VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS) ANNUAL ORGANIZATIONAL REPORT FOR FYE 2023

VIRGINIA'S MEDICAID PROGRAM
DMAS

DMAS Annual Organizational Report FYE 2023

August 15, 2023

Report Mandate:

Item 308 (DMAS) Administrative and Support Services.2022 Appropriation Act.

C. 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.

Summary

The following annual report provides a detailed account of the agency's organization and operations through fiscal year-end 2023.

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 2023 and a chart with workforce data demonstrating filled positions and separations.

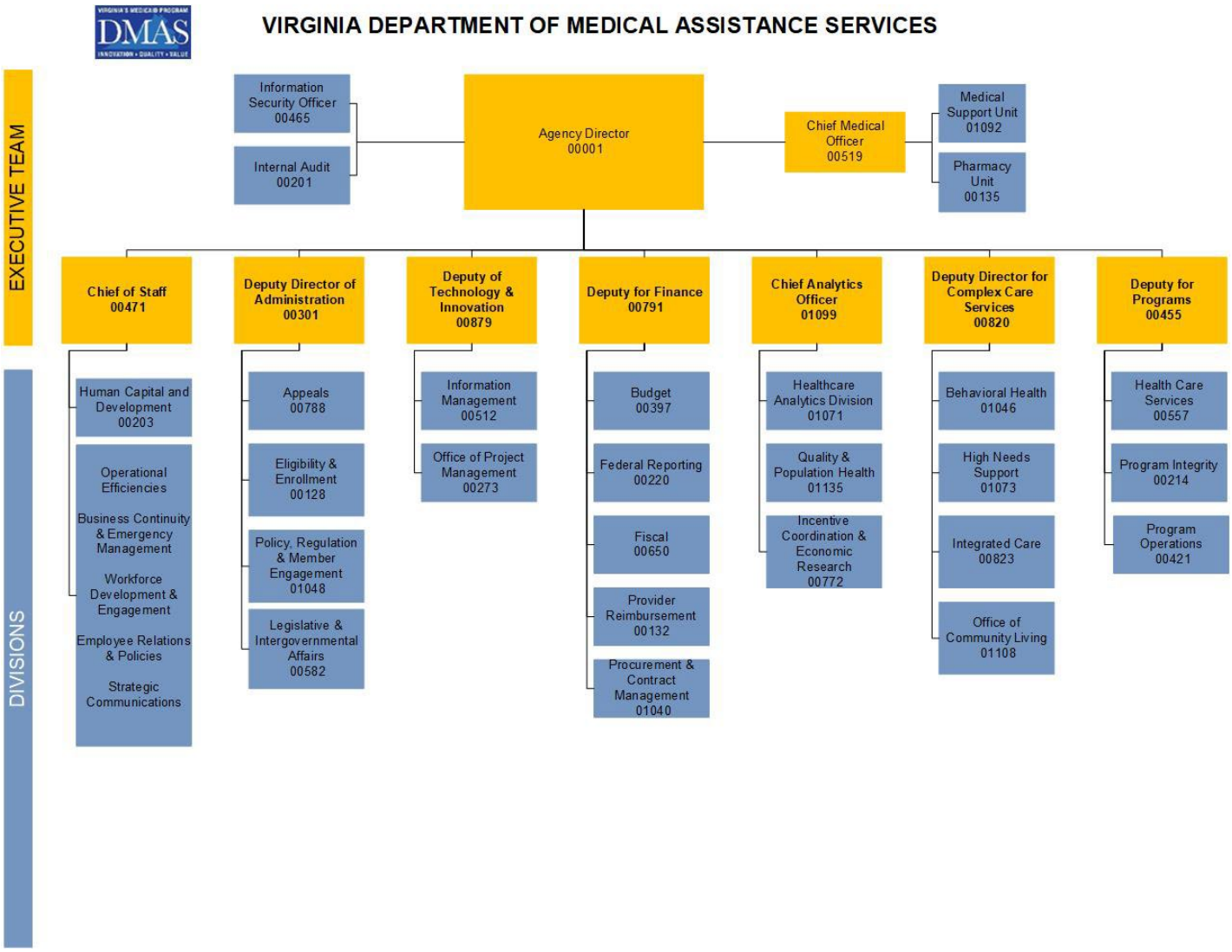
The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 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 women, 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 newly eligible, 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.

DMAS Overall Agency Organizational Chart



Appeals Division

The Appeals Division reports to the Deputy of Administration. 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.

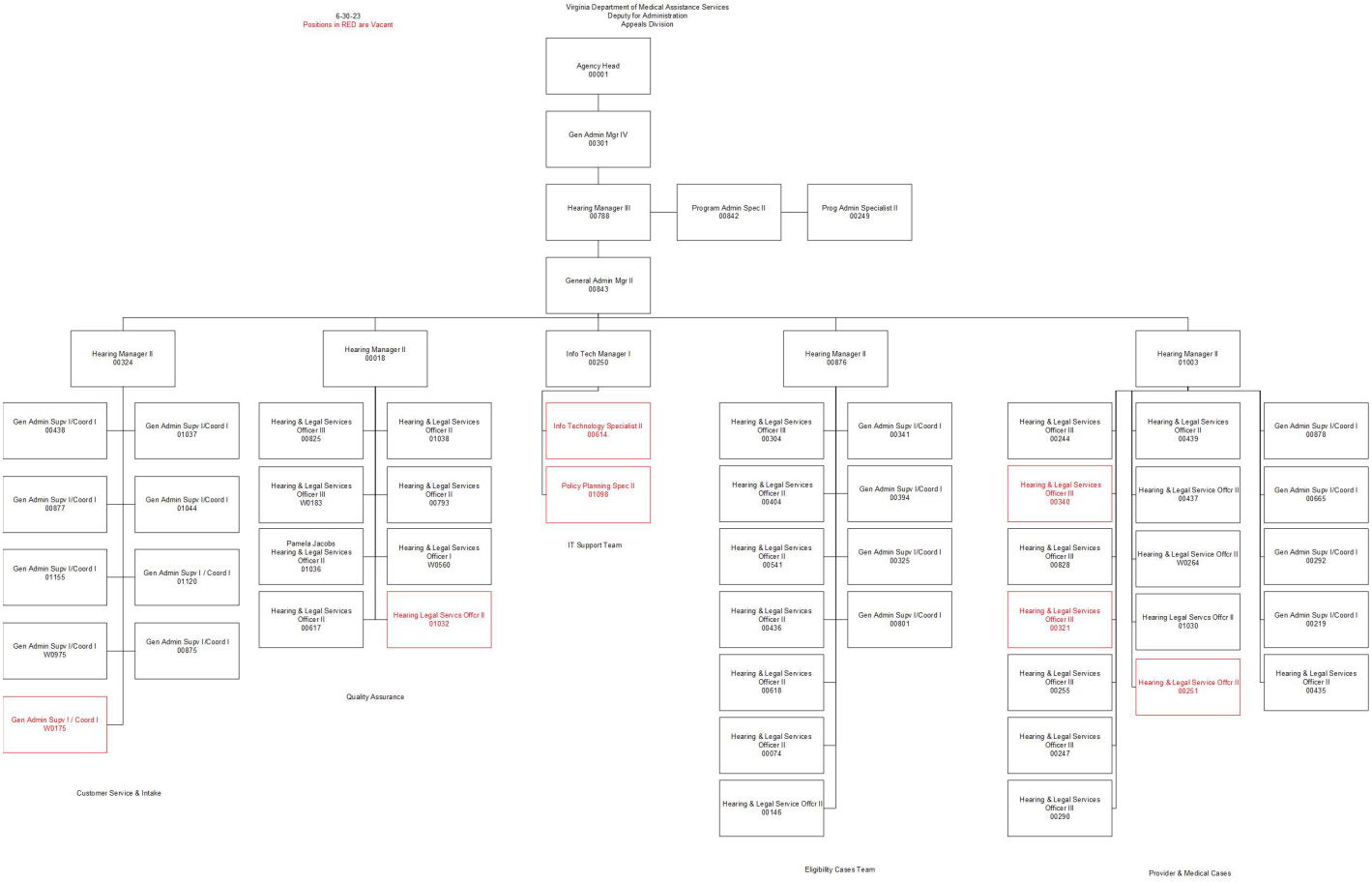
Client Appeals

Client appeals involve eligibility for Medicaid or 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.


6-30-23
Positions in RED are Vacant
Virginia Department of Medical Assistance Services
Deputy for Administration
Appeals Division
Agency Head
00001
Gen Admin Mgr IV
00301
Hearing Manager III
00788
Program Admin Spec II
00842
Prog Admin Specialist II
00249
General Admin Mgr II
00843
Hearing Manager II
00324
Gen Admin Supv I/Coord I
00438
Gen Admin Supv I/Coord I
01037
Gen Admin Supv I/Coord I
00877
Gen Admin Supv I/Coord I
01044
Gen Admin Supv I/Coord I
01155
Gen Admin Supv I / Coord I
01120
Gen Admin Supv I/Coord I
W0975
Gen Admin Supv I/Coord I
00875
Gen Admin Supv I / Coord I
W0175
Customer Service & Intake
Hearing Manager II
00018
Hearing & Legal Services Officer III
00825
Hearing & Legal Services Officer II
01038
Hearing & Legal Services Officer III
W0183
Hearing & Legal Services Officer II
00793
Pamela Jacobs
Hearing & Legal Services Officer II
01036
Hearing & Legal Services Officer I
W0560
Hearing & Legal Services Officer II
00617
Hearing Legal Servcs Offcr II
01032
Quality Assurance
Info Tech Manager I
00250
Info Technology Specialist II
00614
Policy Planning Spec II
01098
IT Support Team
Hearing Manager II
00876
Hearing & Legal Services Officer III
00304
Gen Admin Supv I/Coord I
00341
Hearing & Legal Services Officer II
00404
Gen Admin Supv I/Coord I
00394
Hearing & Legal Services Officer II
00541
Gen Admin Supv I/Coord I
00325
Hearing & Legal Services Officer II
00436
Gen Admin Supv I/Coord I
00801
Hearing & Legal Services Officer II
00618
Hearing & Legal Services Officer II
00074
Hearing & Legal Service Offcr II
00146
Eligibility Cases Team
Hearing Manager II
01003
Hearing & Legal Services Officer III
00244
Hearing & Legal Services Officer II
00439
Gen Admin Supv I/Coord I
00878
Hearing & Legal Services Officer III
00340
Hearing & Legal Service Offcr II
00437
Gen Admin Supv I/Coord I
00665
Hearing & Legal Services Officer III
00828
Hearing & Legal Service Offcr II
W0264
Gen Admin Supv I/Coord I
00292
Hearing & Legal Services Officer III
00321
Hearing Legal Servcs Offcr II
01030
Gen Admin Supv I/Coord I
00219
Hearing & Legal Services Officer III
00255
Hearing & Legal Service Offcr II
00251
Hearing & Legal Services Officer II
00435
Hearing & Legal Services Officer III
00247
Hearing & Legal Services Officer III
00290
Provider & Medical Cases

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: Budget Operations – Administration; Budget Operations – Medical; and the Forecast and Cost Estimate unit.

Budget Operations - Administration

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

Budget Operations - Medical

The Budget Operations - Medical 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 General Assembly actions. In addition, the Budget Operations - Medical 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 and complying with federal regulations, as well as ensuring adequate funding is available. This unit also prepares quarterly reports to meet federal reporting requirements.

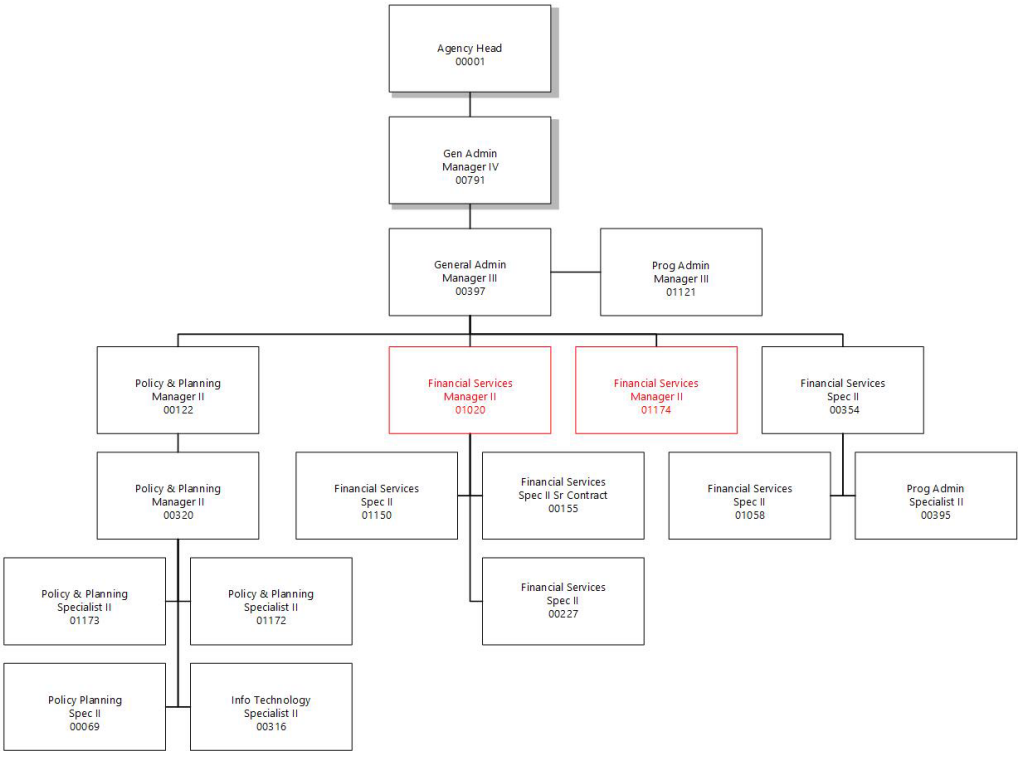
Forecast and Cost Estimate

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

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

REVISED AS OF 6/30/2023

Positions in RED are VACANT



Chief of Staff's Office

The Chief of Staff 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 our 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 Chief of Staff's (COS) Office drive workforce and operational efficiencies within the organization. COS Office business functions include: Workforce Development and Engagement, Employee Relations & Policies, Business Continuity and Efficiencies, Emergency & Facility Management, Agency Risk Management, Public Relations/Strategic Communications, and oversight of the Operational 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.

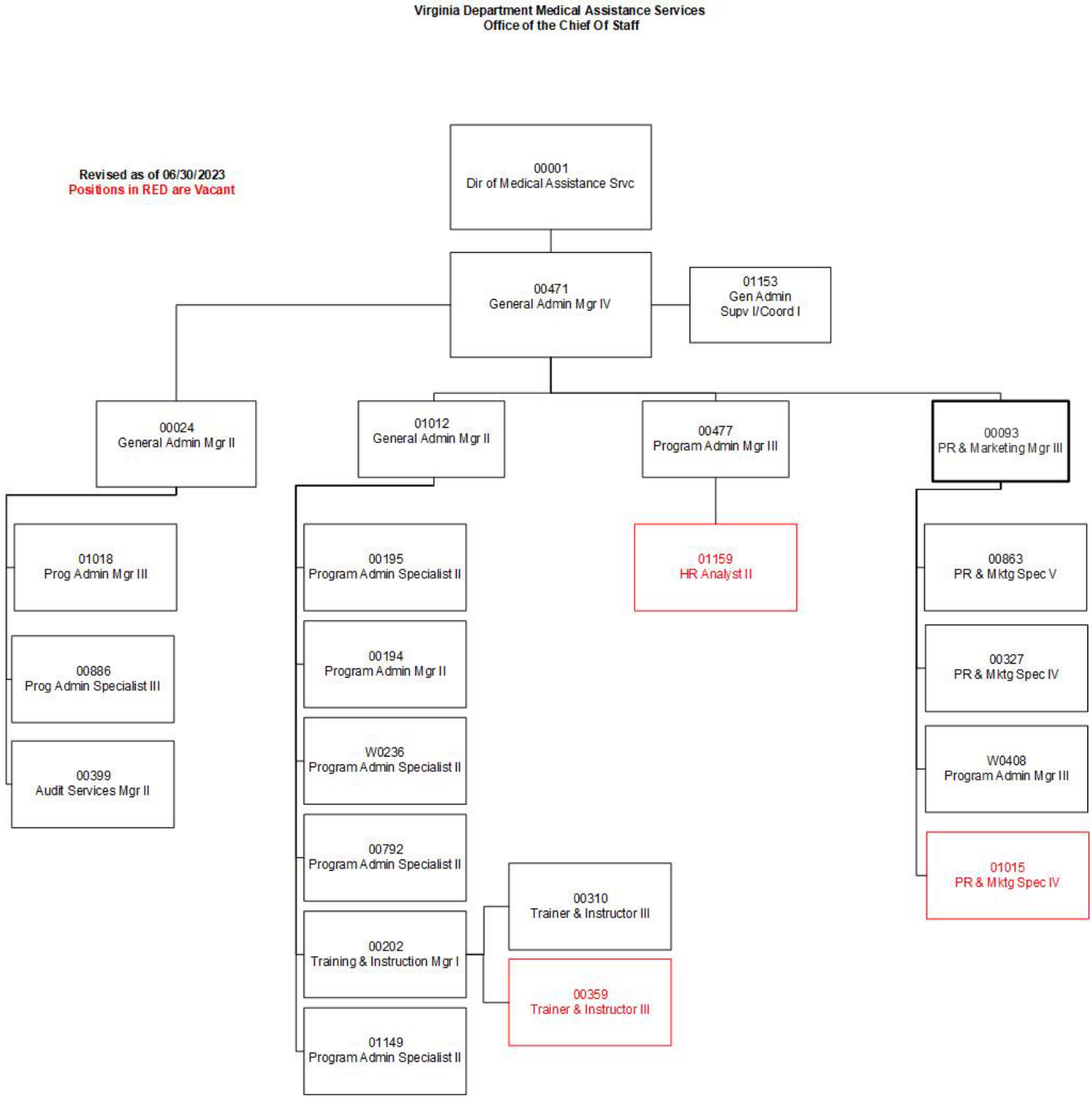
The COS has a direct focus on internal business functions, operations, and workforce. This function is different from that of the Chief Deputy, whose primary focus is on agency policy, external stakeholders and serving as a backup for the agency Director in external meetings.

The Office of the Chief of Staff oversees major operational and business processes and ensures coordination on strategic goals for the agency based on the priorities of agency executive leadership. This includes coordinating all executive leadership meetings and decision memos. The Chief of Staff's Office strengthens the DMAS workforce by ensuring a safe physical environment, promoting workforce development, and ensuring all workforce members have the opportunity to succeed and excel in their careers. The Chief of Staff enhances DMAS business functions through strategic planning, resource planning and business continuity planning. As the agency lead for strategic communications, this area provides communications on behalf of the Executive Leadership Team (ELT) on high-priority issues, handles media inquiries and events, supports digital accessibility, and manages the agency website and social media accounts. The Chief of Staff Office promotes "one Agency voice" with internal and external stakeholders, increasing 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:

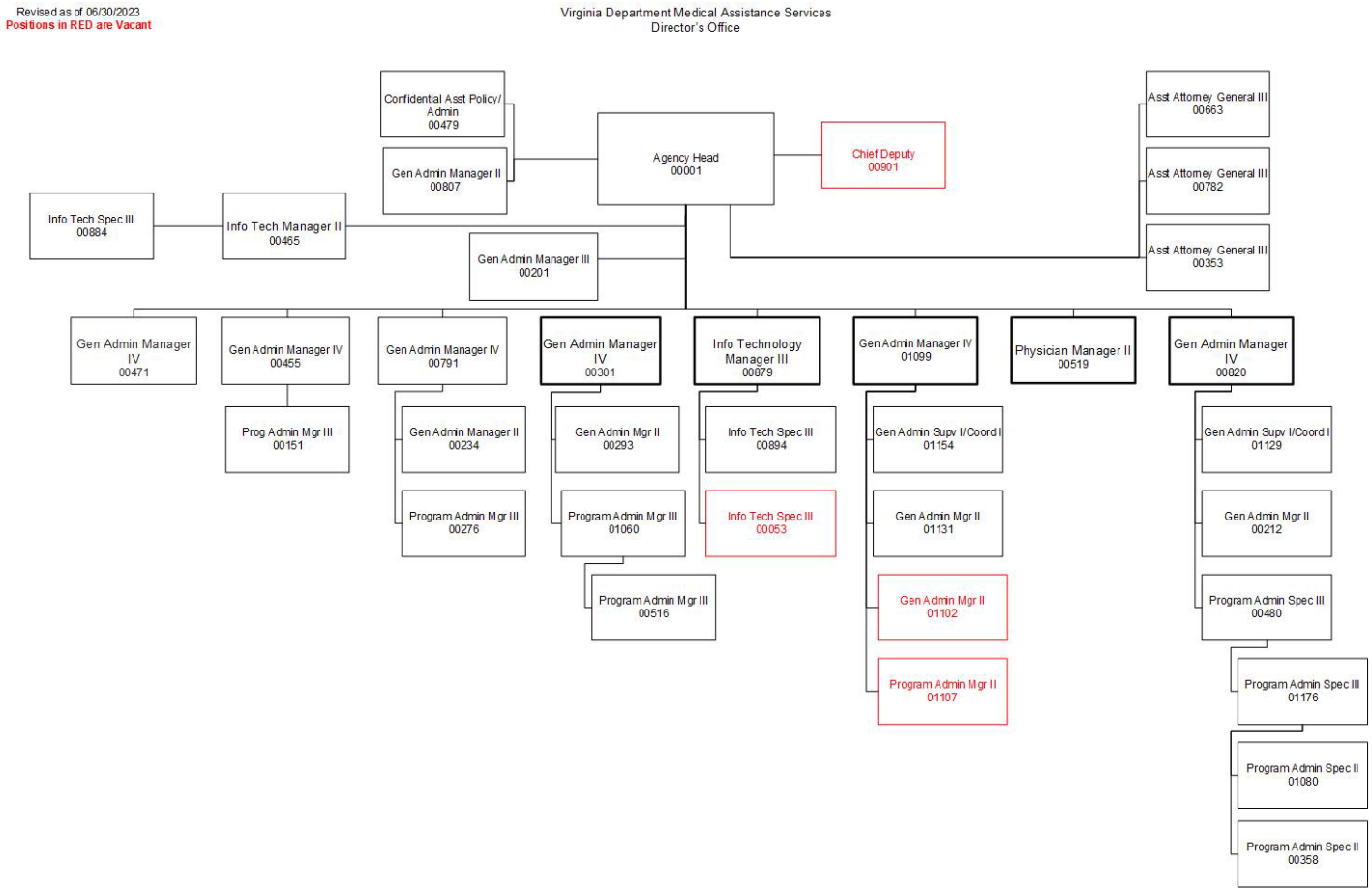
1. Enhance current business functions & efficient Agency Operations: Greater streamlined operations in order to improve the services being provided to our Medicaid Members and ensure Business Continuity for the Agency. In addition to ensuring the Agency has all of the resources needed in order to carry out daily functions and strategic initiatives.
2. Ensuring we identify, assess, analyze and control threats to the DMAS Agency via Risk Management: Greater focus on identifying and mitigating internal risks.
3. Ensuring effective communications 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 find information they need so they can make the best decisions about their health care coverage.

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



Director's Office

The Director's Office is comprised of executive leadership, executive assistants, senior advisors and their direct reports. The Chief of Staff is responsible for managing the operations and budget of the Director's Office.



Division of High Needs Supports

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 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:

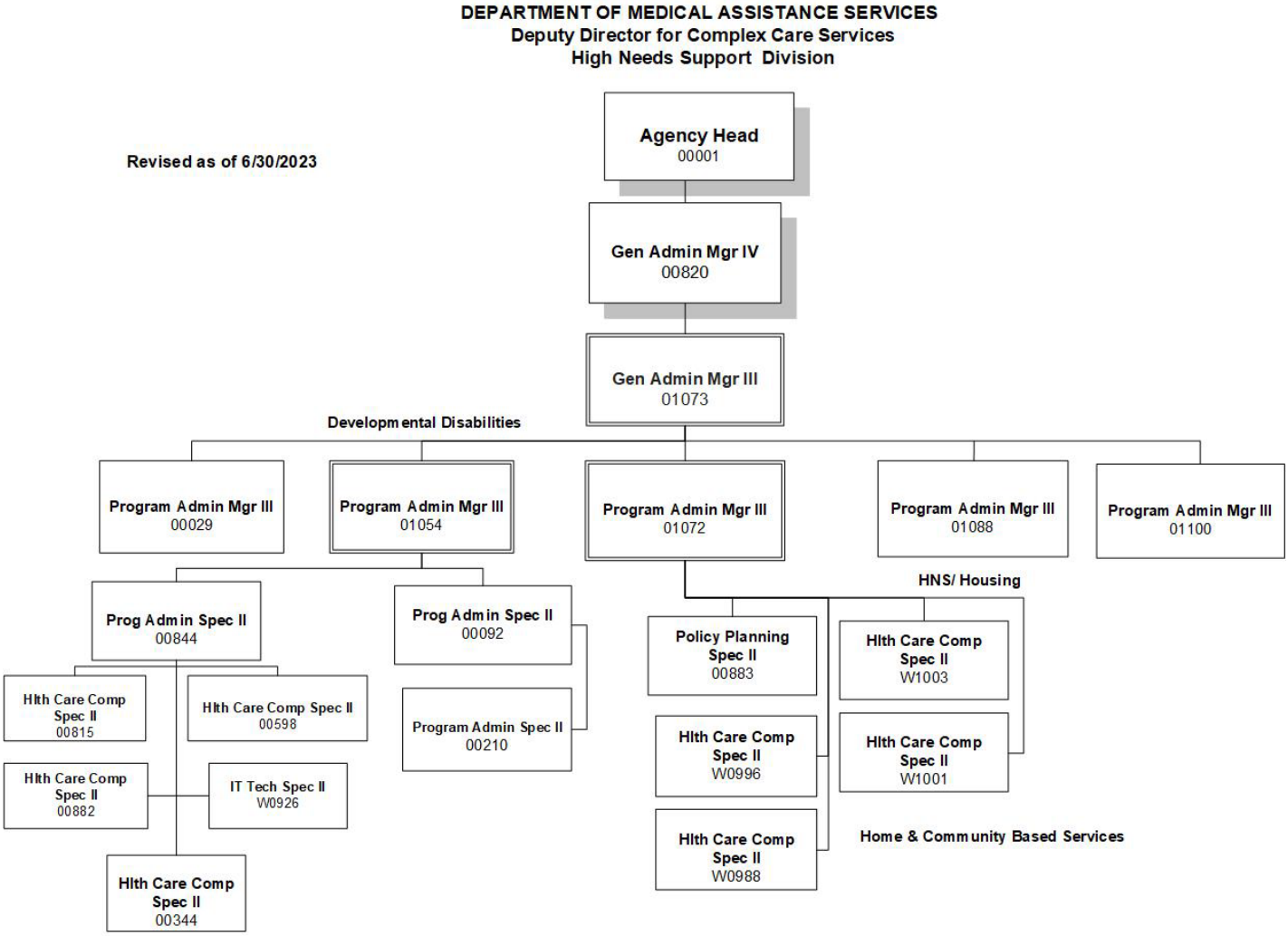
- Facilitates housing and employment supports for individuals experiencing mental illness or with other complex needs
- Develops, updates, and clarifies policies related to those efforts
- DMAS designee for Employment First state initiative
- DMAS designee for housing efforts to include state Interagency 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 to begin July 2023
- 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

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

- Ongoing participation in Status Conference with DOJ, OAG, and Judge Gibney
- Ongoing review and participation in Independent Reviewer studies
- Facilitate agency improvements in specified areas related to Settlement requirements
- Facilitate data exchange needed for the demonstration of compliance with the Settlement



Eligibility and Enrollment Division

The Division of Eligibility and Enrollment reports to the Deputy Director of Administration. It brings together all activities related to Medicaid/FAMIS Eligibility and Enrollment in a single division staffed with a coordinated, expert team. The division is comprised of six units, each with a distinct function: Eligibility Policy Unit, Newborn and Member Enrollment Unit, Cover Virginia, Reporting and Performance Management Unit, and Business Systems Unit.

Eligibility Policy Unit

The Eligibility Policy Unit is responsible for Medicaid/FAMIS eligibility policy development, revising and maintaining the Medicaid Eligibility Policy Manual, Medicaid and FAMIS Member Handbooks, and providing 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 also work with the DMAS Information Management (IM) Division and selected vendors on developing requirements and testing for the new Medicaid Enterprise System (MES).

Newborn and Member Enrollment Unit

The Newborn and Member Enrollment Unit is responsible for ensuring all newborns born to Medicaid and FAMIS MOMs members are enrolled in coverage accurately and timely. The unit accepts notifications from providers and health plans, adding the babies in Medicaid Management Information System (MMIS) at the newborn's date of birth and then notifying the local department of social services eligibility worker to add the newborn in the DSS Virginia Case Management System (VaCMS). 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) MMIS based on requests from local DSS agencies; patient pay corrections in MMIS based on requests from local agencies/providers; cancellation of coverage for deceased individuals based on reporting from the Virginia Department of Health (VDH); processing returned mail; research and correction of duplicate enrollments; researching and resolving monthly enrollment reports related to Social Security number discrepancies, open ended coverage for Medically Needy individuals, assisting with patient pay corrections, and other 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. The Cover Virginia central site includes Virginia's state-wide Medicaid call center, central

processing unit for Medicaid and FAMIS applications, a mailroom, and a quality assurance unit. Cover Virginia is responsible for the processing of applications, annual redeterminations, and maintenance of cases for individuals who are justice involved within the Cover Virginia Incarcerated Unit (CVIU). The CVIU handles this work through collaboration with the Department of Corrections, local and regional jails, and the Department of Juvenile Justice. This unit also is responsible re-entry case processing for these individuals to ensure individuals have access to care at release.

Reporting and Performance Management Unit

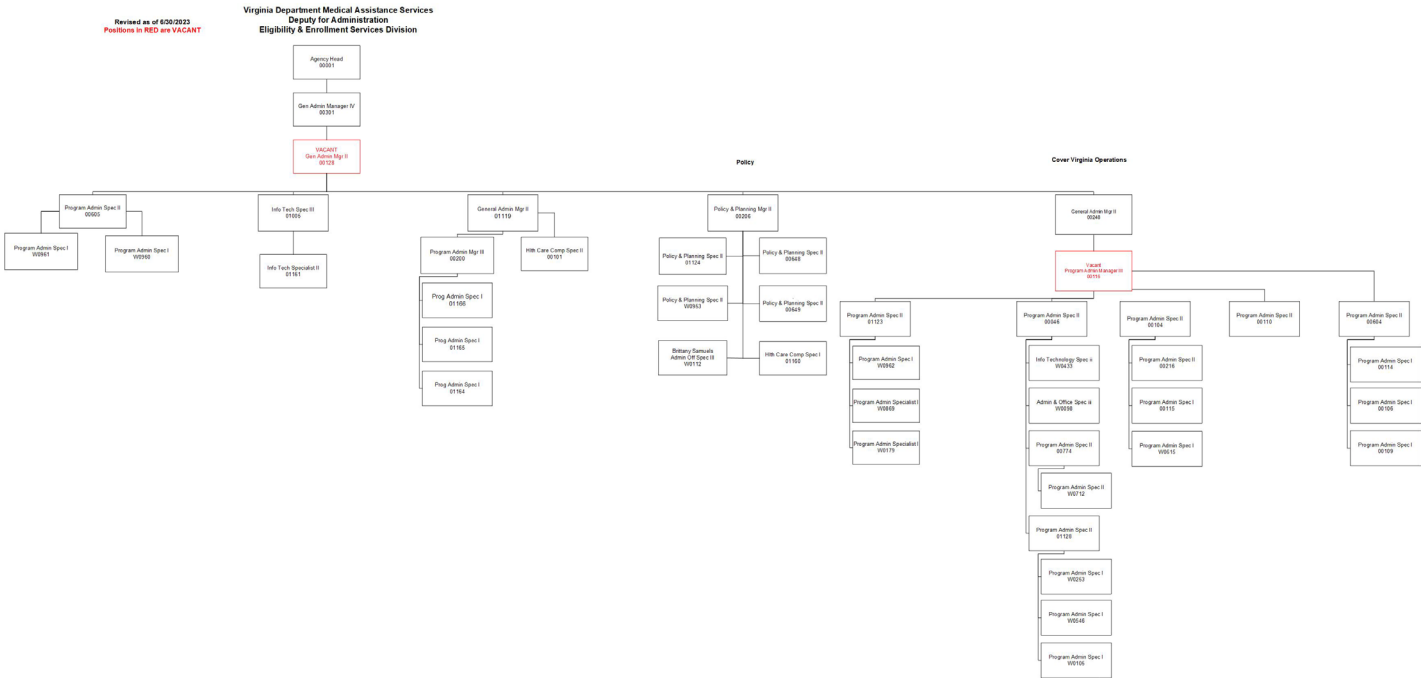
The Eligibility Reporting and Performance Management (RPM) Unit performs several functions critical to the operations of the Eligibility and Enrollment Services Divisions. This unit's functions include:

- 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
- American Rescue Plan Act (ARPA) Unwinding Eligibility- staff augmentation process to offer statewide assistance in the unwinding.

Additionally, the unit is responsible for the Eligibility Performance Management Program (EPMP) which was legislatively mandated for DMAS to work with VDSS and other stakeholders to develop 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, in ensuring that local departments of social services, as well as Cover Virginia are accurately and timely determining, enrolling, and re-determining eligibility for qualified individuals.

Business Systems Unit

The Business Systems Unit is responsible for developing and submitting Medicaid and FAMIS system change requests for the Virginia Case Management System (VaCMS). Staff participate in requirement and design sessions as well as perform testing to ensure that the changes implemented accurately reflect laws, regulations, and policy. This unit also works with DMAS Information Management (IM) staff to gauge the impact of VaCMS changes in the Medicaid Enterprise System (MES), and if there is an impact, works with IM staff to determine any needed changes in that system.


Revised as of 6/20/2023
Positions in RED are VACANT
Virginia Department Medical Assistance Services
Deputy for Administration
Eligibility & Enrollment Services Division
Agency Head
00001
Gen Admin Manager IV
00301
VACANT
Gen Admin Mgr II
00128
Program Admin Spec II
00603
Program Admin Spec I
W0961
Program Admin Spec I
W0960
Info Tech Spec III
01005
Info Tech Specialist II
01161
General Admin Mgr II
01119
Program Admin Mgr III
00200
Prog Admin Spec I
01166
Prog Admin Spec I
01165
Prog Admin Spec I
01164
Hlth Care Comp Spec II
00101
Policy
Policy & Planning Mgr II
00206
Policy & Planning Spec II
01124
Policy & Planning Spec II
W0963
Brittany Samuels
Admin Off Spec III
W0112
Policy & Planning Spec II
00648
Policy & Planning Spec II
00649
Hlth Care Comp Spec I
01160
Cover Virginia Operations
General Admin Mgr II
00248
Vacant
Program Admin Manager III
00155
Program Admin Spec II
01123
Program Admin Spec I
W0962
Program Admin Specialist I
W0849
Program Admin Specialist I
W0175
Program Admin Spec II
00344
Info Technology Spec II
W0435
Admin & Office Spec III
W0936
Program Admin Spec II
00774
Program Admin Spec II
W0712
Program Admin Spec II
01128
Program Admin Spec I
W0253
Program Admin Spec I
W0548
Program Admin Spec I
W0106
Program Admin Spec II
00164
Program Admin Spec II
00216
Program Admin Spec I
00115
Program Admin Spec I
W0515
Program Admin Spec II
00110
Program Admin Spec II
00464
Program Admin Spec I
00114
Program Admin Spec I
00105
Program Admin Spec I
00109

Federal Reporting Division

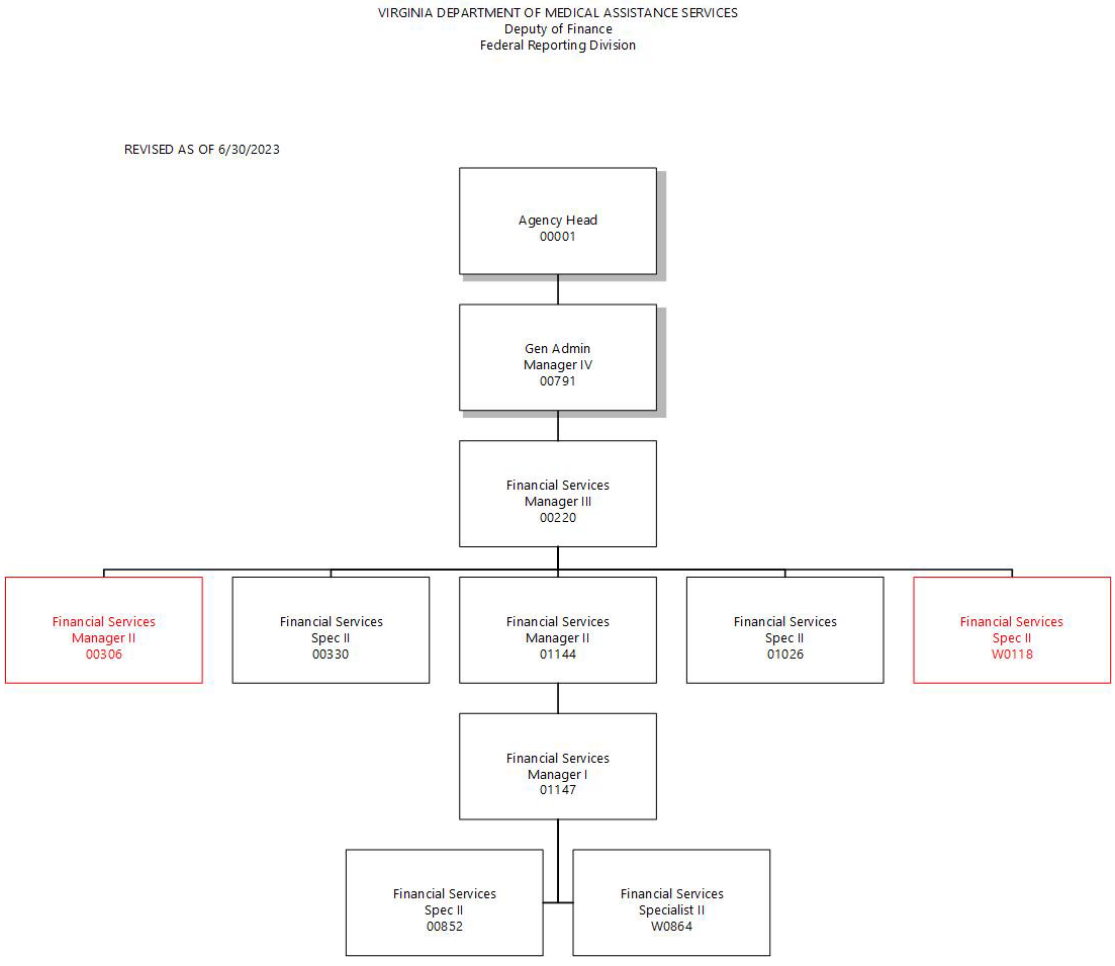
The Federal Reporting Division reports to the Deputy Director for Finance/Chief Financial Officer. The division consists of two units that manage and direct all aspects of the agency's financial reporting to the federal government. The division is responsible for the compilation and submission of the 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).



Fiscal Division

The Fiscal Division reports to the Deputy Director for Finance/Chief Financial Officer. The division consists of six units: Accounts Payable and Disbursements; Accounts Receivable; Cash Management; 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 to assist DMAS managers and staff in meeting their responsibilities for protecting the resources of the Commonwealth.

Accounts Payable and Disbursements

The Accounts Payable and Disbursements unit is responsible for processing agency payments, including 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 MMIS. The unit is also responsible for the review and certification of the agency's payroll.

Accounts Receivable

The Accounts Receivable Unit's objective is to properly manage accounts receivable to account, report, and collect funds due to the agency, ensuring proper internal control in accordance with federal (CFA §433.300) and state (CAPP §20505) regulations. The unit manages the agency's accounts receivable and debt recovery efforts (excluding TPL) in accordance with state and federal regulations.

Cash Management

The Cash Management Unit manages agency recording and reporting of general cash receipts, including requested and volunteer refunds (miscellaneous and TPL health insurance provider); the 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 MMIS remittance checks and electronic funds transfer 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.

General Ledger and State Reporting

This unit reconciles all accounts in the Cardinal Accounting System to the agency's Oracle Accounting System monthly 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 prepares and submits year-end financial schedules and other requested data to DOA for preparation of the Comprehensive Annual Financial Report.

Grants Management

On a quarterly basis, the Grants Management unit prepares, certifies and submits the Federal Financial Report (FFR or SF-425), which includes all quarterly federal cash receipts, as well as the cumulative federal cash disbursements (by grant award sub-account), to the Department of Payment Management (DPM) through the DPM -Payment Management System. As part of the annual statewide interest liability calculation, the unit prepares, coordinates, and submits Cash Management Improvement Act reporting requirements to DOA specifically for Medicaid and Children's Health Insurance Program (CHIP) federal grant awards. The unit completes and submits federal schedules to 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.

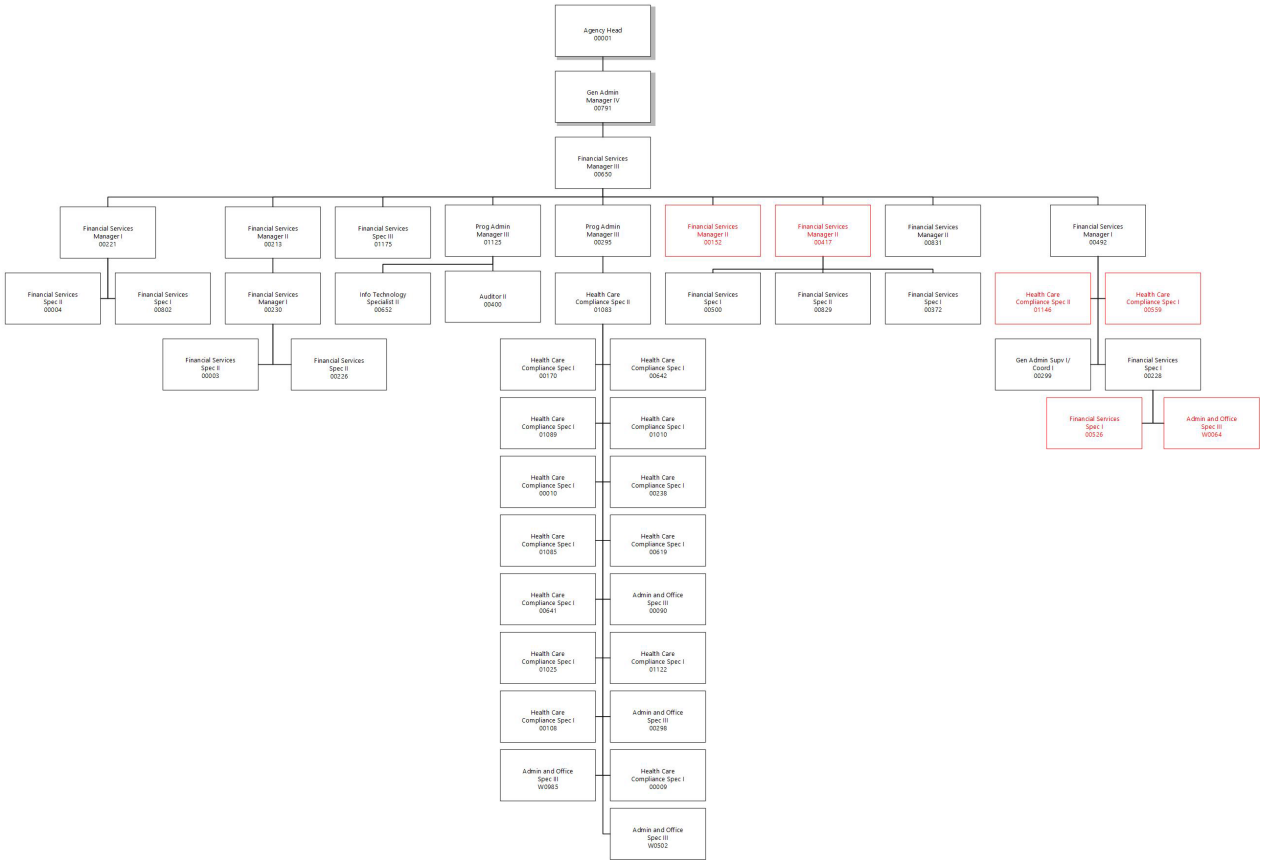
Third Party Liability (TPL)

Medicaid is the payer of last resort. The TPL unit works in partnership with the outside vendor Health Management Services (HMS), which 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. In addition, the unit performs daily and monthly accounts receivable reconciliations between TPLRS and the Oracle financial system for recovery cases established by the TPL unit.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Finance
Fiscal Division

REVISED AS OF 6/30/2023

Positions in RED are VACANT



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 currently called Medallion 4.0 that covers more than 1.6 million children, pregnant members, childless adults, and Medicaid expansion adults through six managed care health plans. Medallion 4.0 is an integrated delivery system that provides acute, complex, behavioral health and other services to the Medicaid /FAMIS population. In addition, HCS is the 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, including foster care services and specialized children's services and programs, 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:

HCS is responsible for the oversight of contracts with the six managed care organizations that deliver comprehensive health care to approximately 1.6 million Medicaid members. To support this work, the following HCS operational units provide support, management, and oversight: Systems and Reporting; Managed Care Administration; Compliance and Oversight; Policy and Contracting; and Member and Provider Solutions.

Member and Provider Solutions

Offers support and service to Medallion 4.0 members and Medallion 4.0 managed care 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 both the Medallion 4.0 and CCC Plus managed care programs.

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 Medallion 4.0 managed care contract requirements and reporting compliance standards. Oversees compliance enforcement, corrective action plan development and sanctions.

Contracting and Policy

Creates and manages the Medallion 4.0 contract in coordination with CCC plus 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 Medallion 4.0, dental, and maternal and child health programs. Creates and maintains the managed care technical manual requirements. Oversees encounter data management, new MMIS indicatives, and any special IM-focused projects.

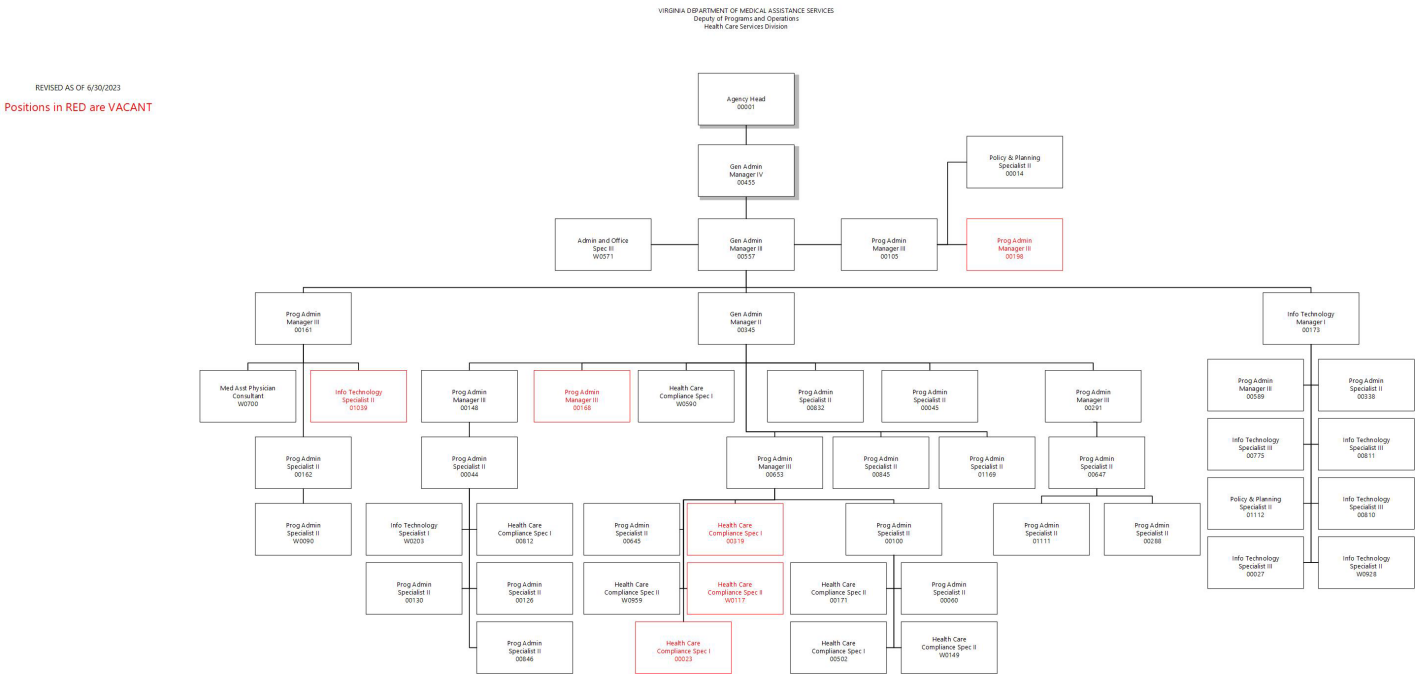
Specialized Program and Services Units

Dental

Manages the dental program's pediatric and adult dental services for Medicaid/FAMIS members. Oversees the dental 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.



Human Capital & Development Division

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

Human Capital and Development is dedicated to excellent, timely customer service in support of the agency's values and mission. The HCD team comprises trusted HR professionals available to provide guidance and assistance to staff on a myriad of HCD programs and policies. The HCD Division consists of three units: Compensation and Classification, Talent Acquisition, and Benefits and Transactions. The division director is responsible for the overall management of the HCD team operations, policy development, interpretation and guidance, and legal compliance.

Compensation and Classification Unit

The Compensation and Classification Unit is accountable for developing, managing, and operating the classification, compensation at DMAS to ensure 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 unit advises management team members of the proper procedures for position role changes, in-band salary adjustments and movement of staff within the agency. The unit ensures internal equity in compensation activities at DMAS while also enhancing the agency's external competitiveness in the market.

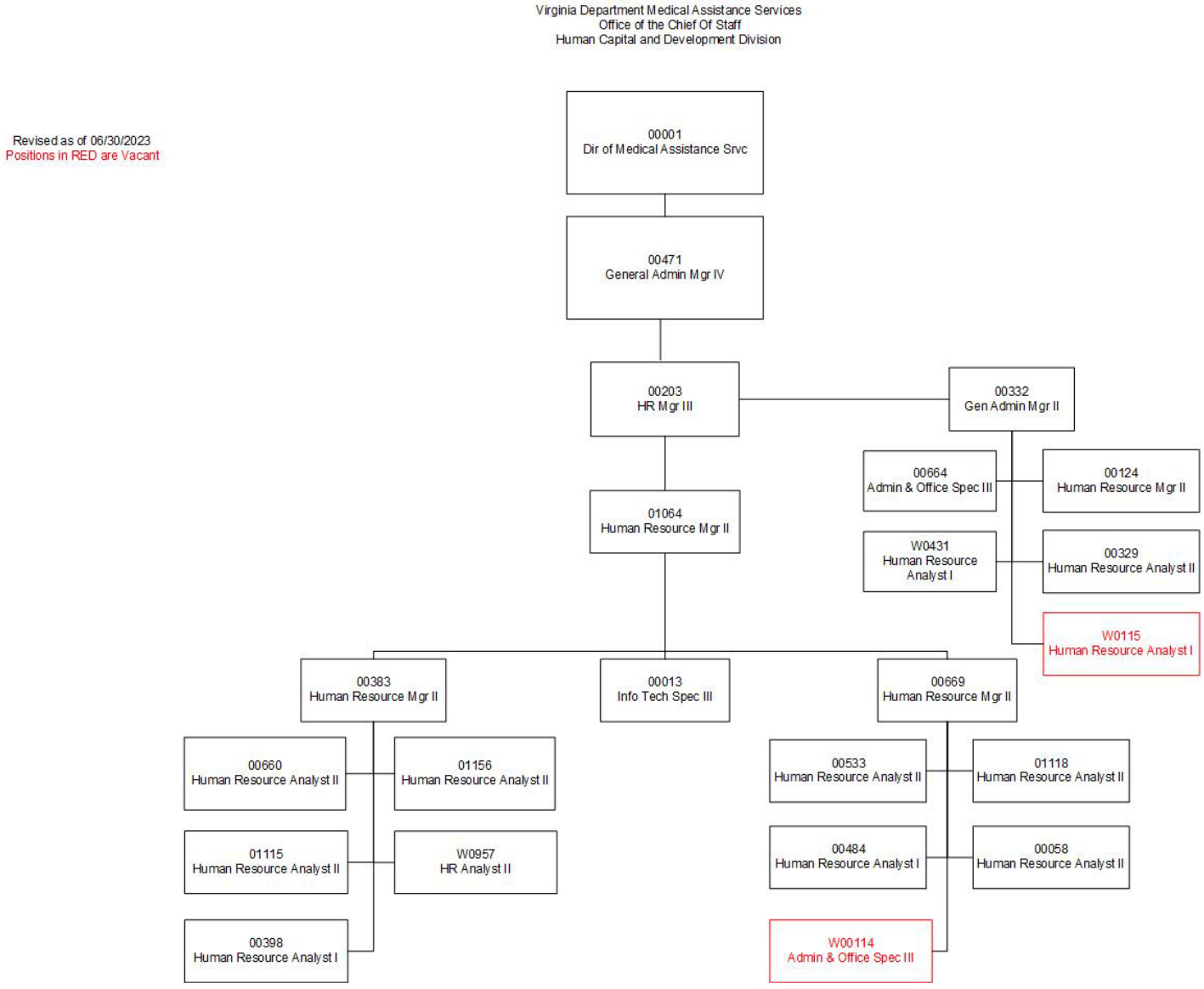
Talent Acquisition Unit

The Talent Acquisition (TA) Unit administers and directs all aspects of agency employment policies and practices. This function provides written (e.g., advertisements and postings) and verbal support to hiring managers regarding employment policies, practices, and procedures as well as providing tools to guide managers through recruitment and selection decisions. Employment support includes assisting applicants (internal and external), providing guidance to hiring managers, and finding alternate recruitment solutions. Talent Acquisition also handles administration of the state's Recruitment Management System (RMS) and tracking and updating applicant records.

Benefits and Transactions Unit

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 for all payroll processing for the agency. The Operations and Benefits Unit conducts New Employee Orientation and announces all staff changes. This unit is responsible for ensuring I-9 compliance for United States Citizenship and Immigration Services via the E-Verify system. Operations is also accountable for leave administration and tracking in the Time, Attendance and

Leave System, Workers Compensation, OSHA Reporting, Bureau of Labor Statistics reporting, Virginia Employment Commission (VEC) claims and hearings, managing employee recognition programs (e.g., state service awards) and all required personnel records retention ensuring compliance with Library of Virginia standards. The Physical Access Control Security (PACS) badge system is administered and controlled by HCD Operations. The Operations Unit updates and maintains the Personnel Management Information System (PMIS) with all personnel transactions and handles administration and reconciliations of the Virginia Retirement System for the agency.



Information Management Division & Project Management Office

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 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 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 who need it to assist 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, built and maintains the Encounter Processing and Care Management Systems and maintains a multitude of software components supporting the agency's day to day operations.

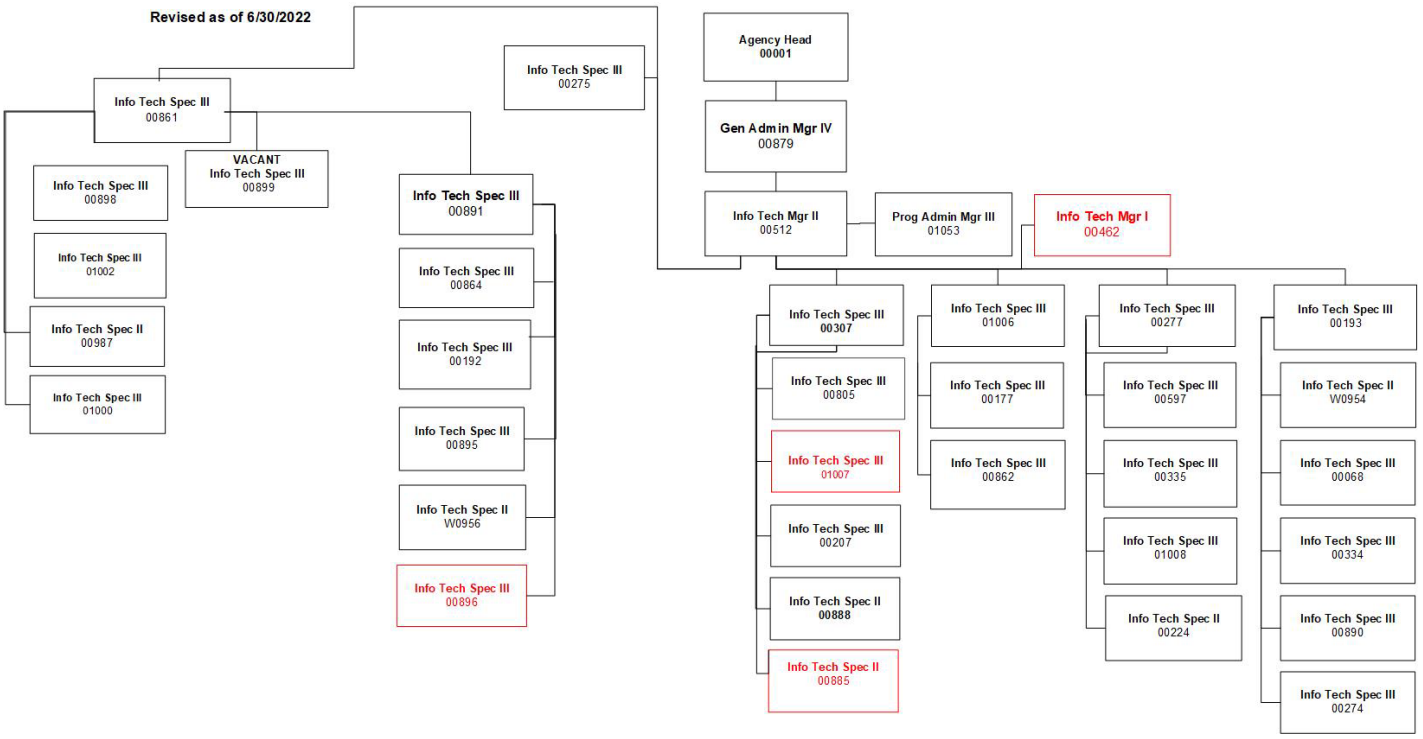
IT Support Team

The Information Technology Support team manages all agency used equipment including laptops, cell phones, iPads, 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. All connectivity to external entities and VITA coordination is also maintained by this team.

System Development Analyst Team and Electronic Data Interchange Team

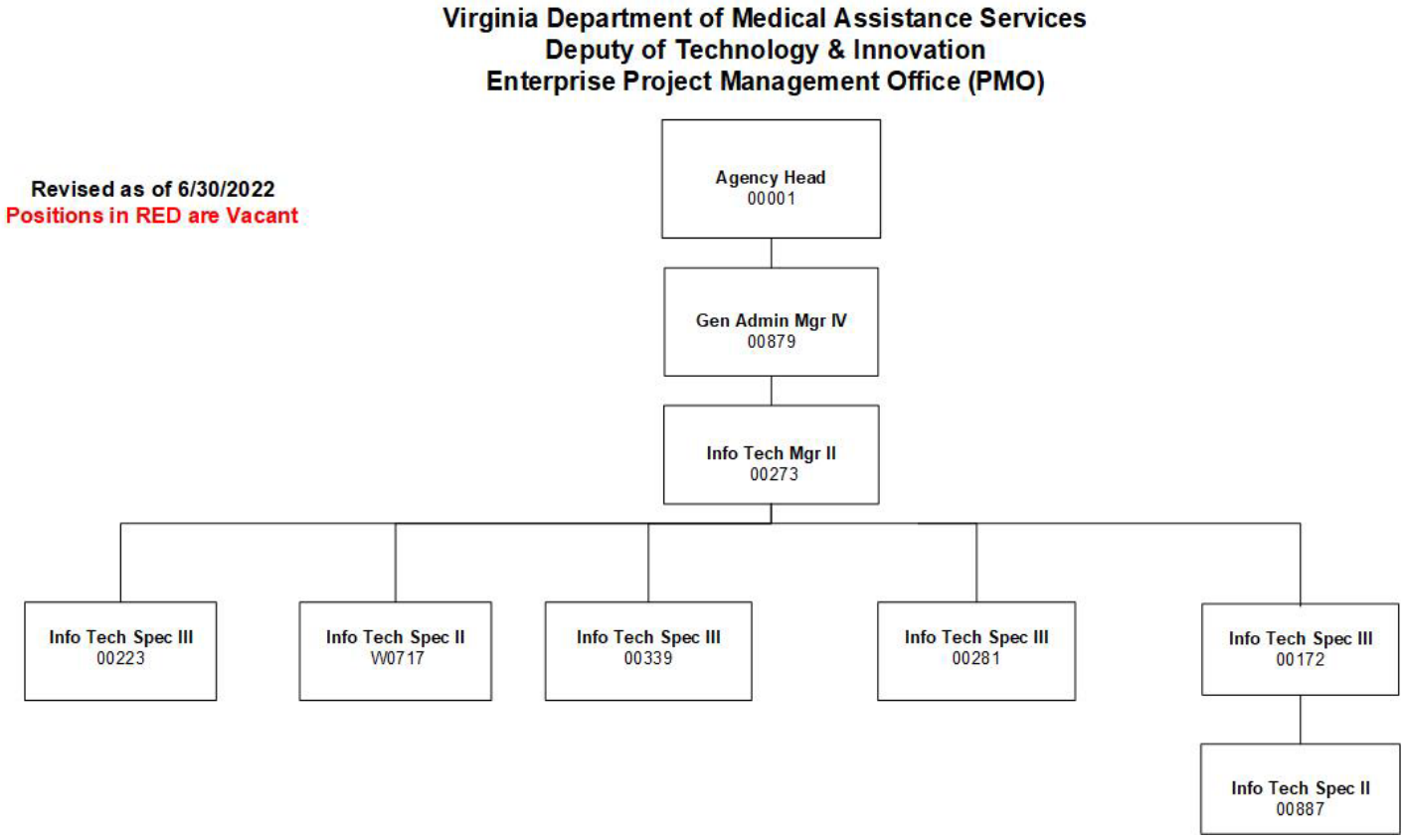
The System Development Analyst Team and Electronic Data Interchange (EDI) Team coordinate with subject matter experts throughout the agency, documenting and translating business requirements to technical specifications, assisting with immediate needs with file transfers, and finding solutions to issues 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 generally work to assist in making the transition from Business Vision to Technical Implementation seamless and efficient.

Virginia Department of Medical Assistance Services Deputy Director for Technology and Innovation Information Management Division



Project Management Office

The Project Management Office (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 Division

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 duals special needs plans (DSNP) for dual eligible members. The CCC Plus Program encompasses care coordination services to develop a person-centered plan of care that 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
- Regularly interact 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 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)

The division provides oversight, review, technical assistance, and training for existing PACE programs and works to expand new programs across the Commonwealth

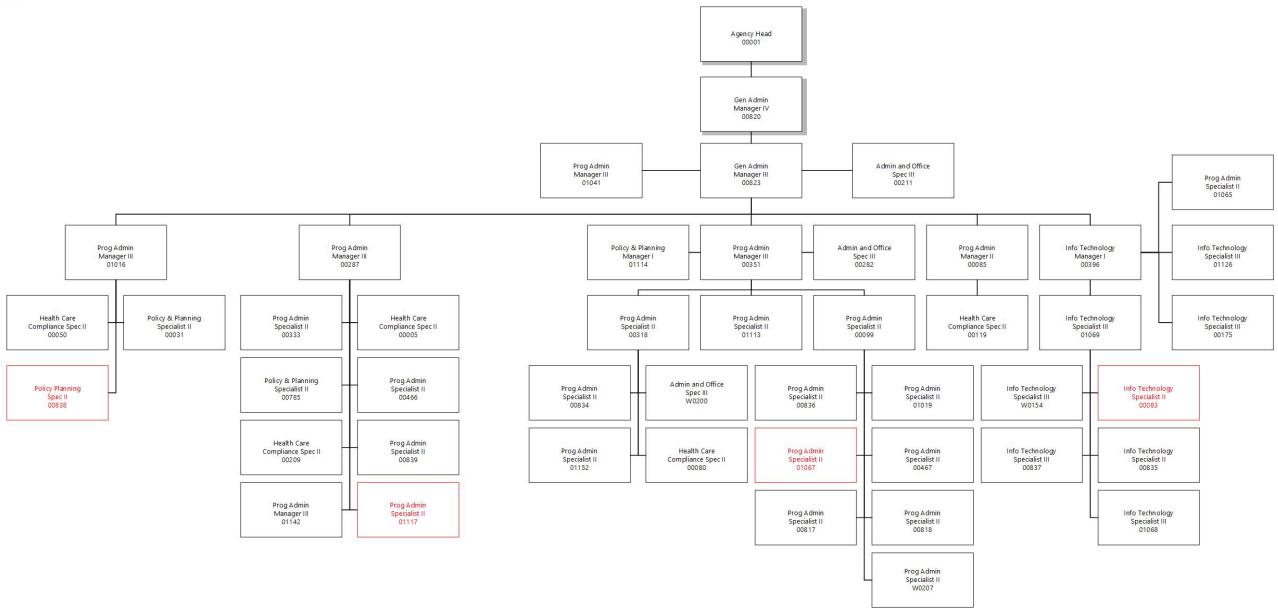
State Plan Services

The division is responsible for regulatory and policy development, revisions, and maintenance for nursing facility, durable medical equipment, hospice, home health and rehabilitation services. The division also provides written and verbal policy clarifications, legislative support, and internal and external policy training.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Complex Care Services
Integrated Care Division

REVISED AS OF 6/30/2023

Positions in RED are VACANT



Internal Audit Division

The purpose of the Internal Audit Division is to provide independent and objective assurance and consulting services that are designed to add value and improve operations. Internal Audit 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, Internal Audit recommends actions to improve efficiencies, cost savings, compliance, and/or controls over processes, programs, and systems. The Internal Audit Division reports directly to the Chief of Staff.

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

Internal Audits
Internal Audit conducts various types of audits (including financial, compliance, operational, fraud, program performance, and contractual) as appropriate on DMAS business processes and in accordance with its Audit Plan.

IT Security Audits
Internal Audit performs or coordinates third-party performance of IT Security Audits of DMAS systems to assess the effectiveness of system controls and measure compliance with the Commonwealth of Virginia Information Security Standard and other applicable federal and state regulations.

Audit Finding Resolution
Internal Audit tracks all internal and external DMAS audit findings and recommendations. They monitor the status of Corrective Action Plans (CAPSs) for unresolved findings and recommendations until there is a resolution, report 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
Internal Audit 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.

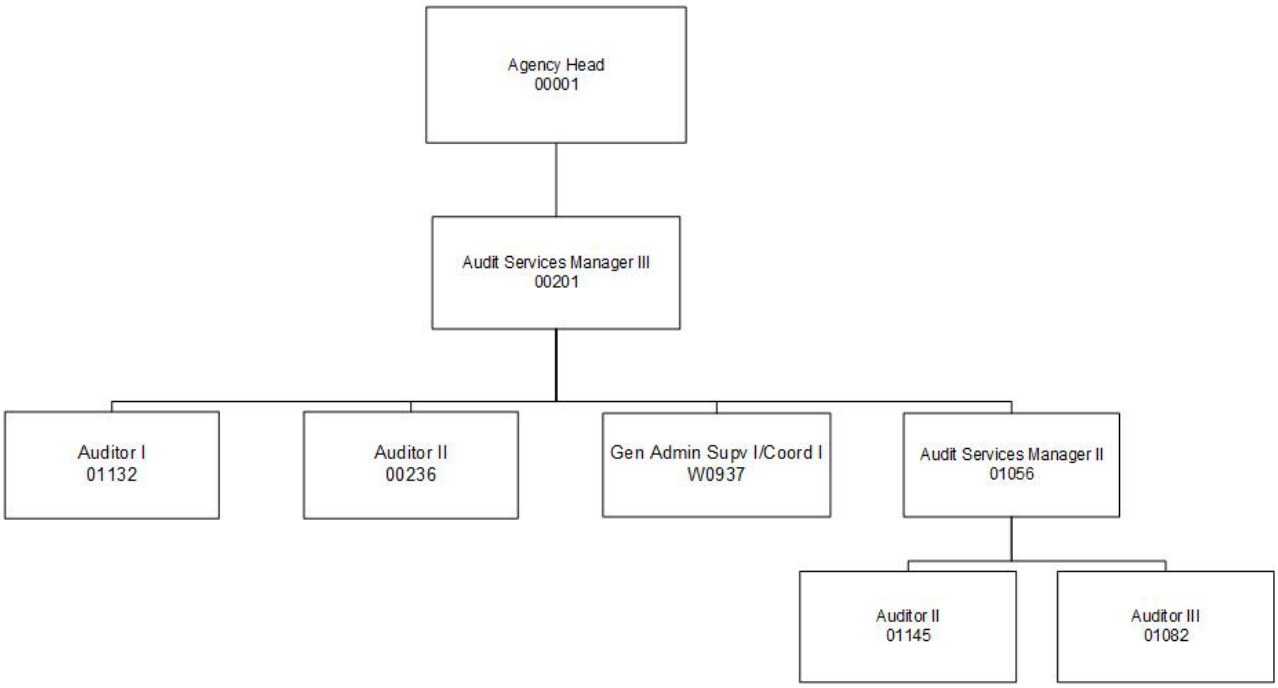
State Fraud, Waste, and Abuse Hotline
Internal Audit investigates cases referred from the State Fraud, Waste, and Abuse Hotline and issues a report to the Office of State Inspector General. If a case involves Medicaid Providers or members, the unit refers the case to the Program Integrity Division or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

Third-Party Service Provider Audit Assurance

Internal Audit 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. Internal Audit communicates the information security risks to DMAS Stakeholders and provides objective opinions on the adequacy of the providers' controls. Internal Audit also monitors the process of corrective action taken by third-party providers to address the security risks.

Revised as of 06/30/2023

Virginia Department Medical Assistance Services
Internal Audit

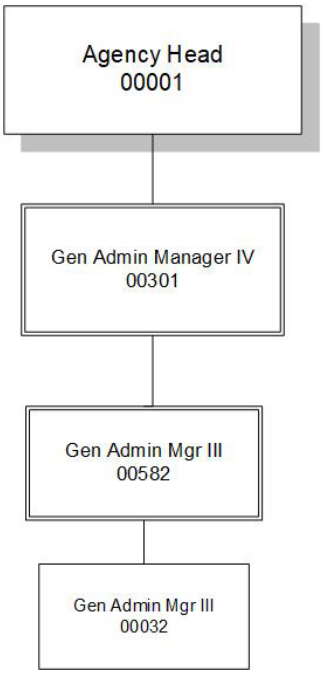


Legislative and Intergovernmental Affairs Division

The Legislative and Intergovernmental Affairs (LIA) Division reports to the Deputy for Administration. The LIA Division coordinates and tracks all legislation affecting DMAS; and tracks agency progress and responses in completing studies and reports originating from legislative direction. The LIA Division is also responsible for providing attorney review of Memorandum of Agreements (MOU's), data sharing agreements, contracts, settlements, and data privacy. The division also serves as the agency's Tribal Liaison.

Virginia Department of Medical Assistance Services
Constituent, Legislative and Intergovernmental Affairs Division

REVISED as of 6/30/2023
Positions in RED are VACANT



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 supports needs through effective programs and policies that ensure continued community integration for those who choose to receive services in their home and community.

The primary business functions of OCL are as follows:

Waiver Administration – Responsible for the development of 1915 (c) home and community-based waiver applications, renewals, and amendments. Completes required CMS reporting, including the annual cost-effectiveness and quality evidence reports. Serves as the primary contact for CMS related to the 1915 c waivers.

Commonwealth Coordinated Care Plus (CCC Plus) Waiver Serves as the subject matter experts for the CCC Plus waiver that serves over 40,000 members in the community instead of a nursing facility. Maintains waiver regulations, and provider manuals and provides technical assistance for providers and members. Monitors the provision of private duty nursing services for individuals that are not enrolled in managed care.

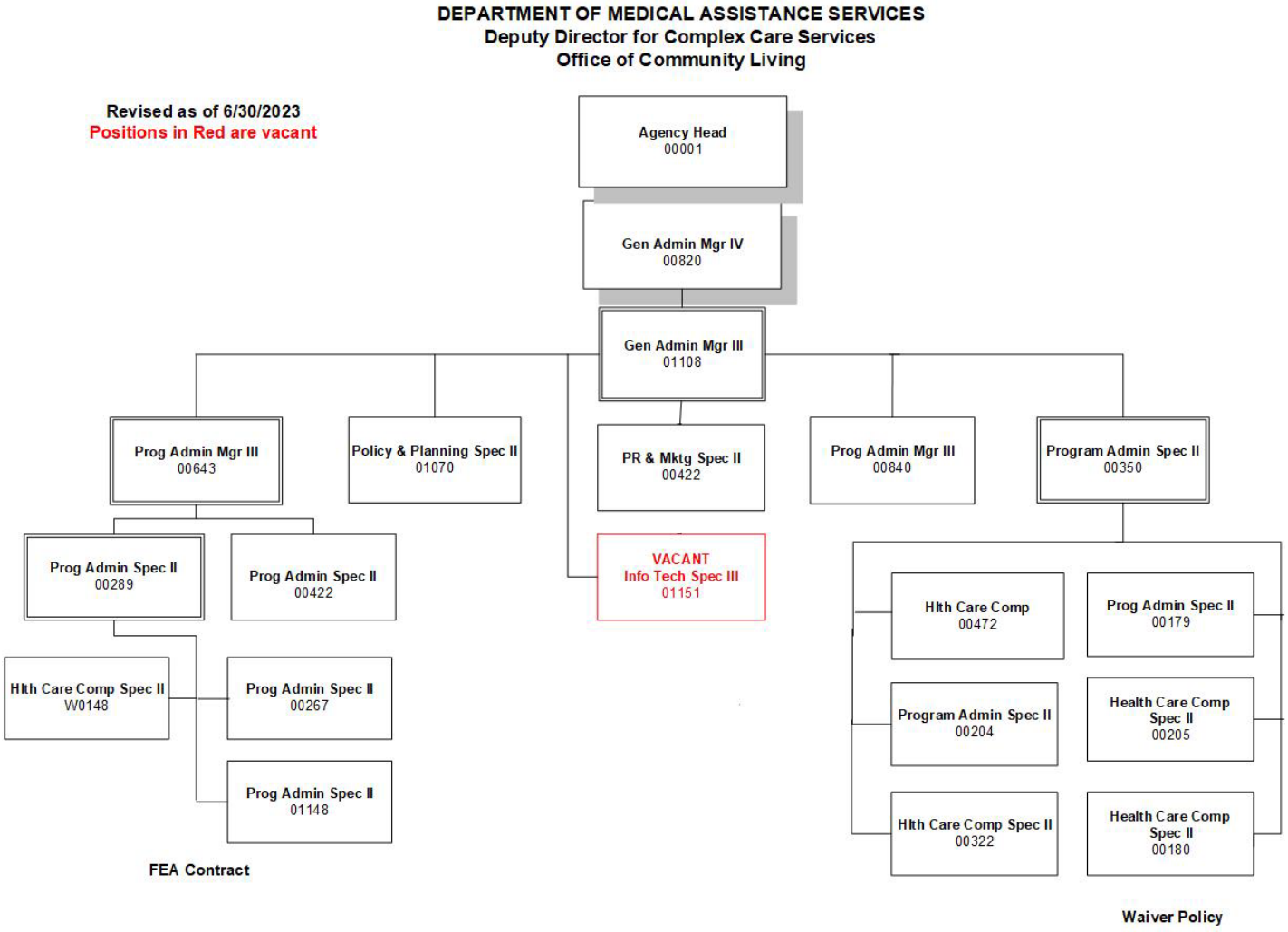
Screening for Long-Term Services and Supports

The division develops the regulatory standards, training, and oversight for the screening process that determines functional eligibility for Medicaid long-term services and supports, PACE programs, access to the Commonwealth Coordinated Care Plus (CCC Plus) program or nursing facility services. Responsibilities include a multi-year study to validate children's screening criteria and assess whether screening teams are making appropriate recommendations.

Quality Assurance- Provides oversight of the quality management review (QMR) process conducted by the managed care organizations. 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 including 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 has been taken.

Consumer Direction- Consumer direction empowers members/families to direct personal care, respite, and companion services by employing and managing their attendants. OCL develops and maintains policy and procedures while overseeing CD services. **Fiscal/Employer Agent**- OCL staff is responsible for monitoring the vendor that provides payroll services on behalf of employers using consumer-directed services. The F/EA is responsible for enrolling employers, verifying qualifications of attendants, and conducting payroll processes for attendants, including withholding appropriate

taxes and other withholdings. The F/EA 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 CPT/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 fee-for-service member services including, but not limited to out of state medical care, out of state outpatient (O/P) scans (MRI, CT, 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:

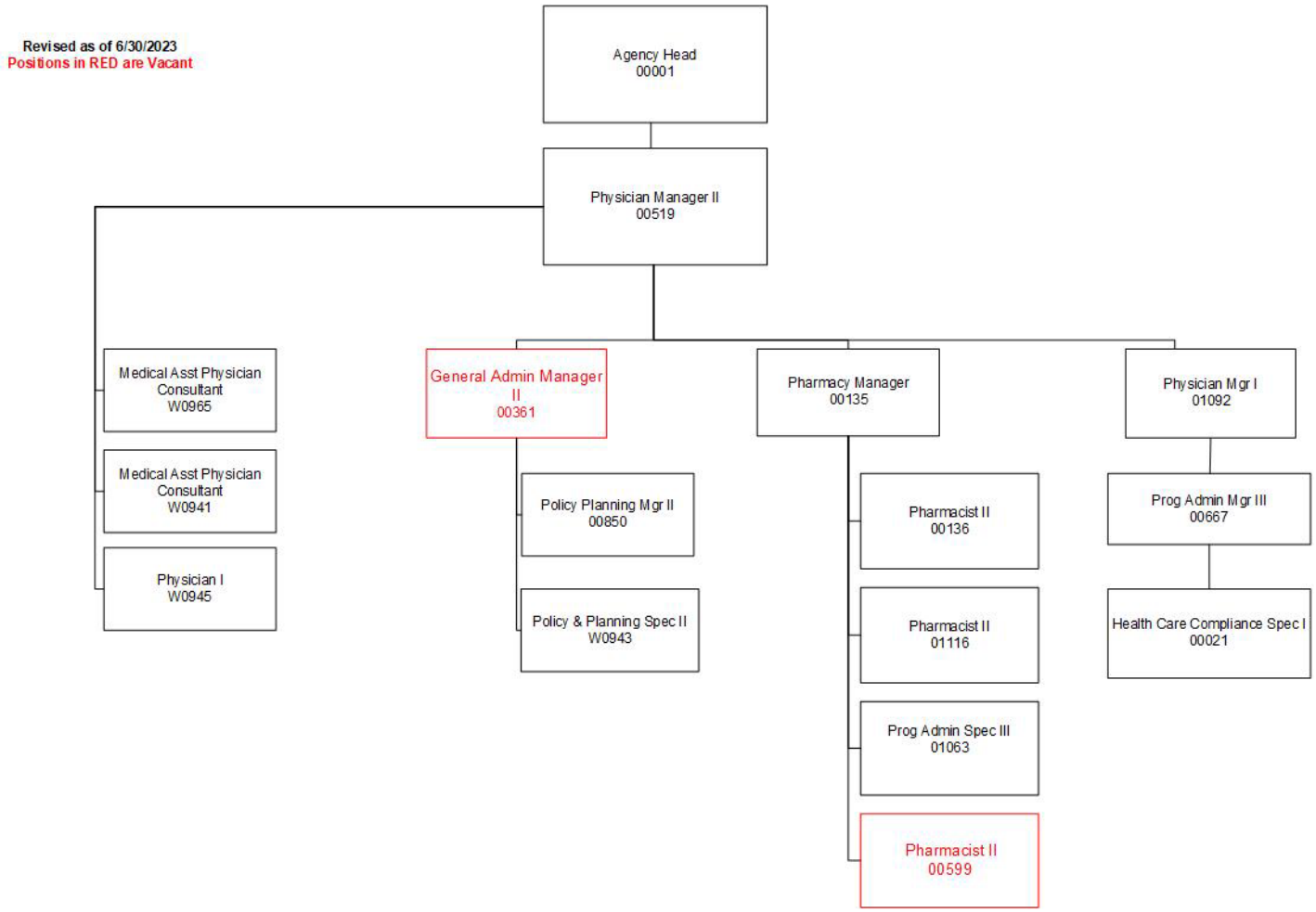
- Supporting the mission and goals of the Pharmacy and Therapeutics (P&T) Committee including the development and administration of the DMAS Preferred Drug List (PDL). The P&T Committee evaluates clinical evidence and cost in the context of population health to determine which drugs are the highest value to the Commonwealth and should be included on the DMAS Preferred Drug List 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' (MCO's) pharmacy programs. The DMAS Pharmacy Unit is responsible for aligning pharmacy policies including clinical guidelines, standards and controls across all Medicaid programs (i.e., FFS, Medallion 4.0 and CCC Plus), including: drafting contract language and technical manual requirements for pharmacy related services and drug coverage as needed, and monitoring 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.

Virginia Department of Medical Assistance Services
Office of Chief Medical Officer

Revised as of 6/30/2023
Positions in RED are Vacant



Healthcare Analytics Division

The Healthcare Analytics Division (HAD), formerly Office of Data Analytics ODA, reports to the Chief Analytics Officer as part of the Healthcare Analytics and Transformation team. Their mission is to empower data-driven decision-making. 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 Department 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

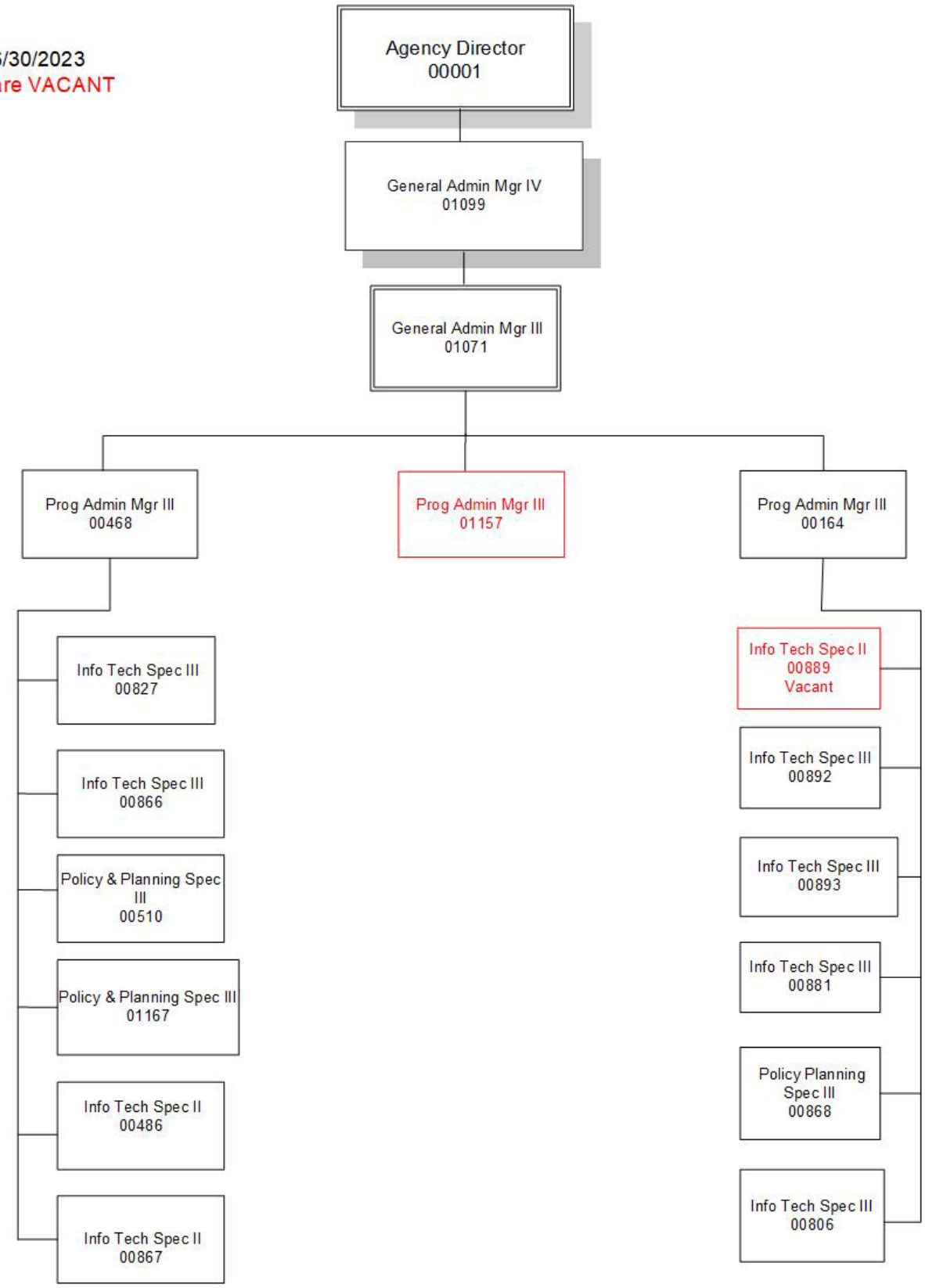
Creates the business intelligence necessary for understanding current views of agency operations such as Tableau dashboards. Provides critical historic analyses essential to understanding the impact of agency activities on our members, providers, and sister agencies. Focuses on why a phenomenon has occurred and what may happen next.

Enterprise Data Warehouse System

Includes a suite of technologies that provide data storage and documentation. Ad hoc analyses answering the “what happened” questions that drive policy evaluation and performance improvement. Provides technical support of the SAS analytics platform.

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

Revised as of 6/30/2023
Positions in RED are VACANT



Incentive Coordination and Economic Research Division

The Incentive Coordination and Economic Research Division (formerly known as the Office of Value Based Purchasing (VBP)) reports to the Chief Analytics Officer as part of the Healthcare Analytics and Transformation team. The ICER Division works on policies to encourage effective and efficient provision of care to Medicaid members through both financial and non-financial incentives while overseeing the agencies 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 (ICER) comprises two units:

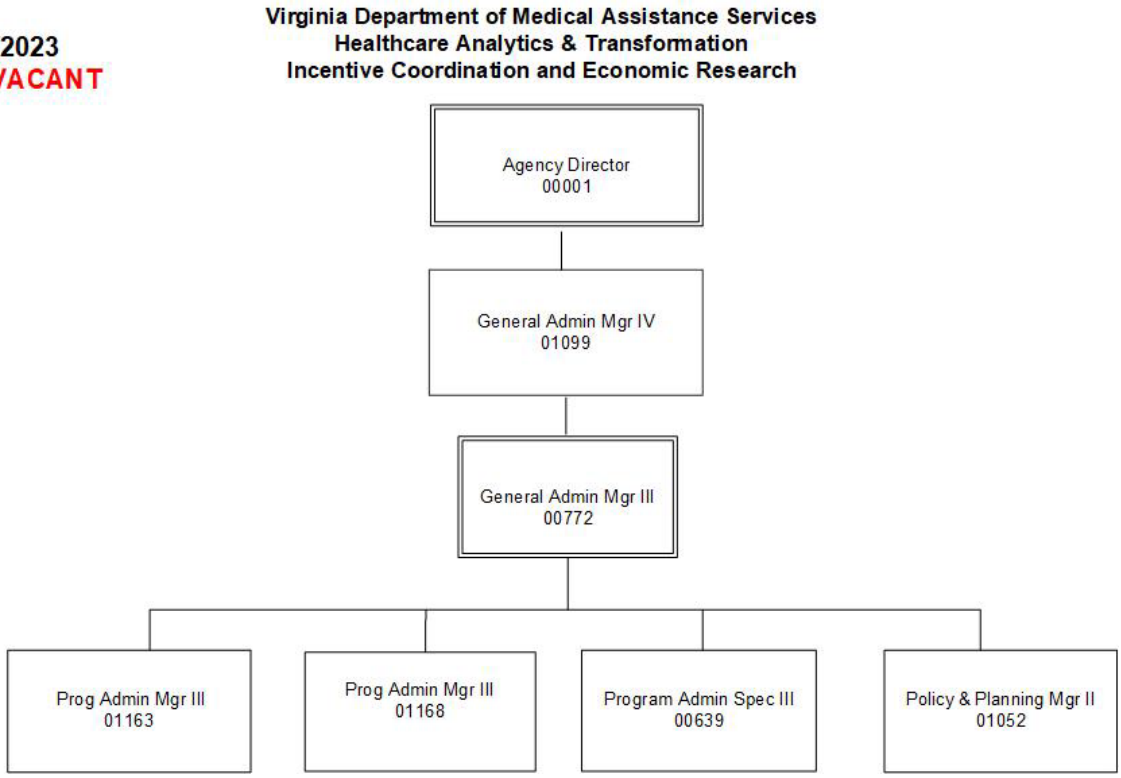
Value Based Purchasing Unit

Promotes policies that utilize both financial and non-financial incentives to encourage the provision of high quality, efficient care to Medicaid members; resulting 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

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.

Revised as of 6/30/2023
Positions in RED are VACANT



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

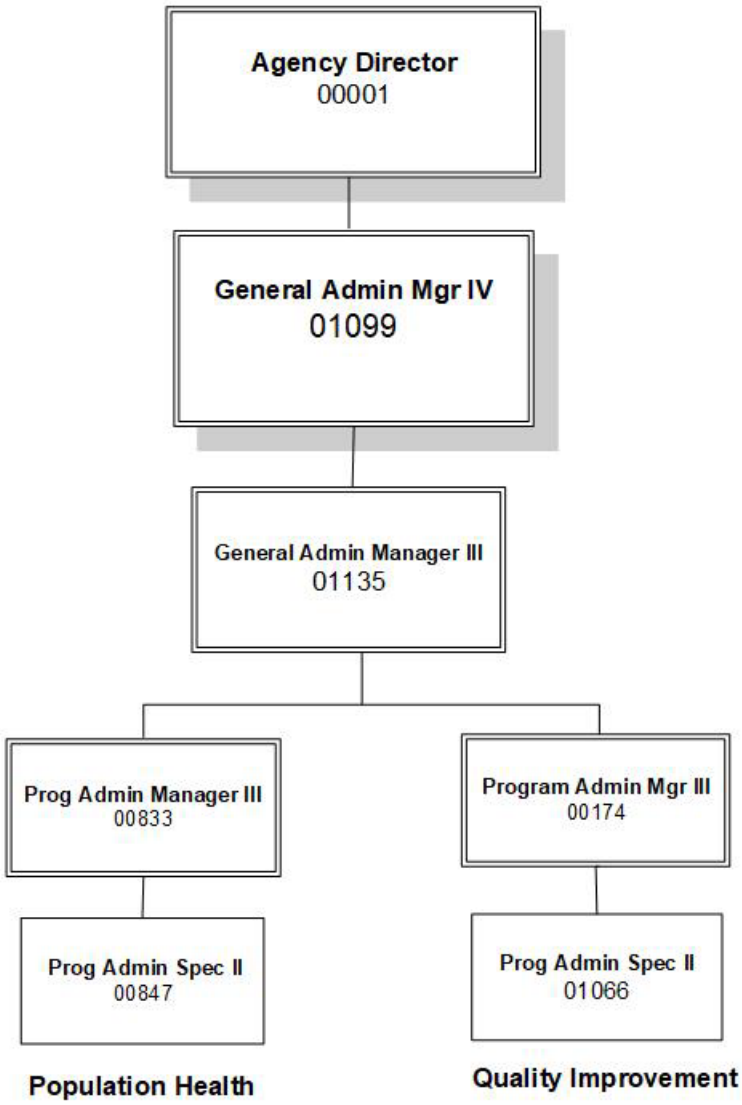
Oversees the External Quality Review Organization (EQRO) contract to ensure all federally required quality activities (mandatory or optional) are conducted in accordance with managed care regulations (42 CFR 438 Subpart E: Quality Measurement and Improvement). In additional, the team ensures MCOs receive 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

Helps with coordinating projects for DMAS, focusing on population health trends and possible health care gaps; including 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 Medical Assistance Services
Office of Quality & Population Health

Revised as of 6/30/23
Positions in RED are VACANT



Policy, Regulation, and Member Engagement Division

The Policy, Regulation, and Member Engagement (PRME) Division reports to the Deputy for Administration. The PRME Division provides comprises two units, each with distinct functions:

Regulations and Manuals/Policy Unit

The individuals in the Regulations and Manuals group plan, draft, and promulgate regulations and State Plan Amendments (SPAs) with subject matter experts (SMEs). In addition, the individuals in this unit maintain agency Provider Manuals and coordinate/develop updates with agency SMEs. Individuals in this unit also coordinate with agency SMEs for 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, Office of the Attorney General, and the Department of Planning and Budget to obtain certification and approval of regulations and SPAs. Business functions of this unit also include responding to Freedom of Information Act (FOIA) requests, responding to constituent requests, and providing administrative support to the Board of Medical Assistance Services (BMAS).

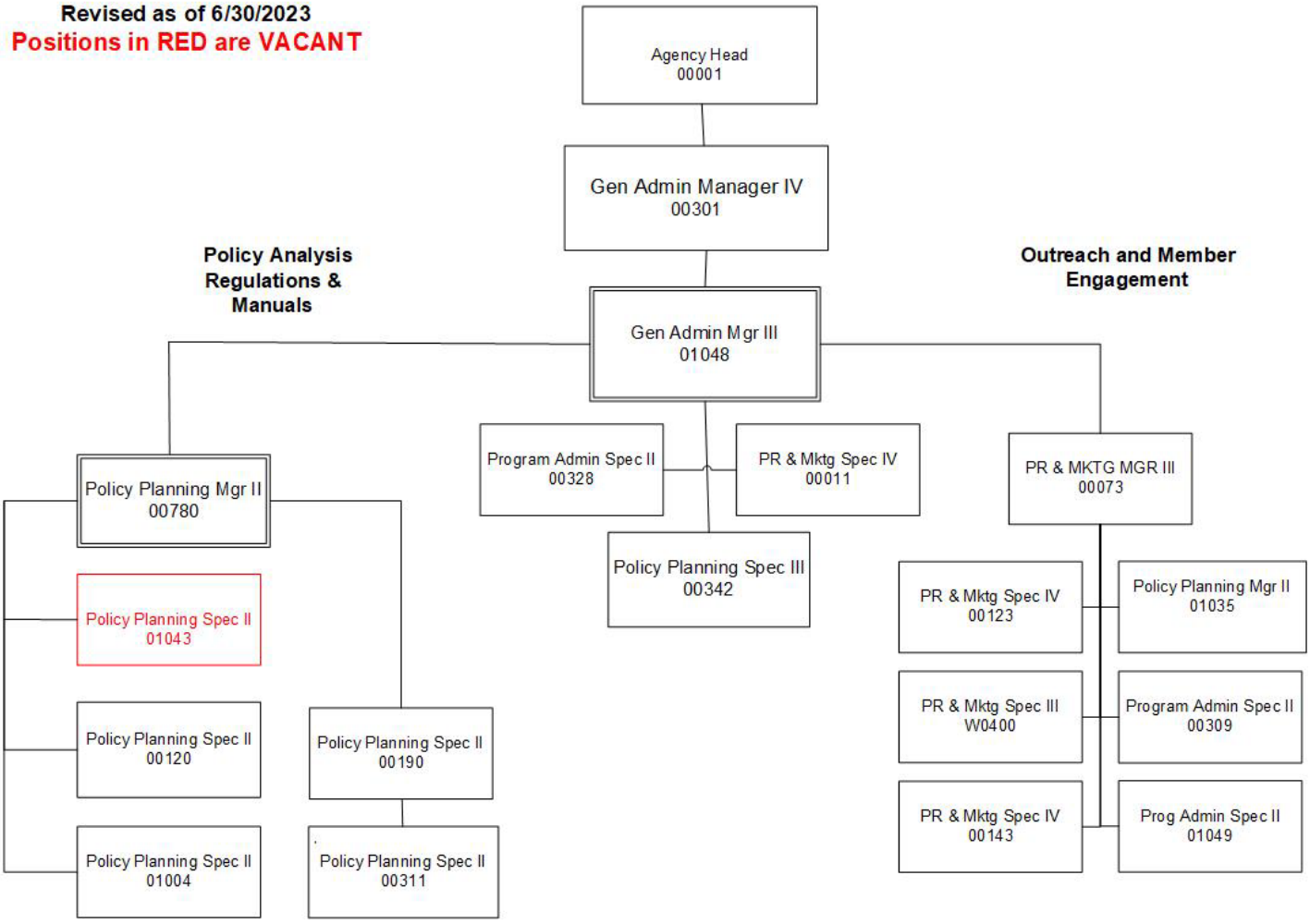
The individuals in the policy group provide assistance and guidance to the agency through cross-divisional policy planning and management, providing transparent, consistent availability of information and thorough collection, storage and maintenance of digital content. In addition, individuals in this unit provide research, legislative analysis, policy statements, reports and background documents, as well as coordination of the Children's Health Insurance Program Advisory Committee (CHIPAC), and maintenance of the 1115 CHIP Waiver.

Outreach and Member Engagement Unit

The individuals in this unit are responsible for providing outreach and strategic community engagement initiatives for the Medicaid and FAMIS programs across the Commonwealth. Additionally, individuals in this unit provide member and community education, application assistance, and oversight of the Member Advisory Committee (MAC) and the DMAS Support Team for Application Response (STARs).

Virginia Department Medical Assistance Services
Policy, Regulation, & Member Engagement Division

Revised as of 6/30/2023
Positions in RED are VACANT



Procurement & Contract Management Division

The Procurement & Contract Management (PCM) Division reports to the Deputy Director for Finance/Chief Financial Officer (CFO). The PCM division directs and manages the agency's procurement and contracting activities for large/complex and small procurements, inter-agency agreements between the agency and other state entities. PCM assures all contracting activities are completed in accordance with the Commonwealth's governing authorities that includes the Virginia Public Procurement Act (VPPA), the Agency Purchasing and Surplus Property Manual (APSPM), the VITA Buy-IT manual, as well as federal law and regulations. The PCM division also directs some of the agency general services including mail services, fleet management, and other miscellaneous activities. Work is completed through three (3) subunits: Procurement Management, Contract Management, and Compliance & General Management.

Procurement

The Procurement Unit develops and awards new contracts through one of the approved procurement methods as outlined in the VPPA. Small purchasing activities include procurements under $100K, utilization of state contracts, mail services, fleet, and other general services. In the development of high-risk solicitations this unit coordinates the internal review process prior to posting a solicitation and prior to final award. As part of the high-risk review this team must work with the Attorney General, Department of General Services, and VITA. The team cross-collaborate with the contract management team to ensure repeat solicitations are documented with previous needs/issues of the previous awarded contract. This team is comprised of six (6) full-time classified employees.

Contract Management

The Contract Management Unit is responsible for the management of newly awarded contracts, all inter-agency agreements, and serves at the point of contact on all awarded major contract and inter-agency agreements. This unit also assist contract administrator with contractual issue and provides guidance and support as necessary. The unit, in partnership with contract administrators, develops and negotiates modifications to agency agreements. Further, the unit is responsible for the management of all interagency agreements. This team must conduct high-risk renewals and must collaborate with the Attorney General, Department of General Services, and VITA in this process. This team is comprised of five (5) full-time classified employees.

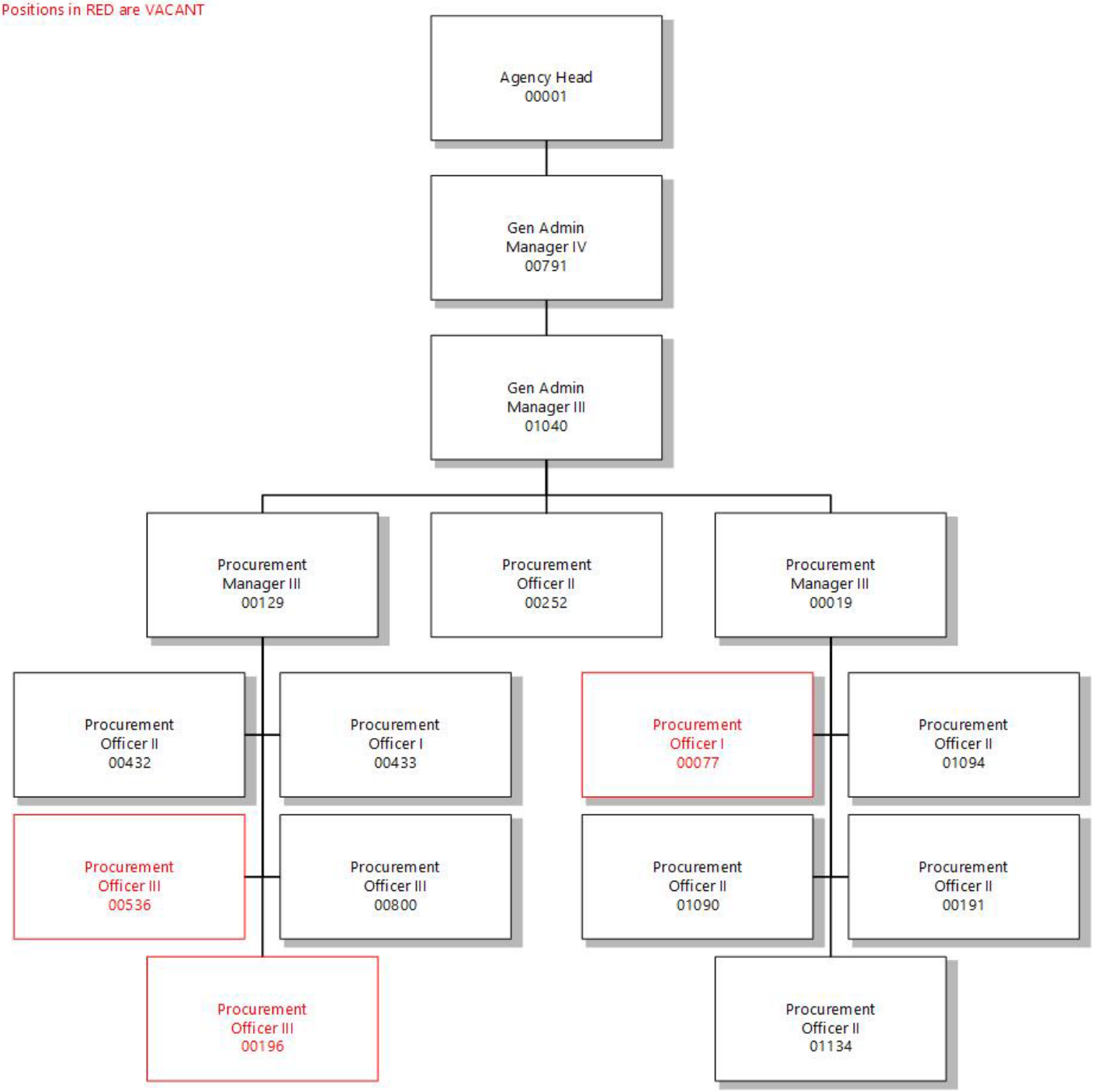
Compliance & General Management

This team is responsible for assuring compliance is conducted in all aspects of the division. Through random sampling this unit will conduct reviews of work completed by the Procurement Management and Contract Management teams. As well, this unit is responsible for developing and reviewing all standard operating procedures for the division. This manages the receiving and processing SWaM reports, tracking and recording vendor invoices, and ensures vendor performance under the terms of the contract. This team also work in conjunction with the division director with all audits – ARMICS, APA, and the agency Internal Audit. Finally, the compliance unit is charged with the ongoing review of current activities, and implementation of best practices. This team is comprised of two (2) full-time classified employees and two contractors.

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

REVISED AS OF 6/30/2023

Positions in RED are VACANT



Program Operations Division

The Program Operations Division reports to the Deputy Director for Programs and Operations. The Program Operations Division (POD) is the agency service center and operational backbone of the Virginia Medicaid Fee-for-Service (FFS) delivery system, 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, and specialized populations and services are covered FFS. 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 provider enrollment for all providers, provider call center and contractors and is the business center for 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, analyzes data and looks for efficiencies in operations. It leads the implementation and modifications of the Division's Medicaid Enterprise System (MES). This Unit also is the gateway to all FFS claims processing and system changes.

Transportation

The Transportation Team oversees Emergent and Non-Emergency Medical Transportation (NEMT) for the FFS and the six managed care NEMT program brokers.

Member Services Unit

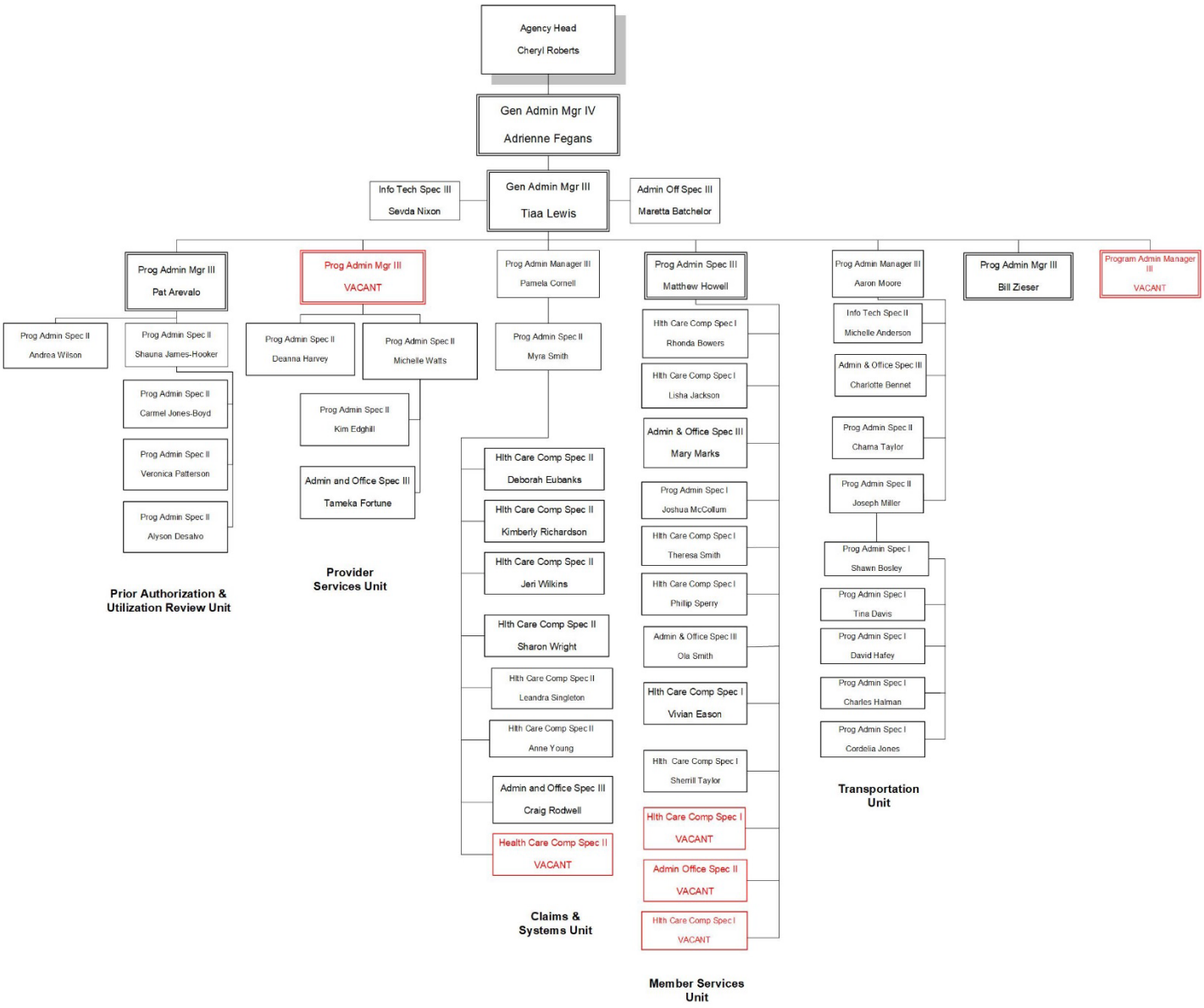
The Member Services Unit manages day-to-day operations of the Health Insurance Premium Payment (HIPP) program, the Buy-In program, FFS Appeals, and Customer Service. The unit also handles, Electronic Health Records and the mass mailing contract for the agency.

This organizational structure positions POD to provide superior customer service to stakeholders, including Medicaid members, providers, DMAS staff and other state agencies. POD also supports agency-wide efforts or major changes in programs relative to Medicaid expansion, Medicaid Enterprise Systems and the pandemic.

POD also serves as the contract monitor for the fiscal agent's Member and Provider Call Center contract, Claims Processing contract, Provider Enrollment Services contract, the FFS NEMT contract, the agency's mass-mailing contract, service authorization contract, a contract for provider training and two contracts for the Electronic Health Records Provider Incentive Payment program.

Revised as of 6/30/2023
Positions in RED are Vacant

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Program Operations Division



Program Integrity Division

The Program Integrity Division reports to the Deputy Director of Programs and Operations. The Program Integrity Division (PID) is entrusted with the responsibility of identifying fraud, waste and abuse within the Virginia Medicaid program, referring potentially fraudulent providers and members to the proper law enforcement entity. The division works with other divisions in the agency and 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 Department of Social Service (LDSS) agencies on alleged acts of criminal welfare fraud and referrals to local Commonwealth Attorneys.
- Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs measure improper payments and review eligibility efficiencies.
- Public Assistance Reporting Information System (PARIS) identifies members potentially receiving benefits in multiple states.

MRU has two sub-units, Recipient Audit Unit (RAU) and 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, the 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 works with DSS to provide training and educational support on eligibility reviews.

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

Provider Review

The PID engages in provider-focused program integrity efforts and oversight to help fulfill its mission to work across the agency to identify providers who may be practicing erroneously, 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 cross delivery systems, FADS mine 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 housed 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.

REVISED AS OF 6/30/2023

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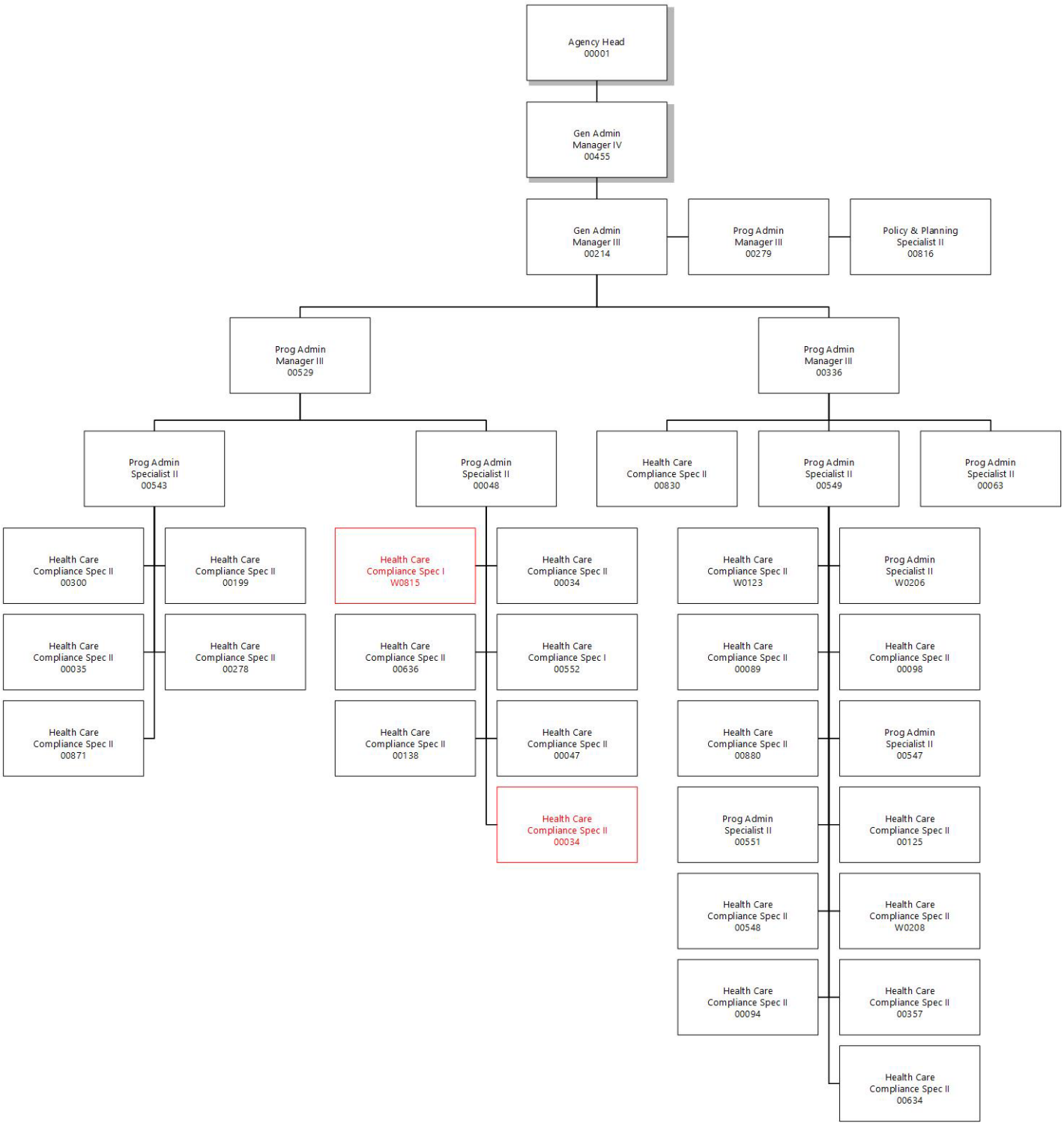
VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy of Programs and Operations
Program Integrity Division



Provider Reimbursement Division

The Provider Reimbursement 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, including calculating, reviewing, and updating 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 utilizing both regulatory and market information to determine appropriate and allowable payments.

There are four units within PRD (Provider Rate Setting, Managed Care Rate Setting, Supplemental Payments, Cost Settlement and Audit) that work collaboratively to accomplish this detailed and essential work.

Provider Rate Setting Unit

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.

Services for which rates are set include but are not limited to:

- Acute/rehabilitation/psychiatric hospitals (inpatient and outpatient)
- Freestanding Psychiatric Facilities and Temporary Detention Orders (TDO)
- Ambulatory surgery centers
- Nursing facilities, Specialized Care, and hospices
- Physicians and other practitioners
- Community Mental Health/Addiction and Recovery Treatment Services (ARTS)
- Personal care and other home or community-based care waiver service providers
- Home health agencies
- Outpatient rehabilitation agencies
- Provider Residential Treatment Facilities PPRTF)

Managed Care Rate Setting Unit

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:

- Medallion 4.0 (acute care services for children, pregnant women and low-income caretakers and adults)
- CCC Plus long-term services and supports and acute care services for the aged, blind and disabled, including dual eligible individuals
- Program for All-inclusive Care for the Elderly (PACE)

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 Medicaid's:

- Pharmacy Reinsurance Program
- ARTS Stop Loss Insurance Program
- Quality withholds and provider incentive payments

Cost Settlement and Audit Unit

The 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.

Providers that file cost reports include:

- Hospitals
- Nursing facilities and specialized care facilities
- Outpatient rehabilitation agencies

State and private intermediate care facilities for individuals with intellectual disabilities (ICF/IID)

- State psychiatric hospitals and training centers
- Federally Qualified Health Centers (FQHC)
- Rural health clinics (RHC)

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 including those that monitor our contractual arrangements and payment of services provided by managed care organizations to Medicaid recipients. Moreover, this unit also oversees upper payment limit (UPL) demonstrations, DSH audits, school-based reimbursement for medical transportation and administrative services, and lump-sum payment transactions.

Supplemental Payments Unit

The Supplemental Payments 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. 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.

Supplemental payments include those for:

- Graduate Medical Education (GME)
- Indirect Medical Education (IME)

- Disproportionate Share Hospitals (DSH)
- Indigent care at state teaching hospitals
- Private acute care hospitals
- Physicians affiliated with general acute care non-state government-owned hospitals
- Physicians affiliated with teaching or children's hospitals
- State & non-state-owned clinics
- Non-state government-owned nursing care facilities

Reimbursement Policy

PRD has a dedicated team member who is responsible for ensuring all reimbursement policy is in alignment and organizes language changes. Activities include:

- Developing and maintaining Reimbursement Policies and Manuals
- Writing and ensuring implementation of Administrative Code changes
- Reimbursement State Plan reviews and development
- Researching and advising on draft budget language
- Reviewing and implementing the federal CMS policy and directives pertaining to reimbursement
- Ensuring reimbursement compliance with federal regulations
- Manage PRD review of proposed budget amendments and legislation

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

REVISED AS OF 6/30/2023

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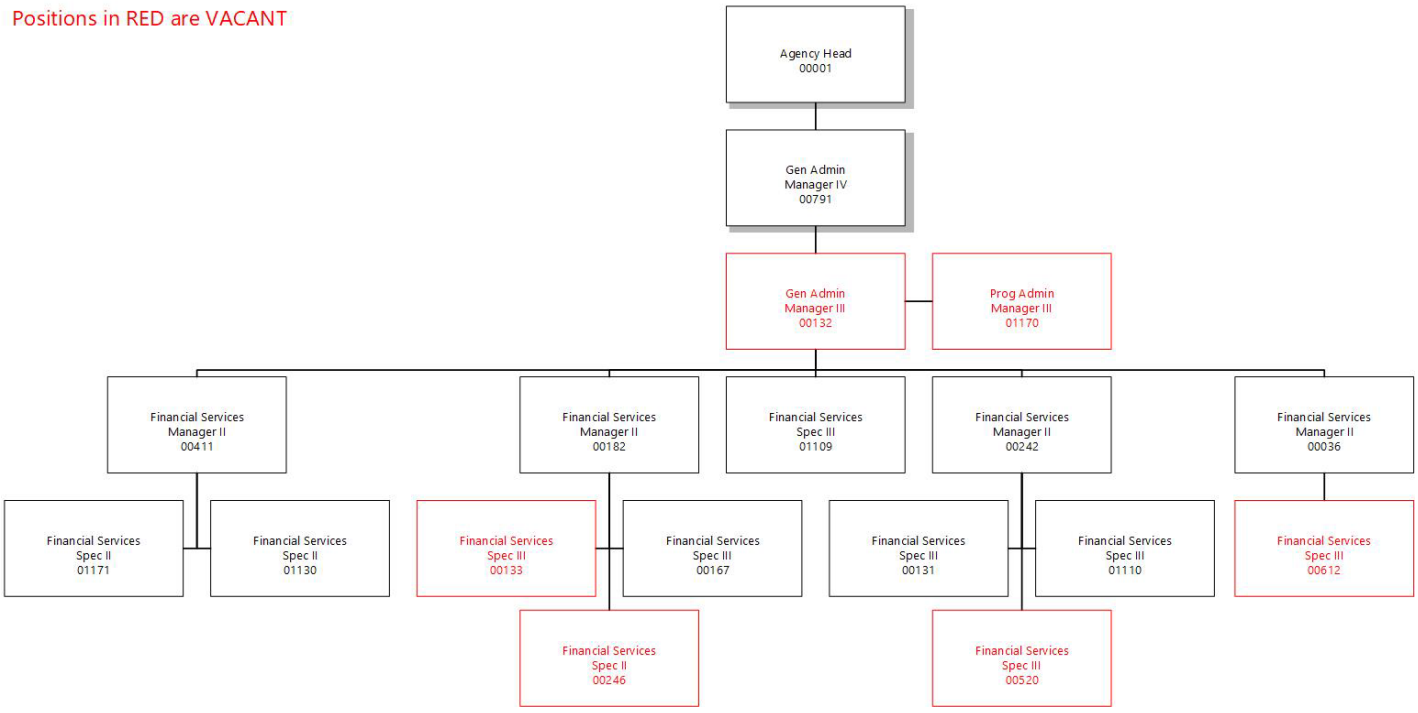

Organizational Changes during Fiscal Year (FY) 2023

During the period July 1, 2022 – June 30, 2023, DMAS made the following organizational changes to ensure that all business functions are aligned:

Consolidation of DADs Division

With the implementation of Virginia's mandatory Managed Long Term Services and Supports (MLTSS) program, called Commonwealth Coordinated Care Plus (CCC Plus), consolidation and oversight of long term care and aging services policy and operational activities was essential. Coupled with growing expertise in aging services, operations, and managed care oversight within Complex Care Services, integration of the existing staff from the Department of Aging and Disability Services (DADS) into the Director's office, the Integrated Care Division and the Office of Community Living ensures program efficiency and alignment with the Department's strategy to streamline agency operations. Two staff in this area retired in FY2023, five staff transitioned to the Office of Community Living, and six staff transitioned to the Integrated Care division. Finally, one staff transitioned to the Director's Office to manage the Civil Money Penalty Reinvestment Program (CMP-RP).

Healthcare Analytics and Transformation (HAT)

The Healthcare Analytics and Transformation (HAT) (formerly known as Division of Health Economics and Economic Policy (HEEP)) is led by the Chief Analytics Officer (formerly known as Chief Health Economist). This fiscal year, HAT updated their division names and aligned business units to evolve with the changing business needs of the agency. HAT includes the Healthcare Analytics Division (HAD), the Incentive Coordination and Economic Research (ICER), and the Quality and Population Health Division (QPH). 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 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 Department'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.

Information Security Officer

The Information Security Officer (ISO), formerly the Office of Security and Compliance, reports to the Agency Head and is responsible for planning, governance, incident reporting, and oversight of the agency's comprehensive privacy and information security program. This function now reports directly to the Agency Head to provide greater oversight of all DMAS information security initiatives and information risk management.

Below is a summary of DMAS Staffing Changes during Fiscal Year 2023 (7/1/2022 – 6/30/2023), as well as previous FY 2020 through FY 2022 data **These figures reflect classified and wage positions filled and separations, not a reflection of our current Maximum Employment Level (MEL).**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Classified Positions filled:	114	80	91	77
Internal Transfers:	29	30	21	19
External Hires:	85	50	70	58
Classified Positions Separations from DMAS:	34	43	50	87
Resignations:	21	25	28	24
Retirements:	9	14	12	22
Other:	4	4	10	41
Wage Positions filled:	37	15	44	4
External hires:	57	14	43	4
Internal transfer from one wage position to another wage position	0	1	1	0
Wage position separations from DMAS:	34	37	25	23
Resignations:	14	24	25	19
Other separations:	20	13	5	4
Other separations breakdown:				
Wage hired as classified:	0	3	5	0
Wage term to temp pos:	0	4	0	0
Intern assign ended:	0	2	0	0
Layoff:				1
Terminations:	20	4	0	3
Total of other separations breakdown:	20	13	5	4

END OF REPORT