CardinalCare
Virginia's Medicaid Program

Joint Subcommittee for Health and Human Resources Oversight

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July 15, 2025

DMAS

Agenda

① Cardinal Care Managed Care Update

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

How We Care for Virginians

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

aetna
Aetna Better Health® of Virginia

Anthem
HealthKeepers Plus
Offered by HealthKeepers, Inc.

Humana

Sentara
Health Plans

United Healthcare

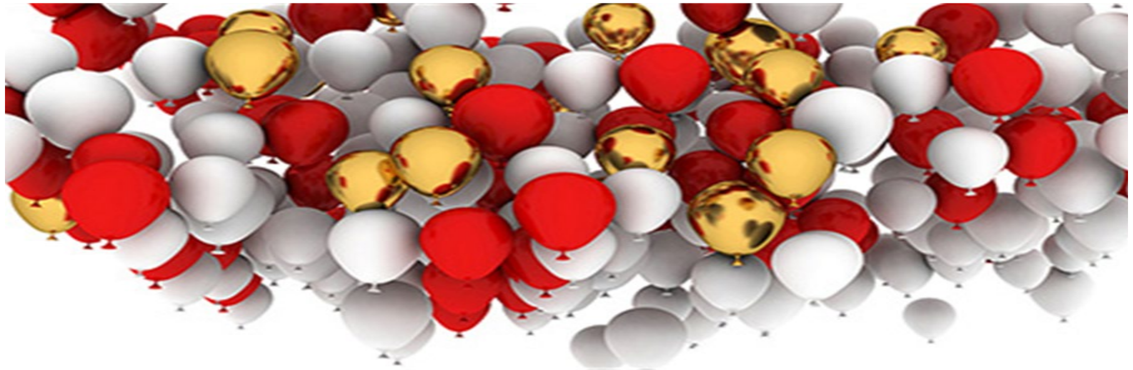
Top Goals of Cardinal Care Managed Care program

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 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



Cardinal Care Managed Care

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

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 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

Source: One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text

Subpart D Increasing Personal Accountability

Expansion Only

Cost Sharing

- Effective October 1, 2028
- *Requires cost sharing greater than zero for Expansion mem*bers 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

Source: One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text

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 one-time application detailing rural transformation plan to be approved or denied by CMS by December 31, 2025, make 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

Subpart C Stopping Abusive Financing Practices

Provider Taxes

- **No New Provider Taxes** (Section 71115)
  - Effective July 4, 2025

- **Provider Coverage Assessment Tax** (Section 71115)
  - Contributes $650 million annually to fund state share of Expansion cost
  - Taxed at 6% of net patient revenue for 63 private acute care hospitals
  - 0.5% step-down starts October 1, 2027, through September 30, 2032
  - No impact on ability to fund Expansion in Virginia
  - 2025 Appropriation Act Item 3-5.14

- **Intermediate Care Facility/Intellectual Disability Tax** (Section 71115)
  - Contributes $15 million annually to Virginia Health Care Fund
  - Tax rate retained at 6%, no reduction
  - 2025 Appropriation Act Item 288(Y)

Source: One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text

Subpart C Stopping Abusive Financing Practices

Provider Taxes

- **Provider Payment Rate Assessment Tax** (Section 71115)
  - Contributes $1 billion annually to fund state share of supplemental (fee-for-service) and state directed payments (MCOs)
  - Taxed at 6% of net patient revenue of all Virginia hospitals, except public, freestanding psych and rehab, children's, long-stay, and long-term acute hospitals
  - 0.5% annual step-down starts October 1, 2027, through September 30, 2032
  - Settles at 3.5% maximum allowable tax rate
  - Reduces state share funding for state directed payments
  - 2025 Appropriation Act Item 3-5.15

Source: One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text

Subpart C Stopping Abusive Financing Practices

State Directed Payments

- **New State Directed Payments** (Section 71116)
  - State Directed Payments (SDPs) only apply to MCOs
  - Supplemental Payments only apply to fee-for-service (e.g., new rules would not affect new VCU Dental Supplemental Payment, Item 288 (WWWWW))
  - Any New SDPs: capped at 100% of Medicare Rate

- **Existing State Directed Payments** (Section 71116)
  - 10% annual step-down to 100% of Medicare starts July 1, 2028
  - Beginning July 1, 2028, DMAS estimates loss of $26 billion over 14 years

Source: One Big Beautiful Bill Act of 2025, https://www.congress.gov/bill/119th-congress/house-bill/1/text

Subpart C Stopping Abusive Financing Practices

State Directed Payments

Fiscal Year	Private Acute Care Hospitals	VCU & UVA Physician	EVMS Physician	Chesapeake Regional Physician
FY25	4,537,015,620	243,573,724	13,368,793	757,253
FY26	4,763,866,401	255,752,410	14,037,233	795,116
FY27	5,002,059,721	268,540,031	14,739,094	834,871
FY28	5,252,162,707	281,967,032	15,476,049	876,615
FY29	4,963,293,758	266,458,845	14,624,866	828,401
FY30	4,690,312,602	251,803,609	13,820,499	782,839
FY31	4,432,345,408	237,954,410	13,060,371	739,783
FY32	4,188,566,411	224,866,918	12,342,051	699,095
FY33	3,958,195,258	212,499,237	11,663,238	699,095
FY34	3,740,494,519	200,811,779	11,511,616	699,095
FY35	3,534,767,321	189,767,131	11,511,616	699,095
FY36	3,340,355,118	179,329,939	11,511,616	699,095
FY37	3,156,635,586	169,466,793	11,511,616	699,095
FY38	3,156,635,586	160,146,119	11,511,616	699,095
FY39	3,156,635,586	151,338,082	11,511,616	699,095
FY40	3,156,635,586	143,014,488	11,511,616	699,095
FY41	3,156,635,586	135,148,691	11,511,616	699,095
FY42	3,156,635,586	130,553,636	11,511,616	699,095
Cumulative Reduction	**(24,804,009,420)**	**(1,294,378,772)**	**(15,833,653)**	**(456,342)**

Source: Virginia Department of Medical Assistance Services, Provider Rate Development Division

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Questions

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