

# Cardinal Care and Federal Action Updates

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June 18, 2025

# Agenda

① Cardinal Care update

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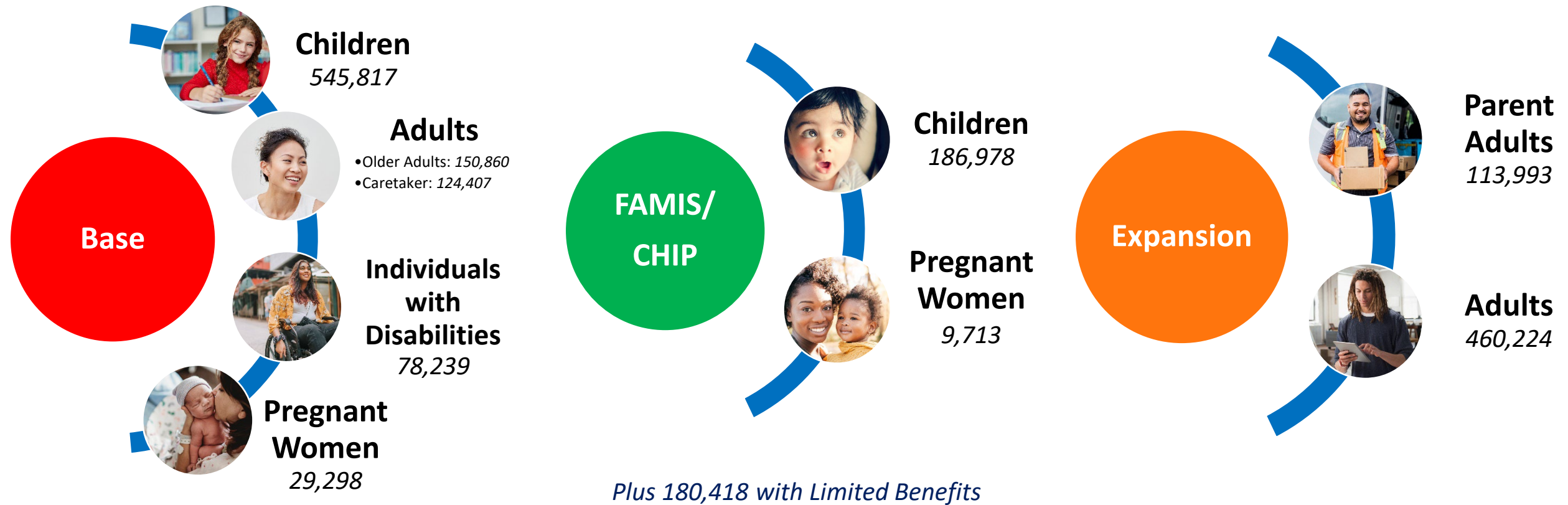
② Federal Policy Considerations

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# Who Do We Cover

June 1, 2025

1,879,947 Virginians



# How We Care for Virginians



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



Aetna Better Health® of Virginia



HealthKeepers Plus  
Offered by HealthKeepers, Inc.

Humana®



Sentara®  
Health Plans



United  
Healthcare

# Cardinal Care Managed Care is launching July 1, 2025

*DMAS is **improving** the Cardinal Care Managed Care (CCMC) program*



# Cardinal Care Managed Care July 1 , 2025

## What's Changing?

- ➔ Humana Healthy Horizons of Virginia is CCMC's new MCO
- ➔ Molina will no longer be available June 30
- ➔ Molina members will move to Humana
- ➔ Providers can begin contracting with Humana now



- ➔ Anthem HealthKeepers Plus will serve as a single statewide Foster Care Specialty Plan (FCSP) for children and youth in foster care, adoption assistance members, and individuals with former foster care eligibility

- ➔ Model of care – with a stronger focus on member centered care, with holistic and responsive care management and new plan program and initiatives
- ➔ Increased compliance and oversight

- ➔ New contracts and rates that include new General Assembly initiatives
- ➔ Total Cardinal Care Managed Care (CCMC) program FY26 capitation rates represent aggregate increase: 10.5%
- ➔ FY26 PMPM rates:
  - ▶ Acute and FAMIS: \$473
  - ▶ MLTSS: \$2,559

# Federal Policies in House & Senate OBBB Act of 2025

➡ *As of June 17:*

- ▶ 27 new proposed policies governing how Medicaid will be operated

Chamber	Identical	Look-Alike	Stand-Alone
House	8	17	2
Senate	8	17	2

- ▶ All proposals are pending until signed into law
- ▶ Focus on four provisions that have significant impact on Virginia Medicaid

# Federal Policies in House & Senate OBBB Act of 2025

Community & Work Engagement

Eligibility Changes

Coverage and Services Changes

Provider & Payment Changes



# Community & Work Engagement

## ➡ Mandate

- ▶ Adults in Expansion (age 19-64) must complete 80-hours each month of **(Identical)**
  - ▶ Work,
  - ▶ Community service,
  - ▶ Education, or
  - ▶ Any combination of the above
  - ▶ Starting December 31, 2026
- ▶ CMS must publish interim guidance by June 1, 2026 **(Senate only)**
- ▶ Prohibits conflict of interest for contractors involved in determining compliance **(Senate only)**

## ➡ Verification

- ▶ States must verify compliance at each eligibility decision, with at least one month of compliance required before applying and between re-checks **(Identical)**
- ▶ Secretary to issue interim guidance within six months **(Senate only)**

## ➡ Exemptions

- ▶ Pregnant women, foster and former foster youth through age 26, American Indian (AI)/Alaskan Native (AN), veterans with disabilities, blind individuals, medically frail, receipt of serious medical illness (SMI) or substance use disorder (SUD) treatment, meet SNAP/TANF work requirements, incarcerated individuals, serious or complex medical conditions, a disabling mental disorder, and primary care givers for children under age 14 Individuals **(Senate only)**
- ▶ Short-term hardship exceptions are allowed **(Senate only)**

# Eligibility Changes

## ➔ Standard

- ▶ States must conduct eligibility for Medicaid Expansion adults every six months starting December 31, 2026 (**Identical**)
- ▶ CMS required to publish Interim Guidance by June 1, 2026 (**Senate only**)
- ▶ Rescinds Eligibility Rule that CMS published July 2024 (**Identical**)
- ▶ Allows coverage of qualified aliens or mother/child lawfully residing (**Senate only**)

## ➔ Concurrent Enrollment

- ▶ Central data base—CMS will build a nationwide system to prevent dual enrollment across states, with monthly Social Security number reporting and quarterly death file checks by September 30, 2029 (**Identical**)

## ➔ Retroactive Coverage

- ▶ Retroactive coverage in Medicaid and CHIP is reduced from three months to one month for Expansion adults and from three months to two months for all other populations (**Senate only**)
- ▶ Starting December 31, 2026 (**Identical**)

# Other Changes

## ➔ State Funding

- ▶ Reduces federal funding for Medicaid Expansion adults by 10% if state offers full Medicaid to certain non-citizens (even if 100% state funded) (**Identical**)
- ▶ Starting October 1, 2026 (**Identical**)

## ➔ Copays

- ▶ Medicaid expansion adults with incomes above 100% FPL may have copays up to \$35 per service (capped at 5% of family income) (**Identical**)
- ▶ Starting October 1, 2028; essential care remains free (**Identical**)

## ➔ Gender Dysphoria Transition

- ▶ Medicaid and CHIP cannot cover gender transition procedures (**Identical**)

## ➔ Provider Screening

- ▶ States must verify quarterly that providers have not been terminated from Medicare, Medicaid, or CHIP in any state, starting in January 1, 2028 (**Identical**)

## ➔ New Rule Rescission

- ▶ Nursing Facility Rule (**Identical**)
- ▶ Streamlined Eligibility and Medicare Savings Plans (**Identical**)

## ➔ Pharmacy Dispensing Fees

- ▶ Managed care plan admin dispensing fees must match fee for service (**Identical**)

# Provider Taxes

- ➡ Prohibits *any* new Medicaid provider taxes, effective upon enactment
- ➡ Prohibits increasing existing Medicaid provider taxes by either:
  - ▶ Raising the tax rate, or
  - ▶ Expanding the base of the tax

# Hold Harmless Arrangements

- ➡ What is a “hold harmless” arrangement?
  - ▶ A taxed provider cannot be *guaranteed* to get back what they paid in taxes through higher Medicaid payments
- ➡ CMS allows states to tax up to 6% of provider base to demonstrate compliance
- ➡ Virginia taxes hospitals and intermediate care facilities at 6% of net patient revenue
- ➡ Senate (no House corollary) proposes a declining percentage for Expansion states only:
  - ▶ Beginning October 1, 2025: ↓ 5.5%, with ↓ 0.5% drop each year down to **3.5%** in 2031
  - ▶ Will reduce supplemental payments to 63 private acute and 8 critical access hospitals

# State Directed Payments to MCOs

Proposal	House	Senate
<b>Cap existing state directed payment</b> 110% of Medicare for non-Expansion states 100% of Medicare for Expansion states	Enactment date	Enactment date
<b>Grandfather existing state directed payments</b> Allows current amount, regardless of Medicare cap, if <i>submitted before OBBA enactment</i>	Enactment date	<i>No equivalent</i>
<b>Grandfather existing state directed payments</b> Beginning January 1, 2027, must reduce by 10% every year until rate equal to Medicare, if <i>submitted before May 1, 2025</i>	<i>No equivalent</i>	Enactment date

# Directed and Supplemental Payments Support Medicaid Providers to Increase Reimbursement

FY24 Supplemental and Directed Payments Type	Total Payments
Enhanced Supp Payment - Primary Acute Care Hospitals for Expansion (63 hospitals)	2,810,557,330
Indirect and Graduate Medical Education, Disproportionate Share Hospital (85 hospitals)	201,583,612
Physician MCO (VCU, UVA, EVMS)	159,383,385
Non-State Government Owned Hospitals (Chesapeake Regional, Norfolk Lake Taylor)	68,967,867
State Government Owned Nursing Facilities (VCU, Dept. of Veterans Svcs)	19,344,820
Physician Fee-for-Service (CHKD, DC Children's National, VCU, UVA, EVMS)	10,941,572
Non-State Government Owned Nursing Facilities (Five locally owned)	3,899,123
Graduate Medical Education High-Needs Specialty Slots (46 slots)	3,450,000
Physician Non-State Government Owned Hospitals (Chesapeake Regional)	572,026
Non-State Government Owned Clinics (Community Service Boards)	92,499
<b>Total Supplemental Payments</b>	<b>\$3,278,792,236</b>

- ➡ Supplemental and Directed Payments directly fund Virginia Medicaid providers to increase reimbursement

# Questions

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