CardinalCare
Virginia's Medicaid Program

BMAS ORIENTATION

Cheryl Roberts, J.D., Department of Medical Assistance Services (DMAS) Director

June 18th, 2024

DMAS

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Agenda

- Medicaid Overview
- Programs and Benefits
- Finance
- DMAS Major Initiatives
- Resources

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DMAS Mission and Values

Our Mission & Values

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

Service | Collaboration | Trust | Adaptability | Problem Solving

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DMAS is Member Focused

DMAS Provides:

- Coverage
- Education and Information
- Services – Accessible and Available
  - Provider Networks
  - Support Services
- Member's ability to chose plans, services and providers
- DMAS listens, learns, evaluates and improves the program

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DMAS Commitment

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

S	O	A	R
Services for Members	Operations & Opportunities	Accountability	Results

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DMAS Executive Leadership Team

Cheryl Roberts
Agency Director

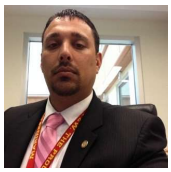
Ivory Banks
Chief of Staff

Adrienne Fegans
Deputy for Programs & Operations

Chris Gordon
Chief Financial Officer

Sarah Hatton
Deputy for Administration

Jeff Lunardi
Chief Deputy Director



John Kissel
Deputy for Technology & Innovation

Rich Rosendahl
Chief Analytics Officer

Dr. Lisa Price-Stevens
Chief Medical Officer

Tammy Whitlock
Deputy for Complex Care

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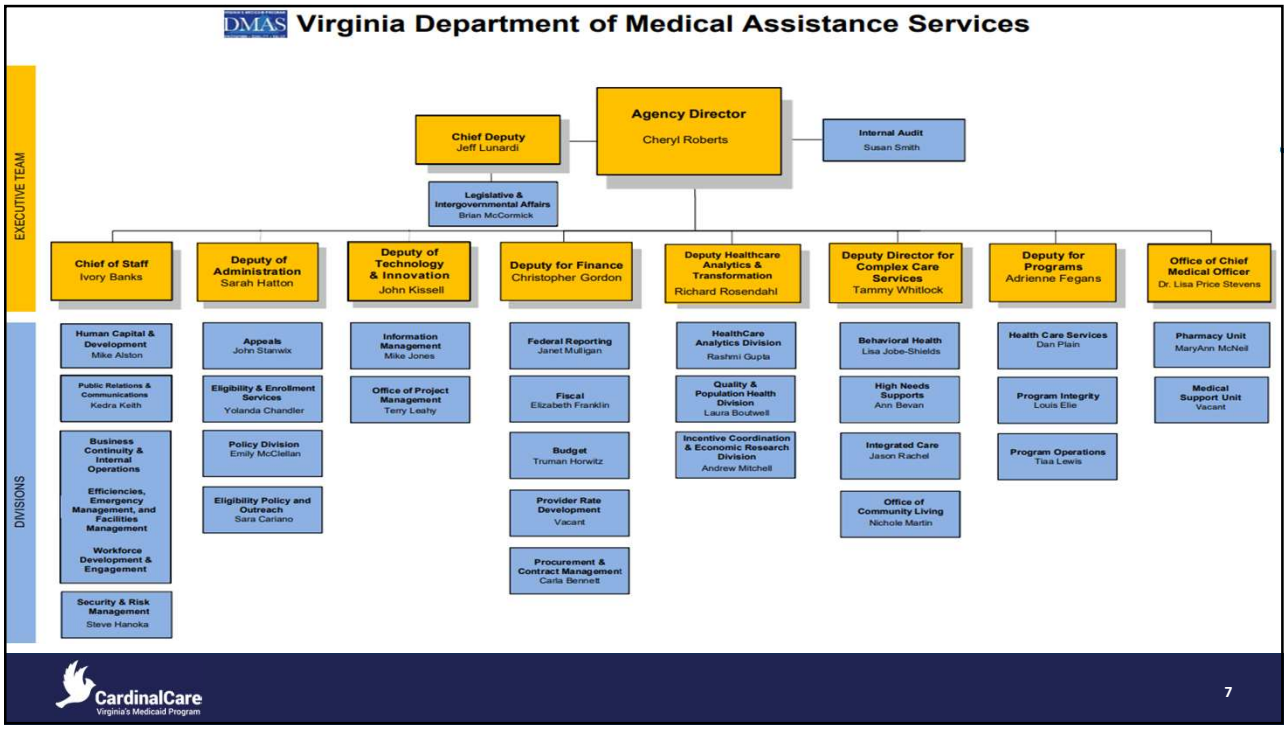

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Medicaid and CHIP (FAMIS) Authority

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

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

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

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

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

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Waivers

Waivers give the State authority to waive select federal Medicaid rules

Waivers require state and federal approval.

- A waiver is a state request that the U.S. Secretary of Health and Human Services (HHS) waive select provisions of the Social Security Act (SSA) to authorize Medicaid program changes that are not otherwise allowed under the federal rules.

Waivers allow exceptions to normal Medicaid rules.

- E.g., to require enrollment in managed care programs, or to provide services not otherwise covered to a targeted population.

Waivers are time-limited.

- Generally approved for three to five years and can be renewed.

Waivers are distinct from State Plan Amendments (SPAs)

- SPAs are used for changes to the Medicaid State Plan that may address program administration (e.g., eligibility, benefits, services, provider payments). Proposed changes must be approved by the state and comply with federal rules.
- If the program change deviates from federal rules, then the State may seek General Assembly approval to apply for a waiver.

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Waiver Types

Medicaid Waivers

§1915(b): Provide services through contracted Managed Care Organizations (e.g., Cardinal Care managed care)

§1915(c): Provide long-term services and supports in the community in lieu of an institution (e.g., CCC Plus Waiver, Developmental Disability Waivers)

§1115: Demonstrate and test new models of care delivery or financing (e.g., residential Addiction and Recovery Treatment Services and coverage for certain former foster care individuals)

Other Waivers

§1332 Waivers are also known as a State Innovation Waiver

Under a **§1332** waiver, states may request permission from the federal government to change elements of the Affordable Care Act that apply to private health insurance coverage

- **§1332** Waivers can be combined with an **§1115** Waiver but will be evaluated separately by the federal government

§1135 Waiver for the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act

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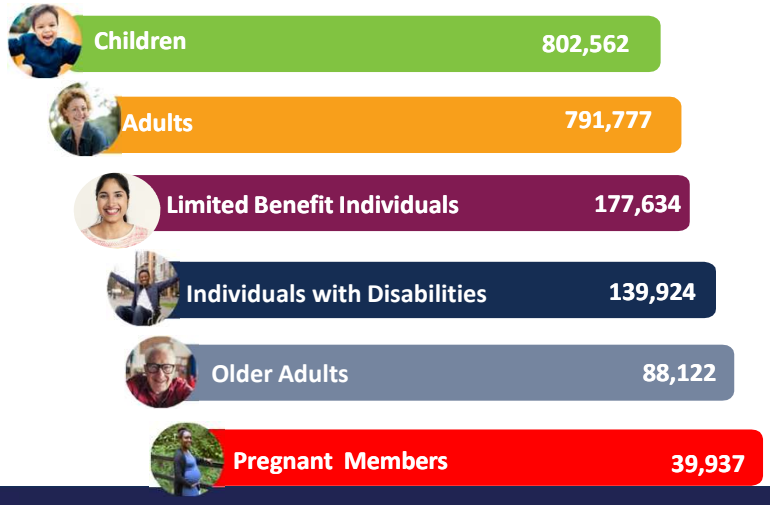
Who Do We Cover?

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



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Source: April 15, 2024 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

Medicaid Eligibility

Medicaid eligibility is complex, but DMAS works closely with sister agencies and advocates to simplify the process

- Eligibility determinations are made based on non-financial and financial requirements.
- Non-financial requirements include things such as age, pregnancy, residency and citizenship.
- Financial requirements include a review of income and resources (where applicable). For most categories of Medicaid, income is compared to the Federal Poverty Level (FPL) in order to determine eligibility.

**These income limits include a 5% FPL disregard.

Virginia's State-Sponsored Health Insurance Programs (Effective January 17, 2024)

	New Health Coverage for Adults Up to 138% FPL** Gross Income		Medicaid for Children under 19 & Medicaid for Pregnant Women Up to 148% FPL** Gross Income		FAMIS, FAMIS MOMS, & Plan First Up to 205% FPL** Gross Income	
Household Size	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$1,732	$20,783	$1,858	$22,289	$2,573	$30,873
2	$2,351	$28,208	$2,521	$30,252	$3,492	$41,902
3	$2,970	$35,632	$3,185	$38,214	$4,411	$52,931
4	$3,588	$43,056	$3,848	$46,176	$5,330	$63,960
5	$4,207	$50,481	$4,512	$54,139	$6,250	$74,989
6	$4,826	$57,905	$5,176	$62,101	$7,169	$86,018
7	$5,445	$65,330	$5,839	$70,064	$8,088	$97,047
8	$6,063	$72,754	$6,503	$78,026	$9,007	$108,076
Additional person add	$619	$7,425	$664	$7,963	$920	$11,029

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Applying for Medicaid

Virginia offers many ways to apply for Medicaid:

CardinalCare

Apply via Virginia Cardinal Care app

Apply online at **www.commonhelp.virginia.gov**

Virginia's Insurance Marketplace

Apply online at the Virginia's Insurance Marketplace at **www.marketplace.virginia.gov**

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Apply by calling Cover Virginia at 833-5CALLVA
(TDD: 1-888-221-1590)

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12-Month Continuous Eligibility (CE) for Children

Medicaid and FAMIS enrolled children receive 12-months of protected coverage, regardless of changes in circumstance.

- CE periods begin at initial enrollment and each renewal
- Coverage cannot be closed or reduced during this period
  - Limited exceptions such as turning 19, moving out of state, or family requesting the coverage end apply.
- Annual renewals are still required
- Continuity of care and uninterrupted access to the essential health coverage.

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Continuous Coverage Unwinding Updates

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Medicaid Continuous Coverage Requirements: Background

The end of the continuous coverage requirement, or "unwinding" has represented the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA).

- The Families First Coronavirus Relief Act required states to maintain enrollment of Medicaid members (enrolled as of March 18, 2020) to receive the additional 6.2 % increase until the end of the month in which the federal Public Health Emergency (PHE) ended.
- In December 2022, the Consolidated Appropriations Act (CAA) 2023 was signed into effect decoupling the PHE from the continuous coverage requirement effective March 31, 2023. Additionally, the CAA:
  - Allowed states 12 months to initiate all renewals, with an additional two months to complete redeterminations. Virginia initiated unwinding renewals in March 2023; February 2024 will be the 12th month of initiations.
  - Stepped down the enhanced federal match rate beginning April 1 and completely phasing out the enhanced match effective December 31, 2023.
  - Virginia received a total of $3.067 billion in enhanced funding beginning in March 2020 through the end of calendar year 2023.
  - Virginia was one of 44 states required to submit a mitigation plan prior to unwinding, which was approved by the Centers for Medicare and Medicaid Services on March 29, 2023.

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Medicaid Continuous Coverage Requirements: Preparation

Health Human Resources (HHR) agencies acted early in the PHE to implement flexibilities and protect needed coverage during the PHE to allow access to services. In a parallel effort, the DMAS and DSS began planning in mid-2020 for the eventual unwinding of those flexibilities. Virginia has been named a leader in the country for innovative and thorough outreach, education, and communication to all stakeholders.

Unwinding Taskforce: Convened by Secretary Littel in January 2022 to include DMAS and DSS leaders and the Office of the Attorney General. In July 2022, the taskforce was expanded to include Senate and House Finance and Department of Planning and Budget staff.

Cover Virginia: Expanded operations to include a redetermination call center and processing services through the end of unwinding. Implemented new permanent units dedicated to pregnant women and application assisters/advocates.

Outreach and Education: Launched outreach campaigns through radio, television, social media, and 3 websites. Development of 4 stakeholder toolkits, 18 outreach templates, 60 provider memos. Engagement through speaking events to include 8 public townhalls to nearly 1000 different stakeholder groups.

25 System Updates: Increased the number of successful "no touch" actions at application, change, and renewal to promote consistency, reduce local worker burden, and allow a stronger focus on high-risk populations which require manual processing.

Training and Information Sessions: eLearning and webinars held for over 3,000 local agency staff. Expanded learning opportunities through existing Virginia Health Care Foundation partnership to increase assistance resources, added trainings for aged and disabled populations.

Managed Care Organization Collaboration: Executed agreement with the six health plans to solidify plans for four round of targeted member outreach across all modalities. Implemented new data sharing processes to include addresses, closures, and closure reason.

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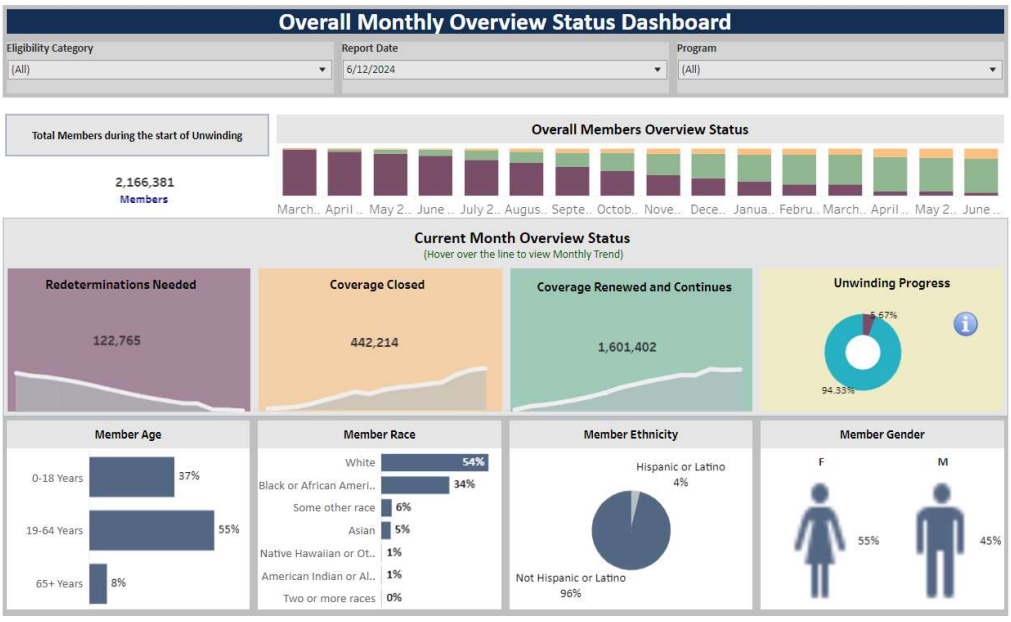

*Data as of 06/05/2024

Completed by Member
2,166,831
2,043,616*
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
1,300,000
1,200,000
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PROGRAMS AND BENEFITS

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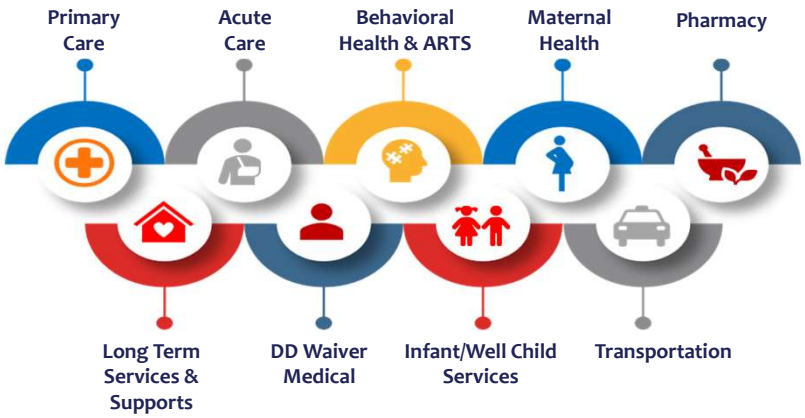
Virginia Medicaid Services



"Carved-out" services include dental, school health, and DD Waiver services

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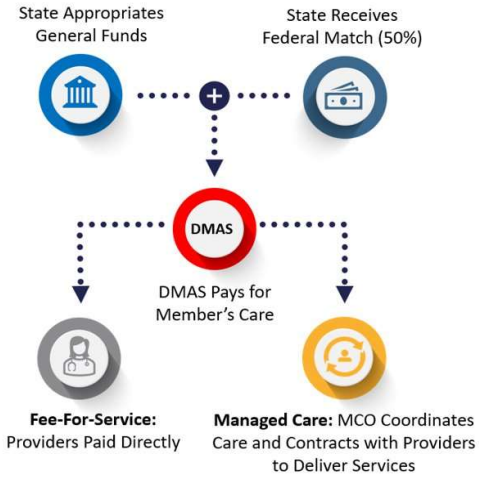
Delivery System



*Managed care serves over **90**% of our members through five accredited health plans.*

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Cardinal Care is DMAS program name that includes all Medicaid members served through managed care and fee-for-service delivery systems

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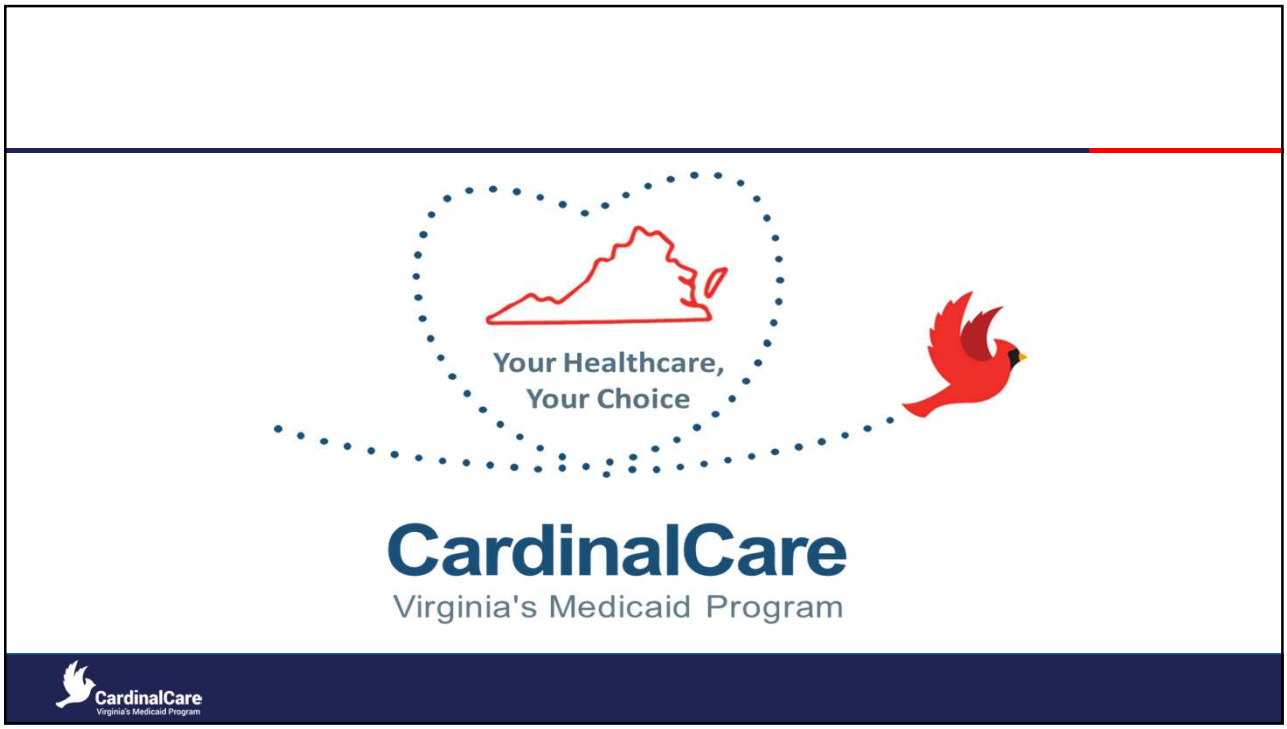

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2021-2023 Cardinal Care Timeline

DMAS's strategy to achieve these legislative directives was implemented in phases, while working closely with the Centers for Medicare and Medicaid Services (CMS) to receive federal approval to consolidate the two managed care waivers and contracts

July 2021

As part of the 2021 Appropriations Act, DMAS was directed to merge our two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus)

Jan 2023

Rebrand as Cardinal Care Cardinal Care, DMAS' program name that includes all Medicaid, and FAMIS members served through both the managed care and fee-for-service delivery systems

Sept 2023

DMAS received approval from CMS to consolidate the Medallion 4.0 and CCC Plus programs under Cardinal Care Managed Care waiver – effective October 1, 2023

Oct 2023

Medallion 4.0 and CCC Plus programs are consolidated under Cardinal Care

2024

The new Cardinal Care Managed Care Program will drive innovation and strengthen quality and accountability

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Cardinal Care Managed Care

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

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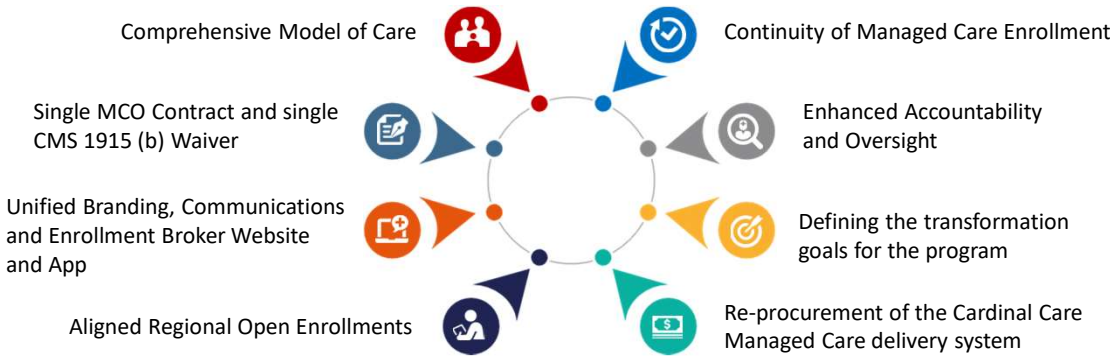
Cardinal Care Managed Care

DMAS is improving the Cardinal Care Managed Care (CCMC) program with these steps:



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What Stays the Same

- Benefits and Services (no reductions or changes)
- Services included in Managed Care (Services carved-out of managed care are not changing)

- Populations eligible for managed care (excluded populations are not changing)
- Members have choice of health plans and providers

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What Changed

- Benefits alignment
- Open enrollment alignment

- No need to switch plans if health care needs change
- Care coordination available to all

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What Will Be Updated

- Communications with members
- Cardinal Care Managed Care App
- FAMIS members enrollment process
- General Assembly actions and Governor's Budget items

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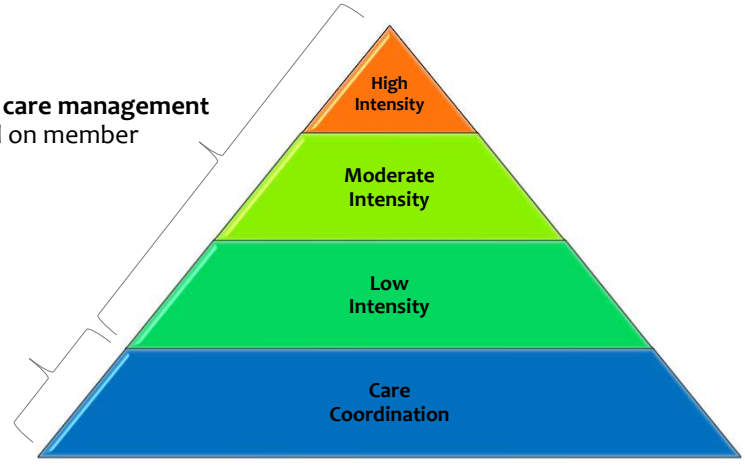
Care Management Intensity

Three levels of care management intensity based on member needs/risks

Care coordination for members with minimal needs



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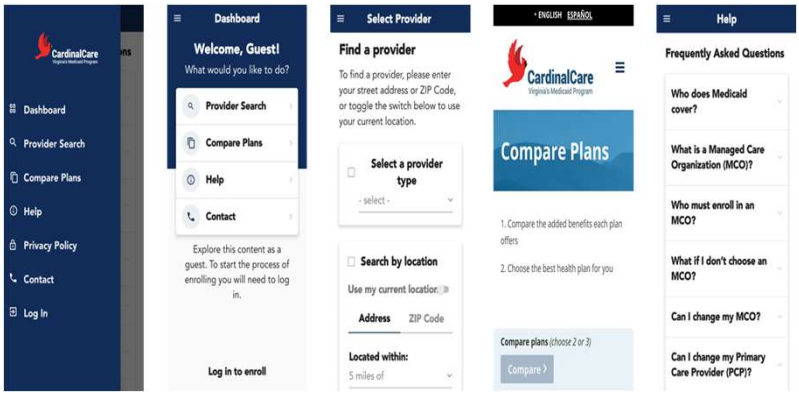
Download the Member App

The Virginia Cardinal Care mobile app is designed to make it simple to find and enroll in a health care plan.

Download for Android or iPhone

Virginia Cardinal Care
MAXIMUS



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Questions?

- **Enrollment Broker Website:** https://virginiamanagedcare.com/
- **Enrollment Broker Phone Number:**
  - **Toll-free number:**
    - 1-800-643-2273
    - **TTY:** 1-800-817-6608
  - **Hours of operation**:

    Monday – Friday

    8:30 a.m. – 6:00 p.m.

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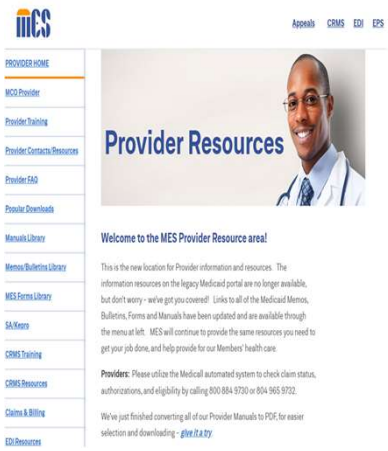
Medicaid Provider Enrollment

- The 21st Century Cures Act (Act) is a federal mandate requiring all Medicaid Managed Care network providers to enroll and periodically revalidate with the state's Medicaid program in PRSS
- Providers can enroll as FFS, FFS+MCO, or MCO only
- PRSS handles federally required background checks, fees, and site visits based on the provider's risk level
- Providers must be enrolled in PRSS prior to contracting with an MCO
- Enrollment information is available at https://vamedicaid.dmas.virginia.gov/training/providers



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Provider Revalidation

- Medicaid fee-for-service and Managed Care Organization (MCO) network providers need to enroll in PRSS and revalidate enrollment at least every five years
- Providers must submit the revalidation electronically through our Provider Services Solution (PRSS) portal
- Provider notices are sent via email or USPS at least 90 prior to the end of their enrollment period
- Reminder notices are also sent at 60 and 30 days prior to the revalidation deadline
- In accordance with federal requirements, providers who do not revalidate by the revalidation due date will have their Virginia Medicaid participation status terminated from fee-for-service and MCO networks until the provider successfully enrolls/revalidates in PRSS
- MCO network providers who have had their network participation terminated due to failure to revalidate may need to recredential with the MCOs once they have successfully re-enrolled in PRSS. Federal rules prohibit the MCOs from contracting with providers who are not enrolled or have had their enrollment terminated in PRSS.
- Visit the Medicaid Enterprise System (MES) at https://www.dmas.virginia.gov/for-providers/medicaid-enterprise-system/ for more info

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Long Term Services and Supports (LTSS)

Institution Based Care

Nursing Facilities, Specialized Care Nursing Facilities, Long-Stay Hospitals, Out of State Placement, and Intermediate Care Facilities for Individuals with Intellectual Disabilities

Home & Community-Based Services (HCBS)

Provides supports for individuals in a community-based setting. These services are available for both children and adults. The services will differ based on the individual needs and program criteria met.

Developmental Disability (DD) Waivers

- For individuals with developmental disabilities through three waivers. Services may include residential, day, and employment supports.

Commonwealth Coordinated Care Plus Waiver

- For seniors or individuals with physical disabilities, services include personal care, respite, and adult day healthcare.

Program for All-Inclusive Care Services for the Elderly (PACE)

- For adults ages 55+ who are living with chronic health care needs and/or disabilities and receive community-based health care services and supports from an approved PACE program.

Home and Community Based Waivers

The Medicaid home and community-based waivers (§1915(c)) offer individuals who require assistance with activities of daily living and/or supportive services the opportunity to receive care in the community rather than in a facility setting

Waiver	Features
Community Living Waiver	Provides 24/7 services and supports for adults and some children with exceptional medical and/or behavioral support needs. This includes residential supports and a full array of medical, behavioral and non-medical supports.
Family and Individual Supports Waiver	Provides supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.
Building Independence Waiver	Provides supports for adults able to live independently in the community with housing subsidies and/or other types of support. The supports available in this waiver will be periodic or provided on a regular basis as needed.
Commonwealth Coordinated Care Plus Waiver	Provides supports for elderly and disabled individuals, including adult day health care; medication monitoring; personal care services; respite care; and personal emergency response systems. Also provides supports for children and adults who are chronically ill or severely impaired and require both a medical device and substantial and ongoing skilled nursing care to avert further disability or to sustain their lives

Specialized Medicaid Programs

The following specialized Medicaid benefits and programs target certain services and interventions to designated populations

Program	Features
Program of All-Inclusive Care for the Elderly (PACE)	The Program of All-Inclusive Care for the Elderly (PACE) is a community-based program that serves individuals receiving Medicare and Medicaid who are age 55 or older and qualify for nursing facility level of care. Through an interdisciplinary care model, the PACE program offers a community alternative to nursing facility care and provides the full continuum of medical and social supports for older adults.
Addiction and Recovery Treatment Services (ARTS)	In response to the statewide opioid epidemic, DMAS launched the Addiction and Recovery Treatment Services (ARTS) benefit April 1, 2017. The ARTS benefit provides the full continuum of evidence-based addiction treatment to any of the 2.1 million Medicaid and FAMIS members.
Early Intervention Services	Early Intervention Services (EIS) are defined as services provided through Part C of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1431 et seq.), designed to meet the developmental needs of each child and the needs of the family, to enhance the child's development. Early Intervention Services must be provided in natural environments for the child, such as the home and community settings. Services consist of speech, physical and occupational therapies, along with individualized developmental programming and coordination.

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FINANCE

DMAS

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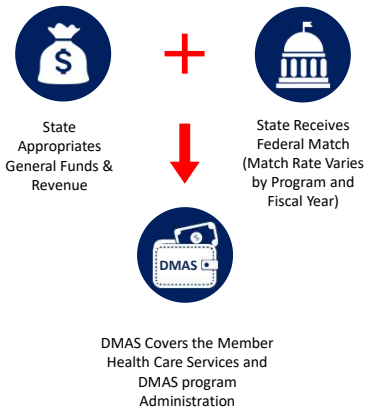
Medicaid Funding and Authority

- Current Appropriations is $22.7 billion
- $0.22 out of every state tax dollar collected annually goes to fund the state share of Medicaid



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Finance Overview
FY24 Appropriation (Chapter 1, 2024 Special Session I)

		FY24 Appropriation (In Millions)
Title XIX Base Medicaid & Medicaid Expansion	$	21,730.9
Title XXI Children's Health Insurance Program		590.1
Administration		340.2
Temporary Detention Orders		11.8
Insurance Premiums for HIV-Positive Individuals		0.6
Uninsured Medical Catastrophe		0.3
Total	**$**	**22,673.9**

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Source: PB Reports, as of May 20, 2024 https://pbreporting.virginia.gov/rdPage.aspx

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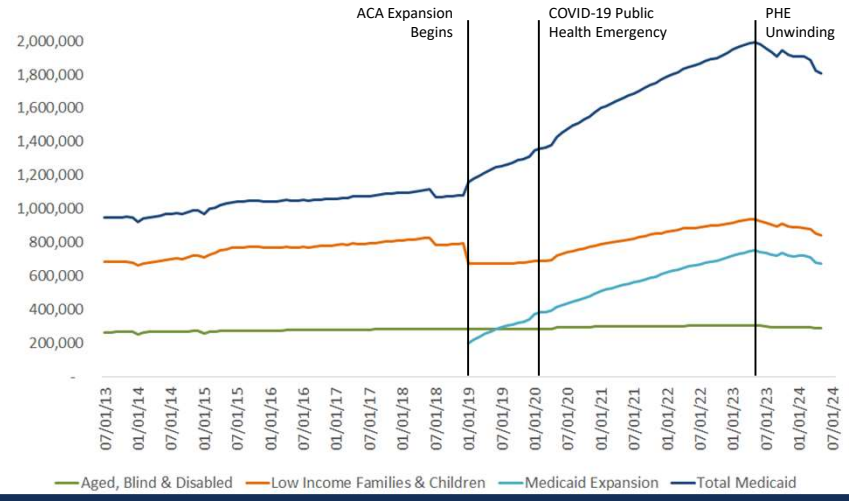
Historical Enrollment: Title XIX Since FY14



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Source: DMAS Enrollment Report as of May 2024 (https://www.dmas.virginia.gov/data/enrollment-reports/)

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Summary – All Programs

*SFY2024 reflects claims paid July 1 – December 31, 2023

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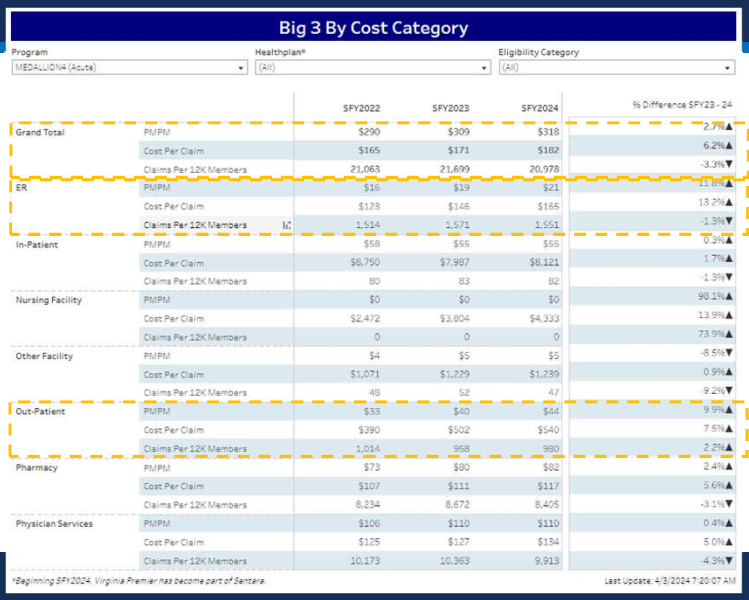
Cardinal Care Acute Overview (Managed Care)



Big 3 By Cost Category

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

		SFY2022	SFY2023	SFY2024	% Difference SFY23 - 24
Grand Total	PMPM	$290	$309	$318	2.7%▲
	Cost Per Claim	$165	$171	$182	6.2%▲
	Claims Per 12K Members	21,063	21,699	20,978	-3.3%▼
ER	PMPM	$16	$19	$21	11.8%▲
	Cost Per Claim	$123	$146	$165	13.2%▲
	Claims Per 12K Members	1,514	1,571	1,551	-1.3%▼
In-Patient	PMPM	$58	$55	$55	0.3%▲
	Cost Per Claim	$8,750	$7,987	$8,121	1.7%▲
	Claims Per 12K Members	80	83	82	-1.3%▼
Nursing Facility	PMPM	$0	$0	$0	98.1%▲
	Cost Per Claim	$2,472	$3,804	$4,333	13.9%▲
	Claims Per 12K Members	0	0	0	73.9%▲
Other Facility	PMPM	$4	$5	$5	-8.5%▼
	Cost Per Claim	$1,071	$1,229	$1,239	0.9%▲
	Claims Per 12K Members	48	52	47	-9.2%▼
Out-Patient	PMPM	$33	$40	$44	9.9%▲
	Cost Per Claim	$390	$502	$540	7.5%▲
	Claims Per 12K Members	1,014	958	980	2.2%▲
Pharmacy	PMPM	$73	$80	$82	2.4%▲
	Cost Per Claim	$107	$111	$117	5.6%▲
	Claims Per 12K Members	8,234	8,672	8,405	-3.1%▼
Physician Services	PMPM	$106	$110	$110	0.4%▲
	Cost Per Claim	$125	$127	$134	5.0%▲
	Claims Per 12K Members	10,173	10,363	9,913	-4.3%▼

*Beginning SFY2024, Virginia Premier has become part of Sentara.

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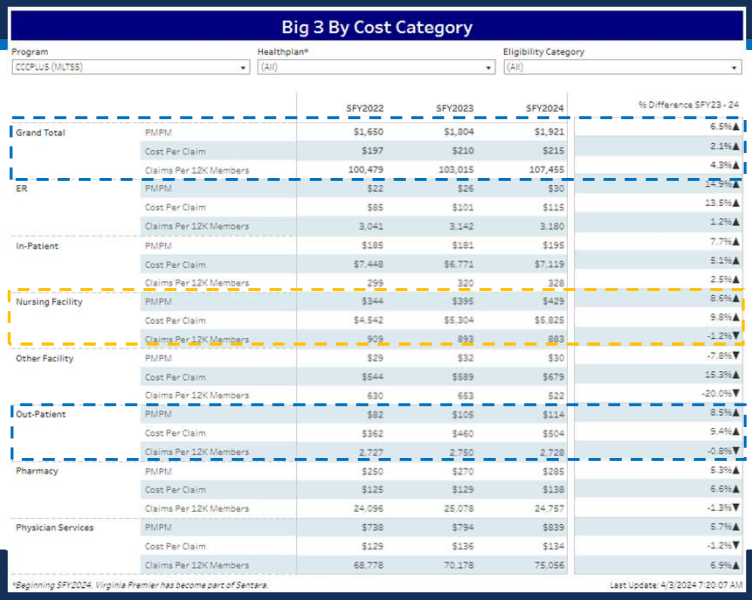
Cardinal Care Complex Overview (Managed Care)



Big 3 By Cost Category

Program: CCCPLUS (MLTSS) | Healthplan*: (All) | Eligibility Category: (All)

		SFY2022	SFY2023	SFY2024	% Difference SFY23 - 24
Grand Total	PMPM	$1,650	$1,804	$1,921	6.5%▲
	Cost Per Claim	$197	$210	$215	2.1%▲
	Claims Per 12K Members	100,479	103,015	107,455	4.3%▲
ER	PMPM	$22	$26	$30	14.9%▲
	Cost Per Claim	$85	$101	$115	13.5%▲
	Claims Per 12K Members	3,041	3,142	3,180	1.2%▲
In-Patient	PMPM	$185	$181	$195	7.7%▲
	Cost Per Claim	$7,448	$6,771	$7,119	5.1%▲
	Claims Per 12K Members	299	320	328	2.5%▲
Nursing Facility	PMPM	$344	$395	$429	8.6%▲
	Cost Per Claim	$4,542	$5,304	$5,825	9.8%▲
	Claims Per 12K Members	909	893	883	-1.2%▼
Other Facility	PMPM	$29	$32	$30	-7.6%▼
	Cost Per Claim	$544	$589	$679	15.3%▲
	Claims Per 12K Members	630	653	522	-20.0%▼
Out-Patient	PMPM	$82	$105	$114	8.5%▲
	Cost Per Claim	$362	$460	$504	9.4%▲
	Claims Per 12K Members	2,727	2,750	2,728	-0.8%▼
Pharmacy	PMPM	$250	$270	$285	5.3%▲
	Cost Per Claim	$125	$129	$138	6.6%▲
	Claims Per 12K Members	24,096	25,078	24,757	-1.3%▼
Physician Services	PMPM	$738	$794	$839	5.7%▲
	Cost Per Claim	$129	$136	$134	-1.2%▼
	Claims Per 12K Members	68,778	70,178	75,056	6.9%▲

*Beginning SFY2024, Virginia Premier has become part of Sentara.

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DMAS MAJOR INITIATIVES

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Medicaid Enterprise Solution (MES)

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Medicaid Enterprise Solution (MES)

MES Module	Vendor
Integrated Services Solution (ISS)	Deloitte
Provider Services Solution (PRSS)	Gainwell
Fiscal Agent Services Solution (FAS)	Conduent
Enterprise Data Warehouse Solution (EDWS)	Optum
Pharmacy Benefit Management Solution (PBMS)	Prime Therapeutics (Tx)
Appeals Information Management Solution (AIMS)	Visionary Integration Professionals (VIP)
Encounter Processing Solution (EPS)	DMAS
Care Management Solution (CRMS)	DMAS

External Vendors | Trading Partners | Sister Agencies | MCOs

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Module Contract End w/Options and Description

- **ISS (9/30/2027)**
  - The central coordinator for all the information flowing through MES. Data flows from module to module in the cloud, with ISS directing the traffic to the right place. ISS includes the MES Portal, where users can connect to any module they are approved for, right from their web browser.
- **PRSS (11/30/2027)**
  - Provides overall management for provider related activities including enrollment services for fee-for-service and managed care network providers.
- **FAS (6/30/2027)**
  - Core of Medicaid Management including Member enrollment, claims adjudication, financials, and payment processing.
- **EDWS (9/30/2027)**
  - Main storage repository for data within MES and receives and supplies data on demand to MES modules through ISS and the source for data analytics and dashboards.
- **PBMS (9/30/2025)**
  - Manages pharmacy benefits across the Provider and Member communities.
- **AIMS (9/30/2027)**
  - Automates member and provider appeals processes.
- **EPS (N/A)**
  - Rules engine for receipt and validation of encounter claims submitted by MCOs and other Trading Partners.
- **CRMS (N/A)**
  - CRMS streamlines and standardizes the information exchange among MCOs and DMAS business areas through Member Transition Records and offers a comprehensive set of health records for Behavioral Health and Long-Term Care using eMLS, LOCERI and PACE web applications.

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Pharmacy Services

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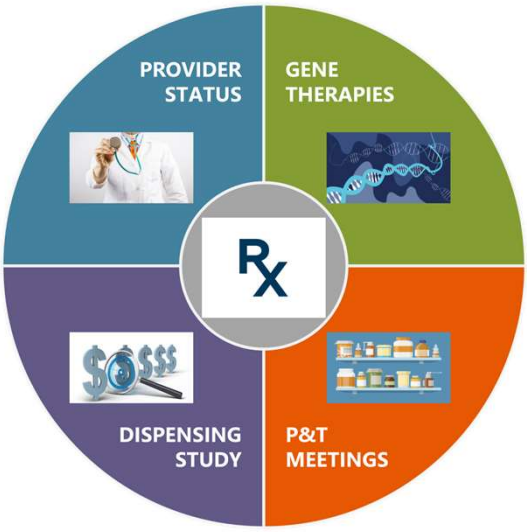
Pharmacy Services



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Behavioral Health Services Redesign & Crisis

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Behavioral Health Services in Medicaid

2017

Addiction Recovery Treatment Services (ARTS) Benefit

1115 Demonstration Waiver

2018

Behavioral health rehabilitative services begin to be included in managed care

2019-2021

Joint DMAS-DBHDS planning for Behavioral Health Redesign for Access, Value, and Outcomes (BRAVO) Phase 1 implementation

2022-2026

Right Help. Right Now. Plan announced
RHRN Medicaid service redesign

ARTS
ADDICTION & RECOVERY TREATMENT SERVICES

PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

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

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The Commonwealth's Behavioral Health Plan is founded on six pillars

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

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

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

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

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

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

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

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

Initiatives to redesign adult (Pillar 3) and youth (Pillar 6) Medicaid services arose in two Pillars

Source: VA HHR

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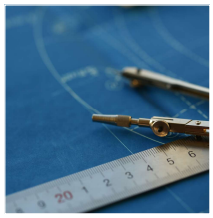
Medicaid Behavioral Health Services Redesign Priorities

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

Promote earlier intervention and increase access through tiered service design



Design services to complement Virginia's complex behavioral health delivery system

Integrate workforce priorities and workforce supports into service design and implementation

Implement the program in both FFS and the managed care organizations

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Virginia's Medicaid Program

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Project Overview

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

The project seeks to redesign DMAS' youth and adult legacy services: intensive in home, therapeutic day treatment, mental health skill building, psychosocial rehabilitation, and targeted case management.

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

The project will include stakeholder engagement, and policy and rate development for youth and adult services redesign as well as QMHP/BH Technician planning and integration.

This project will work with Managed Care Organizations and providers on all aspects of the program and implementation.

CardinalCare Virginia's Medicaid Program

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Serving Medicaid Members in Behavioral Health Crisis

- In December 2021, Virginia Medicaid implemented four crisis specific services to support the implementation of a statewide Crisis Now Model for all Virginians.

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

Mobile Crisis Response	23 Hour Crisis Stabilization	Residential Crisis Stabilization	Community Stabilization (transition service)

- July 2022: All Medicaid providers must be under Memorandum of Understanding with the regional crisis hubs and use statewide Crisis CONNECT data platform
- December 2023: Medicaid Mobile Crisis Response service dispatched via regional mobile crisis hubs and regional 9-8-8 call centers, in line with the Crisis Now Model. *20,000 Medicaid members have received a mobile crisis response during State Fiscal Year 2024 so far.*

CardinalCare Virginia's Medicaid Program

988 SUICIDE & CRISIS LIFELINE

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General Assembly and State Based Exchange

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DMAS Legislative Role

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

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2024 General Assembly Session – Major Topics

- Proposed new Medicaid benefits
- Changes to rules for paid family caregivers (legally responsible adults)
- Eligibility changes for waiver recipients
- Proposed pharmacy benefit changes
- Provider rate increases

DMAS and Virginia's State Based Exchange

CardinalCare Virginia's Medicaid Program

- Department of Medical Assistance Services
- **2 million** members
- Funded jointly by federal and state governments

Core Areas of Collaboration

Policy Alignment

System Integration

Member/Consumer Outreach and Communication

Virginia's Insurance Marketplace

- Health Benefit Exchange, State Corporation Commission
- **400,000** consumers
- Individual premiums and cost sharing; federally funded premium tax credits and cost-sharing reductions

CardinalCare
Virginia's Medicaid Program

Maternal and Child Health

DMAS

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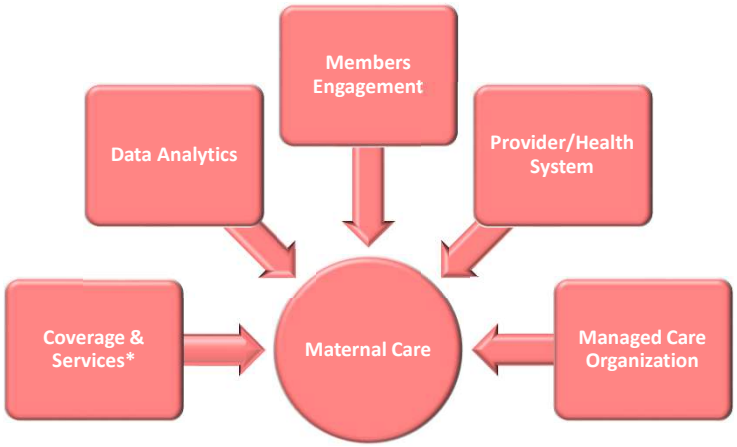
Virginia Medicaid – Maternal Care Levers

Five levers are involved in Virginia Medicaid maternal health



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Virginia's Medicaid Program

* Requires Federal and state authority and funding

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DMAS Covers 1/3 of the Births in the Commonwealth

Four basic coverage categories receive full Medicaid benefits to include maternal and comprehensive health services, dental, transportation, behavioral health, and no cost sharing

- ❖Medicaid for Pregnant Women
- ❖Medicaid Base
- ❖Medicaid Expansion
- ❖FAMIS Moms

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Virginia's Medicaid Program

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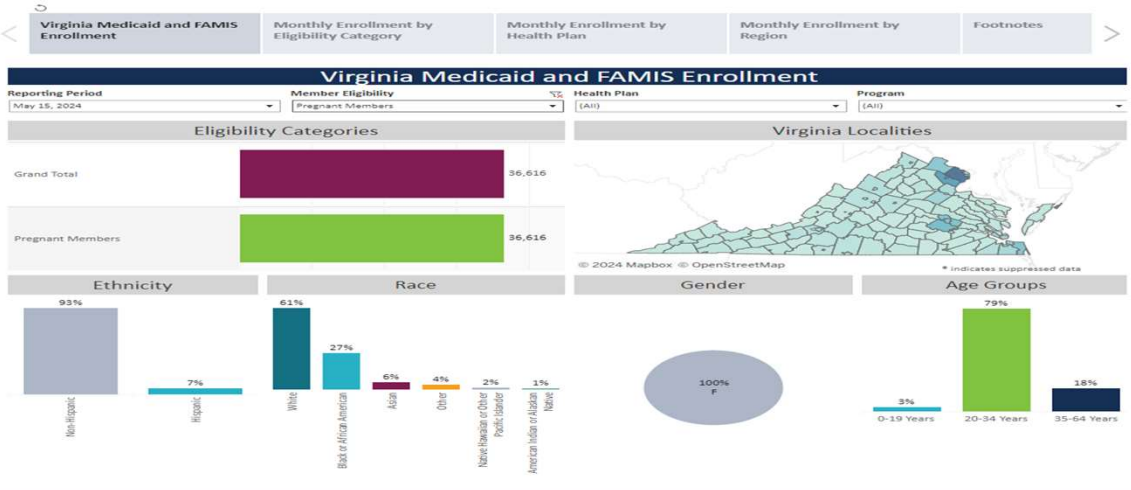
DMAS Enrollment Dashboard



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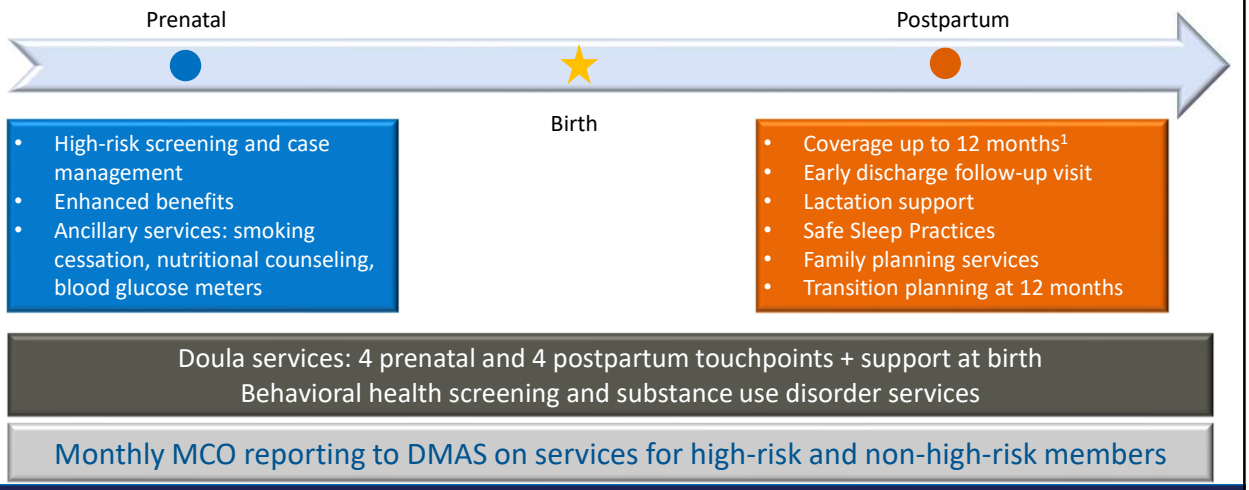
Virginia Medicaid's Perinatal System of Care



CardinalCare Virginia's Medicaid Program

[1] Virginia extended postpartum coverage to 12 months through an existing 1115 waiver. As a result, the demonstration is subject to rigorous evaluation.

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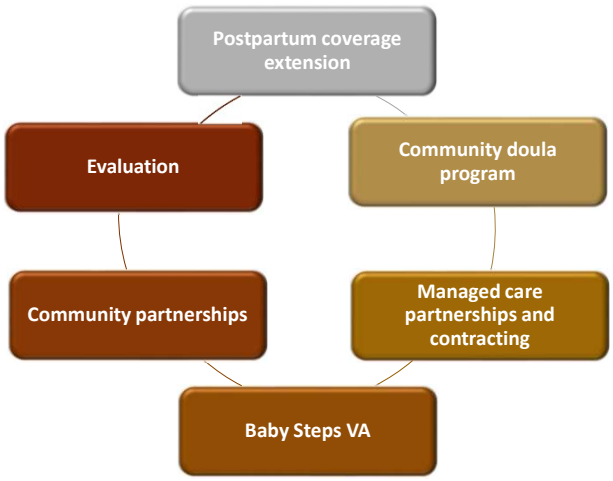
Programs To Support Parents In The Postpartum Period



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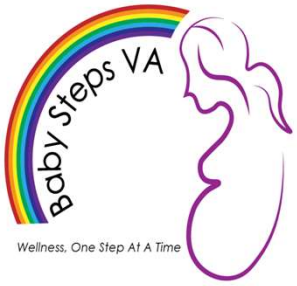
Baby Steps VA

- **Eligibility and Enrollment**
- **Outreach and Information**
- **Connections**
- **New and Improved Services and Policies**
- **Program Oversight**



Our next meeting is **Friday July 12th from 10-11:30am**

BabyStepsVA@dmas.virginia.gov

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Managed Care Organizations

- Managed Care Organizations (MCO) develop comprehensive maternity care programs that align with DMAS goals
- MCOs have specialized clinical programs as well as provide transportation, support services, and client connection teams such as doulas, community health workers, and home visitors
- Additional added benefits provided by MCOs may include:
  - Free diapers, highchairs, and car seats
  - Baby showers
  - Grocery gift cards
  - Meals sent after delivery
  - Health related social needs such as food and housing

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Care Management for High-Risk Pregnant Individuals

- Care management services must be provided to pregnant individuals deemed high-risk by the health plan
- Within three (3) business days of a member being identified as high-risk, the health plan makes efforts to contact the member and/or their physicians to identify and assess their specialized needs (medical, psychosocial, nutritional, etc.)
- The health plan monitors the risk status of pregnant members not originally considered “high-risk maternity” for potential enrollment in their high-risk maternity programs

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What We Measure

Healthcare Effectiveness Data and Information Set (HEDIS) measures

- The percentage of deliveries of live births that received a **prenatal visit** in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization
- The percentage of deliveries of live births that had a **postpartum visit** on or between 7 and 84 days after delivery

Utilization data from claims

Program data from evaluation and monitoring reports from EQRO

More info available at https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/

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DMAS Actions to Connect the Dots

- Reviewing data to inform policies and programs
- Reviewing national trends and state searches for best practices
- Working with the provider community on extended hours
- Adding the postpartum visit to the hospital discharge checklist
- Special mailings to members who have not had a prenatal or postpartum visit
- Participating in National Governor's Association learning opportunity with VDH
- Participating with the Governor and Secretary of Health and Human Resources on the Maternal Health Roundtable

HEALTHY MOMS FAMILIES COMMUNITIES

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CardinalCare Virginia's Medicaid Program

Resources

DMAS

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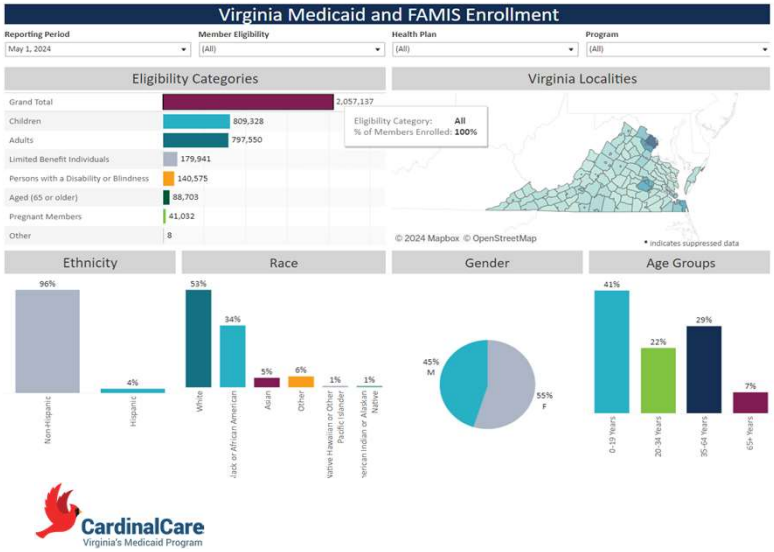
Resources: Medicaid/FAMIS Enrollment Dashboard



- Updated twice/month
- Historical enrollment totals are shown for each month
- Part of DMAS's efforts to provide transparency in our data for stakeholder engagement
- Storyboard #1 provides an overview of enrollment and demographic data
- Additional storyboards display monthly enrolment data by Eligibility Category, Health Plan and Region
- Medicaid/FAMIS Enrollment Dashboard

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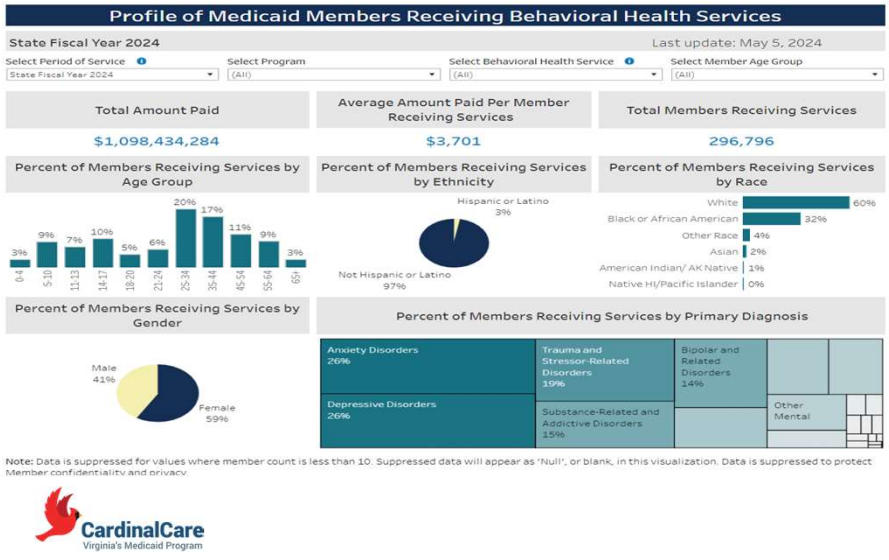
Resources: Behavioral Health Service Utilization and Expenditures Dashboard



- Published June 2022
- Part of DMAS' efforts to provide transparency in our data for stakeholder engagement
- This dashboard allows for high-level examination and asking deeper questions about access to care and our behavioral health system
- Storyboard #1 gives an overview of BH services received, member demographics and costs.
- Behavioral Health Service Utilization and Expenditures

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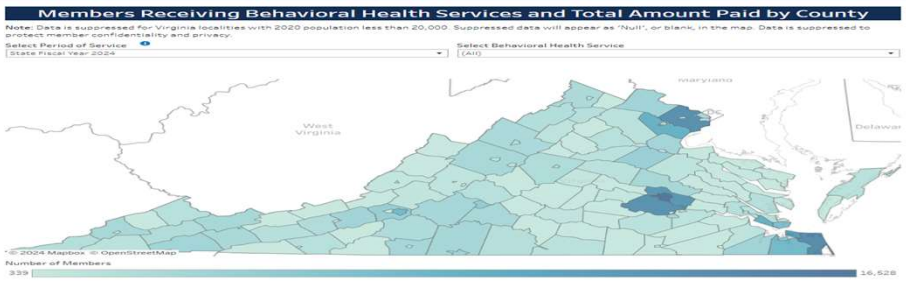
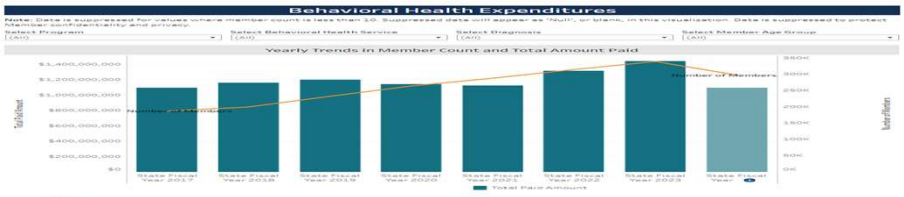
Resources: Behavioral Health Service Utilization and Expenditures Dashboard





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- Storyboard #2 shows the number of members using BH services and the total cost of BH claims in each county. The map can be filtered by State Fiscal Year and BH service.
- Storyboard #3 shows the annual cost of BH claims by State Fiscal Year and a count of unique members using BH services. The bar chart can be filtered by Program, BH Service, Diagnosis, and Age Group

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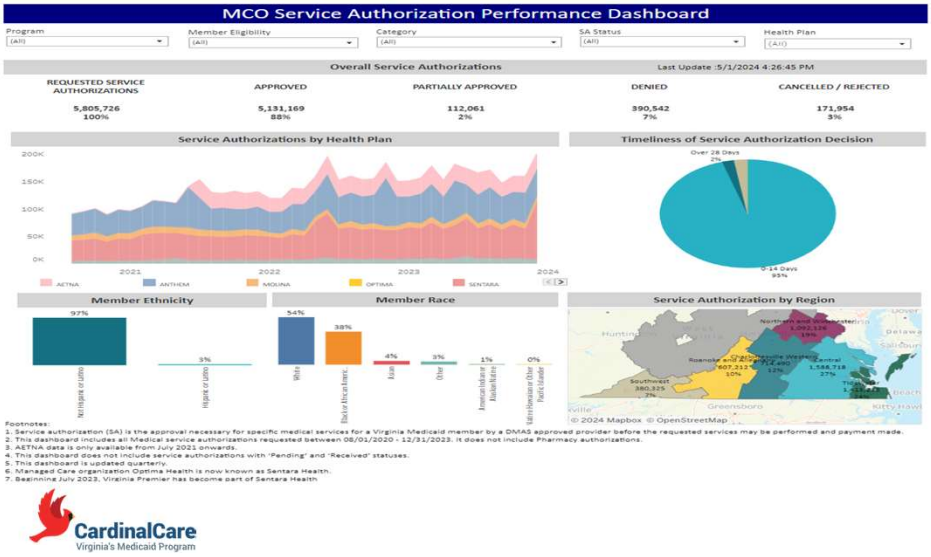
Resources: MCO Service Authorization Performance Dashboard



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- Updated quarterly
- Displays medical service authorizations submitted by MCOs
- Created as a result of Legal Aid Justice Center agreement for more transparent data collection practices around service authorization data from MCOs
- Aetna data is only available from July 2021 and forward
- MCO Service Authorization Performance Dashboard

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Resources: Digital Communications

DMAS website
www.dmas.virginia.gov

CoverVA website
www.coverva.org

CubreVirginia website
www.cubrevirginia.org

Email
Dmas.info@dmas.virginia.gov

CoverVA Facebook
https://www.facebook.com/coverva/

YouTube
https://www.youtube.com/channel/UCbE_bPvIPQTJfCS2MfCmVHA

Cardinal Care App/Apple
https://apps.apple.com/us/app/virginia-cardinal-care/id1444177386

Cardinal Care App/Android
https://play.google.com/store/apps/details?id=com.maximus.enrollment.vamedallion&pcampaignid=web_share

Twitter
https://twitter.com/VaMedicaidDir

Email/text campaigns
Sign up at www.coverva.org

AvePoint Citizen Portal
https://www.ask.vamedicaid.dmas.virginia.gov/ask-va-medicaid#/

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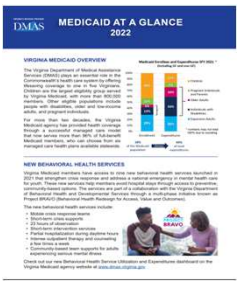
Resources: Publications



2022 Medicaid At A Glance
Medicaid at a Glance | DMAS - Department of Medical Assistance Services (virginia.gov)

FY 21-22 Biennial Report
Board of Medical Assistance Services FY19/20 Biennial Report (virginia.gov)

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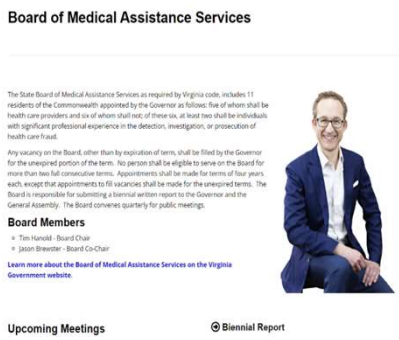
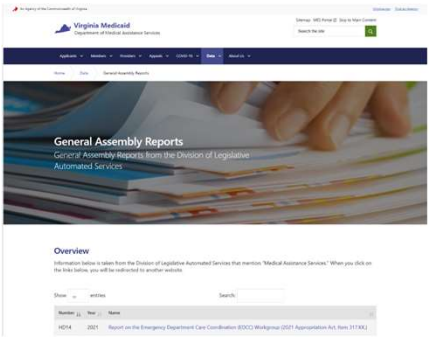
Resources



Board Meeting Materials

Board of Medical Assistance Services (BMAS) (virginia.gov)



Studies and Reports

General Assembly Reports (virginia.gov)

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