2024-26 Strategic Plan

Department of Medical Assistance Services [602]

Mission, Vision, and Values

Mission

The mission of the Department of Medical Assistance Services (DMAS) is to improve the health and well-being of Virginians through access to high quality health care coverage and services.

Vision

Our agency strives to fulfill this mission by upholding our core values of service, collaboration, trust, adaptability, and problem solving.

Values

Service: We are committed to serving all who are touched by our system with caring, integrity, and respect.

Collaboration: We value professional, respectful cooperation to achieve common goals. Everyone's input is welcome.

Trust: We are continuously building a culture that is honest, supportive, and fosters integrity.

Adaptability: We work together to anticipate and embrace change to meet Virginia's health care needs.

Problem Solving: We promote problem-solving processes and respond to challenges with a forward-thinking approach.

Agency Background Statement

The Department of Medical Assistance Services (DMAS), a state agency within Virginia's Health and Human Resources secretariat, administers the Commonwealth's Medicaid and Children's Health Insurance Program (CHIP)/ Family Access to Medical Insurance Security (FAMIS) programs. DMAS and the managed care health plans currently serve approximately 2 million members in the Cardinal Care Medicaid program, providing access to primary and specialty health care, inpatient care, dental care, behavioral health services, and addiction and recovery treatment services. Medicaid long-term services and supports enable thousands of Virginians to receive the care they need while remaining in their homes, or to access residential and nursing home care. Medicaid covered populations 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 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as 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.

Agency Status *(General Information About Ongoing Status of the Agency)*

DMAS recently launched Cardinal Care, a single, unified brand that includes all Medicaid, FAMIS, and limited benefit members, served through the managed care and fee-for-service delivery systems. With Cardinal Care, DMAS has consolidated the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC+) managed care programs, waivers, and contracts into a single unified program with a focus on continuity for members who will no longer need to transition between two managed care programs. DMAS has taken a strategic approach to build a responsive, member-focused model of care that prioritizes financial accountability, access to high-quality care, and support for targeted populations, including behavioral and maternal health and members in the child welfare system. Cardinal Care Managed Care provides a strong foundation for the Governor's priority initiatives, including *Right Help, Right Now.*

DMAS plays a key role in the governor's *Right Help, Right Now* Behavioral Health Transformation to reform the current behavioral health system in Virginia and support individuals in crisis. The goal of *Right Help, Right Now* is to ensure an aligned approach to behavioral health that provides access to timely and effective community-based care. DMAS is working to provide more effective, evidence-based, accessible services to members and is seeking opportunities to identify and implement innovations and best practices. Examples include outcome-based payment, performance incentives, and a focus on targeted collaboration with sister agencies, health plans, and community partners.

A key priority of *Right Help, Right Now* is to provide needed services to more Virginians with developmental disabilities. Virginia's Developmental Disabilities Waiver program currently provides a variety of supports with medical care, employment, community living, behavioral interventions, and other services that support employment. The increased number of waiver slots available will help achieve the *Right Help, Right Now* goals and enable more members to receive life-changing services and supports in their community.

Governor Youngkin's administration and DMAS are revitalizing Virginia's focus on maternal and child health. This includes driving improvements in both prenatal and postpartum care across all communities in the Commonwealth, from rural to urban. Key priorities include engaging with providers and members, supporting maternal health care access in rural Virginia, and extending clinic hours.

Information Technology

DMAS continues to improve upon the Medicaid Enterprise System (MES) having successfully received CMS certification for all but one module. The certification process for the Care Management Solution (CRMS) is in the final stages and is with CMS for final disposition which will afford enhanced funding for the Agency for work completed post implementation through final certification. CRMS is an Agency developed solution that helps to coordinate care for our members and is a key communication device for sharing information with our Managed Care Organizations.

Cardinal Care Managed Care is the Agency's effort to achieve better outcomes for members by merging the previous Medallion 4.0 and Commonwealth Coordinated Care Programs into a single program. System changes will be made to support the new program, which will involve various MES modules such as supporting enrollment, intelligent assignment, provider enrollment and management, care coordination, and electronic data interchange.

MES is an ever-evolving solution composed of different modules. Over the next biennium, DMAS will look to replace the Fiscal Agent Services (FAS) module with a more modernized and interoperable module. The existing solution was initially installed in 2003 and consists of an old mainframe central processing component that makes it difficult to connect with more modern cloud-based solutions. FAS consists of claims processing, member management, financial management, and plan management for the Agency's Medicaid management. Replacing this module is key in finalizing the modernization of the infrastructure supporting the Medicaid program.

The Pharmacy Benefit Management Solution (PBMS) which supports point of sale pharmacy claims processing as well as the rebate process will also need to be re-procured, as the current contract reaches end-of-life. Modularity offers the ability to perform Design, Development, and Implementation of various components simultaneously.

DMAS will also endeavor to implement a Third-Party Liability (TPL) module using MS Dynamics as the core technology. We will be awarding a contract through CAI after having evaluated via a competitive procurement process. The current system relies on manual processes that will be replaced with workflows and electronic document storage, streamlining current processes, and lessening the burden of the workforce.

The DMAS Enterprise Development unit is developing a change management solution using Oracle Apex which will create a single-entry point for all work intake and alleviate the usage of disparate systems to manage service requests. The solution will offer reports and dashboards from a single system that will offer the Agency's leadership immediate insight into work efforts, providing progress and status reports, offering real-time views into the health of projects. This single intake entry point will also ensure control over Agency initiatives informing stakeholders via workflows of actions or approvals that need to be taken.

Security integration efforts are underway to encompass additional tools and applications under our Single Sign-On (SSO). Our Service Authorization application, change management solution, TPL solution are all scheduled to be integrated with our SSO solution, enhancing the Agency's security and reducing any point of failures. Security integration will also be addressed by introducing an access certification solution with the ability to monitor and grant or revoke access to MES.

Workforce Development

DMAS is a highly professional and efficient organization with an average of 8 years of service and experience. DMAS has 24 Divisions and/or Offices where the Executive Leadership Team has oversight for essential business functions within the Agency & Medicaid activities for over 2 million Members across the Commonwealth.

DMAS received 28 additional allotted MEL in SFY2025, resulting in a total of 567 authorized Classified positions (for SFY2025) with an average of 514 filled positions and 9% vacancy rate; compared to ending SFY2024 with a 5% vacancy rate. DMAS also utilizes about 138 hourly and contract employees to supplement the agency's workforce due to pertinent agency priorities and initiatives. DMAS has put a concentration on lessen the long-term staff augmentation contractors/consultants within Classified recruitments which has resulted in a decrease of 45 long-term staff augmentation contractors.

DMAS has put a greater focus on workforce engagement and development initiatives 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. This includes continuing to improve hiring processes and increasing access to potential candidates from diverse populations, continuing to retain and promote a diverse workforce, creating and maintaining a climate that is supportive and respectful, continuing to provide an environment where conflict, concerns, and complaints are addressed expeditiously, and continuing to provide training and educational workshops available to all employees. Some of the opportunities DMAS has created are as follows:

- Enhanced recruitment processes and procedures stemming from established metrics.
- Implementation of the DMAS Accelerator Internship Program, to address the Commonwealth's need for talented, trained and prepare

government leaders. DMAS' internship program has established a talent pipeline for current and future business needs, by successfully hiring 4 interns at the conclusion of the Cohorts.
- Launch of DMAS Partners in Agency Learning Program, that matches new hires with tenured employees.
- Implementation of Wellness days and advanced work of the DMAS Culture and Engagement Committee.
- Enhanced Learning Objectives, Employee Relations and Performance Management Processes.

These efforts continue to ensure the essential functions of the Virginia Medicaid Program are carried out to improve the health and well-being of Virginians. DMAS is still working on innovative ways to energize staff & retain staff. However, DMAS still has concerns regarding DMAS' retention of essential workforce members. Retirements could potentially have a significant impact on the agency's operations. The retention of highly-skilled employees continue to be a high goal of the Agency.

Staffing

Authorized Maximum Employment Level (MEL)	567
Salaried Employees	514
Wage Employees	76
Contracted Employees	62

Physical Plant

DMAS is in a privately leased building at 600 E. Broad Street, Richmond, VA 23219. Sharing the space with local and federal partners requires increased security to protect the DMAS staff. Space limitations are becoming a challenge with the addition of new MEL.

Key Risk Factors

Changes in Federal and State Administrations – Because Medicaid is a joint federal-state program, transitions of administrations at both the state and federal level can impact the continuity of directives and priorities, posing challenges to implementation of the agency's long-term strategies.

Enrollment Uncertainty Post Unwinding – In January of 2019, Virginia implemented Medicaid expansion and began enrolling newly eligible adults. In spring of 2020, the COVID-19 federal public health emergency was declared, leading to a federal suspension of Medicaid eligibility closures. In spring of 2023, states began a return to normal Medicaid eligibility processes, called "unwinding." Now, as we emerge from unwinding, DMAS is analyzing trends in enrollment, covered populations, and utilization and seeking to understand the new Virginia Medicaid landscape post-COVID with the sizeable new adult population. Gaining an understanding of these enrollment and utilization trends is critical to developing the agency's budget and ensuring adequate service availability.

Current Agency Resources (Staffing and Succession Planning) – Retirements and resignations have the potential to hamper the efficiency and effectiveness of agency operations. Ensuring adequate staffing through hiring and retention of highly skilled employees is critical to all strategic priorities and is a top priority for the Agency.

Competing Priorities – Recent years have brought unprecedented change to DMAS, with new state and federal mandates, the recent implementation of the Cardinal Care Managed Care program, managed care contract RFPs and renewals, significant expansions in enrollment, benefits, and other major changes in programs and operations. The agency must focus on successfully implementing these changes and priories while simultaneously ensuring efficient and effective ongoing operations. This will continue to evolve in conjunction with Key Risk number one, changes in federal and state administrations.

IT Security Risks and Challenges – Data breaches and attacks in the health care sector continue to increase in scale and severity, bringing significant risk to DMAS and its critical partner systems (managed care organizations, vendors, sister agencies).

Insufficient Funding to Meet Increased Capacity Needs – Funding to meet increased capacity needs, including an overall higher enrollment due to Medicaid expansion and normal population growth, is essential to the agency's ability to provide cost-efficient operations and manage new initiatives. Examples include funding for necessary contract increases, adequate funding of projects and programs, and sufficient staffing in the administrative budget.

Potential Litigations – The U.S. Supreme Court's June 2024 decision in Loper Bright Enterprises v. Raimondo, overturning the longstanding practice of Chevron deference to agency regulatory decisions, opens new avenues for regulated entities to challenge CMS decisions creating uncertainty for state programs. DMAS relies on current federal rules and guidance to implement Virginia's Medicaid program. So, if those rules are overturned, it could cause significant disruptions in Virginia.

Finance

Financial Overview

The initial appropriation in this table was established for the biennium budget in the 2024 Appropriation Act. DMAS' base budget is currently funded with approximately 28% state general funds and 72% non-general funds. The non-general funds are comprised of federal trust funds, special revenue, and dedicated special revenue. The descriptions of the non-general fund categories are listed below:

DMAS has two federal funds grants: Medicaid - Title 19 (XIX) (CFDA# 93.778) and Children's Health Insurance Program (CHIP) - Title 21 (XXI) (CFDA# 93.767).

DMAS has five dedicated special revenue accounts: Virginia Health Care Fund (09490), Uninsured Medical Catastrophe Fund (09105), Health Care Coverage Assessment Fund (09780), Health Care Rate Assessment Fund (09790), and the Children's Medical Security Insurance Plan (09033).

DMAS also has six special revenue accounts: State and Local Hospitalization (02044), Opioid Abatement Fund (02095) Nursing Facility Sanctions (02104), Medicaid Intergovernmental Transfers (02207), Breast and Cervical Cancer Pharmacy & Therapeutics (02235), and DMAS Special Revenue (02602).

The Federal Medical Assistance Percentage (FMAP) rate for the Virginia Medicaid program will vary over the course of the biennium for different programs:

Program	FMAP 07/01/24-09/30/24	FMAP 10/01/24-9/30/25	FMAP 10/01/25-06/30/26
Base Medicaid (Title XIX)	51.22%	50.99%	50.22%
Children's Health Insurance Program (Title XXI)	65.85%	65.69%	65.15%
Medicaid Expansion	90.00%	90.00%	90.00%

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	6,880,624,122	17,656,606,990	7,270,962,990	18,948,282,759
Changes to Initial Appropriation	0	0	0	0

Revenue Summary

The Agency's total revenue consists of two types of resources: general funds (GF) and non-general funds (NGF). General fund revenues are derived from routine taxes paid by citizens and businesses in Virginia. DMAS uses this revenue to provide matching state funds required by the federal government for federal grants.

The majority of non-general funds (NGF) are federal funds and grants are the largest single source of non-general fund revenue for DMAS. About 88% of all NGF revenue is from these federal sources. The remaining non-general fund revenue is from various sources such as funds returned due to cost settlements, audit collections, and pharmacy rebates. Non-general fund revenue also includes the provider coverage assessment, which is a tax on private acute hospitals operating in Virginia. This dedicated special revenue is used to cover the non-federal share of Medicaid expansion costs.

Agency Statistics

Statistics Summary

No data

Statistics Table

Description	Value
Grand total	2,017,896
Children	791,757
Adults	772,281
Persons with a disability or blindness	138,516
Limited benefit individuals	186,663
Aged 65 or older	89,234
Pregnant individuals	39,472

Customers and Partners

Anticipated Changes to Customer Base

Virginia Medicaid's customer base is large and diverse. Approximately 23% of the state's population is enrolled in Medicaid as of June 2024.

In March 2020 at the start of the COVID-19 pandemic, the federal government declared a public health emergency. A Maintenance of Effort was implemented under the federal public health emergency which allowed Medicaid members to keep their coverage during the pandemic. In exchange for continuous coverage during the PHE, the state received an enhanced FMAP of an additional 6.2%. From March 2020 through March 2023, the Commonwealth experienced an increase of 653,784 enrollees (a 43% in enrollment growth). This enrollment growth was most prominent for non-elderly, non-disabled adults and slower among children and aged, blind and disabled (ABD) eligibility groups.

When the federal PHE ended in April 2023, DMAS, in partnership with the Department of Social Services and the 120 local agencies were required to redetermine eligibility for all Medicaid enrollees over a twelve-month period. The end of the continuous coverage requirement (also referred to as the 'unwinding') in the Commonwealth presented the single largest health event since the first open enrollment of the Affordable Care Act (ACA). The unwinding has changed the member portfolio and has created a level of uncertainty in modeling future trends.

Current Customer List

Predefined Group	User Defined Group	Number Served Annually	Potential Number of Annual Customers	Projected Customer Trend
Health Professions	Medicaid Providers	54,085	0	Stable
Low-Income	Total beneficiaries / clients in Medicaid and FAMIS (Title XIX and XXI)	1,984,977	0	Increase
Low-Income	Low-income, Aged, and Disabled Virginians with Mental Health or Intellectual Disability in facilities (e.g., nursing facilities, ICF/MRs)	19,243	0	Stable
Low-Income	Low-income, aged, or disabled Virginians with a diagnosis of HIV+	0	0	Stable
Low-Income	Qualified Medicare Beneficiaries (Limited Benefit)	67,156	0	Increase
Low-Income	FAMIS MOMS - Uninsured pregnant women with income > 133% FPL and < 200% FPL **	3,966	0	Stable
Low-Income	Prenatal Care for Otherwise Eligible Pregnant Women	4,428	0	Stable
Low-Income	CHIP: Uninsured children age 6 to 19 with family income between 109% and 143% FPL	93,612	0	Stable
Low-Income	CHIP: Uninsured children under 19 with family income > 143% FPL (federal poverty level) and < 200% FPL *	96,502	0	Stable
Low-Income	Medicaid: Caretaker Adults	141,024	0	Increase
Low-Income	Medicaid: Pregnant Women	29,056	0	Stable
Low-Income	Medicaid: Children	589,532	0	Increase
Low-Income	Medicaid: Family Planning (Limited Benefit)	52,532	0	Stable
Low-Income	Department of Corrections 2014 Eligibility Rules (Limited Benefit)	24,310	0	Increase
Low-Income	Department of Corrections ACA Eligibility (Limited Benefit)	38,556	0	Increase
Low-Income	Program of All-inclusive Care for the Elderly (PACE)	1,820	0	Stable
Low-Income	LTC in the community (waivers)	60,733	0	Increase
Low-Income	Low Income Aged Blind and Disabled not in Long Term Care	142,906	0	Decrease
Low-Income	ACA Expansion: Caretaker Adults	132,023	0	Increase
Low-Income	ACA Expansion: Childless Adults	487,720	0	Increase

Partners

Name	Description
Federal agencies	Centers for Medicare and Medicaid Services (CMS)

Managed Care Organizations and Service Delivery Contractors	Aetna, Anthem, Molina, Sentara and United Healthcare, DentaQuest, ModivCare, Acentra Health, Consumer Direct Care Network Virginia, Magellan Pharmacy Benefit Services Manager.
Industry Associations	Virginia Hospital and Healthcare Association (VHHA), Virginia Community Healthcare Association (VCHA), Virginia Association of Health Plans (VAHP), Virginia Health Care Foundation (VHCF), Virginia Association of Community Services Boards (VaCSBs), Virginia Health Care Association (VHCA), Virginia Association of Free and Charitable Clinics, Medical Society of Virginia, National Association of Medicaid Directors (NAMD).
State and local entities	Governor's Office, State Legislature, Office of Health and Human Resources, Department of Planning and Budget, Virginia Department of Social Services, Virginia Department of Health, Department of Behavioral Health and Developmental Services, Department of Aging and Rehabilitative, Virginia Board for People with Disabilities, Virginia Department of Health Professions, Virginia Department of Corrections, Virginia Department of Education, Virginia Information Technology Agency, Office of Attorney General, Virginia Department of Corrections, Virginia Department of Juvenile Justice.
Advocacy groups	Virginia Poverty Law Center (VPLC), Legal Aid Justice Center, The Arc of Virginia, Virginia Association of Personal Care Providers, The League of Social Services and other provider associations.
Boards and committees	Board of Medical Assistance Services (BMAS), Children's Health Insurance Advisory Committee (CHIPAC), Medicaid Member Advisory Committee (MAC), Medicaid Managed Care Advisory Committee, Pharmacy & Therapeutics (P&T), Pharmacy Liaison Committee, Drug Utilization Review Board, External Financial Review Council (EFRC), Medicaid Physician and Managed Care Liaison Committee (MPMCLC).

Major Products and Services

As permitted under federal law, the Virginia Medicaid program covers a broad range of services. There are two types of services – those required by federal law and those that are optional for the state. Virginia Medicaid covers all federally mandated services, including inpatient and outpatient and emergency hospital; physician and nurse midwife; clinic, laboratory and x-ray; transportation; family planning; nursing facility; home health; and the Early and Periodic Screening, Diagnosis, and Treatment program for children (EPSDT).

In addition to required services, Virginia Medicaid also covers several optional services, including certified pediatric nurse and family nurse practitioner services; dental care updates, primary care and behavioral health services for uninsured individuals with serious mental illness; prescription drugs; rehabilitation services either in or outside of the home (physical and occupational therapy, and speech language pathology services; hospice; certain mental health and substance abuse services; 12 months of postpartum coverage, and intermediate care facilities for individuals with developmental and intellectual disabilities and related conditions.

Medicaid members also receive coverage through home and community-based waiver programs. These waivers provide community-based long-term services and supports as an alternative to institutionalization.

The Commonwealth Coordinated Care Plus (CCC Plus) Waiver provides care and provides care through a variety of supports and services for successful living, including personal care, private duty nursing, respite care, adult day health services, assistive technology and environmental modifications. Virginia's three Developmental Disability Waivers (DDW) include Building Independence (BI) for individuals 18 and older, Family & Individual Support (FIS), and Community Living (CL). The DDW serves individuals with developmental disabilities, including intellectual disabilities and includes a wider array of services (approximately 32 individual services), such as congregate living, independent living and community integration options. The Program for All-Inclusive Care for the Elderly (PACE) provides an additional opportunity for members 55 and older to receive services in the community.

In addition, DMAS offers behavioral health services for adults and youth through nine behavioral health services that establish a comprehensive crisis system and strengthen community and facility-based services that serve as discharge and diversion options for inpatient hospitalization. In 2021, DMAS implemented an array of new behavioral health services for adults and youth through Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes). Project BRAVO includes nine new behavioral health services that establish a comprehensive crisis system and strengthen community and facility-based services that serve as discharge and diversion options for inpatient hospitalization. In 2022 Governor Younkin announced Virginia's new Right Help. Right Now, behavioral health plan to improve access to timely, effective, and community-based care to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families. Included in the RHRN Plan is the plan to redesign DMAS' youth and adult legacy services and replace with evidence-based, trauma-informed services.

Performance Highlights

DMAS continuously strives to make the Medicaid and FAMIS programs even more cost-effective and quality-focused. DMAS has been working to eliminate disparities in its system, especially when it comes to maternal and infant health and behavioral health. Virginia Medicaid has implemented several new maternal health initiatives over the past few years, and DMAS is now focused on 1) innovation in policies and 2) upholding

infrastructure.

Additionally, in the Behavioral Health space, following the DMAS-DBHDS BRAVO Phase 1 implementation, DMAS was authorized in the 2024 Appropriation Act to redesign DMAS' youth and adult legacy services and replace with evidence-based, trauma-informed services.

DMAS is committed to improving health outcomes for our maternal and child health population. DMAS works with managed care organizations, provider associations and other stakeholders through Baby Steps to disseminate best practices in the field. Nationally, DMAS was the third state to implement 12 months postpartum coverage and fourth state to cover doulas.

Selected Measures

Measure ID	Measure	Alternative Name	Esitmated Trend
602.0023	Number of emergency department visits for members participating in BRAVO services		Improving
602.0029	Number of health deliveries (Baby Steps VA)		Improving
602.0031	Percentage of children and adolescents receiving well-care visits		Improving
602.0028	Percentage of deliveries of live births that has a postpartum visit 7-84 days after delivery		Improving

Agency Goals

- **DMAS Goal 1: Medicaid Enrollment - Monitoring Enrollment and Understanding Potential Population Trends Post-Unwinding**

  Summary and Alignment

  During the unwinding from the COVID 19 Public Health Emergency (PHE), DMAS monitored enrollment trends as it does every year. Enrollment was much higher than forecasted for FY24 for several reasons: 1) while all members had their redetermination initiated timely, the final determination for those not automatically renewed through the automated ex parte process was reliant on a local worker (or Cover Virginia) to process the renewal form, and not all local agencies were able to do so within the targeted timeline due to workforce issues and increased caseloads; 2) the state was enrolling approximately 20k new members every month which was higher than previously forecasted; and 3) changes initiated during the PHE and updated CMS guidance provided during unwinding resulted in more individuals remaining enrolled. While the unwinding was an unprecedented event to forecast, there were lessons learned to ensure programmatic changes are shared and impacts to the forecast identified sooner in the process. In addition, the unknown factor of new enrollments could greatly impact forecasting, especially during Open Enrollment of Virginia's new State Based Exchange (SBE), the Virginia Insurance Marketplace (VIM) Monitoring enrollment aligns with several Objectives and Key Results (OKRs), namely the percent of enrollees re-determined. However, enrollment drives all other OKRs as enrollment will lead to services utilized (related OKRs include increased % of utilization for pregnant/postpartum individuals) and managed care placement (related OKRs include residential treatment services and managed care procurement). Monitoring the enrollment numbers and make up also helps determine if there are sufficient resources to handle the caseloads and initial enrollment/maintenance work required for eligibility. With an understanding of what the population looks like now, this can drive communication and training of Cover Virginia and the local DSS agencies (related OKR is the reduction of payment errors found in eligibility audits). The same applies to agency measures, however the most impactful areas of enrollment are budget forecasting, utilization and automation.

  Objectives

  » **Monitor Enrollment to Understand Potential Population Trends Post-Unwinding**

  Description

  While the unwinding was an unprecedented event to forecast, there were lessons learned to ensure programmatic changes are shared and impacts to the forecast identified sooner in the process. Monitoring strategies will include: Understanding population post-unwinding; monthly reporting; and process automation.

  Objective Strategies

  • Understanding Population Post-Unwinding: In the summer of 2024, the department contracted with a third-party consultant to provide population analytics on the current Medicaid population in Virginia post-unwinding. The goal of the study is to better understand the key drivers of enrollment in the current environment to identify potential future trends and determine how to forecast enrollment over the next few years.

  • Monthly Reporting: Teams will receive not only prospective data on monthly redeterminations, but also information on current backlogs. The unwinding focused on cases with renewals March 2020 through February 2023 due to the months where redeterminations were paused, however redeterminations are an ongoing annual process for all members and a backlog is to be expected to be continued due to the need of additional verifications and/or the size of caseloads and the complexity of some members' eligibility. Per federal guidance, before closing eligibility, the individual must be evaluated for all other types of coverage. This means individuals may need a more involved evaluation especially if they were not previously subject to a resource test. Also, DMAS will work with the SBE to ensure their projections for account transfers (Ats) for Medicaid/CHIP eligibility through determinations and referrals are shared as soon as available so the forecast can take this into account, especially during Open Enrollment as this occurs directly after the forecast is provided.

  • Process Automation: Increased use of automated processes ensures accurate processing and can relieve staff to work on more

complicated/involved cases. Removing manual processes will add efficiencies and help mitigate the number of potential determinations in the backlog.

Measures

- Successful Ex parte and system automations

- **DMAS Goal 2: Behavioral Health**

Summary and Alignment

Redesigning behavioral health services in Medicaid is just one component of a larger vision shared by Virginians, the General Assembly, the Youngkin Administration, and a number of prior administrations: to keep Virginians well and thriving in their communities, to ensure the right help is available at the right time, that no Virginian is turned away in a time of crisis and to shift our system's focus on restrictive, high acuity services to a more recovery and wellness oriented system of care that provides earlier inter rehabilitative, and long-term recovery supports. Redesigned services will emphasize earlier access to care and recovery orientation, updates to align with the managed care service delivery system, evidence-based and trauma-informed interventions, and alignment with behavioral health workforce initiatives such as new Department of Health Professions regulations for Qualified Mental Health Professionals (QMHP) and Behavioral Health Technicians. In addition to redesigning legacy rehabilitative services, DMAS plans to seek 1115 waiver authority to cover short term residential and inpatient mental health treatment in Institution for Mental Disease (IMD)s. DMAS created the ARTS benefit to address the opioid epidemic that is impacting thousands of Virginians every year through overdoses and fatalities. By implementing the ARTS benefit, DMAS expanded access to care through substantial increases in the supply and utilization of the number of addiction treatment providers and services for Medicaid members. While ARTS began with the goal of addressing the impacts of the opioid epidemic, it continues to evolve to expand and address the ongoing drug overdose death rates that remain at dangerous and unprecedented levels. For example, ARTS has recently expanded its Outpatient Based Opioid Treatment model to become an Outpatient Based Addiction Treatment model to allow the flexibility to address other substance use problems which require attention at the same level of care. Our goals currently address ongoing improvements to increase access and improve quality of the ARTS benefit.

Objectives

» Community Mental Health Rehabilitative Services

Description

Redesign Legacy Community Mental Health Rehabilitative Services

Objective Strategies

• Conduct rate study and develop policies and regulation for replacement services, including estimated utilization by July 2025

• Develop statewide level of care model and associated assessment, including data sharing with MCOs to ensure that services are appropriate and members needs are being met by services by July 2025

• Implement new service array and new assessment/level of care model to replace intensive in home, therapeutic day treatment, mental health skill building, psychosocial rehabilitation, and targeted case management by July 2026 through fee-for-service and managed care delivery system.

Measures

- Number of legacy services with a budget neutral plan for a replacement array

» 1115 Waiver

Description

Seek 1115 waiver authority for short term residential and inpatient mental health treatment in IMDs

Objective Strategies

• Engage contractor to support development of initial application to CMS and submit initial 1115 application to CMS by January 2025.

• Develop scope of work for development of all required plans and strategies to implement 1115 SMI waiver to include detailed implementation plan, health IT plan, and evaluation plan; procure contractor and complete scope of work by May 2025 (pending budget authority in Session 2025.

• Upon approval of initial application and development of all required materials, submit all required materials to CMS to begin Federal Financial Participation (FFP) for services under waiver authority

Measures

- Number of stakeholder input surveys and interviews completed to inform design of redesigned services.

» ARTS Benefit

Description

Enhance Access and Quality of Substance Use Disorder services (Addiction Recovery and Treatment Services- (ARTS Benefit)

Objective Strategies

• Receive CMS approval for 5 additional years of waiver authority for ARTS services implemented under current 1115 waiver.

• Implement discharge bridge program funded by Opioid Abatement Authority to include technical assistance statewide in 2025 and hospital incentive funding for startup programs in 2026.

• Transition credentialing and quality oversight of Office Based Addiction Treatment (OBAT) to health plans.

• Update ARTS benefit and collaborate with DBHDS on service regulations to align with newly released ASAM 4th edition criteria.

Measures

- Initiation (Init) and Engagement (Eng) in Treatment for Members with Substance Use Disorders

- **DMAS Goal 3: Financial and Fiscal Stability**

Summary and Alignment

As a state agency that receives state and federal taxpayer dollars, it is imperative for DMAS to have strong financial stewardship of these dollars and robust internal controls to deter and detect fraud, waste and abuse. It is critical for the organization to maintain strict compliance with accepted financial standards to protect these resources. DMAS will continue to rigorously examine the way it operates to reduce waste and prevent fraud and abuse. To assist in maintaining stakeholder trust, the organization will also continue to identify ways to increase its transparency.

Objectives

» Budget Forecast Accuracy

Description

DMAS will continuously evaluate its Medicaid programs to ensure that they are operating as efficiently and effectively as possible. To achieve this, DMAS will: maintain internal financial reporting to measure expenditures to budget and maintain an external dashboard on utilization of finances to support Medicaid.

Objective Strategies

• In addition to external dashboards available on the agency's website, the agency will continue to provide transparency in its forecast and rate-setting processes by holding meetings three times per year with staff from various legislative committees as well as the Joint Legislative Audit and Review Commission, the Department of Planning and Budget, and the Secretary of Health and Human Resources to review key policy changes.

• The agency will hold townhalls throughout the process of any rebasings of reimbursement rates to provide an opportunity for stakeholder input as well as townhalls on other rates changes for the upcoming state fiscal year.

• The Fiscal division incorporates separation of duties to protect against fraud. This includes segregation of duties across cash management, accounts receivable and accounts payable.

• The Third-Party Liability (TPL) unit of the Fiscal Division is responsible for ensuring that Medicaid is the payer of last resort and works to recoup claim payments that are paid by Medicaid if it is determined that a third-party insurer is responsible for covering the claim. TPL works with MCOs, insurance companies, the Office of the Attorney General (OAG) and attorneys to identify Medicaid members who receive a settlement from a third-party insurance provider for claims paid by Medicaid.

• Financial policies should include appropriate guidance on the use of fund balances to ensure the agency is appropriately spending down available funding in the Virginia Health Care Fund when appropriate. The effective use of these funds will reduce the amount of General Fund dollars required to cover expenditures.

Measures

- Medical Loss Ratio for each MCO
- Percentage accuracy of agency budget forecast

- **DMAS Goal 4: Improve Managed Care Processes and Oversight of the Cardinal Care Program**

Summary and Alignment

In June 2021, the Virginia General Assembly mandated that DMAS combine the CCC Plus and Medallion 4.0 programs under a single contract. The strategy to combine the programs, as described in the Department's November 2020 Report to the General Assembly, included rebranding DMAS programs as Cardinal Care. DMAS rebranded its overall Medicaid and FAMIS programs Cardinal Care in 2023. Cardinal Care Managed Care (CCMC) is DMAS' comprehensive managed care program serving all populations previously enrolled in acute care (formerly Medallion 4.0) and MLTSS (formerly Commonwealth Coordinated Care Plus (CCC Plus)). The Cardinal Care program ensures an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, strengthens families, safeguards vulnerable citizens, ensures individuals become and remain self-sufficient and adds value for its providers and the Commonwealth. In August 2023, the Department released an RFP to procure a best-in-class managed care delivery system that advances the Commonwealth's priorities to improve the health and wellbeing of Cardinal Care members. Selected Contractors will arrange for the provision of services for

over 1.8 million eligible managed care members statewide. This procurement also seeks to arrange the provision of services for children and youth in the child welfare system into one consolidated health plan.

Objectives

» Best-In-Class Managed Care Delivery System

Description

Create a best-in-class, statewide Medicaid and FAMIS managed care delivery system providing a full range of acute care, behavioral health care, and long-term services and supports (LTSS) for all eligible populations.

Objective Strategies

• Administer a statewide coordinated managed care delivery system that focuses on innovations and efficiencies that add value to the Commonwealth by improving quality, access, and health outcomes for Medicaid and FAMIS members enrolled in the Cardinal Care Managed Care (CCMC) program.

• Implement and assign CCMC members in foster care to the Foster Care Specialty Plan, which will provide care and services targeted to meet their unique physical and behavioral health needs. The Foster Care Specialty Plan will also be available to serve eligible CCMC members in Adoption Assistance and members formerly in foster care.

• Work collaboratively with MCOs and other Health and Human Resources (HHR) Agencies in Virginia, including but not limited to the Department of Social Services (DSS), and the Department of Behavioral Health and Developmental Services (DBHDS).

• Advance the Commonwealth's priorities such as improving behavioral health and population health outcomes.

• Provide member-centered holistic care that meaningfully engages and addresses unique needs of all members.

• Enhance availability and accessibility of care across all care settings.

• Enable participants utilizing LTSS to live in their setting of choice and promote their well-being and quality of life.

• Leverage new technologies, payment models, and best practices for accountability and impact.

Measures

- Improve compliance, oversight, and strengthen program integrity.
- Improve provider experience and engagement
- Percent of members receiving Breast cancer screenings
- Robust and responsive care management and enhanced member engagement

- **DMAS Goal 5: Improve maternal and child health outcomes**

Summary and Alignment

The Department of Medical Assistance Services (DMAS) is committed to providing access to comprehensive care for pregnant and postpartum women, as well as care for infants and children. To achieve this, DMAS developed a cross- divisional team to support program initiatives and advance maternal and child health outcomes.

Objectives

» Aligning programmatic areas towards shared strategies

Description

Utilize newly developed cross- divisional team to support shared program initiatives and advance maternal and child health outcomes.

Objective Strategies

• Increase access to high quality prenatal and postpartum services.

• Improve birth outcomes for members and their newborns.

• Ensure pregnant and postpartum members with high-risk health conditions, including behavioral health and substance use disorders receive evidence-based interventions and care coordination to reduce mortality and morbidity.

• Increase access and utilization of high-quality preventative health services for children.

Measures

- Childhood immunization status- combination 3
- Percent of newborns with low birth weight (<2,500)

- Percentage of children and adolescents receiving well-care visits
- Percentage of deliveries of live births that has a postpartum visit 12 months after delivery

- **DMAS Goal 6: Compliance with State and Federal Requirements**

Summary and Alignment

The Centers for Medicare and Medicaid Services (CMS) finalized several major multi-faceted regulatory measures in 2024. These final rules, in combination with Medicaid provisions in the federal Consolidated Appropriations Act of 2023 (CAA 2023), will require significant planning and implementation efforts and will impact the agency's programs and operations throughout the current biennium and beyond. The rules are aimed at increasing transparency and accountability, standardizing data and monitoring, streamlining processes and creating opportunities for states to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care, across both fee-for-service and managed care delivery systems. Key reforms related to Medicaid Home and Community Based Services (HCBS) include requirements for home care rate transparency and payment adequacy, strengthened standards for person-centered service plans; and updated procedures for monitoring access to care, quality of care, critical safety incidents and beneficiary grievances. Major requirements related to access, payments, quality, and oversight include monitoring enrollee access to care, enhancing transparency and standardization of provider payment data, requirements related to state-directed payments, calculation of medical loss ratios, and managed care quality standards. Compliance with these sweeping provisions will affect all DMAS divisions and will require a cross-agency approach with sustained efforts over the coming years, with new requirements and standards related to federal data reporting and monitoring, stakeholder engagement and transparency, payment processes, language and disability access, and oversight of quality and access. DMAS also considers timely delivery of all required state legislative reports a priority, and we are including a measure below to ensure accountability for these agency deliverables to the General Assembly.

Objectives

» Compliance with CMS Final Rules

Description

The CMS Final Rules will require significant planning and implementation efforts and will impact the agency's programs and operations throughout the current biennium and beyond. Compliance with these sweeping provisions will affect all DMAS divisions and will require a cross-agency approach with sustained efforts over the coming years

Objective Strategies

• DMAS will form cross-agency project management teams to ensure the agency meets all required compliance dates within the current biennium—and are on track to achieve compliance by future effective dates —for the following federal regulations: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule ("Eligibility Rule" - April 2024) Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule ("Managed Care Rule" - April 2024) Ensuring Access to Medicaid Services Final Rule ("Access Rule" - May 2024) Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance (Section 504) Nondiscrimination in Health Programs and Activities (Section 1557) Nondiscrimination on the Basis of Disability; Accessibility of Web Information and Services of State and Local Government Entities

• DMAS will collaborate with the Department of Corrections, local and regional jails, and the Department of Juvenile Justice to implement the necessary changes to eligibility, operations, and delivery systems to meet the Consolidated Appropriations Act of 2023 requirement to provide certain screening, diagnostic, and targeted case management services to Medicaid-eligible justice-involved youth.

• DMAS will continue to meet all requirements related to 12-month continuous eligibility for Medicaid and CHIP/FAMIS children, as mandated by the Consolidated Appropriations Act of 2023.

Measures

- 100% compliance with all federal regulatory requirements regarding Medicaid Advisory Committee and Beneficiary Advisory Council by July 9, 2025

» Timely Report Delivery

Description

DMAS also considers timely delivery of all required state legislative reports a priority, and we are including a measure below to ensure accountability for these agency deliverables to the General Assembly.

Objective Strategies

• Submit all required General Assembly reports for fiscal years 2024-2026 to the Secretary of Health and Human Resources by the mandated deadlines.

Measures

- Report submission by mandated deadlines

- **DMAS Goal 7: Improve Operational Processes and Procedures to Reduce Risk While Increasing Performance and Results.**

Summary and Alignment

DMAS is committed to enhancing the current business functions & streamlining operations to ensure continuity, and each workforce member

have the tools necessary to be successful in their positions. Effective and Efficient business functions directly impact the agency's operations and ability to improve the services being provided to Virginia Medicaid members. Operational risk management includes, but not limited to: • Review agency internal processes and re-align resources within the Agency to meet the needs of daily operations, special projects and agency implementations. • Greater focus on identifying, assessing and mitigating operational and programmatic risks to the Agency's continuity and ability to provide adequate services to the Medicaid population. • Strengthening agency branding and mission awareness via communications on the Agency's website, newsletters and social media platforms.

Objectives

» Enhance current business functions & efficient Agency Operations

Description

Enhance current business functions & efficient Agency Operations by aligning adequate workforce resources with essential business functions and ensuring documentation of agency-wide Standard Operating Procedures (SOPs)

Objective Strategies

• Aligning adequate workforce resources with essential business functions increases the Agency's ability to improve the health and well-being of Virginians through access to high-quality health care coverage and services. DMAS is committed to further streamlining current business functions and operations across the agency to promote transparency, collaboration, and cross training. This initiative will include continued automation of manual documents, increased agency trainings, a greater focus on succession planning, continued enhancements to the continuity of operations plans and business impact analysis, including any additional impacts on essential business functions.

• Agency-wide Standard Operating Procedures (SOPs) ensures DMAS has documented every operational function and corresponding procedure across all levels and divisions within the Agency. Standardized documented processes and procedures ensure consistency in daily routine operations, strengthens our overall organizational efficiency, and impacts succession planning and resource allocation. To date, over 660 business functions and 170 SOPs across 30 divisions and specialized areas have been identified across the agency. The Agency will continue to lead this effort, and utilize data collected to identify areas of improvements related to business continuity, succession planning, and resource allocation

Measures

- Increase the percentage of retaining classified critical workforce members to 95% in FY25 and 97% in FY26.
- Increase the percentage of Workforce Professional Development by 20% in FY25 and 25% in FY26.

» Strengthen agency branding, mission awareness via communications

Description

DMAS is committed to clearly communicating agency programs and services, changes to policies, program news and priorities. Ensuring that the agency presents "one voice" across all communication materials to members, providers and stakeholders, improving member, provider, and external stakeholder communications through innovative communication tactics will enable members to make informed decisions about their health care. Improving internal communications with timely and relevant news will help improve job performance and fosters a more connected workforce and increased connection to Medicaid members.

Objective Strategies

• This initiative will include a greater use of email, text, newsletters, consistent updated agency website and social media content for members, providers, external stakeholders, and DMAS workforce members. Whether through a press release, fact sheet, flyer, or agency website/social media update, the agency's goal is to focus on ensuring clearer pathways for members to find the right information they need to make the best decisions about their healthcare coverage and services.

• DMAS has begun revamping the website, external stakeholder newsletters, and social media platforms to ensure it is considered one of the best-in-class sources for members, providers, advocacy groups, and external stakeholders to find key benefit and services information. DMAS has reviewed other State Medicaid Agencies and Commonwealth Sister Agencies websites to get a feel of what ours can look like and also incorporated feedback from Subject Matter Experts within the Cardinal Care Program and within the Agency.

Measures

» Ensure we identify, assess, analyze and control threats to the DMAS Agency via Risk Management

Description

Operational Risk Management includes the overall functionality, compliance and security, detection and response to Federal and State Audits and data protection. DMAS continues to be dedicated to updated Internal Audit Plans to strengthen our ability to detect risks prior to Federal and State Audit Findings, and also to improve threat detection responses, and the operational functionality of our current systems that are vital to our Medicaid Program. DMAS has an exceptionally challenging technology ecosystem with the management and governance of more than 30 sensitive systems internally as well as third parties such as Vendors. To that end, and to meet the SEC530 requirements DMAS seeks to gain greater structure, urgency, and accountability for Security Program related activities. To do so, the Agency will implement a three-prong strategy.

Objective Strategies

• First, to lower the cost and increase the security capabilities by migrating key platforms and environment to the Cloud Infrastructure.

• Second, increase governance of SEC530 and COV Ramp oversight and remediation.

• Third, establish an overarching data governance capability to cover data architecture, data use agreements, and other data acquisition and reporting needs both for the proper protection of sensitive data and to open the possibility of new data products to benefit the Commonwealth. In addition, this data governance would provide oversight of emerging AI controls, including evaluation of how data is being used as an input and how AI data outputs could be used to benefit the Commonwealth. These initiatives will help the Agency successfully navigate a highly sensitive security environment which maintains the personal health information of our members and providers amidst a constantly evolving line of defense.

Measures

- Decrease the percentage of Overdue Security/System VITA Findings by 10% in FY25 and 15% in FY26.
- Decrease the percentage of unresolved State Audit Findings resulting in points by 20% in FY25 and 25% in FY26.

Supporting Documents

Title	File Type

Reimbursements for Medical Services Related to Involuntary Mental Commitments [32107]

Description of this Program / Service Area

An Involuntary Mental Commitment, also known as a Temporary Detention Order (TDO), is the detainment of an individual who (a) has been determined to be mentally ill and in need of hospitalization, (b) presents an imminent danger to self or others as a result of the mental illness or is so seriously mentally ill as to be substantially unable to care for self, and (c) is incapable of volunteering or unwilling to volunteer for treatment. A magistrate issues the TDO. The duration of the order shall not exceed 72 hours prior to a commitment hearing. If the 72-hour period terminates on a Saturday, Sunday, or legal holiday, such persons may be detained until the next business day.

DMAS ensures that all other available payment resources, including Medicaid, have been exhausted prior to payment by this program, which is funded only through state funds. DMAS determines the allowable eligibility period for the client who is under an involuntary mental commitment and enrolls the client in the involuntary mental commitment program. Once this is completed, DMAS processes and adjudicates claims for the allowable services provided to clients under an involuntary mental commitment.

Mission Alignment and Authority

Va. Code 37.2-809

This service area is in line with DMAS' mission to provide access to a comprehensive system of high quality and cost-effective health care services to qualifying Virginians. By ensuring that appropriate services are provided to eligible persons, DMAS provides access to needed care for this population of clients.

Products and Services

Description of Major Products and Services

Operations (Enrollment & Member Services) – Determination of the involuntary mental commitment eligibility and enrollment for providers and clients

Operations (Provider Enrollment, Services and Reimbursement) – Determination of the per diem rate of reimbursement for all services provided
Operations (Health Care Services) – Coverage for involuntary mental commitment services

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Reimbursements for Medical Services Related to Involuntary Mental Commitments	Va. Code 37.2-809	2024 Appropriation Act Item 286	Required	12,787,539	0

Anticipated Changes

No significant changes are anticipated for this program.

Factors Impacting

Although the TDO fund covers payment for Medicaid and non-Medicaid members, involuntary commitment numbers for Medicaid members are expected to decrease over time with the addition of BRAVO services (including crisis, team-based care models, and intensive clinic services) and the Right Help. Right Now. plan.

The number of clients placed under an involuntary mental commitment may be affected by efforts change and improve services through Right Help, Right Now.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	12,787,539	0	14,373,976	0

Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan [44602]

Description of this Program / Service Area

The Family Access to Medical Insurance Security (FAMIS) program is Virginia's Title XXI Children's Health Insurance Program (CHIP) for uninsured children living below 200% of the federal poverty level (FPL). FAMIS provides access to comprehensive health care services for qualifying children through a managed care benefit plan modeled on the previous state-employee health plan, Key Advantage; and through a Medicaid "lookalike" benefit plan for fee-for-service enrollees.

DMAS also operates the FAMIS MOMS program for uninsured pregnant women living below 200% FPL, as well as FAMIS Select, a small premium assistance program for FAMIS-eligible children who have access to employer-sponsored health insurance through a family member

Mission Alignment and Authority

Va. Code 32.1-351

FAMIS provides access to a comprehensive system of high quality and cost-effective health care services to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private health insurance. This coverage is also now available to children of eligible low-income state employees.

Products and Services

Description of Major Products and Services

Coverage of comprehensive health care services through managed care or fee-for-service delivery models.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan	Title XXI of the Social Security Act and Va. Code 32.1, Chap. 13	42 CFR, Part 457; 2024 Appropriation Act Item 287	Required	11,654,289	276,849,876

Anticipated Changes

Congress passed an extension of federal CHIP funding in 2018, first through federal fiscal year (FFY) 2023 in the HEALTHY KIDS Act, which was incorporated into the January 22, 2018 continuing resolution, and for an additional four years, through FFY 2027, in the Bipartisan Budget Act of 2018. The Consolidated Appropriations Act of 2023 further extended federal CHIP funding through FFY 2029.

Factors Impacting

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through FAMIS. Unlike Medicaid, CHIP is not an entitlement program.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	119,654,289	276,849,876	127,487,135	291,452,666
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

CHIP Health Services Initiatives for Family Access to Medical Insurance Security Medical Services [44636]

Description of this Program / Service Area

A CHIP Health Services Initiative (HSI) funds a subset of the fee-for-service (FFS) medical costs for the FAMIS Prenatal program, authorized under the federal CHIP From-Conception-to-End-of-Pregnancy (FCEP) option for coverage of the mother in cases where the infant when born will be a U.S. citizen eligible for Medicaid or FAMIS.

Mission Alignment and Authority

Va. Code 32.1-351

FAMIS provides access to comprehensive, high quality, and cost-effective health care services to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private health insurance. Pursuant to Item 287.H, of the 2024 Appropriation Act under the federal CHIP From-Conception-to-End-of-Pregnancy (FCEP) option, FAMIS includes health coverage for the mother if, upon birth, the child will be a U.S. citizen eligible for Medicaid or FAMIS.

Products and Services

Description of Major Products and Services

Subset of the fee-for-service (FFS) medical costs for the FAMIS Prenatal program

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
CHIP Health Services Initiatives for Family Access to Medical Insurance Security Medical Services	Title XXI of the Social Security Act and Va. Code 32.1, Chap. 13	2024 Appropriation Act Item 287	Discretionary	175,724	338,840

Anticipated Changes

Congress passed an extension of federal CHIP funding in 2018, first through federal fiscal year (FFY) 2023 in the HEALTHY KIDS Act, which was incorporated into the January 22, 2018 continuing resolution, and for an additional four years, through FFY 2027, in the Bipartisan Budget Act of 2018. The Consolidated Appropriations Act of 2023 further extended federal CHIP funding through FFY 2029.

Factors Impacting

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through FAMIS. Unlike Medicaid, CHIP is not an entitlement program.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	175,724	338,840	182,576	352,054
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

Payments for Graduate Medical Education Residencies [45606]

Description of this Program / Service Area

$5,850,000 the first year and $5,850,000 the second year from the general fund and $5,850,000 the first year and $5,850,000 the second year from non-general funds shall be used for supplemental payments to fund graduate medical education for 3 residents who began their residencies in July 2021; 19 residents who began their residencies in July 2022; 30 residents who began their residencies in July 2024.

Mission Alignment and Authority

32.1, Chapters 9-10, VA Code

By providing supplemental payments for graduate medical education residencies, DMAS promotes access to a comprehensive system of high quality and cost-effective health care services to our customers.

Products and Services

Description of Major Products and Services

The supplemental payment for each qualifying residency slot shall be $100,000 annually minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose number of residency slots are above the cap set by the Centers for Medicare and Medicaid Services or have exceeded the Upper Payment Limit (UPL) set by CMS, the supplemental payments for each qualifying residency slot shall be $50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible. Supplemental payments shall be made for up to four years for each qualifying resident.

The Department of Medical Assistance Service, in cooperation with the Virginia Health Workforce Development Authority, shall determine which new residency slots to fund based on priorities developed by the authority. Preference shall be given for residency slots located in underserved areas. Applications for slots that involve multiple medical care providers collaborating in training residents and that involve providing residents the opportunity to train in underserved areas are encouraged. A majority of the new residency slots funded each year shall be for primary care. The department shall adopt criteria for primary care, high need specialties and underserved areas as developed by the Virginia Health Workforce Development Authority. The department shall also review and consider applications from non-hospital sponsoring institutions, such as Federally Qualified Health Centers (FQHCs).

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Payments for Graduate Medical Education Residencies	Title 32.1, Chapter 9 and 10, Code of Virginia	2024 Appropriation Act, Item 288.UU.; 12VAC30-70-281	Discretionary	5,850,000	5,850,000

Anticipated Changes

No significant changes are anticipated for this program.

Factors Impacting

Workforce shortages in specific specialties and subfields of the medical profession may result in those areas being prioritized during the review of applications, depending on funding availability and any specific guidance set by the appropriation act.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	5,850,000	5,850,000	5,850,000	5,850,000
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities [45607]

Description of this Program / Service Area

This service area reimburses facilities owned and operated by the Department of Behavioral Health and Development Services (DBHDS) for medically necessary services provided to Medicaid eligible recipients residing in these facilities. Virginia's public mental health, intellectual disability and substance abuse services system is comprised of 16 state facilities and 40 locally run community services boards (CSBs). The CSBs and facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, intellectual disabilities, or substance use disorders. DMAS works in partnership with the DBHDS to ensure that services are medically necessary and provide the most appropriate setting, as well as that reimbursement rates are sufficient to help maintain the financial viability of these facilities.

Mission Alignment and Authority

Va. Code 32.1-326

DMAS is helping to ensure that a comprehensive system of high quality and cost-effective health services are provided to qualifying Virginians in DBHDS managed facilities, a vulnerable population, by processing and reimbursing all appropriate Medicaid funding available.

Products and Services

Description of Major Products and Services

Coverage of Mental Health, Intellectual and Developmental Disability Health Care Services

Prior Authorization

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities	Title 32.1, Chapters 9 and 10, Code of Virginia; P.L. 89-97, as amended, Title XIX, Social Security Act, Federal Code	2024 Appropriation Act Item 288	Required	28,964,751	30,204,343

Anticipated Changes

A settlement between Virginia and the U.S. Department of Justice, regarding compliance with the ADA and the Olmstead decision, requires that Virginia continue to focus on the needs of individuals with developmental disabilities and provide for appropriate services and slots to promote community integration. As community integration has increased, the ongoing census in state ICFs decreases so that now there are only 75 beds available at the state level. Privately owned ICFs will continue to develop and have heightened scrutiny to ensure that individuals are provided choice between community-based care and institutional care.

Factors Impacting

Federal regulations limit the types of individuals who are eligible to receive Medicaid coverage in Institutions for Mental Disease (IMD). Virginia's state mental health facilities qualify as IMDs. The Code of Federal Regulations (CFR) prohibits Medicaid from covering individuals between age 22 through age 64 while residing in an IMD. This does not apply to individuals diagnosed with Intellectual Disabilities. Total reimbursement to the facilities is limited by State appropriations.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???

Initial Appropriation for the Biennium	28,964,751	30,204,343	28,998,773	30,170,321
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Reimbursements for Medical Services [45609]

Description of this Program / Service Area

This service area represents expenditures associated with coverage of general medical services in the Title XIX Medicaid program. Services provided within this service area are within 'Base Medicaid'.

Mission Alignment and Authority

Va. Code 32.1-325

By providing coverage of general medical services, DMAS promotes access to a comprehensive system of high quality and cost-effective health care services to our customers.

Products and Services

Description of Major Products and Services

Coverage of general medical services includes inpatient and outpatient hospital services, physician and clinic services, prescribed drugs, lab and x-ray services, dental, transportation services, as well as many others. General medical services are provided through two delivery models – capitated managed care and fee-for-service.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Medical Services	Title XIX of the Social Security Act; Code of Virginia 32.1, Chapter 9	2024 Appropriation Act, Item 288	Required	5,275,412,035	7,860,491,209

Anticipated Changes

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided for general medical services in Base Medicaid.

Factors Impacting

The following factors will impact the services provided within this service area:

- Federal policy changes and Medicaid reform initiatives
- Health care cost inflation
- Managed care penetration by geographic area and population type
- Legislative initiatives/priorities
- Budgetary/resource restraints
- Growing emphasis on cost containment and program integrity

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	5,275,412,035	7,860,491,209	5,524,140,128	8,212,224,190
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

Reimbursements for Long-Term Care Services [45610]

Description of this Program / Service Area

Provide access to a system of high-quality facility and community-based long-term services and supports for seniors and persons with disabilities to ensure health, safety, and welfare.

Mission Alignment and Authority

Va. Code 32.1-325

By assisting seniors and persons with disabilities to obtain high-quality, cost-effective long-term services and supports in the least restrictive environment that meets their needs, the Commonwealth saves money over more costly and more restrictive placements.

Products and Services

Description of Major Products and Services

Coverage of Long-Term Care & Waiver Programs (Nursing facility care; Home and community-based services).

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Long Term Services and Supports	Title XIX of the Social Security Act and Va. Code 32.1, Chap. 9	42 CFR, Part 431; 2024 Appropriation Act Item 288	Required	0	0
Nursing Facility	Social Security Act Section 1902 and Va. Code 31.1-325	42 CFR, Part 483, Subpart B; 2024 Appropriation Act Item 288	Required	0	0
CCC Plus Waiver	§ 1915(c) waivers of the Social Security Act (42 USC § 1396n)	42 CFR § 441.300; 2024 Appropriation Act Item 288	Discretionary	0	0
DD Waivers	§ 1915(c) waivers of the Social Security Act (42 USC § 1396n)	42 CFR § 441.300; 2024 Appropriation Act Item 288	Discretionary	0	0
Program of All-Inclusive Care for the Elderly (PACE)	Social Security Act Section 1934 and Va Code 321-330.3	42 CFR, Part 460; 2024 Appropriation Act Item 288	Discretionary	0	0

Anticipated Changes

Nursing Facility:

DMAS has a robust Civil Money Penalty Reinvestment Program. In SFY 2024, DMAS with CMS approval funded eleven programs. Implementation of Nursing Facility Quality Improvement program is planned for FY2025. Impacts of timeline and requirements of the new federal Nursing Facility minimum staffing requirements.

CCC Plus Waivers: DMAS will submit waiver amendments to CMS to permanently allow legally responsible individuals to be reimbursed to provider personal care services.

DD Waivers: DMAS will submit the waiver renewal in 2023 for one of the DDW DMAS will be finalizing the final compliance stages of the HCBS Final Rule requirements issued in 2013 in 2023. Submitted and approved. Home and Community Based Statewide Transition Plans still in place and slated to end by December 2025.

Factors Impacting

The Department's focus on care coordination across all areas of the Medicaid program will affect the delivery of long-term care services.

Brain Injury Waiver:

2022 Appropriation Act, Item #308 CC.1. CC.1. directed DMAS, in conjunction with relevant stakeholders, shall convene a workgroup to develop a plan for a neurobehavioral science unit and a waiver program for individuals with brain injury and neuro-cognitive disorders. Convened and

concluded with the implementation of the BIS TCM benefit in January 2024

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	1,243,200,097	1,320,179,152	1,363,048,283	1,439,025,842
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

Payments for Healthcare Coverage for Low-Income Uninsured Adults [45611]

Description of this Program / Service Area

This service area includes all services provided in Medicaid Expansion. In January 2019, Virginia expanded eligibility for the Medicaid program under the Patient Protection and Affordable Care Act to include caretaker adults and childless adults aged 19-64 with incomes up to 138% of the Federal Poverty Level.

Mission Alignment and Authority

Affordable Care Act of 2014

By providing coverage to an expanded population, DMAS promotes access to a comprehensive system of high-quality and cost-effective health care services to improve the health and well-being of Virginians.

Products and Services

Description of Major Products and Services

Most services provided to the Medicaid Expansion population in this service area are for general medical care; however, services also include behavioral health and long-term care services. Services are provided through the Fee-For-Service and Managed Care delivery systems.

The majority of services provided to the Medicaid Expansion population in this service area is general medical care, however services also include behavioral health and long-term care services. Services are provided through the Fee-For-Service and Managed Care delivery systems.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Payments for Healthcare Coverage for Low-Income Uninsured Adults	Affordable Care Act of 2014	2024 Appropriation Act Item 288	Discretionary	0	7,748,564,616

Anticipated Changes

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided for general medical services in Medicaid Expansion.

Factors Impacting

The following factors will impact the services provided within this service area:

- Federal policy changes and Medicaid reform initiatives
- Health care cost inflation
- Managed care penetration by geographic area and population type
- Legislative initiatives/priorities
- Budgetary/resource constraints
- Growing emphasis on cost containment and program integrity

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

The state receives 90% FMAP for medical services provided to the Medicaid Expansion population. The remaining 10% state share is covered through the Coverage Assessment paid by private acute care hospitals.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	0	7,748,564,616	0	8,476,559,388
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Insurance Premium Payments for HIV-Positive Individuals [46403]

Description of this Program / Service Area

This service area ensures that HIV clients can maintain their medication protocol. The program provides reimbursement for health insurance premium payments to ensure that those approved individuals can maintain and utilize their private health insurance. In order to qualify an individual must (1) be a resident of Virginia (2) be able to provide documentations from a physician verifying disability within three months due to HIV diagnosis; (3) have family income no greater than 250% of the federal poverty level; (4) have countable liquid assets no more than $10, 000; (4) not be eligible for Medicaid; and (5) be eligible for and have availability of continuing health insurance. DMAS staff determines eligibility for the program and assumes the responsibility of providing health insurance premium payment in a timely matter.

Mission Alignment and Authority

Va. Code 32.1-330.1

By providing financial assistance to health insurance premiums, the program enables eligible individuals to maintain maximum comprehensive health care benefits and deflect the expenses away from the Medicaid program. If these individuals do not maintain their private health insurance coverage, they will likely become Medicaid eligible due to the significant costs for HIV pharmacy products.

Products and Services

Description of Major Products and Services

Financial assistance for health insurance premiums

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Insurance Premium Payments for HIV-Positive Individuals	VA Code 32.1-330.1	2024 Appropriation Act Item 289	Required	556,702	0

Anticipated Changes

The Department does not anticipate any changes to the products and services.

Factors Impacting

The services provided by the HIV Unit are extremely important to eligible enrollees and is limited only by funding options. There has always been a waiting list. There is a growing need for insurance continuations for this population as the drug therapies improve. Complicating this situation is the fact that premiums for commercial insurance have been increasing yearly at double digit rates.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	556,702	0	556,702	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

Reimbursements from the Uninsured Medical Catastrophe Fund [46405]

Description of this Program / Service Area

This service area provides payment for medical services to eligible, uninsured Virginians diagnosed with a life-threatening medical catastrophe. Eligibility is based on income, legal residency in the Commonwealth of Virginia, life-threatening injury or illness and an approved treatment plan. Applications are taken on a first-come, first-served basis and funding is expended until appropriation is exhausted.

Mission Alignment and Authority

Va. Code 32.1-324.3

Individuals determined eligible for services under the program are provided access to life-saving health care services.

Products and Services

Description of Major Products and Services

Life-saving health care services based on Medicaid rates, eligibility determination, treatment plan approval, and determination of treatment plan costs.

Contract with providers for services approved on the treatment plan; verify services rendered and initiate payment to the provider.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Reimbursements from the Uninsured Medical Catastrophe Fund	Code of Virginia 32.1-324.3	2024 Appropriation Act Item 289	Required	225,000	40,000

Anticipated Changes

No significant changes are anticipated for this program.

Factors Impacting

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	225,000	40,000	225,000	40,000
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

Reimbursements for Medical Services Provided to Low-Income Children [46601]

Description of this Program / Service Area

The extension of Medicaid eligibility for children ages 6-19 and 100-133% of the federal poverty level (FPL) is part of Virginia's Title XXI Children's Health Insurance Program (CHIP). Prior to this CHIP-funded expansion of Medicaid eligibility, children under age 6 with family income up to 133% FPL could qualify for Medicaid benefits, but children from ages 6 to 19 would only qualify for Medicaid if their family income was less than or equal to 100% FPL. While children from ages 6 to 19 with income between 100-133% FPL might qualify for the FAMIS program instead, this meant that children in the same family would be enrolled in different programs and families would have to navigate two different systems of care.

Effective September 2002, children in Virginia's Title XXI program are split into two groups – Family Access to Medical Insurance Security (FAMIS) for uninsured children aged 0-19 with income above the cutoff for Medicaid but less than or equal to 200% FPL, and the CHIP Medicaid program for children age 6-19 with income from 100-133% FPL. Children covered by the CHIP Medicaid program receive full Medicaid benefits but are funded with the enhanced Title XXI match rate.

Mission Alignment and Authority

Va. Code 32.1-325

The CHIP Medicaid program carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children age 6 to 19 with income between 100% FPL and 133% FPL.

Products and Services

Description of Major Products and Services

Coverage for comprehensive health care services through managed care or fee-for-service delivery models.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Reimbursements for Medical Services Provided to Low-Income Children (46601)	Title 32.1, Chapters 9, 10 and 13, Code of Virginia; P.L. 89-97, as amended, Titles XIX and XXI, Social Security Act, Federal Code.	2024 Appropriation Act Item 290	Required	82,447,645	164,682,299

Anticipated Changes

Congress passed an extension of federal CHIP funding in 2018, first through federal fiscal year (FFY) 2023 in the HEALTHY KIDS Act, which was incorporated into the January 22, 2018 continuing resolution, and for an additional four years, through FFY 2027, in the Bipartisan Budget Act of 2018. The Consolidated Appropriations Act of 2023 further extended federal CHIP funding through FFY 2029.

Factors Impacting

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through the CHIP Medicaid Expansion.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	82,447,645	164,682,299	89,206,542	177,084,248
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Service Area Plan

Medicaid payments for enrollment and utilization related contracts [49601]

Description of this Program / Service Area

Amounts appropriated in this area shall fund administrative expenditures associated with contracts between the department and companies providing dental benefit services, consumer-directed payroll services, claims processing, behavioral health management services and disease state/chronic care programs for Medicaid recipients.

Mission Alignment and Authority

Title 32.1, Chapters 9 and 10

Contracts providing services such as dental benefits and claims processing are essential to the Medicaid program and creating a healthier Virginia.

Products and Services

Description of Major Products and Services

Administrative expenditures related to claims processing, behavioral health service authorization and dental benefits

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Medicaid payments for enrollment and utilization related contracts	Title 32.1, Chapters 9 and 10, Code of Virginia; P.L. 89-97, as amended, Titles XIX, Social Security Act, Federal Code.	2024 Appropriation Act Item 291	Required	12,706,041	32,130,279

Anticipated Changes

No significant changes are anticipated for this program

Factors Impacting

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	12,706,041	32,130,279	12,706,041	32,130,279
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

CHIP payments for enrollment and utilization related contracts [49632]

Description of this Program / Service Area

Amounts appropriated in this area shall fund administrative expenditures associated with contracts between the department and companies providing dental benefit services, consumer-directed payroll services, claims processing, behavioral health management services and disease state/chronic care programs for FAMIS recipients.

Mission Alignment and Authority

Contracts providing services such as dental benefits and claims processing are essential to the FAMIS program and creating a healthier Virginia.

Products and Services

Description of Major Products and Services

Administrative expenditures related to claims processing and dental benefits.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
CHIP payments for enrollment and utilization related contracts (49632)	Title 32.1, Chapters 9 and 10, Code of Virginia; P.L. 89-97, as amended, Titles XIX and XXI, Social Security Act, Federal Code. Chapter 2 Item 307	2024 Appropriation Act Item 291	Required	1,686,713	898,594

Anticipated Changes

No significant changes are anticipated for this program.

Factors Impacting

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	1,686,713	898,594	1,686,713	898,594
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

General Management and Direction [49901]

Description of this Program / Service Area

This service area includes the staffing, operations, administrative support, technology, policy and research and contractual services necessary to successfully operate the Agency's programs and activities.

Mission Alignment and Authority

Va. Code 32.1-325

By performing the functions within this service area, DMAS provides access to a comprehensive system of high-quality and cost-effective health care services to qualifying Virginians.

Products and Services

Description of Major Products and Services

Description of Major Products and Services

- Administration – Appeals, eligibility and enrollment, eligibility policy and outreach, and policy
- Chief Medical Office – pharmacy, medical support
- Complex Care Services – high needs support, behavioral health, integrated care and community living
- Financial Services – fiscal and accounting services, federal reporting, budget, provider rate development, and procurement and contract management
- Healthcare Analytics and Transformation – healthcare analytics, quality and population health, incentive coordination and economic research
- Human Capital and Development
- Information Security
- Innovation and Technology – Information management and project management
- Internal Audit
- Programs – health care services, program integrity, and program operations

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
General Management and Direction (49901)	Title 2.2, Chapter 26, Code of Virginia	2024 Appropriation Act Item 292	Required	74,547,220	223,931,195

Anticipated Changes

No significant changes are anticipated for this program.

Factors Impacting

The Department must remain flexible and adapt to new programs and priorities to maintain the quality and timeliness of all recipient services. Any changes to Medicaid programs or services, including updates to rates, services and eligibility, CMS Rules and other state and federal laws and regulations impact the workload of staff to operationalize these requirements. Sufficient funding and staffing resources are vital for the agency to maintain these services.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	74,547,220	223,931,195	79,595,737	252,574,131
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Administrative Support for the Family Access to Medical Insurance Security Plan [49932]

Description of this Program / Service Area

This service area includes expenditures associated with administration of Virginia's CHIP program, Family Access to Medical Insurance Security Plan (FAMIS).

Mission Alignment and Authority

Va. Code 32.1-351

Products and Services

Description of Major Products and Services

Administrative support funded under this item includes marketing and outreach services to promote enrollment.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
Administrative Support for the Family Access to Medical Insurance Security Plan	Title 2.2, Chapter 26, Code of Virginia	2024 Appropriation Act Item 292	Required	5,353,917	10,832,819

Anticipated Changes

Congress passed an extension of federal CHIP funding in 2018, first through federal fiscal year (FFY) 2023 in the HEALTHY KIDS Act, which was incorporated into the January 22, 2018 continuing resolution, and for an additional four years, through FFY 2027, in the Bipartisan Budget Act of 2018. The Consolidated Appropriations Act of 2023 further extended federal CHIP funding through FFY 2029.

Factors Impacting

Federal and state appropriations and regulations impact the nature and scope of what can be funded with CHIP administrative dollars and within the CHIP federal allotment.

CHIP administrative expenditures are subject to a 10% cap, meaning that up to 10% of a state's total CHIP spending can be used for CHIP state plan administrative expenses. (A state may also use up to 10 percent of its total CHIP spending for certain allowable activities such as outreach and HSIs, after it covers CHIP state plan administrative expenses.)

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	5,353,917	10,832,819	5,353,917	10,832,819
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

CHIP Health Services Initiatives [49936]

Description of this Program / Service Area

Provides funding for the three poison control centers serving Virginia as part of a CHIP Health Services Initiative to draw down enhanced federal matching dollars.

Mission Alignment and Authority

Va. Code 32.1-351

CHIP Health Services Initiatives (HSIs) are projects or programs funded with federal Title XXI dollars that improve the health of low-income children. Pursuant to Item 292.T of the 2024 Appropriation Act, Virginia's Poison Control HSI leverages federal funding at the enhanced CHIP match rate to provide funding for Virginia's three poison control centers.

Products and Services

Description of Major Products and Services

CHIP Health Services Initiative (HSI) provides funding for Virginia's three poison control centers.

Products / Services					
Product / Service	**Statutory Authority**	**Regulatory Authority**	**Required Or Discretionary**	**GF**	**NGF**
CHIP Health Services Initiatives	Section 2105(a)(1)(D)(ii) of the Social Security Act	2024 Appropriation Act Item 292	Discretionary	875,000	1,625,000

Anticipated Changes

Congress passed an extension of federal CHIP funding in 2018, first through federal fiscal year (FFY) 2023 in the HEALTHY KIDS Act, which was incorporated into the January 22, 2018 continuing resolution, and for an additional four years, through FFY 2027, in the Bipartisan Budget Act of 2018. The Consolidated Appropriations Act of 2023 further extended federal CHIP funding through FFY 2029.

Factors Impacting

Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through FAMIS. Unlike Medicaid, CHIP is not an entitlement program.

CHIP HSIs are funded out of the administrative portion of a state's CHIP allotment and are subject to the 10% CHIP administrative cap. A state may use up to 10 percent of its total CHIP spending for certain allowable activities such as outreach and HSIs, after it covers CHIP state plan administrative expenses.

Financial Overview

The initial appropriation in the table was established for the biennium budget included in the 2024 Appropriation Act.

Biennial Budget

	???	???	???	???
Initial Appropriation for the Biennium	875,000	1,625,000	875,000	1,625,000
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title **File Type**

Strategic Planning Measure Details

Agency Code	Agency Name	Measure Name	Measure Class	Measure Frequency	Preferred Trend	Measure Type	Year Type
602	Department of Medical Assistance Services	Successful Ex parte and system automations	Agency Key	Annually	Increase	Output	State FY
602	Department of Medical Assistance Services	Number of legacy services with a budget neutral plan for a replacement array	Agency Key	Annually	Increase	Output	State FY
602	Department of Medical Assistance Services	Number of stakeholder input surveys and interviews completed to inform design of redesigned services.	Agency Key	Annually	Increase	Output	State FY
602	Department of Medical Assistance Services	Initiation (Init) and Engagement (Eng) in Treatment for Members with Substance Use Disorders	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Percentage accuracy of agency budget forecast	Agency Key	Annually	Stable	Outcome	State FY
602	Department of Medical Assistance Services	Medical Loss Ratio for each MCO	Agency Key	Annually	Stable	Outcome	State FY
602	Department of Medical Assistance Services	Percent of members receiving Breast cancer screenings	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Robust and responsive care management and enhanced member engagement	Agency Key	Annually	Increase	Output	State FY
602	Department of Medical Assistance Services	Improve provider experience and engagement	Agency Key	Annually	Increase	Output	State FY
602	Department of Medical Assistance Services	Improve compliance, oversight, and strengthen program integrity.	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Percentage of deliveries of live births that has a postpartum visit 12 months after delivery	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Percentage of children and adolescents receiving well-care visits	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Childhood immunization status- combination 3	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Percent of newborns with low birth weight (<2,500)	Agency Key	Annually	Decrease	Outcome	State FY
602	Department of Medical Assistance Services	100% compliance with all federal regulatory requirements regarding Medicaid Advisory Committee and Beneficiary Advisory Council by July 9, 2025	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Report submission by mandated deadlines	Agency Key	Annually	Stable	Output	State FY
602	Department of Medical Assistance Services	Decrease the percentage of unresolved State Audit Findings resulting in points by 20% in FY25 and 25% in FY26.	Agency Key	Annually	Decrease	Output	State FY
602	Department of Medical Assistance Services	Decrease the percentage of Overdue Security/System VITA Findings by 10% in FY25 and 15% in FY26.	Agency Key	Annually	Decrease	Output	State FY
602	Department of Medical Assistance Services	Increase the percentage of retaining classified critical workforce members to 95% in FY25 and 97% in FY26.	Agency Key	Annually	Increase	Outcome	State FY
602	Department of Medical Assistance Services	Increase the percentage of Workforce Professional Development by 20% in FY25 and 25% in FY26.	Agency Key	Annually	Increase	Outcome	State FY

20 Rows