2026 Special Session I

Budget Bill - HB30 (Chapter 1)

Bill Order » Office of Health and Human Resources » Item 291

Department of Medical Assistance Services

Item 291	First Year - FY2027	Second Year - FY2028
Medicaid Program Services (45600)	**$29,049,133,478**	**$30,632,271,110**
Payments for Graduate Medical Education Residencies (45606)	$17,100,000	$17,100,000
Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607)	$58,125,422	$58,020,754
Reimbursements for Behavioral Health Services (45608)	$43,897,969	$44,715,321
Reimbursements for Medical Services (45609)	$16,886,846,863	$17,936,986,714
Reimbursements for Long-Term Care Services (45610)	$3,281,309,764	$3,474,362,339
Payments for Healthcare Coverage for Low-Income Uninsured Adults (45611)	$8,761,853,460	$9,101,085,982
Fund Sources:		
General	$8,221,315,702	$8,758,261,987
Special	$9,512,946	$9,512,946
Dedicated Special Revenue	$2,888,589,343	$2,988,699,452
Federal Trust	$17,929,715,487	$18,875,796,725

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

A. If any part, section, subsection, paragraph, clause, or phrase of this Item or the application thereof is declared by the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services to be in conflict with a federal law or regulation, such decisions shall not affect the validity of the remaining portions of this Item, which shall remain in force as if this Item had passed without the conflicting part, section, subsection, paragraph, clause, or phrase. Further, if the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services determines that the process for accomplishing the intent of a part, section, subsection, paragraph, clause, or phrase of this Item is out of compliance or in conflict with federal law and regulation and recommends another method of accomplishing the same intent, the Director, Department of Medical Assistance Services, after consultation with the Attorney General, is authorized to pursue the alternative method.

B. To the extent that appropriations in this Item are insufficient, the Department of Planning and Budget shall transfer general fund appropriation, as needed, from Children's Health Insurance Program Delivery (44600) and Medical Assistance Services for Low Income Children (46600), if available, into this Item to be used as state match for federal Title XIX funds.

C. Notwithstanding any other provision of law, any unexpended general fund appropriation remaining in this Item on the last day of each fiscal year shall revert to the general fund and shall not be reappropriated in the following fiscal year.

D.1. The Department of Medical Assistance Services shall delay the last quarterly payment of certain quarterly amounts paid to hospitals, from the end of each state fiscal year to the first quarter of the following year. Quarterly payments that shall be delayed from each June to each July shall be Disproportionate Share Hospital payments, Indirect Medical Education payments, and Direct Medical Education payments. The department shall have the authority to implement this reimbursement change effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall make the monthly capitation payment to managed care organizations for the member months of each month in the first week of the subsequent month. The department shall have the authority to implement this reimbursement schedule change effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. In every June, the remittance that would normally be paid to providers on the last remittance date of the state fiscal year shall be delayed one week longer than is normally the practice. This change shall apply to the remittances of Medicaid and FAMIS providers. This change does not apply to providers who are paid a per-month capitation payment. The department shall have the authority to implement this reimbursement change effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such change.

E. Out of this appropriation, $28,998,773 the first year and $28,998,773 the second year from the general fund and $29,126,649 the first year and $29,021,981 the second year from the federal trust fund is provided for reimbursement to the institutions within the Department of Behavioral Health and Developmental Services.

F.1. The estimated revenue for the Virginia Health Care Fund is $399,050,000 the first year and $388,350,000 the second year, to be used pursuant to the uses stated in § 32.1-367, Code of Virginia.

2. Notwithstanding any other provision of law, revenues deposited to the Virginia Health Care Fund shall only be used as the state share of Medicaid unless specifically authorized by this act.

3. Notwithstanding § 32.1-366, Code of Virginia, the State Comptroller shall deposit 41.5 percent of the Commonwealth's allocation of the Master Settlement Agreement with tobacco product manufacturers, as defined in § 3.2-3100, Code of Virginia, to the Virginia Health Care Fund.

4. The state share, not including hospital assessment dollars, of any repayment by managed care organizations resulting from exceeding their profit caps for not meeting the medical loss ratios pursuant to their contracts with the Department of Medical Assistance Services, shall be deposited to the Health Care Fund.

G. At least 45 days prior to the submission of any state plan or waiver amendment or renewal of such, to the Centers for Medicare and Medicaid Services or change in the contracts with managed care organizations, the Department of Medical Assistance Services shall provide written notification to the Director, Department of Planning and Budget as to the purpose of such change. This notice shall also assess whether the amendment will require any future state regulatory action or expenditure beyond that which is appropriated in this act. If the Department of Planning and Budget, after review of the proposed change, determines that it may likely result in a material fiscal impact on the general fund, for which no legislative appropriation has been provided, then the Department of Medical Assistance Services shall delay the proposed change until the General Assembly authorizes such action and notify the Chairs of the House Appropriations and Senate Finance and Appropriations Committees of such action.

H.1. The Director, Department of Medical Assistance Services shall seek the necessary waivers from the United States Department of Health and Human Services to authorize the Commonwealth to cover health care services and delivery systems, as may be permitted by Title XIX of the Social Security Act, which may provide less expensive alternatives to the State Plan for Medical Assistance.

2. At least 30 days prior to the submission of an application for any new waiver of Title XIX or Title XXI of the Social Security Act, the Department of Medical Assistance Services shall notify the Chairs of the House Appropriations and Senate Finance and Appropriations Committees of such pending application and provide information on the purpose and justification for the waiver along with any fiscal impact. If the department receives an official letter from either Chair raising an objection about the waiver during the 30-day period, the department shall not submit the waiver application and shall request authority for such waiver as part of the normal legislative or budgetary process. If the department receives no objection, then the application may be submitted. Any waiver specifically authorized elsewhere in this Item is not subject to this provision. Waiver renewals are not subject to the provisions of this paragraph.

3. The director shall promulgate such regulations as may be necessary to implement those programs which may be permitted by Titles XIX and XXI of the Social Security Act, in conformance with all requirements of the Administrative Process Act.

I.1. Notwithstanding § 30-347, Code of Virginia, or any other provision of law, the Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act (PPACA).

2. In the event that the increased federal medical assistance percentages for newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA are modified through federal law or regulation from the methodology in effect on January 1, 2014, resulting in a reduction in federal medical assistance as determined by the department in consultation with the Department of Planning and Budget, the Department of Medical Assistance Services shall disenroll and eliminate coverage for individuals who obtained coverage through 42 U.S.C. § 1396d(y)(1) [2010] of the PPACA. The disenrollment process shall include written notification to affected Medicaid beneficiaries, Medicaid managed care plans, and other providers that coverage will cease as soon as allowable under federal law following the date the department is notified of a reduction in Federal Medical Assistance Percentage.

J. The Department of Medical Assistance Services shall adjust the medically needy income limits for the Medicaid program annually to account for changes in the Consumer Price Index.

K. The Department of Medical Assistance Services, in cooperation with the Department of Social Services' Division of Child Support Enforcement (DSCE), shall identify and report third party coverage where a medical support order has required a custodial or noncustodial parent to enroll a child in a health insurance plan. The Department of Medical Assistance Services shall also report to the DCSE third party information that has been identified through their third party identification processes for children handled by DCSE.

L.1. Notwithstanding the provisions of § 32.1-325.1:1, Code of Virginia, upon identifying that an overpayment for medical assistance services has been made to a provider, the Director, Department of Medical Assistance Services shall notify the provider of the amount of the overpayment. Such notification of overpayment shall be issued within the earlier of (i) four years after payment of the claim or other payment request, or (ii) four years after filing by the provider of the complete cost report as defined in the Department of Medical Assistance Services' regulations, or (iii) 15 months after filing by the provider of the final complete cost report as defined in the Department of Medical Assistance Services' regulations subsequent to sale of the facility or termination of the provider.

2. Notwithstanding the provisions of § 32.1-325.1, Code of Virginia, the director shall issue an informal fact-finding conference decision concerning provider reimbursement in accordance with the State Plan for Medical Assistance, the provisions of § 2.2-4019, Code of Virginia, and applicable federal law. The informal fact-finding conference decision shall be issued within 180 days of the receipt of the appeal request, except as provided herein. If the agency does not render an informal fact-finding conference decision within 180 days of the receipt of the appeal request or, in the case of a joint agreement to stay the appeal decision as detailed below, within the time remaining after the stay expires and the appeal timeframes resume, the decision is deemed to be in favor of the provider. An appeal of the director's informal fact-finding conference decision concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the State Plan for Medical Assistance provided for in § 32.1-325, Code of Virginia. The Department of Medical Assistance Services and the provider may jointly agree to stay the deadline for the informal appeal decision or for the formal appeal recommended decision of the Hearing Officer for a period of up to sixty (60) days to facilitate settlement discussions. If the parties reach a resolution as reflected by a written settlement agreement within the sixty-day period, then the stay shall be extended for such additional time as may be necessary for review and approval of the settlement agreement in accordance § 2.2-514 of the Code of Virginia. Once a final agency case decision has been made, the director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the informal fact-finding conference decision or the final agency case decision. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313, Code of Virginia, from the date the Director's agency case decision becomes final.

M.1.a. As of July 1, 2026, the Community Living (CL) waiver authorizes 12,520 slots.

b. As of July 1, 2026, the Family and Individuals Support (FIS) waiver authorizes 8,559 slots.

c. As of July 1, 2021, the Building Independence (BI) waiver authorizes 400 slots.

2. Notwithstanding Chapters 228 and 303 of the 2009 Virginia Acts of Assembly and §32.1-323.2 of the Code of Virginia, the Department of Medical Assistance Services shall not add any slots to the Intellectual Disabilities Medicaid Waiver or the Individual and Family Developmental Disabilities and Support Medicaid Waiver other than those slots authorized specifically to support the Money Follows the Person Demonstration, individuals who are exiting state institutions, any slots authorized under Chapters 724 and 729 of the 2011 Virginia Acts of Assembly or §37.2-319, Code of Virginia, or authorized elsewhere in this act.

3. Upon approval by the Centers for Medicare and Medicaid Services of the application for renewal of the CL, FIS and BI waivers, expeditious implementation of any revisions shall be deemed an emergency situation pursuant to § 2.2-4002 of the Administrative Process Act. Therefore, to meet this emergency situation, the Department of Medical Assistance Services shall promulgate emergency regulations to implement the provisions of this act.

N.1. Effective July 1, 2026, the Department of Medical Assistance Services shall have the authority to include modifications to the Cardinal Care Managed Care Contract as necessary to implement actions specifically authorized through language included in this act.

2. Any managed care contract with selected managed care organizations shall not include the following services, which shall remain in fee-for-service: (i) dental services; (ii) developmental disability waiver services; (iii) and other services currently excluded from the managed care contracts. The Department of Medical Assistance Services shall not include any new services in the contract unless explicitly authorized by the General Assembly.

3. The Department of Medical Assistance Services shall ensure that the cost of any programmatic and/or contractual changes are fully accounted for in the Appropriation Act and shall not create any future funding commitments unless authorized by the General Assembly.

4. The Department of Medical Assistance Services (DMAS) may make changes to the member intelligent

assignment process and may suspend random assignments to a managed care organization (MCO) if the MCO has 40 percent of enrolled lives within an operational region. DMAS shall make no changes in the reassignment methodology unless specifically authorized by the General Assembly.

5. The Department of Medical Assistance Services shall track and report on compliance with NCQA response time standards for each managed care organization, broken down by service type. Such tracking shall include: (i) How often total response time, from initial submittal until service authorization or denial, exceeds the NCQA standards; and (ii) How often appeals are filed, and of those, how often are services subsequently approved and how often they are denied. The department shall publish the data on these items on a quarterly basis to the department's website.

6. The Department of Medical Assistance Services shall report to the General Assembly on spending and utilization trends within Medicaid managed care, with detailed population and service information and include an analysis and report on the underlying reasons for these trends, the agency's and managed care organizations' initiatives to address undesirable trends, and the impact of those initiatives. The report shall be submitted each year by September 1.

O.1. The Department of Medical Assistance Services shall include in all its contracts with managed care organizations (MCO) the following:

a. A quality withhold program including but not limited to increasing withhold amount from one percent to three percent as well as DMAS internal processes and reporting responsibilities. The withhold amount shall not exceed one percent in the first and second years of the contract. In years three and four of the contract the withhold amount shall not exceed two percent. Beginning in year five of the contract, the withhold shall not exceed three percent.

b. A provision requiring the managed care organizations to return 50 percent of the underwriting gain in excess of three percent of Medicaid premium income up to six percent; return 75 percent of the underwriting gain in excess of six percent of Medicaid premium income up to eight percent and return 100 percent of the underwriting gain above eight percent.

c. A requirement for detailed financial and utilization reporting. The reported data shall include: (i) income statements that show expenses by service category; (ii) balance sheets; (iii) information about related-party transactions; and (iv) information on service utilization metrics.

d. Behavioral health-specific metrics to identify undesirable trends in service utilization.

e. A report on managed care organization policies and processes for identifying behavioral health providers who provide inappropriate services and the number of such providers that are disenrolled.

f. A requirement for annual reporting with regard to Medicaid Community Mental Health Rehabilitation Services on: (i) the number of providers in their network and their geographic locations; (ii) the total number of provider terminations by year since fiscal year 2018 and the number terminated with and without cause; (iii) the localities the terminated providers served; and (iv) the number of Medicaid members the providers were serving prior to termination of their provider contract. The department shall report this data annually, not later than November 1, to the Joint Subcommittee for Health and Human Resources Oversight.

2. The Department of Medical Assistance Services (DMAS) shall amend its July 1, 2016, managed care contracts in order to conform to the requirement pursuant to House Bill 1942 / Senate Bill 1262, passed during the 2015 Regular Session, for prior authorization of drug benefits.

P. The Department of Medical Assistance Services (DMAS) shall be authorized to include the following provisions

in the Cardinal Care Managed Care Contract provided such items do not alter cost factors as authorized by this act or add future costs to the Commonwealth.

a. Revise managed care organization staffing requirements.

b. Include language related to readiness review requirements.

c. Require the timely processing of clean claims.

d. Require network adequacy/access reporting requirement.

e. Require managed care organizations to inform providers 30 days prior to any policy or procedure change and must train providers on changes.

f. Make changes as required by the Virginia Information Technology Agencies and Office of Attorney General high-risk reviews.

g. Require managed care organizations to use the Council for Affordable Quality Healthcare (CAQH) standardized credentialing form if available for their provider type.

h. Require managed care organizations to invite ombudsman representatives to advisory committee meetings.

i. Include value-based payment models and requirements.

j. Require managed care organizations to collaborate with DMAS as part of community and programmatic initiatives; however any locality partnership initiatives must be specifically authorized by the General Assembly through a general appropriation act.

k. Maintain a foster care specialty plan via a competitive procurement process among the current contractors.

l. Maintain care coordination, reporting, member outreach and monitoring, working with community stakeholders in EPSDT sections to ensure quality of care and monitoring or providers.

m. Include managed care organization care coordination screening requirements for Health-Related Social Needs, Behavioral Health and Cancer.

n. Include language requiring managed care organizations to account for specific needs and actions in the plan for identifying, assessing and engaging members on Health-Related Social Needs as part of care coordination activities.

o. Maintain maternal and child health policies and processes, including, using CMS' Maternal Core Quality Measure set, value based payment targets, and managed care organization outreach.

p. Require an annual plan on coordination with the dental benefit administrator.

Q. The Department of Medical Assistance Services shall direct its actuary as part of the rate setting process to:

a. Identify potential inefficiencies in the Cardinal Care Managed Care program and adjust capitation rates for expected efficiencies. The department is authorized to phase-in this adjustment over time based on the portion of identified inefficiencies that managed care organizations can reasonably reduce each year.

b. Monitor medical spending for related-party arrangements and adjust historical medical spending when deemed

necessary to ensure that capitation rates do not cover excessively high spending as compared to benchmarks. Related-party arrangements shall mean those in which there is common ownership or control between the entities and shall not include Medicaid payments otherwise authorized in this Item.

c. Adjust capitation rates in the Cardinal Care Managed Care program to account for a portion of expected savings from required initiatives.

d. Allow negative historical trends in medical spending to be carried forward when setting capitation rates.

e. Annually rebase administrative expenses per member per month for projected enrollment changes.

f. Annually incorporate findings on unallowable administrative expenses from audits of managed care organizations into its calculations of underwriting gain and administrative loss ratios for the purposes of ongoing financial monitoring, including enforcement of the underwriting gain cap.

g. Adjust calculations of underwriting gain and medical loss ratio by classifying as profit medical spending that is excessively high due to related-party arrangements.

R.1. The Department of Medical Assistance Services shall develop and pursue cost saving strategies internally and with the cooperation of the Department of Social Services, Virginia Department of Health, Office of the Attorney General, Children's Services Act program, Department of Education, Department of Juvenile Justice, Department of Behavioral Health and Developmental Services, Department for Aging and Rehabilitative Services, Department of the Treasury, University of Virginia Health System, Virginia Commonwealth University Health System Authority, Department of Corrections, federally qualified health centers, local health departments, local school divisions, community service boards, local hospitals, and local governments, that focus on optimizing Medicaid claims and cost recoveries. Any revenues generated through these activities shall be transferred to the Virginia Health Care Fund to be used for the purposes specified in this Item.

2. The Department of Medical Assistance Services shall retain the savings necessary to reimburse a vendor for its efforts to implement paragraph R.1. of this Item. However, prior to reimbursement, the department shall identify for the Secretary of Health and Human Resources each of the vendor's revenue maximization efforts and the manner in which each vendor would be reimbursed. No reimbursement shall be made to the vendor without the prior approval of the above plan by the Secretary.

S. The Department of Medical Assistance Services shall have the authority to pay contingency fee contractors, engaged in cost recovery activities, from the recoveries that are generated by those activities. All recoveries from these contractors shall be deposited to a special fund. After payment of the contingency fee any prior year recoveries shall be transferred to the Virginia Health Care Fund. The Director, Department of Medical Assistance Services, shall report to the Director, Department of Planning and Budget, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees any increase in recoveries associated with this program as well as the areas of audit targeted by contractors by November 1 each year.

T.1. The Department of Medical Assistance Services shall reimburse school divisions who sign an agreement to provide administrative support to the Medicaid program and who provide documentation of administrative expenses related to the Medicaid program 50 percent of the Federal Financial Participation by the department.

2. The Department of Medical Assistance Services shall retain five percent of the Federal Financial Participation for reimbursement to school divisions for medical and transportation services.

3. The Department shall amend the State Plan for Medical Assistance to allow payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions, regardless of whether the student receiving care has an

individualized education program or whether the health care service is included in a student's individualized education program. Such services shall include those covered under the State Plan for Medical Assistance Services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

U. The Department of Medical Assistance Services shall impose an assessment equal to 6.0 percent of revenue on all ICF-ID providers. The department shall determine procedures for collecting the assessment, including penalties for non-compliance. The department shall have the authority to adjust interim rates to cover new Medicaid costs as a result of this assessment.

V. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services to implement a modified emergency room utilization program, consistent with the requirements necessary for approval by the Centers for Medicare and Medicaid Services, effective January 1, 2024. The department shall have the authority to implement this change prior to the completion of any regulatory process undertaken in order to effect such change.

W. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services under Title XIX to modify the definition of readmissions to include cases when patients are readmitted to a hospital for the same or a similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice. If the patient is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at 50 percent of the normal rate, except that a readmission within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. The department shall have the authority to implement this reimbursement change effective July 1, 2020, and prior to the completion of any regulatory process undertaken in order to effect such change. The department shall report quarterly on the number of hospital readmissions, the cost, and the primary diagnosis of such readmissions to the Joint Subcommittee for Health and Human Resources Oversight.

X. The Department of Medical Assistance Services shall implement continued enhancements to the drug utilization review (DUR) program. The department shall continue the Pharmacy Liaison Committee and the DUR Board. The department shall continue to work with the Pharmacy Liaison Committee, meeting at least semi-annually, to implement initiatives for the promotion of cost-effective services delivery as may be appropriate. The department shall solicit input from the Pharmacy Liaison Committee regarding pharmacy provisions in the development and enforcement of all managed care contracts. The Pharmacy Liaison Committee shall include a representative from the Virginia Community Healthcare Association to represent pharmacy operations and issues at federally qualified health centers in Virginia. The department shall report on the Pharmacy Liaison Committee's and the DUR Board's activities to the Board of Medical Assistance Services and to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and the Department of Planning and Budget no later than December 15 each year of the biennium.

Y.1. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, the Department of Medical Assistance Services, in consultation with the Department of Behavioral Health and Developmental Services, shall amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a Preferred Drug List. In developing the modifications, the department shall consider input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, and others, as appropriate.

2.a. The department shall utilize a Pharmacy and Therapeutics Committee to assist in the development and ongoing administration of the Preferred Drug List program. The Pharmacy and Therapeutics Committee shall be

composed of 8 to 16 members, including the Commissioner, Department of Behavioral Health and Developmental Services, or his designee. Other members shall be selected or approved by the department and shall include one physician from each contracted managed care organization. The membership shall include a ratio of physicians to pharmacists of 2:1 and the department shall ensure that at least one-half of the physicians and pharmacists are either direct providers or are employed with organizations that serve recipients for all segments of the Medicaid population. Physicians on the committee shall be licensed in Virginia, one of whom shall be a psychiatrist, and one of whom specializes in care for the aging. Pharmacists on the committee shall be licensed in Virginia, one of whom shall have clinical expertise in mental health drugs, and one of whom has clinical expertise in community-based mental health treatment. The Pharmacy and Therapeutics Committee shall recommend to the department (i) which therapeutic classes of drugs should be subject to the Preferred Drug List program and prior authorization requirements; (ii) specific drugs within each therapeutic class to be included on the preferred drug list; (iii) appropriate exclusions for medications, including atypical anti-psychotics, used for the treatment of serious mental illnesses such as bi-polar disorders, schizophrenia, and depression; (iv) appropriate exclusions for medications used for the treatment of brain disorders, cancer and HIV-related conditions; (v) appropriate exclusions for therapeutic classes in which there is only one drug in the therapeutic class or there is very low utilization, or for which it is not cost-effective to include in the Preferred Drug List program; and (vi) appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens that have proven to be clinically effective. In developing and maintaining the preferred drug list, the cost effectiveness of any given drug shall be considered only after it is determined to be safe and clinically effective.

b. The Pharmacy and Therapeutics Committee shall schedule meetings at least semi-annually and may meet at other times at the discretion of the chairperson and members. At the meetings, the Pharmacy and Therapeutics committee shall review any drug in a class subject to the Preferred Drug List that is newly approved by the Federal Food and Drug Administration, provided there is at least thirty (30) days notice of such approval prior to the date of the quarterly meeting.

3. The department shall establish a process for acting on the recommendations made by the Pharmacy and Therapeutics Committee, including documentation of any decisions which deviate from the recommendations of the committee.

4. The Preferred Drug List program shall generate savings as determined by the department that are net of any administrative expenses to implement and administer the program.

5. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, to implement these changes, the Department of Medical Assistance Services shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. With respect to such State Plan amendments and regulations, the provisions of § 32.1-331.12 et seq., Code of Virginia, shall not apply. In addition, the department shall work with the Department of Behavioral Health and Development Services to consider utilizing a Preferred Drug List program for its non-Medicaid clients.

6. The Department of Medical Assistance Services shall (i) continually review utilization of behavioral health medications under the State Medicaid Program for Medicaid recipients; and (ii) ensure appropriate use of these medications according to federal Food and Drug Administration (FDA) approved indications and dosage levels. The department may also require retrospective clinical justification according to FDA approved indications and dosage levels for the use of multiple behavioral health drugs for a Medicaid patient. For individuals 18 years of age and younger who are prescribed three or more behavioral health drugs, the department may implement clinical edits that target inefficient, ineffective, or potentially harmful prescribing patterns in accordance with FDA-approved indications and dosage levels.

7. The Department of Medical Assistance Services shall ensure that in the process of developing the Preferred Drug List, the Pharmacy and Therapeutics Committee considers the value of including those prescription medications which improve drug regimen compliance, reduce medication errors, or decrease medication abuse through the use

of medication delivery systems that include, but are not limited to, transdermal and injectable delivery systems.

8. The Pharmacy and Therapeutics Committee shall ensure that when making recommendations to the Department of Medical Assistance Services related to any non opioid drug approved by the federal Food and Drug Administration for the treatment or management of pain, the drug shall be considered for safety and clinical efficacy, as supported by available clinical data, and cost effectiveness pursuant to 12VAC30-130-1000 of the Virginia Administrative Code.

9. Recommendations made by the Pharmacy and Therapeutics Committee that result in changes to the Common Core Formulary shall not be implemented by the Department of Medical Assistance Services until a fiscal impact review is conducted by the agency's fiscal division and is reviewed by the Chief Financial Officer and the Director.

Z.1. The Department of Medical Assistance Services may amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a specialty drug program. In developing the modifications, the department shall consider input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, the Pharmacy Liaison Committee, and others as appropriate.

2. In developing the specialty drug program to implement appropriate care management and control drug expenditures, the department shall contract with a vendor who will develop a methodology for the reimbursement and utilization through appropriate case management of specialty drugs and distribute the list of specialty drug rates, authorized drugs and utilization guidelines to medical and pharmacy providers in a timely manner prior to the implementation of the specialty drug program and publish the same on the department's website.

3. In the event that the Department of Medical Assistance Services contracts with a vendor, the department shall establish the fee paid to any such contractor based on the reasonable cost of services provided. The department may not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses cannot be based on the percentage of cost savings generated under the benefit management of services.

4. The department shall: (i) review, update and publish the list of authorized specialty drugs, utilization guidelines, and rates at least quarterly; (ii) implement and maintain a procedure to revise the list or modify specialty drug program utilization guidelines and rates, consistent with changes in the marketplace; and (iii) provide an administrative appeals procedure to allow dispensing or prescribing providers to contest the listed specialty drugs and rates.

5. The department shall have authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act to effect these provisions.

AA. In the event that the Department of Medical Assistance Services decides to contract for pharmaceutical benefit management services to administer, develop, manage, or implement Medicaid pharmacy benefits, the department shall establish the fee paid to any such contractor based on the reasonable cost of services provided. The department may not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses cannot be based on the percentage of cost savings generated under the benefit management of services.

BB.1. Effective July 1, 2021, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to revise per diem rates paid to psychiatric residential treatment facilities (PRTF) using the provider's audited cost per day from the facility's cost report for provider fiscal years ending in state fiscal year 2018. New

Virginia-based residential psychiatric facilities must submit proforma cost report data, which will be used to set the initial per diem rate for up to two years. After this period, the department shall establish a per diem rate based on an audited cost report for a 12-month period within the first two years of operation. Providers that do not submit cost reports shall be paid at 75 percent of the established rate ceiling. If necessary to enroll out-of-state providers for network adequacy, the department shall negotiate rates. If there is sufficient utilization, the department may require out-of-state providers to submit a cost report to establish a per diem rate. In-state and out-of-state provider per diem rates shall be subject to a ceiling based on the statewide weighted average cost per day from fiscal year 2018 cost reports. The department shall have the authority to implement these changes effective July 1, 2021, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall have the authority to establish rebasing of PRTF rates every three years. The first rebasing of rates shall take effect July 1, 2023. All PRTF and Addiction and Rehabilitation Treatment Services (ARTS) providers who offer qualifying services under 12VAC30-70-418(C) shall be required to submit cost reports as a part of rebasing. Out of state providers with more than 1,500 paid days for Virginia Medicaid members in the most recently completed state fiscal year shall also be required to submit a cost report. A rate ceiling shall be established based on a statewide weighted average cost per day. Rate ceilings shall be established independently for PRTFs and participating ARTS residential services. The department shall have the authority to implement these changes effective July 1, 2022 and prior to the completion of any regulatory process to effect such change.

3. DMAS shall establish inflation increases for each non-rebasing fiscal year for both PRTF and qualifying ARTS providers. Inflation rates shall be tied to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate. The department shall have the authority to implement these changes effective July 1, 2023, and prior to the completion of any regulatory process to effect such change.

4. Effective July 1, 2022, the department shall adjust PRTF rates by 8.89 percent to account for inflation since the last audited cost report of fiscal year 2018. The rate ceiling shall increase to $460.89 per day. The department shall have the authority to implement these changes effective July 1, 2022, and prior to the completion of any regulatory process to effect such change.

5. The department shall revise reimbursement methodologies for PRTF rates to implement inflation increases for each fiscal year to be effective July 1, 2024. Inflation rates shall be tied to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate. The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such change.

6. Notwithstanding paragraphs BB.2., BB.3., and BB.5. above, the Department of Medical Assistance Services shall maintain the rate ceilings that were in effect as of June 30, 2026 for psychiatric residential treatment facilities and participating addiction and recovery treatment services residential services.

7. Notwithstanding any other provision of law, effective July 1, 2026, the Department of Medical Assistance Services shall amend the state plan for medical assistance services to eliminate rebasing and inflation adjustments for psychiatric residential treatment facilities and qualifying addiction and recovery treatment services residential services providers. The department shall promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

CC. The Department of Medical Assistance Services shall amend the state plans under Titles XIX and XXI of the Social Security Act, and any waivers thereof, and make any changes to managed care contracts as necessary to enable children served in psychiatric residential treatment facilities (PRTF) to maintain their enrollment in

managed care during their treatment. The payment for PRTF per diem payments and PRTF required services shall be carved out of managed care and paid as a fee-for-service benefit. Required services include assessment and diagnosis, physician medication management and supervision, urine testing and psychological professional services when delivered by facility staff or contractors. Any service eligible for reimbursement through the Children's Services Act shall not be included in managed care. The department shall have the authority to create a new capitation payment structure to reflect this change in managed care service delivery. Costs associated with any carved-out services shall be excluded from managed care payment methodologies. The department shall have the authority to implement this change effective July 1, 2025 and prior to the completion of any regulatory process.

DD. Effective July 1, 2013, the Department of Medical Assistance Services shall establish a Medicaid Physician and Managed Care Liaison Committee including, but not limited to, representatives from the following organizations: the Virginia Academy of Family Physicians; the American Academy of Pediatricians – Virginia Chapter; the Virginia College of Emergency Physicians; the American College of Obstetrics and Gynecology – Virginia Section; Virginia Chapter, American College of Radiology; the Psychiatric Society of Virginia; the Virginia Medical Group Management Association; and the Medical Society of Virginia. The committee shall also include representatives from each of the department's contracted managed care organizations and a representative from the Virginia Association of Health Plans. The committee will work with the department to investigate the implementation of quality, cost-effective health care initiatives, to identify means to increase provider participation in the Medicaid program, to remove administrative obstacles to quality, cost-effective patient care, and to address other matters as raised by the department or members of the committee. The committee shall establish an Emergency Department Care Coordination work group comprised of representatives from the committee, including the Virginia College of Emergency Physicians, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Academy of Family Physicians and the Virginia Association of Health Plans to review the following issues: (i) how to improve coordination of care across provider types of Medicaid "super utilizers"; (ii) the impact of primary care provider incentive funding on improved interoperability between hospital and provider systems; and (iii) methods for formalizing a statewide emergency department collaboration to improve care and treatment of Medicaid recipients and increase cost efficiency in the Medicaid program, including recognized best practices for emergency departments. The committee shall meet semi-annually, or more frequently if requested by the department or members of the committee. The department, in cooperation with the committee, shall report on the committee's activities annually to the Board of Medical Assistance Services and to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and the Director, Department of Planning and Budget no later than October 1 each year.

EE.1. Included in this appropriation is $7,067,076 the first year and $10,008,396 the second year from the general fund and $26,366,543 the first year and $29,212,840 the second year from nongeneral funds to reimburse the Virginia Commonwealth University Health System for indigent health care costs as reported by the hospital and adjusted by the department for indigent care savings related to Medicaid expansion. This funding is composed of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4.

2. Included in this appropriation is $35,513,809 the first year and $39,114,876 the second year from the general fund and $50,250,319 the first year and $53,866,844 the second year from nongeneral funds to reimburse the University of Virginia Health System for indigent health care costs as reported by the hospital and adjusted by the department for indigent care savings related to Medicaid expansion. This funding is comprised of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4.

3. The general fund amounts for the state teaching hospitals have been reduced to mirror the general fund impact of reduced and no inflation for inpatient services in prior years. It also includes reductions associated with prior year indigent care reductions. However, the nongeneral funds are appropriated. In order to receive the nongeneral funds in excess of the amount of the general fund appropriated, the health systems shall certify the public

expenditures.

4. The Department of Medical Assistance Service shall have the authority to increase Medicaid payments for Type One hospitals and physicians consistent with the appropriations to compensate for limits on disproportionate share hospital (DSH) payments to Type One hospitals that the department would otherwise make. In particular, the department shall have the authority to amend the State Plan for Medical Assistance to increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate as demonstrated by University of Virginia Health System and Virginia Commonwealth University Health System, to change reimbursement for Graduate Medical Education to cover costs for Type One hospitals, to case mix adjust the formula for indirect medical education reimbursement for HMO discharges for Type One hospitals and to increase the adjustment factor for Type One hospitals to 1.0. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

5. Effective July 1, 2022, any hospitals acquired by or that become fully-owned by designated Type One hospitals shall be considered Type Two facilities for reimbursement including, but not limited to: Indirect Medical Education payments, Graduate Medical Education Payments, Direct Medical Education payments, Disproportionate Share Hospital payments, hospital rate-setting purposes, aggregated cost settlements, and physician supplemental payments. Facilities acquired prior to July 1, 2022, by Type One hospitals shall continue to be designated as Type One hospitals for reimbursement purposes.

FF.1. The Department of Medical Assistance Services shall monitor the capacity available under the Upper Payment Limit (UPL) for all hospital supplemental payments and adjust payments accordingly when the UPL cap is reached. The department shall make an adjustment to stay under the UPL cap by reducing or eliminating as necessary supplemental payments to hospitals based on when the first supplemental payments were actually made so that the newest supplemental payments to hospitals would be impacted first and so on.

2. The Department of Medical Assistance Services shall have the authority to implement reimbursement changes deemed necessary to meet the requirements of this paragraph prior to the completion of any regulatory process in order to effect such changes.

GG. The Department of Medical Assistance Services shall submit a report annually on all supplemental payments made to hospitals through the Medicaid program. This report shall include information for each hospital and by type of supplemental payment (Disproportionate Share Hospital, Graduate Medical Education, Indirect Medical Education, Upper Payment Limit program, and others). The report shall include total Medicaid payments from all sources and calculate the percent of overall payments that are supplemental payments. Furthermore, it shall include a description of each type of supplemental payment and the methodology used to calculate the payments. Each report shall reflect the data for the prior three fiscal years and shall be submitted to the Director, Department of Planning and Budget and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by September 1 each year.

HH. The Department of Medical Assistance Services shall have the authority to amend the state plan for medical assistance services and associated regulations to remove any obsolete provider supplemental payments that were authorized prior to July 1, 2021. This includes any supplemental payments that have no qualifying providers, have sunset or for which no payments have ever been made. 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.

II. The Department of Medical Assistance Service shall have the authority to amend the State Plan for Medical Assistance to implement a supplemental disproportionate share hospital (DSH) redistribution methodology for DSH funds that allows the redistribution of excess DSH payments to other eligible DSH hospitals that have not met their uncompensated care costs. This supplemental redistribution shall be budget neutral and not use state funds in excess of those already appropriated for DSH payments. The department shall have the authority to implement

these changes prior to completion of any regulatory process undertaken in order to effect such change.

JJ.1.a. The Department of Medical Assistance Services shall promulgate regulations to make supplemental payments to Medicaid physician providers with a medical school located in Eastern Virginia that is a political subdivision of the Commonwealth. The amount of the supplemental payment shall be based on the difference between the average commercial rate approved by the Centers for Medicare and Medicaid Services (CMS) and the payments otherwise made to physicians. The department shall have the authority to implement these reimbursement changes consistent with the effective date in the state plan amendment approved by CMS and prior to completion of any regulatory process in order to effect such changes.

b. The department shall increase payments to Medicaid managed care organizations for the purpose of securing access to Medicaid physician services in Eastern Virginia, through higher rates to physicians affiliated with a medical school located in Eastern Virginia that is a political subdivision of the Commonwealth subject to applicable limits. The department shall revise its contracts with managed care organizations to incorporate these supplemental capitation payments, and provider payment requirements, subject to approval by CMS. No payment shall be made without approval from CMS.

c. Funding for the state share for these Medicaid payments is authorized in Item 170.

2.a. The Department of Medical Assistance Services (DMAS) shall have the authority to amend the State Plan for Medical Assistance Services (state plan) to implement a supplemental Medicaid payment for local government-owned nursing homes. The total supplemental Medicaid payment for local government-owned nursing homes shall be based on the difference between the Upper Payment Limit of 42 CFR §447.272 as approved by CMS and all other Medicaid payments subject to such limit made to such nursing homes. There is hereby appropriated sum-sufficient funds for DMAS to pay the state share of the supplemental Medicaid payment hereunder. However, DMAS shall not submit such state plan amendment to CMS until it has entered into an intergovernmental agreement with eligible local government-owned nursing homes or the local government itself which requires them to transfer funds to DMAS for use as the state share for the supplemental Medicaid payment each nursing home is entitled to and to represent that each has the authority to transfer funds to DMAS and that the funds used will comply with federal law for use as the state share for the supplemental Medicaid payment. If a local government-owned nursing home or the local government itself is unable to comply with the intergovernmental agreement, DMAS shall have the authority to modify the state plan. The department shall have the authority to implement the reimbursement change consistent with the effective date in the state plan amendment approved by CMS and prior to the completion of any regulatory process undertaken in order to effect such change.

b. If by June 30, 2017, the Department of Medical Assistance Services (DMAS) has not secured approval from the Centers for Medicare and Medicaid Services to use a minimum fee schedule pursuant to 42 C.F.R. § 438.6(c)(1)(iii) for local government-owned nursing homes participating in Cardinal Care Managed Care (Cardinal Care) at the same level as and in lieu of the supplemental Medicaid payments authorized in Section JJ.2.a., then DMAS shall: (i) exclude Medicaid recipients who elect to receive nursing home services in local government-owned nursing homes from Cardinal Care; (ii) pay for such excluded recipient's nursing home services on a fee-for-service basis, including the related supplemental Medicaid payments as authorized herein; and (iii) prohibit Cardinal Care contracted health plans from in any way limiting Medicaid recipients from electing to receive nursing home services from local government-owned nursing homes. The department may include in Cardinal Care Medicaid recipients who elect to receive nursing home services in local government-owned nursing homes in the future when it has secured federal CMS approval to use a minimum fee schedule as described above.

3. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance Services to implement a supplemental payment for clinic services furnished by the Virginia Department of Health (VDH) effective July 1, 2015. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by the Centers for Medicare and Medicaid Services and all other Medicaid payments. VDH may transfer general fund to the department from funds already appropriated to VDH to cover the non-federal

share of the Medicaid payments. The department shall have the authority to implement the reimbursement change effective July 1, 2015, and prior to the completion of any regulatory process undertaken in order to effect such changes.

4. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the supplemental physician payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50 percent Medicaid inpatient utilization in fiscal year 2014 to the maximum allowed by the Centers for Medicare and Medicaid Services within the limit of the appropriation provided for this purpose. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by the Centers for Medicare and Medicaid Services and all other Virginia Medicaid fee-for-service payments. The department shall have the authority to implement these reimbursement changes effective July 1, 2016, and prior to the completion of any regulatory process undertaken in order to effect such change.

5.a. The Department of Medical Assistance Services shall amend the State plan for Medical Assistance to implement a supplemental inpatient and outpatient payment for Chesapeake Regional Hospital based on the difference between reimbursement with rates using an adjustment factor of 100 percent minus current authorized reimbursement subject to the inpatient and outpatient Upper Payment Limits for non-state government owned hospitals, and for managed care claims based on the difference between the amount included in the capitation rates for inpatient and outpatient services based on historical paid claims for non-state government hospitals and the maximum managed care directed payment supported by the department's calculations and allowed by CMS, subject to CMS approval under 42 C.F.R. section 438.6(c). The department shall include in its contracts with managed care organizations a percentage increase for Chesapeake Regional Hospital consistent with the approved managed care directed percentage increase. The department shall adjust capitation payments to Medicaid managed care organizations to fund this percentage increase. Both the contract changes and capitation rate adjustments shall be compliant with 42 C.F.R. 438.6(c)(1)(iii) and subject to CMS approval.

b. The Department of Medical Assistance Services shall also amend the State Plan for Medical Assistance to implement supplemental physician payments for practice plans employed by or under contract with Chesapeake Regional Hospital to the maximum allowed by the Centers for Medicare and Medicaid Services. The department shall increase payments to Medicaid managed care organizations for the purpose of providing higher rates to physicians employed by or under contract with Chesapeake Regional Hospital based on the maximum allowed by CMS. The department shall revise its contracts with managed care organizations to incorporate these managed care directed payments, subject to approval by CMS. The department shall have the authority to implement these reimbursement changes effective July 1, 2022, and prior to completion of any regulatory process undertaken in order to effect such change.

c. Prior to submitting the state plan amendment or making the managed care contract changes, Chesapeake Regional Hospital shall enter into an agreement with the department to transfer the non-federal share for these payments. The department shall have the authority to implement these reimbursement changes consistent with the effective date(s) approved by CMS.

6.a. There is hereby appropriated sum-sufficient nongeneral funds for the department to pay the state share of supplemental payments for nursing homes owned by Type One hospitals (consisting of state-owned teaching hospitals) as provided in the State Plan for Medical Assistance Services. The total supplemental payment shall be based on the difference between the Upper Payment Limit of 42 CFR § 447.272 as approved by CMS and all other Medicaid payments subject to such limit made to such nursing homes. The Department of Medical Assistance Services shall enter into a transfer agreement with any Type One hospital whose nursing home qualifies for such supplemental payments, under which the Type One hospital shall provide the state share in order to match federal Medicaid funds for the supplemental payments. The department shall have the authority to implement these reimbursement changes consistent with the effective date in the state plan amendment approved by CMS and prior to completion of any regulatory process in order to effect such changes.

b. The Department of Medical Assistance Services (DMAS) shall adjust capitation payments to Medicaid managed care organizations to fund a minimum fee schedule compliant with requirements in 42 C.F.R. § 438.6(c)(1)(iii) at a level consistent with the state plan amendment authorized above for nursing homes owned by Type One hospitals. The department shall revise its contracts with managed care organizations to incorporate these supplemental capitation payments and provider payment requirements. DMAS shall enter into a transfer agreement with any Type One hospitals whose nursing home qualifies for such supplemental payments, under which the Type One hospital shall provide the state share in order to match federal Medicaid funds for the supplemental payments. The department shall have the authority to implement these reimbursement changes consistent with the effective date approved by CMS. No payment shall be made without approval from CMS.

7. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to implement a supplemental inpatient payment for Lake Taylor Transitional Care Hospital based on the difference between Medicaid reimbursement and the inpatient Upper Payment Limit for non-state government owned hospitals, and for managed care claims based on the difference between the amount included in the capitation rates for inpatient and outpatient services based on historical paid claims for non-state government hospitals and the maximum managed care directed payment supported by the department's calculations and allowed by CMS, subject to CMS approval under 42 C.F.R. section 438.6(c). The department shall include in its contracts with managed care organizations a percentage increase for Lake Taylor Transitional Care Hospital consistent with the approved managed care directed fee for service supplemental payment percentage increase. The department shall adjust capitation payments to Medicaid managed care organizations to fund this percentage increase. Both the contract changes and capitation rate adjustments shall be compliant with 42 C.F.R. 438.6(c)(1)(iii) and subject to CMS approval. Prior to submitting the state plan amendment or making the managed care contract changes, Lake Taylor Transitional Care Hospital shall enter into an agreement with the department to transfer the non-federal share for these payments. The department shall have the authority to implement these reimbursement changes consistent with the effective date(s) approved by CMS. The originating funding for this program will come entirely from Lake Taylor.

8.a. The Department of Medical Assistance Services shall develop a State Plan for Medical Assistance amendment to make supplemental payments to private hospitals and related health systems who intend to execute affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the non-federal share of the authorized payments. Virginia community colleges, Virginia public institutions of higher education, local governments, and instrumentalities of local government are public entities that are authorized to transfer funds to the department for purposes of covering the non-federal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. The department shall develop a plan, that could take effect July 1, 2023, for making managed care directed payments or supplemental payments as follows: Physician fee-for-service (FFS) supplemental payments through a state plan amendment and physician managed care directed payments through managed care contracts up to the Average Commercial Rate for practice plans that are a component of the participating hospitals or health system. The plan shall identify the public entity who will transfer funds to the department, the amount and duration of such transfers, the purpose and amount of any supplemental payment or managed care direct payments made to private hospitals and related health systems, and the impact, if any, on other supplemental payment programs currently in effect. The plan shall also include the appropriate references that provide authority for such payments.

b. The department shall have the authority to amend the State Plan for Medical Assistance and managed care contracts to make supplemental payments and managed care directed payments to private hospitals for physician services effective July 1, 2024. Reimbursement changes shall be effective prior to completion of any regulatory process in order to effect such changes. No payment shall be made without approval from CMS and an Interagency Agreement with a public entity capable of transferring the non-federal share of authorized payments to the department. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. Such funds may not be paid from any private agreements with public entities that are in excess of fair market value or that alleviate pre-existing financial burdens of such public entities. Public entities are authorized to use general fund dollars to accomplish this transfer. As part of the Interagency Agreements the department shall require the public entities to

attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. Upon notification by the department of any deferral or disallowance issued by CMS regarding the supplemental or managed care directed payment arrangement, the hospital provider will return the entire balance of the payment to the department within 30 days of notification. If the hospital does not return the entire balance of the payment to the department within the specified timeframe, a judgement rate of interest set forth in Title 6.2-302 will be applied to the entire balance, regardless of whatever portion has been repaid. In addition, the non-federal share of the agency's administrative costs directly related to administration of the programs authorized in this paragraph, including staff and contractors, shall be funded by participating public entities. These funds shall be deposited into a special fund created by the Comptroller and used to support the administrative costs associated with managing this program. Any funds 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.

c. The purposes to which the additional payments authorized in paragraph JJ.9.b. of this Item shall be applied include: (i) increasing and enhancing access to outpatient care for Medicaid recipients; (ii) stabilizing and supporting critical healthcare workforce needs; and (iii) advancing the department's health and quality improvement goals; these shall contain specific measurable outcomes that will be approved, and monitored by the department quarterly. Payment shall be dependent on progress towards goal attainment on all three purposes. Participating organizations must submit quarterly updates and annual reports on programs no later than October 1. The department, with the assistance of the participating organizations, shall report to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 1 of each year on the impact of this initiative.

9. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, for an acute care hospital chain with a level one trauma center in the Tidewater Metropolitan Statistical Area (MSA) in 2020, upon the execution of affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the non-federal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Public entities are authorized to use general fund dollars to accomplish this transfer. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. As part of the Interagency Agreements the department shall require the public entities to attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

10. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, for an acute care hospital system whose Virginia hospitals are located entirely in planning districts 1, 2, and 3, upon the execution of affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the non-federal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Public entities are authorized to use general fund dollars to accomplish this transfer. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. As part of the Interagency Agreements, the department shall require the public entities to attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. In addition, the non-federal share of the agency's administrative costs directly related to administration of the programs authorized in this paragraph, including staff and contractors, shall be funded by participating public entities. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

11.a. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to make

supplemental indirect medical education payments for managed care services for private teaching hospitals that have executed affiliation agreements with public entities that are capable of transferring funds to the Department for purposes of covering the non-federal share of the authorized payments. Such public entities would enter into an Interagency Agreement with the department for this purpose. Public entities are authorized to use general fund dollars to accomplish this transfer. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. As part of the Interagency Agreements the department shall require the public entities to attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. In addition, the non-federal share of the agency's administrative costs directly related to administration of the programs authorized in this paragraph, including staff and contractors, shall be funded by participating public entities. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

b. The supplemental indirect medical education payments for managed care services shall be based on the Medicare formula using total residents reported to the Department annually by the hospital prior to the beginning of the fiscal year for the resident to bed ratio applied to managed care hospital payments reported to the Department through the encounter system adjusted to cost minus IME payments for managed care services currently authorized. The Department shall calculate these supplemental indirect medical education payments prior to the beginning of the fiscal year based on the most recently available data and these payments shall be final.

12. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, not to exceed $30,000,000 total computable for teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The public entity shall transfer the non-federal share of the authorized supplemental payments. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. Such funds may not be paid from any private agreements with Virginia Tech Carilion School of Medicine that are in excess of fair market value or that alleviate pre-existing financial burdens of the school. The Virginia Tech Carilion School of Medicine is authorized to use general fund dollars to accomplish this transfer. The Virginia Tech Carilion School of Medicine would enter into an Interagency Agreement with the department for this purpose and must attest to compliance with applicable CMS criteria. In addition to funds transferred from the public entity, the agency may utilize qualified charitable contributions as a source for the non-federal share. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

13. The Department of Medical Assistance Services (DMAS) shall amend the Medicaid State Plan for Medical Assistance and regulations to provide supplemental payments for dentists employed by or contracted with Virginia Commonwealth University's School of Dentistry. The total supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. DMAS shall enter into a transfer agreement with Virginia Commonwealth University for such supplemental payments, in which the University shall provide the non-federal share in order to match federal Medicaid funds for the supplemental payments. The department shall have the authority to implement these reimbursement changes consistent with the effective date in the state plan amendment approved by CMS and prior to completion of any regulatory process in order to effect such changes.

14. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, for an acute care hospital chain with a level two trauma center in the Peninsula EMS region in 2023, upon the execution of affiliation agreements with public entities that are capable of transferring funds to the department for purposes of covering the non-federal share of the authorized payments. The level of these additional IME supplemental payments may be up to the amounts supported by the formula applicable to Type One hospitals. Such public entities would enter into an Interagency

Agreement with the department for this purpose. Public entities are authorized to use general fund dollars to accomplish this transfer. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. As part of the Interagency Agreements the department shall require the public entities to attest to compliance with applicable CMS criteria. The department shall also require any private hospital and related health systems receiving payments under this Item to attest to compliance with applicable CMS criteria. In addition, the non-federal share of the agency's administrative costs directly related to administration of the programs authorized in this paragraph, including staff and contractors, shall be funded by participating public entities. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

15. The Department of Medical Assistance Services shall periodically assess the quality measures that are submitted to the Centers for Medicare and Medicaid Services for supplemental payments to ensure that appropriate quality measures are being included for supplemental payments such that the additional funding is improving the Medicaid program's quality and delivery of health care services.

KK.1. Effective, January 1, 2026, the Department of Medical Assistance Services (DMAS) is authorized to establish objective and measurable performance measures for any hospitals that are receiving private hospital enhanced payments authorized in § 3-5.14 of this act. These measures shall assess whether the additional payments improve services for Medicaid members. Specifically, DMAS shall include requirements to ensure access to care by Medicaid members through network adequacy requirements to prevent a hospital from reducing its service offerings in a manner that would have an adverse impact on Medicaid members in the community. In addition, DMAS shall include requirements to ensure improved coordination of care for behavioral health patients, including continued participation by hospitals in the acute bed registry. DMAS shall establish a process for measuring progress and may include a process to allow for corrective actions required for hospitals that do not achieve the specific performance measures established by DMAS. DMAS is authorized to measure progress toward these performance measures on a quarterly basis, unless DMAS determines that a specific measure is more appropriately measured on a longer timeframe. DMAS shall consult with impacted stakeholders in developing the performance measures and associated processes. A hospital that does not achieve the specific performance measures established by DMAS and is not able to fulfill the necessary corrective actions in the timeframe required by DMAS, shall lose eligibility for private enhanced payments for the associated period as determined by DMAS.

2. DMAS shall have the authority to seek necessary federal approval for state plan amendments and changes to the preprint to the Centers for Medicare and Medicaid Services to effectuate the provisions of paragraph KK.1.

LL.1. Effective July 1, 2017, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the formula for indirect medical education (IME) for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 as a substitute for disproportionate share hospital (DSH) payments. The formula for these hospitals for IME for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers shall be identical to the formula for Type One hospitals. The IME payments shall continue to be limited such that total payments to freestanding children's hospitals with greater than 50 percent Medicaid utilization do not exceed the federal uncompensated care cost limit to which DSH payments are subject, excluding third party reimbursement for Medicaid eligible patients. The department shall have the authority to implement these changes effective July 1, 2017, and prior to completion of any regulatory action to effect such changes.

2. The Department of Medical Assistance Services (DMAS) shall have the authority to create additional hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs effective June 2, 2017. Effective July 1, 2026, these new payments shall equal the greater of what would have been paid to the freestanding children's hospitals under the current disproportionate share hospital (DSH) formula or annually the DSH formula effective in fiscal year 2026. These additional hospital supplemental payments shall take precedence over supplemental payments for private hospitals. The department shall have the

authority to implement these changes prior to completion of any regulatory process undertaken in order to effectuate such change.

MM. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to adjust the formula for indirect medical education (IME) reimbursement for managed care discharges for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 by increasing the case mix adjustment factor to the greater of 3.2962 or the most recent rebasing. Total payments for IME in combination with other payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 may not exceed the hospital's Medicaid costs. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

NN. The Department of Medical Assistance Services shall implement managed care directed payments for physician services for practice plans affiliated with a freestanding children's hospital with more than 50 percent Medicaid utilization in fiscal year 2009 for $11,050,000 annually but not to exceed the average commercial rate. The department shall have the authority to implement this reimbursement change effective July 1, 2023, and prior to the completion of any regulatory process undertaken in order to effect such changes. The agency shall implement this by determining at the beginning of each year the percent of Medicaid that will result in estimated payments of $11,050,000 annually.

OO. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to implement a supplemental disproportionate share hospital (DSH) payment for Chesapeake Regional Hospital up to its hospital-specific disproportionate share hospital limit (OBRA '93 DSH limit) as determined pursuant to 42 U.S.C. Section 1396r-4. The payment shall be made annually based upon the hospital's disproportionate share limit for the most recent year for which the disproportionate share limit has been calculated subject to the availability of DSH funds under the federal allotment of such funds to the department. Prior to submitting the State Plan amendment, Chesapeake Regional Hospital shall enter into an agreement with the department to transfer the non-federal share of the supplemental DSH payment. Payment of the supplemental DSH payment is contingent upon receipt of intergovernmental transfer of funds or certified public expenditures from Chesapeake Regional Hospital. In the event that Chesapeake Regional Hospital is ineligible to transfer or certify necessary funds pursuant to federal law, the department may amend the State Plan for Medical Assistance to terminate the supplemental DSH payment program. The department shall have the authority to implement these reimbursement changes consistent with effective date(s) approved by the Centers for Medicare and Medicaid Services (CMS). No payments shall be made without CMS approval. In the event that CMS recoups supplemental DSH hospital funds from the department, Chesapeake Regional Hospital shall reimburse such funds to the department.

PP. The Department of Medical Assistance Services (DMAS) is authorized to amend the State Plan for Medical Assistance Services to implement a supplemental Medicaid payment for Department of Veterans Services (DVS) state government-owned nursing facilities. The total supplemental Medicaid payment for DVS state government owned nursing homes shall be based on the difference between the Upper Payment Limit of 42 CFR 447.272, as approved by the Centers for Medicare and Medicaid Services (CMS), and all other Medicaid payments subject to such limit made to such nursing homes. DMAS shall not submit any State Plan amendment to CMS that implements this payment until DMAS enters into an intergovernmental agreement with DVS. This agreement shall include the following provisions: 1) DVS shall transfer funds to DMAS for use as the state share of the full cost of the supplemental Medicaid payment for which each nursing home is entitled; 2) DVS must demonstrate that it has the authority and ability to transfer the necessary funds to DMAS; and, 3) DVS shall attest that any funds provided for state match will comply with federal law for use as the state share for the supplemental Medicaid payment. If DVS is unable to enter into or comply with the provisions of such an intergovernmental agreement, then DMAS shall immediately modify the Medicaid State Plan and adjust any supplemental payments accordingly. DMAS shall have the authority to implement the reimbursement changes consistent with the effective date in the State Plan amendment approved by CMS and prior to the completion of any regulatory process undertaken in order to effect such change.

QQ.1.a. Out of this appropriation, $8,550,000 the first year and $8,550,000 the second year from the general fund and $8,550,000 the first year and $8,550,000 the second year from nongeneral funds shall be used for supplemental payments to fund graduate medical education for 3 residents who began their residencies in July 2021; 18 residents who began their residencies in July 2022; 38 residents who began their residencies in July 2024; 55 residents who began their residencies in July 2025 and 21 residents who begin their residencies in July 2026.

b. Of the amounts appropriated in QQ.1.a., $450,000 the first year and $450,000 the second year from the general fund and $450,000 the first year and $450,000 the second year from nongeneral funds shall be used for supplemental payments to fund graduate medical residencies for 4 psychiatric residents who began their residencies in July 2024; 2 additional psychiatric residents who began their residencies in July 2025 and 2 additional psychiatric residents who begin their residency in July 2026.

c. Of the amounts appropriated in QQ.1.a., $700,000 the first year and $700,000 the second year from the general fund and $700,000 the first year and $700,000 the second year from nongeneral funds shall be used for supplemental payments to fund graduate medical residencies for 6 obstetric-gynecological residents who began their residencies in July 2024 and 2 additional obstetric-gynecological residents who began their residencies in July 2025; and 4 additional obstetric-gynecological residents who begin their residency in July 2026.

2. The supplemental payment for each qualifying residency slot shall be $145,000 annually minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose number of residency slots are above the cap set by the Centers for Medicare and Medicaid Services or have exceeded the Upper Payment Limit (UPL) set by CMS, the supplemental payments for each qualifying residency slot shall be $72,500 from the general fund annually minus any Medicare residency payments for which the residency program is eligible. Supplemental payments shall be made for up to four years for each qualifying resident. Payments shall be made quarterly following the same schedule used for other medical education payments

3.a. By July 1 of each year, the Department of Medical Assistance Services shall determine the number of residency slots that could be funded in the next two fiscal years within the resources provided in this Item. In addition, DMAS shall issue a call for applications to all hospitals in the Commonwealth to determine the number of residency slots, by hospital, that could be filled in the following fiscal year.

b. The Department of Medical Assistance Service, in cooperation with the Virginia Health Workforce Development Authority, shall determine which new residency slots to fund based on priorities developed by the authority. Preference shall be given for residency slots located in underserved areas. Applications for slots that involve multiple medical care providers collaborating in training residents and that involve providing residents the opportunity to train in underserved areas are encouraged. A majority of the new residency slots funded each year shall be for primary care. The department shall adopt criteria for primary care, high need specialties and underserved areas as developed by the Virginia Health Workforce Development Authority. The department shall also review and consider applications from non-hospital sponsoring institutions, such as Federally Qualified Health Centers (FQHCs).

c. By July 1 of each year, the Department of Medical Assistance Services shall develop a prioritized list of hospitals for which residencies are recommended. Using this list, DMAS shall request budget authorization for those residencies that can be supported with the funds as appropriated in this Item.

4. The sponsoring institution will be eligible for the supplemental payments as long as it maintains the number of residency slots in total and by category as a result of the increase. The sponsoring institutions must certify by June 1 each year that they continue to meet the criteria for the supplemental payments and report any changes during the year to the number of residents.

5. The department shall require all sponsoring institutions receiving Medicaid medical education funding to report annually by September 15 on the number of residents in total and by specialty/subspecialty. Medical education

funding includes payments for graduate medical education (GME) and indirect medical education (IME). The department shall make the report available to the Virginia Health Workforce Development Authority to assist in their efforts to set priorities for and manage graduate medical education programs overseen by the Commonwealth.

6.a. Effective July 1, 2024, the department shall make supplemental payments to the following sponsoring institutions for the specified number of primary care residencies: Carilion Medical Center (6 Internal Medicine residencies), Centra Health (3 Family Medicine residencies), Riverside Regional Medical Center (1 Family Medicine residency and 6 Internal Medicine residencies), Sentara Norfolk General (1 Internal Medicine residency), University of Virginia Health System (2 Family Medicine residencies), and Johnston Memorial Hospital (2 family medicine residencies). The department shall make supplemental payments to Carilion Medical Center for 4 Psychiatry residencies. The department shall make supplemental payments to Children's Hospital of the King's Daughters for 3 Pediatric residencies. The department shall make supplemental payments to Riverside Regional Medicine Center for 4 Emergency Medicine residencies. The department shall make supplemental payments to Macon and Joan Brock Virginia Health Sciences for 1 Obstetrics and Gynecology residency, Virginia Commonwealth University for 2 Obstetrics and Gynecology residencies, and INOVA Fairfax Hospital for 3 Obstetrics and Gynecology residencies.

b. Effective July 1, 2025, the department shall make supplemental payments to the following sponsoring institutions for the specified number of primary care residencies: Augusta Health (12 Internal Medicine residencies), Carilion Medical Center (7 Internal Medicine residencies), Centra Health (3 Family Medicine residencies), Mary Washington Healthcare (6 Family Medicine residencies), and Riverside Regional Medical Center (1 Family Medicine residency and 13 Internal Medicine residencies). The department shall make supplemental payments to Carilion Medical Center for 2 Psychiatry residencies. The department shall make supplemental payments to Children's Hospital of the King's Daughters for 1 Child and Adolescent Psychiatry fellowship. The department shall make supplemental payments to Riverside Regional Medicine Center for 8 Emergency Medicine residencies. The department shall make supplemental payments to Macon and Joan Brock Virginia Health Sciences for 1 Obstetrics and Gynecology residency and to Riverside Regional Medical Center for 1 Obstetrics and Gynecology residency.

c. Effective July 1, 2026, the department shall make supplemental payments to the following sponsoring institutions for the specified number of primary care residencies: Augusta Health (2 Internal Medicine), Carilion Medical Center (1 Internal Medicine), Carilion Medical Center (2 Psychiatry), Centra Health (2 Family Medicine), Eastern Virginia Medical School (1 Obstetrics and Gynecology), Johnston Memorial Hospital (1 Internal Medicine), Mary Washington Healthcare (2 Family Medicine), Mary Washington Healthcare (2 Internal Medicine), Riverside Regional Medical Center (1 Emergency Medicine), Riverside Regional Medical Center (1 Internal Medicine), Riverside Regional Medical Center (1 Family Medicine), Riverside Regional Medical Center (3 Obstetrics and Gynecology) and Bon Secours St. Francis Medical Center (2 Family Medicine).

7.a. The Virginia Health Workforce Development Authority shall require all sponsoring institution hospitals receiving state supplemental Graduate Medical Education funding to participate in an annual data collection and reporting process designed to evaluate the effectiveness, geographic distribution, and workforce outcomes of state-supported residency and fellowship training.

b. Required reporting shall include, at a minimum, the number and name of residents supported with state funds, by specialty and training year, including the medical school each resident attended and their primary state of residence prior to medical school, the number of first year positions created or sustained with state support, identification of rural and underserved training locations and annual duration of training at such sites, program accreditation status, and total approved compared to filled positions by post-graduate year. The report shall also include the amount of Medicare Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) funding submitted for the most recently completed Medicare cost reporting year, including an attestation that state funding does not supplant existing Medicare funding under the institution's approved DGME cap. The report shall further include the institution's Per Resident Amount (PRA), if established; the number of resident full-time

equivalents (FTEs) claimed for DGME; the number of resident positions exceeding the institution's DGME cap for programs beyond the five-year cap-building period; and an annual budget reconciliation for supplemental funding. Additional data may be requested as deemed necessary by the Authority to assess workforce alignment of state health needs and facilitate physician workforce forecasting.

c. The Authority shall compile the submitted information into a biennial statewide Graduate Medical Education Impact Report and shall use the reported data to inform funding recommendations, program eligibility and future appropriations. The Impact Report shall be submitted to the Governor and Chairs of the House Appropriations and Senate Finance and Appropriations Committees.

8. The Department of Medical Assistance Service shall provide the Virginia Health Workforce Development Authority with quarterly reports detailing the occurrences of supplemental federal and state Medicaid payments made for Graduate Medical Education. Such reports shall include completed and pending aggregate payment amounts by sponsoring institutions and residency programs, as necessary to support statewide supplemental Graduate Medical Education oversight and reporting.

9. The Virginia Health Workforce Development Authority shall create and manage a Graduate Medical Education (GME) technical assistance program to provide residency and fellowship programs with technical support, guidance on program development and accreditation, and opportunities for networking and collaboration. The program shall facilitate data analysis and forecasting on residency supply and demand, assist programs in securing funding, and partner with academic and clinical institutions to expand training opportunities, particularly in rural and underserved regions. The Authority shall also monitor program outcomes and issue an annual report with findings and recommendations to inform statewide GME planning and policy.

RR.1. The Department of Medical Assistance Services shall work with stakeholders to review and adjust medical necessity criteria for Medicaid-funded nursing services including private duty nursing, skilled nursing, and home health. The department shall adjust the medical necessity criteria to reflect advances in medical treatment, new technologies, and use of integrated care models including behavioral supports. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Titles XIX and XXI of the Social Security Act to include changes to services covered, provider qualifications, medical necessity criteria**,** and rates and rate methodologies for private duty nursing. The adjustments to these services shall meet the needs of members and maintain budget neutrality by not requiring any additional expenditure of general fund beyond the current projected appropriation for such nursing services.

2. The department shall have authority to implement these changes to be effective July 1, 2022. The department shall also have authority to promulgate any emergency regulations required to implement these necessary changes within 280 days or less from the enactment date of this act. The department shall submit a report and estimates of any projected cost savings to the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees 30 days prior to implementation of such changes.

SS.1. The Department of Medical Assistance Services (DMAS) shall have the authority to implement programmatic changes to service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the following existing Medicaid behavioral health services: assertive community treatment, mental health partial hospitalization programs, crisis intervention and crisis stabilization services.

2. The department shall have the authority to develop new service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the following new Medicaid behavioral health services: multi-systemic therapy, family functional therapy, intensive outpatient services, mobile crisis intervention services, 23 hour temporary observation services and residential crisis stabilization unit services.

3. Effective on or after July 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: assertive community treatment, multi-systemic therapy and family functional therapy.

4. Effective on or after July 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services and residential crisis stabilization unit services.

5. In the development and implementation of these changes, the department shall ensure appropriate utilization and cost efficiency. Reimbursement rate changes shall be budget neutral and must not exceed the funding appropriated in the act for these services.

6. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

TT. 1. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, Intensive In Home Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management-Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services. All new and modified services shall be evidence based and trauma informed. To facilitate this transition, DMAS shall have the authority to implement programmatic changes to service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the legacy and redesigned services identified in this paragraph. DMAS shall only proceed with the provisions of this paragraph if the authorized Medicaid behavioral health modifications and programmatic changes can be implemented in a budget neutral manner within appropriation provided in this act for the identified legacy services. Moreover, any new or modified services shall be designed such that out-year costs are in line with the current legacy service spending projections. No new Medicaid behavioral health services or rates shall be implemented until corresponding legacy services have ended. Implementation of the redesigned services authorized in this paragraph shall be completed no later than July 1, 2027. The Department of Medical Assistance Services shall have the authority to seek federal authorization through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act, as necessary, to meet the requirements of this paragraph. The department shall have authority to implement the changes authorized in this paragraph upon federal approval and prior to the completion of any regulatory process.

2. The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall continue efforts to qualify for a section 1115 serious mental illness (SMI) waiver. The department is authorized to develop an 1115 SMI waiver application at the appropriate time. In addition to the waiver application, the department shall maintain a plan that includes any proposed service modifications, all potential fiscal implications (including cost savings) and a timeline for implementation. DMAS shall not implement any aspect of this proposed 1115 waiver without direct authorization by the General Assembly. The department shall provide the current version of the waiver plan by September 1 of each year to the Director, Department of Planning and Budget and Chairs of the House Appropriations and Senate Finance and Appropriations Committees.

3. The Department of Medical Assistance Services shall have the authority to add coverage for services provided to Medicaid beneficiaries (ages 21 through 64) during short term stays (not to exceed 60 days) for acute care in psychiatric hospitals or residential treatment settings that qualify as Institutes of Mental Disease through an 1115 serious mental illness waiver. The department shall have the authority to implement these changes consistent with the effective date in the state plan amendment approved by the Centers for Medicare and Medicaid Services and

prior to completion of any regulatory process in order to effect such changes.

4. The Department of Medical Assistance Services shall review and report on all monthly expenditures associated with services provided through the 1115 serious mental illness waiver. The department shall post this information on its website on a quarterly basis. Data should include, but not be limited to, expenditures by service for all services provided through state-run freestanding psychiatric hospitals, private freestanding psychiatric hospitals, and residential crisis stabilization units. In addition, data should include the number of individuals served and expenditures by facility.

UU.1. Effective January 1, 2021, the Department of Medical Assistance Services shall develop and implement an actuarially sound risk adjustment model that addresses the behavioral health acuity differences among the Medicaid managed care organizations for the community well population of individuals who are dually eligible for Medicare and Medicaid currently served through the Cardinal Care program. Behavioral health services shall be defined to include the following: case management services, community behavioral health, early intervention services, and addiction and recovery treatment services. The risk adjustment shall be based on nationally accepted models, such as the Chronic Illness and Disability Payment System (COPS) or Clinical Classifications Software Refined (CCSR) and shall incorporate variables predictive of behavioral health service utilization. Managed care experience shall be utilized as the basis for the risk adjustment.

2. Effective January 1, 2021, the Department of Medical Assistance Services shall develop and implement differential capitation rates for members in behavioral health treatment versus those who are not, for the community well population of individuals who are dually eligible for Medicare and Medicaid currently served through the Cardinal Care program. The rates shall be actuarially sound and the behavioral health rates shall additionally incorporate risk adjustment to account for acuity differences amongst the managed care organizations. Behavioral health services shall be defined to include the following: case management services, community behavioral health, early intervention services, and addiction and recovery treatment services. The risk adjustment shall be based on nationally accepted models, such as The Chronic Illness and Disability Payment System (COPS) or Clinical Classifications Software Refined (CCSR), and shall incorporate variables predictive of behavioral health service utilization. Managed care experience shall be utilized as the basis for the establishment of the capitation rates and the risk adjustment.

3. The risk adjustment model and differential capitation rates in these paragraphs shall be implemented such that the impact is budget neutral.

VV. The Department of Medical Assistance Services shall update its regulations to reflect the Department of Behavioral Health and Developmental Services licensing criteria for the American Society of Addiction Medicine (ASAM) Level of Care 4.0. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

WW.1. The Department of Medical Assistance Services is authorized to amend the State Plan under Title XIX of the Social Security Act to add coverage for the current procedural terminology (CPT) codes for Applied Behavioral Analysis (ABA) that were added to the CPT list in January 2019, or any future updates to these CPT codes. The department shall have the authority to implement related programmatic changes to service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for the Behavioral Therapy Program. The department shall have the authority to implement these changes effective December 1, 2021, and prior to completion of any regulatory process to effect such changes.

2. The Department of Medical Assistance Services (DMAS) shall impose a 20 hour per week cumulative limit per recipient on services provided under ABA, effective July 1, 2026; such limit can be exceeded based upon documented medical necessity under early and periodic screening, diagnostic and treatment (EPSDT). The

department shall require a diagnosis of autism spectrum disorder prior to authorizing ABA services; however, children age 5 and younger may receive a provisional diagnosis for one-year utilizing a protocol designated by DMAS. DMAS shall have the authority to amend the state plan under Titles XIX and XXI of the Social Security Act to effect these changes. DMAS shall provide guidance to ABA providers and facilities on required ABA documentation and shall coordinate with managed care organizations (MCO) to perform periodic pre- and post-payment reviews of ABA payments. DMAS shall require specific reporting from each MCO that can be analyzed across MCOs, by region, by provider, and at a statewide level. The requirements in this amendment do not apply to behavior therapy provided by local education agency providers and reimbursed through the fee-for-service Medicaid school-based services program. The department is authorized to promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

3. The Department of Medical Assistance Services (DMAS) shall convene an ABA benefit Utilization Workgroup for the purpose of examining Medicaid expenditures and utilization trends for this service and identifying strategies to control costs while still preserving access to care for those in need of the therapy. The workgroup shall: (i) identify utilization trends, including trends among those with different diagnosis acuity levels; (ii) examine different delivery methods of ABA services and their impact on utilization; (iii) review utilization and service authorization criteria including standard assessment tools and diagnostic criteria taking into account differing service intensity and duration requirements; (iv) evaluate utilization management tools that align with national clinic practice guidelines promulgated by independent national nonprofit organizations; (v) define medical necessity criteria taking into account behavioral factors, ability to learn, age and development, and skills development including clear criteria for eligibility, scope of services and documentation requirements; (vi) review provider qualification recommendations related to ABA practitioner certification and licensing; and current supervision requirements and standards to help ensure appropriate clinical oversight; (vii) evaluate the appropriateness of ABA services for children with diagnoses other than ASD; and (viii) review the MCO annual reporting data to identify any areas of potential improvement to the delivery of services and any needed changes in regulations or policies from DMAS. The workgroup shall include stakeholders, including ABA service providers, including center-based models and home-based models, representatives from managed care organizations serving Medicaid patients, Virginia licensed behavioral analysts, and a child or adolescent psychiatrist. The workgroup meetings shall be open to the public and offer opportunities for public input.

XX. Effective July 1, 2021, the Department of Medical Assistance Services shall seek federal authority through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act, as necessary, to provide continuous coverage to enrollees for the duration of pregnancy and through 12 months postpartum. 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. The department shall have authority to implement these amendments upon federal approval and prior to the completion of any regulatory process.

YY. Effective July 1, 2021, the Department of Medical Assistance Services shall increase rates by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates. The department shall have the authority to implement these reimbursement changes prior to the completion of any regulatory process to effect such changes.

ZZ. Effective on and after July 1, 2021, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to modify reimbursement for nursing facility services such that the direct peer group price percentage shall be increased to 109.3 percent and the indirect peer group price percentage shall be increased to 103.3 percent. The department shall have the authority to implement these changes effective July 1, 2021 and prior to the completion of any regulatory process undertaken in order to effect such change.

AAA. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to provide

that any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first fair rental value (FRV) capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed. The department shall have the authority to implement these reimbursement changes effective July 1, 2021 and prior to the completion of the regulatory process.

BBB. Effective July 1, 2022, the department shall amend the State Plan for Medical Assistance to establish a new direct and indirect care peer group for nursing facilities operating with at least 80 percent of the resident population having one or more of the following diagnoses: quadriplegia, traumatic brain injury, multiple sclerosis, paraplegia, or cerebral palsy. In addition, a qualifying facility must have at least 90 percent Medicaid utilization and a case mix index of 1.15 or higher in fiscal year 2014. The department shall utilize the data from the most recent rebasing to make this change effective for fiscal year 2023 and subsequent rate years until this change is incorporated into the next scheduled rebasing. This change shall not affect rates established in the most recent rebasing for facilities in any other direct and indirect care peer groups. The department shall have the authority to implement this reimbursement change prior to completion of any regulatory process in order to effect such change. To the extent federal approval requires alternative approaches to achieve the same general results, the department shall have the authority to follow the federal guidance effecting this change. It is the intent of the General Assembly that the Department of Medical Assistance Services continue reimbursing the 15 percent reimbursement rate add on authorized in Item 306, paragraph CCC 7 (Chapter 780, 2016 Acts of Assembly), and the additional 10.4% reimbursement rate add on authorized in Item 313, paragraph KKKK of the 2020 Appropriation Act (Chapter 56, 2020 Special Session I Acts of Assembly). The department shall promulgate emergency regulations to properly reflect these reimbursement policies within 280 days or less from the enactment of this act.

CCC. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to establish specialized care operating rates for fiscal years 2021, 2022 and 2023 by inflating the fiscal year 2020 rates using Virginia nursing home inflation. After fiscal year 2023, the department shall revert to the existing prospective methodology. The department has the authority to implement this change notwithstanding current regulations and consistent with the approved State Plan amendment.

DDD. The Department of Medical Assistance Services shall require Medicaid managed care organizations to reimburse at no less than 90 percent of the state Medicaid program Durable Medical Equipment fee schedule for the same service or item of durable medical equipment, prosthetics, orthotics, and supplies. The department shall have the authority to implement this reimbursement change effective July 1, 2021 and prior to the completion of any regulatory process undertaken in order to effect such change.

EEE. The Department of Medical Assistance Services shall adjust the post eligibility special earnings allowance for individuals in the CCC Plus, Community Living, Family and Individual Support and Building Independence waiver programs to incentivize employment for individuals receiving waiver services. DMAS shall lower the number of hours from at least eight hours but less than 20 hours per week requirement to at least four hours but less than 20 hours per week. The Special Earnings Allowance for waiver participants allows a percentage of earned income to be disregarded when calculating an individual's contribution to the cost of their waiver services when earning income. The current requirement is at least eight hours but less than 20 hours per week for a disregard of up to 200 percent of Supplemental Security Income (SSI) and a disregard of up to 300 percent for individuals that work 20 hours or more per week.

FFF.1. Effective May 1, 2021, the Department of Medical Assistance Services shall increase the rates for agency- and consumer-directed personal care, respite and companion services in the home and community-based services waivers and Early Periodic Screening, and Diagnosis and Treatment (EPSDT) program by 6.4 percent. The

department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

2. Effective January 1, 2022, the Department of Medical Assistance Services shall increase the rates for agency- and consumer-directed personal care, respite and companion services in the home and community-based services waivers and Early Periodic Screening, and Diagnosis and Treatment (EPSDT) program by 12.5 percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

GGG. Effective July 1, 2021, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the practitioner rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates. The department shall ensure through its contracts with managed care organizations that the rate increase is reflected in their rates to providers. The department shall have the authority to implement these reimbursement changes prior to the completion of any regulatory process undertaken in order to effect such changes.

HHH. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance or any waiver under Title XIX of the Social Security Act to increase the income eligibility for participation in the Medicaid Works program to 138 percent of the Federal Poverty Level. The department shall have the authority to implement this change prior to the completion of the regulatory process necessary to implement such change.

III. Effective July 1, 2021, the Department of Medical Assistance Services shall increase rates for skilled and private duty nursing services to 80 percent of the benchmark rate developed by the department and consistent with the appropriation available for this purpose. The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such changes.

JJJ. Effective, January 1, 2021, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any necessary waivers, to authorize time and a half up to eight hours and effective July 1, 2021, up to 16 hours for a single attendant who works more than 40 hours per week for attendants providing Medicaid-reimbursed consumer-directed (CD) personal assistance, respite and companion services. The department shall have authority to implement this provision prior to the completion of any regulatory process undertaken in order to effect such change.

KKK.1. Effective July 1, 2021, the Department of Medical Assistance Services shall have the authority to amend the State Plan of Medical Assistance under Title XIX of the Social Security Act to provide a comprehensive dental benefit to adults. The department shall work with its Dental Advisory Committee, including members of the Virginia Dental Association, the Virginia Health Catalyst, the Virginia Commonwealth University School of Dentistry, the Virginia Dental Hygienists Association, the Virginia Health Care Association, a representative of the developmental and intellectual disability community, the Virginia Department of Health and the administrator of the Smiles for Children program to develop the benefit. The benefit shall be modeled after the existing benefit for pregnant women. The benefit shall include preventive and restorative services and shall not include any cosmetic services or orthodontic services. The Dental Advisory Committee shall design a benefit that does not exceed the appropriated funds to provide such services. The department shall work with its dental benefit administrator, the Virginia Dental Association, the Virginia Association of Free and Charitable Clinics, the Virginia Community Healthcare Association and other stakeholders to ensure an adequate network of providers and awareness among beneficiaries. The department shall have authority to promulgate emergency regulations to implement these changes within 280 days or less from the enactment date of this act.

2. The Department of Medical Assistance Services shall seek federal authority to amend the state plans under Titles XIX and XXI of the Social Security Act and any applicable waivers to impose a $2,000 annual spending limit per recipient on adult dental services. The department shall promulgate emergency regulations to implement this

change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

LLL.1.a. The Department of Medical Assistance Services shall increase nursing home and specialized care per diem rates by $20 per day per patient effective until June 30, 2021, and by $15 per day effective July 1, 2021. Such adjustment shall be made through existing managed care capitation rates as a mandated specified rate increase. DMAS shall adjust capitation rates to account for the nursing facility rate increase. The department shall have the authority to file all necessary regulatory authorities without delay, make any necessary contract changes, and implement these reimbursement changes without regard to existing regulations. The specified rate increase in this paragraph applies across fee-for-service and Medicaid managed care.

b. Out of this appropriation, $35,000,000 the first year from the general fund and $35,000,000 the first year from nongeneral funds is provided to increase nursing home and specialized care per diem rates effective until June 30, 2027. The Department of Medical Assistance Services shall have the authority to distribute the funding as an add-on payment to the per diem rates in effect as of June 30, 2026. This add-on payment shall be effective until June 30, 2027. Such adjustment shall be made through existing managed care capitation rates as a mandated specified rate increase. DMAS shall adjust capitation rates to account for the nursing facility rate increase. The department shall have the authority to file all necessary regulatory authorities without delay, make any necessary contract changes, and implement these reimbursement changes without regard to existing regulations. The specified rate increase in this paragraph applies across fee-for-service and Medicaid managed care.

2.a. The Department of Medical Assistance Services (DMAS) shall work with appropriate nursing facility stakeholders and the Cardinal Care managed care organizations (MCOs) to maintain a unified, value-based purchasing (VBP) program that includes enhanced funding for facilities that meet or exceed performance and/or improvement thresholds as developed, reported, and consistently measured by DMAS. Nursing facility performance evaluation under the program shall prioritize maintenance of adequate staffing levels and avoidance of negative care events, such as hospital admissions and emergency department visits. The program may also consider performance evaluation in the areas of preventive care, utilization of home and community-based services, including community transitions, and other relevant domains of care. Facilities under complaint surveys due to major quality or safety issues can be found ineligible for VBP enhanced funds for a period determined by the department. Special Focus Facilities (SFF) are barred from receiving VBP rewards until they successfully graduate from SFF status. The department shall receive information from the Virginia Department of Health's Office of Licensure and Certification to support the evaluation of facility performance and eligibility for enhanced VBP.

b. All funding appropriated for the VBP program shall be disbursed to participating nursing facilities that qualify for the enhanced funding according to the aforementioned unified VBP arrangement's annually published methodology. DMAS shall ensure that program funding is restricted to facilities demonstrating sufficiently high quality of care as determined by the department. Components of the program subject to modifications by DMAS include, but are not limited to, timing of enhanced payments, performance metrics, thresholds determinations, and minimum eligibility requirements for earning program payments. To inform program modifications, DMAS may require facilities to provide documentation on how earned payments from previous program years were utilized to improve the quality of care for Medicaid members. Facilities failing to meet quality standards shall not receive any enhanced payments.

c. DMAS shall conduct an annual comprehensive evaluation of the VBP program to assess its effectiveness in improving the quality of care provided to Medicaid beneficiaries in nursing facilities. This evaluation shall include an analysis of whether the program's incentive structure is successfully rewarding high-performing facilities and appropriately withholding payments from those failing to meet care standards. The evaluation shall also include stakeholder input which includes program progress and a discussion of potential modifications to components of the arrangement.

d. Out of this appropriation, $20,000,000 the first year and $20,000,000 the second year from the general fund and $20,807,998 the first year and $20,807,998 the second year from nongeneral funds shall be provided to increase nursing facility value-based payments effective July 1, 2024 pursuant to paragraph LLL.2.b. in this item. To the extent that this increase each year meets or exceeds the amount otherwise required under clause 3 of Chapters 482 and 438 of the 2023 Acts of Assembly, this increase shall be considered to satisfy that requirement.

e. DMAS shall submit an annual report to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees detailing the outcomes of the VBP program evaluation. The report shall include data on quality improvements, financial impacts, and recommendations for program adjustments to ensure continued progress toward improved care quality.

f. The department shall implement the necessary regulatory changes and other necessary measures to be consistent with federal approval of any appropriate changes to the State Plan or relevant waivers thereof, and prior to the completion of any regulatory process undertaken to effect such change.

MMM. The Department of Medical Assistance Services shall seek federal authority through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act to expand the definition of durable medical equipment per 42 CFR 440.70 (b) (3), so that the definition is no longer limited to items primarily used in the home but also extends to any setting where normal activities take place. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

NNN. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to authorize the reimbursement, using a budget neutral methodology, of pharmacy-administered immunizations for all vaccinations covered under the medical benefit for Medicaid members. Reimbursement for fee-for-service members shall be the cost of the vaccine plus an administration fee not to exceed $16. Reimbursement for pharmacy-administered vaccinations for pediatric Medicaid members eligible for free vaccinations through the Vaccines For Children (VFC) program shall include only the administration fee. The department is authorized to set the administration fee for COVID-19 vaccines at the same level as Medicare reimbursement for such vaccines. The department shall promulgate regulations to become effective within 280 days or less from the enactment date of this act to implement this change.

OOO. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to authorize coverage for clinically appropriate audio-only services, provider-to-provider consultations, store-and-forward, and virtual check-ins with patients. The department shall promulgate regulations to become effective within 280 days or less from the enactment date of this act to implement this change.

PPP. The Department of Medical Assistance Services (DMAS) shall have the authority to make necessary changes to waivers and/or the Medicaid State Plan to ensure that all adult Medicaid members have access to COVID-19 vaccinations. The department shall have the authority to implement such changes effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such changes.

QQQ. The Department of Medical Assistance Services shall amend the Medicaid and CHIP State Plans to authorize prescriptions of contraceptives up to a 12-month supply for eligible beneficiaries in the Medicaid and CHIP programs. 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.

RRR. The Department of Medical Assistance Services, in coordination with the Department of Behavioral Health and Developmental Services, shall submit a request to the Centers for Medicare and Medicaid Services to amend its 1915(c) Home and Community-Based Services (HCBS) waivers to allow telehealth and virtual and/or distance

learning as a permanent service option and accommodation for individuals on the Community Living, Family and Individual Services and Building Independence Waivers. The amendment, at a minimum, shall include all services currently authorized for telehealth and virtual options during the COVID-19 pandemic. The departments shall actively work with the established Developmental Disability Waiver Advisory Committee and other appropriate stakeholders in the development of the amendment including service elements and rate methodologies. The department shall have the authority to implement these changes prior to the completion of the regulatory process.

SSS. Effective July 1, 2022, the Department of Medical Assistance Services shall have the authority to increase the rates for agency- and consumer-directed personal care, respite and companion services by 7.5 percent to reflect additional increases in the state minimum wage while maintaining the existing differential between consumer-directed and agency-directed rest-of-state rates as well as the northern Virginia and rest-of-state rates. The department shall have the authority to implement these changes prior to completion of any regulatory process to effect such change.

TTT. Effective July 1, 2022, the Department of Medical Assistance Services shall have the authority to amend the State Plan under Title XIX of the Social Security Act, and any waivers thereof as necessary to amend coverage of preventive services for adult, full-benefit Medicaid individuals who are not enrolled pursuant to the Patient Protection and Affordable Care Act (PPACA) to align with the preventive services coverage provided under the PPACA. The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such changes.

UUU. The Department of Medical Assistance Services shall amend the state plans under Titles XIX and XXI of the Social Security Act, and any waivers thereof as necessary to remove all cost sharing, including co-payments, co-insurance, and deductibles for enrollees. Such change shall be effective April 1, 2022, or upon expiration of the federal public health emergency related to the Coronavirus Disease 2019 (COVID-19) pandemic, whichever is earlier. The department shall have the authority to implement this change prior to the completion of any regulatory process to effect such changes.

VVV.1. Effective July 1, 2022, the Department of Medical Assistance Services (DMAS) shall have the authority to increase Medicaid Title XIX and CHIP Title XXI reimbursement rates for dental services by 30 percent. The department shall have the authority to implement these reimbursement changes prior to the completion of any regulatory process to effect such changes.

2. Effective July 1, 2024, the Department of Medical Assistance Services shall have the authority to increase Medicaid Title XIX and CHIP Title XXI reimbursement rates for dental services by three percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

WWW. Effective July 1, 2022, the Department of Medical Assistance Services shall have the authority to increase Medicaid Title XIX and CHIP Title XXI reimbursement rates for physician primary care services, excluding those provided in emergency departments, to 80 percent of the federal FY 2021 Medicare equivalent as calculated by the department and consistent with the appropriation available for this purpose. The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such changes.

XXX.1. Appropriation amounting to $175,793,045 in FY 2023 and $201,197,348 in FY 2024 from the general fund and $182,060,495 in FY 2023 and $208,539,425 in FY 2024 from nongeneral funds was provided to increase Developmental Disability (DD) waiver rates set forth in the following paragraph.

2. Effective July 1, 2022, the Department of Medical Assistance Services shall have the authority to update the rates for DD waiver services using the most recent rebasing estimates, based on their review of the model assumptions as appropriate and consistent with efficiency, economy, quality and sufficiency of care and reported no later than July 1, 2022. Rates shall be increased according to tiered payments contained in the rebasing model, where appropriate

for the type of service provided. Rates shall be increased for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Private Duty and Skilled Nursing, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, DD Case Management and Benefits Planning. The department shall have the authority to implement these changes prior to completion of any regulatory process to effect such change.

YYY. Effective July 1, 2022, the Department of Medical Assistance Services shall have the authority to increase Medicaid Title XIX and CHIP Title XXI reimbursement rates for obstetrics and gynecology covered services by 15 percent. The department shall have the authority to implement these reimbursement changes prior to the completion of any regulatory process to effect such changes.

ZZZ. Effective July 1, 2022, the Department of Medical Assistance Services shall have the authority to increase reimbursement rates for children's covered vision services for Medicaid Title XIX and CHIP XXI programs by 30 percent. The department shall have the authority to implement these reimbursement changes prior to the completion of any regulatory process to effect such changes.

AAAA.1. The Department of Medical Assistance Services shall seek federal authority through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act to allow enrollment in a Medicaid managed care plan for individuals who are Medicaid eligible 30 days prior to release from incarceration. The department shall modify its contracts with managed care organizations to require a video or telephone conference with incarcerated individuals that are enrolled in a managed care plan in order to create a transition plan during the 30 days prior to release from incarceration. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

2. The Department of Medical Assistance Services shall have the authority to make any necessary managed care contract changes and to amend the state plans under Titles XIX and XXI of the Social Security Act, and any waivers thereof, as necessary to provide covered services, including screenings, diagnostic services, and targeted case management, in the 30 days pre-release and immediately post-release to eligible incarcerated youth and young adults in accordance with section 5121 of the federal Consolidated Appropriations Act of 2023. The department shall have the authority to implement this change prior to the completion of any regulatory process.

BBBB. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to authorize coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Medicaid enrollee who is determined by a licensed dentist in consultation with the enrollee's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care to an enrollee age ten or younger. The department shall have the authority to implement this change effective July 1, 2022 and prior to the completion of any regulatory process to effect such change.

CCCC. Effective July 1, 2022, the Department of Medical Assistance Services shall increase Medicaid rates for peer recovery and family support services in private and public community-based recovery services settings from $6.50 to $13.00 per 15 minutes for individuals and from $2.70 to $5.40 per 15 minutes for groups.

DDDD. Effective July 1, 2022, the Department of Medical Assistance Services is authorized to increase rates by 12.5 percent, relative to the rates in effect prior to July 1, 2021, for: (i) adult day health care; (ii) consumer-directed facilitation services; (iii) crisis supervision, crisis stabilization and crisis support services; (v) transition coordinator services; (vi) mental health and early intervention case management services; and (vii) community behavioral health and habilitation services. The department shall have the authority to implement these changes prior to the completion of any regulatory process undertaken in order to effect such change. The department shall include any and all Early Periodic Screening Diagnosis and Treatment (EPSDT) Therapeutic Group Homes in such rate increase effective January 1, 2024, regardless of the number of providers and whether or not such facilities were previously included in the list of eligible procedure and revenue codes provided in the Medicaid Bulletin to Providers of Home

and Community Based Services Waivers and EPSDT services participating in Virginia Medical Assistance Programs and Medicaid Managed Care Organizations dated October 16, 2021. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

EEEE. Contingent on approval by the Centers for Medicare and Medicaid Services, the Department of Medical Assistance Services shall allow legally responsible individuals (parents of children under age 18 and spouses) to provide personal care/personal assistance services and be paid for those services. Any legally responsible individual who is a paid aide or attendant for personal care/personal assistance services shall meet all the same requirements as other aides or attendants. The department shall have the authority to implement these changes effective July 1, 2022 and prior to completion of any regulatory process to effect such change.

FFFF. Effective for dates of service on or after January 1, 2024, the Department of Medical Assistance Services shall increase the reimbursement rates for Early Intervention services, excluding case management, by 12.5 percent for all children under age three enrolled in Early Intervention in Virginia Medicaid.

GGGG.1. Effective January 1, 2024, the Department of Medical Assistance Services shall increase rates by 10 percent for the following Medicaid-funded community-based services: Intensive In-Home, Mental Health Skill Building, Psychosocial Rehabilitation, Therapeutic Day Treatment, Outpatient Psychotherapy, Peer Recovery Support Services -- Mental Health.

2. Effective January 1, 2024, the Department of Medical Assistance Services shall increase rates by 10 percent for the following Medicaid-funded community-based services: Comprehensive Crisis Services (which include 23-hour Crisis Stabilization, Community Stabilization, Crisis Intervention, Mobile Crisis Response, and Residential Crisis Stabilization), Assertive Community Treatment, Mental Health - Intensive Outpatient, Mental Health - Partial Hospitalization, Family Functional Therapy and Multisystemic Therapy.

HHHH. The Department of Medical Assistance Services shall increase the rates for mental health partial hospitalization from a per diem rate of $250.62 to $500.00 and shall increase the rate for mental health intensive outpatient programs from a per diem of $159.20 to $250.00. The department shall have the authority to implement this reimbursement change effective January 1, 2024, and prior to the completion of any regulatory process undertaken in order to effect such change.

IIII. Effective January 1, 2024, the Department of Medical Assistance Services is authorized to amend the State Plan for Medical Assistance Services to: (i) extend the age limitation for children receiving fluoride varnish from non-dental providers from "through age 3" to "through age 5"; (ii) remove the current limitation on the number of times a dentist can bill the behavioral management code when treating adults with disabilities; (iii) provide payment for crowns for patients who received root canal therapy prior to becoming a Medicaid beneficiary; and (iv) provide reimbursement for pre-treatment evaluations performed by dentists treating patients requiring deep sedation or general anesthesia to mirror the Centers for Medicare and Medicaid Services (CMS) guidelines. The department shall have the authority to implement these changes consistent with the effective date in the state plan amendment approved by CMS and prior to the completion of any regulatory process undertaken in order to effect such change.

JJJJ. Effective January 1, 2024, the Department of Medical Assistance Services shall have the authority to increase the rates for agency and consumer-directed personal care, respite and companion services by five percent. The department shall have the authority to implement these changes prior to completion of any regulatory process to effect such change.

KKKK. Effective January 1, 2024, the Department of Medical Assistance Services shall have the authority to amend the State Plan under Title XIX of the Social Security Act to provide reimbursement for the provision of behavioral health services that are classified by a Current Procedural Terminology code as collaborative care management services.

LLLL. Effective for dates of service on or after July 1, 2024, the Department of Medical Assistance Services shall update the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale. Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations.

MMMM.1. The Department of Medical Assistance Services shall amend its regulations and guidance on weight loss drugs to require service authorization for covered weight loss drugs to ensure appropriate utilization. The department shall have authority to implement these provisions prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services (DMAS) shall evaluate pharmaceutical manufacturer programs and other contracting arrangements available to state Medicaid programs that are intended to reduce the costs of glucagon-like peptide-1 (GLP-1) receptor agonists and related therapies. The evaluation shall include: (i) a review of manufacturer-sponsored programs, any arrangements negotiated with the federal government on behalf of state Medicaid programs, and any other contractual arrangements offered to state Medicaid programs; and (ii) an assessment of the fiscal impact and feasibility associated with participation in such programs or arrangements. DMAS shall project cost savings for such programs or contracting arrangements and shall be authorized to implement the program or arrangement with the greatest projected savings to the Medicaid program which results in a price per unit of $245 or less to the Medicaid program and achieves the assumed savings included in the Item.

3. If DMAS determines that the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model negotiated with the federal government has the greatest cost savings, then, effective upon such determination, pursuant to the authority granted in 42 USC 1396r-8 Payment for Covered Outpatient Drugs, DMAS shall amend the State Plan for Medical Assistance Services and 12VAC30-50-520 to cover weight loss medications when prescribed for weight loss where: (i) the individual meets the coverage criteria established under the BALANCE Model as negotiated with the federal government, or (ii) if it is a traditional weight loss medication prescribed for weight loss as FDA approved. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act. The department shall have authority to implement this amendment upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

4. If DMAS determines that another contracting arrangement has the greatest cost savings, then, effective upon such determination, pursuant to the authority granted in 42 USC 1396r-8 Payment for Covered Outpatient Drugs, DMAS shall amend the State Plan for Medical Assistance Services and 12VAC30-50-520 to cover weight loss medications in accordance with the specific provisions of such contracting arrangement. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act. The department shall have authority to implement this amendment upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

5.If DMAS determines that no pharmaceutical manufacturer program or other contracting arrangement available to state Medicaid programs for GLP-1 receptor agonist medications would result in a net price per one-month supply of $245 or less to the Medicaid program and also achieve the assumed savings included in this Item, then pursuant to the authority granted in 42 USC 1396r-8 Payment for Covered Outpatient Drugs, DMAS shall amend the State Plan for Medical Assistance Services and 12VAC30-50-520 to cover weight loss medications when prescribed for weight loss where: (i) in those instances where an individual has a body mass index (BMI) greater than 40; (ii) in those instances where an individual has a BMI greater than 37 and has at least one of the following weight-related comorbid conditions: hypertension, Type II Diabetes Mellitus, or Dyslipidemia; or (iii) if it is a traditional weight loss medication prescribed for weight loss as FDA approved, excluding Glucagon-like peptide-1 drugs and any other newer weight loss medications. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this Act. The department shall have authority to implement this amendment upon federal approval and prior to the completion

of any regulatory process undertaken in order to effect such change.

6. DMAS is authorized to make a change pursuant to this paragraph related to reimbursement policies for GLP-1 receptor agonists with 30 days prior notice to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees, unless either Chair raises an objection within five days of being notified.

7. DMAS is authorized to seek federal authority through the necessary waiver(s) and/or State Plan Amendment(s) under Titles XIX and XXI of the Social Security Act and make pharmacy benefit manager (PBM) contract changes, as needed, to enable the use of any rebate negotiated directly between the Commonwealth and a manufacturer of GLP-1 receptor agonist medications, if the negotiated net price (the gross price minus all applicable rebates) is lower than the net price obtained under the existing rebate agreement through the program's PBM.

NNNN. The Department of Medical Assistance Services (DMAS) shall seek federal authority through waiver and state plan amendments under Titles XIX and XXI of the Social Security Act to implement telehealth service delivery options under the Developmental Disability Waivers for the following services: Benefits Planning, Community Coaching, Community Engagement, Community Guide, Group Day Services, Group and Individual Supported Employment, Independent Living Supports, Individual and family/caregiver training, In-home Support Services, Peer Mentoring, Service Facilitation, Therapeutic Consultation, and Workplace Assistance services. However, DMAS authority is limited to those regulatory changes needed to define service delivery and claims processing requirements for those virtual support services currently authorized by the Appropriation Act or Code of Virginia. Moreover, any such changes shall be budget neutral and not increase costs. The department shall have the authority to amend the Developmental Disability Waivers through the Centers for Medicare and Medicaid Services and to promulgate emergency regulations to implement these changes within 280 days or less from the enactment of this act.

OOOO. The Department of Medical Assistance Services (DMAS) shall seek federal authority through state plan amendments under Titles XIX and XXI of the Social Security Act to expand provider qualifications such that individuals working on their required hours of supervision for certification through the Department of Behavioral Health and Developmental Services (DBHDS) to be eligible for registration through the Department of Health Professions (DHP), may be approved as Medicaid provider type for the provision of mental health and substance use disorder peer supported services. In addition, to increase access to peer recovery services, DMAS is authorized to adjust caseload limits for peer recovery specialists to align with DBHDS and DHP and revised policies to reflect the need to operate within a crisis or emergency room setting. DMAS shall ensure that any provider caseload limit increase does not have any adverse impact on quality of care or program integrity. The department shall have the authority to promulgate emergency regulations to implement these changes within 280 days or less from the enactment of this act.

PPPP. The Department of Medical Assistance Services (DMAS) shall implement a process no later than January 1, 2025 for Federally Qualified Health Centers (FQHCs) to notify the department of any changes in the scope of services offered by a FQHC, pursuant to Section 1902(bb)(3) of 42 U.S.C. 1396a. Notifications of changes in the scope of services shall be submitted no later than October 1, 2024 for timely filing allowed by applicable federal law. Thereafter, notification must be received within 12 months of the increase or decrease in the scope of services by the FQHC. The department is authorized to reimburse FQHCs for unreimbursed costs, as allowed by the applicable federal law, prior to an initial request for a change in scope under the new process.

QQQQ. Effective July 1, 2024, the Department of Medical Assistance Services shall have the authority to update the rates for consumer-directed facilitation services based on the most recent rebasing estimates as follows: Consumer Directed (CD) Management Training shall be increased to $90.14 per hour in Northern Virginia and to $80.91 per hour in the rest of the state; CD Initial Comprehensive Visit shall be increased to $360.54 per visit in Northern Virginia and to $323.64 per visit in the rest of the state; CD Routine Visit shall be increased to $112.67 per visit in Northern Virginia and to $101.14 per visit in the rest of the state; and CD Reassessment Visit shall be increased to $180.27 per visit in Northern Virginia and to $161.82 per visit in the rest of the state. The department shall have

the authority to implement these changes prior to completion of any regulatory process to effect such change.

RRRR. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall set the reimbursement rate to 100 percent of the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for specific Durable Medical Equipment (DME) products, including enteral products and supplies and in the following categories in the DMAS fee schedule for Feeding Kits and Tubes and Nutrition Kits/Feeding Tubes. DMAS shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

SSSS. Effective July 1, 2024, the Department of Medical Assistance Services shall increase the rates for peer mentoring consistent with the most recent rate study by Burns and Associates.

TTTT. The Department of Medical Assistance Services shall develop guidelines for a statewide Collaborative Care Model program. The department shall submit a report on progress developing and implementing the guidelines annually by October 1 to the Joint Commission on Health Care and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees.

UUUU. The Department of Medical Assistance Services shall modify requirements for consumer-directed services facilitators to eliminate the requirement that individuals providing these services have an associate's or bachelor's degree in order to provide services. Work experience shall be listed as sufficient in the list of requirements. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

VVVV. The Department of Medicaid Assistance Services shall have the authority to draw down federal funds to cover unreimbursed Medicaid costs for services provided by nonstate government-owned nursing facilities as certified by the provider through cost reports not to exceed the upper payment limit for each nursing facility. The department shall have the authority to implement this reimbursement change prior to completion of any regulatory process in order to effect such change.

WWWW. Effective July 1, 2024, the Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to increase the per diem rates paid to therapeutic group homes (TGH) that accept children requiring early and periodic screening, diagnosis, and treatment (EPSDT) services by 50 percent.

XXXX.1. Effective July 1, 2024, the Department of Medical Assistance Services shall have the authority to update the rates for DD waiver services by three percent for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Private Duty and Skilled Nursing, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning. The department shall have the authority to implement these changes prior to completion of any regulatory process to effect such change.

2. Effective July 1, 2025, the Department of Medical Assistance Services shall have the authority to update the rates for DD waiver services by three percent for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Private Duty and Skilled Nursing, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning. The department shall have the authority to implement these changes prior to completion of any regulatory process to effect such change.

YYYY.1. Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall increase the rates for agency- and consumer-directed personal care, respite and companion services in the home and community-based services waivers and Early Periodic Screening, and Diagnosis and Treatment (EPSDT) program by two percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

2. Effective July 1, 2025, the Department of Medical Assistance Services shall increase the rates for agency- and consumer-directed personal care, respite and companion services in the home and community-based services waivers and Early Periodic Screening, and Diagnosis and Treatment (EPSDT) program by two percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

ZZZZ. The Department of Medical Assistance Services shall have the authority to change the reimbursement methodology for adult day health care from a daily rate to an hourly rate, however, such reimbursement is limited to no more than six hours per day. Any such reimbursement rate adjustment must be budget neutral and not increase the cost of this service. The department shall have the authority to implement this change prior to the completion of any regulatory process to effect such changes.

AAAAA. The Department of Medical Assistance Services shall modify the nursing facility reimbursement methodology described in 12 VAC 30-90-44 to use the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG). This change to reimbursement methodology shall be implemented in a budget neutral manner no later than October 1, 2025. The department shall have the authority to implement this change prior to the completion of any regulatory process to effect such changes.

BBBBB. The Department of Medical Assistance Services (DMAS) shall submit final exempt regulatory packages to repeal existing provider reimbursement regulations in 12 VAC 30-70, 12 VAC 30-80, and 12 VAC 30-90 and replace them with new sections containing text that is substantially identical to the Medicaid state plan as it was in effect on March 1, 2026. Changes shall not impact any aspect of the Medicaid program or increase costs. These regulatory packages shall be promulgated according to the following schedule: Chapter 70 sections shall be submitted for executive branch review within 45 days from the enactment date of this act; Chapter 80 sections shall be submitted for executive branch review within 75 days from the enactment date of this act; Chapter 90 sections shall be submitted for executive branch review within 95 days from the enactment date of this act.

CCCCC. The Department of Medical Assistance Services shall require that liable third-party payers are barred from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules.

DDDDD. Effective July 1, 2025, the Department of Medical Assistance Services shall amend the state plan for medical assistance services to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital emergency department or hospital inpatient setting. This payment shall be unbundled from the hospital daily rate.

EEEEE.1. Effective July 1, 2025, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to authorize coverage for a continuous glucose monitor (CGM) and related supplies for the treatment of a Medicaid enrollee under the Medicaid medical and pharmacy benefit if the enrollee: (i) has been diagnosed with diabetes by his or her primary care physician, or another licensed health care practitioner authorized to make such a diagnosis; (ii) is being treated with insulin; and/or (iii) has a history of problematic hypoglycemia; (iv) the enrollee's treating practitioner has concluded that the enrollee (or enrollee's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription; and (v) the CGM is prescribed in accordance with the Food and Drug Administration indications for use.

2. Coverage shall include the cost of any necessary repairs or replacement parts for the continuous glucose monitor.

3. To qualify for continued coverage under this section, the Medicaid enrollee must participate in follow-up care with his or her treating health care practitioner, in-person or through telehealth, at least once every six months

during the first 18 months after the first prescription of the continuous glucose monitor for the recipient has been issued under this section, to assess the efficacy of using the monitor for treatment of diabetes. After the first 18 months, such follow-up care must occur at least once every 12 months.

4. Effective July 1, 2026, the Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to authorize the collection of supplemental drug rebates on continuous glucose monitors and related supplies.

FFFFF. The Department of Medical Assistance Services shall ensure the reimbursement for a service provided by a licensed certified midwife or licensed midwife shall be in the same amount as the Medicaid reimbursement paid a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

GGGGG. The Department of Medical Assistance Services shall seek the appropriate waiver authority for a project to add neurobehavioral and neurorehabilitation facilities to support 20 individuals with traumatic brain injuries and neurocognitive disorders. The neurobehavioral and neurorehabilitation facilities shall be considered as a specialized institutional placement for individuals with a traumatic brain injury diagnosis. The department shall set service definitions, administrative structure, eligibility criteria, eligibility and enrollment processes, and reimbursement rates required for administration of a program for such facilities. The department shall have authority to implement these changes prior to the completion of any regulatory process undertaken in order to effect such change.

HHHHH. The Department of Medical Assistance Services (DMAS) is authorized to reimburse at the applicable Indian Health Services (IHS) outpatient all-inclusive rate published annually in the Federal Register for clinic services or federally qualified health center (FQHC) services provided to Medicaid-eligible American Indians and Alaska Natives (AI/AN) by facilities operated by Tribal Health Clinics and tribal FQHCs funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities, provided such payments are eligible for reimbursement at a federal medical assistance percentage (FMAP) of 100 percent. Any services provided by IHS or Tribal 638 facilities that are not eligible for reimbursement at a 100 percent FMAP shall be reimbursed at standard Medicaid rates (the rates otherwise paid to non-tribal facilities for the same services) and not at the IHS outpatient all-inclusive rate. DMAS is authorized to make any necessary managed care contract changes and seek all necessary federal authority through state plan or waiver amendments submitted to the Centers for Medicare and Medicaid Services under Titles XIX and XXI of the Social Security Act to implement the provisions of this paragraph. The department shall implement this reimbursement change consistent with the effective date of the appropriate federal authority, and prior to the completion of any regulatory process. If the above rate structure is not approved by the Centers for Medicare and Medicaid Services, then DMAS shall seek approval to reimburse IHS facilities, tribal clinics and tribal FQHCs at the standard Medicaid rate for all services.

IIIII. Effective July 1, 2025, the Department of Medical Assistance services shall increase the rates by 6.5 percent for Office Based Addiction Treatment, Opioid Treatment Services, Partial Hospitalization Services, and Intensive Outpatient Services.

JJJJJ.1. Out of this appropriation, $38,646,266 the first year and $43,063,826 the second year from the general fund and $43,137,525 the first year and $46,860,081 the second year from nongeneral funds is provided to increase Medicaid state plan or waiver rates as set forth in the following paragraphs.

2. Effective July 1, 2026, the Department of Medical Assistance Services shall have the authority to update the rates for Developmental Disability waiver services using the 2025 DD Waiver Rate Study conducted pursuant to the Permanent Injunction (Civil Action No. 3:12CV59-JAG). Rates shall be increased according to the methodology included in the rate study for the following services: Community Coaching (T2013), Community Engagement (T2021), Independent Living Supports (T2032), In-Home Support Services (H2014), Therapeutic Consultation (97139 and 97530), and Workplace Assistance (H2025). The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such change.

3. Effective July 1, 2026, the Department of Medical Assistance Services shall have the authority to increase the rates by two percent for the following services: Group Day Support (97150), Group Day Support Customized Rate (T2025), Community Guide (H2015), Peer Monitoring (H0038), Supported Employment Individual (H2023), Supported Employment Enclave (H2024), Group Home Residential 4 or fewer (H2022-UA), Group Home Residential 5 or more (H2022), Group Home Customized Rate (T2016), Sponsored Residential (T2033), Supported Living Residential (H0043), Shared Living (T1020), and Benefits Planning (T1023). The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such change.

4. Effective July 1, 2026, the Department of Medical Assistance Services shall have the authority to increase the rates for the following services: 3.8 percent for Skilled Nursing RN (S9123), 4.5 percent for Skilled Nursing, LPN (S9124), 5.0 percent for Private Duty Nursing, RN (T1002), and 5.0 percent for Private Duty Nursing, LPN (T1003). The department shall have the authority to implement these changes prior to the completion of any regulatory process to effect such change.

KKKKK. The Department of Medical Assistance Services shall limit mobile crisis services payments to four hours per incident. In addition, DMAS shall only reimburse DBHDS licensed and approved mobile crisis providers contracted with community services boards. The department shall promulgate emergency regulations to implement these changes within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

LLLLL. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or state plan amendments under Titles XIX and XXI of the Social Security Act to eliminate the community stabilization service effective July 1, 2026. The department shall promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

MMMMM. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) to implement a 56-hour limit on personal care/assistance services provided under the Community Living and Family and Individual Support developmental disability waivers to mirror 56-hour soft cap limits in the Commonwealth Coordinated Care Plus waiver. The department shall promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

NNNNN. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or state plan amendments under Titles XIX and XXI of the Social Security Act to eliminate the live-in caregiver exemption from electronic visit verification requirements. The department shall promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

OOOOO. The Department of Medical Assistance Services (DMAS) shall require its contracted actuary to review each managed care organization's administrative expenses, after the administrative expense audit is complete, for reasonability of reported administrative expenses to the covered population, to include benchmarking for competitiveness and efficiencies. Attainable adjustments shall be made in the capitation rate development calculation based on the results of this review to ensure efficient use of capitation revenues by the managed care organizations. These adjustments shall be reflected in capitation rates beginning with the rates effective July 1, 2026.

PPPPP. Notwithstanding any other provision of law, the Department of Medical Assistance Services (DMAS) shall seek federal authority through the necessary waiver(s) and/or State Plan Amendment(s) under Titles XIX and XXI of the Social Security Act to eliminate inflation adjustments for hospital rates, freestanding psychiatric facilities, disproportionate share hospitals (DSH) payments, graduate medical education payments, nursing facilities and any other provider rates for FY 2027 and FY 2028. DMAS shall exclude the value of withheld expected FY2027-FY2028 inflation adjustments from future inflation adjustments and hospital and nursing facility rebasings. The department shall promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. The department shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

QQQQQ. The Department of Medical Assistance Services shall update its reimbursement methodology for rehabilitation hospitals to provide more equitable reimbursement rates for each rehabilitation hospital relative to its total cost of services provided to Medicaid recipients. Any such change shall be budget neutral.

RRRRR. In developing capitation rates for the Cardinal Care Managed Care program, the department shall limit the assumed underwriting gain (margin for risk and cost of capital) to one percent of Medicaid adjusted premium revenue on average across all covered populations and rating cells. The department shall ensure that capitation rates are developed in a manner that is actuarially sound while reflecting this one percent underwriting gain assumption. The department shall not incorporate an assumed underwriting gain in excess of one percent in the actuarial rate certification for any contract period unless otherwise expressly authorized by the General Assembly.

SSSSS.1. Effective January 1, 2027, the Department of Medical Assistance Services shall increase the rates for agency and consumer-directed personal care, respite and companion services in the home and community based services waivers and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program by 4 percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.
2. Effective January 1, 2028, the Department of Medical Assistance Services shall increase the rates for agency and consumer-directed personal care, respite and companion services in the home and community based services waivers and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program by 3.9 percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

TTTTT.1. Notwithstanding regulations established at 12VAC30-90-44, the Department of Medical Assistance Services shall submit any required state plan or waiver amendments to defer the next scheduled nursing facility price rebasing, which would have changed rates as of July 1, 2027, with the normal rebasing cycle resuming for rates effective July 1, 2030. Beginning upon enactment of this act through the period of the deferral, the department shall work with stakeholders, to include the Virginia Health Care Association and any others as deemed relevant by the department, to identify and examine methodological concerns with the current nursing facility reimbursement system and to the extent necessary, propose modifications to address any concerns identified for which solutions can be found. Additionally, the group shall review and recommend quality improvement initiatives to be incentivized within the payment rate as appropriate. This process is not intended to increase nursing facility reimbursement in the aggregate, but rather to correct methodological concerns within aggregate reimbursement levels already established as adjusted annually for utilization and inflation while also promoting improved quality. Nothing herein shall preclude separate budget action affecting aggregate reimbursement levels.

2. The department shall report annually each December 1, beginning with 2026 through the deferral period on the identified methodological issues and progress toward solutions. This report shall include an assessment from the department and stakeholders, including dissenting opinions of any stakeholder group, if necessary, on the practicality of any proposed solutions and feasibility and potential timeline for implementing such solutions. The annual report is intended to inform the Governor and General Assembly of the need to continue the deferral or when implementation of the rebasing could take place as defined in regulations albeit with any approved

modifications in place. This report shall be provided to the Governor, Senate Finance and Appropriations and Education and Health Committees, and the House Appropriations and Health and Human Services Committees.

3. This item does not authorize any changes to the reimbursement system as currently defined; subsequent authority must be granted to implement any specific recommended modifications.

UUUUU.1. Each 340B covered entity that dispenses a 340B drug to a Medicaid enrollee shall report such information to the Department of Medical Assistance Services (DMAS), on a quarterly basis and in a format prescribed by DMAS, the following data for each 340B drug dispensed to a Medicaid enrollee during the reporting period: (i) the National Drug Code (NDC) of the drug dispensed; (ii) the date of dispense; (iii) the quantity dispensed; (iv) the 340B acquisition cost of the drug; (v) the amount billed to Medicaid or to a Medicaid managed care organization; (vi) the amount reimbursed by Medicaid or by a Medicaid managed care organization; (vii) whether the claim was submitted through an in-house pharmacy, a contract pharmacy, or a virtual inventory arrangement; and (viii) the identity of any contract pharmacy through which the drug was dispensed.

2. DMAS shall use data collected pursuant to this paragraph to: (i) identify claims for 340B drugs submitted to the Medicaid program that may give rise to a duplicate discount under 42 U.S.C. § 1396r-8(a)(5)(C); (ii) exclude 340B drug claims from Medicaid rebate invoices submitted to manufacturers where required by federal law; and (iii) quantify the aggregate value of 340B discounts received by covered entities on drugs dispensed to Medicaid enrollees and report such findings to the Director, Department of Planning and Budget and the Chairs of the House Appropriations and the Senate Finance and Appropriations Committees by December 1 of each year.

3. DMAS shall incorporate the reporting requirements of this paragraph into provider enrollment agreements and Medicaid managed care organization contracts as a condition of participation. DMAS shall have the authority to pursue any federal waiver or state plan amendment necessary to implement this paragraph.

4. Data collected pursuant to this paragraph shall be confidential and used only for program integrity, rebate administration, and policy evaluation purposes.

VVVVV. The Department of Medical Assistance Services shall amend existing contracts with Medicaid managed care organizations (MCOs) to require the MCOs to adopt performance metrics for Medicaid Non-Emergency Medical Transportation (NEMT) brokers consistent with performance metrics implemented for the Fee-for-Service NEMT program and require such MCOs to report annually, by no later than November 1, to the Department regarding the performance of the NEMT brokers on such metrics.

WWWWW.1. Effective July 1, 2026, the Department of Medical Assistance Services shall seek any necessary waivers and/or State Plan for Medical Assistance amendments under Titles XIX and XXI of the Social Security Act to provide coverage for sickle cell treatments for Medicaid enrollees through the Cell and Gene Therapy Access Model in partnership with the federal Centers for Medicare and Medicaid. The department shall have the authority to implement these changes upon federal approval and prior to completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall have the authority to unbundle the cost of sickle cell disease cell and gene therapy drugs that are eligible for inclusion in the Centers for Medicare and Medicaid Services (CMS) model from the hospital daily rate for the purposes of participating in the Cell and Gene Therapy Access Model. The Department of Medical Assistance Services shall have the authority to implement a value based agreement that is consistent with the CMS model.