

# Joint Commission On Health Care

**Cheryl Roberts, J.D., DMAS Director**

**July 23, 2025**

# Agenda


① Cardinal Care Managed Care Update

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② Federal Policy Actions – One Big Beautiful Bill Act (OBBBA)

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# How We Care for Virginians



Cardinal Care  
Managed Care  
(CCMC) is DMAS's  
program name for  
the managed care  
delivery system.



Aetna Better Health® of Virginia



HealthKeepers Plus  
Offered by HealthKeepers, Inc.

Humana®



Sentara®  
Health Plans










United  
Healthcare

# Top Goals of Cardinal Care Managed Care program

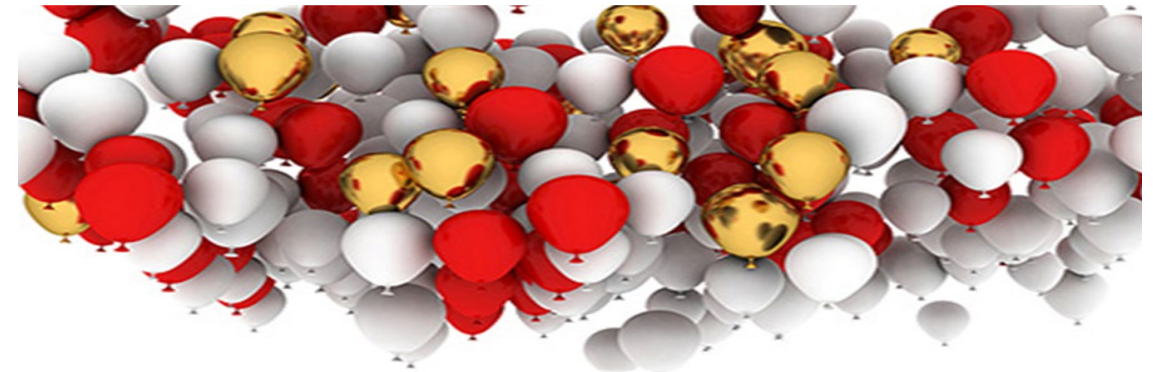


**At the heart of Virginia's Medicaid system, Cardinal Care Managed Care empowers a member-first approach – ensuring care is not only accessible, but personalized and connected.**

-  1 Ensure Medicaid members have appropriate access to quality health care through the contracted managed care plans
-  2 Focus on expanding behavioral health services and improving access as part of the *Right Help, Right Now* initiative
-  3 Improve maternal and child health outcomes through targeted initiatives across the Commonwealth
-  4 Provide children and youth in foster care with a dedicated health plan
-  5 Enhance access to appropriate services, supports and settings for members receiving Long Term Services and supports (LTSS)
-  6 Drive innovation and operational excellence with a focus on data analytics
-  7 Increase MCO reporting, compliance and oversight

# Cardinal Care Managed Care officially launched on July 1, 2025, marking a major step forward in Virginia's Medicaid program

- Transitioned 1.7 million members into the program
- Humana Healthy Horizons of Virginia is CCMC's new MCO
- Children and Youth in foster care are served in a single statewide Foster Care Specialty Plan (FCSP) through Anthem HealthKeepers Plus
- Members may change their health plan for any reason until September 30, 2025
- CCMC had a successful Communications and Outreach campaign for members and providers
- DMAS initiated new CCMC contracts and rates that included the July 1st General Assembly initiatives that were not vetoed



**CardinalCare**  
Virginia's Medicaid Program

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 **Humana**  
Healthy Horizons™

 **Sentara**  
Health Plans

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# Cardinal Care Managed Care

***Cardinal Care Managed Care serves as the platform for a more person-centered, innovative, efficient, and accountable Medicaid delivery system in Virginia***



# **Federal Policy Actions**

## **One Big Beautiful Bill Act(OBBBA)**



# One Big Beautiful Bill Act (OBBBA)

- H.R. 1, the One Big Beautiful Bill Act (OBBBA) was passed by Congress on July 3 and signed into law by the President on July 4, 2025
- OBBBA contains key Medicaid provisions including provider tax restrictions, community engagement requirements, and changes to state-directed payment limits
- Implementation of Medicaid provisions will be a collaboration with input from the Governor's Office, the General Assembly, and federal partners
- CMS implementation guidance will be forthcoming



# Subpart A Reducing Fraud and Improving Enrollment Process

## *Criteria for Expansion Only, and All Populations*

### ➡ **Frequency of Expansion Eligibility Redeterminations (Section 71107)**

- ▶ Effective January 1, 2027
- ▶ Requires a redetermination for Expansion enrolled individuals to occur every six months; currently redeterminations occur on an annual basis

### ➡ **Duplicate Enrollment & Deceased Individuals (Section 71104, 71105)**

- ▶ Effective January 1, 2027/January 1, 2028
- ▶ Requires states to obtain enrollee address information using reliable data sources
- ▶ Requires states to review the Death Master File quarterly to identify deceased individuals

### ➡ **Operational impacts to DMAS, state and local DSS agencies to include systems, staffing, and resources**

# Subpart A Reducing Fraud and Improving Enrollment Process

## *All Populations*

### ➡ **Immigrant Eligibility and Federal Match (Section 71109-77110)**

- ▶ Effective October 1, 2026
- ▶ Narrows the definition of qualified alien from current law
- ▶ Payments for services for an emergency medical condition furnished to an individual eligible for Expansion except for their citizenship status shall be limited to 50% federal match; currently 90%
- ▶ Operational impacts to systems and general fund impact due to match reduction

### ➡ **Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid (Section 71109-77110)**

- ▶ Effective October 1, 2029
- ▶ Pending CMS guidance, intent is to allow recoupment of erroneous payments beyond current Payment Error Rate Measure (PERM)
- ▶ Errors include payments made on behalf of ineligible individuals and when there is insufficient documentation to support eligibility
- ▶ The 3% error rate threshold applies to any audits conducted by the federal Secretary of Health and Human Services (HHS) and, at the Secretary's option, audits conducted by the state

# Subpart B Preventing Wasteful Spending

## *All Populations*

### ➡ **Retroactive Coverage (Section 71120)**

- ▶ Effective January 1, 2027
- ▶ Limits retroactive coverage to one month for Expansion and two months for all other individuals; current limits are three months for all populations except for CHIP/FAMIS
- ▶ Operational impacts to state and local DSS agencies to include systems, staffing and resources

### ➡ **Delay of Nursing Facility Final Rule (Section 71111)**

- ▶ Effective July 4, 2025
- ▶ May not implement prior to October 1, 2034
- ▶ No DMAS operational impacts

# Subpart C Stopping Abusive Financing Practices

## *Provider Taxes and State Directed Payments*

### ➡ **Provider Taxes** (Section 71115)

- ▶ Virginia will retain three existing provider taxes, moratorium on new ones
- ▶ Gradual decline but no impact to Medicaid Expansion
- ▶ No changes to tax rate will occur prior to July 1, 2027

### ➡ **State Directed Payments** (Section 71116)

- ▶ Payments above Medicare will be lowered to 100% of Medicare
- ▶ No changes will occur before July 1, 2028

# Subpart D Increasing Personal Accountability

## *Expansion Only*

### ➔ **Community Engagement and Work Requirements (Section 71119)**

- ▶ Effective December 31, 2026
- ▶ Requires individuals applying for or enrolled in Expansion to participate in a qualifying activity at least 80 hours per month to be eligible
- ▶ Qualifying activities: work, community service, education, or any combination of the above
- ▶ States must verify compliance at application for Medicaid and every six months thereafter
- ▶ Operational impact: systemic and administrative and outreach costs and resources

### **Exemptions (pending CMS guidance):**

- ▶ Pregnant/post-partum women, foster and former foster care, Tribe members, veterans with disabilities, medically frail (physical/intellectual/developmental disability), receipt of serious medical illness or substance use disorder treatment, meet SNAP/TANF work requirements, incarcerated or released within 90 days, individuals with serious mental conditions, primary care givers for children under age 13; short-term hardship exceptions allowed at the state level

# Subpart D Increasing Personal Accountability

## *Expansion Only*

### ➡ Cost Sharing

- ▶ Effective October 1, 2028
- ▶ *Requires cost sharing greater than zero for Expansion members with incomes above 100% of the Federal Poverty Level up to \$35 per service*
- ▶ Exceptions for: primary care, substance use disorder and mental health, services provided by FQHCs, rural and behavioral health clinics
- ▶ Subset of entire Medicaid population, will have additional operational impact

# Subchapter E Expanding Access to Care

## ➔ **Adjustments to Home or Community Based Services (Section 71121)**

- ▶ Effective July 1, 2028

- ▶ Creates a new standalone 1915(c) waiver that does not require participants to be subject to a determination that, but for the provision of home and community-based services (HCBS), those individuals would require nursing facility or ICF/IDD level of care

- ▶ To qualify, states must:

- ▶ Meet requirements for all other 1915(c) waivers and demonstrate the approval of the waiver will not increase average wait time to receive HCBS under any other approved waiver
- ▶ Attest to cost neutrality
- ▶ Agree to submit annual reports detailing the cost of services provided

- ▶ Payments may not be made under the waiver to third parties for benefits such as health insurance, skills training, and other benefits customary for employees



# Chapter 4 Protecting Rural Hospitals and Providers

## *Rural Health Transformation Program*

### ➡ Rural Health Transformation Program (Section 71401)

- ▶ Effective July 4, 2025
- ▶ Establishes a \$50 billion grant program (\$10 billion per fiscal year 2026-2030), no state match required to draw down funds
- ▶ 50% of funds distributed equally among all states
  - ▶ Virginia will receive \$100 million annually, equal to \$500 million over five years
- ▶ 50% of funds allotted based on three criteria:
  - ▶ Percentage of population that is rural
  - ▶ Proportion of rural health facilities in state relative to # of rural facilities nationwide
  - ▶ Situation of hospitals
- ▶ Virginia's one-time application detailing rural transformation plan to be approved or denied by CMS by December 31, 2025, makes state eligible for all funding years

# Chapter 4 Protecting Rural Hospitals and Providers

## *Rural Health Transformation Program (continued)*

### ➡ **Federal intent of new Rural Health Transformation Program:**

- ▶ Promote evidence-based interventions to improve prevention and chronic disease management
- ▶ Provide payments to health care providers for the provision of health care items or services
- ▶ Provide training and assistance to develop technology-enabled solutions to improve care in rural hospitals
- ▶ Recruit and retain clinical workforce talent in rural areas
- ▶ Aid with significant technology advances
- ▶ Assist rural communities to right size health care delivery systems
- ▶ Support access to opioid use disorder, substance use disorder and mental health services
- ▶ Develop projects that support innovative models of care

- ➡ Opportunity for Virginia to help in high priority areas such as rural hospitals and maternal health outcomes
- ➡ Due to short application timeline to receive funds, DMAS will engage a contractor to assist in the development of the state's transformation plan
- ➡ Operational impacts to be determined pending CMS guidance on administrator requirements

# Questions

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