2026 Special Session I

Budget Bill - HB30 (Chapter 1)

Department of Medical Assistance Services

Item 295	First Year - FY2027	Second Year - FY2028
Administrative and Support Services (49900)	**$460,191,265**	**$445,986,550**
General Management and Direction (49901)	$440,784,529	$426,579,814
Administrative Support for the Family Access to Medical Insurance Security Plan (49932)	$16,186,736	$16,186,736
CHIP Health Services Initiatives (49936)	$3,220,000	$3,220,000
Fund Sources:		
General	$93,847,821	$93,196,843
Special	$11,816,854	$7,716,854
Dedicated Special Revenue	$30,104,679	$28,336,172
Federal Trust	$324,421,911	$316,736,681

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

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

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

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

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

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

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

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

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

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

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

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

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

4. DMAS shall convene a meeting three times each fiscal year with the Secretary of Finance, Secretary of Health and Human Resources, or their designees, and appropriate staff from DPB, the House Appropriations and Senate Finance and Appropriations Committees, and the Joint Legislative Audit and Review Commission, to monitor Medicaid expenditures and enrollment growth to determine the program's financial status. At each meeting, DMAS shall report on expenditures (at the service level of detail) and enrollment in the Medicaid and children's health insurance programs to explain any material differences in expenditures compared to the official Medicaid forecast or children's health insurance programs forecasts, adjusted to reflect budget actions from each General Assembly session. In addition, DMAS shall report on enrollment trends by eligibility category and indicate differences in actual enrollment as compared to the most recent forecast of enrollment. If expenditures are exceeding the budget for Medicaid or the children's health insurance programs, DMAS shall provide options to bring expenditures in line with available resources. At each meeting, DMAS shall provide an update on any changes to the managed care programs, or contracts with managed care organizations, that includes detailed information and analysis on any such changes that may have an impact on the capitation rates or overall fiscal impact of the programs, including changes that may result in savings. In addition, DMAS shall provide an analysis at each meeting on spending and utilization trends within the managed care programs with a focus on trends that indicate higher growth than was anticipated in the capitation rates. During each fiscal year, the meetings shall be held in April, July, and October of each year to review the time period since the last meeting.

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

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

E. The Department of Medical Assistance Services shall, within 15 days of receiving a deferral of federal grant funds, or release of a deferral, or a disallowance letter, notify the Director, Department of Planning and Budget, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees of such deferral action or disallowance. The notice shall include the amount of the deferral or disallowance and a detailed explanation of the federal rationale for the action. Any federal documentation received by the department shall be attached to the notification.

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

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

H. No appropriation in this Item shall be used to fund any study of medical assistance provider rates unless the General Assembly has provided specific authorization for such study. This provision shall not apply to routine rate

work that is necessary to administer medical assistance programs under existing state and federal law.

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

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

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

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

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

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

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

M.1. Effective July 1, 2023, the Department of Medical Assistance Services shall be fully responsible for all financial analysis, rates, and budget work associated with Virginia's developmental disability waiver services.

2. Out of this appropriation, $85,000 the first year and $85,000 the second year from the general fund and $85,000

the first year and $85,000 the second year from federal funds is provided for a position to support agency responsibilities associated with developmental disability waiver services.

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

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

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

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

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

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

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

T.1. Out of this appropriation, $9,505,235 the first year and $9,505,235 the second year from the general fund and $112,204,717 the first year and $112,204,717 the second year from nongeneral funds is provided for centralized call center and eligibility operations.

2. Of the amounts in T.1., $9,505,235 the first year and $9,505,235 the second year from the general fund and

$50,230,500 the first year and $50,230,500 the second year from nongeneral funds is provided for the Cover Virginia Call Center and centralized eligibility processing unit (CPU). CPU operations shall be limited to processing Medicaid-only applications and renewals. Funding also supports the Cover Virginia Incarcerated Unit call center and eligibility unit.

3. Of the amounts in T.1., $61,974,217 the first year and $61,974,217 the second year from nongeneral funds is provided to expand Cover Virginia Call Center operations to implement the community engagement and six-month renewal provisions included in H.R. 1, 119th Congress (2025-2026). The Director, Department of Planning and Budget (DPB), shall unallot appropriation in this paragraph until the Department of Medical Assistance Services provides documentation of contractual costs needed to implement the H.R. 1 provisions. DPB shall have the authority to increase nongeneral fund appropriation to reflect actual contract amounts needed for expenditures in each fiscal year.

4. The Department of Medical Assistance Services shall seek opportunities to enhance call center operations through the use of artificial intelligence (AI). All call center related contract procurements, re-procurements, or modifications shall maximize the use of AI to reduce costs and improve service. Any use of AI must ensure the protection of personal information and comply with federal law and regulations.

5. The Department of Medical Assistance Services shall report on the operations and costs of the Cover Virginia Call Center and eligibility unit. This report shall include the number of calls received on a monthly basis, the purpose of the call, the number of applications and renewals for Medicaid submitted through the call center, and the costs of the contract. The report shall also include data related to H.R. 1 implementation. The department shall submit the report by August 15 of each year to the Director, Department of Planning and Budget and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees.

U. Out of this appropriation, $15,462,264 the first year and $15,462,264 the second year from the general fund and $62,407,632 the first year and $62,407,632 the second year from nongeneral funds shall be provided to maintain and operate the Medicaid Enterprise System.

V.1. Out of this appropriation, $10,135,000 the first year and $6,035,000 the second year from special funds is appropriated to the Department of Medical Assistance Services (DMAS) for the disbursement of civil money penalties (CMP) levied against and collected from Medicaid nursing facilities for violations of rules identified during survey and certification as required by federal law and regulation. Based on the nature and seriousness of the deficiency, the agency or the Centers for Medicare and Medicaid Services (CMS) may impose a civil money penalty, consistent with the severity of the violations, for the number of days a facility is not in substantial compliance with the facility's Medicaid participation agreement. Civil money penalties collected by the Commonwealth must be applied to the protection of the health or property of residents of nursing facilities found to be deficient. Penalties collected are to be used for (1) the payment of costs incurred by the Commonwealth for relocating residents to other facilities; (2) payment of costs incurred by the Commonwealth related to operation of the facility pending correction of the deficiency or closure of the facility; and (3) reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or individuals used by the facility to provide services to residents. These funds are to be administered in accordance with the revised federal regulations and law, 42 CFR 488.400 and the Social Security Act § 1919(h), for Enforcement of Compliance for Long-Term Care Facilities with Deficiencies. Any special fund revenue received for this purpose but unexpended at the end of the fiscal year shall remain in the fund for use in accordance with this provision.

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

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

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

5. Of the amounts appropriated in V.1. of this Item, up to $4,100,000 the first year from special funds may be used to support participation in the Centers for Medicare and Medicaid Services Nursing Home Staffing Campaign.

6. By October 1 of each year, DMAS shall provide an annual report for the previous fiscal year that includes the amount of revenue collected and spending activities to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and the Director, Department of Planning and Budget (DPB).

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

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

9. DMAS is authorized to administratively request up to $2,000,000 of additional special fund appropriation for special projects if 1) the appropriated amounts in V.3. are insufficient; and 2) such projects and costs are approved by CMS for the Civil Money Penalty Reinvestment State Plan. DPB shall approve such requests provided the required conditions are met.

W. Out of this appropriation, $100,000 the first year and $100,000 the second year from the general fund and $100,000 the first year and $100,000 the second year from federal funds shall be provided to contract with the Virginia Center for Health Innovation for research, development and tracking of innovative approaches to healthcare delivery. The Department of Medical Assistance Services shall only provide federal matching funds for those expenses eligible for reimbursement by the Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

DD. Out of this appropriation, $300,000 the first year and $300,000 the second year from the general fund and $300,000 the first year and $300,000 the second year from federal funds shall be used by the agency to hire five additional full-time employees to augment existing staff in the agency's finance division. Specifically, the Department of Medical Assistance Services shall hire three additional positions in the budget division, one additional position in the fiscal division and one additional position in the provider reimbursement division.

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

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

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

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

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

JJ. Out of this appropriation, $4,065,218 the first year and $4,065,218 the second year from the general fund and $9,070,391 the first year and $9,070,391 the second year from nongeneral funds is provided for the Department of Medical Assistance Services to contract with a vendor to handle all mail directed to local departments of social

services associated with medical assistance services.

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

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

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

NN. The Department of Medical Assistance Services shall convene a workgroup with staff designees from the Department of Planning and Budget and the House Appropriations and Senate Finance and Appropriations Committees to evaluate options for developing a process that recognizes the true costs of policy changes to the Medicaid program and how to integrate such process as part of the development of the state budget.

OO. The Department of Medical Assistance Services (DMAS), in cooperation with the Virginia Department of Health (VDH), shall create an assessment tool for children under the age of 18 to utilize in long-term services and supports screenings. In addition, the departments shall implement measures necessary to ensure the consistent statewide application of screening criteria. VDH shall implement this tool on or before January 1, 2027. An assessment shall not be conducted more frequently than once every six months unless there is a major life change. DMAS shall promulgate emergency regulations to implement this change within 280 days or less from the enactment of this act. DMAS shall implement this change upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

PP. Effective July 1, 2026, the Department of Medical Assistance Services shall incorporate service facilitation into the statewide service broker model via the Fiscal Employer contract and eliminate service facilitation as a standalone service. 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 effect these changes. 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.

QQ. Notwithstanding Chapter 701, 2025 Virginia Acts of Assembly, or any other provision of law, the Department of Medical Assistance Services shall delay contracting with a single third-party administrator to serve as the state pharmacy benefits manager until January 1, 2027, and such time as sufficient general fund support is provided by

the General Assembly through a general appropriation act.

RR. Notwithstanding § 32.1-325.5 of the Code of Virginia, the Department of Medical Assistance Services shall issue a request for proposals (RFP) for a single third-party administrator to serve as the state pharmacy benefits manager (PBM) to administer all pharmacy benefits for Medicaid recipients, including those enrolled in a managed care organization with whom the Department contracts for the delivery of Medicaid services by January 1, 2028. The RFP for the Medicaid single Pharmacy Benefits Manager shall require that a qualified bidder is one that shares no ownership with any Medicaid managed care organization (excluding a prepaid Ambulatory Health Plan). Furthermore, a qualified bidder must maintain no direct or indirect financial arrangements with drug manufacturers or labelers that create incentives for formulary decisions, drug substitution, or utilization management, including rebates, discounts, chargebacks, claw backs, or data sales. The department shall review and incorporate provisions of PBM legislation considered during the 2026 Session of the General Assembly in developing the RFP, as appropriate, including provisions that ensure network adequacy for Medicaid patients and address transparency. The department shall issue the RFP by January 1, 2027 and award a contract to the single third party administrator by July 1, 2027.

SS. The Department of Medical Assistance Services (DMAS) in collaboration with the Department of Behavioral Health and Developmental Services shall identify the steps necessary for Virginia to transition to a prospective payment system (PPS) as required to fully adopt the Certified Community Behavioral Health Clinic (CCBHC) model including any estimated fiscal impact to the state and to Community Services Boards (CSBs), and report findings to the Chairs of House Appropriations and Senate Finance and Appropriations Committees, and the Behavioral Health Commission by December 1, 2026.

TT. The Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS) shall collaborate on methods to ensure that applicants for and recipients of medical assistance are aware of (i) assistance available for verifying eligibility information and (ii) how to contact the appropriate person if an applicant or recipient receives eligibility information after a due date or experiences difficulty securing eligibility verifications. DMAS and DSS shall make recommendations to the Governor and Secretary of Health and Human Resources by October 1, 2026, if changes are needed that cannot be remedied administratively. DMAS and DSS shall post information in a prominent place on their websites and other social media platforms they regularly use informing recipients of medical assistance about how to receive assistance on eligibility, applications, and eligibility appeals. Such information shall include how applicants and recipients can ensure the agencies receive timely information on eligibility applications and requests to appeal eligibility decisions, as well as U.S. Postal Service recommendations to customers to ensure that postmarks applied to mail match the date of mailing.

UU. The Department of Medical Assistance Services shall issue a Request for Proposals (RFP) for entities interested in a Program of All-Inclusive Care for the Elderly (PACE) program in the Augusta/Rockingham/Harrisonburg area and may make an award to an appropriate entity interested in administering a program in the area.

VV. The Department of Medical Assistance Services shall have authority to amend the State Plans for Medical Assistance under Titles XIX and XXI of the Social Security Act, and any waivers, procurements, and contract modifications thereof, to implement requirements of federal H.R. 1 – 119th Congress (2025-2026). The department shall have authority to implement such standards and practices upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

WW.1. The Director, Department of Medical Assistance Services shall convene a Medicaid Financial Sustainability Workgroup for the purpose of analyzing Medicaid expenditure trends and identifying strategies to moderate the rate of spending growth while preserving access to care, quality, and compliance with state and federal law and policy. The workgroup shall examine historical and projected Medicaid spending growth, including key cost drivers such as enrollment, utilization, provider reimbursement, managed care expenditures, behavioral health spending, pharmacy spending, long-term services and supports, and administrative costs. The workgroup shall evaluate opportunities for improved utilization management, program integrity, payment reform, service delivery redesign,

and administrative efficiencies. The workgroup shall include representatives from the Department of Medical Assistance Services, the Department of Planning and Budget, staff of the House Appropriations and Senate Finance and Appropriations Committees, the Virginia Hospital and Healthcare Association, the Virginia Health Care Association, the Medicaid Society of Virginia, the Virginia Association of Health Plans, at least one of the contracted Medicaid managed care organizations, and other provider representatives as deemed appropriate by the Director, Department of Medical Assistance Services.

2. The department shall submit a report to the Governor and the Chairs of the Senate Finance and Appropriations and House Appropriations Committees by November 1, 2027. The report shall include findings, options for cost containment, and budget and policy recommendations.

XX. The Department of Medical Assistance Services and the Virginia Department of Health shall convene a workgroup to address the barriers that prevent certain licensed midwives (CPMs) and licensed certified midwives (CMs) and licensed certified nurse midwives (CNMs) from contracting with managed care organizations (MCOs) through Cardinal Care. The workgroup shall include MCOs in Cardinal Care, the Virginia Midwives Alliance, an Insurance Broker, Virginia Chapter of the American College of Nurse Midwives, Virginia Birth Center Alliance, Virginia Rural Health Association, Virginia Interfaith Center for Public Policy, March of Dimes, the Diverse Birth Collective, a Medicaid-eligible mom impacted by lack of access, and other relevant stakeholder groups. The work group shall include two CPMs and two CNM/CMs. Of the four midwives, one should be a CPM who currently bills Medicaid and a CPM who does not and one CNM or CM who is employed at a health system and a CNM or CM who works in the community. The workgroup shall present solutions to address those barriers along with budget requests to the GeneralAssembly by December 1, 2027.

YY. Out of this appropriation, $1,000,000 from the general fund and $1,000,000 from nongeneral funds the first year shall be provided to the Department of Medical Assistance Services (DMAS) to contract with a vendor to review and assess program integrity efforts at DMAS and its contracted managed care organizations (MCOs). This review and assessment shall include: (i) detection of fraud, waste and abuse including use of data analytics, auditing, and how suspected fraud is reported; (ii) how referrals are made to the Medicaid Fraud Control Unit and the follow-up on such investigations; (iii) enforcement capabilities; and (iv) how DMAS prevents fraud, waste and abuse through training, education, provider credentialing and enrollment, utilization management, and system edits. The vendor shall review the contractual requirements DMAS has with the MCOs and shall review the program integrity efforts of each MCO. The vendor shall also review and evaluate how the Medicaid program can use Centers for Medicare & Medicaid Services' data, such as the Medicaid Provider Spending by HCPCS dataset, to improve its Medicaid program integrity efforts. The Director, Department of Planning and Budget shall unallot this appropriation until DMAS provides documentation of the contract's cost and shall only allot the amount contracted for with such vendor. DMAS shall report on the review and assessment along with any findings and recommendations to improve program integrity efforts to the Governor, and the Chairs of the House Appropriations and Senate Finance Committees by December 1, 2026. If the vendor has not completed its review by this date, DMAS shall provide an interim report and within 30 days of the vendor completing its work, DMAS shall submit a final report.

ZZ. The Department of Medical Assistance Services (DMAS) shall seek federal authority through the necessary state plan or 1915(c) waiver amendments submitted to the Centers for Medicare and Medicaid Services under Titles XIX and XXI of the Social Security Act to modify the program rules for consumer-directed services available through certain 1915(c) Home and Community-Based Services Medicaid Waivers to allow an individual receiving services to serve as the employer of record (EOR) for his own service delivery and designate another individual to perform all or a portion of the duties of the EOR on the individual's behalf when the individual receiving services is unable to perform such duties or direct his own care. In seeking federal authority to modify such rules, DMAS shall ensure that the employer identification number (EIN) shall be assigned to the individual receiving services and shall not be transferred to another individual except when an individual: (i) has not yet reached the age of majority; (ii) is ineligible to use his existing EIN to facilitate the taxation of benefits; or (iii) is otherwise determined to be ineligible by DMAS by administrative rule. DMAS shall have the authority to limit such state plan

or 1915(c) waiver amendments to specify that an individual receiving services may make such designation no more than twice per calendar year.

AAA. Out of this appropriation, $252,000 from the general fund and $468,000 from nongeneral funds the first year and $252,000 from the general fund and $468,000 from nongeneral funds the second year shall be provided to contract with Reach Out and Read to implement a pilot program of their evidence-based model that promotes early literacy and parental bonding as part of routine pediatric primary care visits in select underserved localities. Effective July 1, 2026, the Department of Medical Assistance Services shall have the authority to amend the Children's Health Insurance Program (CHIP)/Title XXI State Plan to establish a Health Services Initiative (HSI) to authorize and fund this project as allowed by Section 2105(a)(1)(D)(ii)) of the Social Security Act and 42 CFR 457.10. Funding of the project is contingent on approval of the CHIP State Plan Amendments and on the availability of CHIP federal funds. The department shall assess the implementation of the pilot program and provide an interim report on its findings by December 1, 2028.

BBB. Out of this appropriation, $250,000 from the general fund and $250,000 from nongeneral funds the first year and $250,000 from the general fund and $250,000 from nongeneral funds the second year is provided to the Department of Medical Assistance Services (DMAS) to expand Medicaid/FAMIS outreach and enrollment services provided under its contract with the Virginia Health Care Foundation (VHCF). These amounts are in addition to the current outreach and enrollment funding allocated to VHCF by DMAS and shall be used to grow VHCF's outreach and enrollment capacity and reach. Effective July 1, 2026, DMAS shall continue to contract with VHCF to provide Medicaid/FAMIS outreach and enrollment services on an ongoing basis. Where allowable, DMAS shall fund the program with Children's Health Insurance Program Administrative funds and access the applicable federal match.