we are expecting back again.

So, I will go to the end, the last slide, takeaways. Really, it's high-cost drug utilization therapies. Director Roberts mentioned that. I will not speak into a lot of these because Dr. Stevens can speak into that. Bottom line is this is getting a lot of attention, and she can, I am sure, can provide additional information. Next Wednesday, the money committees, the Governor's budget comes out. We are still collaborating with them, making sure they have the best information possible. The new GA session starts January 10 at noon, so we are all engaged with that. Then lastly, just significant declines in the health care fund. Mainly, that's attributed to during COVID, the plans, because of decreased utilization, saw increases in profit and we weren't missing MLR requirements, medical loss ratio. They are, by law, required to return those funds to us. So, we were used to getting several hundred million dollars back every year, and that would be dropped right into the health care fund. That's not the case. This year we are predicting only 8 million coming back in June. That's just attributed to increased utilization, people going back. What that means is the forecast is built on top of the base foundation of the health care fund, but if your house is built on sand, that means you are going to have a gap there. So, we pointed it out. The Department of Planning and Budget and the administration are aware of that.

7. Regulations

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

2023 General Assembly

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

***(02) FAMIS Plan Update:** This regulatory action is intended to make technical program updates, in addition to reducing the overall regulatory burden on the public in accordance with Executive Order 19. The project will do the following:

- Repeal redundant and unnecessary language in 12 VAC 30-141-50 through 12 VAC 30- 141-70, 12 VAC 30-141-670, and 12 VAC 30-141-710 through 12 VAC 30-141-730.

In accordance with Governor Youngkin's Executive Order #19, DMAS completed an internal review and determined that some of the content of these regulation sections already exist in other Virginia Administrative Code (VAC) sections, specifically in 12 VAC 30-110, 12 VAC 30-120, and other sections of 12 VAC 30-141.

- Make technical updates and amendments to multiple sections of Chapter 141. These updates represent current practices that are already in place.
- Update or repeal the appeals-related requirements in 12 VAC 30-141-40 through 12 VAC 30-141-70, 12 VAC 30-141-700, and 12 VAC 30-141-710 through 12 VAC 30-141-730, because they are unnecessary and duplicative.
- Make clarifications and remove obsolete and/or outdated language referencing payments and copayments in 12 VAC 30-141-50, 12 VAC 30-141-150, 12 VAC 30-141-175, 12 VAC 30-141-180, and 12 VAC 30-141-810.
- Remove outdated prior authorization language from 12 VAC 30-141-500 and 12 VAC 30-141-830.
- Repeal 12 VAC 30-141-670 because the definitions are duplicative and DMAS is merging chapter definitions into a single section at 12 VAC 30-141-10

The project is currently circulating for internal review.

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

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

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

***(06) Supplemental Payments for Freestanding Children's Hospital Physician Services:** In accordance with the Medicaid State Plan (Supplement 6 to Attachment 4.19-B) and 12VAC30-80-300, supplemental payments for services provided by physicians at freestanding children's hospitals must be calculated using the Medicare equivalent of the average commercial rate (ACR) methodology prescribed by CMS. DMAS

is required to recalculate the ACR every three years. The last ACR is dated July 1, 2020, and CMS requires DMAS to submit a new ACR calculation effective July 1, 2023. After performing calculations based on data provided by the Virginia freestanding children's hospitals, DMAS determined that the ACR must be increased from 178% of Medicare to 191% of Medicare. Following internal review, this state plan amendment was submitted to CMS for review on 7/24/23 and approved on 10/19/23.

***(07) Nursing Facility Value-Based Purchasing Program:** This SPA will allow DMAS to revise the nursing facility (NF) value-based purchasing (VBP) program for year two of the program. In accordance with the 2022 Special Session, Item 304.OOO, DMAS revised the state plan in 2022 to establish a unified, value-based purchasing (VBP) program that includes enhanced funding for facilities that meet or exceed performance and/or improvement thresholds as developed, reported, and consistently measured by DMAS in cooperation with participating facilities. During the first year of this program, half of the available funding was distributed to participating nursing facilities to be invested in functions, staffing, and other efforts necessary to build their capacity to enhance the quality of care furnished to Medicaid members. This funding was administered as a Medicaid rate add-on. The remaining funding was allocated based on performance criteria as designated under the nursing facility VBP program. Pursuant to the 2022 Special Session, Item 304.OOO, DMAS will revise the state plan again to reflect the second year of the nursing facility VBP program. The amount of funding devoted to nursing facility quality of care investments shall be 25 percent of available funding in the second year of the program before the program transitions to payments based solely on nursing facility performance criteria in the third year of the program. In the third year of this program, such funds as appropriated for this purpose shall be fully disbursed according to the aforementioned unified VBP arrangement to participating nursing facilities that qualify for the enhanced funding. Following internal review, the project was submitted to CMS on 8/15/22 and approved on 10/25/22. The corresponding regulatory project is currently circulating for internal review.

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

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

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

The SPA notes that the exchange will:
"… conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the

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

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

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

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

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

(15)Repeal of Out-of-Date and Unnecessary Regulations: This regulatory action is required in accordance with Governor Youngkin's Executive Order #19. DMAS has completed an internal review of these regulations and has determined that all of the content already exists in the DMAS Eligibility and Enrollment Manual on the DMAS webpage, and that these regulations are redundant and unnecessary, and should be repealed. Following internal review, the project was submitted to the OAG for review on 1/30/23.

(16) OTC Drugs: This SPA is required based on the CMS' request for Virginia to change the language related to over-the-counter (OTC) drugs. CMS asked DMAS to include the following sentence in order to indicate where a list of OTC drugs could be located: "A list of specific covered drug categories is published

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

2022 General Assembly

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

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

(03) Medicaid Enterprise System: The purpose of this final exempt regulatory action is to make technical updates to several of the agency's regulations to reflect the Department's transition of several key information management functions handled through the Virginia Medicaid Management Information System (VAMMIS) to a new technology platform called the Medicaid Enterprise System (MES). The MES replaced the department's VAMMIS on April 4, 2022. The reg project was posted to the Town Hall on 3/7/23 for OAG review.

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

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

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

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

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

2021 General Assembly

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

institutions, aligns DMAS regulations with 42 CFR 411.18(a)(8)(vii) and documents the Department's existing practices. Clarifying ISP review timeframes and grace periods, and clarifying CSAC-Supervisees can bill for substance use case management services, document existing DMAS practices, rather than changes in practices. Following internal review, the project was submitted to the OAG on 1/13/22. DMAS

received OAG inquiries on 1/19/22 and responded to those on 1/27/22. The regulatory action was approved by the OAG on 2/23/22 and was forwarded to DPB for review on 2/24/22. The project was forwarded to HHR on 4/5/22.

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

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

***(04) Consumer-Directed Attendants:** This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer- directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the
project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. DMAS reached out to the OAG to re-engage this project. The OAG sent additional revisions/questions on 9/12/22. DMAS forwarded responses to the OAG on 11/9/22. The OAG sent a request for additional edits on 12/6/22. DMAS coordinated the responses and submitted them to the OAG on 12/21/22. The OAG forwarded additional questions on 1/9/23. DMAS had placed the project on hold to review General Assembly outcomes to determine if pending legislation (SB 886) would impact this regulation. Edits were made to the project and the regulatory action was re-submitted for OAG review on 7/26/23. Additional edits were sent to the OAG on 9/28/23 and 10/25/23. The project was submitted to DPB on 11/9/23. A conf.

call w/ DPB was held on 12/5/23. DMAS submitted follow-up info to DPB on 12/7/23. DPB requested additional info on 12/8/23 and DMAS is currently working of the responses.

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

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

***(07) DSH Changes for Children's Hospitals:** DMAS seeks to create additional hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs, effective June 2, 2017. As part of this SPA, these new hospital supplemental payments, for freestanding children'shospitals, shall equal what would have been paid to the freestanding children's hospitals under the current disproportionate share hospital (DSH) formula without regard to the uncompensated care cost limit. These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional hospital supplemental payments authorized, accordingly. Following internal review, the DPB and Tribal notices for this SPA were submitted on 5/6/21. DPB approved the SPA on 5/10/21
and the project was submitted to HHR on 5/18/21. Following HHR approval on 5/20/21, the SPA was submitted to CMS on 6/7/21. Informal questions were received from CMS on 7/12/21 and responses were forwarded to CMS on 7/19/21. The SPA was approved by CMS on 8/24/21. The corresponding regulatory action was circulated for internal DMAS review and submitted to the OAG for review on 9/28/21. The OAG sent additional questions on 10/7/21 (DMAS response provided on 10/12/21) and 10/12/21 (DMAS response provided on 10/13/21). DMAS withdrew this regulatory action on 9/29/23.

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

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

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

2020 General Assembly

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

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

*(03) 2020 Long Term Services and Supports (LTSS) Screening Changes: For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in accordance with 2020 HB/SB 902 to allow qualified nursing facility staff to complete the Long- Term Services and Supports (LTSS) screening for individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The amendments to the Code include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community-based services. Following internal review, the regulations were submitted to the OAG for review on 11/18/20. Questions were received from

the OAG on 3/24/21 and revisions were forwarded on 4/1/21 and 4/14/21. DMAS submitted the project to DPB on 6/14/21. Questions were received on 6/21/21 and responses were sent to DPB on 6/21/21. A conf. call was held on 6/22/21 to discuss the project. The reg action was submitted to HHR on 6/23/21. The regs were forwarded to the Governor on 11/10/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21 (w/ corrections sent on 12/29/21); published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal DMAS review, the fast-track stage regs were submitted to OAG on 7/26/22. DMAS received comments from the OAG on 10/4/22. DMAS sent revisions to the OAG on 10/7/22. The project was submitted to DPB on 10/13/22 and DMAS responded to DBP questions on 10/18/22 and made additional revisions. The project's economic impact form was uploaded to the Town Hall on 10/13/22. A conference call with DPB was held on 11/7/22 to discuss the project. The reg action was submitted to HHR for review on 11/21/22. The agency response to DPB's economic impact analysis was posted to the Town Hall on 11/29/22. The Ofc. of Regulatory Management economic impact form was uploaded to the Town Hall on 10/13/22. A conf. call with HHR was held on 8/28/23 to discuss changes in reg text and to discuss implications. HHR approved DMAS proceeding with revisions to the regs on 11/2/23 and revisions were made. DMAS is currently awaiting the project's submission for the Gov's signature.

*(04) Update Average Commercial Rate (ACR) for Physicians Affiliated with Type One Hospitals: DMAS is required to recalculate the ACR every three years. The last ACR is dated April 1, 2017, and CMS requires DMAS to submit a new ACR calculation, effective April 1, 2020. After performing calculations based on data provided by Type One hospitals, DMAS determined that the ACR must be reduced from 258% of Medicare to 236% of Medicare. The DPB notification for this SPA was sent to DPB on 4/20/20. Following internal review, the SPA binder was forwarded to HHR for review on 5/20/20 and to CMS on 5/28/20. CMS approved the SPA on 7/31/20. Following internal review, the corresponding regulatory action was submitted to the OAG on 1/27/21. After multiple discussions with the OAG since March '21, DMAS withdrew this regulatory action on 9/29/23.

2017 General Assembly

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

ER was extended through 6/28/20. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21; to DPB on 12/6/21; to HHR on 1/19/22; and to the Governor's Ofc. on 6/1/22. Following approval from the Gov. Ofc., the project was submitted to the Registrar on 11/2/22 and was published in the Register on 12/5/22. Following the internal review of the final stage phase of the project, the regulations were submitted to DPB on 7/18/23 and to HHR on 8/7/23.

2015 General Assembly

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

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

8. New Business/Old Business

9. Public Comment – No public comments

10. Adjournment

Moved by Kannan Srinivasan; seconded by Greg Peters Dr to Adjourn 12:05pm.

Motion: 8 - 0

Voting For: Patricia T Cook MD, Ashley Gray, Kannan Srinivasan, Greg Peters Dr, Paul Hogan, Ashish Kachru, Elwood B Boone, Jason Brewster

Voting Against: None