CardinalCare
Virginia's Medicaid Program

Board of Medical Assistance Services Director's Update

Steve Ford, DMAS Director

March 10, 2026

DMAS

New DMAS Director

WELCOME STEVE FORD

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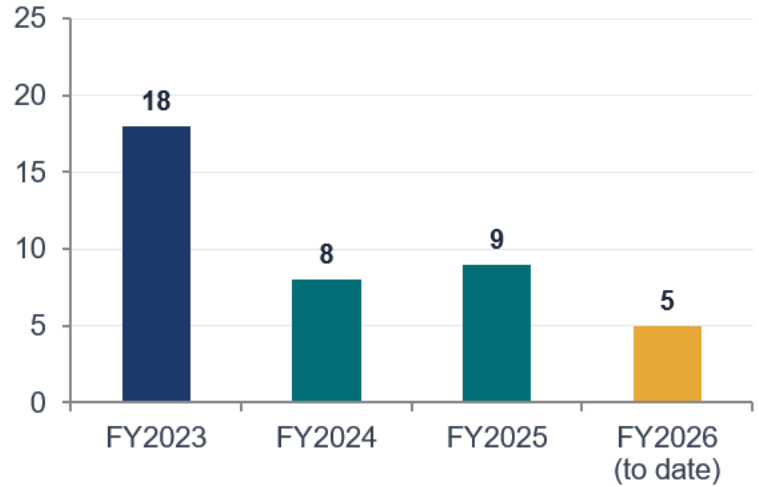
Virginia's Medicaid Program

DMAS Workforce Overview

541	93%	38	32
Filled Positions	**Fill Rate**	**Vacancies**	**Avg. Time to Fill**
Classified	of positions filled	All in recruitment	days (post to hire)

Turnover Rates by Fiscal Year



Workforce Highlights

Retention Unit

Created within Workforce Development & Engagement to focus on retaining critical employees.

Recognition Program (Enhanced)

Flexible schedules, birthday acknowledgements, employee-led recognition, VCU & LinkedIn Learning training.

DMAS Internship Program — Cohort 7

10 interns (May–Aug 2026) | 18 colleges + 2 high schools | 38 total graduates | 20 hired (53%)
Aligned with InternshipsVA & DHRM COVA Internship Connect.

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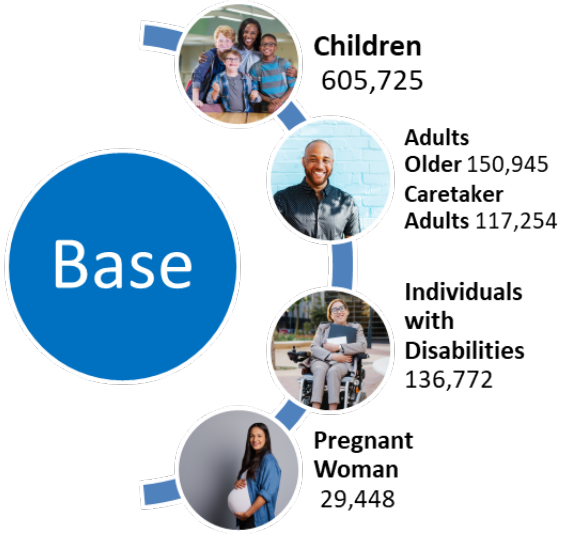
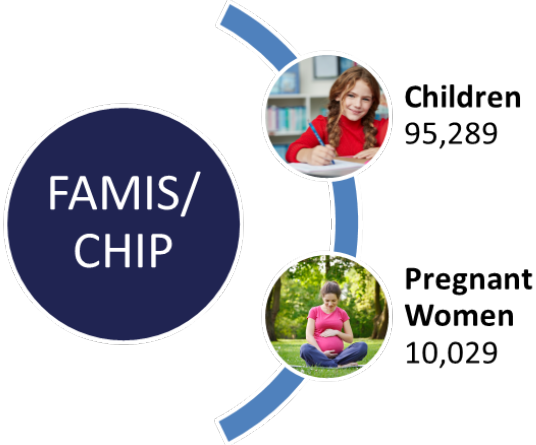
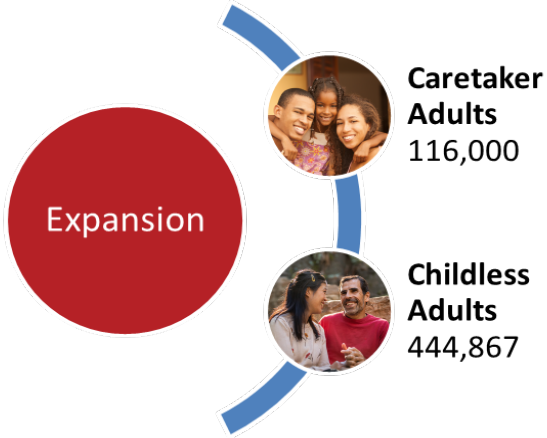
Virginia's Medicaid Program

Who Do We Cover?

1,814,494 Virginians



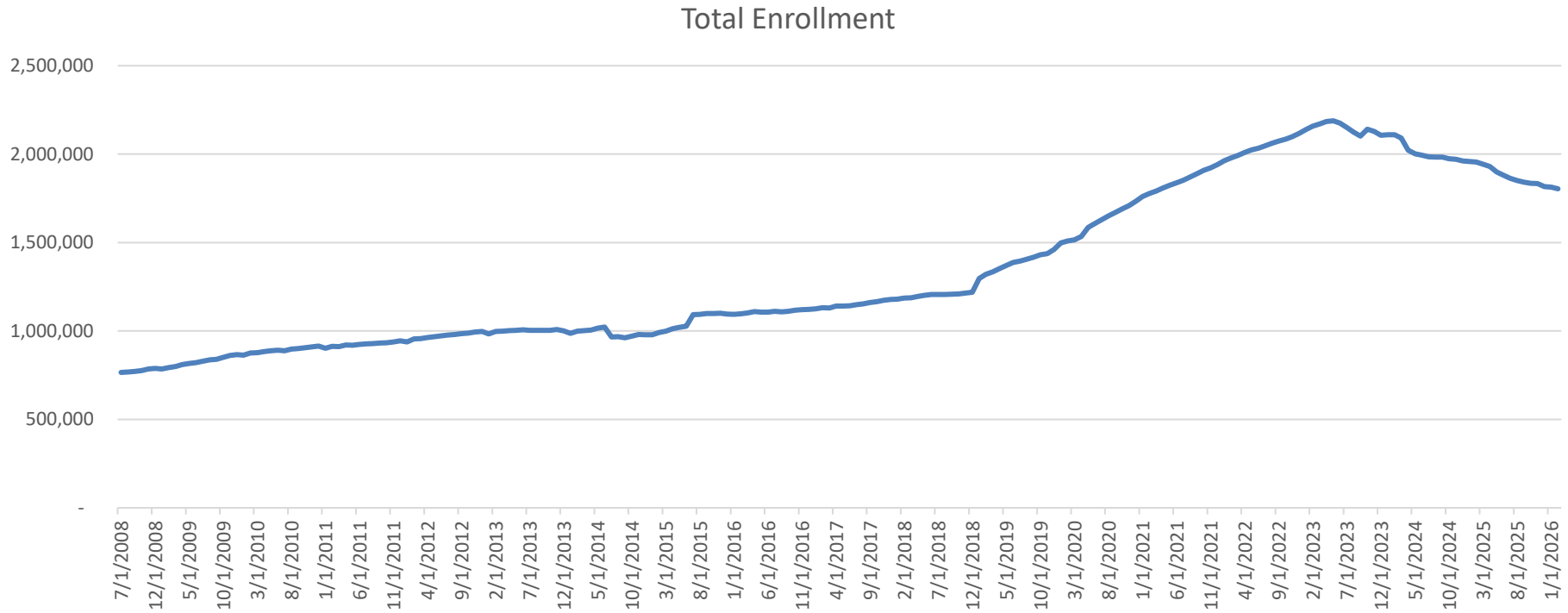




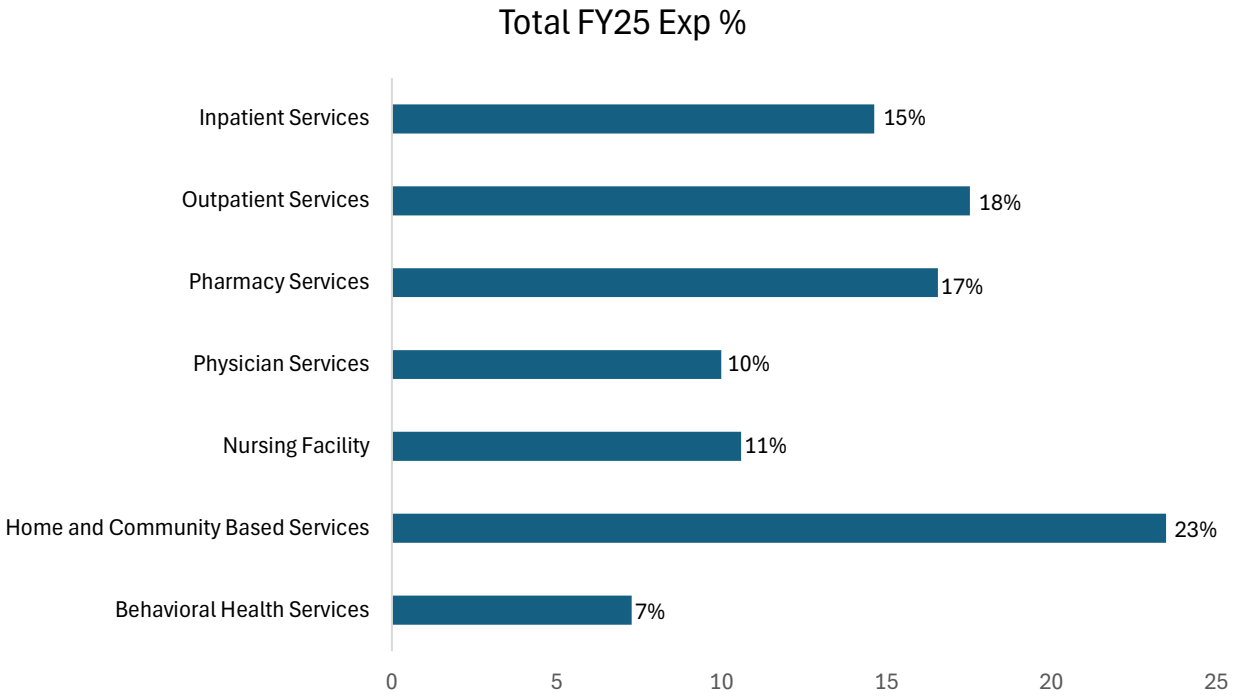
Plus 168,998 with Limited Benefits

Source: DMAS Enrollment Report for March 1, 2026, https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/enrollment-reports/

VA Medicaid Population 2008 to 2026

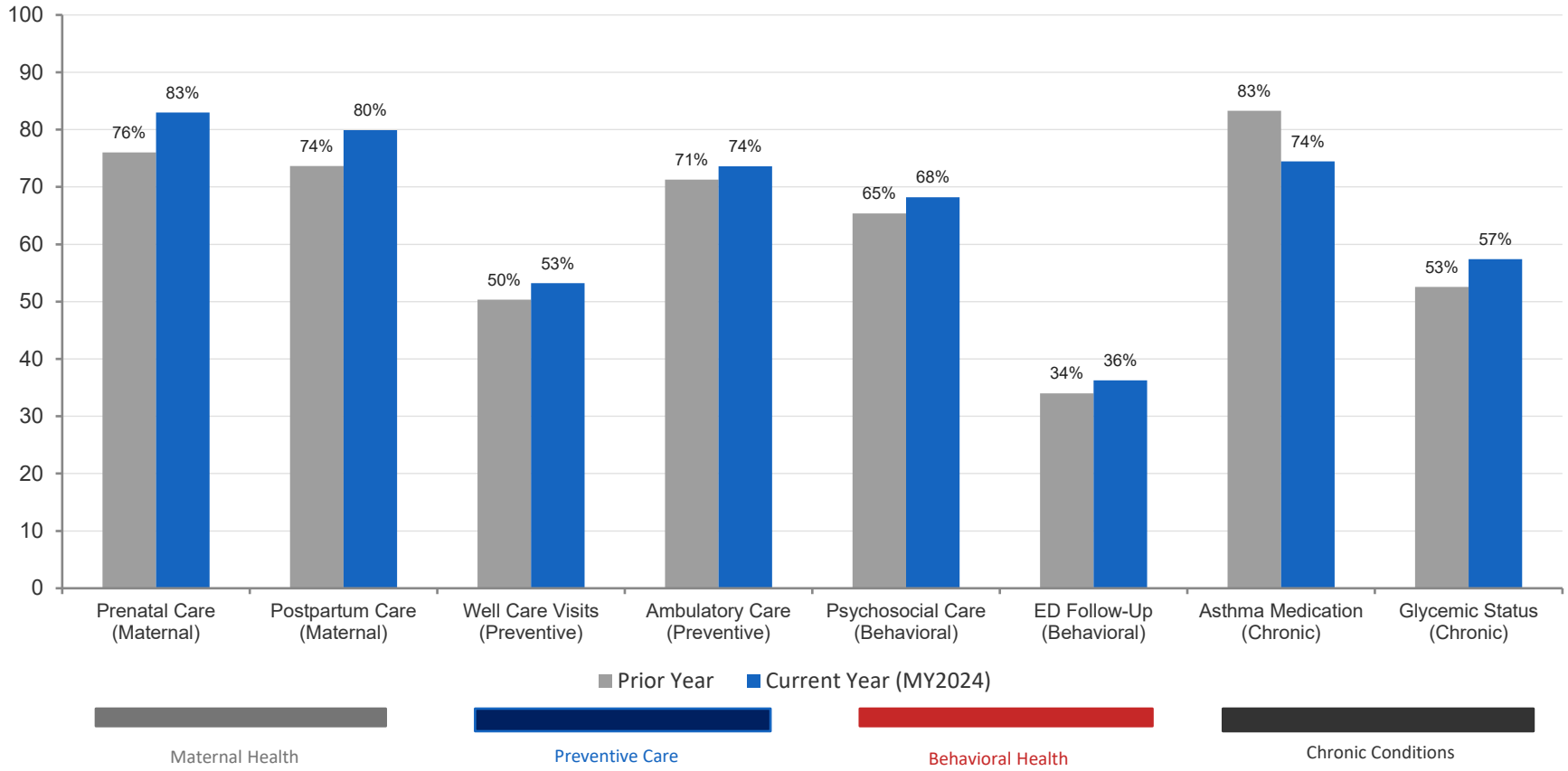


What services does Medicaid pay for?



Quality Measures — HEDIS 2025 (MY2024)

Performance by Category



H.R. 1 Requirements & Implementation Dates

Jul 4, 2025

§ 71115
Provider Taxes

§ 71401
Rural Health Transformation Program

Oct 1, 2025

§ 71113
Federal Payments to Prohibited Entities

Nov 5, 2025

§ 71401
Rural Health Transformation Grant Submission Due Date

Oct 1, 2026

§ 77109
Noncitizen Medicaid Eligibility

§ 71110
Expansion FMAP for Emergency Medicaid

Jan 1, 2027

§ 71103
Reducing Duplicate Enrollment Under the Medicaid and CHIP

§ 71107
Eligibility Renewals (6-month)

§ 71112
Reducing State Medicaid Costs, Reducing Retroactive Coverage

§ 71119
Establish Medicaid Community Engagement Requirements

§ 71104
Ensuring Deceased Individuals Do Not Remain Enrolled

Oct 1, 2027

§ 71115
Provider assessments' percentage caps begin decreasing annually by 0.5% until FY 2032, when the threshold reaches 3.5 %

Jul 1, 2028

§ 71116
State Directed Payments 10% annual step-down to 100% of Medicare

§ 71121
Making Certain Adjustments to Coverage of Home or Community-Based Services under Medicaid

Oct 1, 2028

§ 71120
Modifying Cost Sharing Requirements for Certain Expansion Individuals Under the Medicaid Program

Oct 1, 2029

§ 71106
Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid

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Virginia's Medicaid Program

DMAS other Initiatives

- Rural Health Transformation Program
- Behavioral Health Redesign
- CMS Actions
- Program Integrity
- Cardinal Care Managed Care
- Procurements

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Impacts of H.R. 1

March 5, 2026

DMAS

H.R. 1 Made Changes to Medicaid That States Must Begin Implementing Immediately

Impact of H.R. 1

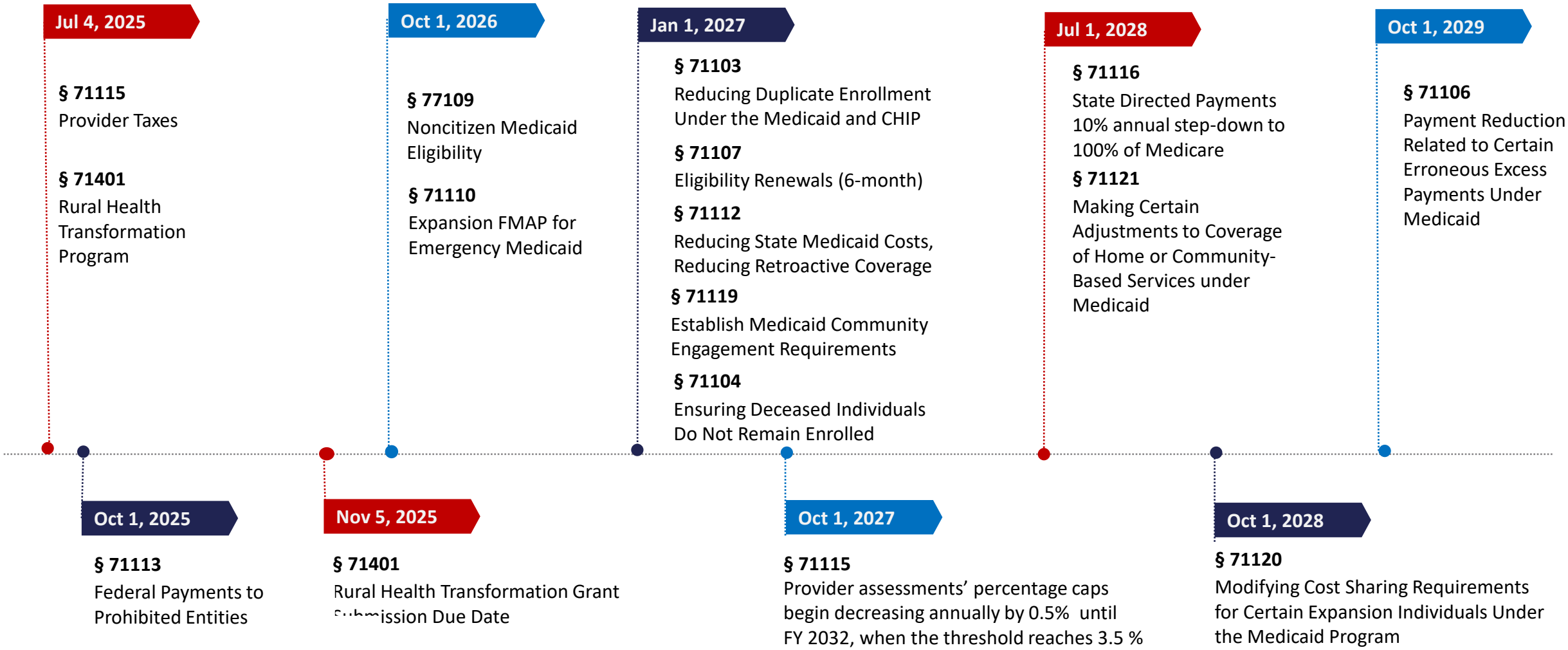
Enacted on July 4, 2025, H.R. 1 made major changes to Medicaid eligibility and financing.

- These changes include, in part:
  - **New eligibility requirements**, including work & community engagements, more frequent eligibility renewals for the Medicaid expansion population and eligibility changes for lawfully present noncitizens.
  - **Changes to state financing of their share** of Medicaid costs including copayments and reimburse health providers.
- H.R. 1's new policies require states to modify their systems and undertake significant changes to Medicaid operations. Virginia has begun implementation to meet the deadlines outlined in H.R. 1.
- CMS has stated that implementing H.R. 1 is their top priority but has released only limited, embargoed guidance. Interim final rules for the work and community engagement requirements are expected to be released in **June 2026**.

Medicaid Footprint

About **1.8 million Virginians** count on Medicaid for their health coverage (**22%** of the state's population).

H.R. 1 Requirements & Implementation Dates



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Medicaid Eligibility Changes

Sara Cariano, Eligibility Policy & Outreach Division Director

DMAS

H.R.1 - Eligibility & Enrollment Changes

Requirements	Effective Date
'Qualified Noncitizen' definition and eligibility changes – Amends the definition of 'qualified alien,' limiting Medicaid eligibility for noncitizens.	October 1, 2026
Reducing duplicate enrollment under Medicaid and CHIP programs – Requires states to use additional data sources to identify potential out of state individuals (including but not limited to the National Change of Address files and Managed Care data), and in the future, to utilize a federal system implemented by HHS.	January 1, 2027 October 1, 2029 HHS system available
Six-month eligibility redeterminations – Requires states to redetermine the eligibility of Medicaid expansion members every 6 months.	January 1, 2027
Work and community engagement requirements – Requires states to implement work and community engagement requirements for Medicaid expansion.	January 1, 2027

H.R.1 - Eligibility & Enrollment Changes

Requirements	Effective Date
Reducing retroactive coverage – Reduces retroactive coverage for Medicaid from three months to one month for Medicaid expansion and two months for all other covered groups. Reduces optional CHIP retroactive coverage from three to two months. VA has not adopted the CHIP retroactive coverage state option.	January 1, 2027
Ensuring deceased individuals do not remain enrolled – Requires states to utilize the quarterly Social Security Administration (SSA) Death Master File (DMF) in addition to state files to identify deceased members.	January 1, 2028
Payment reduction related to certain erroneous excess payments (PERM) – Expands definition of erroneous excess payment and imposes state fiscal impacts for error rate >3%.	October 1, 2029

Noncitizen Eligibility Changes, October 1, 2026

- Limits eligibility for non-pregnant adults to:
  - Legal Permanent Residents (aka Green Card Holders), after 5 years
  - Cuban/Haitian Entrants, 7-year limit
  - Compact of Free Association (COFA) migrants

- Does NOT impact the eligibility rules for:
  - Legally residing children under 19 and pregnant individuals
  - FAMIS Prenatal, pregnancy coverage regardless of status
  - CHIP Health Services Initiatives (HSI)
  - Emergency Medicaid

Noncitizen Eligibility Changes, Non-pregnant Adults

Before October 1, 2026	After October 1, 2026
• Legal Permanent Residents • Compact of Free Association (COFA) migrants • Parolees • Conditional Entrants • Battered noncitizen • Refugees • Asylees • Amerasians • Cuban and Haitian entrants • Deportees whose deportation is withheld • Victims of trafficking and their spouse, child, sibling or parent • Iraqi and Afghan Special Immigrant • SSI recipients • Certain American Indians/Alaskan Natives born in Canada • Legally residing active-duty military/veterans and their spouses and dependent children	• Legal Permanent Residents • Compact of Free Association (COFA) migrants • Cuban and Haitian entrants

Six-Month Eligibility Redeterminations

- Conduct eligibility redetermination (aka renewal) for Medicaid expansion members every six months (currently done every 12 months).
- Certain American Indians/Alaskan Natives are exempt.
- CMS guidance was expected by December 31,2025 – has not been released as of March 2nd.

Projected Impact: Medicaid expansion members (>550,000) will go through the renewal process every six months.

State Implications: System changes, eligibility policy updates, staff training, VDSS/LDSS workload impacts/staff training, possible contract modifications for eligibility and outreach support.

Coordination: DMAS/VDSS/LDSS coordination on workload management, system changes and trainings.

Communication: Communication plan to ensure member, providers, MCOs and other state agencies are aware of the changes.

Work & Community Engagement Requirements, January 1, 2027

Compliance

To fulfill the requirements, an individual must either:

- Work, volunteer, or participate in an education or work program for a total of at least 80 hours per month*;
- Be enrolled in an educational program at least part-time; or
- Have a monthly income of at least $580 (federal minimum wage x 80 hours/month)*.

*Thresholds can be averaged over a 6-month period for seasonal workers.

Exemptions

Certain populations are exempt from the requirements, including:

- Pregnant or postpartum (12 months) individuals
- People with special medical needs, including substance use disorders, serious or complex medical conditions, or disabilities
- Veterans with a 100% disability rating from the VA
- Parents, guardians, or family caregivers for children under 14 or a person with a disability
- American Indians and Alaska Natives
- People incarcerated or are within 3 months of released

States *may* adopt temporary hardship exemptions for individuals:

- Receiving care in a hospital/psychiatric hospital, SNF, or ICF-IID, or care of similar acuity
- Residing in counties with an unemployment rate greater than 8% or greater than 150% of the national average
- Who experienced a natural disaster
- Who must travel outside of their community for necessary medical care

Work & Community Engagement Requirements, January 1, 2027

Impacted Population

Requirements apply to **Medicaid expansion**

- **Medicaid expansion covers** adults aged 19 to 64, with income at or under 138% of the federal poverty level (about $21,597/year for an individual), and not eligible for Medicare.
- There are >550,000 individuals enrolled in Medicaid expansion in Virginia.

Information is based on the state's current understanding of the new requirements. Additional forthcoming federal guidance may result in changes.

Application

1. Be compliant the month before the month that the application is submitted, **or**
2. Meet an exemption in the month that the application is submitted.

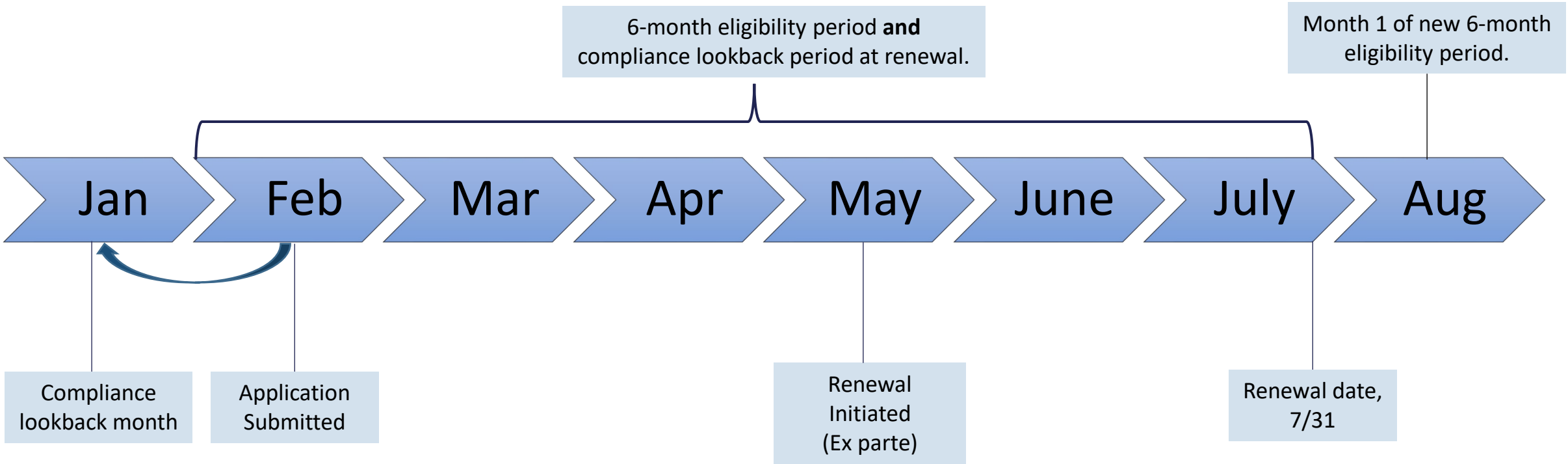
Renewal

1. Have been compliant for at least one month since the last eligibility determination/redetermination, **or**
2. Meet an exemption when the renewal is processed.

Change

Members who meet the work and community engagement requirements at application or renewal are determined to be compliant/exempt for the full 6-month eligibility period.

Member Timeline



Work & Community Engagement Requirements – State Options

1. Medically frail definition – Medical condition that can exempt members from work requirement reporting, as defined by the state and approved by HHS.
2. Self-attestation – States may elect not to require an individual to verify information resulting in deeming an individual exempt from the requirement (*pending CMS guidance*)
3. Compliance – No less frequent than one-month preceding enrollment, or at the states option up to three months.
4. Verification - May occur more frequently than at initial eligibility determination and at redetermination.

Work & Community Engagement Implementation Oversight Structure

HHR Executive Steering Committee

Virginia Secretaries of Health and Human Resources, Administration, Finance, Labor and Education.

Escalate key needs and cross-agency decisions.

DMAS Steering Committee

DMAS Executive Leadership

Reviews project scheduled and deliverables. Responsible for making key decisions and escalating key barriers to HHR.

Project Coordination Team

Project Workstream Leads & Key DMAS Staff

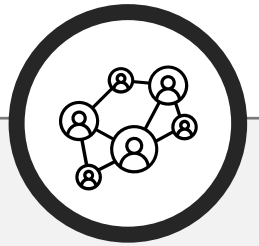
Cross-functional project teams responsible for operating project plan. Provides support for Project workstreams, tracks work plan and deliverables and identifies and escalates barriers.

- Policy & Program Development Workstream
- Systems Workstream
- Delivery Systems (MCO Collaboration) Workstream
- Data & Reporting Workstream
- Contractor & Vendor Management Workstream
- Communications & Outreach Workstream
- DMAS/VDSS Workstream
- Stakeholder Engagement Workstream
- Contractor Support (Manatt)

H.R. 1 Implementation Goals

Ensure that **eligible** Virginians maintain **coverage and** access to the care and services they need.

Promote efficiency, effectiveness, and sustainability.



Ensure that our initiatives, programs, and systems promote economic mobility and **connect** those who require additional support to achieve economic mobility **to appropriate resources**.

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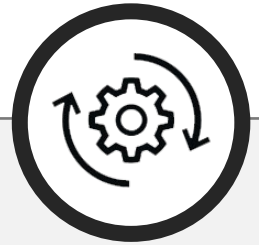
Core Strategies

Virginia is committed to minimizing loss of coverage while maintaining compliance with federal requirements. A strong emphasis has been and will continue to be placed on collaboration with state agency partners and stakeholders, communicating clearly and transparently, and leveraging technology to streamline processes.



Automate

Rely on automation and electronic data sources to minimize administrative burden.

Invest in a Module System to streamline eligibility evaluation.

Build Capacity

Enable Cover Virginia vendor to do renewals for Medicaid Expansion members only.

Enhance CoverVA self-serve options.

Onboard DMAS staff dedicated to work and community engagement.

Collaborate

Cross agency coordination and partnership.

Engage Managed Care Organizations to conduct outreach.

Empower, resource and educate externals stakeholders.

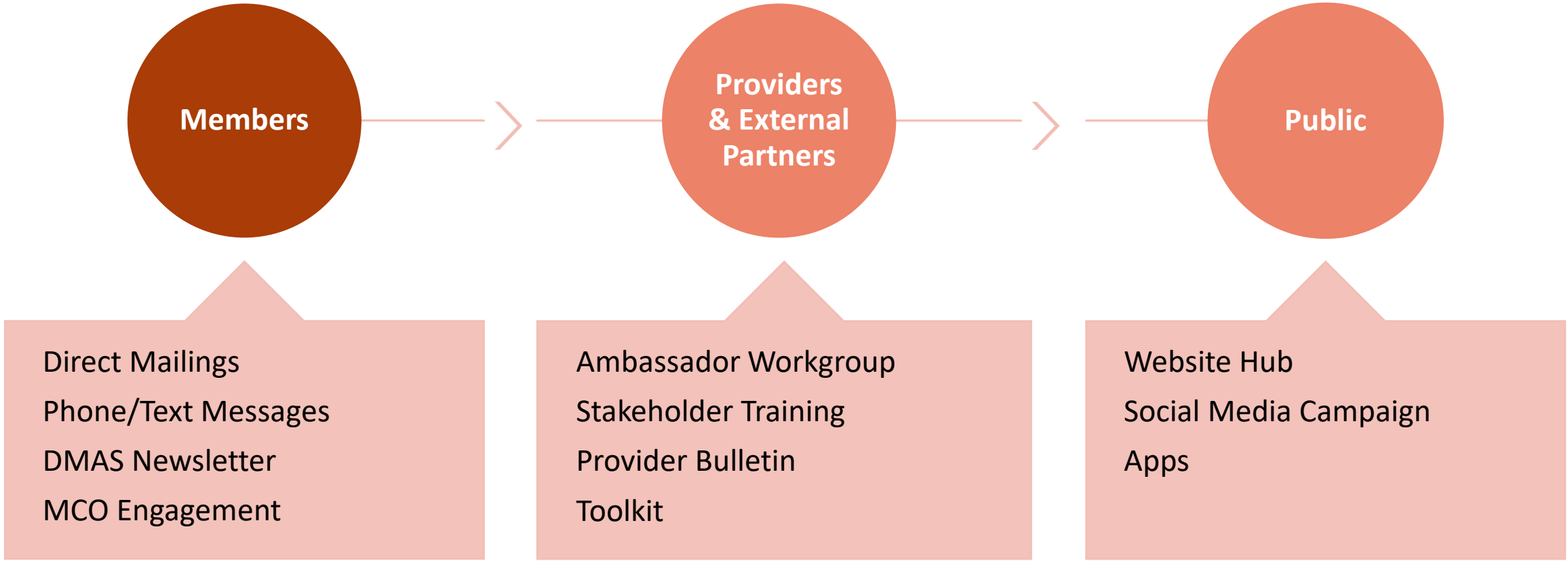
Train

Update and enhance training for eligibility staff.

Train core stakeholders who engage regularly with Medicaid members/eligible populations.

Communication Strategies

Communicate in a clear, concise and transparent manner to all stakeholders.



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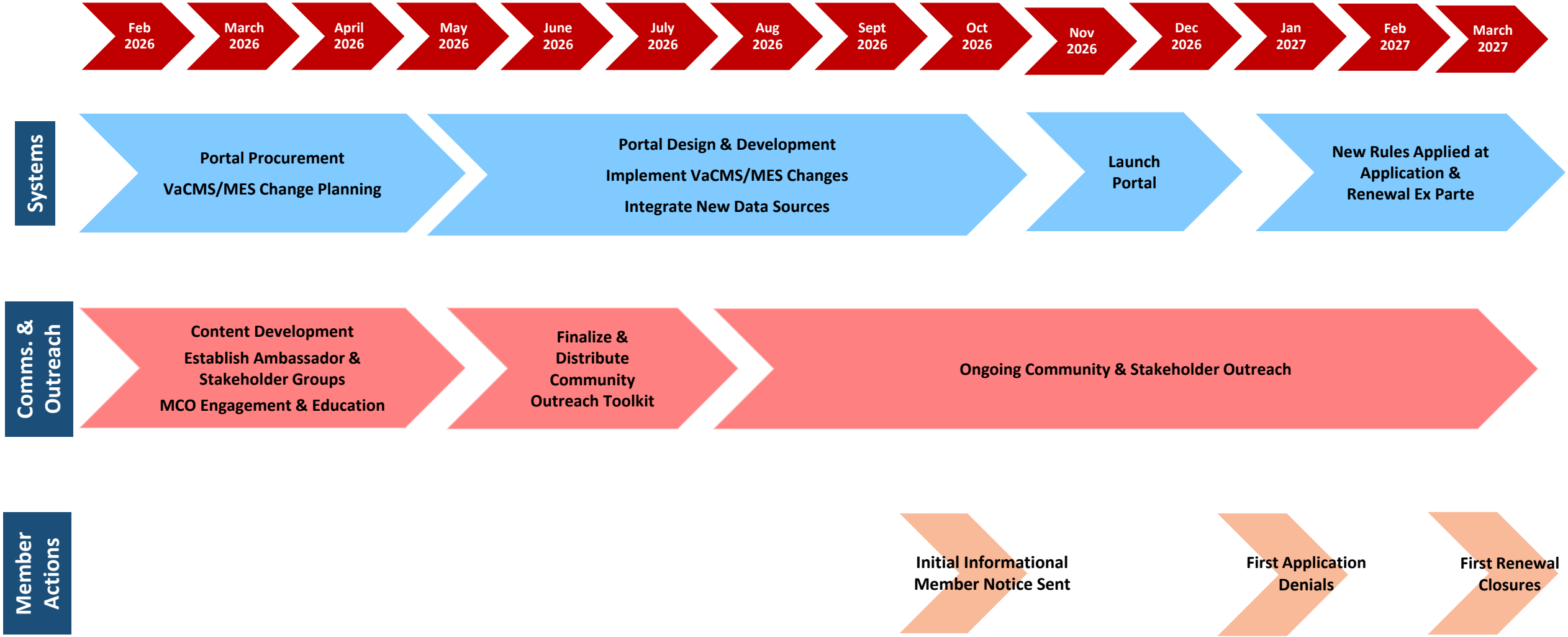
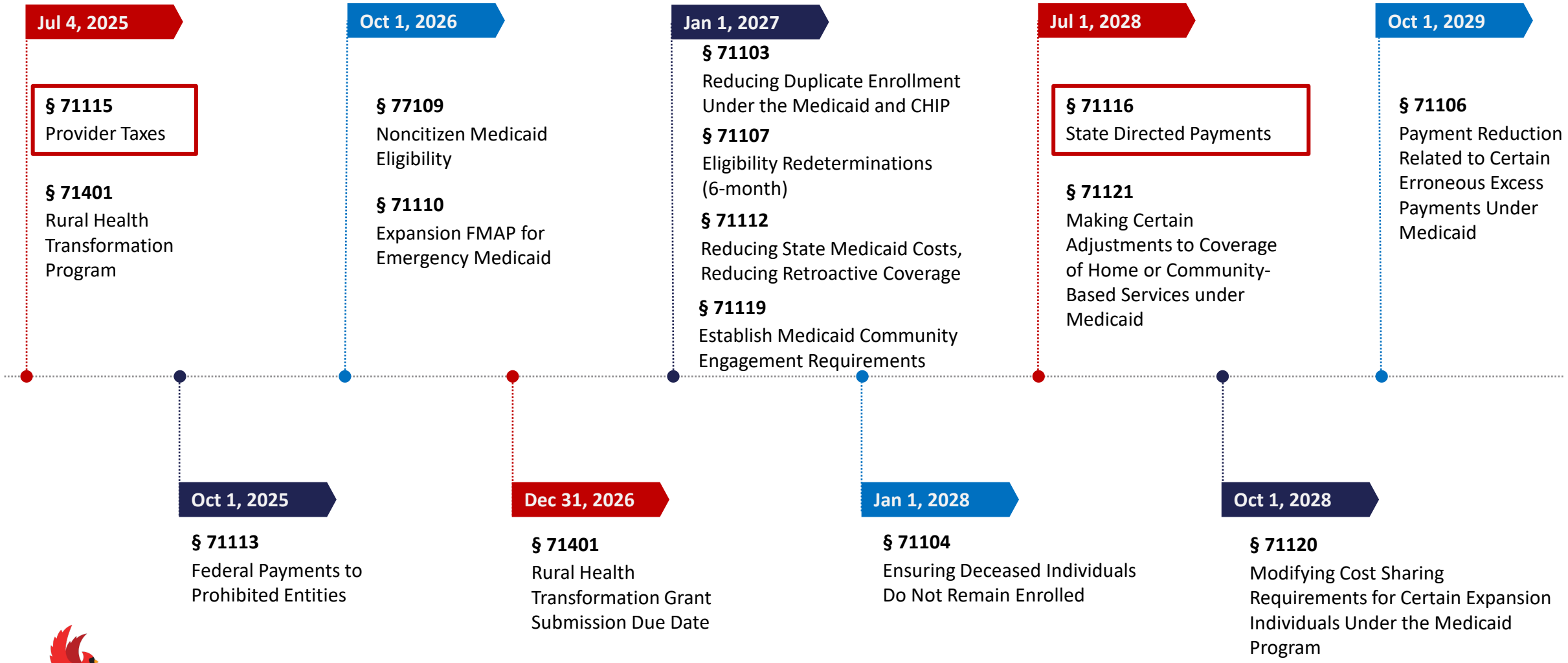
Work & Community Engagement Implementation Timeline



H.R.1 Impact on Provider Assessments

Tanyea Darrisaw, Provider Rate Development, Division Director

H.R. 1 Requirements & Implementation Dates



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Virginia's Medicaid Program

Summary

Virginia's Program

- Provider assessment authorized under Item 3-3-5.14 and Item 3-5.15 (2025 Appropriations Act) Act)
- Funds state share of FFS and managed care enhanced supplemental payments to private acute care hospitals

HR1 Federal Changes (enacted July 4, 2025)

- **Section 71115:** Restricts provider tax increases and and sets future thresholds thresholds
- **Section 71116:** Caps supplemental payment values

Virginia's Private Hospital Assessment Program

Provider Assessment (Item 3-5.15)

- **Purpose:** Bridge MCO payment gaps via supplemental payments

- **Criteria**: Applies to private hospitals — including critical access hospitals
- **Basis:** Net patient service revenue
- **Rate:** Variable, calculated quarterly to fund non-federal share based on FFS & MCO supplemental payment

State Directed Payment (SDP)

- Uniform percentage increase to MCO base payments for inpatient/outpatient services
- Paid quarterly based on actual encounter data
- Maintains 6% indirect hold-harmless compliance

$4.61B

SFY25 SDP Total

$4.99B

SFY26 SDP Total

Section 71115 — Provider Tax Freeze

"Enacted" Test

Full legislative process completed by July 4, 2025; CMS CMS tax waiver approved by July July 4, 2025

"Imposed" Test

State actively collecting revenue revenue as of July 4, 2025

Virginia's Status

Assessment authorized via Item 3-5.15; tax waiver approved September 5, 2018; Amended tax waiver submitted September 30, 2025, pending CMS' approval

Federal Prohibition: No new or increased provider taxes after July 4, 2025. 4, 2025. Any tax not both enacted and imposed by that date faces a **0%** a **0% threshold**. Retroactive changes do not qualify. Virginia's private private hospital assessment satisfies both tests.

Section 71115 — Future Threshold Reductions

Phase-Down Schedule — Virginia

Fiscal Year	Indirect Hold-Harmless Threshold
Current	6.0% of net patient revenue
FY 2028	5.5%
FY 2029	5.0%
FY 2030	4.5%
FY 2031	4.0%
FY 2032+	3.5%

Impact on Virginia

- Reduced provider assessment capacity beginning FY 2028
- Must remain below threshold to maintain federal financial participation
- Constrains ability to increase supplemental payments post-grandfathering

Exception

ICF-IID assessments (6%) are exempt from phase-down but frozen at July 4, 2025 levels — no reductions required, but no increases permitted.

Section 71116 — Supplemental Payment Value Caps

Federal Requirements (Effective July 4, 2025)

- Payment rate limit: **100% of Medicare** (Virginia is an expansion state) or state plan rate
- Non-expansion states: 110% of Medicare
- Applies to inpatient/outpatient hospital, nursing facility, and AMC practitioner services

Grandfathering Provision

- SDPs with completed preprints before May 1 or July 4, 2025, qualify for temporary grandfathering
  - Virginia's FY25 and FY26 preprints were submitted before July 4, 2025
- Total dollar amount capped at **higher of FY25 or FY26 value**
  - FY26 at $4.99B is higher — **locked maximum through January 1, 2028**

Section 71116 – Impact on Virginia

Immediate Constraints

- Maximum supplemental payment value: **$4.99 billion**
- No increases allowed through January 1, 2028 — may only decrease
- Cannot expand program via amendment, renewal, or revision
- **No IGT exemption** — caps apply regardless of financing source

Quality Evaluation Requirements (CIB 9/10/25)

- Must advance quality strategy goals
- Three measures: ED visit reduction, heart failure admissions, network adequacy
- Annual findings required for SDP renewals

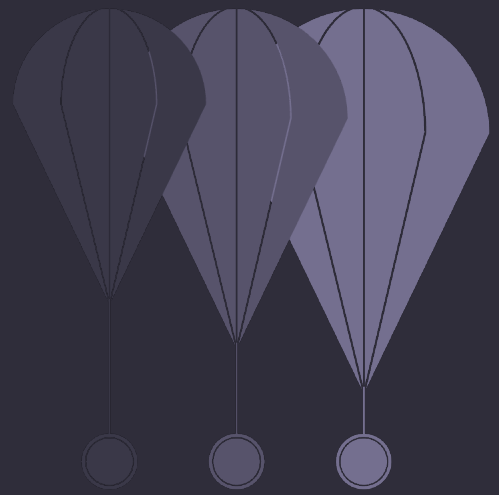
Future Phase-Down (Beginning January 1, 2028)

Grandfathered SDPs subject to gradual reduction toward Medicare or state plan rate limits. Specific phase-down details are pending federal rulemaking.

Grandfathered Phase
Through 1/1/2028, capped at $4.99B

No Increases
Amount may not rise; only decrease

Phase-Down Phase
Post-1/1/2028, reduce toward Medicare limits



Fiscal Impact Analysis

Near-Term: FY26–FY28

- Supplemental payment value frozen at **$4.99 billion maximum**
- Cannot increase to accommodate enrollment growth, utilization changes, or inflation
- Provider assessment rate remains adjustable quarterly within the 6% threshold

Long-Term: FY28 and Beyond

- Threshold reductions from 6% → 5.5% → 3.5% constrain assessment capacity
- Supplemental payment phase-down begins January 2028 (details pending rulemaking)
- Estimated reduction in federal match by FY 2032 — **detailed analysis pending**

Strategic Considerations

- Alternative non-federal share financing strategies needed post-2028
- Potential SDP program redesign to align with Medicare-based limits
- Coordination with hospital stakeholders on long-term payment sustainability

Risks & Mitigation Strategies

CMS Preprint Approval Delays

Both FY25 and FY26 preprints pending; delays impact hospital cash flow and budget certainty.

Mitigation: Regular CMS engagement; prepared for conditional approval requirements.

Grandfathering Interpretation Changes

CMS may revise preliminary determinations following final federal rulemaking.

Mitigation: Monitor Federal Register; submit comments on proposed rules.

Post-2028 Financing Gap

Threshold reductions combined with SDP phase-down create a structural deficit in non-federal share capacity.

Mitigation: Begin alternative financing planning now; explore general fund options.

Quality Evaluation Requirements

Non-compliance with evaluation reporting may jeopardize SDP renewals.

Mitigation: Robust data collection; partnered with HSAG for evaluation support.

Next Steps

Next 90 Days

1

- Continue CMS engagement on FY25/FY26 preprint approvals
- Continue CMS engage on FY26 tax waiver approval
- Monitor federal rulemaking for Section 71116 phase-down details
- Conduct detailed fiscal impact modeling for FY28–FY32

Near-Term: FY27

2

- Develop alternative non-federal share financing scenarios
- Assess SDP redesign options for post-grandfathering alignment
- Engage hospital stakeholders on long-term payment sustainability

Long-Term: FY28+

3

- Evaluate general fund appropriation requirements
- Explore payment methodology changes to maximize allowable rates
- Consider legislative changes to assessment structure if needed

Thank You!

CardinalCare
Virginia's Medicaid Program

Pharmacy Benefit Manager (PBM)

Greg Barabell, Chief Medical Officer

DMAS

How Virginia Medicaid Delivers Pharmacy Benefits Today

- Virginia Medicaid administers pharmacy benefits through two parallel models, with Fee-For-Service (FFS) and the individual Managed Care Organization(MCO)s each contracting with a Pharmacy Benefit Manager (PBM) to provide a service array to their assigned Members.

- DMAS operates a centralized Pharmacy and Therapeutics (P&T) Committee to oversee a Common Core Formulary (CCF) which includes all drugs on the Preferred Drug List (PDL).

Common Core Formulary Program

- Standardizes pharmacy coverage so that a consistent list of drugs are preferred without prior authorization (unless clinically necessary).
- Allows DMAS to collect supplemental rebates from manufacturers for closed drug classes, to offset increasing drug prices.

"Preferred" drugs are selected based first, on safety and clinical efficacy, and then on cost effectiveness.

Common Core Formulary Program

- Closed Class – FFS and MCO provide identical coverage and identical service authorization criteria

- Open Class – FFS and MCOs can add additional drugs for coverage with modified clinical criteria

MCO Contracting, Standards & Compliance

① MCO Contracting

- Each MCO contracts independently with a PBM to administer pharmacy benefits for their enrolled population.
- Pharmacist, pharmacy technician, and pharmacy intern services reimbursed per Code of Virginia §32.1-325(K).
- Reporting requirements per Item 317.T, Chapter 1289, 2020 Virginia Acts of Assembly.

② Shared Standards

- Both FFS and MCO systems use real-time adjudication for immediate billing feedback on product reimbursement.
- Per 21st Century Cures Act, all Medicaid providers across both networks screened & enrolled by the State Medicaid Agency.
- Network adequacy standards monitored per the Cardinal Care Managed Care Contract.

③ Spread Pricing Prohibition

- Any MCO–PBM agreement must prohibit spread pricing with respect to the Contractor's Managed Care plan.
- DMAS provides oversight over MCO specialty and mail-order pharmacy requirements.
- Each MCO maintains a formal cost-based appeals mechanism for pharmacy claims.

CURRENT PROCESS

FFS and the 5 MCOs each continue to contract with their own PBM until a single state PBM (sPBM) is implemented. FFS dispensing fees are authorized under 12VAC30-80-40. MCOs receive actuarially sound capitation rates to administer pharmacy benefits and pay pharmacy claims per their individual DMAS contracts.

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Virginia's Medicaid Program

PBM Service Array

Pharmacy reimbursement and benefit design	Pharmacy benefits manager oversight and auditing	Pharmacy network management	Prescriber/Pharmacy provider services
Clinical programs (MTM, care coordination, etc.)	Member services	Utilization management	Claims adjudication and payment
Systems and technology	Data warehouse, analytics and reporting	Common Core Formulary	Federal and state supplemental drug rebate processing

PBM Policy, Legislation & Transition Roadmap

LEGISLATIVE BACKGROUND

HB 2610 — 2025 General Assembly

Directed DMAS to contract with a single PBM for required use by FFS and all MCOs.

FFS Reimbursement Authority

Rate Framework: 12VAC30-80-40 sets pharmacy reimbursement and dispensing fees.
CMS Mandate: Cost-based data required for drug acquisition cost and dispensing fees.

DMAS Oversight

- Specialty & mail-order pharmacy requirement oversight
- MCO PBM reporting per Item 317.T, Chapter 1289, 2020 Acts
- Cardinal Care contract monitors network adequacy standards

SINGLE PBM TRANSITION ROADMAP

2025

HB 2610 Passed — Active Legislation

General Assembly directed DMAS to contract with a single PBM for use by FFS and all MCOs.

Jul 2026

Original Deadline — Postponed

Initial deadline set for single PBM implementation across FFS and all 5 MCOs. No administrative funding provided.

Jan 2027

Revised Deadline — Current Target

Governor's Introduced Budget postpones the single PBM contracting deadline. Requires administrative funding which is not yet appropriated.

Jan 2028

Proposed budget language postpones the single PBM contract deadline. — Proposed Target

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Virginia's Medicaid Program

VA Medicaid Single Pharmacy Benefit Manager (PBM) Study

Assessment of Virginia's Medicaid Pharmacy Program

Conducted research and stakeholder interviews to understand the current delivery of Virginia's outpatient Medicaid pharmacy benefit and gain stakeholders' perspectives of potential impacts of implementation of changes to the current model. Additionally, conducted the data analyses described below specific to the Medicaid pharmacy benefit and access to pharmacies across the Commonwealth.

Review of Other States' PBM Contracting Strategies

Researched other states' PBM contracting strategies and identified states that have implemented changes to their Medicaid pharmacy delivery models in the past five years. Research focus areas included understanding of the various models used by states, review of payment arrangements and cost data, collection of data on access and pharmacy deserts, and managed care pharmacy activities. The review included interviews of select state leaders to identify successes, challenges, and lessons learned in their implementation and operations of their pharmacy delivery models.

Data Analysis

Analyzed available data to inform the overall study, including review of dispensing fees, potential short-term and long-term costs of implementing a single PBM contract, and comparison of Virginia net pharmacy spend per member to other comparable states with managed care delivery systems.

Legislative Pharmacy Initiatives

Virginia Medicaid Pharmacy Initiatives

2018	2020	2020-21	2021	2022	2025
Common Core Formulary (CCF) Established CCF that applies to FFS and Cardinal Care. MCOs' PDLs must include all drugs on the CCF. MCOs may opt to cover additional drugs.	**Spread Pricing** HB 1291 passed prohibiting spread pricing in Medicaid MCO contracts and required MCOs and their PBMs to operate under pricing models reflecting true cost of prescription drugs.	**Required Reporting** HB 30 and HB 1800 passed requiring MCOs to report drug reimbursement costs and PBM changes to DMAS on a quarterly basis.	**Prescription Drug Cost Data** HB 2007 authorized DMAS to require wholesale distributors to submit prescription drug cost data if information from carriers, PBMs, and manufacturers proved insufficient.	**Data Sharing** Senate Bill (SB) 428 required carriers and PBMs to provide real-time prescription cost and coverage information to members and prescribers, including cost-sharing obligations and PA requirements delivered in accessible format within electronic prescribing or health record systems.	**Single PBM** HB 2610 and Item 292.MM of the Appropriations Act passed requiring DMAS to contract with a single PBM for all Medicaid members by July 1, 2026.

Stakeholder Feedback

Single PBM Design	· Ensuring continuity of care and care coordination during the transition and in ongoing operations. · Ensure data systems support timely access to prescription drug utilization information. · Strong DMAS oversight and monitoring of the single PBM operations and performance.
Financial Considerations	· Align dispensing fees for MCO claims with FFS methodology. · Address pharmacy deserts and pharmacy closure rates · Transition to a universal PDL inclusive of all drug classes may result in savings. · A concern about the lack of transparency regarding rebates collected by the MCOs, dispensing fees and reimbursement amounts paid by the health plans and their PBMs and encouraged our attention to these during our study
Access to Pharmacies	· Closure of independent pharmacies and rural pharmacies are a growing concern for access to services. · Mail order pharmacy may not be a solution for all individuals and their needs. · The administrative burden on pharmacies to comply with the rules of five MCO PBMs creates a hardship and may be contributing to unwillingness of pharmacies to contract with the MCOs.

Single PBM Contracting Considerations

Budget

- Administrative Costs: FFS vs. MCO
- Rebate Savings

Pharmacy Payment

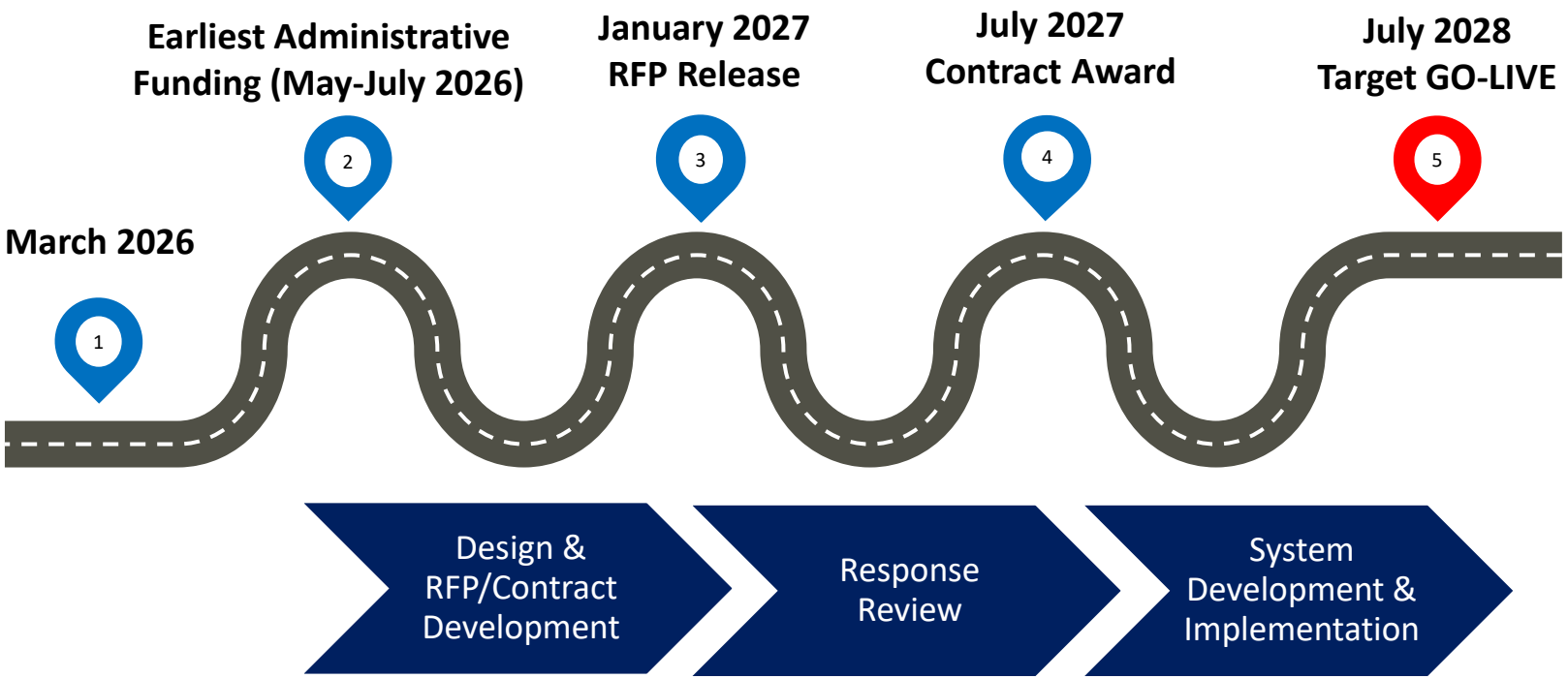
- Dispensing Fee
- Ingredient Reimbursement

Administrative Control

Market Stability

Cost Trend

Best Case Scenario Single PMB Implementation Timeline (contingent on funding/integration with other IT procurements)



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Virginia's Medicaid Program

Single PBM: Fiscal Impact by Year

Potential Costs/(Savings)	RFP/Award/Contract Start (7/26 – 1/28)		YR1 (CY28)		YR 2 (CY29)	
	Best Case	Worst Case	Best Case	Worst Case	Best Case	Worst Case
PBM Administrative Fees (NET)	**$-**	**$-**	**$(10,376,289)**	**$(8,321,872)**	**$(20,752,576)**	**$(16,643,742)**
Current Admin Fees (FFS + MCO)	$-	$-	$(18,593,956)	$(18,593,956)	$(37,187,910)	$(37,187,910)
Single PBM Admin Fees	$-	$-	$8,217,667	$10,272,084	$16,435,334	$20,544,168
One-Time Implementation Fees	**$5,286,667**	**$8,596,000**	**$6,853,333**	**$8,996,000**	**$-**	**$-**
Rebates and Util. Management	**$-**	**$-**	**$1,032,436**	**$4,323,291**	**($2,297,128)**	**$5,375,081**
Current MCO Rebate Loss			$10,905,001	$10,905,001	$21,810,001	$21,810,001
Future rebates and UM efficiencies			($9,872,565)	($6,581,710)	($24,107,129)	($16,434,920)
DMAS Staffing	**$925,000**	**$1,100,000**	**$925,000**	**$1,100,000**	**$925,000**	**$1,100,000**
Estimated Net Fiscal Impact	**$6,211,667**	**$9,696,000**	**$(1,565,519)**	**$6,097,4420**	**$(22,124,704)**	**$(10,168,661)**

CardinalCare
Virginia's Medicaid Program

Virginia General Assembly Update

Will Frank
Senior Advisor for Legislative,
Department of Medical
Assistance Services

DMAS

DMAS Legislative Role

1. Monitor introduced legislation
2. Review legislation and budget language for Secretary and Governor
3. Make position recommendations to Secretary and Governor
4. Communicate Governor’s positions to General Assembly
5. Provide expert testimony and technical assistance to legislators on legislation

2026 GA Session Stats

- 2,864 bills introduced.
- DMAS was assigned 38 lead bills plus took an active role in key legislation led by other agencies.
- DMAS also had 5 bills introduced on behalf of the agency.
- Major topics include:
  - Maternal Health
  - Waiver Issues
  - Pharmacy benefit changes

Maternal Health

- DMAS related maternal health bills included:
  - Remote Patient Monitoring for Pregnant and Postpartum Patients
  - Codifying existing Doula services for Pregnant and Postpartum Patients
- Policies were introduced as both legislation and budget language.

Pharmacy Legislation

- Legislation and Budget Amendments were introduced dealing with Pharmacy Benefits Manager.
- DMAS worked with the Secretary's Office, patrons, and stakeholders to provide technical assistance.
- Legislation impacting DMAS implementation of single PBM failed.
- Language and funding were also included in the budget.

Waiver Services

- Legislation to make changes to consumer directed services to individual receiving services to serve as the employer of record (EOR).
- Legislation to provide oversight of service facilitators.
- Legislation to remove the sunset clause for the SSDI disregard from 2025.

Agency Legislation

- DMAS worked with the Governor's Office to introduce legislation this session.
  - Legislation to remove requirement that guardianship documents are sent to DMAS.
  - Legislation to amend how report on State and Local Hospitalization Program is submitted.
  - Legislation to streamline the Facilitated Enrollment process.

Other Legislation

- Medicaid billing trainings for school districts.
- Expedited review process for Medicaid service authorization requests.
- Changes to the Medicaid Estate Recovery Process.
- Updating the Administrative Process Act dealing with Medicaid appeals.

What's Next

- Governor will then review legislation and budget to sign, amend, or veto.
- General Assembly scheduled to return on April 22nd for the Reconvened Session.
- Unless stated otherwise, legislation and budget go into effect July 1.

Questions

Thank you

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CardinalCare
Virginia's Medicaid Program

Budget Update

Truman Horwitz, Budget Division Director

DMAS

Overview

- Forecast to Actual
- Trends in FY26
- Summary

Forecast to Actual

Title XIX as of January 2026

Title XIX Service Area Forecast to Actual

Year to Date Forecast to Actual

Service Area	Forecast	Actual	Variance	% Difference
Base Medicaid				
Behavioral Health (45608)	25,280,295	19,984,595	(5,295,700)	-21%
General Medicaid (45609)	9,002,275,132	8,808,826,158	(193,448,974)	-2%
Long Term Care (45610)	1,723,927,451	1,695,452,267	(28,475,184)	-2%
Medicaid Expansion				
Medicaid Expansion (45611)	4,771,132,594	4,806,429,287	35,296,693	1%
Total Title XIX	**15,522,615,472**	**15,330,692,307**	**(191,923,165)**	**-1%**

Fund Type	Forecast	Actual	Variance	% Difference
General	4,525,190,745	4,508,804,785	(16,385,960)	0%
Federal	9,683,648,756	9,561,631,666	(122,017,090)	-1%
Coverage Assessment	394,018,558	399,874,375	5,855,817	1%
Rate Assessment	699,408,303	660,365,729	(39,042,574)	-6%
VHCF	220,349,110	200,015,752	(20,333,358)	-9%
Fund Total	**15,522,615,472**	**15,330,692,307**	**(191,923,165)**	**-1%**

- Title XIX (Medicaid) spending is right on track with the Forecast
- We'll cover some trends later in the presentation
- The Caboose is signed so the Forecast is fully funded

Forecast to Actual

Title XXI as of January 2026

Title XXI Service Area Forecast to Actual

Year to Date Forecast to Actual

PROGRAM	Forecast	Actual	Variance	% Difference
FAMIS				
FAMIS MCO	259,161,159	267,690,173	8,529,014	3%
FAMIS FFS	25,031,846	24,599,544	(432,302)	-2%
FAMIS Dental	27,295,167	27,788,740	493,573	2%
Total FAMIS	**311,488,172**	**320,078,457**	**8,590,285**	**3%**
MCHIP				
MCHIP MCO	160,489,130	162,556,650	2,067,520	1%
MCHIP FFS	12,802,388	10,683,796	(2,118,592)	-17%
MCHIP Dental	25,294,512	25,947,338	652,826	3%
MCHIP Pharmacy Rebates	-9,292,132	-4,639,726	4,652,406	-50%
Total MCHIP	**189,293,897**	**194,548,058**	**5,254,161**	**3%**

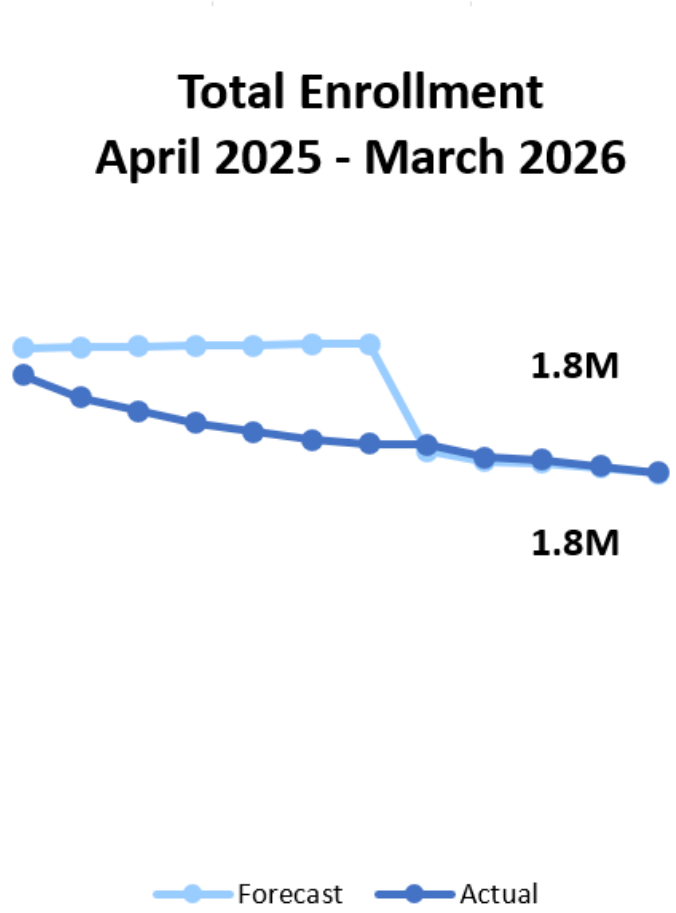
Fund Type	Forecast	Actual	Variance	% Difference
General	165,799,689	166,575,554	775,865	0%
Federal	327,949,567	341,018,146	13,068,579	4%
FAMIS Trust Fund	7,032,814	7,032,814	-	0%
Fund Total	**500,782,070**	**514,626,514**	**13,844,444**	**3%**

- Title XXI (CHIP) spending is right on track with the CHIP Forecast
- We'll cover some trends later in the presentation
- The Caboose is signed so the Forecast is fully funded

Enrollment is right on track with the Forecast

Enrollment as of 3/1/2026

Selected Categories	Forecast	Latest	Variance
Non-Long Term Care (LTC)	149,617	148,477	-1,140
LTC Nursing Facilities	17,663	17,141	-522
LTC HCBS + DD	64,709	63,691	-1,018
Caretaker Adults	117,307	113,996	-3,311
Pregnant Women	28,364	28,764	400
Children	515,494	519,402	3,908
Expansion - Caretaker	105,774	106,670	896
Expansion - Non-Caretaker	366,333	372,095	5,762
Title XIX Total	**1,601,013**	**1,605,042**	**4,029**
MCHIP	88,119	88,866	747
FAMIS Kids	95,294	92,308	-2,986
FAMIS MOMS	5,047	5,015	-32
Title XXI Total	**192,999**	**190,568**	**-2,431**
Total Enrollment	**1,794,012**	**1,795,610**	**1,598**



- Enrollment is on track with the November 2025 Forecast
- Overall enrollment has decreased by about 7.5% since this time last year
- Much of the decreases are in the Expansion Populations, Caretaker adults, children
- Continued increases in the long-term care populations

Trends: FY25 to FY26

Through January

Category	FY25 Actual	FY26 Actual	% Change	Explanation
Title XIX				
Cardinal Acute	4,016,581,029	4,066,209,666	1%	-
Cardinal LTSS	4,699,108,127	5,270,478,961	12%	Increase in rates and LTC populations
Fee for Service - General	1,483,411,970	1,448,814,493	-2%	-
Fee for Service - BH and Rehabilitative	33,453,939	33,421,499	0%	-
Fee for Service - Long Term Supports and Svs	1,655,066,249	1,763,742,839	7%	Increase in LTC Populations
Hospital Supplemental (DSH, IME/GME, Dx)	689,398,768	760,333,621	10%	Increased GME payments in FY26
Rate Assessment Payments	1,938,405,532	2,191,673,486	13%	Increased UPL year-over-year
Pharmacy Rebates	(201,214,859)	(203,982,258)	1%	-
Total Forecasted Title XIX	**14,314,210,755**	**15,330,692,307**	7%	-
Title XXI				
FAMIS MCO	220,131,866	267,690,173	22%	Rate increases
FAMIS FFS	18,994,545	24,599,544	30%	School based services that were paid in FY26
FAMIS Dental	24,670,726	27,788,740	13%	Dental rate increase
MCHIP MCO	156,757,094	162,556,650	4%	Rate increases
MCHIP FFS	8,307,172	10,683,796	29%	School based services that were paid in FY26
MCHIP Dental	24,415,432	25,947,338	6%	Dental rate increase
Pharmacy Rebates	(5,229,888)	(4,639,726)	-11%	Timing is somewhat unpredictable
Total FAMIS/MCHIP	**448,046,947**	**514,626,515**	15%	-
Total Forecasted Medical Programs	**14,762,257,702**	**15,845,318,822**	**7%**	-

Summary and Looking Ahead

- Spending is right on track with the forecast
- GA Session