CardinalCare
Virginia's Medicaid Program

DMAS

Our Mission & Values

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

Service **Collaboration** **Trust** **Adaptability** **Problem Solving**

CardinalCare
Virginia's Medicaid Program

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS) ANNUAL ORGANIZATIONAL REPORT FOR FYE 2024

CardinalCare
Virginia's Medicaid Program

DMAS Annual Organizational Report FYE 2024

August 15, 2024

Report Mandate:
Item 308.C of the 2023 Appropriation Act states:

The Department of Medical Assistance Services shall report a detailed accounting, annually, of the agency's organization and operations. This report shall include an organizational chart that shows all full- and part-time positions (by job title) employed by the agency as well as the current management structure and unit responsibilities. The report shall also provide a summary of organization changes implemented over the previous year. The report shall be made available on the department's website by August 15 of each year.

The mission of the Virginia Medicaid Agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid program and Children's Health Insurance Program (CHIP) for over 2.0 million Virginians.

Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant individuals, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.

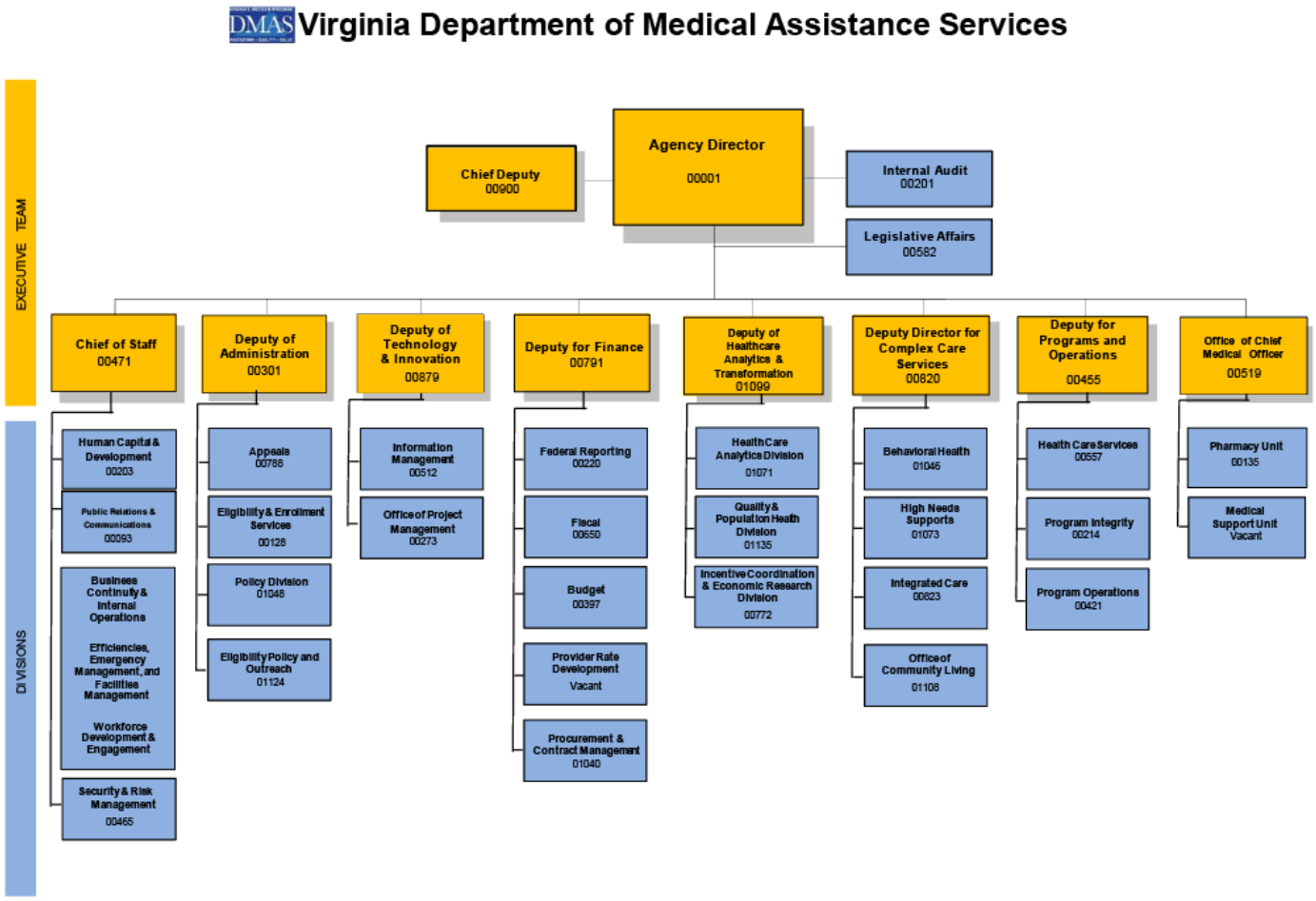
Summary

The following annual report provides a detailed account of the Agency's organization and operations through fiscal year-end 2024.

The report provides summary information by each division along with unit responsibilities and core functions. An organizational chart for each division follows each summary. The organizational chart displays all full and part-time positions, including a position number just below the role title. Each position number is five characters in length and all part-time positions begin with a "W." Part-time positions, also referred to as wage positions, supplement the classified (full-time) positions and are restricted to 1500 hours per year.

Finally, the report provides a narrative summary of organizational changes made during fiscal year 2024 and a chart with workforce data demonstrating filled positions and separations.

DMAS Overall Agency Organizational Chart



Appeals Division

The Appeals Division reports to the Deputy of Administration and Coverage. The mission of the Appeals Division is to provide a neutral forum where Virginians and healthcare providers can understand, and challenge adverse decisions made by DMAS or its contractors and receive due process in a fair and just manner. The purpose of appeals is to provide due process to applicants, members, and providers; afford an opportunity to be heard; guarantee a neutral review of Agency action; and to render a decision in accordance with state and federal law. The Appeals Division has two core functions/units of responsibility: Client Appeals and Provider Appeals.

Client Appeals

Client appeals involve eligibility for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits and medical necessity for every service/equipment that Medicaid covers. Client appeals include individuals enrolled with Virginia Medicaid or seeking enrollment, and case types include eligibility for Medicaid and medical benefits. There is one level of appeal with DMAS for eligibility appeals. If the appeal involves an action taken by a Virginia Medicaid Managed Care Organization (MCO), the individual must exhaust the MCO's internal appeal process before appealing to DMAS. In October 2020, DMAS began conducting all client appeals as *de novo* hearings to comply with federal law. In a *de novo* hearing, all relevant information and documents submitted during the client appeal are considered to determine if coverage can be approved, even if that information was not available during the initial request for coverage.

Provider Appeals

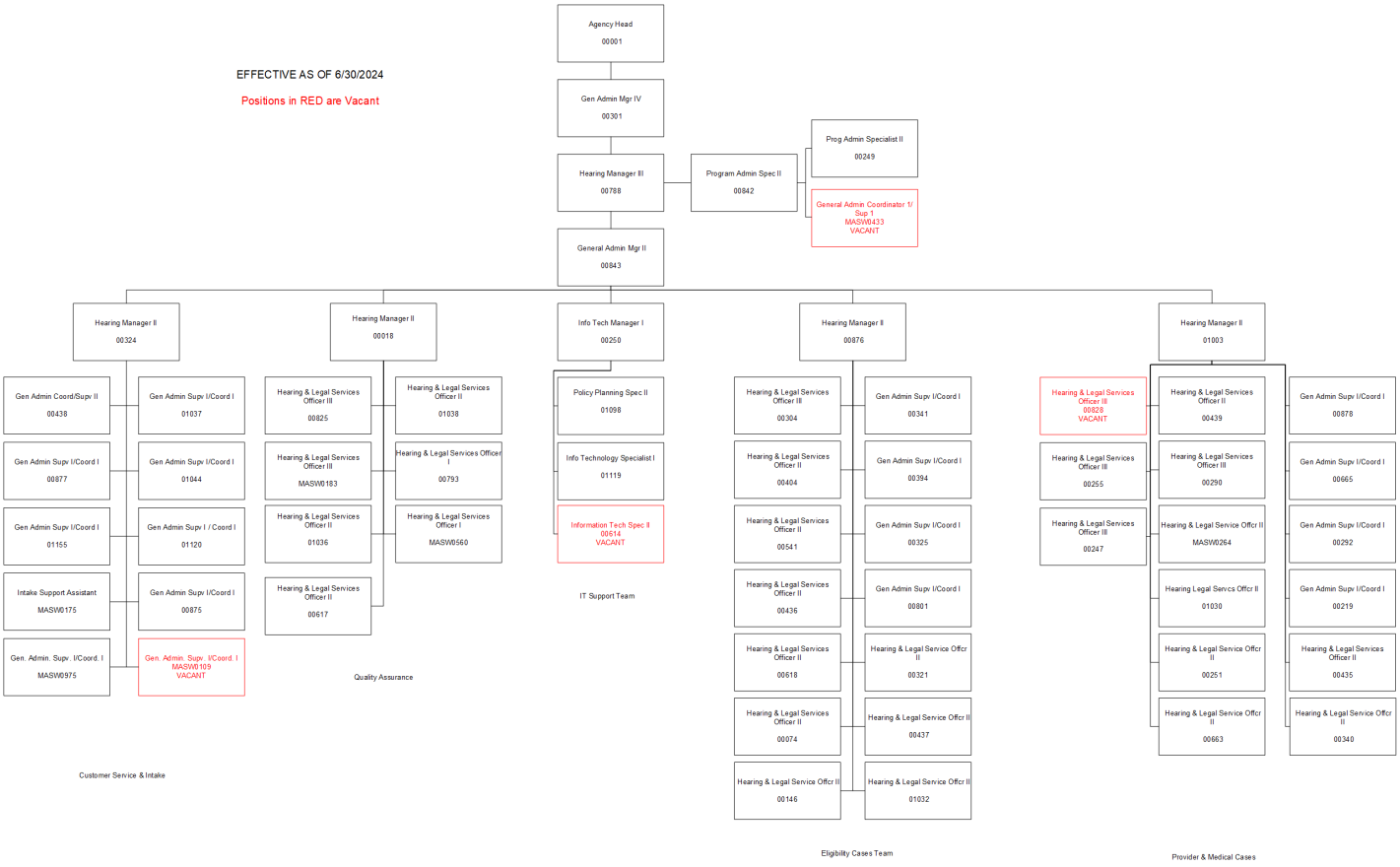
Provider appeals occur after services have already been rendered. Provider appeals involve every type of provider with whom the Agency contracts, including physicians, hospitals, residential treatment facilities, nursing homes, adult care residences, home health agencies, durable medical equipment suppliers, pharmacists, etc. Provider appeals stem from providers who are enrolled with Virginia Medicaid or are seeking enrollment. The case types include service authorization, billing, enrollment, and audits. There are two levels of appeal with DMAS: Informal and Formal appeals.

The DMAS Civil Rights Coordinator also reports to the Appeals Division Director. The Civil Rights Coordinator ensures DMAS complies with language access and disability access requirements for the Virginia Medicaid program. Additionally, the Civil Rights Coordinator investigates grievances from the public alleging violations of civil rights laws.

Virginia Department of Medical Assistance Services
Deputy for Administration
Appeals Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are Vacant



CardinalCare
Virginia's Medicaid Program

Behavioral Health Division

The Behavioral Health (BH) Division reports to the Deputy Director of Complex Care Services. The BH Division serves as subject matter experts for DMAS behavioral health policy and is responsible for statewide policy development and implementation related to a full continuum of mental and substance use disorder services. The BH Division is composed of 12 full time positions and 5 part time positions that include policy, program, and operations expertise. Policy development, program implementation and operationalizing how BH services are implemented within our Fee-For-Service (FFS) and Managed Care (MCO) programs, includes the following responsibilities:

- Develop, implement, maintain, and clarify behavioral health policies, regulations, other policy communications related to new and existing behavioral health services.
- Serve as the main point of contact for Centers for Medicare and Medicaid Services (CMS) for Medicaid covered behavioral health services.
- Serve as primary contact for inquiries from the Office of Attorney General regarding BH services.
- Educate and provide technical assistance, in collaboration with other DMAS divisions, to stakeholders concerning all aspects of providing BH services, from enrollment to claims processing and serves as the Agency subject matter expert for appeals as well as other related audits for BH.
- Monitor, in collaboration with the Program Operations Division, the FFS service authorization contract for administering FFS behavioral health services and carved out behavioral health services, including youth mental health residential services and treatment foster care case management.
- Facilitate stakeholder engagement, including communications, presentations, trainings, and technical assistance; facilitate issue resolution between behavioral health stakeholders, the FFS service authorization contractor, and MCOs; serve as the agency's primary point of contact for any states that may inquire about Virginia Medicaid BH services.
- Track and analyze the impact of Virginia legislative initiatives in coordination with the Policy Division and the Office of Communications, Legislation and Administration.
- Manage and facilitate all aspects of the Addiction and Recovery Treatment Services (ARTS) 1115 waiver to include monthly calls with CMS, reporting at quarterly and annual cadences, interim, midpoint and final evaluations, as well as renewals/amendments to the waiver.
- Manage the required Addiction and Recovery Treatment Services (ARTS) 1115 waiver evaluation with the evaluation contractor.
- Serve as the primary point of contact for the BH components of the External Quality Review Organization's (EQRO) contract and its deliverables.
- Develop and maintain the Preferred Office Based Addiction Treatment (OBAT) applications ensuring their accuracy, as well as review and determine approvals/denials for providers receiving this recognition. Represent DMAS in appeals for providers who appeal denial of OBAT recognition.
- Work collaboratively with other state agencies implementing major behavioral health initiatives to ensure alignment in systems transformation efforts.

Virginia Department Medical Assistance Services
Deputy of Complex Care Services
Behavioral Health Division

EFFECTIVE AS OF 6/30/2024

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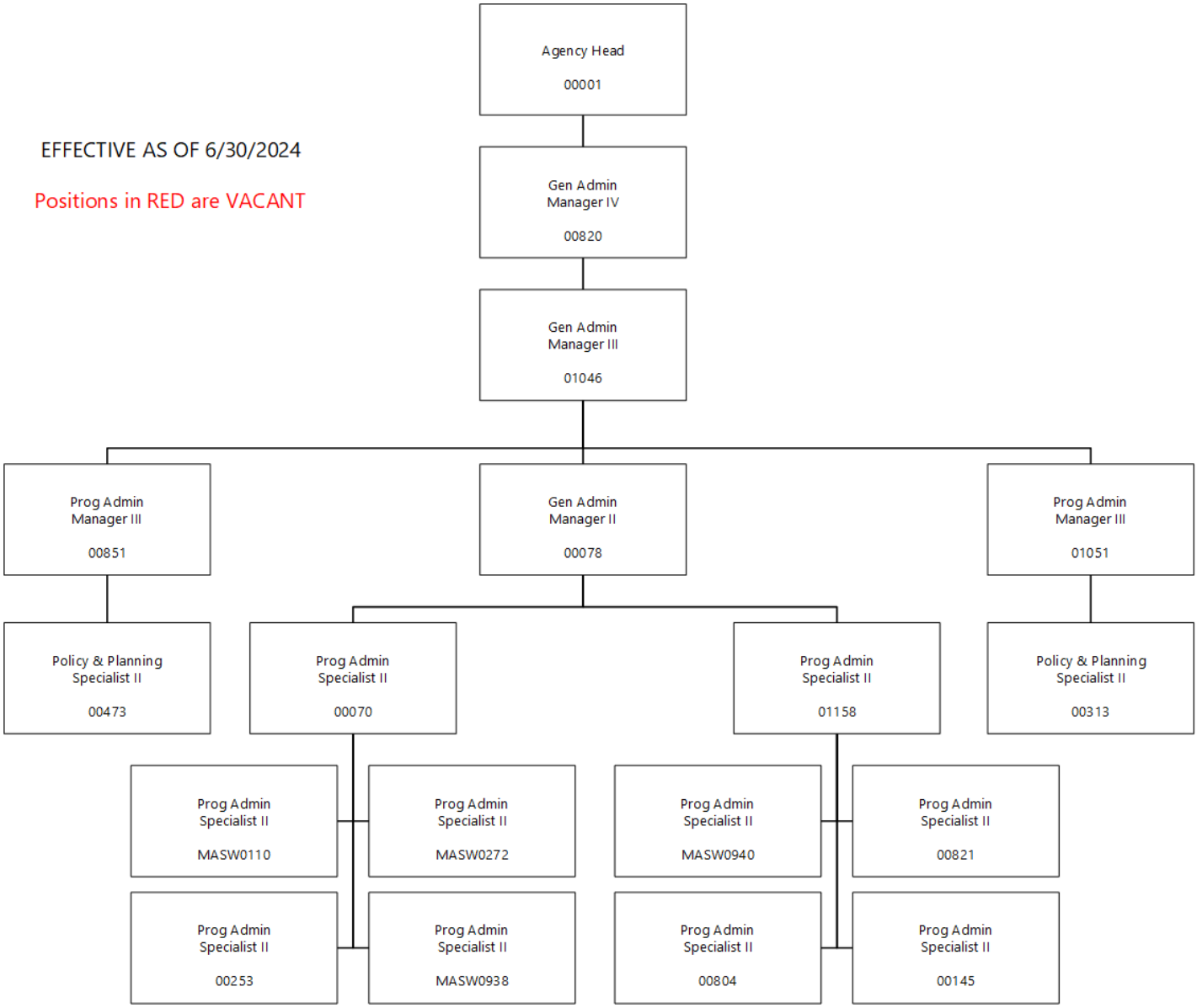


Budget Division

The Budget Division reports to the Deputy Director of Finance/Chief Financial Officer (CFO). The Budget Division's primary role is to support the Agency's mission by securing and managing appropriations in compliance with state and federal regulations and providing well-informed, timely, and accurate budgetary information to all stakeholders.

Key functions of the Budget Division:

- Develop and implement the administrative and medical appropriation for Title XIX (Medicaid), Title XXI (Child Health Insurance Program) and other state-funded health programs.
- Monitor and report the administrative and medical revenues and expenditures for Title XIX (Medicaid), Title XXI (Child Health Insurance Program), and other state-funded health programs.

The Budget Division comprises three units: Administration Budget, Medical Budget, and Forecast and Cost Estimate.

Administration Budget

The Administration (Admin) Budget unit is responsible for budget development for administrative and support services. This includes coordinating the development and submission of decision packages, coordinating the completion of fiscal impact statements, and monitoring/implementing administrative-related reports related General Assembly actions. The Admin Budget unit is also responsible for budget administration. This includes monitoring/reporting administrative revenues/expenditures; monitoring contracts and invoices to ensure proper accounting/funding; and monitoring cash flow to ensure Agency spending is below appropriation.

Medical Budget

The Medical Budget unit is responsible for assisting with budget development of medical-related services, which includes coordinating the development and submission of decision packages, coordinating the completion of fiscal impact statements, and monitoring/implementing medical-related actions of the General Assembly. In addition, the Medical Budget unit is responsible for monitoring/reporting medical-related revenues/expenditures and monitoring contracts and invoices to ensure proper accounting/funding. This involves ensuring costs are accurately monitored/reported within state/federal budgets, compliance with federal regulations, and ensuring adequate funding is available. This unit also prepares quarterly reports to meet federal reporting requirements.

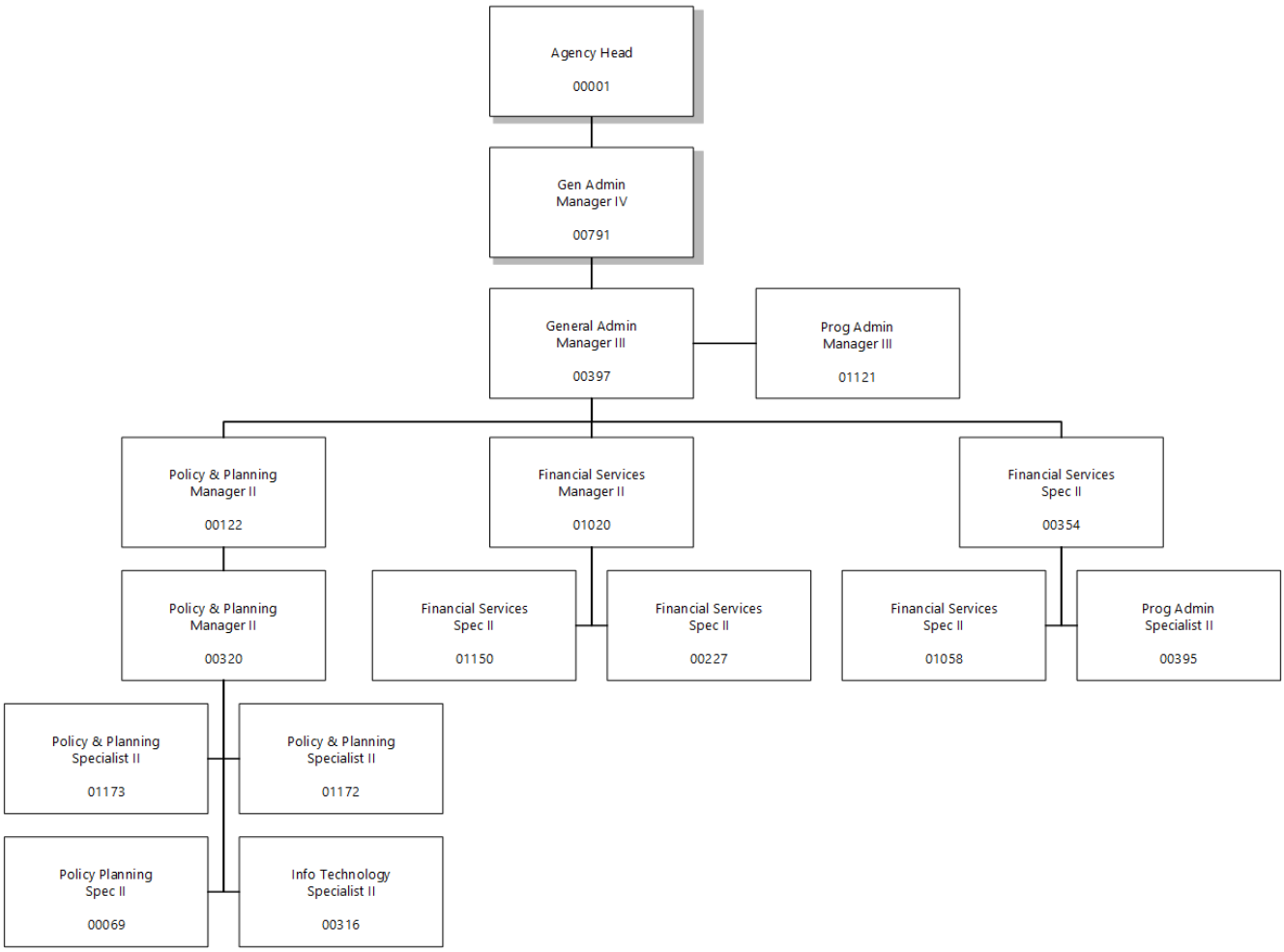
Forecast and Cost Estimate

The Forecast and Cost Estimate unit is responsible for developing the Agency forecast and monitoring the funding needs for all medical services. The unit is responsible for providing medical cost estimates, as needed, for internal and external requests, along with data management. This entails collecting, managing, and reporting expenditure and member data.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Finance and Technology
Budget Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Chief of Staff Office

The Chief of Staff (COS) reports to the DMAS Director and is responsible for managing the day-to-day operations and continuity of the essential business functions within the Agency. The Chief of Staff Office supports the Agency by ensuring that the workforce has the tools needed to carry out the essential business functions that directly affect the delivery-of-services to our Medicaid members. The roles within the COS Office drives workforce and operational efficiencies within the organization. COS Office business functions include Workforce Development and Engagement, Business Continuity and Efficiencies, Emergency and Facility Management, Agency Risk Management, Public Relations and Communications, and oversight of the operational and budgetary aspects of the Director's Office. In addition to these business functions, the Human Capital and Development (HCD) Division reports to the Chief of Staff.

The COS Office has a direct focus on internal business functions, operations, and workforce. This function is different from that of the Chief Deputy, whose primary foci are on Agency policy, external stakeholders, special projects, and serving as a backup for the Agency Director in external meetings.

The COS Office is responsible for the day-to-day operations of the Director's Office and the internal operations of the Virginia Medicaid Program. It works collaboratively with others in Executive Leadership to ensure proper coordination and streamlining of activities within the Agency, coordination and implementation of operational business processes, and arranges coordination of strategic goals. It ensures innovative, efficient and effective internal operations, creates and implements the Agency's business continuity plans, and coordinates all executive leadership meetings and decision memos. The COS Office strengthens the DMAS workforce by providing a safe physical environment, promoting the necessity of workforce development and engagement, and establishing an environment where all workforce members can succeed and excel in their careers. The COS enhances DMAS business functions through strategic planning and adequate resource alignment with the Agency's priorities. It also provides communications on behalf of the Executive Leadership Team (ELT) surrounding high-priority issues, handles media inquiries and events, supports digital accessibility, and manages the Agency's website and social media accounts. The COS Office promotes "One Agency voice" with internal and external stakeholders in an effort to increase transparency and awareness across the Agency.

The Office of the Chief of Staff provides leadership on the following goals for the Department of Medical Assistance Services and its Medicaid members:

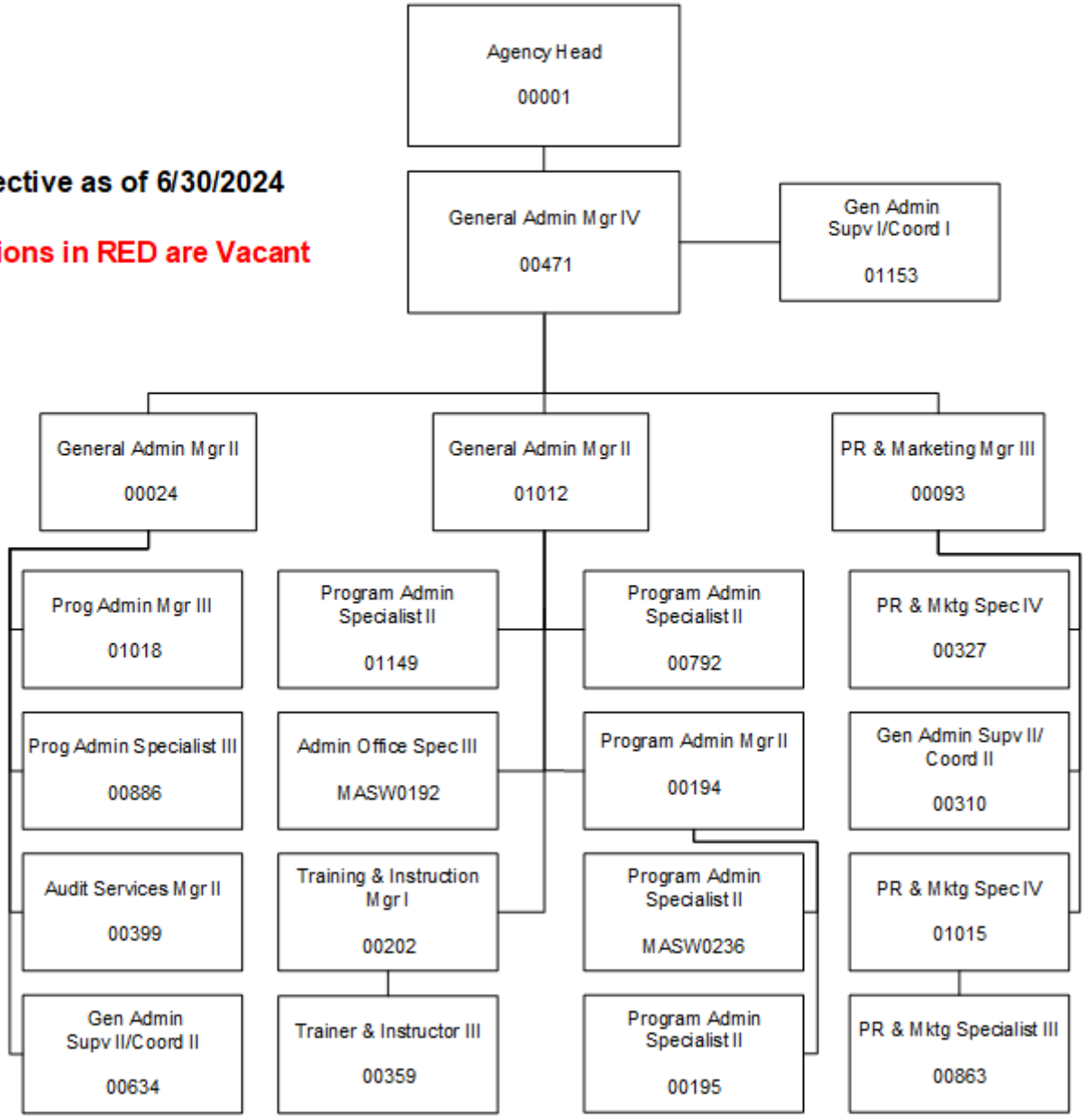
1. Increase efficiencies in both current business functions and Agency Operations: Additional streamlining of operations in order to improve the services being provided to Medicaid Members and also ensure Business Continuity for the Agency. Certify that the Agency has all of the resources needed in order to carry out daily functions and strategic initiatives.
2. Ensure identification, assessment, and analysis, of threats to the DMAS Agency via Risk Management: Apply greater focus toward identifying and mitigating internal risks.
3. Communicate effectively internally and externally: Improve member communications with a focus on better coordination of websites, and other digital platforms, to ensure clearer pathways for members to locate necessary information to support their abilities to make the best decisions about their health care coverage.

4. Ensure each member of DMAS feels safe, supported, and valued. Provide the tools necessary to be successful in their positions and identify opportunities for advancement: To include attracting, developing, training, and retaining qualified employees.

Virginia Department Medical Assistance Services
Office of the Chief Of Staff

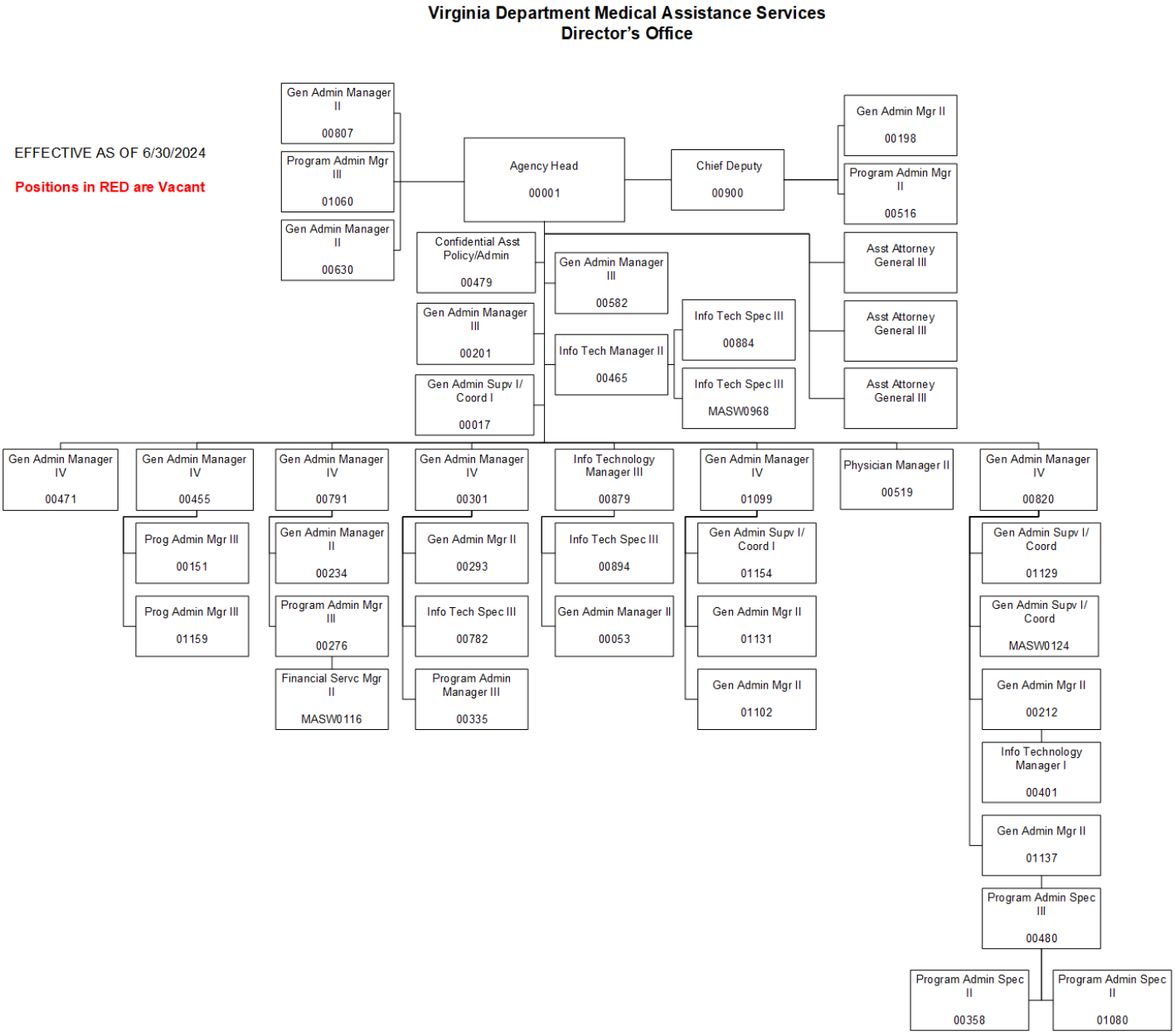
Effective as of 6/30/2024

Positions in RED are Vacant



Director's Office

The Director's Office is comprised of executive leadership, executive assistants, senior advisors, and their direct reports. Specifically: The Agency Director, Chief Deputy, Chief of Staff, Deputy of Administration, Deputy of Technology and Innovation, Deputy of Finance, Deputy of Healthcare Analytics and Transformation, Deputy of Complex Care Services, Deputy of Programs, and Office of the Chief Medical Officer. The Director's Office also has the following functions within it: Legislative Affairs and Nursing Facilities Quality Unit, of which, the latter reports directly to the Deputy of Complex Care.



Eligibility and Enrollment Services

The Division of Eligibility and Enrollment Services (EES) reports to the Deputy Director of Administration and Coverage. EES brings together all activities related to eligibility and enrollment in the Medicaid and FAMIS programs in a single division staffed with a coordinated, expert team. The division is comprised of three units, each with a distinct function: the Newborn and Member Enrollment Unit, Cover Virginia Operations Unit, and Reporting and Performance Management Unit.

Newborn and Member Enrollment Unit

The Newborn and Member Enrollment Unit is responsible for ensuring all newborns born to Medicaid and FAMIS members are enrolled in coverage accurately and timely. The unit accepts birth notifications from providers and health plans, enrolls newborns in coverage, and provides notification of enrollment to local Departments of Social Services (DSS) and providers. This unit plays an important role in ensuring newborns born to an individual enrolled in Medicaid can quickly access any needed medical care and services. This unit is also responsible for enrollment coverage corrections, such as requests from local DSS agencies, cancellation of coverage for deceased individuals based on reporting from the Virginia Department of Health (VDH), research and correction of duplicate enrollments, research and resolution of monthly enrollment reports related to Social Security number discrepancies, and other enrollment related issues.

Cover Virginia

Cover Virginia is both a central site for acceptance and processing of Medicaid/FAMIS applications, as well as a site for co-located DMAS staff to monitor the Cover Virginia contract and resolve complex case issues. Cover Virginia's operations house several centralized operations which support the Medicaid program in Virginia to include:

- Call Center: the state's federally mandated centralized call center which accepts telephonic applications, renewals, and members' reports of changes in circumstances. Additionally, the call center provides resources and information to callers.
- Central Processing Unit (CPU): the Cover Virginia CPU supports the Medicaid program through data entry of applications received telephonically, online, and from the state-based exchange, Virginia's Insurance Marketplace.
- Cover Virginia Incarcerated Unit (CVIU): the CVIU works directly with the Department of Corrections (DOC), local and regional jails, and the Department of Juvenile Justice (DJJ) to process applications for justice involved populations. Additionally, the CVIU maintains cases for this population to include the processing of annual renewals, changes in circumstances, and reevaluating individuals for ongoing coverage upon reentry into the community to ensure access to care at release.

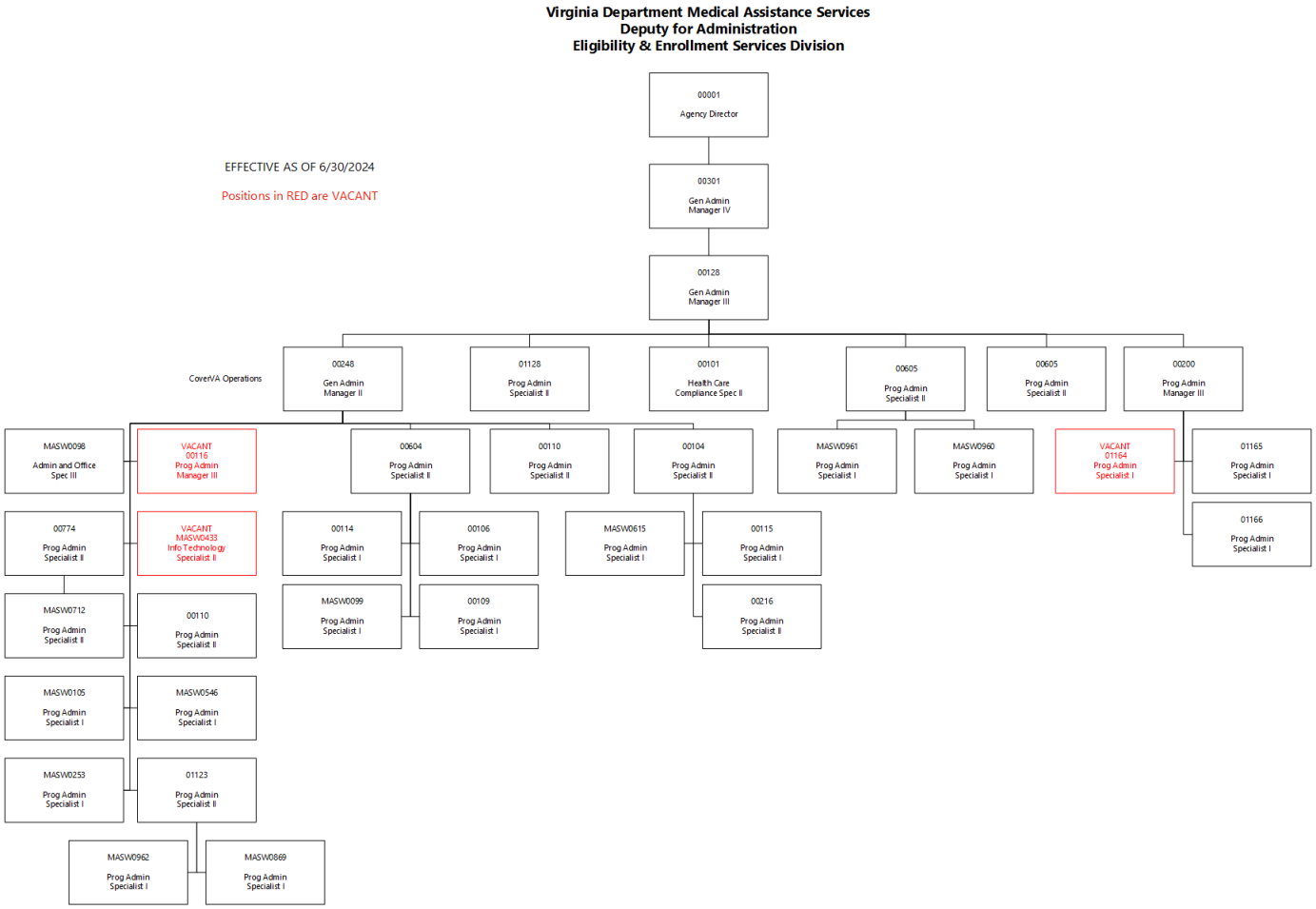
The Cover Virginia operations also include a mailroom and Quality Assurance Unit.

Reporting and Performance Management Unit

The Reporting and Performance Management (RPM) Unit performs several functions critical to the operations of the Eligibility and Enrollment Services Divisions. This unit's functions include:

- Facilitated enrollment-outreach to interested applicants based on information received from the Department of Taxation
- Federal Reporting- eligibility reviews in compliance with federal reporting claim reviews
- Eligibility Audits and Reviews- eligibility review activities for state and federal eligibility audits
- State Based Exchange-coordination and collaboration on eligibility determination functions

Additionally, the unit is responsible for the Eligibility Performance Management Program (EPMP), which was legislatively mandated for DMAS to work with the Virginia Department of Social Services and other stakeholders. It develops performance measures to be followed by both local departments of social services and the Cover Virginia central site. The purpose is to improve accountability for DMAS, as the single state Medicaid Agency, by ensuring that local departments of social services, as well as Cover Virginia are accurately determining, enrolling, and re-determining eligibility for qualified individuals.



Eligibility Policy and Outreach

The Eligibility Policy and Outreach Division (EPO) reports to the Deputy Director of Administration. It is comprised of the Eligibility Policy Unit and the Outreach and Member Engagement unit. EPO is responsible for tracking and implementing state and federal legislation, guidance, and mandates related to Medicaid/FAMIS eligibility. The division also develops resources to educate members and community-based stakeholders about new initiatives and program changes.

Eligibility Policy Unit

The Eligibility Policy unit is responsible for Medicaid and FAMIS eligibility policy development. It, revises and maintains the state's Medicaid Eligibility Policy Manual, Medicaid and FAMIS Member Handbooks, and provides written and verbal policy clarifications. The unit provides legislative support, internal and external policy training, and assistance in resolving systems-issues related to eligibility. Staff in this unit work with Department of Social Services' (DSS) staff to develop requirements for systems changes and perform testing before changes related to Medicaid or FAMIS eligibility are implemented. Staff in this unit collaborate with the DMAS Information Management (IM) Division and selected vendors to develop requirements and testing for the new Medicaid Enterprise System (MES).

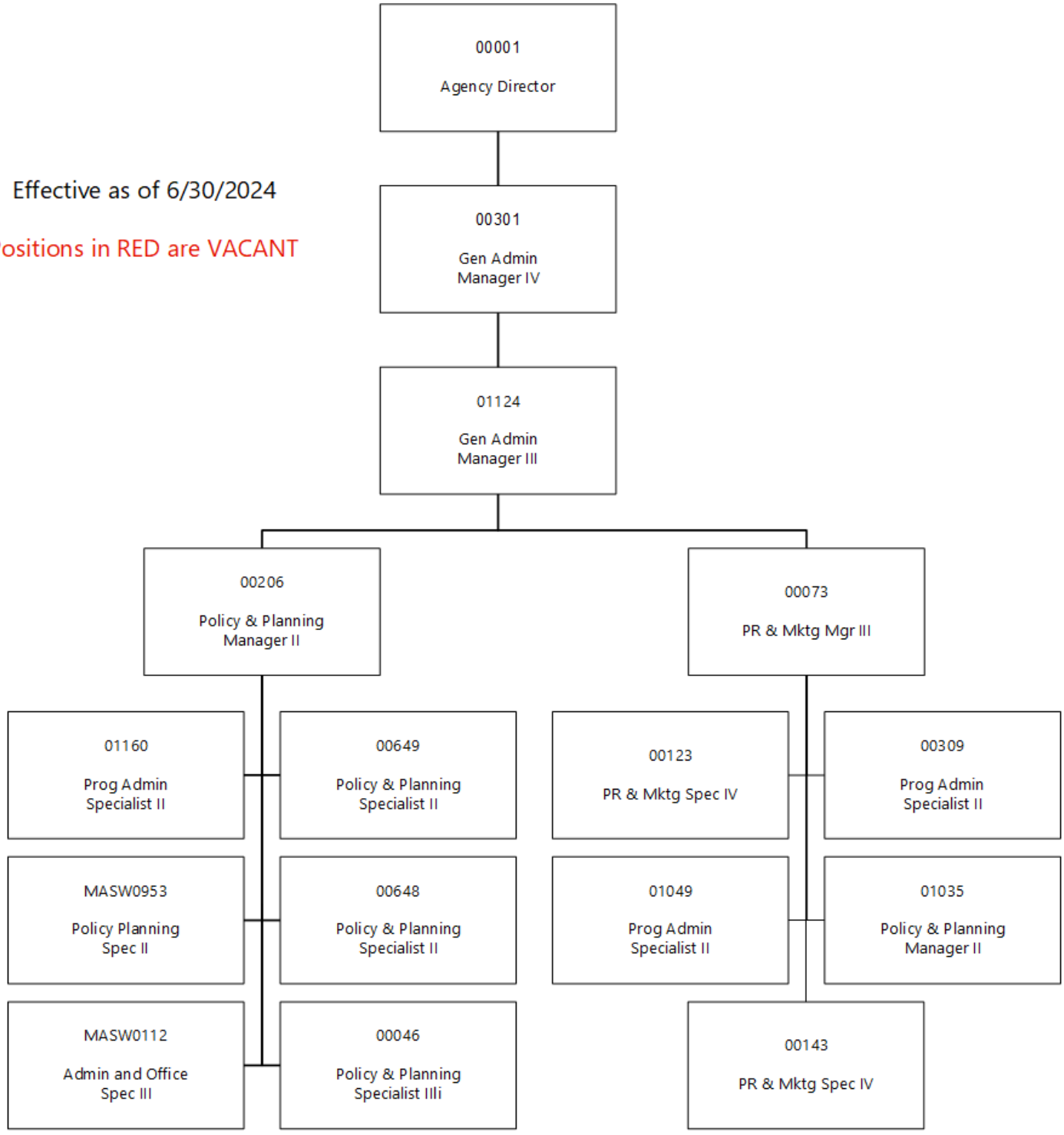
Outreach and Member Engagement Unit

The Outreach and Member Engagement unit is responsible for providing outreach and strategic community engagement initiatives for the Medicaid and FAMIS programs across the Commonwealth. Additionally, this unit provides member and community education, oversight of the Member Advisory Committee (MAC), and houses the DMAS Support Team for Application Response (STARs).

Virginia Department Medical Assistance Services
Deputy for Administration
Eligibility Policy & Outreach Division

Effective as of 6/30/2024

Positions in RED are VACANT



Federal Reporting

The Federal Reporting Division reports to the Deputy Director for Finance/Chief Financial Officer. The division consists of two units that manage and direct all aspects of the Agency's financial reporting to the federal government. The division is responsible for the compilation and submission of the following reports: CMS-64, CMS-21, CMS-372, CMS-416, and the Public Assistance Cost Allocation Plan and Amendments. The division is also responsible for processing quarterly cost allocations and serves as the primary contact with federal financial reviewers and auditors.

Reporting

The Reporting unit is primarily responsible for compiling the quarterly medical cost reports (CMS 64.9 Traditional Medicaid, 64.VIII Medicaid Expansion, 64.21 MCHIP and CMS 21 CHIP). This responsibility includes complex reconciliations; fluctuations analysis; waiver reports for cost-neutrality (CMS 372); and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participation report.

Planning

The Planning unit is responsible for compilation of the Agency's Public Assistance Cost Allocation Plan and executes the quarterly cost allocations in accordance with federal mandates. This function includes reviewing other agency cost allocation plans and Inter-Agency Agreements. The unit is also responsible for the compilation of the quarterly administrative cost reports (CMS 64.10 and CMS 21 CHIP Adm.) and Statistical Enrollment reports (CMS-21E, CMS-64.21E and CMS-64.EC).

Virginia Department Medical Assistance Services
Deputy of Finance
Federal Reporting Division

EFFECTIVE AS OF 6/30/2024

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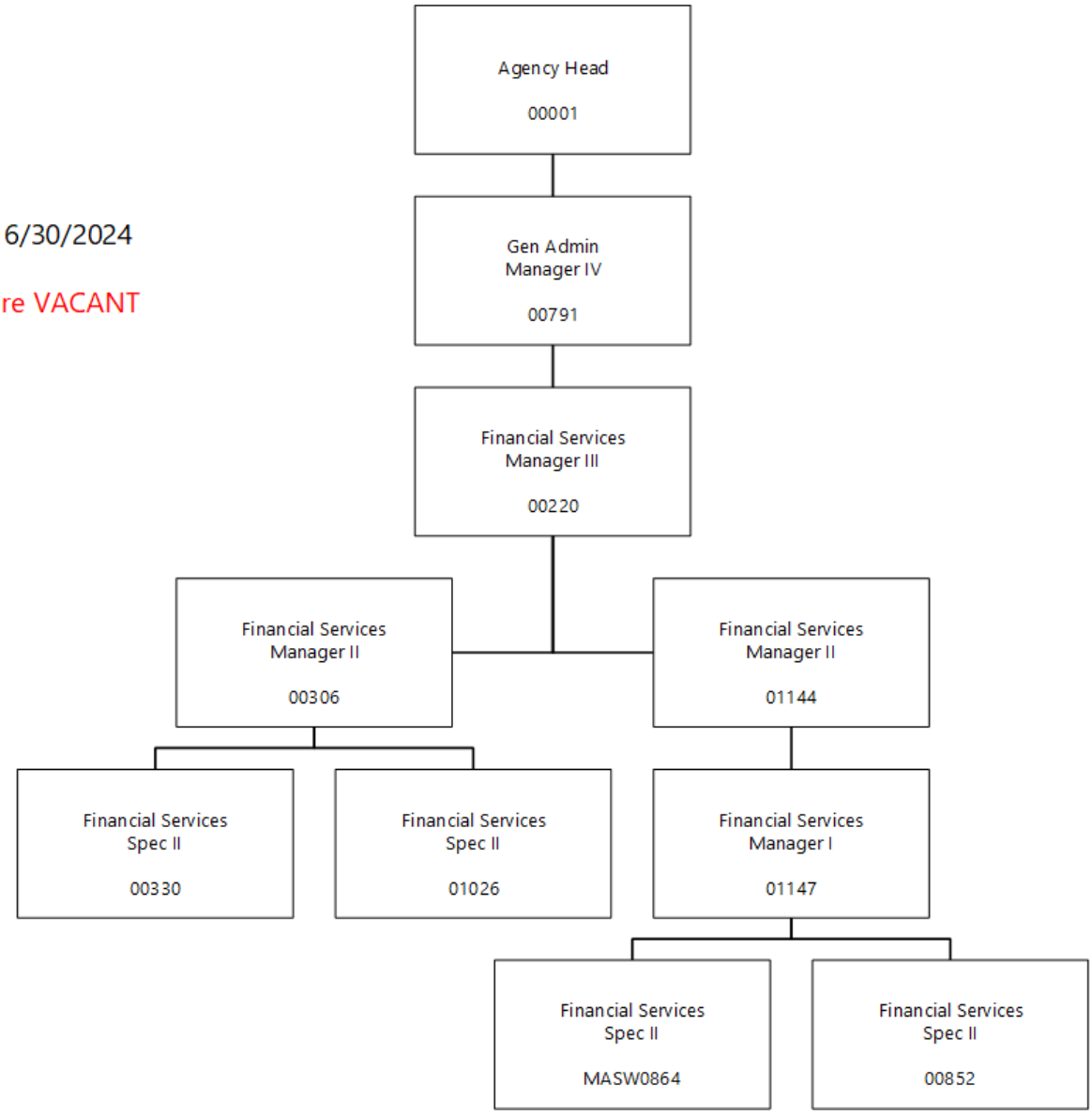

Fiscal Division

The Fiscal Division reports to the Deputy Director for Finance/Chief Financial Officer. The Fiscal Division provides accounting, reporting, and financial management services to the Department. The division consists of six units: Accounts Payable and Disbursements; Cash Management & Accounts Receivable; General Ledger and Reporting; Grants Management; and Third-Party Liability (TPL). The Fiscal Division is the Agency's center for business transactions. The division is responsible for overseeing, evaluating, and reporting on Agency financial accountability and compliance with Commonwealth Accounting Policies and Procedures (CAPP) to assist DMAS managers and staff in meeting their responsibilities for protecting the resources of the Commonwealth.

Accounts Payable and Disbursements

The Accounts Payable (AP) and Disbursements unit is primarily responsible for processing Agency payments. This includes processing all vendor payments, travel reimbursements, wire transfers, revenue refunds and petty cash transactions. The unit is responsible for processing the weekly remittance of claims paid by the fiscal agent and the processing of administrative add-pays through the Fiscal Agent Services (FAS) system. This unit ensures 1099 filing related to vendor payments through the Commonwealth's Finance System (Cardinal) are produced/distributed in accordance with CAPP Topic 20319. The unit is also responsible for the review and certification of the Agency's payroll and distribution of employee W-2s.

Accounts Receivable and Cash Management

The Accounts Receivable (AR) and Cash Management unit is responsible for the management and reporting of amounts due to the Agency. It ensures sound internal controls and compliance with federal and state regulations. It also manages the recording and reporting of Agency general cash receipts including requested and volunteer refunds (miscellaneous and TPL health insurance provider), Taxation Debt Set-off Program, TPL Casualty Recovery Application, electronic health record-incentive, provider enrollment fees, and Civil Monetary Penalties. The unit manages fiscal agent processing of provider and payee FAS remittance checks and electronic funds transfer (ETF) stop pays (reissues and voids), as well as Advance Payment Requests across all benefit programs. The unit also validates provider registration fee deposits and refunds and reviews provider and payee annual 1099 files. The unit also ensures Agency receivables are properly managed and reported, and that funds due to the Agency are collected in accordance with federal (42 CFR §433.300) and state (CAPP Topic 20505) requirements.

General Ledger and State Reporting

This unit reconciles all accounts in the Cardinal Accounting System to the Agency's Oracle Accounting System on a monthly basis and certifies to the Department of Accounts (DOA). The unit analyzes and reconciles Agency expenditures by program, fund, and expense code each month. It manages processes for monthly and fiscal year-end close of accounting systems in accordance with directives from the State Comptroller. The unit also accounts for Agency assets and leases as required by state procedures (CAPP Topic 30105-31310). The unit prepares and submits year-end financial schedules and other requested data to DOA for preparation of the Comprehensive Annual Financial Report.

Grants Management

This unit is responsible for preparing the weekly request for federal funds from the corresponding federal grant to support the federal share of the Agency's expenses. The unit reviews medical and administrative cash receipts to identify the "federal funds returned to program (FRTP)" and ensures these funds are wired to the Federal Division of Payment Management. As part of the annual statewide interest liability calculation, the unit prepares, coordinates, and submits Cash Management Improvement Act reporting requirements to the DOA specifically for Medicaid and Children's Health Insurance Program (CHIP) federal grant awards. The unit completes and submits federal schedules to the DOA for preparing the annual statewide Schedule of Expenditures of Federal Awards for the Single Audit Report Amendments of 1996, and Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Third Party Liability (TPL)

Medicaid is the payer of last resort. The TPL unit works in partnership with the outside vendor Health Management Services (HMS). HMS performs data matches with insurance carriers to update members' third-party resource information to pursue recoveries from primary insurance carriers. The unit also processes referrals related to members' primary health insurance verifications to ensure they can enroll in programs and receive needed services. The unit pursues recovery related member casualty events as required by 4 CFR 433.138. The unit is also responsible for estate recoveries as required by Section 1917 of the Social Security Act, Code of Virginia §32.1-326 and §32.1-327. In addition, the unit performs daily and monthly accounts receivable reconciliations between the Third-Party Liability Recovery System (TPLRS) and the Oracle financial system Accounts Receivable module for recovery cases established by the TPL unit. The unit is also responsible for Hospital Credit Balance Reporting to recover credit balances reported on the hospitals quarterly Credit Balance Report.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Finance
Fiscal Division

EFFECTIVE AS OF 6/30/2024

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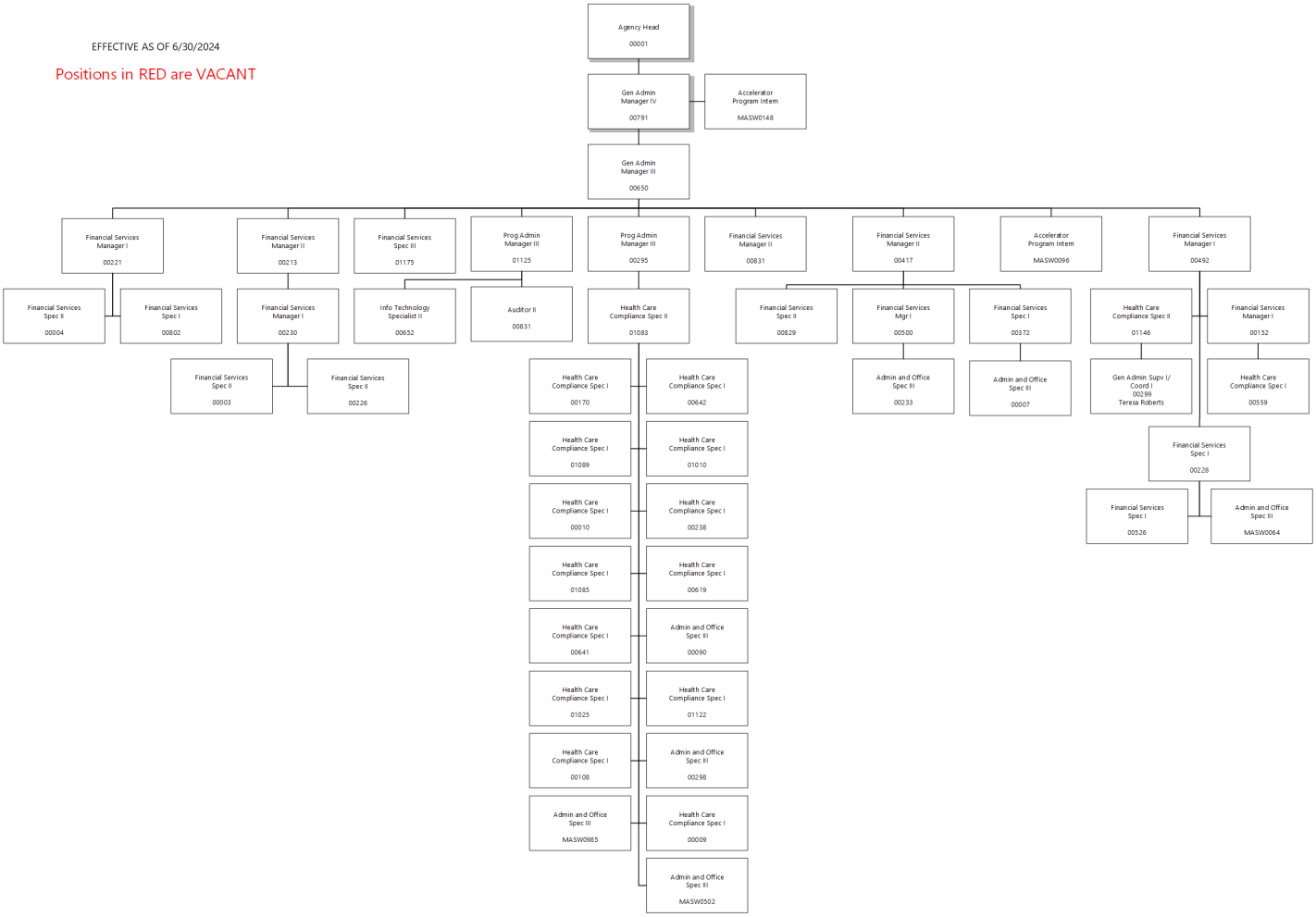

Healthcare Analytics and Transformation (HAT)

Healthcare Analytics and Transformation (HAT) reports to the Deputy of Healthcare Analytics and Transformation. HAT includes the Healthcare Analytics Division, the Incentive Coordination and Economic Research Division, and the Quality and Population Health Division. HAT and its team of data analytics, economic research, policy, and healthcare quality professionals support DMAS in acquiring and transforming data into meaningful and useful information for business analysis purposes. HAT is responsible for providing the "data story" to educate and inform policymakers on DMAS activities. It is intended to improve the clinical outcomes of the Commonwealth's Medicaid and FAMIS beneficiaries while promoting cost effective and efficient delivery of care. HAT represents DMAS' interests on high priority utilization, payment, and delivery system reform issues, and supports the Agency's efforts to build and maintain relationships with external stakeholders to increase their understanding of, and support for, DMAS's mission and strategic goals. In addition, HAT provides internal and external stakeholders with analysis and recommendations on cost, coverage, quality, and utilization trends, which could affect the Department's future work.

Healthcare Analytics Division

The Healthcare Analytics Division (HAD), formerly the Office of Data Analytics (ODA), reports to the Chief Analytics Officer as part of the Healthcare Analytics and Transformation team. Its mission is to empower data-driven decision-making. It provides top-tier analytics and analytical support within the Agency and to external stakeholders by supplying accurate and timely reporting, data analyses, visualizations, and special projects. HAD provides a structured analytics environment for data integrity, data consistency, well-documented research, and repeatability. It comprises two units: the Data Visualization Unit and Enterprise Data Warehouse Solution (EDWS) Unit. HAD works with external agencies to find avenues to share and analyze different aspects of health data. These functions allow the Agency to achieve insight into quality measures that can help DMAS assess the effectiveness of current programs, proposed programs, and new programs.

The Healthcare Analytics Division (HAD) comprises two units:

Data Visualization

The Data Visualization unit creates the business intelligence necessary for understanding current views of Agency operations, such as dashboards using business analytics software like Tableau dashboards. It provides critical historic analyses essential to understanding the impact of Agency activities on our members, providers, and sibling agencies. It focuses on why a phenomenon has occurred and what may happen next.

Enterprise Data Warehouse Solution

The Enterprise Data Warehouse Solution unit has a suite of technologies. The suite of technologies provide data storage and documentation, completes ad hoc analyses answering the "what happened" questions that drive policy evaluation and performance improvement, and provides technical support of the SAS analytics platform.

Virginia Department of Medical Assistance Services
Healthcare Analytics & Transformation
Healthcare Analytics Division

Effective as of 6/30/2024

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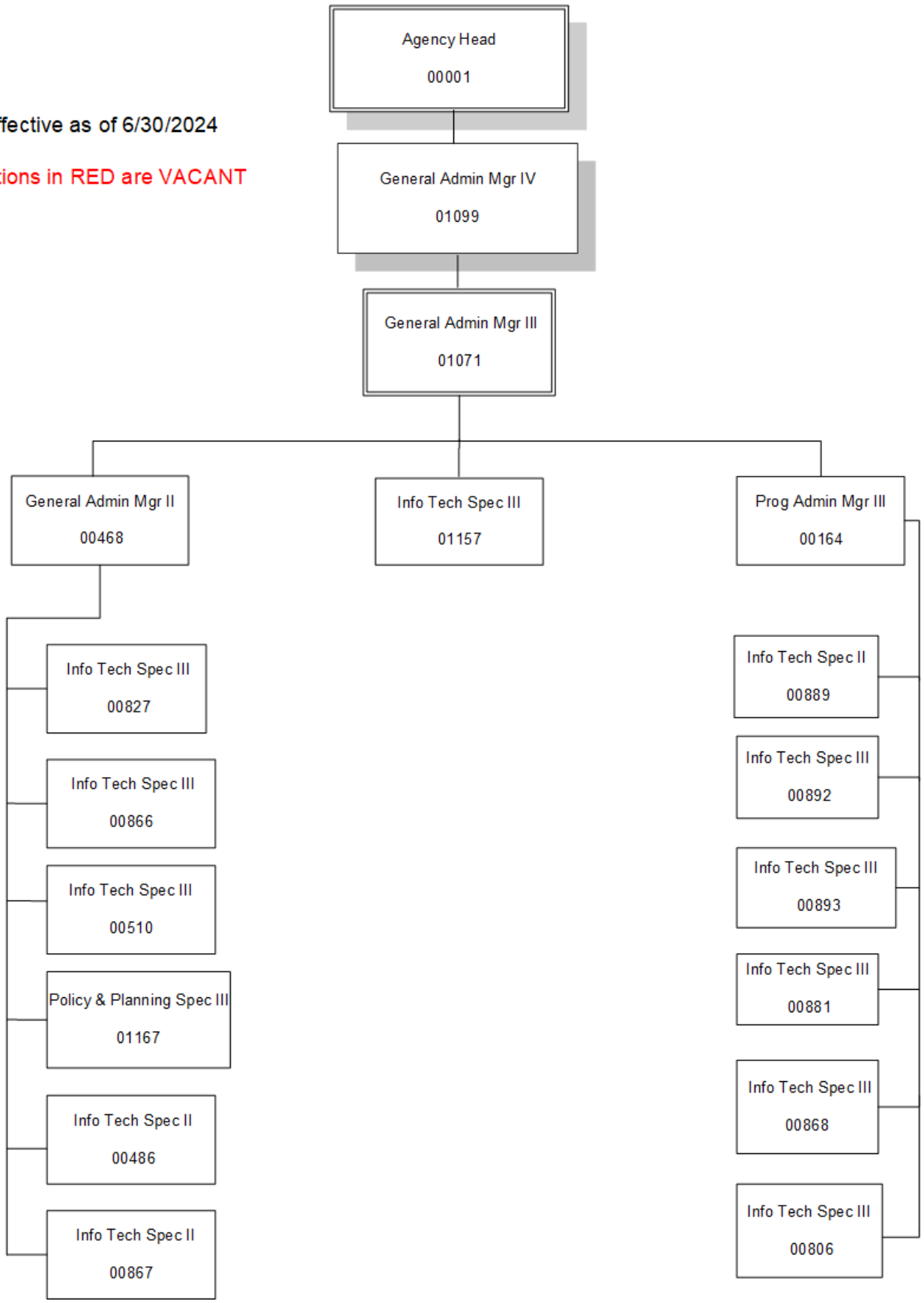


Health Care Services Division

The Health Care Services Division (HCS) reports to the Deputy Director of Programs and Operations. HCS is the home of the managed care program, Cardinal Care, which covers more than 1.6 million children, pregnant members, childless adults, and Medicaid expansion adults through five managed care health plans. Cardinal Care is an integrated delivery system that provides acute, complex, behavioral health and other services to the Medicaid /FAMIS population. In addition, HCS is home to the dental unit and the dental program Smiles for Children (SFC, soon to be Cardinal Care Smiles), which oversees the delivery of dental care to both pediatric and adult Medicaid/FAMIS members through a dental benefits administrator. The Maternal and Child Health Unit provides oversight of services for maternal and child health and the Baby Steps initiatives, foster care services, and specialized children's services and benefits, such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Early Intervention.

The mission of HCS is to deliver quality care to eligible members by collaborating closely with key stakeholders, providers, sister agencies, and other DMAS divisions to support consistent, high-quality, cost-effective, member-focused, and compassionate health care across the Commonwealth.

HCS and Related Managed Care Units

Member and Provider Solutions
Offers support and service to Cardinal Care managed care members and providers. Provides case management to members; reviews and approves MCO member marketing practices; and oversees the enrollment broker contract. The enrollment broker provides managed care enrollment, network, and program information to members in Cardinal Care.

Managed Care Administration Oversees the provisions of the managed care contracts and manages the operational relationship between DMAS and the MCOs, including network oversight and services.

Compliance and Oversight
Provides oversight and enforces Cardinal Care managed care contract requirements and reporting compliance standards. Oversees compliance enforcement, corrective action plan development and sanctions.

Policy and Contracts
Creates and manages the Cardinal Care contract in coordination with the Integrated Care team. Creates State Plan Amendments (SPAs), waivers and regulations. Provides policy guidance and leads General Assembly studies, new programs and initiatives. Manages Agency relationship with CMS for managed care programs.

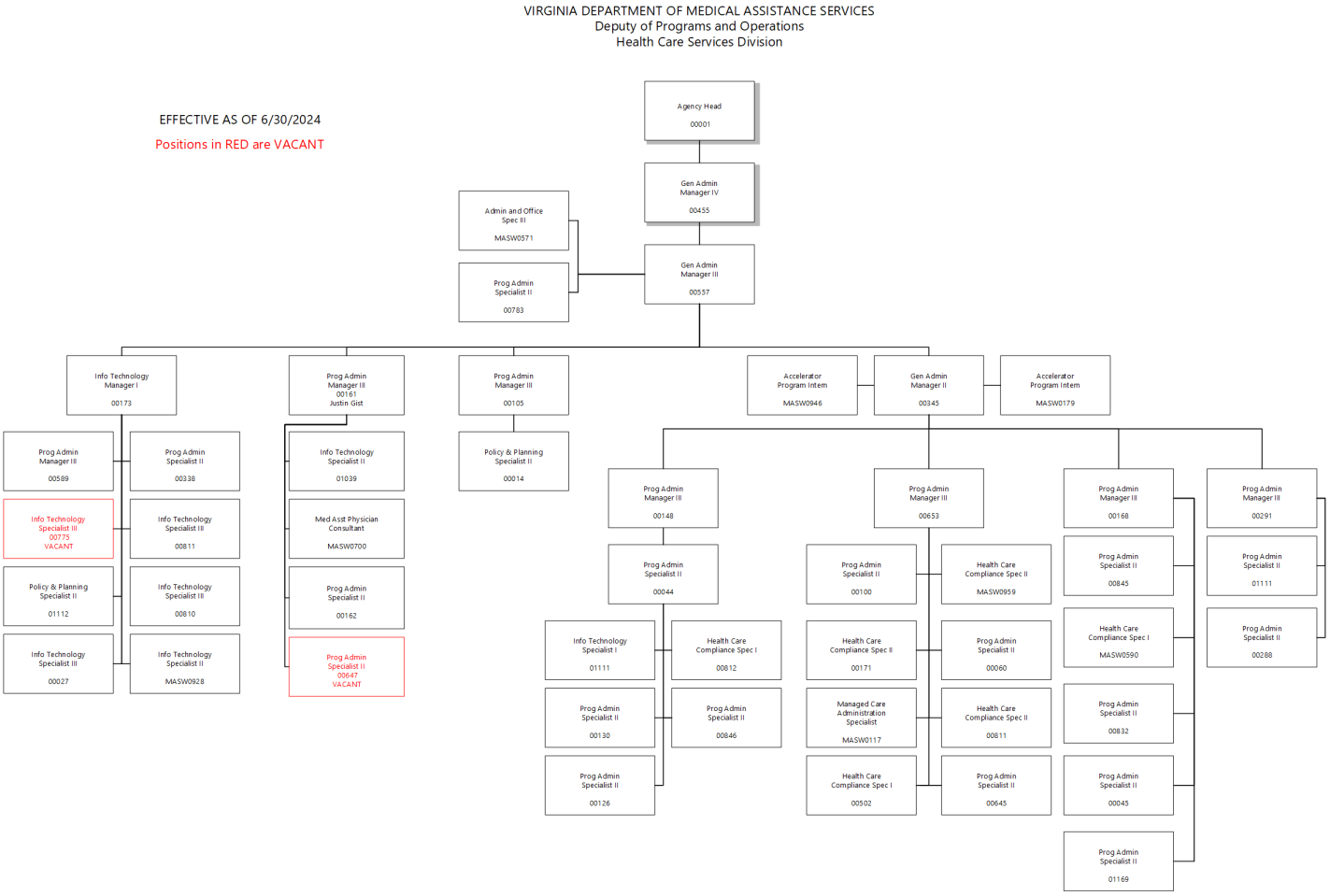
Systems and Reporting
Provides systems and reporting support for HCS, including Cardinal Care, dental, and maternal and child health programs. Creates and maintains the managed care technical manual requirements. Oversees encounter data management, new Medicaid Management Information System (MMIS) initiatives, and any special IM-focused projects.

Specialized Programs and Services Units

Dental

Manages the dental program's pediatric and adult dental services for Medicaid/FAMIS members. Oversees the dental benefit administrator contract and offers support to members, dentists, providers, and stakeholders. Leads the Dental Advisory Committee team. Works with oral health stakeholders.

Maternal and Child Health Oversees programs and services to improve the health and well-being of Medicaid/FAMIS-eligible mothers and children, including children and youth in foster care and adoption assistance. Collaborates with stakeholders and sister agencies in support of mothers and children.



High Needs Support Division

The Division of High Needs Supports (HNS) reports to the Deputy Director of Complex Care Services. The division creates policies that improve provider quality and critical support services for Medicaid members in the Commonwealth. The division is committed to addressing long-term support needs, including the social and environmental needs of Virginians that affect health, well-being, and medical expenditures. In coordination with the Department of Behavioral Health and Developmental Services (DBHDS), HNS administers and provides oversight of the Development Disability (DD) Waivers, in addition to policy and program issues.

Critical functions within the division include:

- Monitoring compliance with all federal waiver requirements and assurances
- Regulatory and policy development
- Analysis of trending issues, utilization of services, and the quality of those services
- Implementation of legislative actions and initiatives
- Quality management reviews to include information related to CMS performance measures
- Ongoing authorization audits of DBHDS as the operational authority to ensure compliance
- Facilitation of the DD Waiver Advisory Committee which consists for key stakeholders across the DD community
- Monitoring of the DBDHS Interagency Agreement and facilitator of reimbursements for that contract

HNS also provides oversight to Housing and Employment efforts. The division does the following:

- Facilitates housing and employment supports for individuals experiencing mental illness or with other complex needs
- Develops, updates, and clarifies policies related to those efforts
- DMAS designee for Employment First state initiative
- DMAS designee for housing efforts to include state Interagency Leadership Team; Supportive Housing Council; Interagency Housing Advisory Committee; Permanent Supportive Housing Committee

HNS is responsible for the development and implementation of programs related to Brain Injury Services:

- Development and implementation of case management services that began in January 2024
- Development and research related to waiver supports and subsequent report for the General Assembly
- Development and research related to neurobehavioral program and subsequent report for the General Assembly
- Facilitation and ongoing engagement with out of state placement contracts for those with brain injury

HNS acts as the Agency subject matter expert for Intermediate Care Facilities for IDD:

- Responsible for the admission oversight and data entry for those entering Intermediate Care Facilities (ICF) with Intellectual Disabilities (IDs)

- Works with DBHDS and provides information to the statewide ICF Roundtable for providers
- Oversees compliance with admission requirements for children's ICFs related to DBHDS reviews

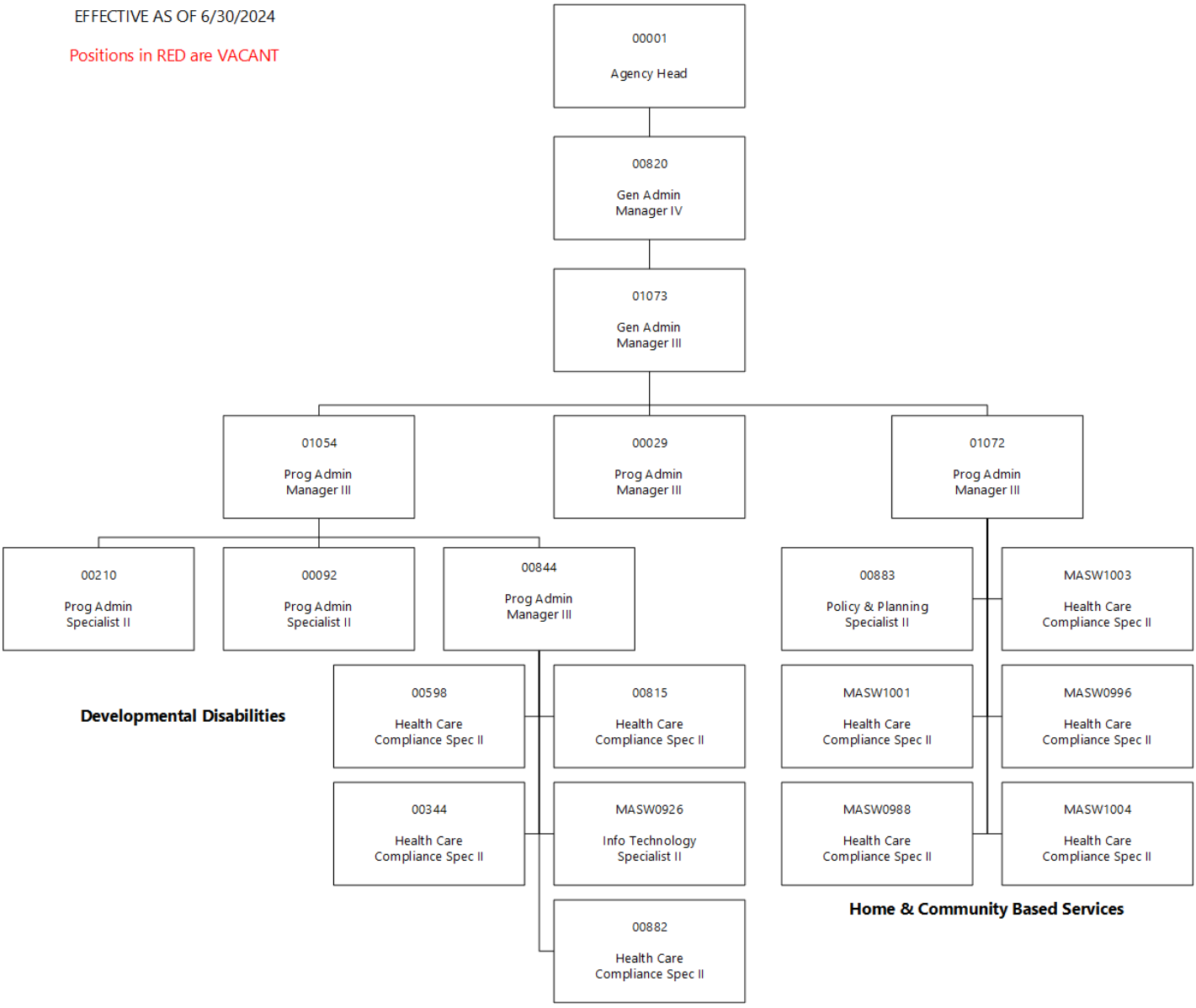
Lastly, HNS is responsible for ensuring implementation of the requirements set forth in the Department of Justice Settlement Agreement with the Commonwealth:

- Ongoing participation in monthly closed status conferences with the Department of Justice (DOJ), Office of the Attorney General (OAG), and the relevant federal judge
- Ongoing participation in open status conferences and contempt hearings
- Ongoing review and participation in Independent Reviewer studies
- Facilitation of Agency improvements in specified areas related to Settlement requirements
- Facilitation of data exchange needed for the demonstration of compliance with the Settlement

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy Director for Complex Care Services
High Needs Support Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Human Capital and Development

The Human Capital and Development (HCD) Division reports to the DMAS Chief of Staff. HCD's goal is to become an "Employer of Choice" in the Commonwealth of Virginia. HCD, along with the Chief of Staff's Office, ensures each member of DMAS feels safe, supported, valued, and has the tools necessary to be successful in their positions and have opportunities for advancement. HCD is responsible for attracting, developing, training, and retaining qualified employees.

HCD is dedicated to excellent, timely customer service in support of the Agency's values and mission. The HCD team is comprised of trusted human resource (HR) professionals available to provide guidance and assistance to staff on a myriad of HCD programs and policies. The HCD Division consists of four units: Talent Acquisition and Outreach Recruitment with External Classification and Compensation, Benefits and Transactions with Internal Classification and Compensation, Employee Relations, and HR Policy and Compliance. The Agency's compensation and classification functions are housed in two HCD units. Those functions are in the Talent Acquisition unit for external actions involving recruitment activities and, are in the Benefits, and Transaction unit for internal employees pay actions.

The Division Director is responsible for the overall management of the HCD team, policy development, interpretation and guidance, legal compliance, investigation of allegations of discrimination, employee relations matters requiring corrective action, performance management, and Americans with Disabilities Act (ADA) compliance. HCD also administers access control for Commonwealth of Virginia (COV) accounts. The Physical Access Control Security (PACS) badge system, Kastle, is administered and controlled by the HCD Access Control Manager, under the Operations Manager.

Talent Acquisition (TA) and Outreach Recruitment with External Classification and Compensation
The Talent Acquisition (TA) Unit administers and directs all aspects of Agency hiring policies and practices. This function provides written (e.g., advertisements and postings) and verbal support to hiring managers regarding hiring policies, practices, and procedures as well as providing tools to guide managers through recruitment and selection decisions. Hiring support includes assisting applicants (internal and external), providing guidance to hiring managers, and finding alternate recruitment solutions. Talent Acquisition also handles the administration of the state's Applicant Tracking System, Page Up, and the tracking and updating of recruitment records. The unit is also responsible for recruitment outreach and maintaining a social media presence regarding recruitment activities. Within the Talent Acquisition unit is an External Classification and Compensation Analyst, ensuring appropriate classification of vacant positions for recruitment, and enhancing the Agency's external competitiveness in the market with attractive starting pay.

Benefits and Transaction Administration (BaTs) with Internal Classification and Compensation
The Benefits and Transactions Unit is responsible for administration of state benefits programs such as group health insurance and the Virginia Sickness and Disability program and provides guidance and counsel on benefits inquiries/reports. This unit is the liaison to the Department of Accounts, Payroll Services Bureau (in coordination with the Fiscal Office) for all payroll processing for the Agency. The Benefits and Transactions Unit conducts New Employee Orientation and announces all staff changes. This unit is responsible for ensuring I-9 employment eligibility verification compliance for United States Citizenship and Immigration Services via the E-Verify system. The Benefits and Transactions Unit is also accountable for administering and tracking employees' leave (paid time off, medical leave, etc.) balances in the Cardinal Human Capital Management System, Workers Compensation, Occupational Safety and Health Administration Reporting, Bureau of Labor Statistics reporting,

Virginia Employment Commission (VEC) claims and hearings, and all required personnel records-retention ensuring compliance with Library of Virginia standards. The Benefits and Transactions Unit updates and maintains the Human Capital Management System, Cardinal HCM with all personnel transactions and handles administration and reconciliations of the Virginia Retirement System in the Virginia Navigator system (VNAV) for the Agency. The Benefits and Transaction Unit also processes all Compensation and Classification actions for internal employees. Analysis of all internal position classification and pay requests are reviewed by a Compensation and Classification Analyst, ensuring consistent application of Agency pay practices in accordance with the Agency Salary Administration Plan, the state's compensation program, and applicable state and federal laws The analyst advises management team members of the proper procedures for position role changes, in-band salary adjustments and movement of staff within the Agency. The analyst ensures internal equity in compensation activities at DMAS while also enhancing the Agency's external competitiveness in the market. Final approval of the analysts' recommendations is processed by the Benefits and Transactions Unit in the Human Capital Management System.

Employee Relations

The Employee Relations unit works to create and maintain a positive working experience for staff throughout their employment with DMAS. The unit assists in the prevention and resolution of conflict within interpersonal relationships, and it acts as a liaison or intermediary between employees and managers where conflict may exist. It promotes positive communication between employees, supervisors, and managers while addressing the root causes of workplace distractions and guiding members through conflict resolution. Additionally, the unit provides guidance, in the form of performance improvement approaches to various levels of leadership as well as assistance navigating the disciplinary process. Also, the Employee Relations Unit consults with employees and reviews ADA requests for accommodation.

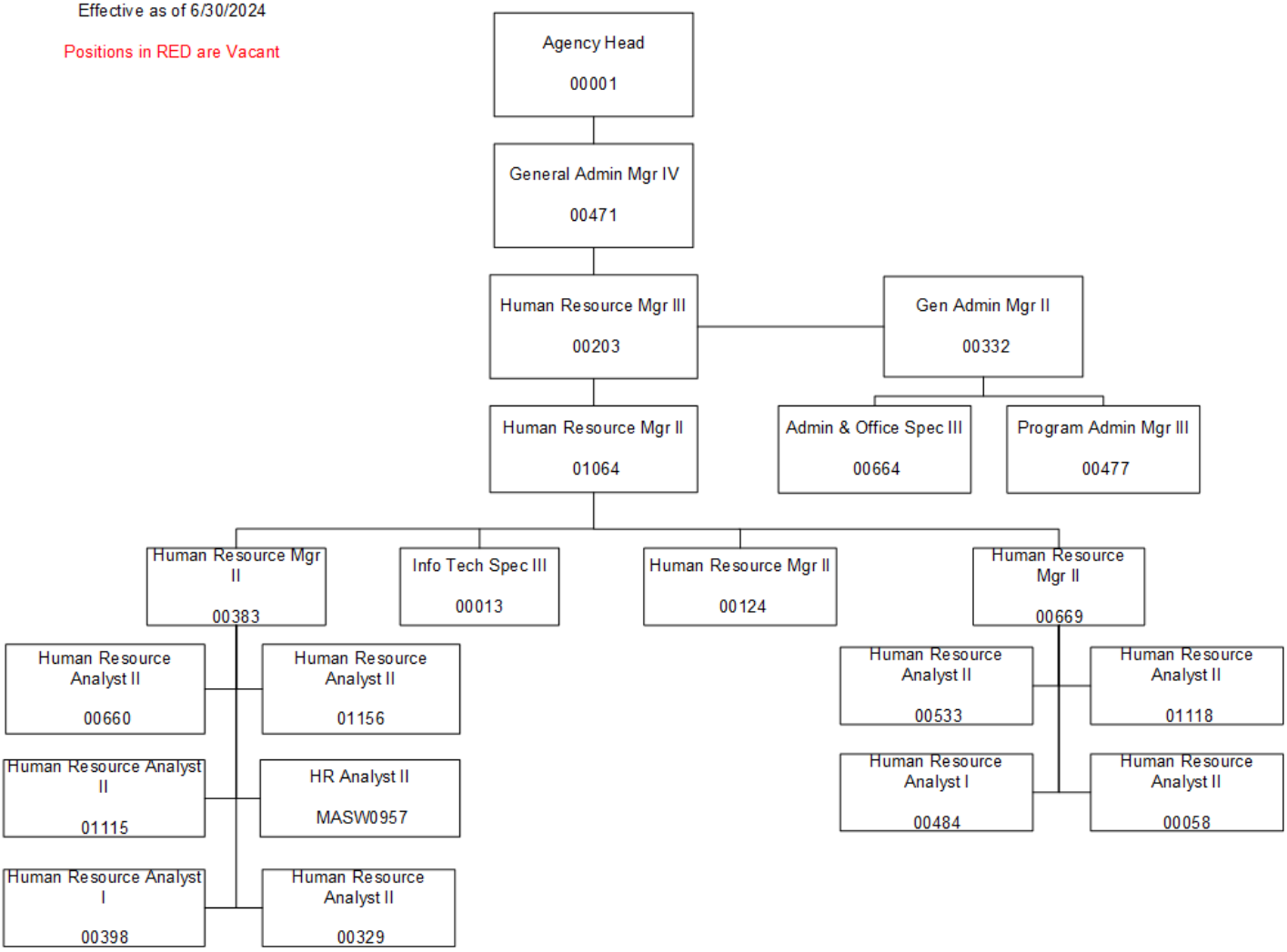
HCD Policy and Compliance

HCD Policy and Compliance provides guidance and consultation to managers and supervisors to ensure compliance with current federal and state employment laws and Commonwealth of Virginia HR policies and procedures. It interprets regulations in collaboration with HCD Leadership and the Chief of Staff. HCD Policy and Compliance develops DMAS specific HR-related policies and/or procedures related to new programs or initiatives as assigned. The unit conducts regular reviews of the Agency's Salary Administration Plan, facilitates annual policy reviews, and revises DMAS HR policies, as appropriate, and develops and updates HCD's Agency-facing SharePoint Pages.

Virginia Department Medical Assistance Services
Office of the Chief Of Staff
Human Capital and Development Division

Effective as of 6/30/2024

Positions in RED are Vacant



Incentive Coordination and Economic Research Division

The Incentive Coordination and Economic Research Division (ICER) reports to the Chief Analytics Officer as part of the Healthcare Analytics and Transformation team. The ICER Division examines and enhances policies to encourage effective and efficient provision of care to Medicaid members. This is done through both financial and non-financial incentives while overseeing the Agency's internal and external research efforts. The division coordinates with external parties to transfer data in support of DMAS data needs, initiatives, and research studies.

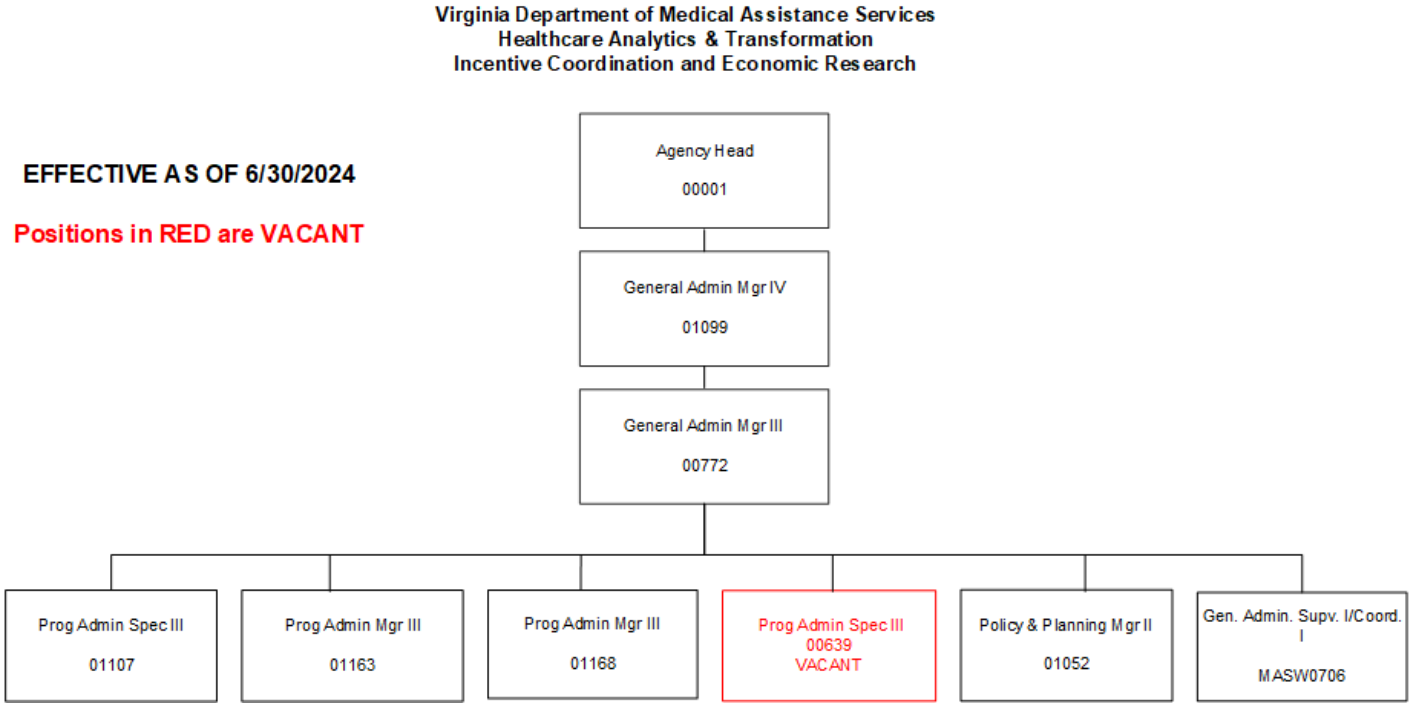
The Incentive Coordination and Economic Research Division comprises two units:

Value Based Purchasing Unit

The Value Based Purchasing Unit promotes policies that utilize both financial and non-financial incentives to encourage the provision of high quality, efficient care to Medicaid members. This results in better care outcomes for members while maximizing the value the Commonwealth receives for its state and federal health care dollars. This includes systemic payment and contract policy innovations that integrate performance accountability into various facets of Virginia Medicaid, including managed care plans, providers, and delivery systems.

Economic Research Unit

The Economic Research Unit oversees and supports DMAS's internal and external research efforts while staying up to date on national and industry trends. Economic research – including policy evaluation and proactive analyses – is critical to the Agency's mission to provide cost-effective and efficient care to our members.



Information Management and Project Management

The Division of Information Management (IM) reports to the Deputy Director of Technology. The IM Division is responsible for managing the day-to-day technical activities of the Medicaid Management Information System (MMIS) with the fiscal agent. These activities include provider enrollment, member enrollment, Fee-for-Service (FFS) and Encounter adjudication, payment to FFS providers and MCOs and Administrative Services Organizations (ASOs) like consumer directed services vendor, dental, behavioral health services administrators and most all other vendors that do business with the Agency. IM also supports federal reporting needs out of the MMIS, such as the Transformed Medicaid Statistical Information System (T-MSIS) and Medicaid Automated Reporting System (MARS) and manages the financial systems that interface with Department of Accounts' Cardinal System. IM also sends enrollment data to all the MCOs, ASOs and other vendors that need it to assist with the daily operations of various programs.

Systems Development

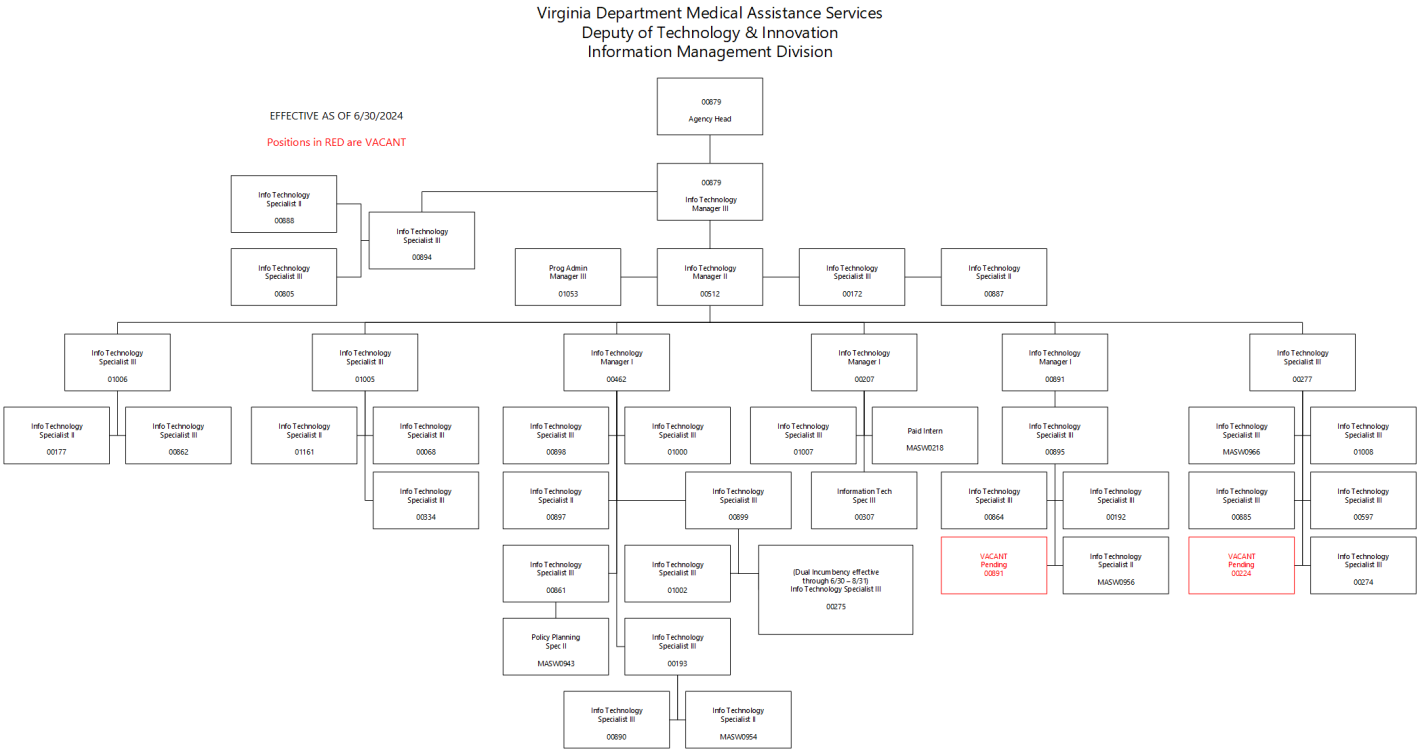
The IM Division houses an internal Systems Development team which automates workflows, manages the intranet and DMAS external website, builds and maintains the Encounter Processing and Care Management Systems and maintains a multitude of software components supporting the Agency's day to day operations.

IT Support Team

The Information Technology Support team manages all Agency-used equipment including laptops, cell phones, tablets, internally housed servers, telecommunication equipment and all peripheral technology. The team has also been integral in modernizing the office space and audio-visual equipment used throughout the Agency. All connectivity to external entities and Virginia Information Technologies Agency (VITA) coordination is also maintained by this team.

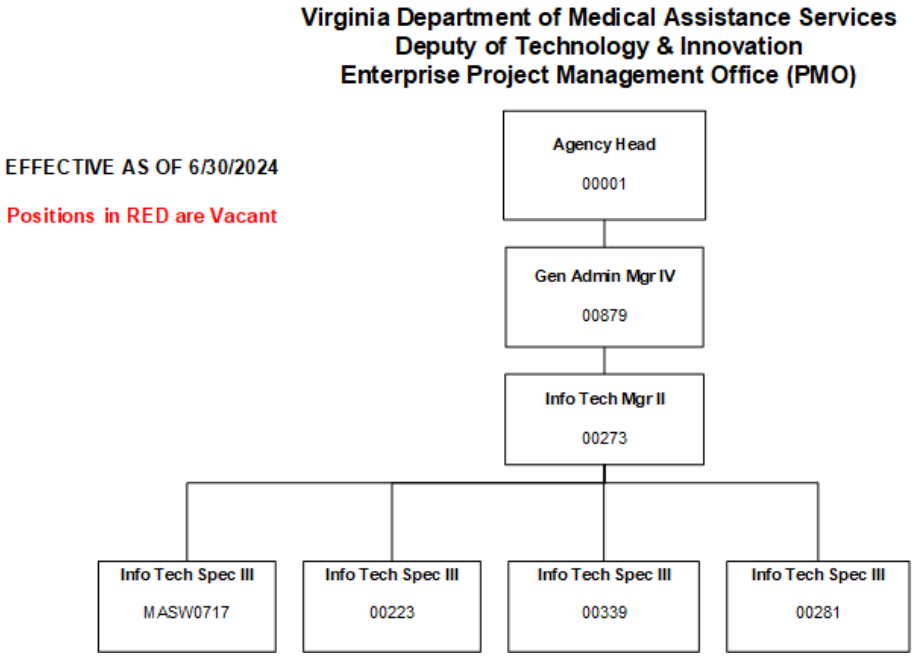
System Development Analyst Team and Electronic Data Interchange Team

The System Development Analyst Team and Electronic Data Interchange (EDI) Team coordinate with subject matter experts throughout the Agency to document and translate business requirements to technical specifications, assist with the immediate needs of file transfers, and find solutions to issues proposed by various business units. The EDI team oversees hundreds of file transfers with external entities including, but not limited to, CMS, Sister Agencies, and numerous vendors. Analysts within this group coordinate the various phases of the change management life cycle, perform research, and assist in making the transition from business vision to technical implementation seamless and efficient.



Project Management Office

The Project Management Office (PMO) reports to the Deputy Director of Technology. The PMO manages all projects associated with the Medicaid Enterprise Solution (MES) as well as any IT related projects, including releases for the Fiscal Agent Services (FAS) Solutions. MES was instituted to transform the monolithic MMIS system with a modular system, making it better able to react to the ever-changing technological environment and evolving program needs. This included assisting with the procurement of new systems, design, and development activity with various vendors through the implementation and certification of these systems. PMO also supports business projects for new and existing services from procurement to implementation. To this end, PMO works closely with the Office of Attorney General (OAG), Virginia Information Technologies Agency (VITA), the Centers for Medicare and Medicaid Services (CMS), the Department of Social Services (DSS), and the Department of Behavioral Health and Developmental Services (DBHDS).



Integrated Care

The Integrated Care Division reports to the Deputy Director for Complex Care Services. This division provides direct oversight and management of the Commonwealth Coordinated Care Plus (CCC Plus) Program, which began in August 2017. The CCC Plus Program is an integrated health care delivery model that includes medical services, behavioral health services and long-term services and supports (LTSS). The division also provides direct oversight and management of the dual special needs plans (DSNP) for dual eligible members. The CCC Plus Program encompasses care coordination services to develop a person-centered plan of care. The plan addresses the needs of members with disabilities and medically complex members to ensure timely access to appropriate services. The Integrated Care Division's core functions include support to CCC Plus members, providers, and contractors; oversight and administration of the CCC Plus contracts; focus on care coordination to improve the quality of life for our members; compliance monitoring and enforcement; and systems and reporting support including data exchange between DMAS and the health plans.

Contract Refinement

- Coordinate contract revisions as changes to business processes, initiatives, or regulations necessitate
- Assess impact of changes in legislation, policy, or the insurance market on CCC Plus and DSNP contracts

Contract Monitoring

- Identify and document all CCC Plus contract deliverables (Contract Monitoring Plan)
- Update the Contract Monitoring Plan with each contract revision
- Interact regularly with contractors to monitor progress towards deliverables
- Respond to ad hoc stakeholder concerns (internal and external)

Contract Compliance

- Monitor MCO data to identify performance issues
- Enforce and oversee corrective action plans to improve performance

Enrollment Broker Contract

- Develop and update Enrollment Broker contract
- Monitor Enrollment Broker deliverables and compliance
- Provide technical assistance to Enrollment Broker
- Provide ad hoc operational support

Data and Operations

- Evaluate and monitor the quality of contractor encounter data (encounter scorecard)
- Use encounter data to monitor contractor performance by analyzing trends
- Ensure MMIS is functioning appropriately and correct enrollment file inaccuracies
- Perform ad hoc MMIS or Episodic Payment System (EPS) queries

Care Coordination Training and Support

- Provide training and support for contractor care coordination
- Clarify contract requirements
- Share best practices and resources
- Facilitate opportunities for problem-solving and learning

Member and Provider Relations

- Triage and respond to all CCC Plus related inquiries (member and provider)

Program of All Inclusive Care for the Elderly (PACE)

- Provide oversight, review, and technical assistance
- Provide training for existing PACE programs
- Assist with the expansion of new programs across the Commonwealth

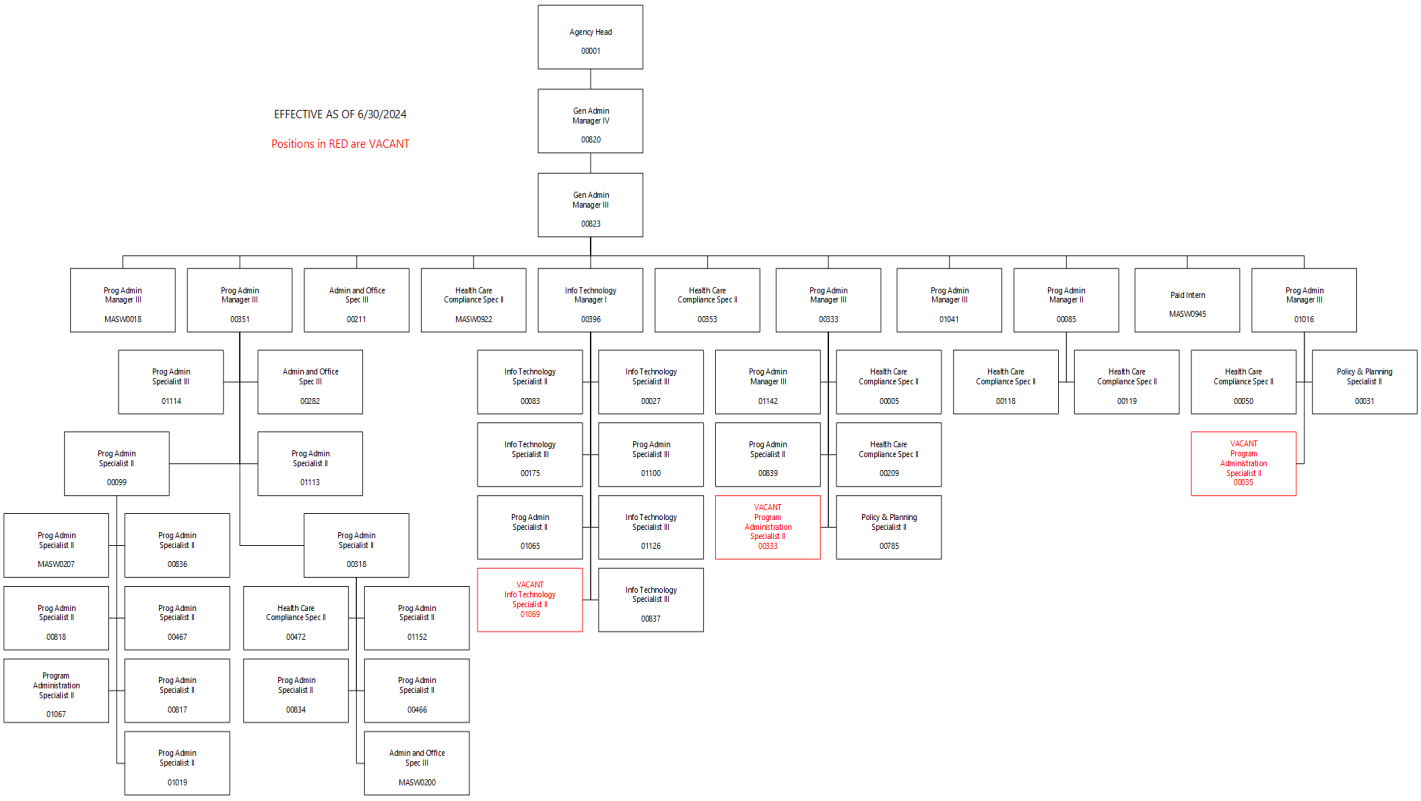
State Plan Services

- Responsible for regulatory and policy development, revisions, and maintenance for nursing facilities, durable medical equipment, hospice, home health and rehabilitation services
- Provides written and verbal policy clarifications
- Provides legislative support and internal/external policy training

Virginia Department Medical Assistance Services
Deputy of Complex Care Services
Integrated Care Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Internal Audit

The Internal Audit Division (IAD) reports directly functionally to the Agency Director and administratively to the Chief of Staff. The Internal Audit Division provides independent and objective assurance and consulting services that are designed to add value and improve operations. IAD assists DMAS in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the Agency's risk management, control, and governance processes. From its work, the IAD recommends actions to improve efficiencies, cost savings, compliance, and/or controls over processes, programs, and systems.

The six primary business functions of the Division are summarized below:

Internal Audits

IAD conducts various types of audits, as appropriate, on DMAS business processes and in accordance with its Audit Plan. The types of audits included are financial, compliance, operational, fraud, program performance, and contractual.

IT Security Audits

The IAD performs or coordinates third-party performance of IT Security Audits of DMAS systems. This is done to assess the effectiveness of system controls and measure compliance with the Commonwealth of Virginia Information Security Standard as well as other applicable federal and state regulations.

Audit Finding Resolution

The IAD tracks all internal and external DMAS audit findings and recommendations. It monitors the status of Corrective Action Plans (CAPs) for unresolved findings and recommendations until there is a resolution. It reports on the status of the CAPSs to Agency management, Department of Accounts, Office of the State Inspector General, Virginia Information Technologies Agency and the Centers of Medicare and Medicaid Services.

External Audit Liaison

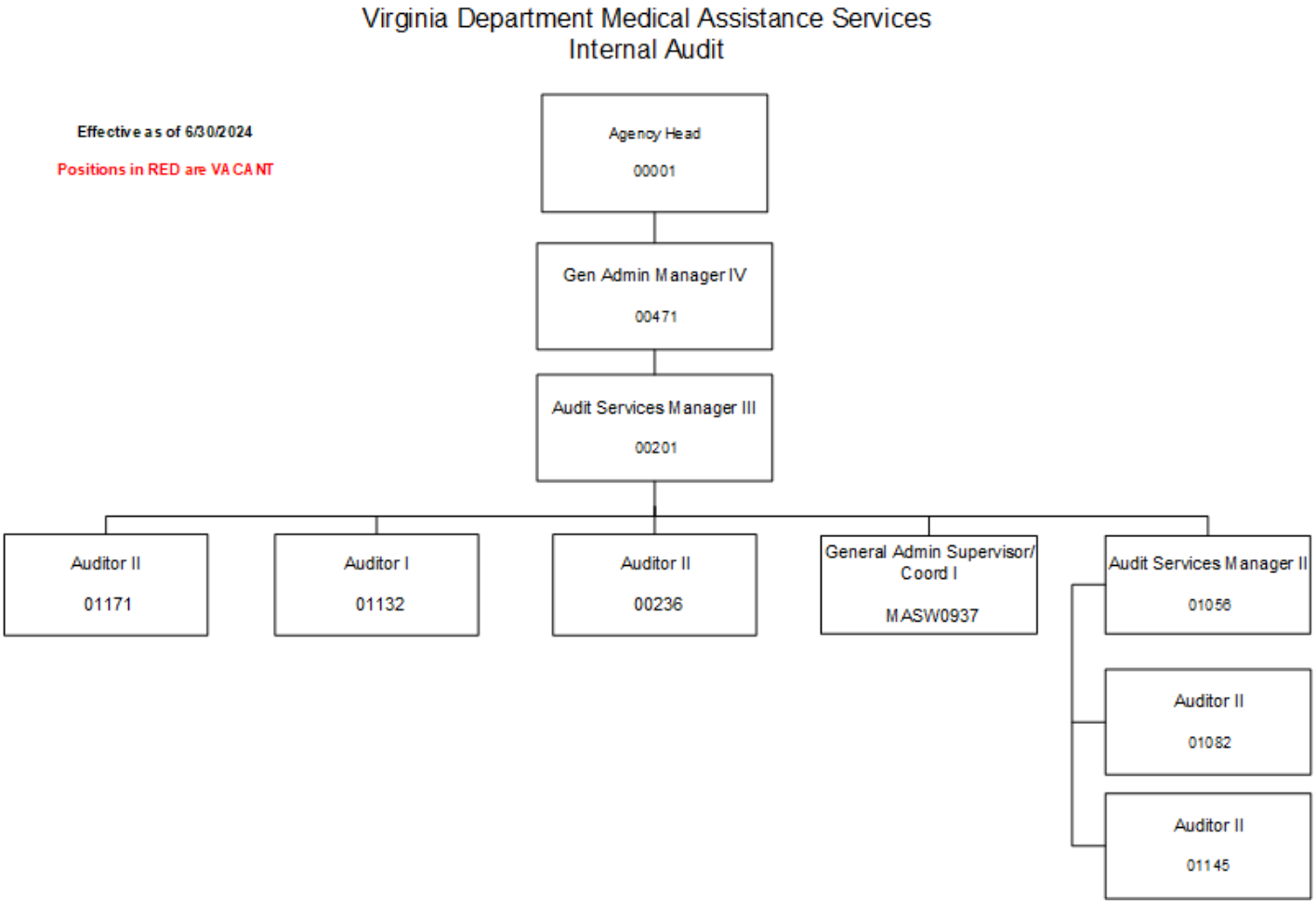
The IAD serves as the initial DMAS contact point and coordinator for external audits such as Auditor of Public Accounts, Department of Accounts, Office of Inspector General, and the Centers of Medicare and Medicaid Services.

State Fraud, Waste, and Abuse Hotline

The IAD investigates cases referred from the State Fraud, Waste, and Abuse Hotline and issues a report to the Office of State Inspector General. If a case involves Medicaid Providers or members, the case is referred to the Program Integrity Division or another applicable division. To ensure that all cases are appropriately addressed, the Internal Audit Division tracks all referral responses and their results.

Third-Party Service Provider Audit Assurance

IAD reviews and evaluates independent information security audit reports and Service Organization Control (SOC) reports. DMAS requires all third-party vendors to submit these reports to provide assurance that they have implemented adequate controls to protect critical DMAS business functions and sensitive DMAS data. IAD communicates the information-security risks to DMAS stakeholders and provides objective opinions on the adequacy of the providers' controls. It also monitors the process of corrective action taken by third-party providers to address the security risks.



Office of Community Living

The Office of Community Living (OCL) reports to the Deputy Director of Complex Care Services. The mission of the Office of Community Living is to improve the quality of life for Virginians with long-term services and support their needs through effective programs and policies that ensure continued community integration for those who choose to receive services in their home and community. The OCL is responsible for the administration of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver, management of and oversight of the consumer-directed program, and the contracted Fiscal-Employer Agent. OCL also oversees the screening of individuals for CCC Plus Waiver, Program of All-inclusive Care for the Elderly (PACE), or nursing facility care.

The primary business functions of OCL are as follows:

Waiver Administration

Develop 1915 (c) home and community-based waiver applications, renewals, and amendments. Complete required CMS reporting, including the annual cost-effectiveness and quality evidence reports. Serve as the primary contact for CMS for anything related to the 1915 (c) waivers.

Commonwealth Coordinated Care Plus (CCC Plus) Waiver

Serve as the subject matter experts for the CCC Plus waiver which serves over 40,000 members in the community instead of a nursing facility. Maintain waiver regulations and provider manuals and also provides technical assistance for providers and members. Monitor the provision of waiver services for individuals that are not enrolled in managed care.

Screening for Long-Term Services and Supports

The OCL develops the regulatory standards, training, and oversight for the screening process that determines functional eligibility for Medicaid long-term services and supports. It includes PACE programs, the Commonwealth Coordinated Care Plus (CCC Plus) Waiver, or nursing facility services. OCL monitors screening teams to ensure assessments are conducted appropriately and timely.

Quality Assurance

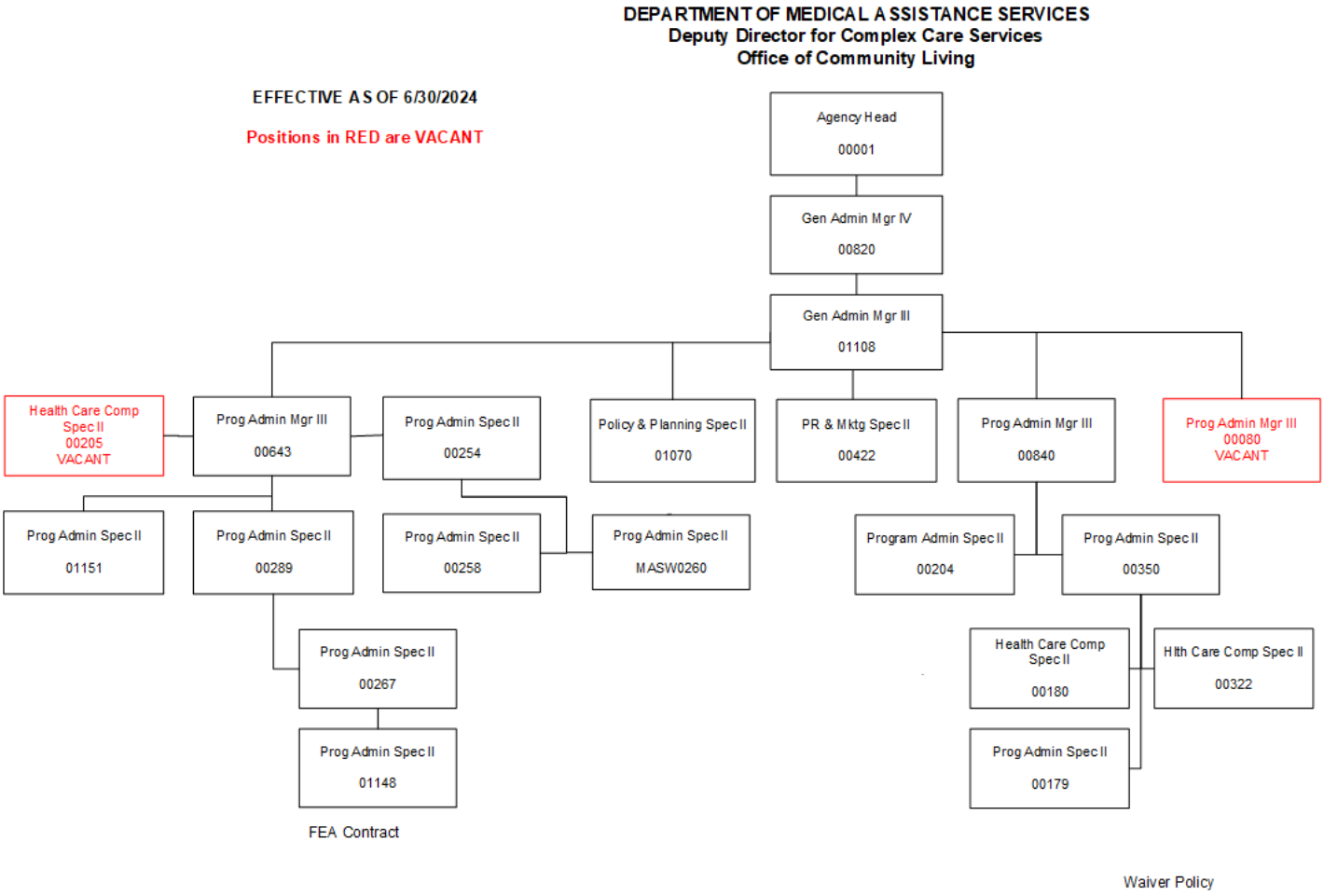
The OCL oversees the quality management review (QMR) process conducted by the managed care organizations. The QMR consists of record reviews to ensure provider compliance with waiver and provider participation requirements. QMR measures compliance of CMS quality assurances related to health and welfare, provider qualifications, and service-plan development and delivery. OCL monitors the remaining CMS quality assurances. These include requirements pertaining to waiver administration, level of care, and financial integrity using data collection, aggregation, and analysis. OCL monitors critical incidents occurring in the waiver population to ensure appropriate action is taken.

Consumer Direction

Consumer direction (CD) empowers members/families to direct personal care, respite, and companion- services by employing and managing their attendants. The OCL develops and maintains policy and procedures while overseeing CD services.

Fiscal/Employer Agent

The OCL staff monitors the vendor that provides payroll services on behalf of employers using consumer-directed services. The Fiscal/Employer Agent enrolls employers, verifies qualifications of attendants, and conducts payroll processes for attendants to include the withholding of appropriate taxes and other withholdings. The Fiscal/Employer Agent files all employer-related taxes with state and federal entities.



Office of the Chief Medical Officer

The Office of the Chief Medical Officer reports to the Agency Director for DMAS. The primary responsibility of the Office of the Chief Medical Officer (OCMO) is to improve the health and well-being of those enrolled in the Medicaid Program. The office achieves this goal through four distinct functions: establishing and managing clinical policy, overseeing pharmacy operations, informing healthcare quality, and catalyzing innovation to advance population health. It delivers on these functions through regular internal activities and responsibilities, as outlined for its two units below, as well as through collaborative efforts with internal partners (i.e., Division of Health Analytics and Transformation, Behavioral Health Division, Health Care Services Division, and Integrated Care Division) other Commonwealth Departments, MCOs, and provider and member representatives.

The Office of the Chief Medical Officer comprises two units: the Medical Support Unit (MSU) and the Pharmacy Unit.

Medical Support Unit (MSU)

The Medical Support Unit (MSU) establishes and manages clinical policy through:

- Leading evidence-based reviews to determine appropriateness and conditions of coverage of new and existing services. The review process includes enacting and updating coverage of Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes, maintaining existing fee-for-service (FFS) coverage policy, and assessing managed care organization (MCO) coverage policies.
- Providing clinical guidance and leadership on a wide range of topics, including maternal/child health (e.g., vaccination, birth control, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)), the opioid epidemic, hepatitis C, Emergency Department Care Coordination, telehealth, value-based care, health quality, and social drivers of health.
- Reviewing service authorization requests for select FFS member services including, but not limited to out of state medical care, out of state outpatient (O/P) scans (Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Positron Emission Tomography (PET)), organ transplants, private duty nursing (PDN), specific physician administered drugs (not pharmacy related), molecular genetic testing, and continuous glucose monitoring.

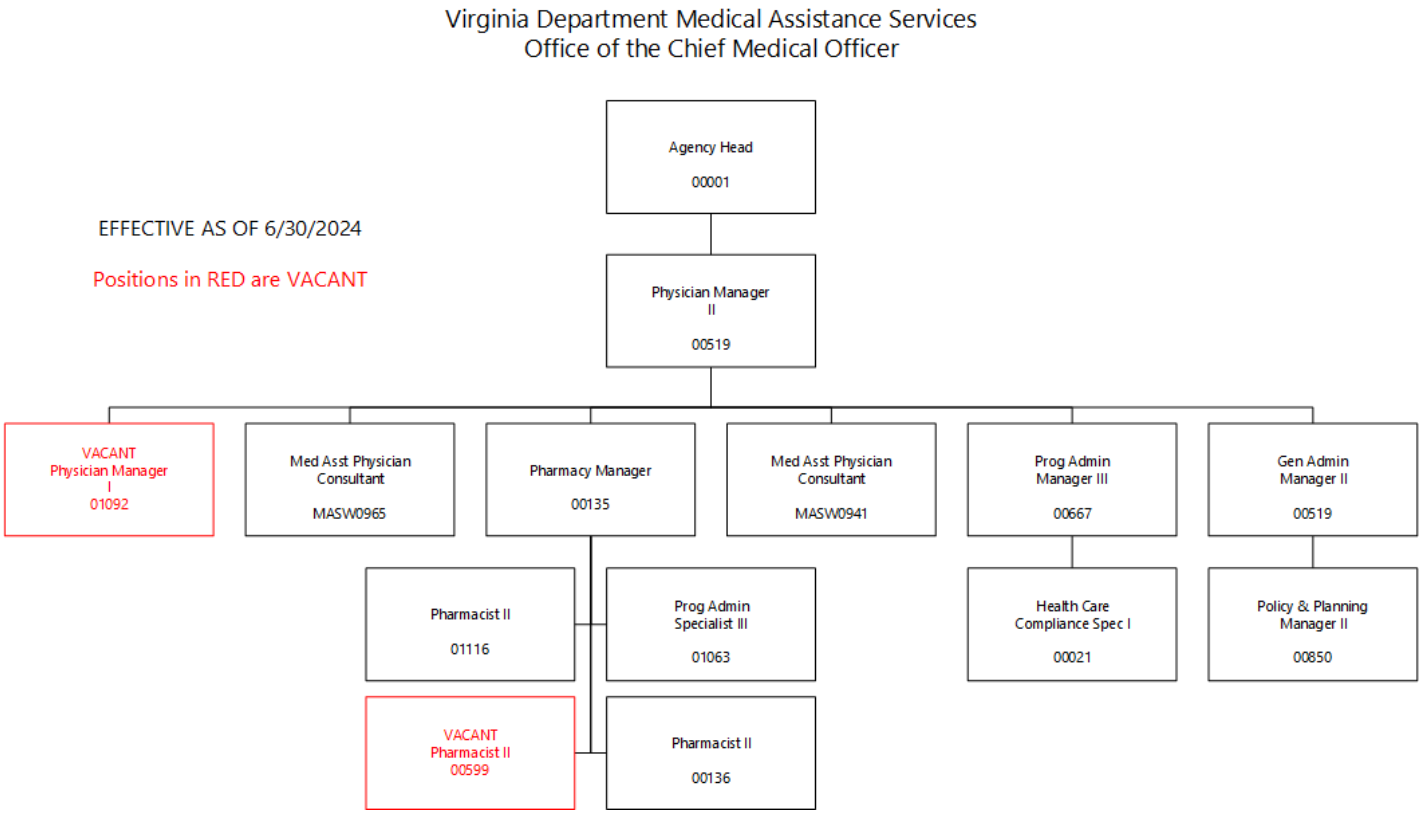
Pharmacy Unit

The Pharmacy Unit establishes pharmaceutical policy through:

- Supporting the mission and goals of the Pharmacy and Therapeutics (P&T) Committee including the development and administration of the DMAS Preferred Drug List (PDL). The P&T Committee evaluates clinical evidence and cost in the context of population health to determine which drugs are the highest value to the Commonwealth and should be included on the DMAS PDL. The Pharmacy Unit monitors MCO compliance with the Common Core Formulary and assists members with issues/complaints related to drug access.
- Administration of a Drug Utilization Review (DUR) program that complies with 42 CFR 456, Subpart K. The DUR Program is responsible for ensuring the health and safety of patients through the appropriate use of drugs. Physicians, pharmacists, and nurse practitioners

appointed by the DMAS Director serve on the DUR Board, which defines the parameters of appropriate medication use within federal and state guidelines; meets periodically to review, revise, and approve new criteria for the use of prescription drugs; and develops drug utilization review criteria by addressing situations in which potential medication problems may arise. DMAS's DUR efforts include leading the prospective DUR (ProDUR) – review of patients' drug therapy history prior to prescription orders being filled - and the retrospective DUR (RetroDUR) – examining a history of medication used to identify certain patterns of use.

- Administration of the Medicaid Drug Rebate Program in accordance with 42 U.S.C. § 1396r-8. Pharmacy Unit administration of an aggressive drug rebate program seeks out all available drug rebates and discounts available from all pharmaceutical manufacturers.
- Oversight of the Managed Care Organizations' (MCOs') pharmacy programs. The DMAS Pharmacy Unit is responsible for aligning pharmacy policies, clinical guidelines, standards, and controls across all Medicaid programs to include FFS, Medallion 4.0, and CCC Plus. It drafts contract language and manual requirements for pharmacy-related services and drug coverage as needed, and monitors MCO compliance with the Common Core Formulary and uniform pharmacy policies.
- Oversight of DMAS' FFS Pharmacy Benefit Administrator (PBA). The Pharmacy Unit's oversight provides the interface for functionalities such as FFS Point of Sales (POS) claims adjudication, electronic Prior Authorizations for medications, and operational data.



Policy Division

The Policy Division reports to the Deputy for Administration and Coverage. The Policy Division is responsible for the facilitation of meetings and orientations for the Board of Medical Assistance Services as well as the coordination of all Freedom of Information Act (FOIA) and constituent and legislator requests. The Policy Division is comprised of three units, each with distinct functions.

Regulations and Manuals Unit

The Regulations and Manuals Unit plans, drafts, and promulgates regulations and State Plan Amendments (SPAs) in collaboration with subject matter experts (SMEs) across DMAS. In addition, this unit maintains Agency Provider Manuals and coordinates/develops updates with Agency SMEs. It coordinates development and release of provider memos. As part of these efforts, individuals in this unit facilitate meetings with SMEs, Centers for Medicare and Medicaid Services (CMS), Office of the Attorney General, and the Department of Planning and Budget to obtain certification and approval of regulations and SPAs.

Policy Unit

The policy group provides assistance and guidance to the Agency through cross-divisional policy planning and management. It provides transparent, consistent availability of information and thorough collection, storage and maintenance of digital content. It also provides research, legislative analysis, policy statements, reports and background documents.

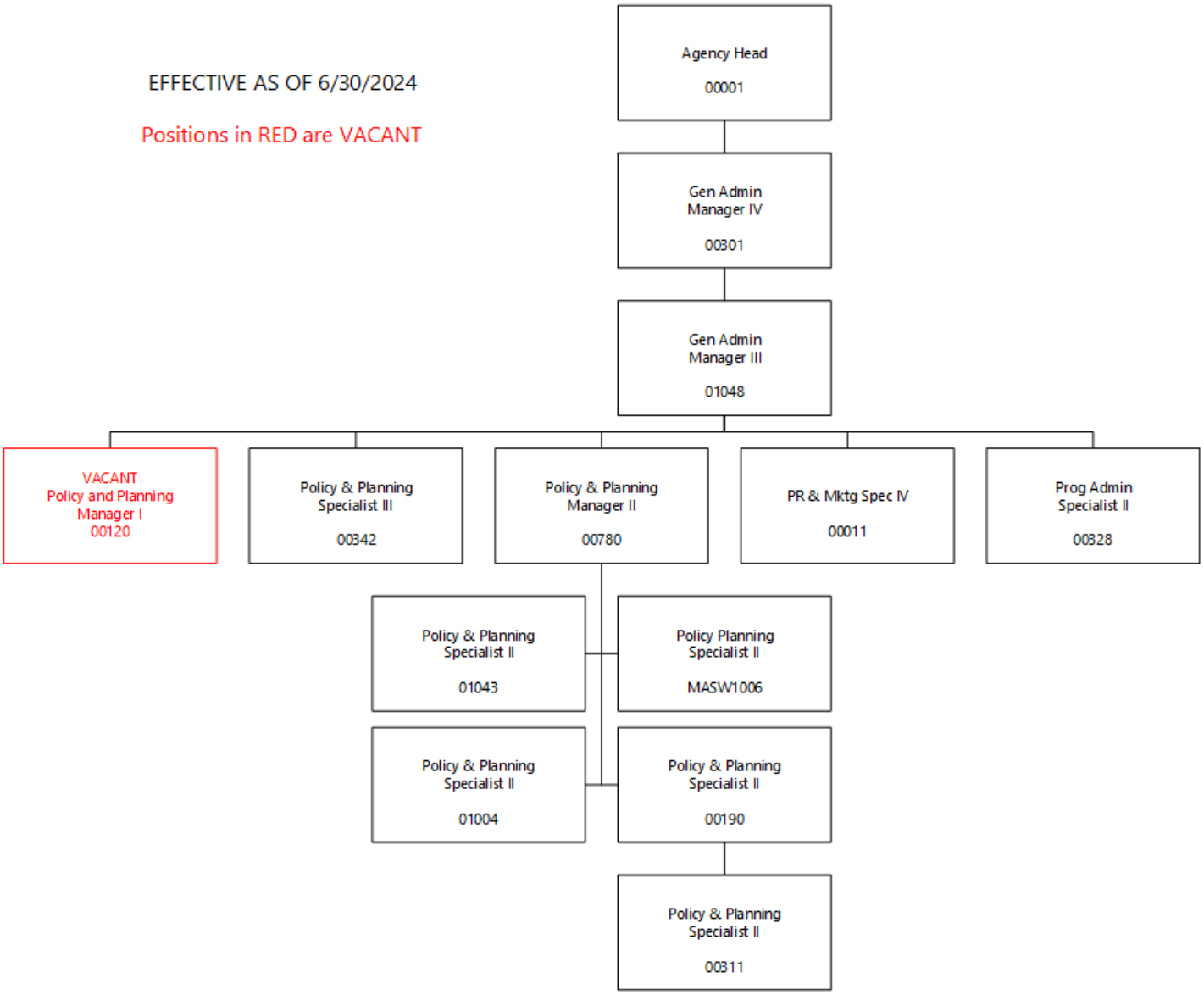
Children's Health Insurance Program (CHIP) Unit

This unit is responsible for managing all aspects of CHIP (known as "FAMIS" in Virginia). This includes the CHIP State Plan, the FAMIS MOMS 1115, the FAMIS Prenatal Program, and the 12-month postpartum coverage extension. It also coordinates the General Assembly mandated Children's Health Advisory Council (CHIPAC).

Virginia Department Medical Assistance Services
Deputy of Administration
Policy Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Procurement and Contract Management

The Procurement and Contract Management (PCM) Division reports to the Deputy Director for Finance/Chief Financial Officer (CFO). PCM plays a critical role within the DMAS Finance team working collaboratively with key internal and external stakeholders in the development, negotiation, and management of Agency contracts and awards, as well as providing daily administrative services in support of Agency operations. Work is completed through four (4) units: Procurement Management, Contract Management, Administrative Services, and Compliance.

Procurement Management

The Procurement Management unit develops and awards new contracts through one of the applicable approved procurement methods outlined in the Virginia Public Procurement Act (VPPA), Agency Purchasing and Surplus Property Manual (APSPM), and VITA Buy-IT manual. Contracts may be small (under $100k), large ($100k+), and/or high-risk. High-risk contracts require collaboration with the Office of the Attorney General, Department of General Services, and VITA.

Contract Management

The Contract Management unit manages the newly awarded large ($100K+) contracts and inter-agency agreements. In partnership with contract administrators throughout the Agency, this team develops, negotiates, and completes modifications and renewals; ensures vendor performance under the terms of the contract; and conducts high-risk renewals requiring collaboration with the Office of the Attorney General, Department of General Services, and VITA.

Administrative Services

The Administrative Services unit oversees the following critical daily operations in support of the Agency: staff augmentation policy and standard operating procedures, onboarding, tracking, and reconnaissance mail services; fleet and rental vehicle management, policy, and procedures; processing small purchase requests, including office supply ordering, delivery, and inventory; secure storage and transfer of cash payments; and shred bin services.

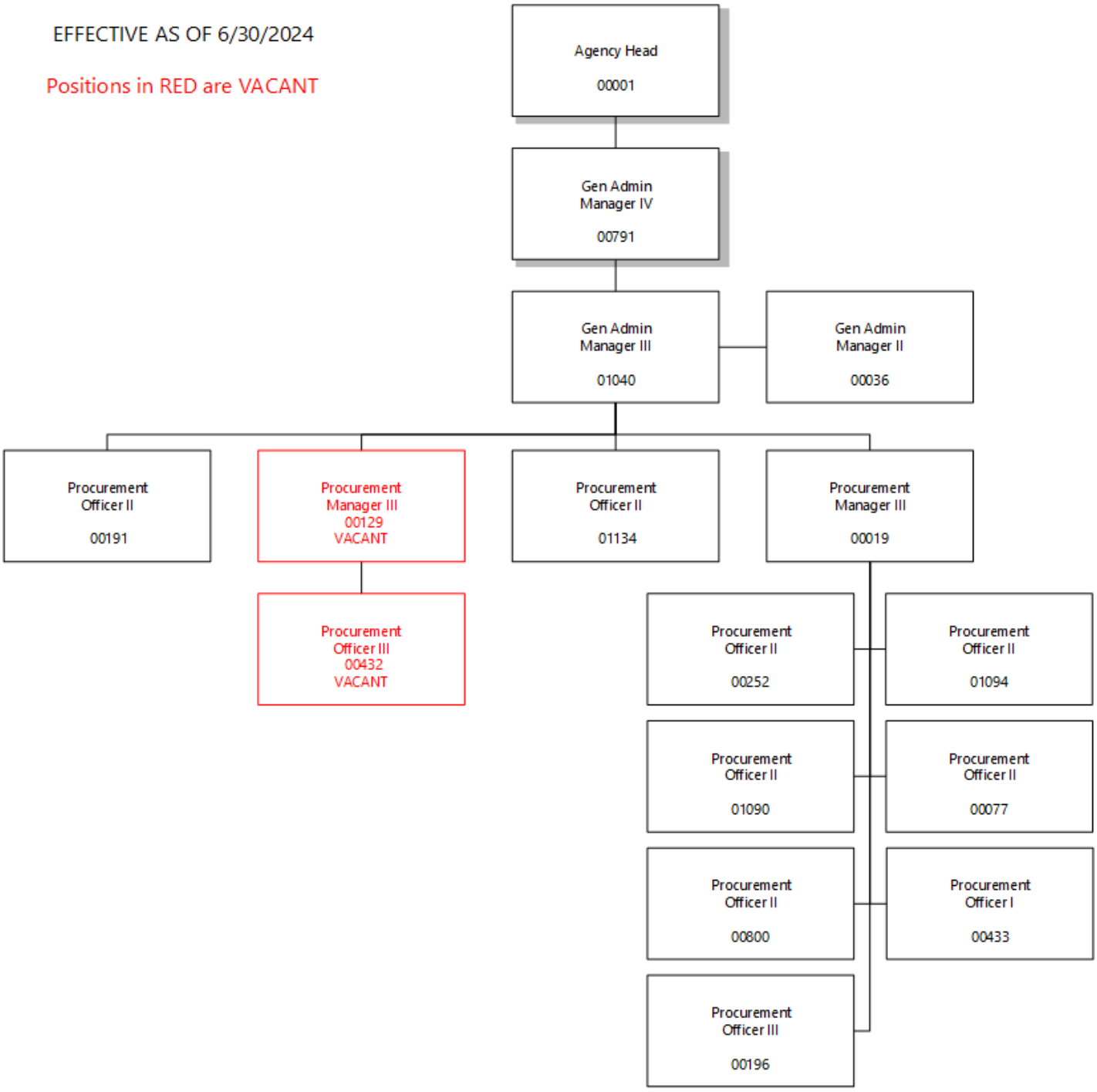
Compliance

The Compliance unit performs ongoing reviews of PCM's current responsibilities and performance, It oversees its policies and standard operating procedures to ensure implementation of best practices. Through random sampling, it conducts reviews of work completed by the PCM teams, monitors the Small, Women-owned, and Minority-owned Business certification program (SwaM) reports, and tracks and records vendor invoices and semi-annual contract performance evaluations. The team works in conjunction with the division director on all audits conducted by Agency Risk Management and Internal Control Standards (ARMICS) from DOA, the Auditor of Public Accounts (APA), and DMAS' Internal Audit Division.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Finance and Technology
Procurement and Contract Management Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Program Integrity Division

The Program Integrity Division (PID) reports to the Deputy Director of Programs and Operations. The PID is entrusted with the responsibility of identifying fraud, waste, and abuse within the Virginia Medicaid program. It refers potentially fraudulent providers and members to the proper law enforcement entity. The PID works with other divisions in the Agency, CMS, and the Office of the Attorney General on integrity issues and special projects. The PID comprises two primary units: the Member Review Unit (MRU) and the External Provider Auditing and Policy (EPAP) Unit.

Member Review Unit

To fulfill its mission, PID engages in the following member-focused integrity activities:

- MRU collaborates with local Departments of Social Service (LDSS) agencies on alleged acts of criminal welfare fraud and referrals to local Commonwealth Attorneys.
- Administers Medicaid Eligibility Quality Control (MEQC) and assist with the Payment Error Rate Measurement (PERM).
- Public Assistance Reporting Information System (PARIS) identifies members potentially receiving benefits in multiple states.

MRU has two sub-units, the Recipient Audit Unit (RAU) and the Eligibility Review Unit (ERU) that monitor member activities.

Recipient Audit Unit

The RAU is responsible for investigating allegations of acts of fraud, waste, or abuse committed by members of the Medicaid and FAMIS Programs, which result in misspent funds expended by the Department of Medical Assistance Services.

The RAU also investigates drug diversion and performs joint investigations with law enforcement, Virginia State Police, Social Security Administration (SSA), the Federal Bureau of Investigation (FBI), and other federal/state agencies.

The RAU identifies overpayments due to member fraud and abuse and tries to prevent and deter future losses through the following dispositions of their investigations:

- Administrative recovery from members of the overpaid benefits loss
- Criminal prosecution of member fraud, related penalties, sanctions and restitution as ordered by the courts.

Eligibility Review Unit

The ERU is responsible for specialized eligibility review projects. The ERU focuses on programs, populations, and processes Medicaid Eligibility Quality Control (MEQC), Public Assistance Reporting Information System (PARIS), assists on PERM audits and reviews and other targeted quality audits and reviews.

The ERU also oversees the Eligibility Quality Review Program (EQRP). The EQRP identifies statewide and locality-specific errors and trends. It provides data analysis, review, and specific and targeted areas of opportunity as requested.

Provider Review

The PID engages in provider-focused program integrity efforts and oversight. This helps fulfill its mission of working across the Agency to identify providers who may be practicing erroneously and/or abusively, or involved in fraudulent activities. PID efforts include:

- The Fraud and Abuse Detections System (FADS) is a suite of complementary, web-based components. As information crosses delivery systems, the FADS mines provider, member and claims data for potential fraud, waste and abuse (FWA); it also contains a system for tracking cases.
- PID has engaged nationally recognized audit vendors to augment their activities.

External Provider Audit and Policy (EPAP) Unit

The EPAP unit is responsible for the oversight and integrity of contracts and activities for the Agency's Managed Care contracts. EPAP also monitors nationally recognized contractors who perform additional provider audits. In addition, the unit leads the managed care program integrity collaborative and houses the Provider Review Unit (PRU).

Provider Review Unit

As a sub-unit of EPAP, the PRU conducts audits of fee-for-service provider claims. These audits examine a selection of claims paid during prior fiscal years to ensure proper payment practices per DMAS and Medicaid policy.

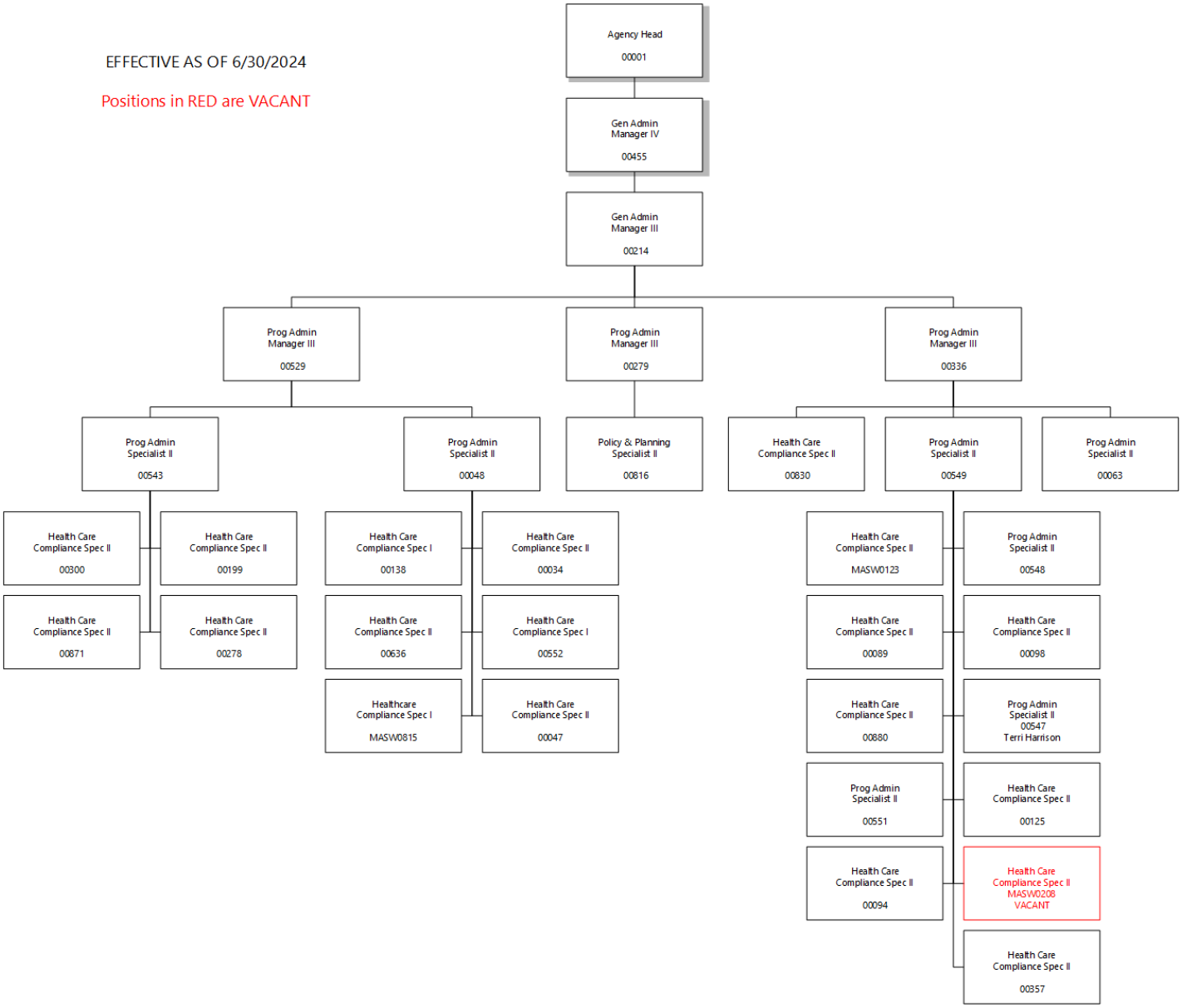
Policy, Research & Planning

Policy staff is responsible for assisting in the development of policies and procedures to support compliance with Federal and State regulations from a program integrity perspective. The objectives are to engage in research, strategic planning, team building, project management, and program design activities. Policy staff coordinates and leads complex projects and related work-groups. This includes the facilitation of teams and the development of RFPs, regulations, evaluations, memorandums of understanding, contracts, and compliance monitoring policy and procedures. Policy staff also serves as the Agency's liaison with the Medicaid Fraud Control Unit which is embedded within the Office of the Attorney General.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Programs and Operations
Program Integrity Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Program Operations Division

The Program Operations Division (POD) reports to the Deputy Director for Programs and Operations. The POD is the Agency service-center and operational backbone of the Virginia Medicaid Fee-for-Service (FFS) delivery system. It also acts as the service-center hub and serves as the gateway to managed care. Enrollees are placed in FFS at the beginning of their Medicaid enrollment and again when the plan assignment changes. Specialized populations and services are covered in FFS as well. Program Operations is divided into five units: Member Services, Provider Services, Service Authorization, Transportation and Claims, and Systems.

Provider Services Unit

The Provider Services unit has responsibility for the enrollment of all providers, the provider call center, and the contractors that manage the Provider Services Solution (PRSS) contract. It is the business center for the PRSS provider enrollment module.

Service Authorization - Payment Processing Unit

The Service Authorization-Payment Processing unit manages the FFS Service Authorization contract and pre-authorization of medical and behavioral health services.

Claims and Systems

The Claims and Systems unit oversees systems-implementations that affect operations. It analyzes data and looks for efficiencies in operations. It leads the implementation and modifications of the Division's Medicaid Enterprise System (MES). The unit is the business advisor for the claims and call center pieces of the Fiscal Agent Services contract. This unit also is the gateway to all FFS claims processing and system changes.

Transportation

The Transportation Team oversees Emergency and Non-Emergency Medical Transportation (NEMT) for the FFS contract. It oversees the complaint process for NEMT program brokers and coordinates with the MCO NEMT staff.

Member Services Unit

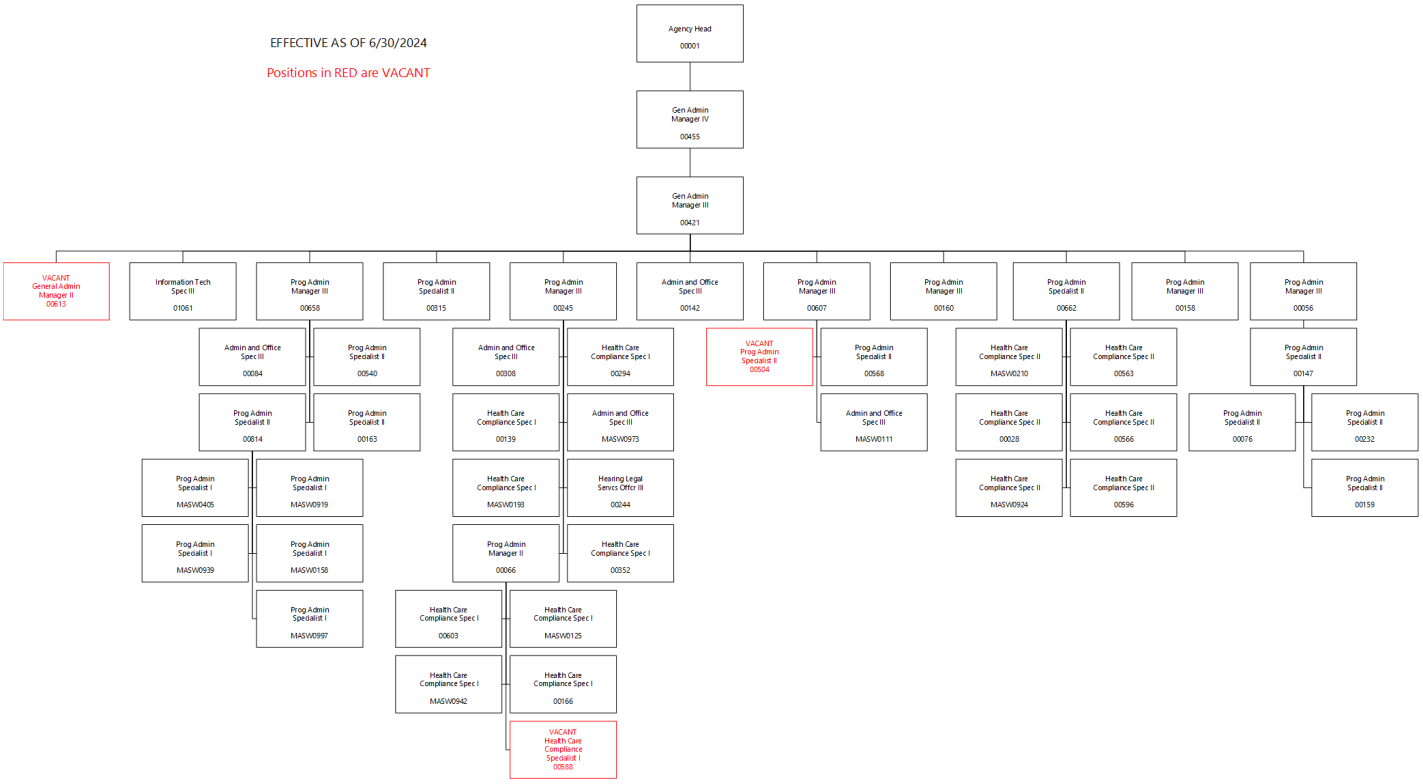
The Member Services Unit manages day-to-day operations of the Health Insurance Premium Payment (HIPP) program, the Buy-In program, FFS Appeals, and Customer Service. The unit also handles the mass mailing contract for the Agency.

This organizational structure positions POD to provide superior customer service to stakeholders, including Medicaid members, providers, DMAS staff, and other state agencies.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Programs
Program Operations Division

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Provider Rate Development Division

The Provider Rate Development Division (PRD) reports to the Deputy Director of Finance/Chief Financial Officer (CFO). The PRD is responsible for determining the payments for participating providers in Virginia Medicaid. It calculates, reviews, and updates Medicaid capitation and provider payment rates. In addition, PRD calculates and administers supplemental payments and associated assessments to hospitals, nursing care facilities, physicians, and some clinics. An important part of this work includes the settlement and auditing of institutional providers' cost reports and utilization of both regulatory and market information to determine appropriate and allowable payments.

There are three units within PRD (Provider Rate Setting, Capitation Rate Setting, and Supplemental Payments) that work collaboratively to accomplish this detailed and essential work.

Provider Rate Setting

The Provider Rate Setting Unit is responsible for developing, implementing, and maintaining rates for acute and long-term care services/providers; modeling the impact of proposed changes to payment policies and providing other analyses to support decision-making; assisting in the development of SPA and regulations to effectuate approved legislation; and working with providers and contractors to support accurate rate setting and payment.

Managed Care Rate Setting

The Managed Care Rate Setting Unit has the same kinds of responsibilities as the Provider Rate Setting Unit as they apply to the provision of capitated services, including:

- Cardinal Care Managed Care
    - Acute care services for children, pregnant women and low-income caretakers and adults, and aged, blind and disabled, including dual eligible individuals
    - Long-term services and supports (LTSS) for those with complex needs
- Program for All-inclusive Care for the Elderly (PACE)
- Non-Emergency Medical Transportation

This unit manages a large contract with a national actuarial consultant to assist in setting Medicaid managed care rates. In addition, this unit is responsible for administration of the following Medicaid programs:

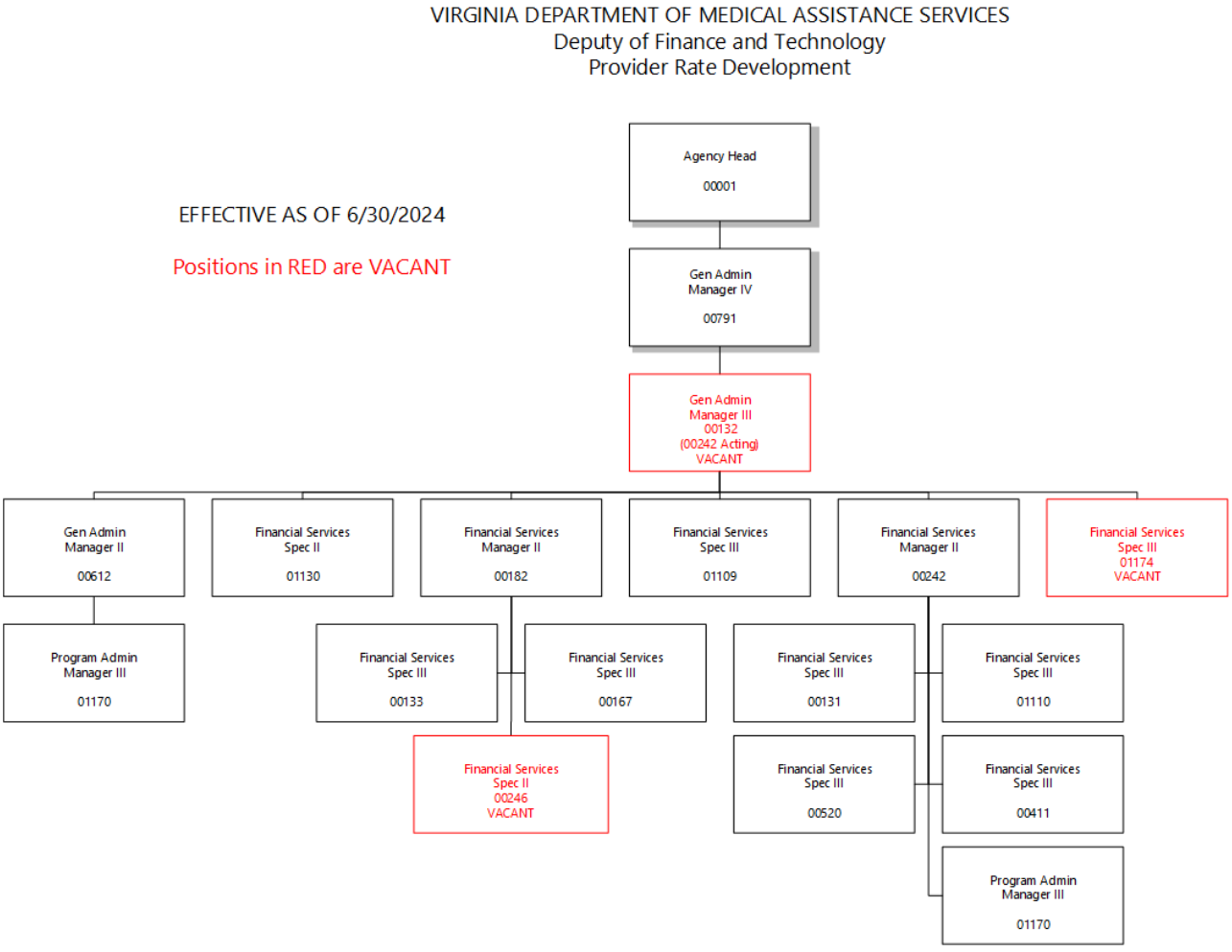
- Pharmacy Reinsurance Program
- Minimum Medical Loss Ratio (MLR) and Underwriting Gain Program
- COVID Administrative Claim Reimbursement Program
- Medicaid Expansion Risk Corridor Program
- Monthly Maternity Kick Payments

This unit reviews actuarial rate calculations and is responsible for ensuring that rates are loaded into the payment processing system. This unit is also responsible for coordinating the capitation rate loading process with the contract amendment submission to CMS. Capitation rates must be reviewed for actuarial soundness and to ensure that all federal and State requirements are met. The capitation rate setting unit is also tasked with monitoring MCO financial performance on a quarterly basis.

Supplemental Payments and Cost Settlement & Audit

The Supplemental Payments and Cost Settlement and Audit unit has the same type of responsibilities as the Provider Rate Setting Unit and Managed Care Rate Setting Unit as they apply to supplemental payments, cost settlement and audits. This unit administers private acute care hospital assessments and all supplemental and directed payments, including supporting CMS documentation, state regulations and interagency agreements. The unit also provides quarterly budget updates on supplemental payments and represent PRD at year-end budget meetings.

In addition, the Supplemental Payments and Cost Settlement and Audit unit is responsible for cost report related activities of institutional providers who file cost reports. Cost reports must be settled to ensure correct reimbursement for previous years and, for some provider types, their rate for the subsequent year. Financial information from cost reports is also used for rebasing certain rates. The unit also manages field audits to ensure that reported costs are correct and consistent with the Virginia Administrative Code and federal reimbursement principles. Much of this unit's work involves managing a contract with an independent certified public accounting firm, including approval of work to be completed and budgeted hours, review of audit findings, approval of any special/supplemental payments, and oversight of other consulting services. Additionally, this unit oversees upper payment limit (UPL) demonstrations, Disproportionate Share Hospital (DSH) audits, school-based reimbursement for medical transportation and administrative services, and lump-sum payment transactions.



Quality and Population Health Division

The Quality and Population Health Division (formerly known as the Office of Quality and Population Health) reports to the Chief Analytics Officer as part of the Healthcare Analytics and Transformation team. The Division advises DMAS on strategic policy initiatives to ensure access to high quality care, improve quality and population health outcomes, and reduce the cost of care for all members of Virginia's Medicaid program. The Division provides oversight of quality programs throughout the Agency and spearheads projects that enable DMAS to measure, monitor, and improve the quality of the care and services provided to its members through the Quality Strategy, a three-year framework for quality improvement activities across the Agency.

The Quality and Population Health Division (QPH) comprises two units:

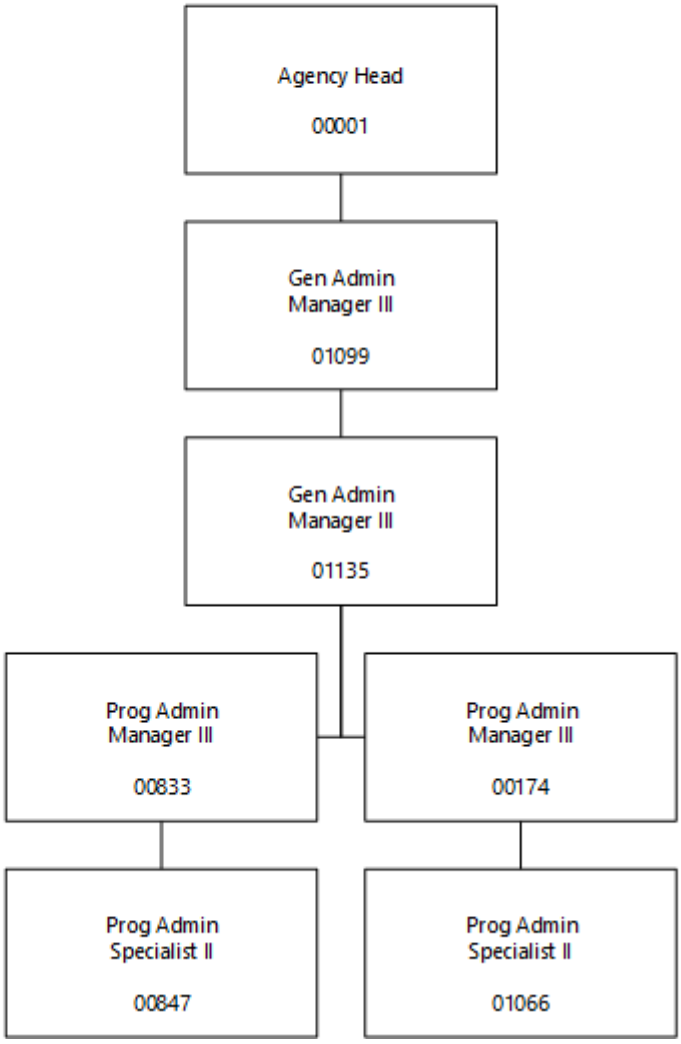
Quality Improvement Unit
Oversees the External Quality Review Organization (EQRO) contract to ensure all federally required quality activities (mandatory or optional) are conducted in accordance with managed care federal regulations (42 CFR 438 Subpart E: Quality Measurement and Improvement). In additional, the team ensures MCOs receive and maintain National Committee on Quality Assurance (NCQA) managed care accreditation, and any other NCQA certification or distinction as required by DMAS. The unit also works with the Population Health unit, MCOs and internal DMAS divisions, members, and stakeholders to share and disseminate results to ensure data driven support for policy and programmatic quality improvement recommendations.

Population Health Unit
Coordinates projects for DMAS, focusing on population health trends and possible health care gaps. This includes maternal health, behavioral health, foster care, health disparities, and social determinants of health. The PH Unit is responsible for identifying, collecting, carefully studying, and maintaining quality and population health data from managed care organizations (MCOs), namely Healthcare Quality Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience data. The unit also works with the Quality Improvement unit, MCOS and internal DMAS divisions, members, and stakeholders to provide feedback and recommendations on areas of opportunity for improvement in population health trends.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Healthcare Analytics & Transformation
Office of Quality & Population Health

EFFECTIVE AS OF 6/30/2024

Positions in RED are VACANT



Organizational Changes during Fiscal Year (FY) 2024

During the period July 1, 2023 – June 30, 2024, DMAS made the following organizational changes to ensure that all business functions are aligned:

Deputy for Administration Changes

This year the Eligibility and Enrollment Services division branched into two separate divisions to better align business functions. The Eligibility Policy and Outreach division is responsible for tracking and implementing state and federal legislation, guidance, and mandates related to Medicaid/FAMIS eligibility. The division also develops resources to educate members and community-based stakeholders about new initiatives and program changes. This division brought together resources from the Policy Division and the Eligibility and Enrollment Services division to better align the business functions of eligibility policy and member outreach. The remaining business function in Eligibility and Enrollment Services division are focused on operations for newborn and member enrollment, Cover Virginia operations, reporting and performance management. Both EES and EPO report to the Deputy for Administration.

Deputy for Finance Changes

This fiscal year, the Provider Reimbursement Division was rebranded to Provider Rate Development Division. This strategic change was made to help better define the division's role within the organization. Since the rebranding, the recruitment efforts in filling vacancies within the division has improved, including candidate pools that are better aligned with the skillsets required within the division's team.

Director's Office Changes

A new DMAS Chief Deputy was appointed in early FY24. This addition boosted the capacity of the Director's Office and the legislative affairs business functions, previously reporting to the Deputy of Administration, transitioned to the Director's Office.

Below is a summary of DMAS Staffing Changes during Fiscal Year 2024 (7/1/2023 – 6/30/2024), as well as previous FY 2021 through FY 2023 data These figures reflect classified and wage positions filled and separations, not a reflection of our current Maximum Employment Level (MEL).	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Classified Positions filled:	80	91	77	104
Internal Transfers:	30	21	19	35
External Hires:	50	70	58	69
Classified Positions Separations from DMAS:	43	50	87	42
Resignations:	25	28	24	1
Retirements:	14	12	22	7
Other:	4	10	41	34
Wage Positions filled:	15	44	4	35
External hires:	14	43	4	31
Internal transfer from one wage position to another wage position	1	1	0	4
Wage position separations from DMAS:	37	25	23	21
Resignations:	24	25	19	15
Other separations:	13	5	4	6
Other separations breakdown:				
Wage hired as classified:	3	5	0	3
Wage term to temp pos:	4	0	0	
Intern assign ended:	2	0	0	1
Layoff:			1	1
Terminations:	4	0	3	1
Total of other separations breakdown:	13	5	4	6

END OF REPORT