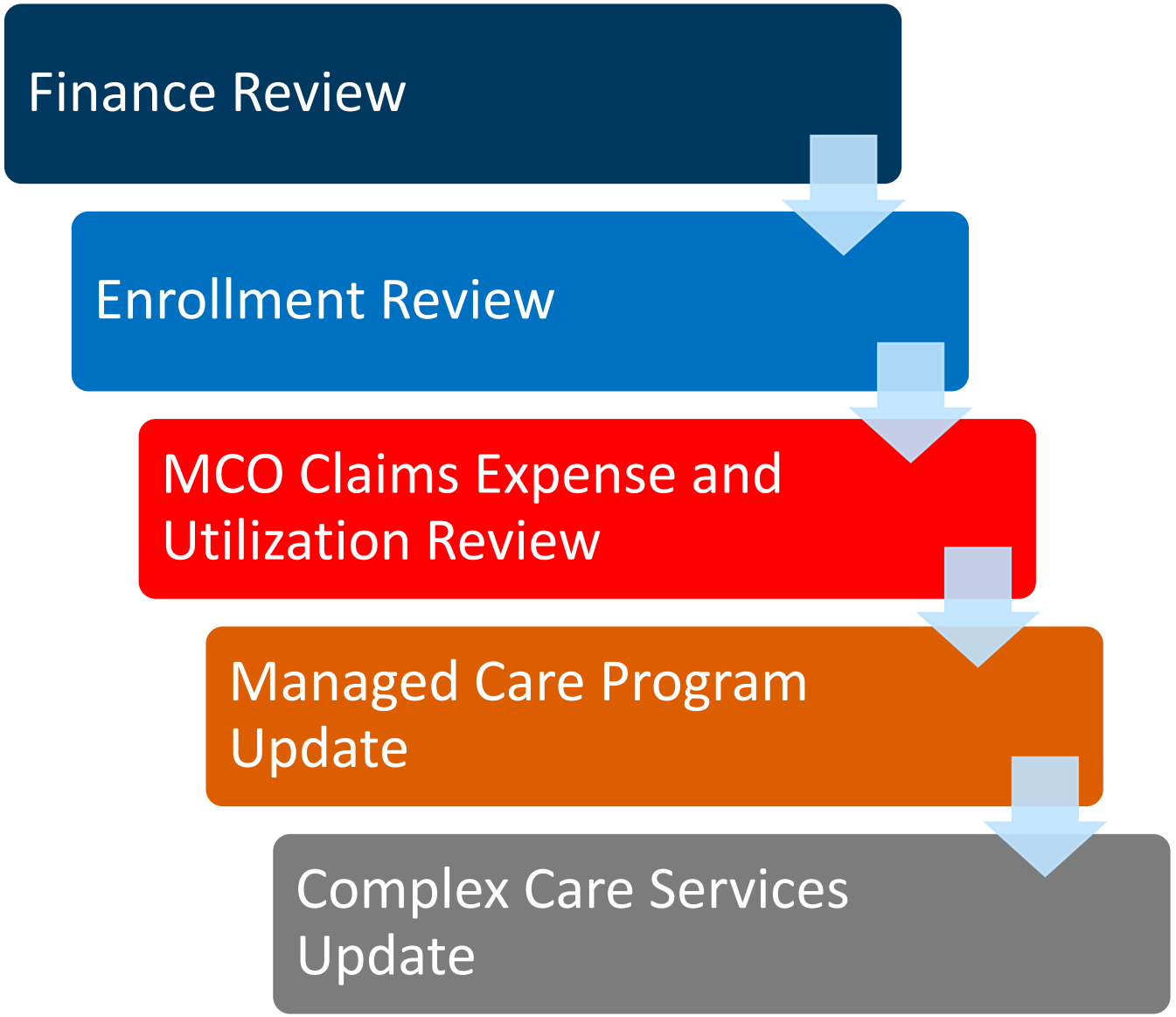
CardinalCare
Virginia's Medicaid Program

External Finance Review Committee (EFRC) Meeting

October 23, 2024

DMAS

Agenda


Finance Review
Enrollment Review
MCO Claims Expense and Utilization Review
Managed Care Program Update
Complex Care Services Update

EFRC Meeting Requirements
Chapter 2 of the 2024 Appropriation Act

Item 292.B.4. The Department of Medical Assistance Services shall convene a meeting three times each fiscal year with the Secretary of Finance, Secretary of Health and Human Resources, or their designees, and appropriate staff from the Department of Planning and Budget, House Appropriations and Senate Finance and Appropriations Committees, and Joint Legislative Audit and Review Commission to explain any material differences in expenditures compared to the official Medicaid forecast, adjusted to reflect budget actions from each General Assembly Session. The main purpose of each meeting shall be to review and discuss the most recent Medicaid expenditures to determine the program's financial status. At each meeting, the department shall report on enrollment trends by eligibility category and indicate differences in actual enrollment as compared to the most recent forecast of enrollment. If necessary, the department shall provide options to bring expenditures in line with available resources. At each meeting, the department shall provide an update on any changes to the managed care programs, or contracts with managed care organizations, that includes detailed information and analysis on any such changes that may have an impact on the capitation rates or overall fiscal impact of the programs, including changes that may result in savings. In addition, the department shall report on utilization and other trends in the managed care programs. During each fiscal year, the meetings shall be held in April, July, and October of each year to review the time period since the last meeting.

CardinalCare
Virginia's Medicaid Program

Finance Review

Truman Horwitz, Budget Division Director

DMAS

Overview

- Five-Year Expenditure comparison
- Forecast to actual for FY 2025
- MCO financials

Expenditure Comparison
In Millions

Five Year Look-back (Through September)

	Actuals through September					FY24 vs. FY25	
Expenditures	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**Change**	**% Change**
Cardinal Acute	1,185.3	1,412.3	1,668.4	1,753.3	1,948.0	195	11.1%
Cardinal LTSS	1,455.2	1,608.8	1,793.0	1,950.1	2,491.1	541	27.7%
Fee-For-service: General Medicaid	361.1	397.1	490.0	508.5	734.6	226	44.5%
Fee-For-service: BH & Rehabilitative	14.3	22.9	12.7	15.0	15.4	0	2.6%
Fee-For-service: Long-Term Care Services	383.1	405.0	555.0	601.4	729.7	128	21.3%
Hospital Supplemental (DSH, IME/GME, Dx)	91.0	240.6	212.8	101.0	213.1	112	110.9%
Hospital Rate Assessment Payments	291.4	410.4	509.5	632.5	1,082.4	450	71.1%
Pharmacy Rebates	(244.3)	(150.6)	7.1	(0.1)	(0.1)	(0)	138.2%
Title XIX Total	**3,537.2**	**4,346.6**	**5,248.5**	**5,561.8**	**7,214.1**	**1,652**	**29.7%**
Fund Type							
General	953.8	1,069.4	1,284.4	1,584.8	2,126.5	542	34.2%
Coverage Assessment	87.6	111.4	141.9	174.6	164.5	(10)	-5.8%
Rate Assessment	81.9	109.6	135.8	179.6	285.1	106	58.8%
VA Health Care Fund	100.0	195.8	215.0	0.0	125.1	125	276963.9%
Federal	2,313.9	2,860.3	3,471.4	3,622.8	4,512.8	890	24.6%
Total	**3,537.2**	**4,346.6**	**5,248.5**	**5,561.8**	**7,214.1**	**1,652**	**29.7%**

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October capitation payments for Base Medicaid accelerated into September before FMAP changed on October 1. This saved approximately $1.2m in GF.

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This reflects the increase in **IP/OP rates**, the growth in **tribal spending**, and **Medicare Premiums** that were carried into FY25 during the FY24 year-end spend-down.

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Utilization of new **DD Waiver slots** added and rate increases over the last several years, as well as Nursing Facility **rebasing,** and an increase in FFS bed days due to **churn**.

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Reflects the **Supplemental Payments** that were carried into FY25 during the FY24 spend-down.

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Decreasing Medicaid Expansion population leads to higher rate assessment payments. Additionally, retroactive adjustments in the first payment resulted in a higher than normal payment.

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Current Year **Pharmacy Rebates** do not typically appear until January – what you are seeing here are administrative adjustments.

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Medicaid Expansion enrollment down from Sept 2023.

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Decrease in the coverage assessment leads to an increase in the rate assessment, driven by a decrease in the **Medicaid Expansion** population.

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Total	**3,537.2**	**4,346.6**	**5,248.5**	**5,561.8**	**7,214.1**	**1,652**	**29.7%**

This is mostly a product of timing of when revenues are received and reclassified into the fund.

Expenditure Comparison – Another way to Look at the Data

In Millions

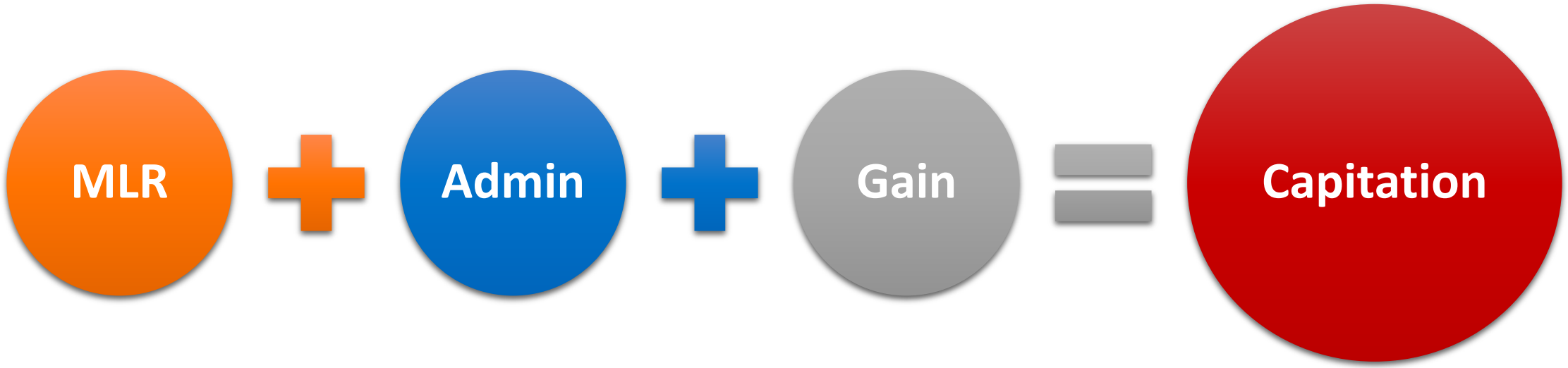
FY 2025 Compared Against the Forecast

Expenditures	YTD FY 2025	YTD Forecast	Variance
Cardinal Acute	1,948.0	1,673.0	16.4%
Cardinal LTSS	2,491.1	1,995.6	24.8%
Fee-For-service: General Medicaid	734.6	504.1	45.7%
Fee-For-service: BH & Rehabilitative	15.4	11.1	39.0%
Fee-For-service: Long-Term Care Services	729.7	647.1	12.8%
Hospital Supplemental (DSH, IME/GME, Dx)	213.1	284.7	-25.2%
Hospital Rate Assessment Payments	1,082.4	829.1	30.6%
Pharmacy Rebates	(0.1)	7.0	-101.8%
Title XIX Total	**7,214.1**	**5,951.7**	**21.2%**
Fund Type			
General	2,126.5	1,636.4	29.9%
Coverage Assessment	164.5	156.5	5.1%
Rate Assessment	285.1	260.7	9.4%
VA Health Care Fund	125.1	112.9	10.8%
Federal	4,512.8	3,785.2	19.2%
Total	**7,214.1**	**5,951.7**	**21.2%**

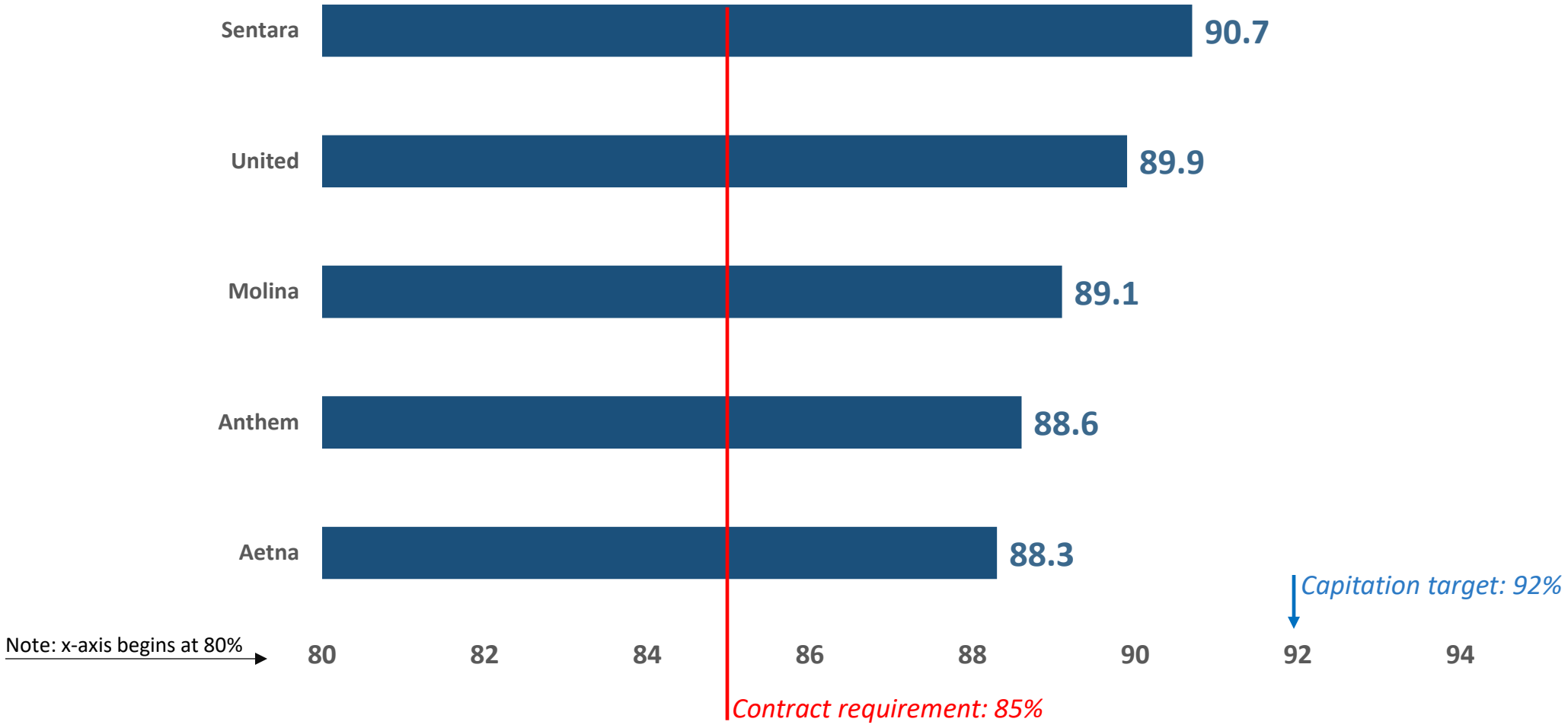
FY25 is trending higher than Forecast, the major drivers being:

1. Supplemental Payments and Medicare Premiums carried-over into FY25 due to slower Unwinding.
2. Acceleration of the October capitation payment into September to take advantage of a favorable FMAP.
3. The forecast, produced a year ago, would not also capture the impact of GA actions (such as rate increases) or the impact of rebasings (NF and Hospital).

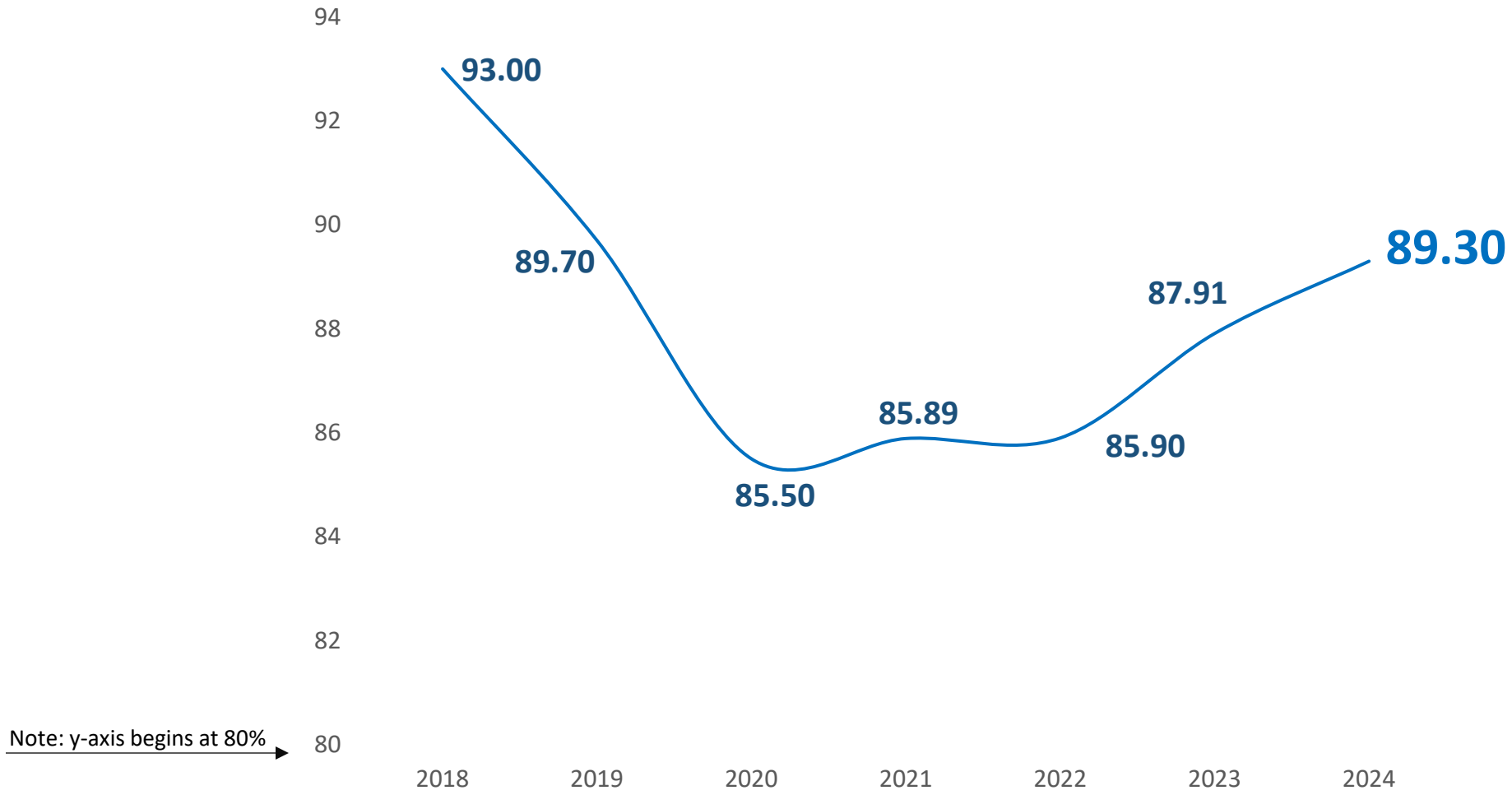
FY24 MCO Financials



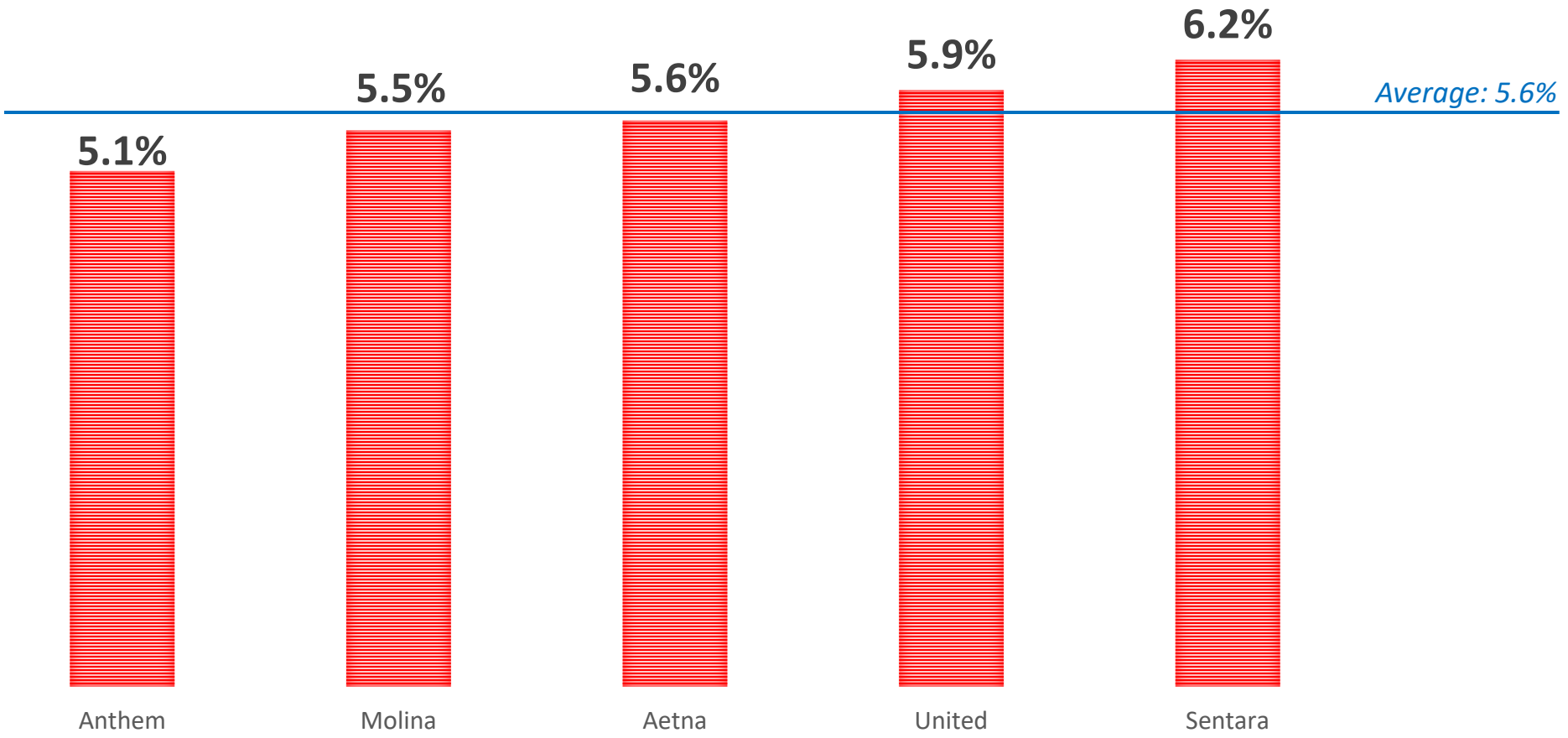
FY24 MCO Financials: Medical Loss Ratio



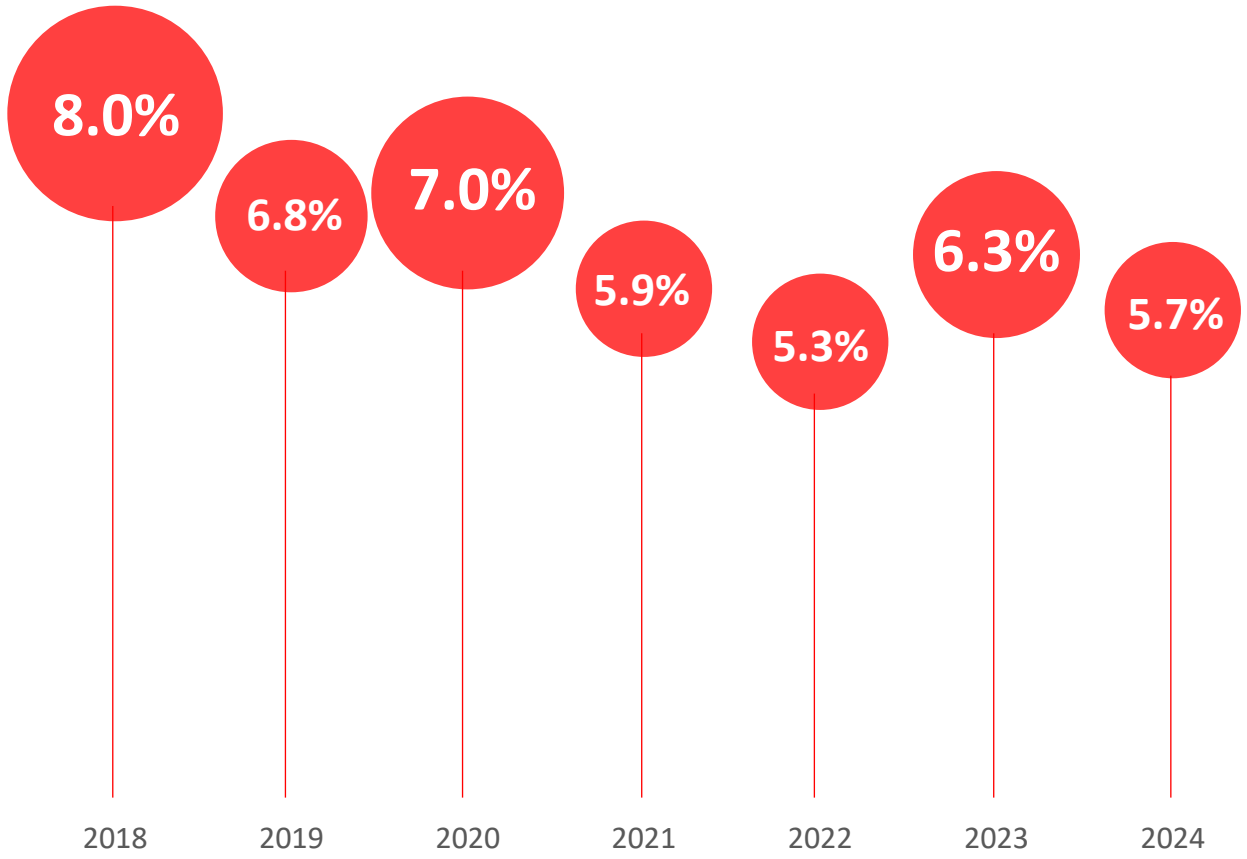
FY18-24 MCO Financials: Medical Loss Ratio



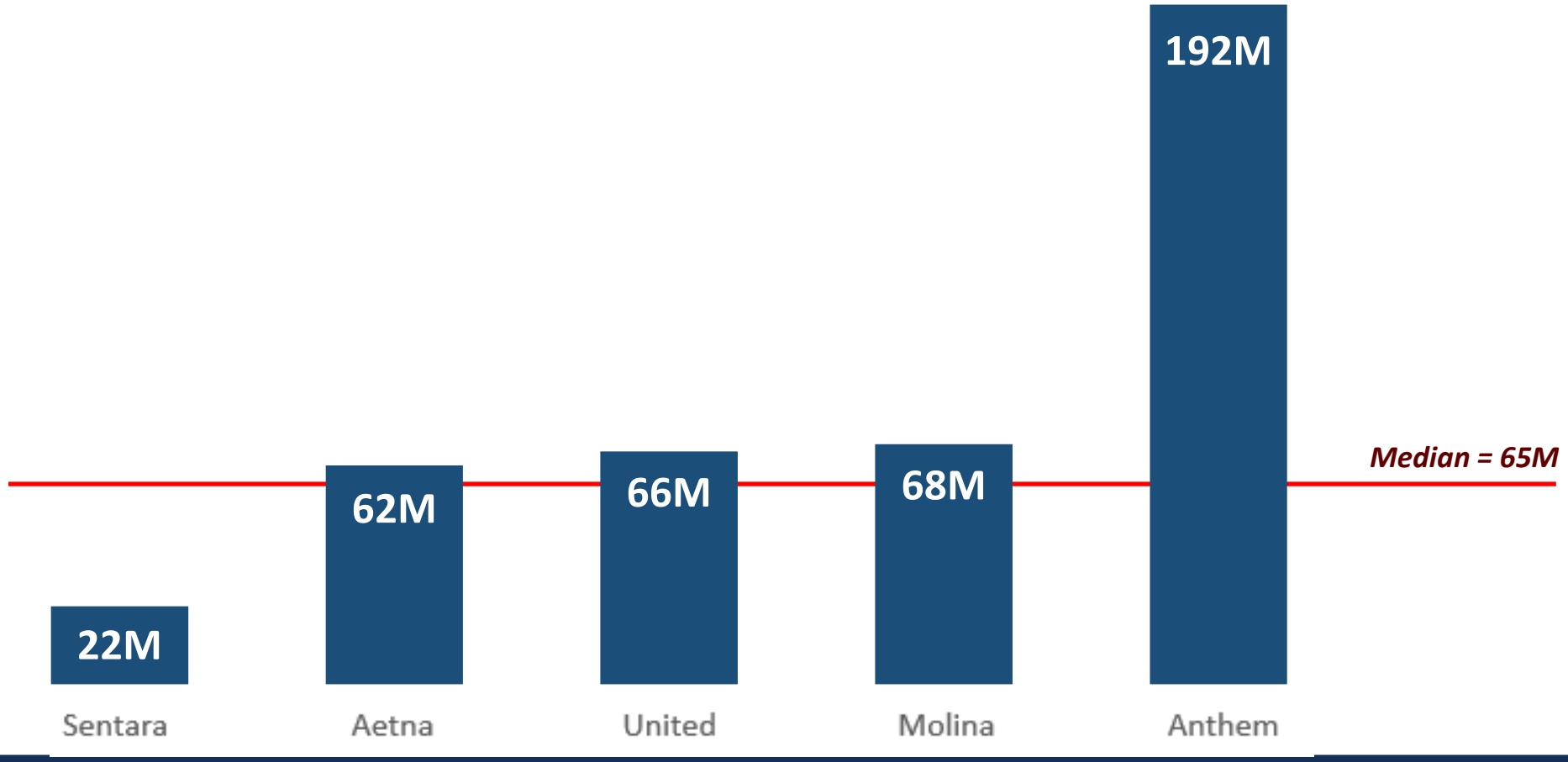
FY24 MCO Financials: Admin Expense Ratio



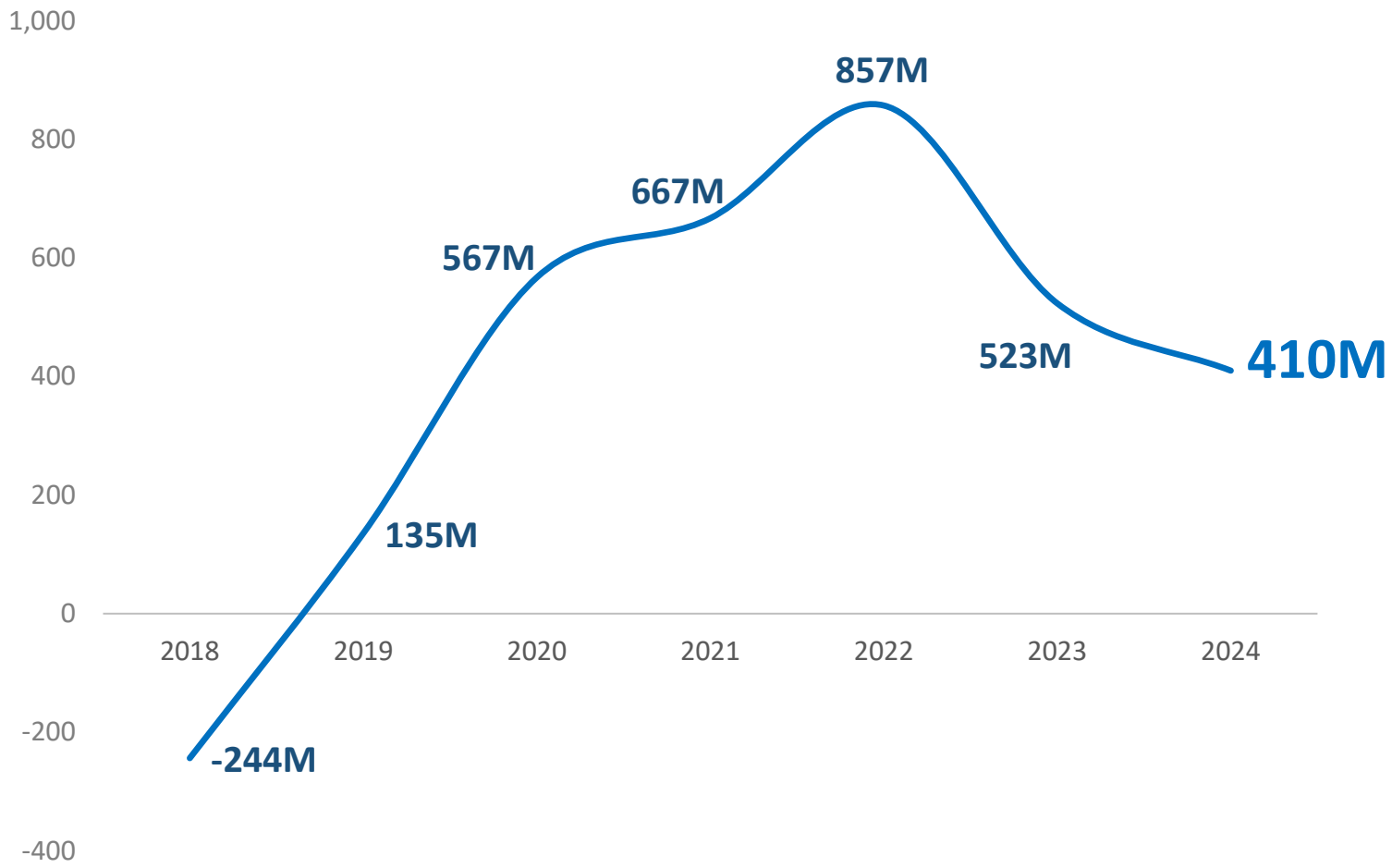
FY18-24 MCO Financials: Admin Expense Ratio



FY24 MCO Financials: Net Gain



FY18-24 MCO Financials: Net Gain



Summary

- Financial data shows a variance from forecast due to slower unwinding/the knock-on effects of the actions taken in FY24.
- This will influence the Forecast and the ultimate need outlined in the Budget Process.

CardinalCare
Virginia's Medicaid Program

Enrollment Review

Sarah Hatton, Deputy for Administration & Coverage

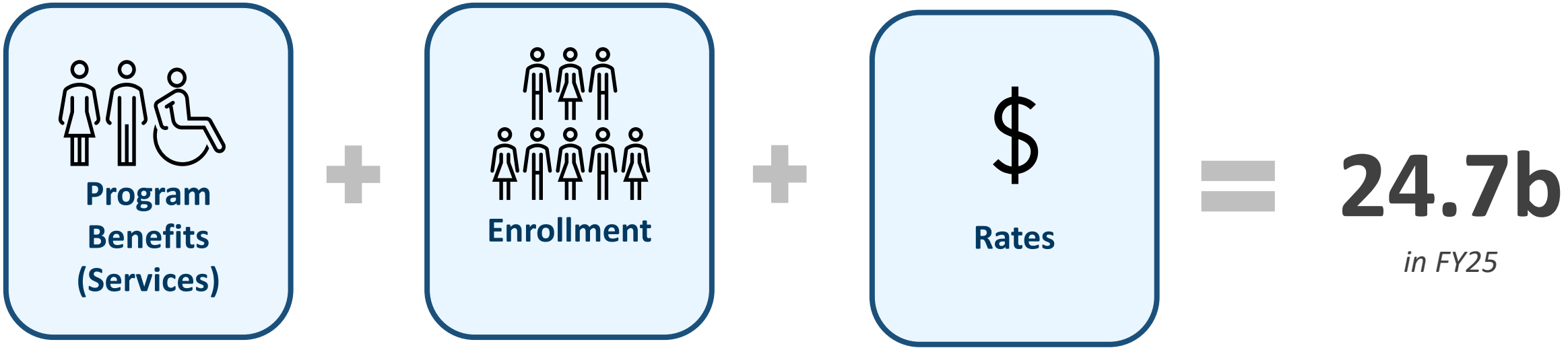
Chris Gordon, Chief Financial Officer

DMAS

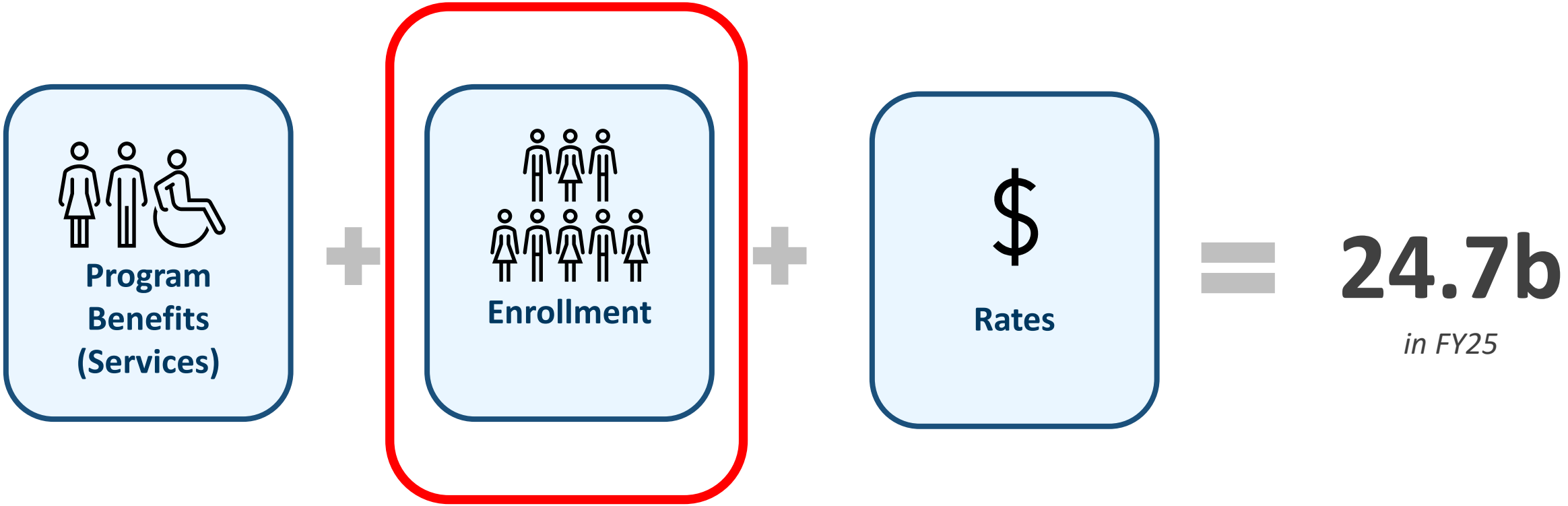
Overview

- Redeterminations
- Current Enrollment
- What We’re Watching

Medicaid: Three Main Cost Drivers



Medicaid: Three Main Cost Drivers



Current Redetermination Status

- **Unwinding redetermination**: 98.4% complete
- **Remaining members**: 34,985
- DMAS continues to pay capitation payments and fee-for-service costs for members pending redetermination

Source: DMAS Eligibility Tracker for October 2024, www.dmas.virginia.gov/data-reporting/eligibility-enrollment/eligibility-redetermination-tracker/

Current Enrollment

1,974,006

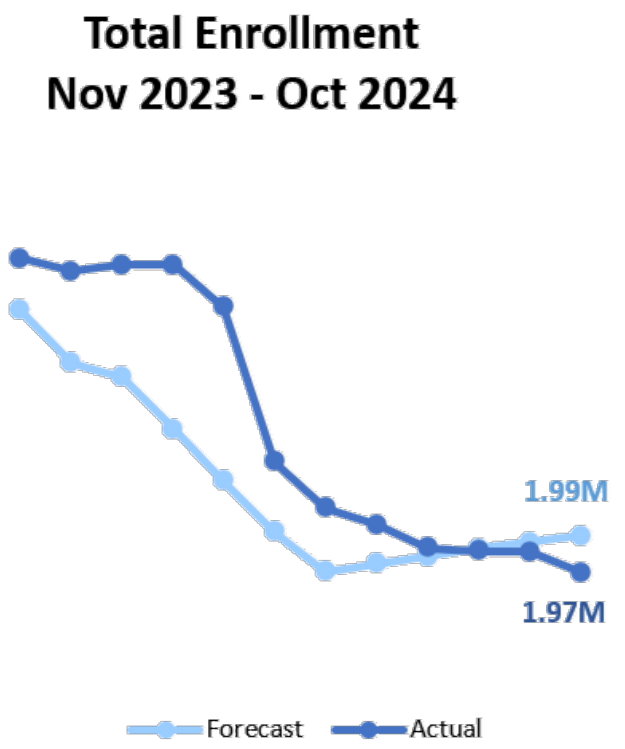
As of October 1, 2024

Source: DMAS Enrollment Report for October 2024, www.dmas.virginia.gov/data-reporting/eligibility-enrollment/enrollment-reports/

Current Enrollment

Enrollment as of 10/1/2024			
Selected Categories	**Forecast**	**Latest**	**Variance***
Non-Long Term Care (LTC)	148,455	141,572	-6,883
LTC Nursing Facilities	20,752	19,241	-1,511
LTC HCBS	58,915	62,278	3,363
Caretaker Adults	141,083	138,667	-2,416
Pregnant Women	27,170	28,342	1,172
Children	588,242	582,384	-5,858
Expansion - Caretaker	139,411	128,436	-10,975
Expansion - Non-Caretaker	511,829	485,674	-26,155
Title XIX Total	**1,813,414**	**1,776,517**	**-36,897**
MCHIP	83,040	96,148	13,108
FAMIS Kids	85,614	92,766	7,152
FAMIS MOMS	3,424	4,181	757
Title XXI Total	**176,880**	**197,489**	**20,609**
Total Enrollment	**1,990,294**	**1,974,006**	**-16,288**

**Variance = + / - 10% of forecast*



CardinalCare
Virginia's Medicaid Program

Source: DMAS Enrollment Report for October 2024, www.dmas.virginia.gov/data-reporting/eligibility-enrollment/enrollment-reports/

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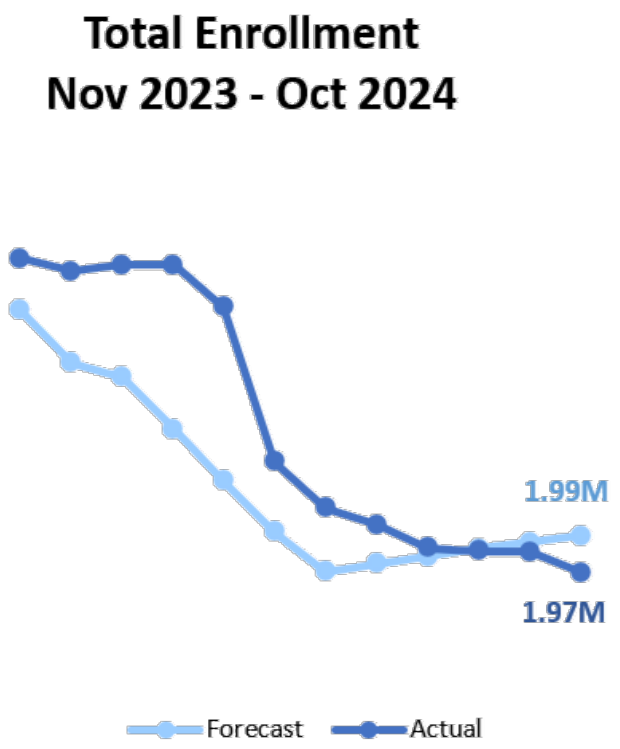

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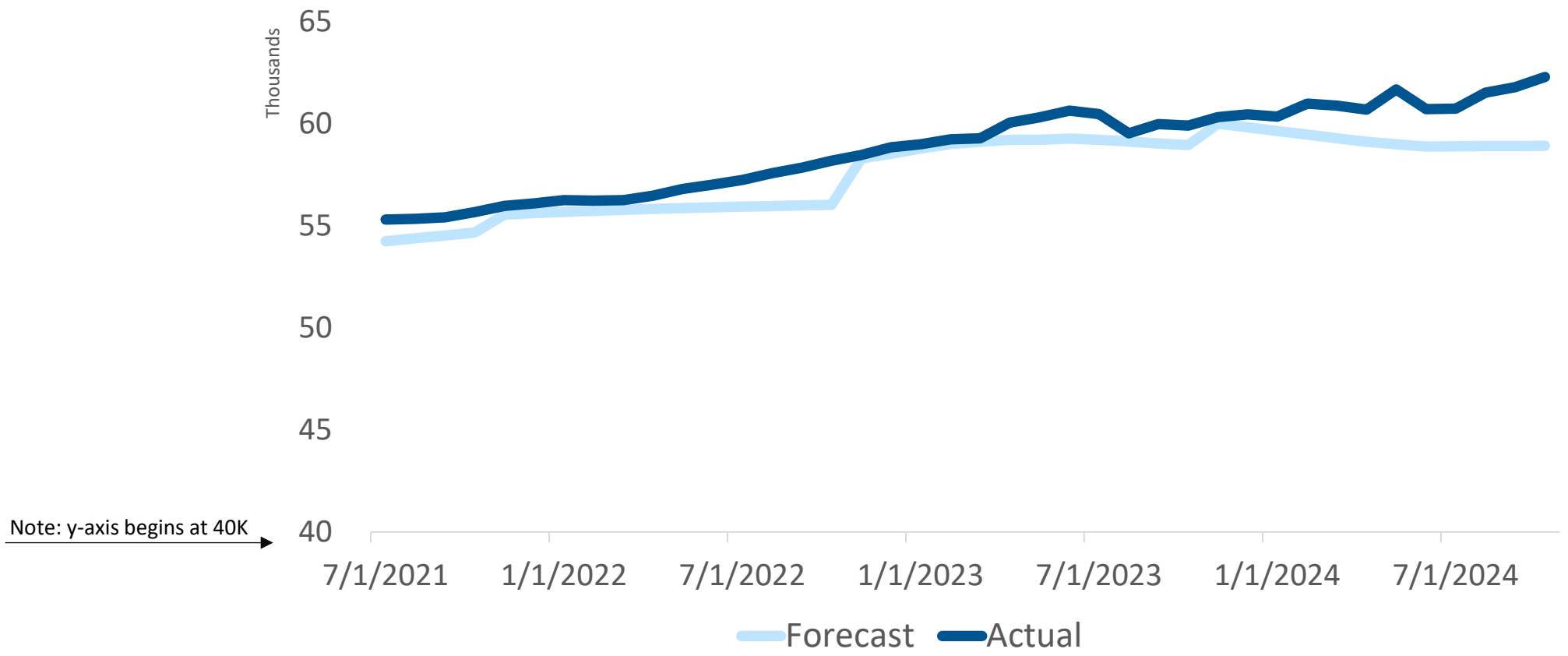
Focus: Long-Term Care Waiver (HCBS)



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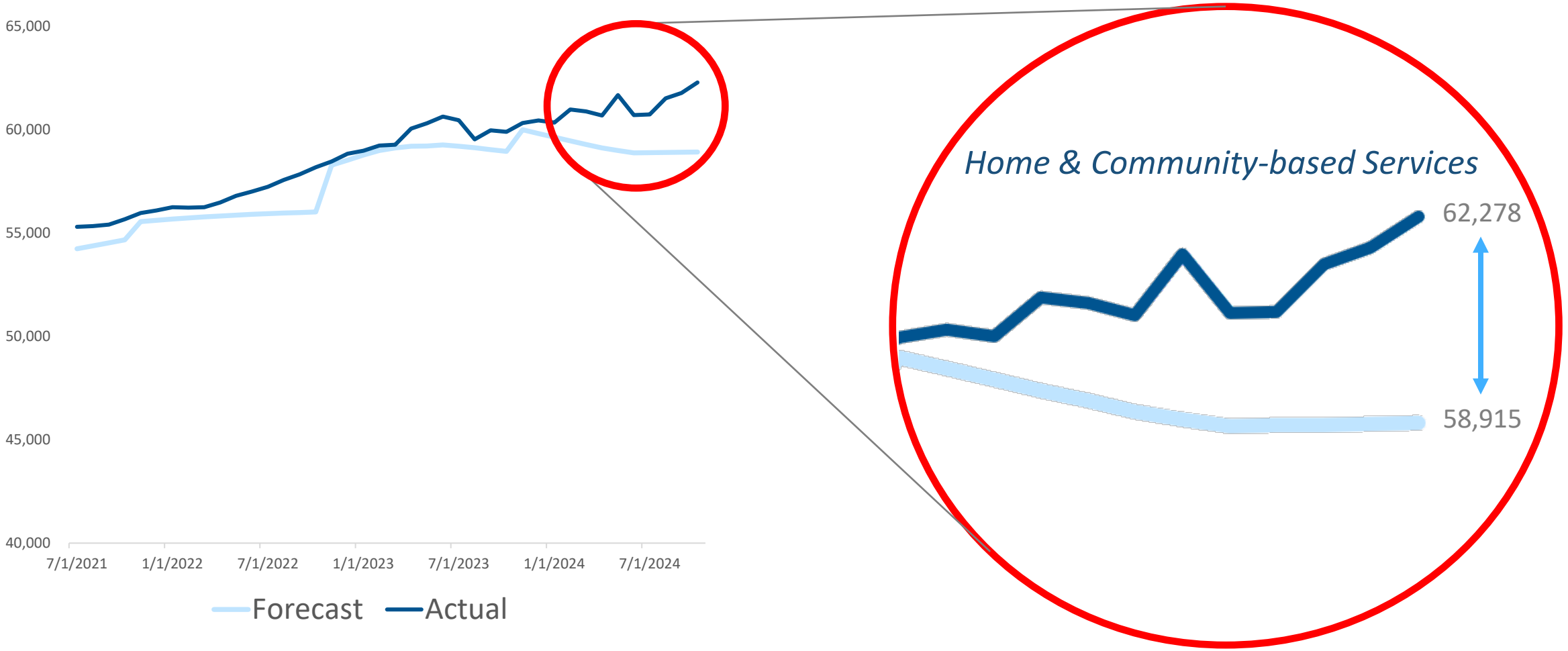

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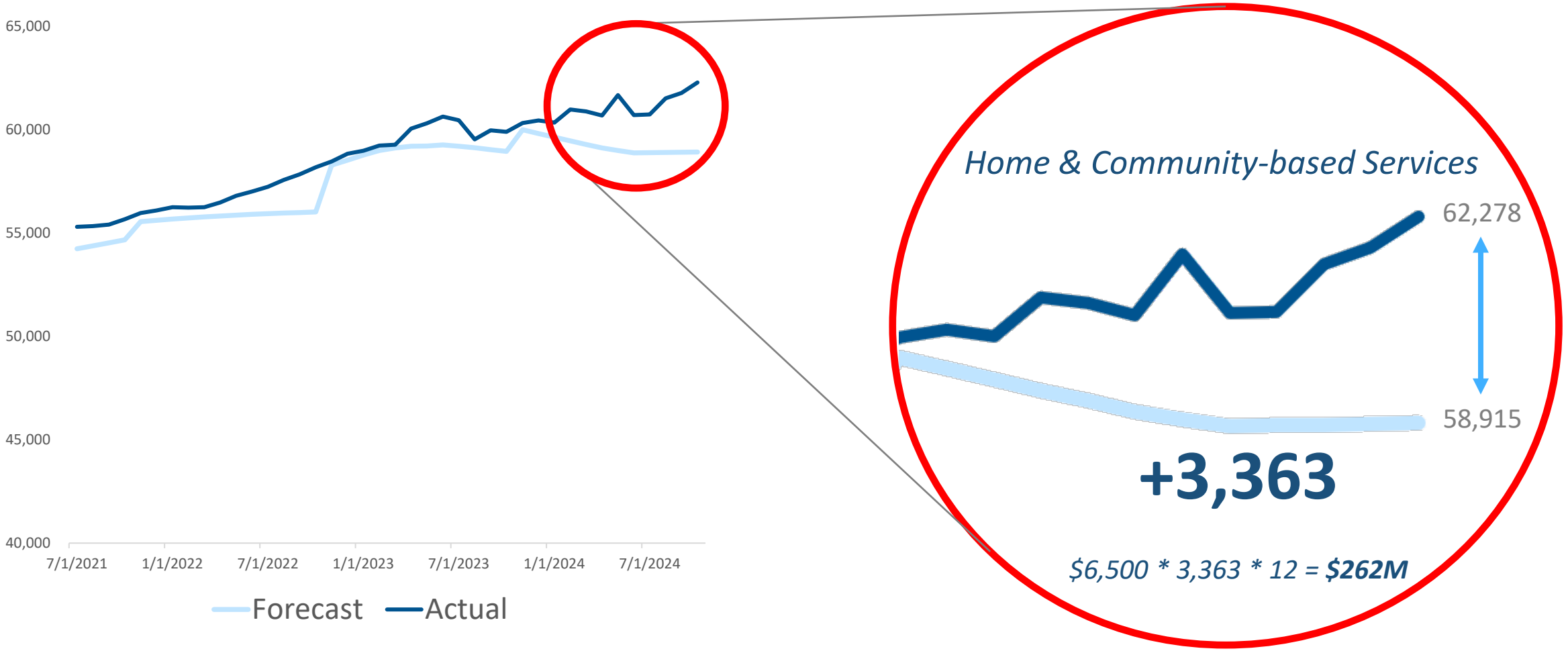

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Focus: Offsetting Enrollment

Enrollment as of 10/1/2024

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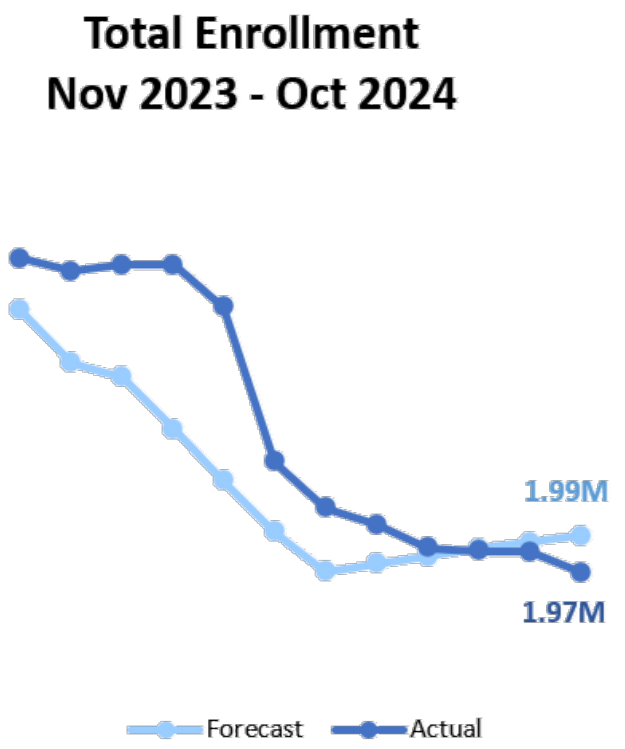

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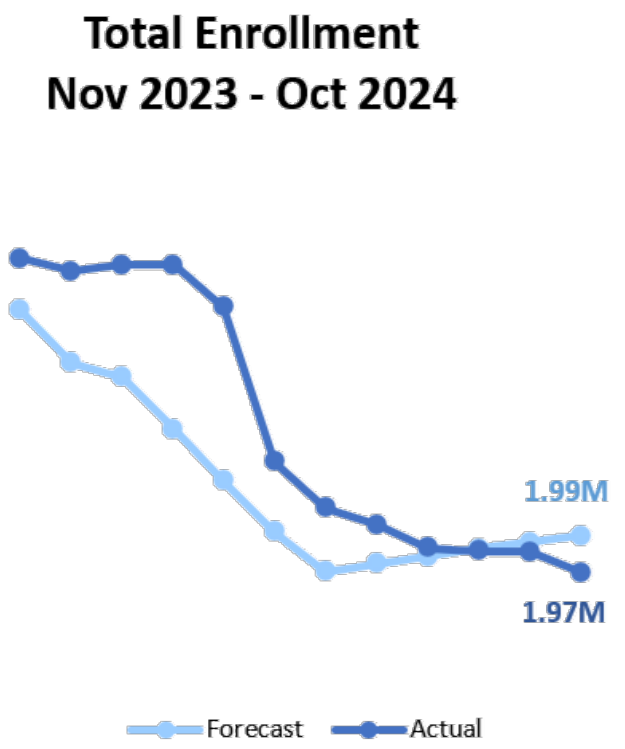

CardinalCare
Virginia's Medicaid Program

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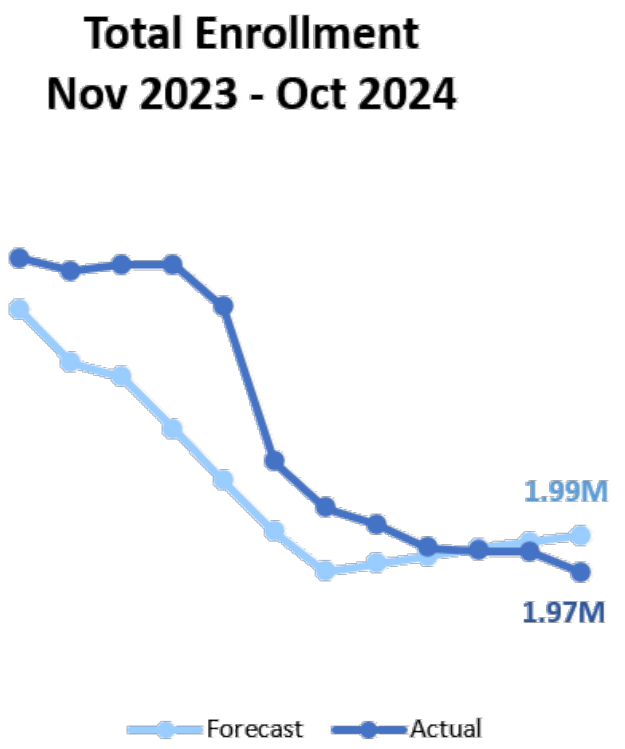

CardinalCare
Virginia's Medicaid Program

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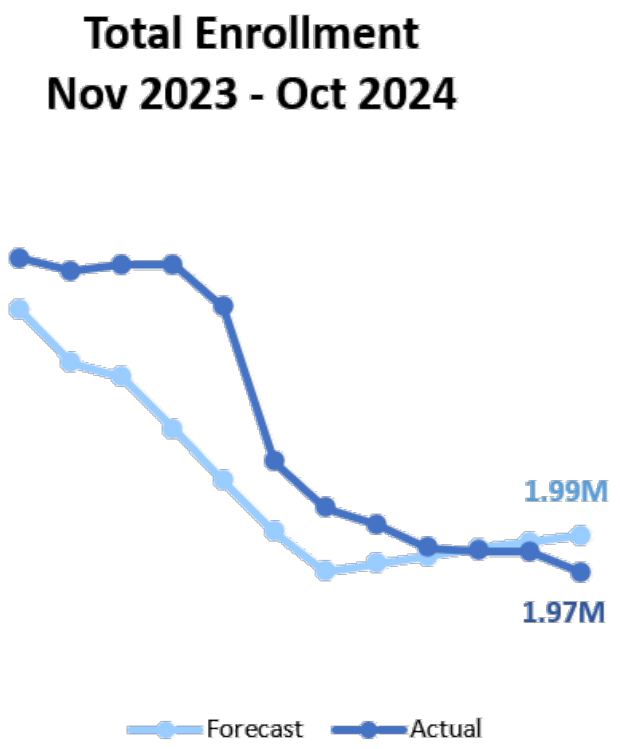

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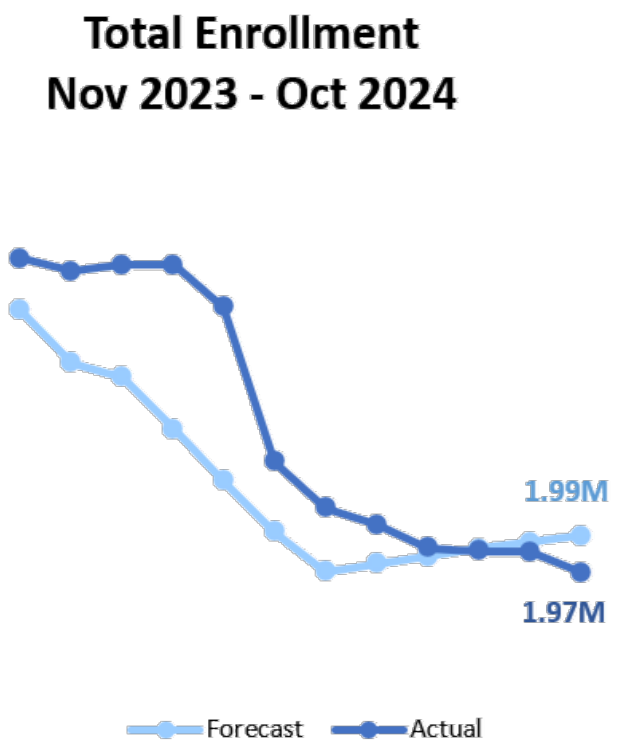


CardinalCare
Virginia's Medicaid Program

Source: DMAS Enrollment Report for October 2024, www.dmas.virginia.gov/data-reporting/eligibility-enrollment/enrollment-reports/

Focus: Offsetting Enrollment (Base)

Member Eligibility Group	Forecasted Enrollment	Actual Enrollment	Difference	FY25 Capitation Rate	Cost Savings
Non-Long-Term Care	148,455	141,572	-6,833	430	35.3 million
Long-Term Care NF	20,572	19,241	-1,511	6,500	117.9 million
Caretaker Adults	141,083	138,667	-2,216	550	14.2 million
Kids	588,242	582,384	-5,858	265	18.6 million
				Total	**$186.4 million**

CardinalCare
Virginia's Medicaid Program

Source: DMAS Enrollment Report for October 2024, www.dmas.virginia.gov/data-reporting/eligibility-enrollment/enrollment-reports/
FY25 MCO Capitation Rates: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/managed-care-capitation/

Summary

- Redetermination lag continues to impact high-cost rate cells

- This will influence the November 1 Forecast and create a state-share general fund need in FY25

CardinalCare
Virginia's Medicaid Program

MCO Claims Expense and Utilization Review

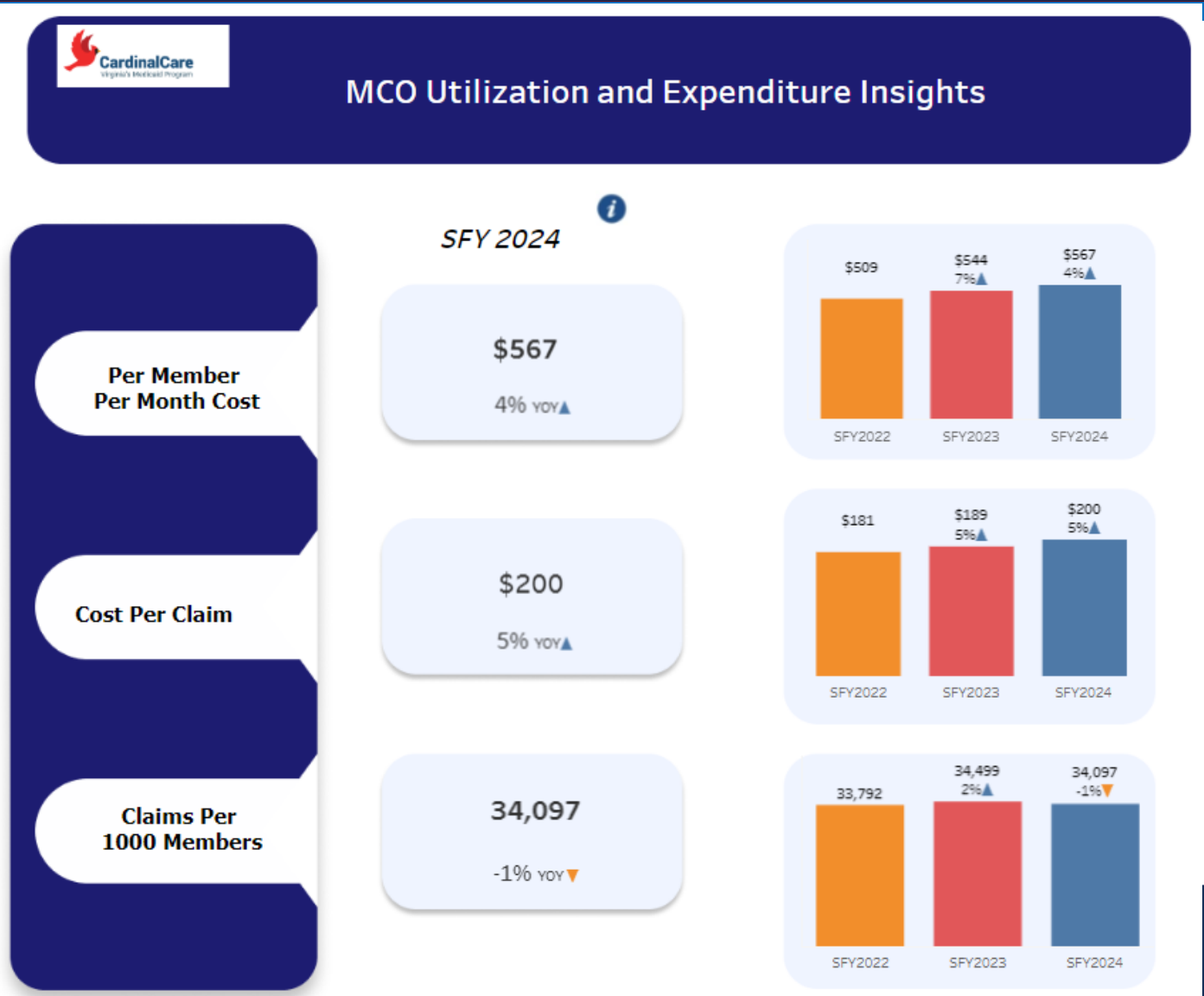
Rich Rosendahl, Deputy of Healthcare Analytics and Transformation

October 2024

DMAS

Summary – All Programs

*SFY2024 reflects claims paid July 1 – June 30, 2024



Stoplight – PMPM Changes by Program

Outpatient (+9.5%)
Pharmacy (+5.0%)
ER (+4.8%)

Grand Total (+1.3%)

In-Patient (-2.0%)
Physician Svcs (-2.8%)
Other Facility (-7.0%)

ACUTE

Outpatient (+11.7%)
ER (+11.1%)
Pharmacy (+7.1%)

Grand Total (+5.8%)
Physician Svcs (+5.6%)
In-Patient (5.4%)
Nursing Facility (5.1%)

Other Facility (-12.6%)

MLTSS

Cardinal Care Acute Overview (Managed Care)

Big 3 By Cost Category

Program: MEDALLION4 (Acute) | Healthplan*: (All) | Eligibility Category: (All)

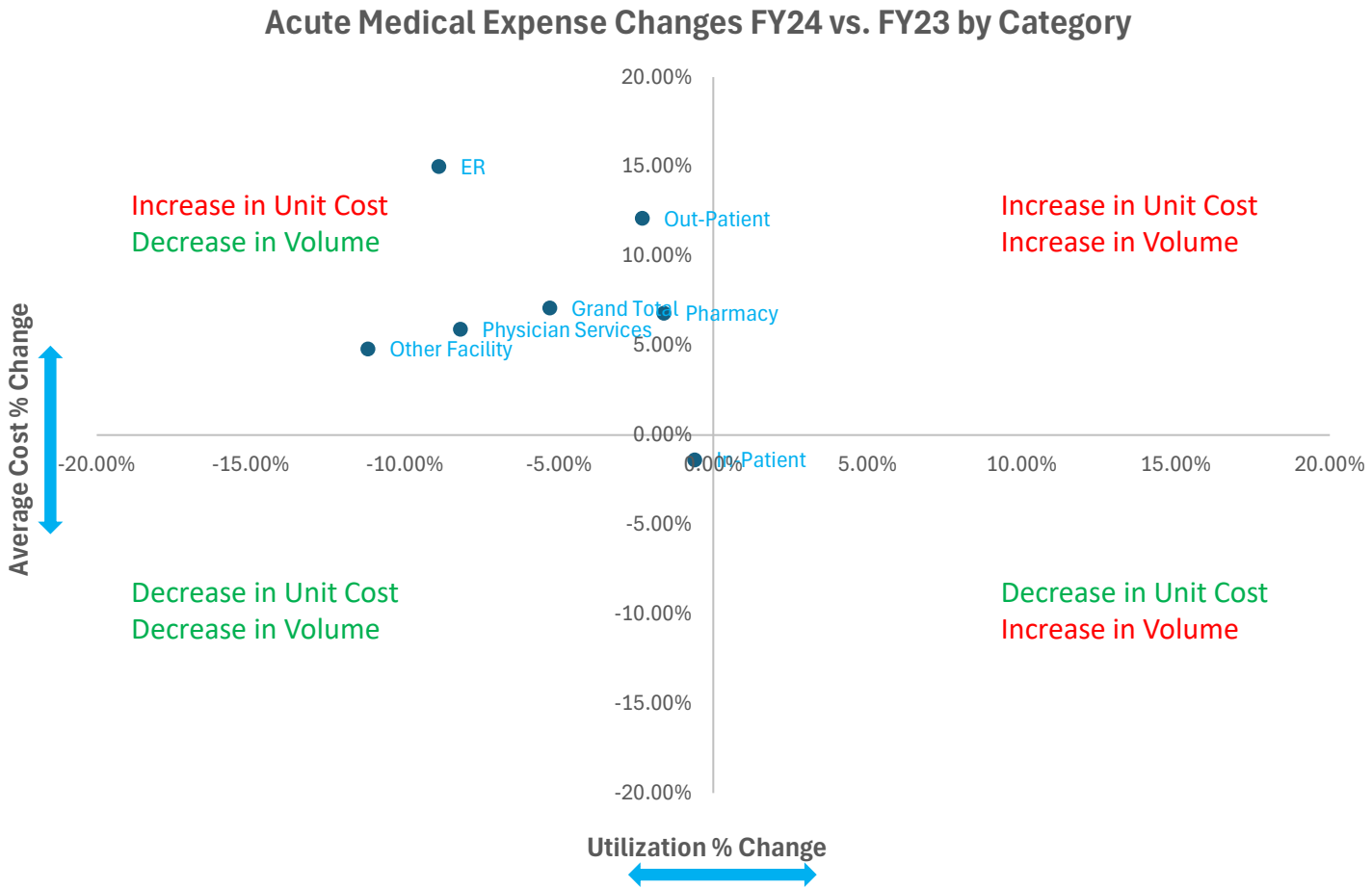
		SFY2022	SFY2023	SFY2024	% Difference SFY23 - 24
Grand Total	PMPM	$291	$311	$315	1.3%▲
	Cost Per Claim	$166	$171	$183	7.1%▲
	Claims Per 12K Members	21,060	21,770	20,606	-5.3%▼
ER	PMPM	$16	$19	$20	4.8%▲
	Cost Per Claim	$123	$144	$166	15.0%▲
	Claims Per 12K Members	1,513	1,577	1,437	-8.9%▼
In-Patient	PMPM	$59	$56	$55	-2.0%▼
	Cost Per Claim	$8,822	$8,143	$8,030	-1.4%▼
	Claims Per 12K Members	80	83	82	-0.6%▼
Nursing Facility	PMPM	$0	$0	$0	41.9%▲
	Cost Per Claim	$2,466	$3,828	$4,152	8.5%▲
	Claims Per 12K Members	0	0	0	30.8%▲
Other Facility	PMPM	$4	$5	$5	-7.0%▼
	Cost Per Claim	$1,070	$1,224	$1,283	4.8%▲
	Claims Per 12K Members	48	52	46	-11.2%▼
Out-Patient	PMPM	$33	$40	$44	9.5%▲
	Cost Per Claim	$390	$495	$555	12.1%▲
	Claims Per 12K Members	1,014	969	947	-2.3%▼
Pharmacy	PMPM	$73	$80	$84	5.0%▲
	Cost Per Claim	$107	$111	$118	6.8%▲
	Claims Per 12K Members	8,233	8,671	8,533	-1.6%▼
Physician Services	PMPM	$106	$110	$107	-2.8%▼
	Cost Per Claim	$125	$127	$135	5.9%▲
	Claims Per 12K Members	10,172	10,418	9,562	-8.2%▼

*Beginning SFY2024, Virginia Premier has become part of Sentara.

Last Update: 10/1/2024 8:18:11 PM

CardinalCare
Virginia's Medicaid Program

Cardinal Care Acute PMPM Drivers (Managed Care)



Cardinal Care Complex Overview (Managed Care)

Big 3 By Cost Category

Program: CCCPLUS (MLTSS) | Healthplan*: (All) | Eligibility Category: (All)

		SFY2022	SFY2023	SFY2024	% Difference SFY23 - 24
Grand Total	PMPM	$1,650	$1,809	$1,913	5.8%▲
	Cost Per Claim	$197	$210	$216	3.1%▲
	Claims Per 12K Members	100,471	103,431	106,074	2.6%▲
ER	PMPM	$22	$26	$29	11.1%▲
	Cost Per Claim	$85	$100	$115	15.0%▲
	Claims Per 12K Members	3,041	3,156	3,048	-3.4%▼
In-Patient	PMPM	$186	$181	$191	5.4%▲
	Cost Per Claim	$7,450	$6,874	$7,211	4.9%▲
	Claims Per 12K Members	299	317	318	0.4%▲
Nursing Facility	PMPM	$344	$395	$415	5.1%▲
	Cost Per Claim	$4,544	$5,304	$5,823	9.8%▲
	Claims Per 12K Members	908	894	856	-4.3%▼
Other Facility	PMPM	$29	$32	$28	-12.6%▼
	Cost Per Claim	$543	$587	$641	9.2%▲
	Claims Per 12K Members	630	658	526	-20.0%▼
Out-Patient	PMPM	$82	$105	$118	11.7%▲
	Cost Per Claim	$362	$455	$500	9.9%▲
	Claims Per 12K Members	2,726	2,774	2,819	1.6%▲
Pharmacy	PMPM	$250	$270	$289	7.1%▲
	Cost Per Claim	$125	$129	$138	6.5%▲
	Claims Per 12K Members	24,095	25,070	25,208	0.6%▲
Physician Services	PMPM	$738	$798	$843	5.6%▲
	Cost Per Claim	$129	$136	$138	1.6%▲
	Claims Per 12K Members	68,772	70,562	73,299	3.9%▲

*Beginning SFY2024, Virginia Premier has become part of Sentara.

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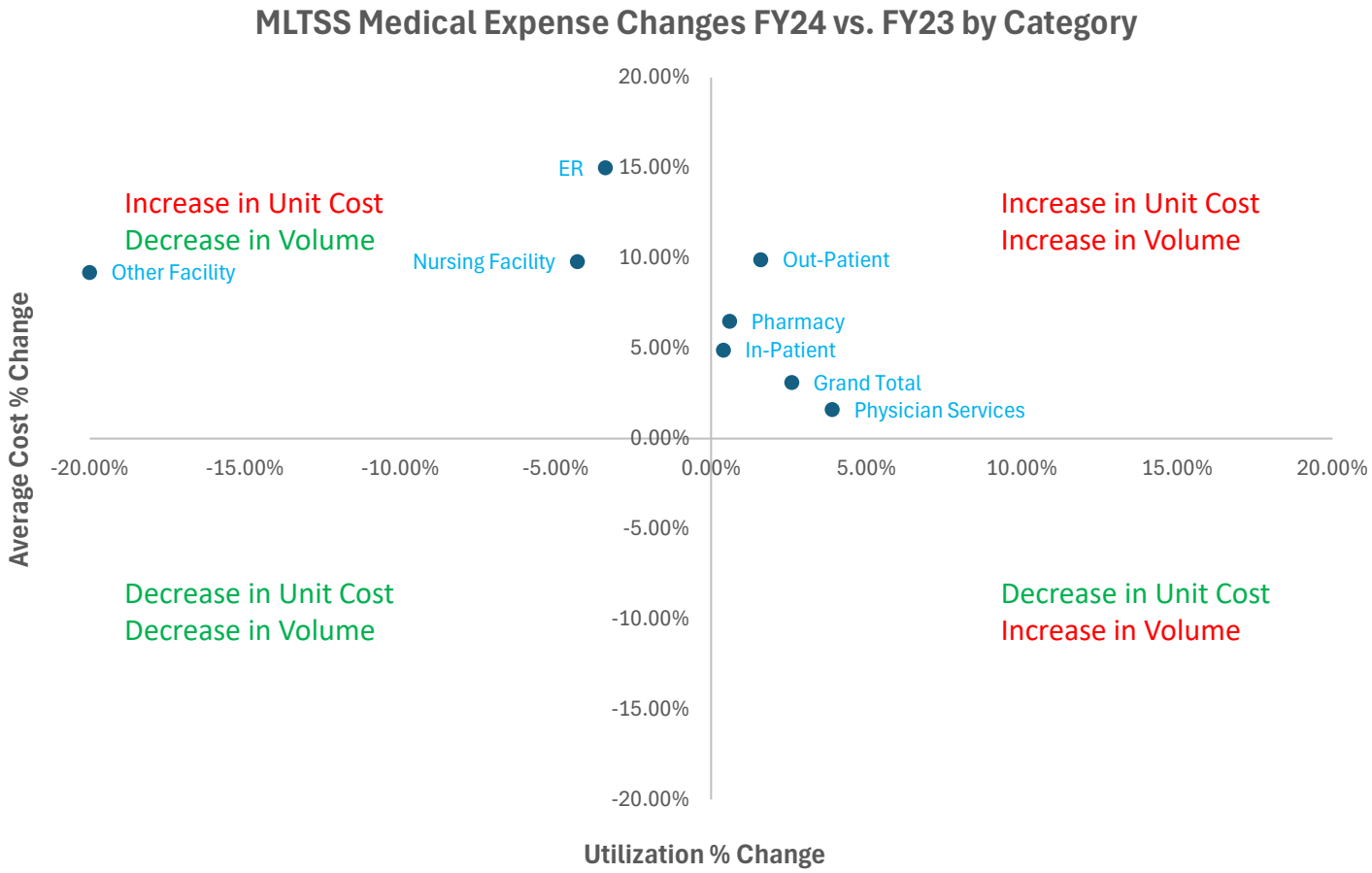
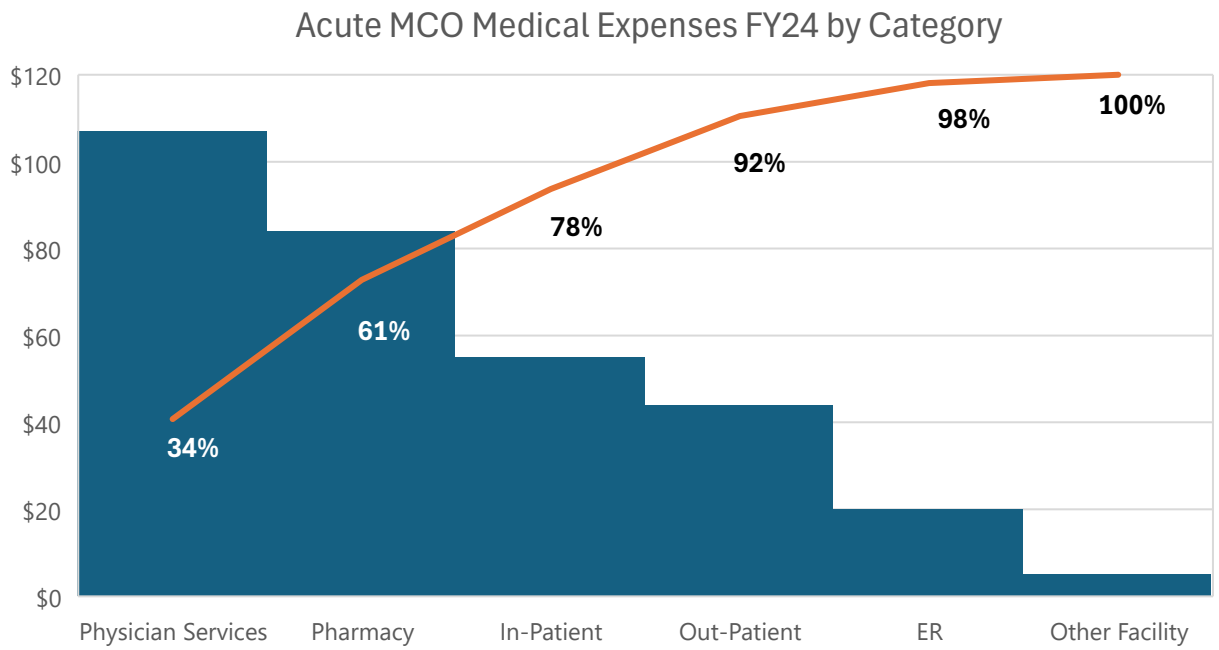
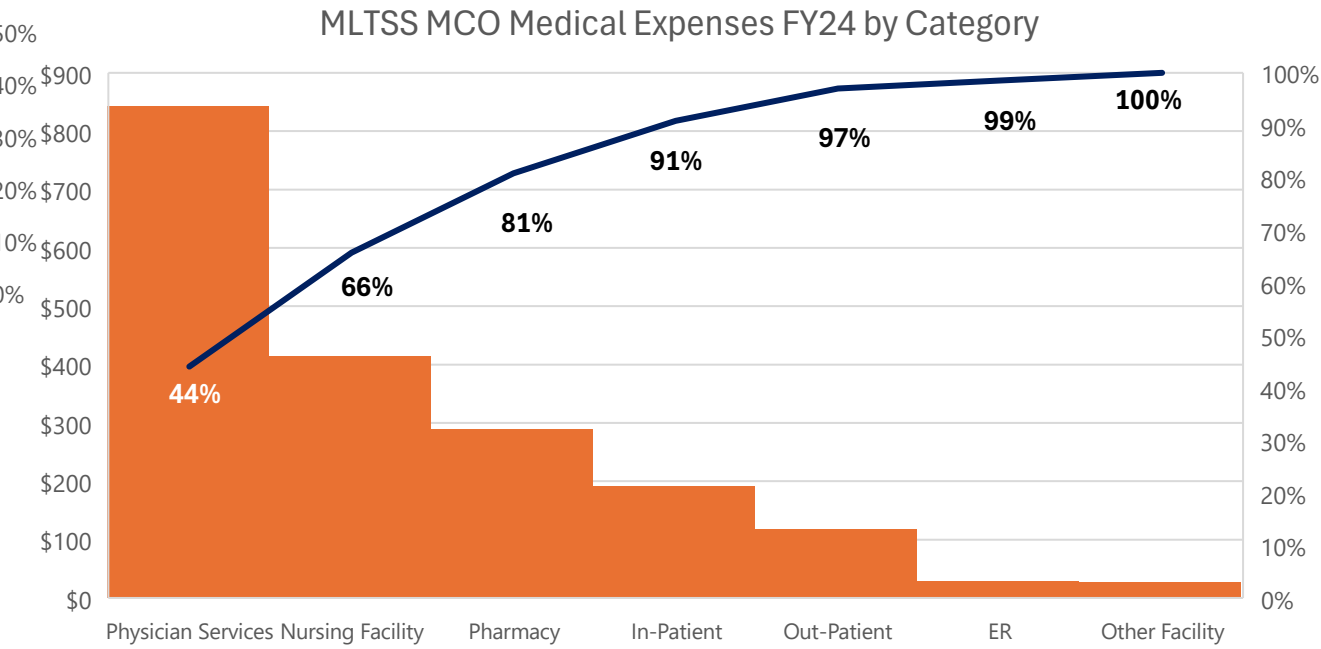
Cardinal Care MLTSS PMPM Drivers (Managed Care)



Cost Category Comparison by Program



- 78% of Acute MCO spend in FY24 in Physician Services, Pharmacy and In-Patient
- ER accounts for 6% of Acute FY24 medical expense



- 81% of MLTSS MCO spend in FY24 in Physician Services, Nursing Facility and Pharmacy

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Key Metric Definitions

- Three ingredients give you all three standardized key Metrics
  - Enrollment – Count of members enrolled each month
  - Cost – MCO expenditures on medical and pharmacy claims
  - Claim count – Count of MCO medical and pharmacy claims
- PMPM
  - “Per member per month”
  - Standardized way of looking at cost based on enrollment trends
    - Critical as we have large fluctuations in membership
  - Total Cost divided by Enrollment
- Utilization
  - Annualized metric for assessing volume of claims and services received by membership
  - Total Count of Claims divided by Enrollment (which is divided by 1,000)
- Cost per Claim
  - Average cost of a paid claim
  - Total Cost divided by Total Count of Claims

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Virginia's Medicaid Program

Managed Care Programs Update

Adrienne Fegans, Deputy for Programs

DMAS

Program Updates

- New Access and Managed Care final rules
  - Workgroups to determine timeline and impact to the agency
- New Office of Compliance and Monitoring
- Working with MCOs on Hurricane Helene response
- New guidance on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) from CMS

Maternal Health Updates

- Executive Order 32 Maternal Health Data and Quality Measures Task Force met October 17th
- Staff attended meeting the Rural Maternal and Child Health Convening with the National Governor's Association in early October
  - Cross departmental workgroup will identify short term goals to improve mental health and SUD outcomes in rural areas
- DMAS submitted expression of interest for the CMS affinity groups on maternal behavioral health and maternal cardiovascular health

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Complex Care Services Update

Tammy Whitlock, Deputy for Complex Care

DMAS

Agenda

- Legally Responsible Individuals (LRI)
- Behavioral Health Redesign
- 1115 SMI Waiver
- CMS Access Final Rules

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Legally Responsible Individuals (LRI)

DMAS

LRI Timeline

- 1915c Waiver Amendments submitted September 20th to incorporate HB909/SB488 which finalizing rules regarding when a Legally Responsible Individual (LRI) is the paid attendant for the personal care service).

- CMS has 90 days to approve the Amendments.

- LRI Respite Report (HB909/SB488) has been drafted and due to HHR November 1st
  - Options include changing the definition to allow provision of respite when the LRI is an unpaid caregiver all or part of the time and when there are multiple adult caregivers providing any portion of unpaid care for the waiver-receiving child or changing the definition to include all primary caregivers, regardless of their paid or unpaid status.

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RHRN Medicaid Behavioral Health Services Redesign Project

RIGHT HELP. RIGHT NOW.
Transforming Behavioral Health Care for Virginians

DMAS

RHRN Service Redesign - Project Overview

DMAS, in coordination with DBHDS, DHP and DMAS health plans, is employing an integrated and comprehensive approach to address rate, service, and workforce/provider roles for Medicaid over the next two years.

The project seeks to redesign DMAS' youth and adult legacy services: Intensive In-home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation, and Targeted Case Management.

The budget language authorizes DMAS to move forward with budget neutral changes to replace the legacy services with evidence-based, trauma-informed services.

Medicaid Behavioral Health Services Redesign Priorities

Strengthen the evidence-based, trauma-informed service continuum for youth and adults

Promote earlier intervention and increase access through tiered service design

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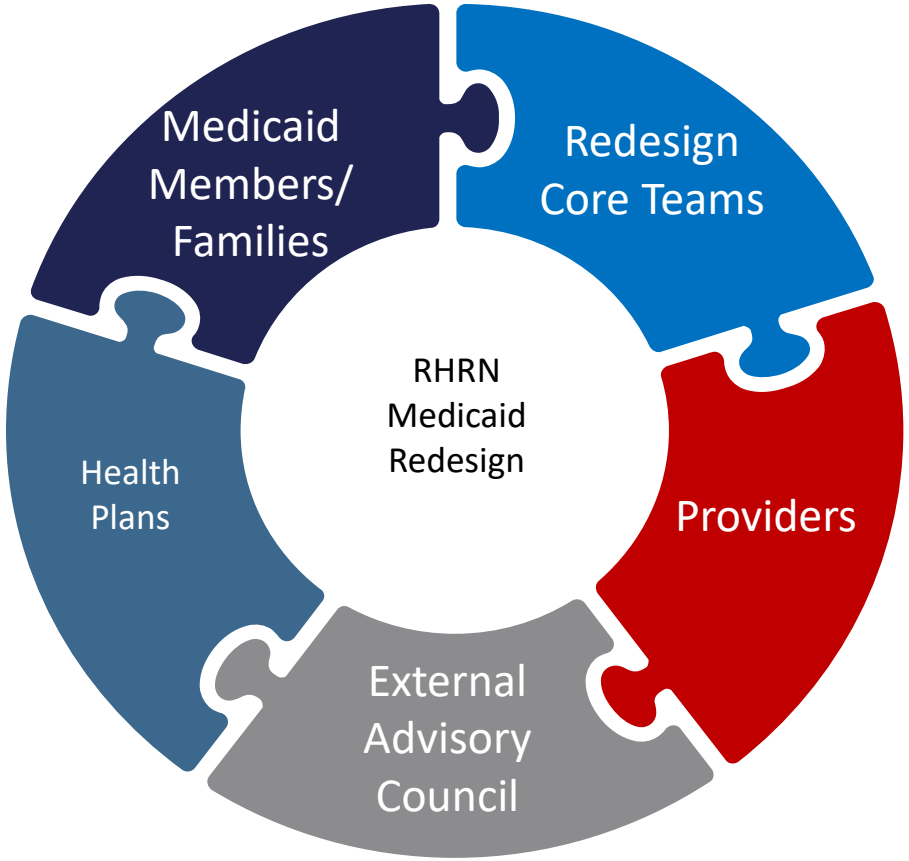
Design services for Virginia's managed care service delivery system and multipayer system

Integrate workforce priorities and workforce supports into service design and implementation

RHRN Medicaid Behavioral Health Services Redesign Continuum

Stakeholder Input



Methods of Input	Provider Surveys
	Informational Webinars
	Listening Sessions
	Member engagement
	Public Comment Periods

Current Stakeholder Engagement Opportunities

Information Webinars

- July 2024
- Sept 16th, Provider Online Survey

Providers

- Provider Online Survey (Sept 16-Oct 16)
- Provider Office Hours
- Advisory Council November 2024 TBD
- In-Person listening sessions at four conferences in October

Advocates

- Two Virtual Listening Sessions
  - Oct 4th @ 11 and 1:30pm

Members

- Four Listening Sessions
- In-Person
  - 10/29/24 Richmond, VA
  - 10/28/2024 Blacksburg, VA
- Virtual
  - Oct 7th @ 1pm
  - Oct 8th @ 5:30pm
- Member Online Survey

Medicaid Behavioral Health Services Redesign Timeline
July 2024-June 2026

Year 1

July 2024-June 2025

- Service research, stakeholder input, contractor support to develop service requirements
- Develop service definitions and requirements
- Develop FFS rates for each proposed new service
- Estimate utilization, cost and budget impact for redesigned services

Year 2

July 2025-June 2026

- Operationalize new services through licensure, regulatory, and policy manual changes
- Prepare providers to transition to new services
- Ensure MCO readiness to implement new services
- New Services Go Live
  Potential phased in approach of service implementation

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1115 Demonstration Waiver for Serious Mental Illness (SMI): Amendment Application

VIRGINIA BUILDING AND TRANSFORMING COVERAGE, SERVICES, AND SUPPORTS FOR A HEALTHIER VIRGINIA

DMAS

Amending Virginia's 1115 Demonstration Waiver

Building and Transforming Coverage, Services, and Supports for a Healthier Virginia (Number: 11-W-00297/3)

- Virginia submitted a renewal application to extend the existing Substance Use Disorder (SUD) and Former Foster Care Youth (FFCY) components to CMS August, 2024
- With this amendment application, we are seeking to add a waiver program for Serious Mental Illness (SMI), an opportunity that was announced in 2018
- The intent of the amendment is to allow inpatient and residential crisis stabilization services for adults 21-64 in Institutions for Mental Disease (IMDs)

Overview of SMI 1115 Waiver Opportunity

The SMI demonstration opportunity allows states, upon CMS approval of their demonstrations, to receive Federal Financial Participation (FFP) for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services.

Five Required Goals for 1115 SMI Waiver Opportunity

Goal #1:	1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
Goal #2:	• Reduced preventable readmissions to acute care hospitals and residential settings
Goal #3:	• Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
Goal #4:	• Improved access to community-based services to address the chronic mental healthcare needs of beneficiaries with SMI or SED, including through increased integration of primary and behavioral health care; and
Goal #5:	• Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Services Included in Proposed Amendment

- We do not propose adding any new services through this amendment
- However, we propose adding the excluded IMD setting to two existing services for adults 21-64:
  - Inpatient psychiatric treatment
  - Residential crisis stabilization

What Would Change with the Proposed Amendment?

Inpatient Psychiatric Treatment for Adults 21-64

Current

Currently, medically necessary psychiatric inpatient care can be provided to adults 21-64 in psychiatric units of general acute care hospitals

Managed care health plans may cover medically necessary psychiatric inpatient care for adults 21-64 in IMDs for up to 15 days under the “in lieu of service” provision

Proposed

Medically necessary psychiatric inpatient care would be available to adults 21-64 in both psychiatric units of general acute care hospitals as well as up to 60 days in IMDs

Although up to 60 days could be covered if medically necessary, Virginia would be required to keep average length of stay below 30 days

What Would Change with the Proposed Amendment?

Residential Crisis Stabilization Units

Current

Currently, residential Crisis Stabilization services are limited to 16 beds or fewer and the service is not covered in IMDs (for any ages)

Managed care health plans may cover medically necessary residential crisis stabilization in IMDs for up to 15 days under the “in lieu of service” provision

Proposed

Medically necessary psychiatric residential crisis stabilization would be allowable in settings with more than 16 beds

This would allow for co-location of multiple services within a single facility such as:

16 youth crisis beds co-located with 16 adult crisis beds

Crisis beds added to SUD settings with 16+ beds already covered by the SUD 1115 waiver

SMI Waiver Application Timeline

- BCG is engaged to develop our initial application. Ongoing working session with DMAS and DBHDS. Federal budget neutrality analysis is required in addition to the plan and other components of the application.
- External stakeholder engagement will be minimal as no new services are being added; Presented to the Behavioral Health Advisory Committee October 10th and the draft application will be posted for 30 days public comment in November.
- Goal is to submit to CMS in January.
- A full year of planning and detailed implementation plan development, evaluation plan development, and Health IT planning will be required between initial application and negotiated terms and conditions to implement the waiver. We have authority to apply at this time but not authority to implement.

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2024 CMS Access Final Rules

DMAS

CMS Final Rules – Enhancing Access to Medicaid Services

- Empower the member voice through expanded Medicaid Advisory Committees
- Promote transparency, standardized reporting and enhanced accountability in HCBS
- Support rate transparency and access monitoring in FFS
- Address timely access to care, quality-based provider payments, and quality improvement in managed care

CMS Access Final Rule – HCBS Provisions

The Access Final Rule includes new payment provisions and program standards and processes to enhance access and quality

Payment for HCBS & Direct Care Workers

1. Payment Adequacy
2. Payment Transparency
3. Interested Parties Advisory Group

Oversight of HCBS Access, Quality and Safety

1. Person-centered Service Plan
2. Grievance System
3. Incident Management System
4. Access Reporting
5. Quality Measure Set
6. HCBS Reporting Requirement & Transparency

CMS Access Final Rule – HCBS Provisions Timeline

Effective Date	Payment Adequacy and Transparency HCBS Access, Quality, and Safety
July 2026	Payment Rate Disclosure/Transparency Publication (Habilitation *and* Home Care Services)
	Interested Parties Advisory Group
	FFS Grievance Systems for HCBS Recipients
	Medicaid Advisory Committee (MAC) & Beneficiary Advisory Council (BAC)
July 2027	Person Centered Service Plan
	Incident Management System (see also 2029 for electronic system requirement)
	Website Availability and Accessibility
	Habilitation and Home Care Services Access Reporting
July 2028	HCBS Quality Measure Set
	Payment Adequacy (annual reporting on compensation % for home care *and* habilitation services)
July 2029	Incident Management Systems –electronic data collection/tracking/trending
July 2030	Payment Adequacy (compliance with 80% compensation standard for home care services; not habilitation)

CMS Access Final Rule – HCBS Provisions

- CMS requires that 80% of Medicaid payments for home care services must go to ‘compensation’ for home care workers or direct care workers.
  - Eligible compensation includes salary/wages, benefits, and the employer share of payroll taxes.
  - Eligible direct care workers include licensed and unlicensed workers performing eligible services, including nursing staff who provide nursing services to HCBS beneficiaries.
- Exclusions and flexibilities for states and providers –
  - Automatic exclusions – required trainings, worker travel and personal protective equipment
  - Excluded providers – workers under a self-direct model with enrollee-determined rates & tribal health programs
  - Other optional state-defined exemptions