DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 21, 2026

Steve Ford
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

Dear Mr. Steve Ford:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Virginia's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on March 28, 2025, and a final revised preprint was received on October 22, 2025. The proposal has a control name of VA_Fee_IPH.OPH_Renewal_20250701-20260630**.**

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform increase for inpatient and outpatient services for the rating period covering July 1, 2025 through June 30, 2026, incorporated in the capitation rates through a separate payment term up to $4,987,975,478.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of a grandfathered SDP (as specified in item 4 of the current SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.07.21 15:16:14 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2025 - June 30, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Cardinal Care
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $4,987,975,478
   a. Identify the estimated federal share of this state directed payment: $3,387,577,483
   b. Identify the estimated non-federal share of this state directed payment: $1,600,397,995

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

SFY 25, SFY 24, SFY 23, SFY22, SFY21, SFY20, SFY19

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☒ Other; please describe:

Payment level changed

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Consistent with 42 CFR §438.6(c)(1)(iii)(C), the contracted Cardinal Care MCOs provide a uniform percentage increase to the base health plan payments made to Virginia private hospitals for actual inpatient and outpatient services provided to Medicaid managed care enrollees. The uniform percentages for inpatient and outpatient encounters represents the difference between health plan base reimbursement rates and Average Commercial Rate. This methodology maintains compliance with the 6% indirect hold harmless threshold applied to provider assessments. MCO encounter data for services rendered during the SFY26 rating period will be used to link payments to utilization of inpatient and outpatient services by facility for plan enrollees. MCOs are required to submit encounter data to DMAS in accordance with formatting and timeliness standards set forth in their contracts with the State. Due to the uniform percentage increase being calculated after the encounter has been received, the directed payments will occur retroactively to each MCO for conveyance to the hospital providing the services. After the close of a quarter, DMAS will calculate each hospital's payment increase by MCO using valid reported encounters received during the previous quarter.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Virginia's State Plan Amendment (SPA) 18-0008, Alternative Benefit Plan - Medicaid Expansion.
https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VA/VA-18-0008.pdf

Hospital IP and OP State Plan Page 1, Attachment 3.1-A&B Supplement 1 and State Plan Page 1, Attachment 4.19-A.
https://www.dmas.virginia.gov/media/5362/31ab-s1-amount-duration-and-scope-categorically-and-medically-needy.pdf
https://www.dmas.virginia.gov/media/5355/419a-payment-rates-inpatient-care-general.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
☐ Multi-Payer Delivery System Reform
☐ Medicaid-Specific Delivery System Reform
☐ Performance Improvement Initiative
☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☒ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- **a.** Check the basis for the fee schedule selected above.
  - **i.** ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]
  - **ii.** ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
  - **iii.** ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
    1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- **b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- **a.** ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- **b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- **c.** Indicate the number of exemptions to the requirement:
  - **i.** Expected in this contract rating period (estimate)
  - **ii.** Granted in past years of this payment arrangement
- **d.** Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

The uniform percentage increase to align reimbursement with ACR for FY26. These UPL gap percentages are currently 169.5% for inpatient and 238.6% for outpatient claims.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Medicaid health plan encounter data for services rendered during the SFY26 rating period will be used to link payments to utilization of inpatient and outpatient services by facility for plan enrollees. Medicaid health plans are required to submit encounter data to the Virginia Department of Medical Assistance Services in accordance with formatting and timeliness standards set forth in their contracts with the State. Upon completion of a quarter, DMAS will calculate each hospital's payment increase by MCO using valid reported encounters received during the previous quarter. DMAS will then issue a supplemental capitation payment to each Medicaid health plan based on the increase calculated for inpatient and outpatient services provided to the health plan's enrollees. Due to the uniform percentage increase being calculated after the encounter has been received, the directed payments will occur retroactively to each health plan for conveyance to the hospital providing the service(s).

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

Establishing a uniform percent increase for inpatient and outpatient hospital services at ACR will maintain, if not increase, access to needed medical services in the communities where enrollees live.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

☒ inpatient hospital service
☒ outpatient hospital service
☐ professional services at an academic medical center
☐ primary care services
☐ specialty physician services
☐ nursing facility services
☐ HCBS/personal care services
☐ behavioral health inpatient services
☐ behavioral health outpatient services
☐ dental services
☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Virginia private hospitals that provide inpatient and/or outpatient services to Virginia Medicaid managed care enrollees will participate in the payment arrangement as a single provider class. For purposes of this payment arrangement, “private hospitals” will exclude public hospitals, freestanding psychiatric and rehabilitation hospitals, children’s hospitals, long stay hospitals, and long-term acute care hospitals.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

See response to Question 8.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

Under this payment arrangement, all Virginia hospitals in the private hospital class providing inpatient and/or outpatient hospital services to Medicaid managed care enrollees during the SFY26 rating period will receive a uniform percentage increase for inpatient services and a uniform percentage increase for outpatient services, respectively, to align reimbursement with ACR. Health plan encounter data will be used to link payments to utilization of inpatient and outpatient services for plan enrollees using the same methodology across the class.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☐

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Inpatient Services	37.1%	62.9%			100%
b. Outpatient Services	29.5%	70.5%			100%
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☐ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☒ Other; Please define: Average Commercial Rates

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The percentages of ACR in Table 2.A were developed based on Commercial data and Medicaid managed care data received from hospital reported surveys. Data is from hospital reporting year ending in state fiscal year 2024 which is within the three most recent and complete years from the SFY 26 rating period. Using this survey data, an ACR per diem for inpatient and an ACR per claim for outpatient were developed. Projected FY 26 Medicaid managed care data was derived from reviewing more recent Medicaid managed care claims experience to apply the realized and expected trends in Medicaid managed care inpatient and outpatient claims payments to develop estimated claims costs for the FY 26 rating period.

The FY 24 Medicaid managed care and commercial data was used to calculate the respective ratio between Medicaid managed care encounter payments and commercial rates for an inpatient per diem and outpatient claim. This historical relativity factor was applied to SFY 26 projected Medicaid managed care claims costs to compute the estimated financial impact of the directed payment.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

Establishing a uniform percent increase for inpatient and outpatient hospital services at ACR allows the Medicaid program to remain competitive in the market. DMAS expects that the increased Medicaid rates should at least maintain, if not increase, access to needed medical services in the communities where enrollees live.

The total reimbursement provided by the proposal is equal to the average commercial rates based on hospital reported data.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

MCR-VA-CCMC-20250701-20260630-CERTIFICATION-20250528

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 12.1.9

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-VA-CCMC-20250701-20260630-CERTIFICATION-20250528		Yes	
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The separate payment term arrangement eases the administrative burden on the health plans and hospitals to renegotiate provider agreements under compressed time frames. Furthermore, the separate payment term arrangement mitigates unintended financial impacts to health plans due to varying utilization of the provider class, to the extent material variances exist, and creates greater transparency regarding payments to facilities.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☐ State general revenue

b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity

c. ☒ Health Care-Related Provider tax(es) / assessment(s)

d. ☐ Provider donation(s)

e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Provider Payment Rate Assessment	Inpatient and Outpatient Hospital Services	No	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. Provider Payment Rate Assessment	June 21, 2018	Approved	09/05/2018
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.dmas.virginia.gov/media/5569/va2023-dmas-quality-strategy-f1.pdf
- **b.** The effective date of quality strategy. February 21, 2023

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Support Efficient and Value-Driven Care: Goal 3 Focus on Paying for Value	Decrease Emergency Department Visits	Page 147
b. Providing Whole-Person Care for Vulnerable Populations: Goal 5.1, Improve Outcomes for Members with Chronic Conditions	Decrease Heart Failure Admission Rate	Page 152
c. Promote Access to Safe, Gold-Standard Patient Care: Aspirational Goal 2.1 Ensure Access to Care	Ensure Provider Network Adequacy	Page 159
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

Given Virginia's relatively recent (1) increase in managed care enrollment resulting from expansion of coverage to newly eligible individuals and (2) movement of enrollees into Medallion 4.0 and CCC Plus (merged into Cardinal Care Managed Care in 2023) because of planned program transitions, a multi-year effort will be required to evaluate improved access and the impact on inappropriate utilization and total cost of care due to increased private hospital funding. DMAS expects that payment of Medicaid rates that more closely align with Medicare and commercial rates should at least maintain, if not increase, access to needed medical services in the communities where recipients live. Increased access to care in the community usually allows for more appropriate utilization of health care services, including a reduction in emergency department visits.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. HEDIS: Ambulatory Care-Emergency Department visits/1000 Member Years; NQF # (NA); Please note change from MM to MY reflected in data updated this year.	CY 2019	835.68	Decrease year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets.	See detailed findings in Supplemental Attachment.
ii. PQI-08: Heart Failure Admission Rate; NQF #0277	CY 2019	118.31	Decrease year over year measure rate to meet VBP and Performance Withhold Program performance targets	Rate is for the unweighted average of CCC Plus population only; See detailed findings in Supplemental Attachment.
iii. Quarterly Network Adequacy Maps and Scorecards	SFY2020	Percent of members with access to all other specified, non-exempt providers (non-PCP) in which the member travels to receive covered benefits within required time and distance standards.	At least 75% of members within a county must be able to access all other specified, non-exempt providers (non-PCPs, including acute care hospitals) within required time and distance standards established in the Medallion 4.0 contract (now Cardinal Care Managed Care contract).	See detailed findings in Supplemental Attachment.
iv. Monthly Network Adequacy Maps and Scorecards	SFY2020	Percent of members with access to all other specified, non-exempt providers (non-PCP) in which the member travels to receive covered benefits within required time and distance standards.	At least 75% of members within a county must be able to access all other specified, non-exempt providers (non-PCPs, including acute care hospitals) within required time and distance standards established in the Cardinal Care Managed Care contract.	See detailed findings in Supplemental Attachment.

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

DMAS expects that payment of Medicaid rates that more closely align with Medicare and commercial rates should at least maintain, if not increase, access to needed medical services in the communities where recipients live.

DMAS has included data, findings, limitations, and evaluation details in the evaluation template submitted with this proposal. Briefly, the findings show that was progress towards performance goals for measures with one measure showing neither benchmark nor trending performance improvements. Limitations to the review of the evaluation metrics include the significant impact of the COVID-19 public health emergency and trending from previous years is suggested with caution. DMAS will continue to evaluate the performance of the selected measures for evaluating this payment arrangement to review for trends that would further impact quality of care for Virginia Medicaid members, while adjusting to the impacts of the ongoing COVID-19 pandemic. Additionally, some trending will be impacted under CCMC reporting for the evaluation of performance, and those measures will be noted in the preprint and/or supplemental documentation.

Relative to the establishment of measurements and performance targets for the current quality goals, DMAS worked with Health Services Advisory Group (HSAG) to revise the three year DMAS agency wide quality strategy that covers the Medallion 4.0 Program, the Commonwealth Coordinated Care (CCC) Plus Program and DMAS fee-for-service (FFS), as well as the change to Cardinal Care Managed Care (CCMC), for the 2023-2025 period. Benchmarks have been set to be consistent with current contract standards for the MCOs within the Quality Strategy and this application. DMAS continues to work with internal stakeholders to develop processes to continuously evaluate the effectiveness of the quality strategy through the creation of short- and long-term goals and regular progress review.

For both the managed care program, DMAS worked with its actuary to conduct an analysis of its rate-setting data to identify potentially preventable, avoidable, and/or medically unnecessary ER visits, hospital admissions, and hospital readmissions (i.e. Clinical Efficiency [CE]) analysis). DMAS distributed performance reports that allow for assessment of individual MCO performance in the areas of preventable and/or medically unnecessary ER visits, hospitalizations, and readmissions. This process also included the development of technical specifications for these metrics. The MCO withhold methodology was also implemented starting in SFY 2021, where MCOs can earn back a portion of withheld funds based on performance against metrics in each CE area. This significantly improves incentives to alter behavior and improve performance because the MCOs must avoid preventable and medically unnecessary utilization in targeted areas to earn back the withheld funds. DMAS continues work to develop comparable measures to track performance at the hospital level.

The Virginia MCOs successfully completed the federally required three-year compliance review during CY2024 to review, at a minimum, all applicable federal and state regulatory requirements including network adequacy standards and will undergo the next compliance review in CY2027.