2025 Session

Budget Bill - HB1600 (Enrolled)

Bill Order » Office of Health and Human Resources » Item 292

Department of Medical Assistance Services

Item 292	First Year - FY2025	Second Year - FY2026
Administrative and Support Services (49900)	~~$317,165,151~~ ***$320,635,151***	~~$350,856,604~~ ***$354,153,548***
General Management and Direction (49901)	~~$298,478,415~~ *$301,948,415*	~~$332,169,868~~ *$335,466,812*
Administrative Support for the Family Access to Medical Insurance Security Plan (49932)	$16,186,736	$16,186,736
CHIP Health Services Initiatives (49936)	$2,500,000	$2,500,000
Fund Sources:		
General	~~$80,776,137~~ *$81,923,962*	~~$85,824,654~~ *$87,129,375*
Special	$7,329,800	$7,329,800
Dedicated Special Revenue	~~$10,162,173~~ *$10,249,348*	~~$10,218,212~~ *$10,257,513*
Federal Trust	~~$218,897,041~~ *$221,132,041*	~~$247,483,938~~ *$249,436,860*

Authority: Title 32.1, Chapters 9 and 10, Code of Virginia; P.L. 89-97, as amended, Titles XIX and XXI, Social Security Act, Federal Code.

A.1.a. Notwithstanding any other provision of law, by November 1 of each year, the Department of Medical Assistance Services (DMAS) shall prepare and submit a forecast of Medicaid expenditures, upon which the Governor's budget recommendations will be based, for the current and subsequent two years to the Director, Department of Planning and Budget (DPB) and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees.

b. The forecast shall be based on current state and federal laws and regulations.

c. The forecast shall reflect only expenditures for medical services provided in Program 45600 and shall exclude service area 45606, service area 45607, and administrative expenditures.

d. Rebasing and inflation estimates that are required by existing law or regulation for any Medicaid provider shall be included in the forecast.

e. The forecast shall include a projection of the increases or decreases in managed care costs, including the rates that will be reflected in the upcoming July 1 contracts as well as changes in managed care rates for a three-year period including the current year.

f. In preparing for each year's forecast of the managed care portions of the budget, DMAS shall submit to its actuarial contractor a letter of request, with a copy sent to the Director, DPB and the Chairmen of the House

Appropriations and Senate Finance and Appropriations Committees. This letter shall document the department's request for a point estimate of managed care rates and changes in rates, based on the application of actuarial principals and methodologies and information available at the time of the forecast. The letter also shall require that the contractor reflect the years being forecasted, and shall specify the population groupings for which estimates are requested. The department shall request that the contractor reply in writing with a copy to all parties copied on the department's letter of request.

2. In addition to the November 1 forecast submission, DMAS shall provide: 1) a separate accounting of forecasted expenditures by caseload/utilization, inflation and policy changes; and 2) an enrollment forecast for the same period of the forecast.

3. In the development and execution of the official forecast, DMAS shall collaborate with staff from the Department of Planning and Budget (DPB), House Appropriations Committee and Senate Finance and Appropriations Committee. Further, DMAS shall consult with DPB and money committee staff throughout the year, as necessary, to review any issues that may influence the current or upcoming forecasts. Upon request from such staff, DMAS shall provide the information necessary to evaluate factors that may affect the Medicaid forecast; including, but not limited to, program utilization, enrollment, lump sum payments, and rate changes. At a minimum, DMAS shall provide such staff with program updates within 30 days after the end of each General Assembly session and fiscal year. By October 15 of each year, DMAS shall make a preliminary forecast of Medicaid expenditures available for review to staff from DPB and the House Appropriations and Senate Finance and Appropriations Committees. DMAS shall consider feedback generated from this review in the official November 1 forecast.

B.1. The Department of Medical Assistance Services (DMAS) shall submit monthly expenditure reports of the Medicaid program by service that shall compare expenditures to the official Medicaid forecast, adjusted to reflect budget actions from each General Assembly Session. *In addition, the department shall include information on service level detail, including explanations of budget and expenditure variances.* The monthly report shall be submitted to the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees within 20 days after the end of each month.

2. The Department of Medical Assistance Services shall prepare a quarterly report summarizing managed care expenditures by program and service category through the most recent quarter with three months of runout. The report shall summarize the data by service date for each quarter in the current fiscal year and the previous two fiscal years and update prior quarter expenditures. The department shall publish the report on the department's website no later than 30 days after the end of each quarter and shall notify the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees. *The department shall include in such notification information on unexpected trends that may have a significant budgetary impact.*

3. The Department of Medical Assistance Services shall track expenditures for the prior fiscal year that ended on June 30, that includes the expenditures associated with changes in services and eligibility made in the Medicaid and FAMIS programs adopted by the General Assembly in the past session(s). Expenditures related to changes in services and eligibility adopted in a General Assembly Session shall be included in the report for five fiscal years beginning from the first year the policy impacted expenditures in the Medicaid and FAMIS programs. The department shall report the expenditures of each funding change separately and show the impact by fiscal year. The report shall be submitted to the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees by December 1 of each year.

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.~~ *The Department of Medical Assistance Services (DMAS) 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 monitor Medicaid expenditures and enrollment growth to determine the program's financial status. At each meeting, DMAS shall report on expenditures (at the service level of detail) and enrollment in the Medicaid and children's health insurance programs to explain any material differences in expenditures compared to the official Medicaid forecast or children's health insurance programs forecasts, adjusted to reflect budget actions from each General Assembly Session. In addition, DMAS shall report on enrollment trends by eligibility category and indicate differences in actual enrollment as compared to the most recent forecast of enrollment. If expenditures are exceeding the budget for Medicaid or the children's health insurance programs, the department shall provide options to bring expenditures in line with available resources. At each meeting, DMAS 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, DMAS shall provide an analysis at each meeting on spending and utilization trends within the the managed care programs with a focus on trends that indicate higher growth than was anticipated in the capitation rates. 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.*

5. DMAS shall monitor the Medicaid and children's health insurance programs to ensure cost-effectiveness of these programs in the delivery of health care services and develop strategies to achieve such cost-effectiveness and report on such strategies to the Governor and the General Assembly on an annual basis, by no later than September 1 of each year.

6. DMAS may only implement policy or programmatic changes to the Medicaid or children's health insurance programs after performing an analysis of potential costs to the Commonwealth. Any policy or programmatic change with a fiscal impact, for which no appropriation has been provided, shall only be implemented if it has been specifically authorized by the General Assembly through a general appropriation act, a statutory requirement, or is otherwise required by federal law. At least 15 days prior to the implementation of any change that may have a cost for which the agency does not have legislative appropriation, DMAS shall notify the Director, Department of Planning and Budget, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees.

C. The Department of Medical Assistance Services shall report a detailed accounting, annually, of the agency's organization and operations. This report shall include an organizational chart that shows all full- and part-time positions (by job title) employed by the agency as well as the current management structure and unit responsibilities. The report shall also provide a summary of organization changes implemented over the previous year. The report shall be made available on the department's website by August 15 of each year.

D. The Department of Medical Assistance Services shall, within 15 days of receiving a deferral of federal grant funds, or release of a deferral, or a disallowance letter, notify the Director, Department of Planning and Budget, and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees of such

deferral action or disallowance. The notice shall include the amount of the deferral or disallowance and a detailed explanation of the federal rationale for the action. Any federal documentation received by the department shall be attached to the notification.

E.1. It is the intent of the General Assembly that the Department of Medical Assistance Services provide data regarding Medicaid and other programs operated by the department on their public website. The department shall maintain a central website that consolidates data and statistical information to make the information readily available to the general public. At a minimum the information included on such website shall include *(i)* monthly enrollment data~~,~~*; (ii)* expenditures by service~~,~~*; (iii) policy changes authorized by the General Assembly in the prior fiscal year, including the amount appropriated to address the fiscal impact and a 6-year projection of costs; and (iv) a list of programmatic and policy changes, including but not limited to, state plan amendments, federal waiver renewals and amendments, regulatory changes, guidance document changes, provider manuals and memos, managed care contract changes, technical assistance manual changes, or any other communication of official policy proposed by DMAS. The list shall include a brief description of the change, the authority for the change, an assessment of potential costs or savings,* and other relevant data.

2. The department shall make Medicaid and other agency data stored in the agency's data warehouse available through the department's website that includes, at a minimum, interactive tools for the user to select, display, manipulate and export requested data.

3. The Department of Medical Assistance Services shall post on its website the complete State Plan for Medical Assistance along with all amendments in an easily searchable format to be accessible to the public.

4. Within five days of any submission of a State Plan amendment to the Centers for Medicare and Medicaid Services, the Department of Medical Assistance Services shall post such submission on its website. The department shall also post any federal approval documents once the State Plan amendment is approved.

~~5. The department shall publish a document on its website, updated annually, that lists all policy changes, including their fiscal impact, for the Medicaid program for the preceding fiscal year.~~

F. The Department of Medical Assistance Services shall notify the Director, Department of Planning and Budget, and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees at least 30 days prior to any change in capitated rates for managed care companies. The notification shall include the amount of the rate increase or decrease, and the projected impact on the state budget.

G. The Department of Medical Assistance Services, to the extent permissible under federal law, shall enter into an agreement with the Department of Behavioral Health and Developmental Services to share Medicaid claims and expenditure data on all Medicaid-reimbursed mental health, intellectual disability and substance abuse services, and any new or expanded mental health, intellectual disability ~~retardation~~ and substance abuse services that are covered by the State Plan for Medical Assistance. The information shall be used to increase the effective and efficient delivery of publicly funded mental health, intellectual disability and substance abuse services.

H. The Department of Medical Assistance Services (DMAS) shall collect and provide to the Office of Children's Services (OCS) all information and data necessary to ensure the continued collection of local matching dollars associated with payments for Medicaid eligible services provided to children through the Children's Services Act. This information and data shall be collected by DMAS and provided to OCS on a monthly basis.

I. The Department of Medical Assistance Services in cooperation with the State Executive Council, shall provide semi-annual training to local Children's Services Act teams on the procedures for use of Medicaid for residential treatment and treatment foster care services, including, but not limited to, procedures for determining eligibility, billing, reimbursement, and related reporting requirements. The department shall include in this training information on the proper utilization of inpatient and outpatient mental health services as covered by the

Medicaid State Plan.

J. The Departments of Medical Assistance Services (DMAS) and Social Services (DSS) shall collaborate with the League of Social Services Executives, and other stakeholders to analyze and report data that demonstrates the accuracy, efficiency, compliance, quality of customer service, and timeliness of determining eligibility for the Medicaid and CHIP programs. Based on this collaboration, the departments shall develop meaningful performance metrics on data in agency systems that shall be used to monitor eligibility trends, address potential compliance problem areas and implement best practices. DMAS shall maintain on its website a public dashboard on eligibility performance that includes performance metrics developed through collaborative efforts as well as the performance of local departments of social services and any centralized eligibility-processing unit. Effective August 1, 2018 this dashboard shall be updated for the previous quarter and 30 days following the end of each quarter thereafter.

K. In addition to any regional offices that may be located across the Commonwealth, any statewide, centralized call center facility that operates in conjunction with a brokerage transportation program for persons enrolled in Medicaid or the Family Access to Medical Insurance Security plan shall be located in Norton, Virginia.

L. The Department of Medical Assistance Services, in collaboration with the Department of Social Services, shall require Medicaid eligibility workers to search for unreported assets at the time of initial eligibility determination and renewal, using all currently available sources of electronic data, including local real estate property databases and the Department of Motor Vehicles for all Medicaid applicants and recipients whose assets are subject to an asset limit under Medicaid eligibility requirements.

M.1. The Department of Medical Assistance Services shall require eligibility workers to verify income, using currently available Virginia Employment Commission data, for applicants and recipients who report no earned or unearned income. The Department shall require all Medicaid eligibility workers to apply the same protocols when verifying income for all applicants and recipients, including those who report no earned or unearned income.

2. The Department shall amend the Virginia Medicaid application, upon approval of the federal Centers for Medicare and Medicaid Services, to require a Medicaid applicant to opt out if such applicant does not want to grant permission to the state to use his federal tax returns for the purposes of renewing eligibility. The department shall implement the necessary regulatory changes and other necessary measures to be consistent with federal approval of any appropriate State Plan changes, and prior to the completion of any regulatory process undertaken in order to effect such change.

N.1. The Department of Medical Assistance Services shall report on the operations and costs of the Medicaid call center (also known as the Cover Virginia Call Center). This report shall include the number of calls received on a monthly basis, the purpose of the call, the number of applications for Medicaid submitted through the call center, and the costs of the contract. The department shall submit the report by August 15 of each year to the Director, Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees.

2. Out of this appropriation, $3,889,800 the first year and $3,889,800 the second year from the general fund and $10,868,700 the first year and $10,868,700 the second year from nongeneral funds is provided for the enhanced operation of the Cover Virginia Call Center as a centralized eligibility processing unit (CPU) that shall be limited to processing Medicaid applications received from the Federally Facilitated Marketplace, telephonic applications through the call center, or electronically submitted Medicaid-only applications. The department shall report the number of applications processed on a monthly basis and payments made to the contractor to the Director, Department of Planning and Budget and the Chairman of the House Appropriations and Senate Finance and Appropriations Committees. The report shall be submitted no later than 60 days after the end of each quarter of the fiscal year.

O. Out of this appropriation, $15,462,264 the first year and $15,462,264 the second year from the general fund and

$62,407,632 the first year and $62,407,632 the second year from nongeneral funds shall be provided to maintain and operate the Medicaid Enterprise System.

P.1. Out of this appropriation, $6,035,000 the first year and $6,035,000 the second year from special funds is appropriated to the Department of Medical Assistance Services (DMAS) for the disbursement of civil money penalties (CMP) levied against and collected from Medicaid nursing facilities for violations of rules identified during survey and certification as required by federal law and regulation. Based on the nature and seriousness of the deficiency, the agency or the Centers for Medicare and Medicaid Services may impose a civil money penalty, consistent with the severity of the violations, for the number of days a facility is not in substantial compliance with the facility's Medicaid participation agreement. Civil money penalties collected by the Commonwealth must be applied to the protection of the health or property of residents of nursing facilities found to be deficient. Penalties collected are to be used for (1) the payment of costs incurred by the Commonwealth for relocating residents to other facilities; (2) payment of costs incurred by the Commonwealth related to operation of the facility pending correction of the deficiency or closure of the facility; and (3) reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or individuals used by the facility to provide services to residents. These funds are to be administered in accordance with the revised federal regulations and law, 42 CFR 488.400 and the Social Security Act § 1919(h), for Enforcement of Compliance for Long-Term Care Facilities with Deficiencies. Any special fund revenue received for this purpose, but unexpended at the end of the fiscal year, shall remain in the fund for use in accordance with this provision.

2. Of the amounts appropriated in P.1. of this Item, up to $225,000 the first year and $225,000 the second year from special funds may be used for the costs associated with administering CMP funds.

3. Of the amounts appropriated in P.1. of this Item, up to $2,310,000 the first year and $2,310,000 the second year from the special funds may be used for special projects that benefit residents and improve the quality of nursing ~~F~~*f* acilities.

4. Out of the amounts appropriated in P.1. of this Item, $3,500,000 the first year and $3,500,000 the second year from special funds shall be used for a quality improvement program addressing nursing facility capacity building. The program design may be based on the results of the Virginia Gold Quality Improvement Program pilot project, to include peer mentoring, job-related and interpersonal skills training, and work-related benefits. The Department of Medical Assistance Services shall seek approval from the Centers for Medicare &Medicaid Services (CMS) to implement the program.

5. By October 1 of each year, the department shall provide an annual report of the previous fiscal year that includes the amount of revenue collected and spending activities to the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees and the Director, Department of Planning and Budget.

6. No spending or activity authorized under the provisions of paragraph P. of this Item shall necessitate general fund spending or require future obligations to the Commonwealth.

7. The department shall maintain a CMP special fund balance of at least $1.0 million to address emergency situations in Virginia's nursing facilities.

8. The Department of Medical Assistance Services is authorized to administratively request up to $2,000,000 of additional special fund appropriation for special projects if 1) the appropriated amounts in P.3. are insufficient; and 2) such projects and costs are approved by the Centers for Medicare and Medicaid Services (CMS) for the Civil Money Penalty Reinvestment State Plan. The Department of Planning Budget shall approve such requests provided the required conditions are met.

Q. Out of this appropriation, $100,000 the first year and $100,000 the second year from the general fund shall be provided to contract with the Virginia Center for Health Innovation for research, development and tracking of

innovative approaches to healthcare delivery.

R. The Department of Medical Assistance Services shall, prior to the end of each fiscal quarter, determine and properly reflect in the accounting system whether pharmacy rebates received in the quarter are related to fee-for-service or managed care expenditures and whether or not the rebates are prior year recoveries or expenditure refunds for the current year. The state share of pharmacy rebates for the quarter determined to be prior year revenue shall be deposited to the Virginia Health Care Fund before the end of the fiscal quarter. The department shall create and use a separate revenue source code to account for pharmacy rebates in the Virginia Health Care Fund.

S. Out of this appropriation, $87,500 the first year and $87,500 the second year from the general fund and $262,500 the first year and $262,500 second year from nongeneral funds shall be provided for support of the All Payer Claims Database operated by Virginia Health Information. This appropriation is contingent on federal approval of an Operational Advanced Planning Document.

T. Out of this appropriation, $875,000 the first year and $875,000 the second year from the general fund and $1,625,000 the first year and $1,625,000 the second year from nongeneral funds is provided for the Department of Medical Assistance Services to amend the State Plan and any waivers under Title XXI to fund $2,500,000 annually for ~~three~~ *two* Poison Control centers serving Virginia as part of a Health Services Initiative. The department shall have the authority to promulgate emergency regulations to implement these amendments within 280 days or less from the enactment of this Act.

U. Notwithstanding any other provision of law, the Department of Medical Assistance Services (DMAS) shall have the authority to adjust the date of any agency payments should doing so allow the agency to maximize federal reimbursement. This language shall only apply to the extent that any impacted payments or reimbursements are allowable and appropriate under state and federal rules.

V. The Department of Medical Assistance Services shall amend regulations to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of documents and decision deadlines for de novo client hearings. The department shall have the authority to promulgate emergency regulations to implement these amendments within 280 days or less from the enactment of this Act.

W. Out of this appropriation, $447,700 the first year and $447,700 the second year from the general fund and $1,212,666 the first year and $1,212,666 the second year from nongeneral funds is provided to implement the Virginia Facilitated Enrollment Program.

X. Out of this appropriation, $1,319,515 the first year and $1,319,515 the second year from the general fund and $3,798,129 the first year and $3,798,129 the second year from federal funds is provided to support the Emergency Department Care Coordination Program (EDCC) as allowed by the Centers for Medicare and Medicaid Services. The Department of Medical Assistance Services, in cooperation with the Virginia Department of Health, shall establish a work group comprised of the EDCC contractor, the Virginia Health Information, Medicaid and commercial managed care organizations, health systems with emergency departments and emergency department physicians to optimize the use of the system and any enhancements to the system to facilitate communication and collaboration among physicians, other healthcare providers and other clinical and care management personnel about patients receiving services in hospital emergency departments for the purpose of improving the quality of care.

Y. Out of this appropriation, $90,000 the first year and $90,000 the second year from the general fund and $90,000 the first year and $90,000 the second year from federal funds shall be used by the agency to hire a full time employee in the provider reimbursement division. This employee shall have the actuarial and accounting experience necessary to provide ongoing expertise on nursing facility reimbursement and rate methodology issues.

Z. Out of this appropriation, $300,000 the first year and $300,000 the second year from the general fund and $300,000 the first year and $300,000 the second year from federal funds shall be used by the agency to hire five additional full-time employees to augment existing staff in the agency's finance division. Specifically, the Department of Medical Assistance Services shall hire three additional positions in the budget division, one additional position in the fiscal division and one additional position in the provider reimbursement division. The agency shall inform the Director, Department of Planning and Budget once these positions are hired. In addition, these positions shall be highlighted in the agency's annual organizational report.

AA. Out of this appropriation, $551,010 the first year and $551,010 the second year from the general fund and $1,530,583 the first year and $1,530,583 the second year from nongeneral funds is provided for 17 positions to improve Third-Party Liability (TPL) recoveries. These additional positions shall augment the existing 17 positions currently utilized by the Department of Medical Assistance Services to support TPL recovery efforts. DMAS shall utilize a minimum of 34 positions to perform TPL recoveries. DMAS shall make information related to TPL activities available on the agency website. This data should be updated quarterly and include, but not be limited to, state and federal compliance status, backlogs and amounts recovered.

BB. Out of this appropriation, $85,000 the first year and $85,000 the second year from the general fund and $85,000 the first year and $85,000 the second year from federal funds is provided for a position to support agency responsibilities associated with developmental disability waiver services. Effective July 1, 2023, the Department of Medical Assistance Services shall be fully responsible for all financial analysis, rates, and budget work associated with Virginia's developmental disability waiver services.

CC. Three positions are provided to replace contractual staff in the eligibility and enrollment unit. The department shall utilize a minimum of four classified positions to support this unit's activities.

DD. Out of this appropriation, $1,000,000 the first year and $2,200,00 the second year from the general fund and $8,000,000 the first year and $19,800,000 the second year from nongeneral funds is provided to replace the agency fiscal agent services system. The Director, Department of Planning and Budget, shall unallot this appropriation until the Department of Medical Assistance Services provides documentation of actual costs to replace the system and shall only allot the amounts needed for actual expenditures in each fiscal year.

EE. Out of this appropriation, $590,000 the first year and $590,000 the second year from the general fund shall be provided to enhance the oversight of the Cardinal Care Managed Care Contract. The department shall increase the staff support for managed care contract operations by three positions.

FF. The Department of Medical Assistance Services shall improve efforts to determine if individuals applying for and enrolled in the Medicaid and CHIP programs are eligible for alternative health care coverage. The department shall report on its efforts, as well as potential strategies to enhance coverage identifications, to the Chairmen of the House Appropriations and Senate Appropriations and Finance Committees and the Director, Department of Planning and Budget by October 1 of each year.

GG. The Department of Medical Assistance (DMAS) shall convene a workgroup to evaluate the criteria for hospitals to qualify for disproportionate share hospital (DSH) payments. The workgroup shall evaluate current DSH criteria, including the Medicaid inpatient utilization rate, to determine changes that are necessary to reflect the impact from the Commonwealth's expansion of Medicaid in 2019. The workgroup shall recommend a new Medicaid inpatient utilization threshold to qualify for DSH payments to ensure that those hospitals with the largest uncompensated care costs are receiving appropriate DSH payments. The workgroup shall include representatives from DMAS, the Department of Planning and Budget, and staff from the House Appropriations and Senate Finance and Appropriations Committees. The workgroup shall report its findings to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2024.

HH. Out of this appropriation, $500,000 from the general fund and $500,000 from nongeneral funds the first year shall be provided to the Department of Medical Assistance Services (DMAS) to hire a consultant, with Medicaid-specific knowledge related to eligibility determination, process-design and information technology, to evaluate Medicaid eligibility determination in the Commonwealth. The consultant shall conduct a systematic review and evaluate all aspects of Medicaid eligibility determination as performed by DMAS and local departments of social services (LDSS). This review shall include, but not be limited to, the following: (i) evaluate the current information technology systems; (ii) measure the accuracy, processing times and efficiency of current eligibility determination processes; (iii) determine how well the current structure and systems handle high volumes; (iv) assess the current level of automation and determine processes that could be streamlined; (v) analyze the overall cost-effectiveness of how eligibility is conducted, considering staffing costs and ongoing operational expenses; (vi) examine best practices in other states; and (vii) develop cost-effective options for enhancing eligibility determination in the Commonwealth including alternative delivery models. DMAS, the Department of Social Services, and LDSS shall provide full cooperation with the consultant and provide the necessary assistance to conduct the required evaluation. The consultant shall be required to report their findings and recommendations directly to the Governor, Department of Planning and Budget, and Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 15, 2024. The Director, Department of Planning and Budget, shall unallot this appropriation until the Department of Medical Assistance Services provides documentation of the contract's cost, and shall only allot the amount needed for the contract.

II. Out of this appropriation, $162,825 the first year and $48,871 the second year from the general fund and $337,175 the first year and $48,871 the second year from nongeneral funds is provided to support the administrative cost of implementing an 1115 serious mental illness waiver. Any unexpended balance in this paragraph at the close of business on June 30, 2025 associated with unpaid implementation costs shall not revert to the general fund but shall be carried forward and reappropriated.

JJ. Out of this appropriation, $250,000 the first year from the general fund and $250,000 the first year from federal funds shall be provided to contract with the Virginia Task Force on Primary Care (VTFPC) to conduct research dedicated to guiding Medicaid policy as it relates to primary health care. By October 1, 2025, VTFPC shall provide an update to the Department of Medical Assistance Services (DMAS) on its research activities. DMAS shall provide this update to the Director, Department of Planning and Budget and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees upon receipt.

KK. Out of this appropriation, $2,104,607 the first year and $4,065,218 the second year from the general fund and $4,611,459 the first year and $9,070,391 the second year from nongeneral funds is provided for the Department of Medical Assistance Services to contract with a vendor to handle all mail directed to local departments of social services associated with medical assistance services. Any unexpended balance in this paragraph at the close of business on June 30, 2025 associated with unpaid implementation costs shall not revert to the general fund but shall be carried forward and reappropriated.

LL. Out of this appropriation, $235,000 from the general fund and $235,000 from nongeneral funds the first year shall be provided to implement the provisions of House Bill 1804, as passed during the 2025 Regular Session. Any unexpended balances for the purposes specified in this paragraph which are unexpended on June 30, 2025, shall not revert to the general fund but shall be carried forward and reappropriated in fiscal year 2026.

MM.1. Out of this appropriation, $500,000 from the general fund and $500,000 from nongeneral funds the first year shall be provided to the Department of Medical Assistance Services (DMAS) to conduct a comprehensive evaluation of the potential benefits, cost savings, and implementation considerations associated with utilizing a single third-party administrator to serve as the pharmacy benefit manager (PBM) for all Medicaid pharmacy benefits. This evaluation shall include an analysis of financial efficiencies, improved transparency, and the impact on patient access to pharmacy services, including community critical access pharmacies, along with timelines and cost for both implementation and ongoing operation and maintenance. As part of this process, DMAS shall engage an independent consultant with direct experience: (i) advising Medicaid fraud control units; and (ii) working with

states that have transitioned to a single PBM model, to assess best practices and provide guidance on structuring a model that maximizes cost savings and operational effectiveness. The consultant shall not be currently engaged by any managed care organization or by any PBM contracted with a managed care organization.

2. The evaluation shall also include a detailed assessment of the implementation costs associated with transitioning to a single PBM model. Any such implementation costs shall be analyzed in comparison to the projected cost savings identified in the independent evaluation to ensure fiscal accountability. Additionally, the evaluation shall include a review of fee-for-service and managed care pharmacy dispensing fees and provide recommendations for adjustments necessary to maintain adequate pharmacy participation and patient access. DMAS shall report its findings, including projected implementation and ongoing costs, anticipated cost savings, recommended pharmacy dispensing fees, timeline for implementation, and any other recommendations for improving the administration of Medicaid pharmacy benefits, to the Governor and the General Assembly by December 1, 2025. Any unexpended balances for the purposes specified in paragraph MM.1. and MM.2. which are unexpended on June 30, 2025, shall not revert to the general fund but shall be carried forward and reappropriated in fiscal year 2026.

NN. No appropriation in this item shall be used to fund any study of medical assistance provider rates unless the General Assembly has provided specific authorization for such study. This provision shall not apply to routine rate work that is necessary to administer medical assistance programs under existing state and federal law.

OO. The Department of Medical Assistance Services is authorized to conduct a rate study of Developmental Disabilities Services required pursuant to the Permanent Injunction (Civil Action No. 3:12CV59-JAG). The department shall include stakeholders as part of the rate development process and consider their feedback in the process. The department shall submit a report with the recommended rates and associated fiscal impact to the Governor, the Director of the Department of Planning and Budget, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2025.

PP. Out of this appropriation, $206,889 the first year and $3,094,795 the second year from the general fund and $2,832,111 the first year and $16,216,115 the second year from nongeneral funds shall be provided for the Department of Medical Assistance Services to contract with a vendor to implement identified solutions to assist in timely and accurate Medicaid eligibility determinations and redeterminations. Solutions may include additional data checks to verify financial eligibility, additional data matching capability, and a portal to receive and track coverage corrections for enrollment requests between the 120 local departments of social services. Funding may be used to make enhancements to the Medicaid Management Information System and the Virginia Case Management System to implement the identified solutions. The Director of the Department of Planning and Budget shall unallot this appropriation until the Department of Medical Assistance Services provides documentation of the contract's cost and shall only allot the amount contracted for with such vendor.

QQ. Effective upon enactment of this act, the Department of Medical Assistance Services, related to appeals administered by and for the department, shall have authority to amend regulations to require provider appeals to be filed only online through the department's appeal portal. Exceptions may be requested before a filing deadline by a provider for good cause for situations, such as lack of internet access in rural areas or other extenuating circumstances explained by the filing provider. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

RR. The Department of Medical Assistance Services shall make efforts to ensure that pregnant women that apply for Medicaid coverage utilize the Cover Virginia call center, to the maximum extent possible, in order to reduce the processing time of the application and expedite the applicant into coverage. The department shall collaborate with the Department of Social Services to ensure that local departments of social services have in place procedures and processes to connect pregnant women to the Cover Virginia call center to apply for coverage, unless such person is required to apply through a local department due to eligibility for other benefits programs.

SS. The Department of Medical Assistance Services, in collaboration with the Department of Social Services, shall develop cost estimates for the options proposed in the "Evaluation of Medicaid Eligibility Determination" report to the General Assembly in December 2024 and report back to the Governor, the Director of the Department of Planning and Budget, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by September 15, 2025.

TT. The Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS) shall design and institutionalize a joint Steering Committee on Medicaid Eligibility. The Steering Committee shall: (i) document the areas in which DMAS and DSS need to collaborate; (ii) develop and agree upon a charter for the committee that outlines the types of decision rights each agency has independently versus what the Steering Committee oversees, membership, meeting schedule, topics leadership needs routine visibility on, a process for escalating issues to the Steering Committee, a process for the staff to brief the Steering Committee, and a process for coordinating and briefing the Secretary of Health and Human Resources or other state leaders as needed; (iii) determine when special initiatives or task forces are required to ensure focused collaboration on key issues; (iv) have oversight over Medicaid eligibility improvement efforts; and (v) have the authority to establish a stakeholder advisory forum to inform improvement efforts.