DRAFT MINUTES
Tuesday, September 30, 2025
10:00 AM

A quorum of the Board of Medical Assistance Services attended the meeting at the Department of Medical Assistance Services (DMAS) offices at 600 East Broad Street, Richmond. A web-ex option was also available for members of the Board and the public to attend virtually.

Present: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jason Herzog, Jason Brewster, Margaret Roomsburg, Paul Hogan, Ashish Kachru

Present Virtually: Joye Moore

Absent: Dr. Jeff Rich, Jennifer Clarke

DMAS Attendees: Cheryl Roberts-DMAS Director, Jeff Lunardi - Chief Deputy, Adrienne Fegans -Deputy for Programs, Sarah Hatton – Deputy for Administration, Ivory Banks – Chief of Staff, Rich Rosendahl- Deputy for Health Economics and Economic Policy, Terry Leachy, Project Management Office Division Director, Emily McClellan, Morgan Greer, Board counsel and Brooke Barlow, Board Secretary.

Other In-Person Attendees: Amiyah Ponton, Imani Hill, Malon Pernell, Kayla Mbanzerdore, Kennedy Murrell, Troy Washington, Jeremy Lebling, Emily Roller, Heidi Dix, Alan Fowler, Jumelie Miller, Janet Mulligan, Alex Brown, Dan Plain

Virtual Attendees: Arbogast, Charlotte (DARS); Gerald, Jamie (DMAS); McNaughton, Sadie (External); Cindi Jones ; Sherri Captions; Roth, Karin (DARS); Karen Kimsey ; Richardson, Hope (DMAS); Jones, Michael (DMAS); Conner, Christopher (VDSS); Lee, Meredith (DMAS); Shawn Akey ; Katie Boyle; Davis, Doug; Annecchini, Jessica (DMAS); Eva Pfeiffer; Kissel, John (DMAS); Nowell, Danielle (DMAS); Smith, Jasmine (DMAS); Triggs, Michael; Michael Cook; Karen Cameron; Sarah Craddock ; Ashley Callahan; Jacobson, Molly (DMAS); Lawter, Nicole; Scott Johnson; Bea, Jesse (DARS); Molly Dean; Ball, Chynita (DMAS); Callaham, Karla (DMAS); Patricia Hunter; Pope, Rick; Suzanne Gore; LeVar Bowers ; Lauren Schmitt ; Gupta, Rashmi (DMAS); Lauren Eggleton; Kendall, Estelle (DMAS); Newsome, Rhonda (DMAS); Michele Satterlund ; Weatherford, Tina (DMAS); Patrick Finnerty; Mike Tweedy; Blitz, Dan; Andy Berg ; Lewis, Tiaa (DMAS); Woldt, Janine; Michele Satterlund ; Cariano, Sara (DMAS); Lauren Schmitt

1. Call to Order

Jason Brewster, Co-Chair, called to open the regular meeting of the Board of Medical Assistance Services at 10:04 am on Tuesday, September 30, 2025, at 600 East Broad Street, Conference Rooms A & B, Richmond, Virginia 23219.

2. Approval of Minutes

The minutes from the March 11, 2025, meeting were introduced and approved.

Moved by Jason Herzog; seconded by Vienne Murray to Approve Motion Passed: 8 - 0
Voting For: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jason Herzog, Jason Brewster, Margaret Roomsburg, Paul Hogan, Ashish Kachru
Voting Against: None

3. Discussion on Remote Participation and All-Virtual Meetings

After some discussion and questions from the Board to Morgan Greer, Board Counsel, the Board will vote at the next meeting to amend the bylaws.

4. Director's Report

Director Roberts presented to the Board an overview of Medicaid program updates on Maternity Care Deserts, Top Goals of Cardinal Care Managed Care Program, Federal Policy Actions and Rural Health Transformation Program.

Director Roberts also notified the Board of upcoming meetings at DMAS and encouraged all Board members to attend the meetings.

5. Fiscal Agent Solution (FAS)

Terry Leahy, Project Management Office Division Director, presented to the Board an update on FAS.

6. Complex Care Updates

Lisa Jobe-Shields, Behavioral Health Division Director, Angie Vardell, Senior Program Advisor and Rich Rosendahl, Chief Analytics Officer, presented to the Board an update on the Redesign of Medicaid Behaioral Health Rehabilitative Services.

7. Regulations

The Board was provided with updated Regulatory activity.

8. Adjournment

Moved by Paul Hogan; seconded by Ashish Kachru to Adjourn 11:56 am.
Motion: 8 - 0
Voting For: Dr. Basim Khan, Elwood Boone, III, Dr. Vienne Murray, Jason Herzog, Jason Brewster, Margaret Roomsburg, Paul Hogan, Ashish Kachru Voting Against: None

VIRGINA STATE BOARD OF MEDICAL ASSISTANCE SERVICES POLICY FOR THE REMOTE PARTICIPATION OF MEMBERS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2-3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700-3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2. This policy also does not apply to an all-virtual public meeting.

2. DEFINITIONS

a. "Board" means the Virginia State Board of Medical Assistance Services or any committee, subcommittee, or other entity of the Virginia State Board of Medical Assistance Services.

b. "Member" means any member of the Virginia State Board of Medical Assistance Services.

c. "Remote Participation" means participation by an individual member of the Board by electronic communication means in a public meeting where a quorum of the Board is physically assembled, as defined by Va. Code § 2.2-3701.

d. "Meeting" means a meeting as defined by Va. Code 2.2-3701.

e. "Notify" or "notifies," for purposes of this policy, means written notice, such as email or letter. Notice does not include text messages or communications via social media.

3. MANDATORY REQUIREMENTS

Regardless of the reasons why the member is participating in a meeting from a remote location by electronic communication means, the following conditions must be met for the member to participate remotely:

a. A quorum of the Board must be physically assembled at the primary or central meeting location; and

b. Arrangements have been made for the voice of the remotely participating member to be heard by all persons at the primary or central meeting location. If at any point during the meeting the voice of the remotely participating member is no longer able to be heard by all persons at the meeting location, the remotely participating member shall no longer be permitted to participate remotely.

4. PROCESS TO REQUEST REMOTE PARTICIPATION

a. On or before the day of the meeting, and at any point before the meeting begins, the requesting member must notify the Board Chair (or the Vice-Chair if the requesting member is the Chair) that they are unable to physically attend the meeting due to (i) a temporary or permanent disability or other medical condition that prevents the member's physical attendance, (ii) a family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance, (iii) their principal residence location is more than 60 miles from the meeting location, or (iv) a personal matter and identifies with specificity the nature of the personal matter.
b. The requesting member shall also notify the Board staff liaison of their request, but their failure to do so shall not affect their ability to remotely participate.
c. If the requesting member is unable to physically attend the meeting due to a personal matter, the requesting member must state with specificity the nature of the personal matter. Remote participation due to a personal matter is limited each calendar year to two meetings or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. There is no limit to the number of times that a member may participate remotely for the other authorized purposes listed in (i)-(iii) above.
d. The requesting member is not obligated to provide independent verification regarding the reason for their nonattendance, including the temporary or permanent disability or other medical condition or the family member's medical condition that prevents their physical attendance at the meeting.
e. The Chair (or the Vice-Chair if the requesting member is the Chair) shall promptly notify the requesting member whether their request is in conformance with this policy, and therefore approved or disapproved.

5. PROCESS TO CONFIRM APPROVAL OR DISAPPROVAL OF PARTICIPATION FROM A REMOTE LOCATION

When a quorum of the Board has assembled for the meeting, the Board shall vote to determine whether:

a. The Chair's decision to approve or disapprove the requesting member's request to participate from a remote location was in conformance with this policy; and
b. The voice of the remotely participating member can be heard by all persons at the primary or central meeting location.

6. RECORDING IN MINUTES

a. If the member is allowed to participate remotely due to a temporary or permanent disability or other medical condition, a family member's medical condition that requires the member to provide care to the family member, or

because their principal residence is located more than 60 miles from the meeting location the Board shall record in its minutes (1) the Board's approval of the member's remote participation; and (2) a general description of the remote location from which the member participated.

b. If the member is allowed to participate remotely due to a personal matter, such matter shall be cited in the minutes with specificity, as well as how many times the member has attended remotely due to a personal matter, and a general description of the remote location from which the member participated.
c. If a member's request to participate remotely is disapproved, the disapproval, including the grounds upon which the requested participation violates this policy or VFOIA, shall be recorded in the minutes with specificity.

7. CLOSED SESSION

If the Board goes into closed session, the member participating remotely shall ensure that no third party is able to hear or otherwise observe the closed meeting.

8. STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

The Chair (or Vice-Chair) shall maintain the member's written request to participate remotely and the written response for a period of one year, or other such time required by records retention laws, regulations, and policies.

VIRGINA STATE BOARD OF MEDICAL ASSISTANCE SERVICES POLICY FOR ALL-VIRTUAL MEETINGS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2-3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700-3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2.

2. DEFINITIONS

a. "Board" means the Virginia State Board of Medical Assistance Services or any committee, subcommittee, or other entity of the Virginia State Board of Medical Assistance Services .

b. "Member" means any member of the Virginia State Board of Medical Assistance Services.

c. "All-virtual public meeting" means a public meeting conducted by the Board using electronic communication means during which all members of the public body who participate do so remotely rather than being assembled in one physical location, and to which public access is provided through electronic communication means, as defined by Va. Code § 2.2-3701.

d. "Meeting" means a meeting as defined by Va. Code 2.2-3701.

e. "Notify" or "notifies," for purposes of this policy, means written notice, including but not limited to, email or letter. Notice does not include text messages or communications via social media.

3. WHEN AN ALL-VIRTUAL MEETING MAY BE AUTHORIZED

An all-virtual public meeting may be held under the following circumstances:

a. It is impracticable or unsafe to assemble a quorum of the Board in a single location, but a state of emergency has not been declared by the Governor; or

b. Other circumstances warrant the holding of an all-virtual public meeting, including, but not limited to, the convenience of an all-virtual meeting; and

c. The Board has not had more than two all-virtual public meetings, or more than 25 percent of its meetings rounded up to the next whole number, whichever is greater, during the calendar year; and

d. The Board's last meeting was not an all-virtual public meeting.

4. PROCESS TO AUTHORIZE AN ALL-VIRTUAL PUBLIC MEETING

a. The Board may schedule its all-virtual public meetings at the same time and using the same procedures used by the Board to set its meetings calendar for the calendar year; or
b. If the Board wishes to have an all-virtual public meeting on a date not scheduled in advance on its meetings calendar, and an all-virtual public meeting is authorized under Section 3 above, the Board Chair may schedule an all-virtual public meeting provided than any such meeting comports with VFOIA notice requirements.

5. ALL-VIRTUAL PUBLIC MEETING REQUIREMENTS

The following applies to any all-virtual public meeting of the Board that is scheduled in conformance with this Policy:

a. The meeting notice indicates that the public meeting will be all-virtual and the Board will not change the method by which the Board chooses to meet without providing a new meeting notice that comports with VFOIA;
b. Public access is provided by electronic communication means that allows the public to hear all participating members of the Board;
c. Audio-visual technology, if available, is used to allow the public to see the members of the Board;
d. A phone number, email address, or other live contact information is provided to the public to alert the Board if electronic transmission of the meeting fails for the public, and if such transmission fails, the Board takes a recess until public access is restored;
e. A copy of the proposed agenda and all agenda packets (unless exempt) are made available to the public electronically at the same time such materials are provided to the Board;
f. The public is afforded the opportunity to comment through electronic means, including written comments, at meetings where public comment is customarily received; and
g. There are no more than two members of the Board together in one physical location.

6. RECORDING IN MINUTES

Meetings are taken as required by VFOIA and must include the fact that the meeting was held by electronic communication means and the type of electronic communication means used.

7. CLOSED SESSION

If the Board goes into closed session, transmission of the meeting will be suspended until the public body resumes to certify the closed meeting in open session.

STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

BOARD OF MEDICAL ASSISTANCE SERVICES

BYLAWS

ARTICLE I

Board Structure

1.1 Name - This body shall be known as the State Board of Medical Assistance Services, hereinafter referred to as "the Board."

1.2 Composition - The Board shall consist of eleven residents of the Commonwealth, five of whom are health care providers and six of whom are not, all to be appointed by the Governor. Any vacancy on the Board, other than by expiration of term, shall be filled by the Governor for the unexpired portion of the term. The Director of the Department of Medical Assistance Services ("the Director") shall be the executive officer of the Board but shall not be a member thereof.

1.3 Term of Office - Board members shall be appointed for four year terms. No person shall be eligible to serve on the Board for more than two full consecutive terms. Should any Board member be unable to fulfill his/her term on the Board, that member shall provide written notice to the Chairperson of the Board at least 30 days prior to resignation, and shall also provide written notice to the Governor.

1.4 Orientation of New Members - When a new member is appointed to the Board, the Board Chairperson shall assign responsibility for orientation of the new member to one veteran member of the Board. New Board members shall be expected to spend time at the office of the Department of Medical Assistance Services ("the Department") for program orientation provided by Department staff, and to become familiar with issues requiring Board action.

ARTICLE II

Board Meetings

2.1 Regular Meetings - The Board shall hold regular meetings at least quarterly at such times and places as it shall determine.

2.2 Special Meetings - The Board may meet at such other times and places as it determines to be necessary and appropriate. Special meetings of the Board may be called by the Chairperson of the Board or by any three (3) members of the Board. Reasonable effort must be made by the Chairperson to personally notify each Board member of the meeting.

2.3 Meeting Notice - Each member shall file with the Director the address and/or telephone number at which such notice is to be given.

Written notice of all regular meetings shall be sent to the Board at least ten (10) days in advance of the time and place of the meeting. Notice of all regular meetings shall also be announced in advance by publication in the Virginia Register, and a proposed agenda sent to persons on the public participation list.

2.4 Quorum - Six (6) members of the Board shall constitute a quorum.

2.5 Executive Session - Prior to meeting in an executive session, the Board must vote affirmatively to do so and must announce the purpose of the session. This purpose shall consist of one or more of the purposes for which executive or closed meetings are permitted in accordance with §2.2-3711 of the Code of Virginia, the pertinent portion of the Virginia Freedom of Information Act.

Discussion in the executive session must be limited to the subject or subjects stated in the motion. No final action may be taken in executive session. Upon return to open session, any action taken or motion adopted must be re-stated, voted upon, and placed in the minutes in order to become effective.

2.6 Conduct of Business - The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Board in all cases to which they are applicable, to the extent that they are not inconsistent with the laws of Virginia, these Bylaws, or any special rule which the Board may adopt.

2.7 Electronic Participation in Meetings –

2.7.1 Remote Participation of Members - An individual member may participate in a meeting of the Board or a public meeting of any committee established by the State Board through electronic communication from a remote location, as permitted by § 2.2-3708.3 of the Code of Virginia, by following the procedures outlined in Appendix A. During a state of emergency declared by the Governor, the procedures outlined in § 2.2-3708.2 shall be followed.

2.7.2 All-virtual Meetings – The Board may, in its discretion but only as permitted by § 2.2-3708.3, conduct a public meeting using electronic communication means during which all members of the public body who participate do so remotely rather than being assembled in one physical location, and to which public access is provided through electronic means, as defined in § 2.2-3701. The Board shall follow the procedures outlined in Appendix B to conduct all-virtual meetings.

~~An individual member may participate in a meeting of the Board or a public meeting of any committee established by the Board through electronic communication from a remote location for the following reasons, as permitted by § 2.2-3708.2 of the Code of Virginia:~~

~~A temporary or permanent disability or other medical condition prevents the member's physical attendance;~~

~~A family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance; or~~

~~A personal matter prevents the member's physical attendance.~~

~~Procedure for Approval:~~

~~Notification: The member requesting to participate through electronic communication from a remote location must notify the Board or committee chair on or before the day of the meeting.~~

~~Quorum: A quorum of the Board, or a simple majority of the committee, must be physically assembled at the primary or central meeting location identified in the public notice required for the meeting.~~

~~Technological Arrangements: Arrangements must be made for the voice of the remote participant to be heard by all persons at the primary or central meeting location.~~

~~Documentation: The specific reason the member is unable to attend the meeting, and the remote location from which the member participates, shall be recorded in the meeting minutes; notwithstanding this disclosure requirement, the specific medical condition(s) or related clinical information affecting the member requesting virtual participation shall not be publicly disclosed but will instead be treated as consistent with Protected Health Information. The nature of the personal matter shall also be included in the minutes. Pursuant to Va. Code § 2.2-3708.2(A)(2), the remote location from which the member participates need not be open to the public.~~

~~Limitation: Members may only participate through electronic communication due to personal matters for no more than two meetings of the Board or committee per calendar year. This limitation shall not apply to electronic participation due to a member's disability or medical condition, or to a family member's medical condition that prevents the member's physical attendance.~~

~~Approval Process: A member's participation from a remote location shall be approved by a vote of the other members of the Board or committee, unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act (FOIA). If the other members of the Board or committee vote to disapprove the member's electronic participation from a remote location, such disapproval shall be recorded in the minutes.~~

ARTICLE III

Board Authority

3.1 Powers and Duties - The Board shall have the powers and duties as prescribed in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia. (See memorandum of April 13, 2004, from the Office of the Attorney General.)

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided. The Board shall also initiate such cost containment or other measures as are set forth in the Appropriations Act.

The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provision of this chapter.

The Board shall submit biannually a written report to the Governor and the General Assembly.

3.2 Representation of the Board - Individual members of the Board shall represent official positions of the Board only upon action of the Board. When the Board is requested to appear before the General Assembly, legislative committees, study committees, etc., the Board shall be represented by duly designated member(s) who are nominated by the Chairperson and, when practicable, confirmed by the Board.

Individual members of the Board are free to make comments to the media, individual legislators, local boards of health members, legislative committees, etc. Any comments made shall be identified as their personal views and not the position of the Board unless they have been authorized by the Board to express the Board's official position or unless the position they express is a position that has been officially taken by the Board.

3.3 Authority of the Director - The Director shall be vested with the authority of the Board as set forth in Chapters 10, 11, 12, 13 and 13.1 of Title 32.1 of the Code of Virginia.

ARTICLE IV

Board Officers

4.1 Term of Office - At the first meeting of the Board after March 1 of each year, the Board shall elect officers from its membership for the coming year. Those elected shall assume their offices at the meeting following their election and shall serve, unless sooner removed, until their successors are elected.

4.2 Type of Officers - The Board shall have a Chairperson and a Vice Chairperson.

4.3 Duties of Officers

4.3.1 The Chairperson of the Board shall preside, when present, at all meetings of the Board; appoint members to committees of the Board; serve as ex-officio member of all committees; act for the Board in executing resolutions of the Board and communicating the actions of the Board to others; call such special meetings as may be deemed necessary; vote as any other member of the Board on any issue; perform other duties which may be delegated by the Board; and delegate to the Vice Chairperson such duties as may be appropriate.

The Chairperson shall work closely with the Director of the Department, or his/her designee, in determining the type of Board meetings, agenda, reports, communications and involvement that will enable Board members to carry out the responsibilities imposed on the Board by Acts of the General Assembly.

4.3.2 The Vice Chairperson shall assume all the powers and duties of the Chairperson in the absence of the Chairperson at any meeting or in the event that the Chairperson is disabled or of a vacancy in the office. The Vice Chairperson shall also perform such other duties as requested by the Board or by the Chairperson.

4.3.3 The Secretary shall be selected by the Board, but shall not be a member of the Board. The Secretary shall assist the Board in carrying out its administrative duties including the maintenance of minutes and records. The Secretary shall be a member of the Director's staff within the Department.

ARTICLE V

Board Committees

5.1 Special Committees - Special Committees may be constituted at any time by action of the full Board or the Chairperson. Such committees shall be formed when necessary for the efficient functioning of the Board. Members of a special committee and its chairperson shall be appointed by the Chairperson from among the membership of the Board. At the time a special committee is created, its mission shall be specifically established by action of the Board or by the Chairperson. In creating such special committees, the Chairperson shall specify the time within which the Committee is to make its report(s) to the Board.

5.2 Advisory Groups - The Board may, from time to time, seek the advice of various advisory groups, committees or individuals other than members of the Board on issues of concern to the Board and may form a group of such individuals for such purpose. Any member of the Board or the Director may request that such advice be sought. Selection of individuals to serve in such capacity shall be made by the Board with the advice of the Director.

Since the Board possesses legal powers which cannot be delegated or surrendered, all recommendations for action by such individual or group must be submitted to the Board for decision.

5.3 Participation in Various Department Workgroups and Committees – In order to facilitate involvement of Board members in key policy issues and activities of the Department, the Chairperson and Director shall identify and recommend, from time-to-time, Department workgroups or committees to which Board members should be appointed as full and active participants. In addition, Board members also may identify and recommend Department workgroups or committees for which they believe Board participation would be appropriate. Such participation in Department workgroups or committees shall not conflict with any pertinent statutory or regulatory requirements that may exist regarding the composition of such workgroups or committees. Members selected to serve on a Department workgroup or committee shall be appointed by the Chairperson from among the membership of the Board.

5.4 Department Committees – In addition to participation in the Department workgroups or committees pursuant to Section 5.3, Board members are encouraged to attend meetings of any committee of the Department with stakeholders. DMAS staff shall provide information regarding the current committees and meeting schedules to the Board in a timely manner to facilitate member attendance and involvement. Whenever such a committee is added or terminated, DMAS staff shall promptly provide such information to the Board.

ARTICLE VI

Board Documents

6.1 Official Papers - All official records of the Board shall be kept on file at the Department and shall be open to inspection. All files shall be maintained for five years. Minutes of Board meetings shall be permanently retained.

ARTICLE VII

Public Participation

7.1 Public Participation - Citizens may attend all Board meetings, except executive sessions as defined by the Freedom of Information Act, and may record the proceedings in writing or by using a recording device. The Board may make and enforce reasonable rules regarding the conduct of persons attending its meetings.

7.2 Presentations to the Board - Opportunities shall be provided for individuals or citizens representing a group or groups to appear on the agenda of a regular meeting of the Board. Requests to appear before the Board should be made in writing 10 days before a scheduled meeting of the Board in order that they may be included on the agenda. The 10 days may be waived by the Board Chairperson. The request must include the subject to be discussed and the name of the speaker. In honoring such requests, the Board will limit presentations to five (5) minutes, unless an extension is granted by the Board Chairperson.

ARTICLE VIII

Revision and Compliance

8.1 Amendments - The Bylaws of the Board may be amended at any regular meeting of the Board by a majority vote, provided that the proposed amendment was submitted in writing at the previous regular meeting of the Board and is included in the notice of the meeting at which a vote is to be taken.

8.2 Review - The Bylaws shall be reviewed in total at least every two years, with a limited annual review for compliance with the Code of Virginia. Revisions shall be made as necessary, and the Bylaws signed and dated to indicate the time of the last review.

8.3 Effective Date - The foregoing Bylaws shall go into effect on the ____ ~~9th~~ day of _____ 2024. ~~June 2021~~.

Approved:

_____
Chairperson, Board of Medical Assistance Services

_____
Director, Department of Medical Assistance Services

CardinalCare
Virginia's Medicaid Program

Board of Medical Assistance Services Director's Update

Cheryl J. Roberts, J.D., DMAS Director

December 10, 2025

DMAS


THRIVE in 2025
DMAS is committed to providing quality health care coverage and services efficiently to qualified Virginians in the Commonwealth
T
Trust
H
Health
R
Results
I
Integrity
V
Vision
E
Engagement

THRIVE 2025 DMAS Initiatives and Accomplishments

Virginia launched Cardinal Care, modernizing Medicaid for 1.7 million members.

DMAS created a Compliance Office and 360° reviews to strengthen health plan oversight

Virginia launched a Foster Care Specialty Plan and secured $5 million federal grant to support at-risk and justice-involved youth.

Virginia completed the DOJ Settlement requirements, marking major progress in community-based behavioral health.

Postpartum visit rates increased from 61.8% to 73.7%, improving maternal health beyond national trends.

Reduced Avoidable Emergency Department Use up to 70% for some Medicaid members.

Strengthened nursing home quality programs to reward better care and enhance resident health and satisfaction.

Medicaid marked 60 years of strengthening families and improving health in Virginia communities

DMAS completed over 6,000 home and community-based services reviews to protect community living options.

A new Correspondence Center centralized Medicaid mail to improve speed and accuracy for members.

A new liability lien portal automated case intake and tracking, improving Medicaid financial recoveries.

THRIVE 2025 DMAS Initiatives and Accomplishments

DMAS paid providers on time 95.4% of the time in fiscal year 2025.

Completed over 100 legislative and budget directives from the 2025 General Assembly.

Conducted the first statewide survey of long-term services and supports members to improve care.

Reduced audit issues, resolving 2 of 5 FY2024 findings and targeting fewer findings in FY2025

A statewide Language and Disability Access Plan expanded translation, accessible formats, and accommodations.

Enhanced IT Security – DMAS eliminated all overdue critical and high-risk vulnerabilities, improving cybersecurity across systems.

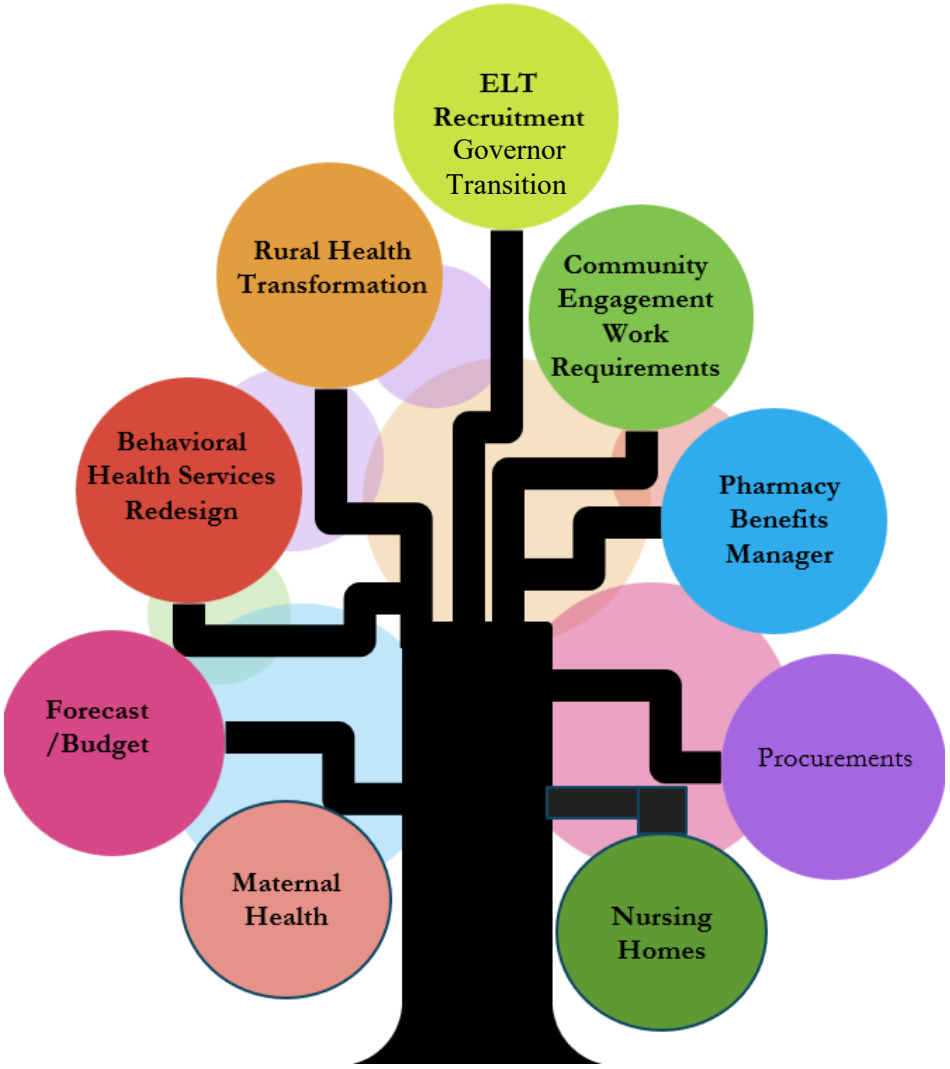
Implemented MES Change Control Board – A new governance board now oversees IT changes for greater coordination and transparency.

Agency-Wide Performance Management Training – Over 70% of staff completed new performance reviews using the PageUp system.

Expanded Digital and Social Media Engagement – DMAS boosted online engagement by 31% and hosted its first Facebook Live to better reach members.

With only 6% turnover, DMAS maintained a 94% employee retention rate in 2025

DMAS current and 2026 initiatives



CardinalCare
Virginia's Medicaid Program

ELT Recruitment Updates

Dr. Greg Barabell has joined DMAS as the new Chief Medical Officer

Cheryl Gallon has joined as the new Deputy of Programs and Operations

CardinalCare
Virginia's Medicaid Program

H.R.1 Requirements

DMAS

Who do we cover?

1,834,310 Virginians

Base (~50/50)

Children
521,185

Adults
- Older Adults: 95,149
- Caretaker: *116,924*

Individuals with Disabilities
90,998

Pregnant Women
29,734

FAMIS/ CHIP (~67/33)

Children
186,587

Pregnant Women
10,232

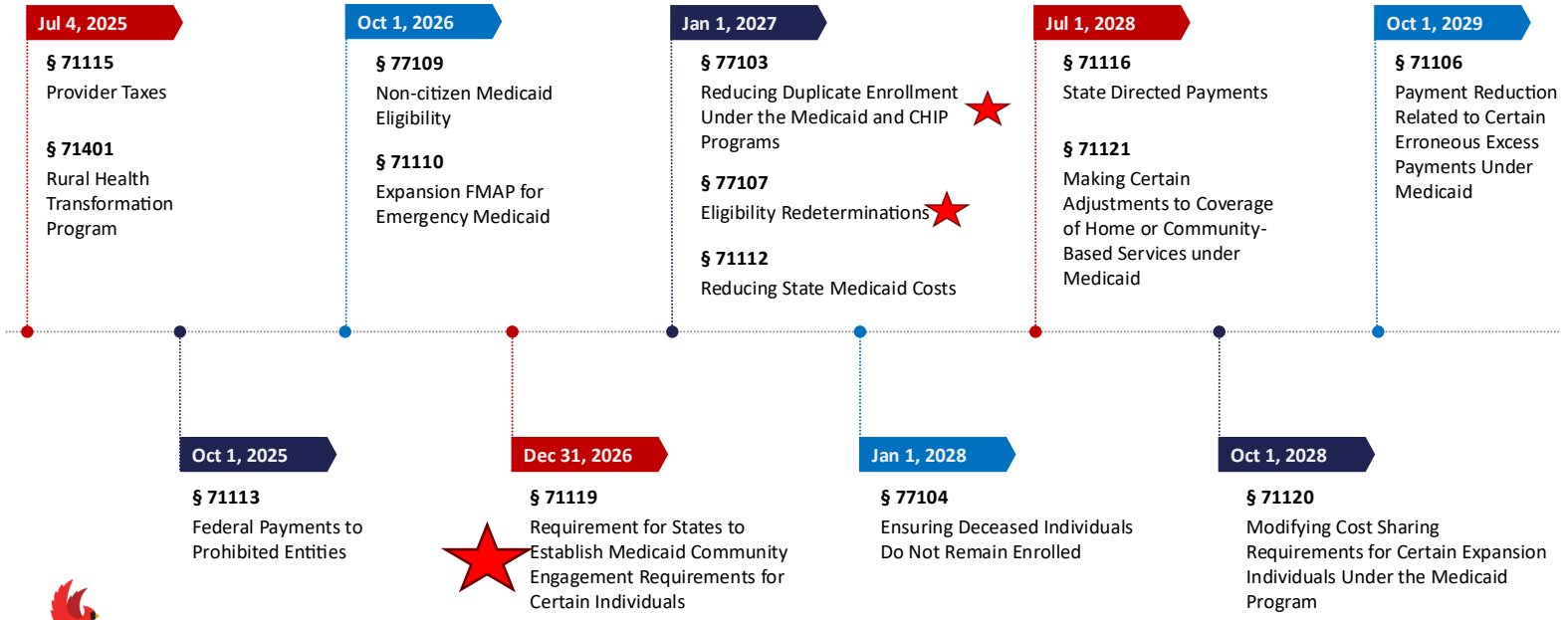
Expansion (90/10)

Parent Adults
118,385

Adults
450,522

Plus 175,467 with Limited Benefits

Compliance Timeline for Medicaid Requirements



CardinalCare
Virginia's Medicaid Program

Cardinal PATHS

"Finding your path for brighter tomorrow"

- Promote Work by Comply with CMS' requirements
- Member Centric
- Hired Consultant
- Build with Community Input
- Ensure Fiscal Responsibility
- Focus on Health as a Pathway to Community Engagement

VA Rural Vitality plan/ Rural Health Transformation Program

Virginia's RHT program application was submitted on November 5, 2025.
CMS will announce awards by December 31, 2025.

CarelQ

- **Tech Innovation Fund** - Grows Virginia's health tech ecosystem through grants to start-ups enhancing rural care delivery.
- **Provider Productivity Fund** - Supports adoption of AI-driven decision-support and workflow tools to reduce administrative burden and ease provider burnout.
- **Provider Interoperability Fund** - Helps rural providers modernize EHR systems, strengthen cybersecurity, and advance data exchange to improve coordination.
- **Remote Patient Monitoring (RPM) Fund** - Expands use of continuous monitoring technologies to track patient outcomes in facilities and at home.

Homegrown Health Heroes

- **Attract and Retain Physicians** - Expands rural residency slots in high-priority specialties and supports long-term retention through wraparound programs.
- **Allied Health Degrees** - Enables community colleges to launch or expand high-demand health programs by funding essential infrastructure and equipment.
- **Earn to Learn Apprenticeships** - Creates paid, work-based learning opportunities with education institutions and health care employer partnerships.
- **Build Career Pipelines** - Establishes high school health academies to introduce students to allied health careers.

Connected Care, Closer to Home

- **Mobile and Hybrid Care** - Expands access to primary and preventive services through mobile units and telehealth.
- **Community Paramedicine** - Funds pilots and startup costs for EMS-led treat-in-place care, preventive visits, and telehealth consultations.
- **Innovative Maternal Care** - Expands rural prenatal and postpartum services with community hubs, mobile units, and telehealth, with a focus on supporting mothers with substance use disorders and preventing rural labor and delivery unit closures.

Live Well, Together

- **Food as Medicine** - Supports infrastructure and start-up costs for food pharmacies that provide nutrition education, medically tailored meals, and produce prescriptions.
- **Consumer Tech** - Funds pilots to test and scale digital health tools that support lasting lifestyle and behavioral changes.
- **Active Kids** - Invests in repurposing of community spaces to create multi-use areas for physical activity.
- **Integrated Care for Duals** - Expands outreach and education to help dual-eligible seniors enroll in integrated care plan options.

CardinalCare
Virginia's Medicaid Program

Behavioral Health Services Redesign Project Update

DMAS

RHRN Service Redesign - Project Overview

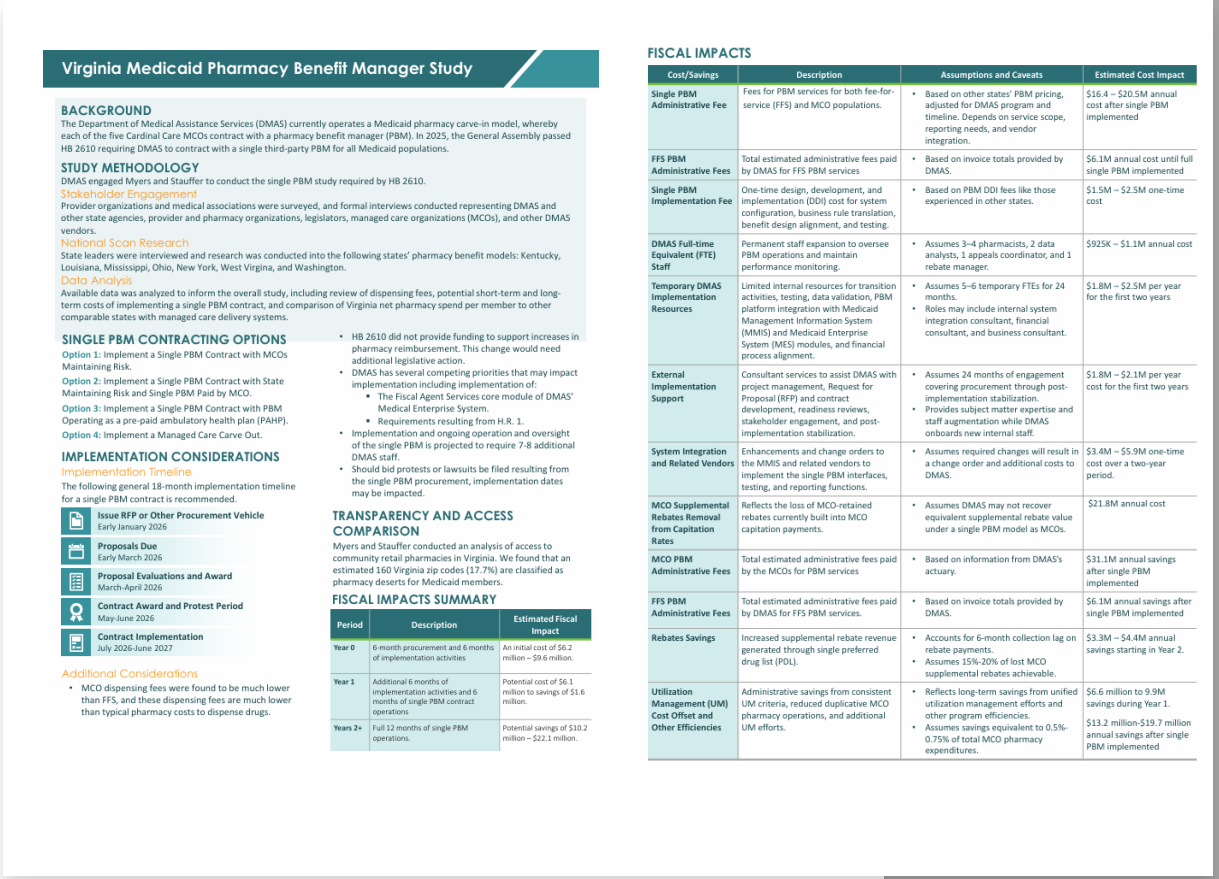
DMAS, in coordination with DBHDS, DHP and DMAS health plans, is employing an integrated and comprehensive approach to address rate, service, and workforce/provider roles for Medicaid over the next two years.

The project seeks to redesign DMAS' youth and adult legacy services: Intensive In-home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation, and Mental Health Targeted Case Management.

The budget language authorizes DMAS to move forward with budget neutral changes to replace the legacy services with evidence-based, trauma-informed services. The timeline for implementing the new services is under discussion.

Pharmacy Benefit Manager (PBM) Study

HB 2610 / SB 875 legislation requires DMAS to complete PBM study.



Virginia Medicaid Pharmacy Benefit Manager Study

BACKGROUND

The Department of Medical Assistance Services (DMAS) currently operates a Medicaid pharmacy carve-in model, whereby each of the five Cardinal Care MCOs contract with a pharmacy benefit manager (PBM). In 2025, the General Assembly passed HB 2610 requiring DMAS to contract with a single third-party PBM for all Medicaid populations.

STUDY METHODOLOGY

DMAS engaged Myers and Stauffer to conduct the single PBM study required by HB 2610.

Stakeholder Engagement

Provider organizations and medical associations were surveyed, and formal interviews conducted representing DMAS and other state agencies, provider and pharmacy organizations, legislators, managed care organizations (MCOs), and other DMAS vendors.

National Scan Research

State leaders were interviewed and research was conducted into the following states' pharmacy benefit models: Kentucky, Louisiana, Mississippi, Ohio, New York, West Virgina, and Washington.

Data Analysis

Available data was analyzed 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.

SINGLE PBM CONTRACTING OPTIONS

Option 1: Implement a Single PBM Contract with MCOs Maintaining Risk.

Option 2: Implement a Single PBM Contract with State Maintaining Risk and Single PBM Paid by MCO.

Option 3: Implement a Single PBM Contract with PBM Operating as a pre-paid ambulatory health plan (PAHP).

Option 4: Implement a Managed Care Carve Out.

IMPLEMENTATION CONSIDERATIONS

Implementation Timeline

The following general 18-month implementation timeline for a single PBM contract is recommended.

- **Issue RFP or Other Procurement Vehicle** — Early January 2026
- **Proposals Due** — Early March 2026
- **Proposal Evaluations and Award** — March-April 2026
- **Contract Award and Protest Period** — May-June 2026
- **Contract Implementation** — July 2026-June 2027

Additional Considerations

- MCO dispensing fees were found to be much lower than FFS, and these dispensing fees are much lower than typical pharmacy costs to dispense drugs.
- HB 2610 did not provide funding to support increases in pharmacy reimbursement. This change would need additional legislative action.
- DMAS has several competing priorities that may impact implementation including implementation of:
  - The Fiscal Agent Services core module of DMAS' Medical Enterprise System.
  - Requirements resulting from H.R. 1.
- Implementation and ongoing operation and oversight of the single PBM is projected to require 7-8 additional DMAS staff.
- Should bid protests or lawsuits be filed resulting from the single PBM procurement, implementation dates may be impacted.

TRANSPARENCY AND ACCESS COMPARISON

Myers and Stauffer conducted an analysis of access to community retail pharmacies in Virginia. We found that an estimated 160 Virginia zip codes (17.7%) are classified as pharmacy deserts for Medicaid members.

FISCAL IMPACTS SUMMARY

Period	Description	Estimated Fiscal Impact
Year 0	6-month procurement and 6 months of implementation activities	An initial cost of $6.2 million – $9.6 million.
Year 1	Additional 6 months of implementation activities and 6 months of single PBM contract operations	Potential cost of $6.1 million to savings of $1.6 million.
Years 2+	Full 12 months of single PBM operations.	Potential savings of $10.2 million – $22.1 million.

FISCAL IMPACTS

Cost/Savings	Description	Assumptions and Caveats	Estimated Cost Impact
Single PBM Administrative Fee	Fees for PBM services for both fee-for-service (FFS) and MCO populations.	• Based on other states' PBM pricing, adjusted for DMAS program and timeline. Depends on service scope, reporting needs, and vendor integration.	$16.4 – $20.5M annual cost after single PBM implemented
FFS PBM Administrative Fees	Total estimated administrative fees paid by DMAS for FFS PBM services	• Based on invoice totals provided by DMAS.	$6.1M annual cost until full single PBM implemented
Single PBM Implementation Fee	One-time design, development, and implementation (DDI) cost for system configuration, business rule translation, benefit design alignment, and testing.	• Based on PBM DDI fees like those experienced in other states.	$1.5M – $2.5M one-time cost
DMAS Full-time Equivalent (FTE) Staff	Permanent staff expansion to oversee PBM operations and maintain performance monitoring.	• Assumes 3–4 pharmacists, 2 data analysts, 1 appeals coordinator, and 1 rebate manager.	$925K – $1.1M annual cost
Temporary DMAS Implementation Resources	Limited internal resources for transition activities, testing, data validation, PBM platform integration with Medicaid Management Information System (MMIS) and Medicaid Enterprise System (MES) modules, and financial process alignment.	• Assumes 5–6 temporary FTEs for 24 months. • Roles may include internal system integration consultant, financial consultant, and business consultant.	$1.8M – $2.5M per year for the first two years
External Implementation Support	Consultant services to assist DMAS with project management, Request for Proposal (RFP) and contract development, readiness reviews, stakeholder engagement, and post-implementation stabilization.	• Assumes 24 months of engagement covering procurement through post-implementation stabilization. • Provides subject matter expertise and staff augmentation while DMAS onboards new internal staff.	$1.8M – $2.1M per year cost for the first two years
System Integration and Related Vendors	Enhancements and change orders to the MMIS and related vendors to implement the single PBM interfaces, testing, and reporting functions.	• Assumes required changes will result in a change order and additional costs to DMAS.	$3.4M – $5.9M one-time cost over a two-year period.
MCO Supplemental Rebates Removal from Capitation Rates	Reflects the loss of MCO-retained rebates currently built into MCO capitation payments.	• Assumes DMAS may not recover equivalent supplemental rebate value under a single PBM model as MCOs.	$21.8M annual cost
MCO PBM Administrative Fees	Total estimated administrative fees paid by the MCOs for PBM services	• Based on information from DMAS's actuary.	$31.1M annual savings after single PBM implemented
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Utilization Management (UM) Cost Offset and Other Efficiencies	Administrative savings from consistent UM criteria, reduced duplicative MCO pharmacy operations, and additional UM efforts.	• Reflects long-term savings from unified utilization management efforts and other program efficiencies. • Assumes savings equivalent to 0.5%-0.75% of total MCO pharmacy expenditures.	$6.6 million to 9.9M savings during Year 1. $13.2 million-$19.7 million annual savings after single PBM implemented

Procurements updates

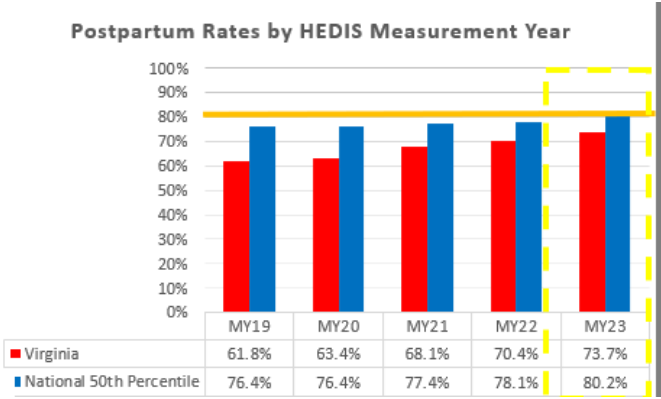
DMAS is currently advancing several major procurement initiatives, including:

- ❑Fiscal Agent Services,
- ❑General Audit Services,
- ❑Non-Emergency Medical Transportation
- ❑Enrollment Broker
- ❑Provider Enrollment services
- ❑Pregnancy-focused mobile application designed to enhance ongoing service delivery.

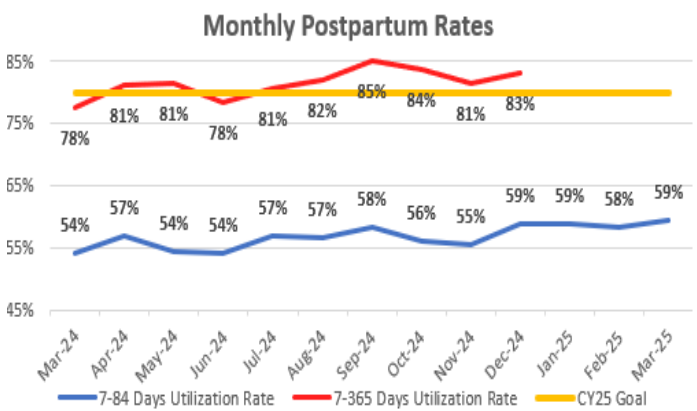
Maternal Health Initiatives

- ❑ DMAS–MCO maternal workgroup meetings
- ❑ CMS Affinity Workgroup and National Academy for State Health Policy (NASHP) MCH PIP
- ❑ Maternal toolkit: Finalizing toolkit and animated videos, breastfeeding factsheet
- ❑ Mobile pregnancy app: RFP finalizing; target October 2026
- ❑ Mobile clinics pilot: 2.5 million dollars for maternity care deserts; partner outreach underway
- ❑ Maternal health deserts work: Regional coordination, labor and delivery closure planning, demographic mapping
- ❑ Perinatal health hubs: 2.5 million dollars in statewide grants; RFA closes December 1

Maternal Health Goals - December 2025



- Percent of women delivering a live birth who receive postpartum care (CMS's annual metric; includes medical record audit)
- Virginia's increase from MY19 to MY23 much greater than national average change
- Increased nearly 12 percentage points since MY19



- Percent of women delivering a live birth who receive postpartum care (DMAS's internal metric)
- Medical claim lag on 12-month postpartum data results in delayed results for 7–365-day rate

Nursing Homes Updates

- Governor Glenn Youngkin's Executive Order #52 – Nursing Home Oversight and Accountability Advisory Task Force
- Working on nursing quality initiatives
- Focus on improving the Nursing Facility Value-Based Purchasing Program


THANK
YOU

Virginia Medicaid Pharmacy Benefit Manager Study

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THRIVE 2025 DMAS Initiatives and Accomplishments

Largest Medicaid Program Launch in Virginia History

On July 1, 2025, Virginia launched the Cardinal Care Managed Care program, moving 1.7 million Virginians into a modernized Medicaid system. Virginia added Humana Healthy Horizons as a new Medicaid health plan and transitioned members from Molina to Humana without service disruptions. Before the launch, DMAS completed detailed readiness reviews for every Managed Care Organization and informed the public through a statewide communication campaign.

Strengthened Oversight and Accountability

DMAS created a new Compliance Office and introduced the MCO 360° Performance Review to improve oversight and increase transparency in how Medicaid health plans operate.

Improved Care for Foster Youth and At-Risk YouthCare

Virginia established its first statewide Foster Care Specialty Plan, ensuring that all foster youth receive consistent support through Anthem HealthKeepers Plus. DMAS also moved all youth in Psychiatric Residential Treatment Facilities into managed care to improve care coordination and support smoother transitions back into their communities. Virginia secured a multi year $5 million federal grant to develop Medicaid reentry services that support the health and successful community reintegration of youth involved in the justice system.

DOJ Settlement Successfully Concluded

After more than a decade, Virginia completed the requirements of the federal Department of Justice Settlement Agreement, which was officially closed and replaced with a Permanent Injunction—marking major progress in community-based behavioral health services.

Nationally Leading Improvement in Postpartum Care

Virginia increased postpartum visit rates from 61.8% to 73.7% between 2019 and 2023, nearly a 12-percentage-point improvement that outpaced national averages and demonstrated strong gains in maternal health.

Reduced Avoidable Emergency Department Use

DMAS brought together Medicaid health plans, hospitals, and other partners to reduce avoidable emergency room visits. Pilot programs reduced unnecessary emergency visits by up to 70% for certain members, lowering healthcare costs and improving patient outcomes.

Nursing Facility Quality Improvements

DMAS strengthened the Nursing Facility Value-Based Purchasing Program to better align nursing home payments with quality results. The agency also launched the Nursing Facility Quality Improvement Program in August 2025 to improve resident safety, satisfaction, and health outcomes.

Medicaid had its 60th birthday this year. Six decades later, it's still strengthening families and improving health outcomes every day. Its impact on public health and community well-being continues to grow.

Large-Scale Home and Community-Based Services Compliance

DMAS completed more than 6,000 reviews of Home and Community-Based Services settings, including 750 reviews completed in 2025 alone, to ensure full compliance with federal rules that protect community living options.

Streamlined Member Communications

DMAS launched the Cardinal Care Correspondence Center, the first statewide system that centralizes Medicaid mail processing to improve accuracy and speed for member communication.

Modernized Third-Party Liability Recovery

A new Third-Party Liability Lien Portal was implemented to automate case intake, track activity, and improve financial recoveries while reducing administrative work.

Financial Operations Efficiency

DMAS achieved a 95.4% prompt-pay rate in fiscal year 2025, ensuring that healthcare providers were paid on time.

Delivery on 2025 General Assembly Requirements

DMAS carried out more than 100 legislative and budget-related directives in 2025, including regulatory changes, provider payment adjustments, contract updates, and formal reports.

First Statewide Long-Term Services and Support Member Experience Survey

DMAS collected feedback from Medicaid members receiving long-term services and supports to identify opportunities for improving care and strengthening person-centered services.

DMAS received only 5 findings in the FY2024 Auditor of Public Accounts Audit and DMAS addressed two of the 5 findings from the FY2024 Auditor of Public Accounts audit and is on target to receive less findings in the FY2025 audit.

Strengthened Language and Disability Access

A statewide Language and Disability Access Plan was implemented, offering translation services, large-print documents, disability accommodations, and a public forum promoting plain-language communication.

Enhanced IT Security

DMAS eliminated all overdue critical and high-risk server vulnerabilities in 2025 by closely monitoring systems and addressing issues before deadlines.

Implemented the Medicaid Enterprise System (MES) Change Control Board

Established a governance structure to review and manage strategic IT updates across DMAS, improving coordination and transparency of technology initiatives.

Agency-Wide Performance Management Training

DMAS trained staff statewide on the new performance management system, PageUp, resulting by October 30, 2025 in 74% of self-evaluations being submitted, 51% completed, and 36% submitted in PageUp.

Expanded Digital and Social Media Engagement

DMAS achieved a 92.6% website click-through rate and a 31.6% increase in social-media followers, and hosted its first Facebook Live event to better inform the public about Medicaid programs.

For 2025, DMAS' turnover rate is 6%, which reflects a strong employee retention rate of 94%. These figures indicate that the organization has been largely successful in maintaining workforce stability and retaining experienced staff throughout the year.

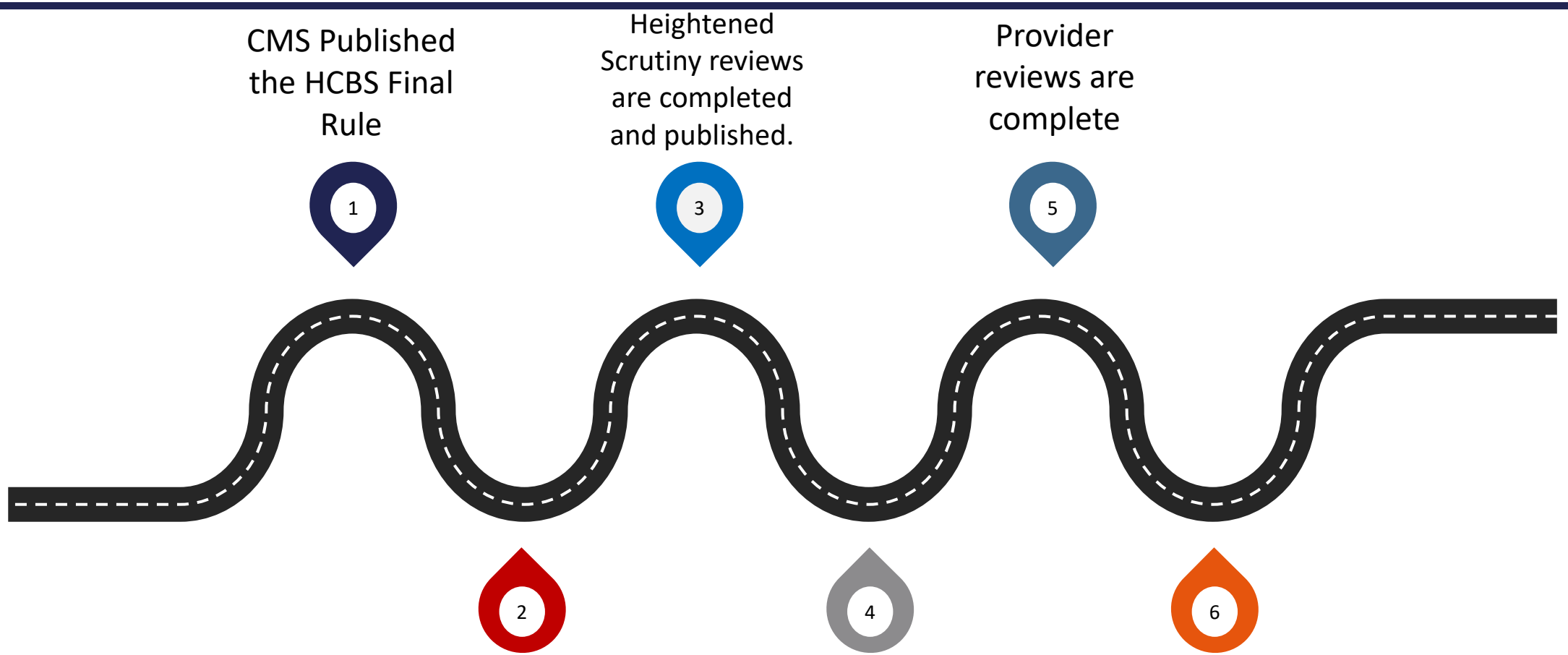
CardinalCare
Virginia's Medicaid Program

Home and Community Based Settings Regulation

HCBS Final Rule

DMAS

Roadmap



CardinalCare
Virginia's Medicaid Program

Background

Why was the HCBS Final Rule created?

- CMS published the final rule in 2014. This rule was a result of many years of advocacy and CMS realizing that many people who were receiving HCBS services still had a very institutional experience and were not living community-based lives.
- CMS developed a set of provisions that must be met for a setting to be considered home and community based.
- These rules are applicable for all 1915c waiver services. Virginia has four 1915c waivers: community living, family and individual supports, building independence and the CCC+ waiver.

Home and Community Based Settings Rule

General Provisions for all HCBS settings

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

Home and Community Based Settings Rule

Person-Centered Planning

- Reflect that the setting was the individual's choice and is integrated in, and supportive of full access of the individual to the greater community.
- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs that have been identified through a functional needs assessment.
- Includes individually identified desired outcomes and support activities.
- Reflect the (paid/unpaid) services/supports, and providers of such services/supports that will assist the individual to achieve identified goals.
- Reflect risk assessment, mitigation, and backup planning.
- Be understandable (e.g. linguistically, culturally, and disability considerate) to both the individual receiving HCBS and the individual's support system.
- Identify the individual and/or entity responsible for monitoring the PCSP.
- With the written, informed consent of the individual, be finalized, agreed to, and signed by all individuals/providers responsible for implementation of the PCSP.
- Be distributed to the individual and others involved in the PCSP.
- Prevent service duplication and/or the provision of unnecessary services/supports.

Home and Community Based Setting Rule

Residential Protections

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of Virginia. For settings in which landlord tenant laws do not apply, there will be a lease, residency agreement or other form of written agreement in place for each HCBS participant, and the document provides protections that address eviction processes and appeals comparable to those provided under the landlord tenant law.
- Each individual has privacy in their sleeping or living unit:
  - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
  - Individuals sharing units have a choice of roommates in that setting.
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals can have visitors of their choosing at any time.
- Setting is physically accessible to the individual (This provision can never be modified).

Home and Community Based Settings Rule

Modifications

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered individual support plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

What is community?

What is NOT community?

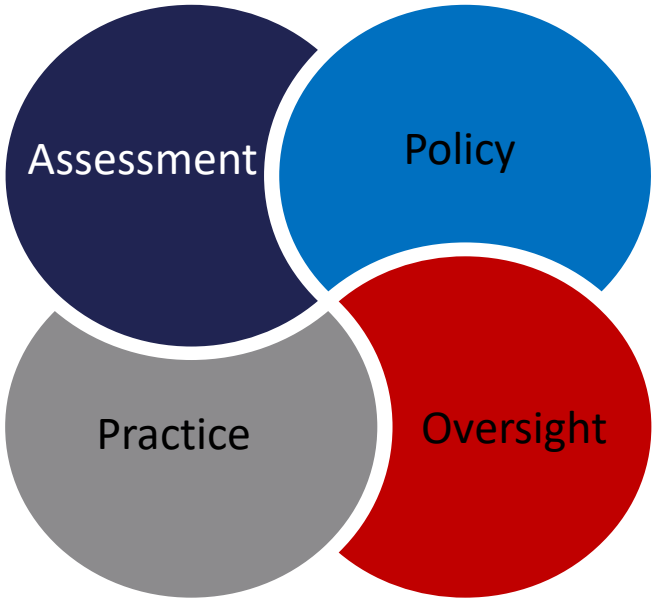
- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Hospital

What is presumed to be institutional?

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Virginia's Compliance Plan

- Virginia drafted our statewide transition plan (STP) and developed a plan for compliance. DMAS received approval from CMS on our STP in 2019.



Heightened Scrutiny

- Any setting that meets the criteria of “presumed to not be community based” must demonstrate how they are meeting the provisions the regulation.
- DMAS identified 68 settings that met the heightened scrutiny criteria.
- DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) worked with the providers to develop compliance action plans to move these settings into compliance.
- Providers took a variety of different approaches to reach compliance. A few providers with “campus-style” housing closed the campuses and relocated to community-based neighborhoods. Other providers rented out homes and turned an isolating environment to a more inclusive environment.

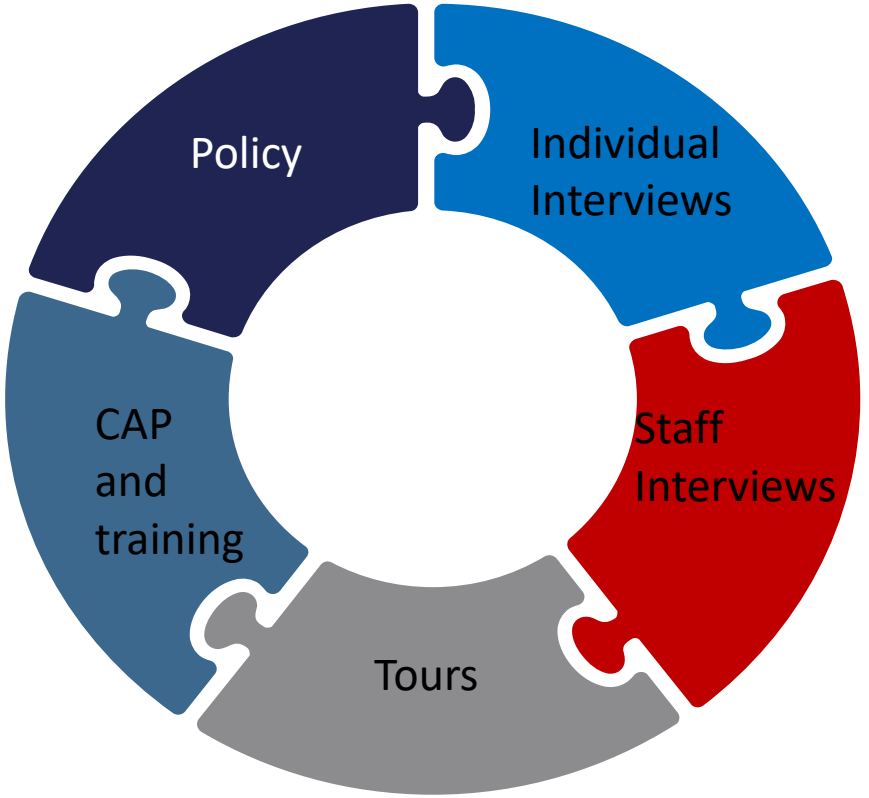
Heightened Scrutiny

- Settings are no longer considered heightened scrutiny. This verbiage was specific to the transition period allowed by CMS to give time for providers who are already in the HCBS system to remain in the system.
- In 2019, CMS issued guidance to states that outlines the steps for any new setting that would meet the “presumed institutional” criteria. Based on the new guidance, any new setting will have to serve non-Medicaid beneficiaries prior to receiving any Medicaid funding. DMAS will complete a review of these settings and speak with the non-Medicaid beneficiaries about their experience and determine if the provisions of the rule are met. DMAS will draft a report of the findings, post the report for public comment and then submit the findings to CMS.

New Providers

- Any new provider who wishes to provide HCBS services must enter the Medicaid network in compliance. There is no transitional period for new providers.
- New providers receive a license from their respective entity and then complete a self-assessment. The self-assessment is an opportunity for new providers to develop strong policies, learn about HCBS and think about including HCBS principles into their day-to-day program.
- Once the self-assessment is completed and approved, the provider receives a letter of compliance, and the provider can use this letter to enroll with DMAS.

Review Process



Ongoing Monitoring

- Virginia completed over 6,000 setting reviews from 2020-2025.
- DMAS has worked with DBHDS and developed a plan for ongoing compliance. Our model will change from a specific HCBS review team to embedding HCBS into our established review processes. We will be using the quality management reviews, quality service reviews and stand alone HCBS reviews.

HCBS Success Stories

Joe lives in a group home and enjoys going for walks around his neighborhood. During the HCBS review of this home, it was discovered that Joe was “not allowed” to go for these walks by himself. This rule was not based on any specific needs, but rather an assumption that Joe could not go for a walk by himself. As part of the CAP the provider was required to retrain on autonomy and presumed competence. Joe now goes for walks on his own and there have been no issues.

Julie wanted to live on her own for many years. However, her family and supporters feared for her safety if she lived on her own. Following the final rule, and education for her support coordinator, Julie was supported to find an apartment and get a job. Julie found a job at Walmart and moved into an apartment about 1 year ago. She has had no issues since moving into the apartment and says she now lives like “any other woman in her 30’s”.

HCBS Success Stories

Romeo and Juliet are a married couple who reside in a supported living apartment setting. Romeo and Juliet both have part-time jobs, and Romeo has a license and car to drive himself and Juliet to work and leisure activities. Prior to the current supported living service, both individual reported feeling of anxiety and depression leading to “behavioral” concerns. However, after finding service that supports both individuals to have freedom to live together (like other married couples) and direct their own lives, all of these “behaviors” have been remediated and both folks report feeling happy and supported. The provider supports the couple with budgeting, housekeeping, safety skills and IADLs. The provider does not over support these folks, and this is exactly how our services should work!

Next Steps

- Development of an HCBS portal
- Re-vamp of the HCBS Toolkit
- Continued training opportunities for individuals, families, providers and support coordinators
- Formal grievance process

CardinalCare
Virginia's Medicaid Program

Budget Update

Truman Horwitz, Budget Division Director

DMAS

Overview

- November 1 Forecast

- Summary

Forecast Overview

Major Drivers

Enrollment is shifting to more expensive members	Full implementation costs of prior policy changes and investments	Members are using more services than they have historically

The forecast indicates DMAS will need $3.2 Billion in General Funds over the current appropriations to cover costs in the FY26-FY28 Biennium.

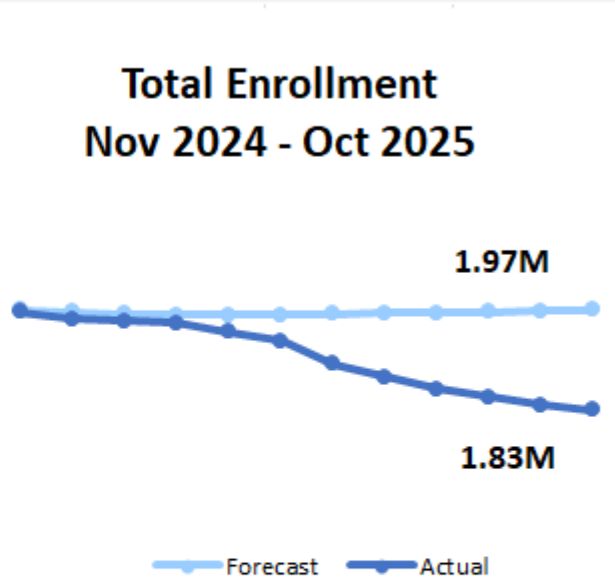
Medicaid Forecast by Funding Source

		(in $ Millions)				
		FY2026 Appropriation	FY2026 Forecast	FY2027 Forecast	FY2028 Forecast	FY2026 - FY2028 Total Forecast
Base Medicaid	GF	7,629	8,040	8,703	9,327	26,070
	Federal	7,635	8,104	8,597	9,281	25,982
Expansion	Coverage Assessment	629	648	709	770	2,127
	Federal	5,710	5,610	5,917	6,370	17,897
Supplemental Rate Payments	Coverage Assessment	1,218	1,583	1,814	1,880	5,277
	Federal	3,356	3,361	3,772	3,833	10,966
	Total Program Cost	**26,177**	**27,346**	**29,512**	31,462	**88,320**
	Total GF Need		**410**	**1,074**	**1,698**	**3,182**
	Total Need All Funds		1,168	3,334	5,284	9,787

Total enrollment is decreasing but higher cost members continue to grow

Enrollment as of 10/1/2025

	Selected Categories	Nov. 1, 2024 Forecast	Actual Enrollment	Variance	PMPM Example
Medicaid Forecast	Aged, Blind and Disabled	145,889	149,069	3,180	$ 1,832
	Nursing Facilities	17,012	17,329	317	5,299
	Special Needs at Home	60,437	62,457	2,020	5,132
	Adult + Child	133,269	119,350	(13,919)	586
	Pregnant Women	27,473	28,858	1,385	707
	Children	577,123	530,826	(46,297)	299
	Expansion - Adult + Child	122,019	109,981	(12,038)	629
	Expansion - Single Adult	422,271	380,773	(41,498)	629
	Title XIX Total	**1,775,680**	**1,641,199**	**(134,481)**	
CHIP Forecast	Kids 6-18 y.o., 100-138 FPL	98,952	89,829	(9,123)	246
	FAMIS Kids 0-18 y.o., 138-200 FPL	89,304	94,148	4,844	274
	FAMIS MOMS	4,712	4,938	226	1,059
	Title XXI Total	**197,193**	**193,431**	**(3,762)**	
	Total Enrollment	**1,972,872**	**1,834,630**	**(138,242)**	



**PMPMs will not calculate to total cost of program*

Managed Care Rate Change Assumptions

	FY2026 Assumed	FY2026 Forecast	FY2027 Forecast	FY2028 Forecast
Base Medicaid	4.5%	8.2%	7.1%	7.0%
Medicaid Expansion	5.8%	15.0%	10.6%	10.6%
Total	5.0%	10.6%	8.2%	8.2%

Rates developed in collaboration with Mercer as CMS requires MCO rates to be certified as actuarially sound.

Summary and Looking Ahead

- Spending is right on track with appropriation (the November 1 Forecast)

- The Governor's Introduced Budget will be released later in the month

Meetings and public hearings

Scheduled for

Future

Agency

All Agencies

Regulatory Board

Board of Medical Assistance Services

Meeting Title Partial Match

Submit

Meeting Scope

H Public hearing to discuss a proposed change to regulation

R Discuss particular regulations / chapters

G General business of the board

Create a New Meeting

34 meetings scheduled for the future relating to Board of Medical Assistance Services

Date and Time		Meeting Title	Board	Scope
Dec-10 2025 (Wed)	10:00 am	Board of Medical Assistance Services Agenda Electronic Access	Board of Medical Assistance Services	G
Dec-11 2025 (Thu)	1:00 pm	Pharmacy Drug Utilization Review Board Meeting Agenda	Board of Medical Assistance Services	G
Dec-11 2025 (Thu)	1:00 pm	Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC) & Annual Maternal and Child Health 1115 Demonstration Post-Award Forum Agenda Electronic Access	Board of Medical Assistance Services	G
Dec-19 2025 (Fri)	10:00 am	Pharmacy Liaison Committee Meeting Agenda	Board of Medical Assistance Services	G
Jan-16 2026 (Fri)	10:00 am	CHIPAC Executive Subcommittee Meeting Electronic Access	Board of Medical Assistance Services	G
Jan-20 2026 (Tue)	3:00 pm	Medicaid Physician and Managed Care Liaison Committee (MPMCLC) Electronic Access	Board of Medical Assistance Services	G
Jan-29 2026 (Thu)	1:00 pm	Pharmacy and Therapeutics Meetiing Agenda	Board of Medical Assistance Services	G
Mar-05 2026 (Thu)	1:00 pm	Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC) Electronic Access	Board of Medical Assistance Services	G
Mar-10 2026 (Tue)	10:00 am	Board of Medical Assistance Services Electronic Access	Board of Medical Assistance	G

			Services	
Mar-12 2026 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Apr-16 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Apr-17 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** **Electronic Access**	Board of Medical Assistance Services	G
Jun-04 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** **Electronic Access**	Board of Medical Assistance Services	G
Jun-09 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** **Electronic Access**	Board of Medical Assistance Services	G
Jun-11 2026 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Jul-09 2026 (Thu)	10:00 am	**Pharmacy Liaison Committee Meeting**	Board of Medical Assistance Services	G
Jul-16 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Jul-17 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** **Electronic Access**	Board of Medical Assistance Services	G
Sep-08 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** **Electronic Access**	Board of Medical Assistance Services	G
Sep-10 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** **Electronic Access**	Board of Medical Assistance Services	G
Sep-10 2026 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Oct-15 2026 (Thu)	1:00 pm	**Pharmacy and Therapeutics Meetiing**	Board of Medical Assistance Services	G
Oct-16 2026 (Fri)	10:00 am	**CHIPAC Executive Subcommittee Meeting** **Electronic Access**	Board of Medical Assistance Services	G
Dec-03 2026 (Thu)	10:00 am	**Pharmacy Liaison Committee Meeting**	Board of Medical Assistance Services	G
Dec-08 2026 (Tue)	10:00 am	**Board of Medical Assistance Services** **Electronic Access**	Board of Medical Assistance Services	G

Dec-10 2026 (Thu)	1:00 pm	**Children's Health Insurance Program Advisory Committee of Virginia (CHIPAC)** **Electronic Access**	Board of Medical Assistance Services	G
Dec-10 2026 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Mar-11 2027 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Jun-10 2027 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Jul-08 2027 (Thu)	10:00 am	**Pharmacy Liaison Committee Meeting**	Board of Medical Assistance Services	G
Sep-09 2027 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Dec-02 2027 (Thu)	10:00 am	**Pharmacy Liaison Committee Meeting**	Board of Medical Assistance Services	G
Dec-09 2027 (Thu)	1:00 pm	**Pharmacy Drug Utilization Review Board Meeting**	Board of Medical Assistance Services	G
Sep-09 9999 (Thu)	12:00 am	**Medicaid Physician and Managed Care Liaison Committee (MPMCLC)** **Electronic Access** Canceled	Board of Medical Assistance Services	G

Regulatory Activity Summary — December 10, 2025
(* Indicates Recent Activity)

2025 General Assembly

***(01) Update to the Medication Assisted Treatment (MAT) Benefit:** This state plan amendment will allow DMAS to remove the end date associated with medication assisted treatment (MAT) for opioid use disorder (OUD). The MAT benefit was initially effective for a five-year period beginning October 1, 2020, and ending September 30, 2025. Section 201 of the Consolidated Appropriations Act, 2024, made the mandatory MAT for OUD benefit at section 1905(a)(29) of the Act permanent by removing the end date of September 30, 2025. Additionally, on August 20, 2025, CMS released an updated SPA template that states are required to use to replace their current state plan Supplement to Attachment 3.1 pages for the MAT benefit to reflect that the benefit is now permanent. Following internal review, the SPA was approved by DPB on 11/24/25 and submitted to HHR for review on 11/29/25.

***(02) Physician-Administered Drugs:** This SPA will allow DMAS to invoice for drug rebates for outpatient physician-administered drugs (PADs). Pursuant to 42 CFR 447.520, in order to receive federal match on spending related to PADs, Medicaid agencies must bill for drug rebates for PADs. Failure to comply with the requirements may result in CMS withholding federal financial participation. DMAS' current practice is to invoice for drug rebates for PADs, so the state plan needs to be updated accordingly. The project is currently circulating for internal review.

***(03) Repeal Out-of-Date Advance Directives Language:** The state plan is being amended to delete all of the text in Attachment 2.8-A of the state plan, which pertains to requirements for advance directives. This text is out-of-date and was replaced by the text in Attachment 4.34-A (all of the language that appears in Attachment 2.8-A is reflected in Attachment 4.34-A). Therefore, the text in Attachment 2.8-A is no longer needed, and the state plan needs to be amended to remove it. Following internal review, the project was submitted to DPB and the Tribal Programs for review on 11/29/25.

***(04) Repeal of Increased Primary Care Service Payments:** This SPA will delete obsolete language from the state plan that pertains to increased primary care service payments. The increased payments were temporary, pursuant to Section 1202 of the Affordable Care Act, which required Medicaid to reimburse certain primary care services at Medicare rates during calendar years 2013 and 2014. Virginia did not submit a subsequent SPA to CMS to extend or make the increased payments permanent. Therefore, the language in the state plan is outdated and no longer in effect, so it needs to be removed. Following internal review, the project was submitted to DPB and the Tribal Programs for review on 11/29/25.

***(05) Provider Appeals AIMS Filing:** This regulatory action amends existing regulations to streamline the provider appeal process in accordance with Item 292 QQ of the 2025 Appropriations Act. The amendments require providers to file appeal notices and other appeals-related documents through the Appeals Information Management System (AIMS), an online appeals portal. Following internal review, the reg project was submitted to the OAG for review on 8/28/25. DMAS reached out to the OAG on 9/17/25 for a status update.

***(06) Reentry Targeted Case Management:** In accordance with Item 288.GGGG.2 of the 2025 Appropriations Act, this SPA provides coverage of targeted case management, in the 30 days pre-release and immediately post-release to eligible incarcerated youth and young adults to comply with section 5121 of the federal Consolidated Appropriations Act of 2023. Following the internal and external reviews, the SPA was submitted to CMS on 9/8/25. CMS issued a Request for Additional Information (RAI) for this SPA on 12/5/25.

***(07) 2025 Non-Institutional Provider Reimbursement Changes:** The state plan is being amended in order to comply with the 2025 Appropriations Act. Specifically:

- Item 288.FFFFF.2: The state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit by three percent. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning provided under home and community-based waivers. These increases are not included in the state plan amendment but via waiver documentation.)

- Item 288.GGGGG.2: The state plan is being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and Diagnosis and Treatment (EPSDT) benefit by two percent. (A corresponding rate increase of two percent will be provided for these services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

- Item 288.MMMMM: The state plan is being revised 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. This payment shall be unbundled from the hospital rate.

- Item 288.PPPPP: The state plan is being revised to 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.

- Item 288.UUUUU: The state plan is being revised to increase the rates for Office Based Addiction Treatment, Opioid Treatment Services, Partial Hospitalization Services, and Intensive Outpatient Services by 6.5 percent.

- Item 288.WWWWW: The state plan is being revised 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.

- Item 3-5.15: the state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for outpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

Following the internal and external reviews, the SPA was submitted to CMS on 9/8/25. CMS issued a RAI for this SPA on 12/5/25.

***(08) 2025 Institutional Provider Reimbursement Changes:** The state plan is being amended in order to comply with the 2025 Appropriations Act. Specifically:

- Item 288.MMMMM: The state plan is being revised 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 inpatient setting. This payment shall be unbundled from the hospital rate.

- Item 288.RRRRR: The state plan is being revised 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.

- Item 3-5.15: The state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for inpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

Following the internal and external reviews, the SPA was submitted to CMS on 9/12/25. CMS issued a RAI for this SPA on 12/5/25.

***(09) 2025 Third Party Liability:** The purpose of this state plan amendment is twofold:

- Add language that is needed to respond to a CMS State Medicaid Director letter (#23-002) requiring Medicaid agencies to amend their state plan to provide assurance that the state has rules in place that bar liable third-party payers 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.

- Provide clarity relating to lien amounts arising from the Medicaid program and asserted against personal injury claims proceeds.

In 2023, DMAS submitted a third party liability SPA to CMS to incorporate the above changes. However, CMS asked DMAS to withdraw the SPA, because the agency did not have a law in place that barred liable third-party payers from refusing payment for an item or service on the basis that such item or service did not receive prior authorization under the third-party payer's rules. Item 288.KKKKK of the 2025 Appropriations Act provides such authority; therefore, DMAS can now resubmit the SPA to CMS. Following internal review, the project was approved by DPB on 7/21/25; approved by HHR on 7/23/25; and submitted to CMS on 8/12/25. The SPA was approved by CMS on 10/31/25.

***(10) Applicability of the OMB Outpatient All-Inclusive Rate:** This state plan amendment will comply with the requirements of the 2025 Virginia Appropriations Act, Item 288.TTTTT, which requires DMAS to seek approval from CMS to amend the State Plan to reflect that services provided by IHS or tribal clinics or tribal FQHCs that are not eligible for the federal medical assistance percentage of 100 percent (services provided to individuals who are not American Indians or Alaska Natives) shall be reimbursed at standard Medicaid rates (the rates otherwise paid to non-tribal facilities for the same services). Following the internal and external reviews, the SPA was submitted to CMS on 7/7/25. CMS issued a RAI for this SPA on 10/2/25.

***(11) Nursing Facility Reimbursement Methodology:** In accordance with the 2025 Appropriations Act, Item 288.IIIII, this SPA modifies the nursing facility reimbursement methodology to the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG). This change shall be implemented in a budget neutral manner. RUGs was developed and used by CMS to classify nursing facility residents into payment groups based on their resource utilization. RUGs expired on September 30, 2023. Between October 1, 2023, and September 30, 2025, CMS allowed state Medicaid agencies to use the Optional State Assessment to extend the use of RUGs IV. CMS will no longer support Medicare RUGs systems after October 1, 2025. PDPM will replace RUGs for classifying Skilled Nursing Facility (SNF) patients in a covered Medicare Part A stay. This shift aims to modernize payment systems and align reimbursement more closely with resident care needs. Following internal review, the DPB and Tribal notices were submitted for review on 11/20/25.

***(12) Repeal of Nursing Facility-Specific Drug Utilization Review and Updates to Nursing Facility Survey and Certification:** The purpose of this SPA is to:

- Delete language related to nursing facility-specific drug utilization review (DUR) in section 4.14g of the state plan. This text is obsolete and the requirement for this text was repealed by the Centers for Medicare & Medicaid Services in 1994. The DMAS DUR Board monitors nursing facilities according to the requirements in 42 CFR 456.703. 42 CFR 456.703(b) stipulates that prospective drug review and retrospective drug use review (including interventions and education) under the DUR program are not required for drugs dispensed to residents of nursing facilities that are in compliance with the drug regimen review procedures set forth in 42 CFR 483.45 (the Virginia Department of Health is responsible for evaluating nursing facilities' compliance with 42 CFR 483.45).

- Update the nursing facility state survey language to reflect that the Division of Licensure and Certification within the Virginia Department of Health has changed its name to the Office of Licensure and Certification (OLC) and OLC no longer contracts with the State Fire Marshall's Office.

Following internal review, the SPA was submitted to DBP and the Tribal Programs for review on 9/18/25. The SPA was submitted to CMS for review on 10/31/25.

***(13) Pharmacy and Therapeutics Committee:** The state plan is being amended to update the quorum that is needed for the Pharmacy and Therapeutics Committee (P&T Committee) to take action. Item 288.CC.2.a of the 2025 Appropriations Act amended the composition of the P&T Committee such that the Committee must be composed of up to 16 members (the Committee is currently composed of 12 members and a quorum is seven members). Amending the composition to 16 members means a quorum of nine members will be needed for the P&T Committee to take action, so the state plan needs to be updated accordingly. Following the internal and external

reviews, the SPA was submitted to CMS on 9/18/25 and approved by CMS on 10/27/25. The corresponding regulatory project is currently circulating for internal review.

(14) Clinic Services: The state plan is being amended in order to comply with a CMS notice indicating that: "The completion of the [SPA] template is mandatory only for states that both cover the clinic services benefit and cover tribal clinics to allow clinic services to be provided outside of the clinic under the clinic services benefit …"

DMAS covers the optional clinic services benefit, and covers tribal clinics, including the "outside of the clinic" benefit, and as a result, is required to file this SPA. The CMS notice was accompanied by a draft template. CMS provided a final version of the template for the SPA on March 10, 2025. CMS has indicated that state Medicaid agencies must file a blank SPA by March 31, 2025 to preserve the option for a January 1, 2025 effective date, while allowing for a tribal consultation period before the completed SPA template is submitted. DMAS submitted a blank SPA template to CMS by March 31, 2025, and submitted a completed template after tribal consultation occurred.

Virginia Medicaid covers:

- Medical and Behavioral Health Clinics;
- IHS and Tribal Clinics;
- Renal Dialysis Clinics; and
- Other Clinics, which include health department clinics, ambulatory surgery clinics, and family planning clinics.

The SPA template requires DMAS to list any limitations on clinic services. DMAS does not intend to make any changes to its practices regarding the scope of clinic services, but to clarify that clinic services provided under 42 CFR 440.90 do not include the following services: dental, pharmacy, home health, hospice, physical therapy, occupational therapy, speech language pathology, transportation, 1915(c) waiver services, and community mental health services. To provide those services, clinics must enroll as that provider type and abide by the state plan requirements for those services. These limitations match current DMAS practice.

In the completed SPA template, DMAS is required to define the scope of tribal clinic services and to confirm that clinic services can be provided outside of the four walls of the clinic. DMAS intends to clarify that the scope of tribal clinic services is the same as for non-tribal clinics. DMAS will also confirm in the completed SPA template that IHS and tribal clinic services can be provided outside of the clinic. Following internal and oversight agency review, the SPA was submitted to CMS on 5/15/25. CMS requested additional information on 6/20/25. DMAS is currently preparing a response and coordination of the associated reg action is forthcoming.

***(15) MR Removal and Updates:** This regulatory action removes the highly offensive term, "mentally retarded" from DMAS regulations and replaces it with either "individuals with developmental disabilities" or, when required to match federal regulations, the more narrow term "individuals with intellectual disabilities". These replacement terms are currently used in DMAS regulations. The reg project also removes references to the Department of Mental Health, Mental Retardation and Substance Abuse Services of the Commonwealth of Virginia (DMHMRSAS), as the agency is now called the Department of Behavioral Health and Developmental Services (DBHDS). Following internal review, the project was submitted to the OAG on 10/16/25 and

revisions were included in the RIS system per OAG request on 11/7/25. The project was submitted to the Governor's Office for review on 11/24/25.

(16) Requirements for Medicaid Consumer-Directed Facilitators: The state plan is being amended to modify requirements for Consumer-Directed (CD) 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. CD Facilitators provide practical skills training (such as providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication, and problem-solving) to enable families and individuals to independently direct and manage their consumer-directed services. Serving as the agent of the individual or family, the facilitator is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the individual/family to be the employer. Following internal review, the SPA was approved by DPB on 6/9/25; approved by HHR on 6/10/25; and submitted to CMS on 7/11/25 and approved on 8/5/25. Coordination of the associated reg action is forthcoming.

(17) Youth Reentry: To meet a federal mandate, DMAS is submitting this SPA on a CMS template in accordance with a CMS State Health Official letter (#24-004) indicating that:

"To comply with the amendments made by section 5121 of the CAA [Consolidated Appropriations Act], 2023, states must submit a Medicaid SPA attesting that the state has developed an internal operation plan, and in accordance with such plan, will provide coverage during the statutory pre- and post-release period of screening, diagnostic, and targeted case management (TCM) services for eligible juveniles who are within 30 days of release post adjudication. For Medicaid, a state must submit a SPA no later than March 31, 2025, to have an effective date of no later than January 1, 2025."

Coverage of pre-release services is a new exception to the longstanding Medicaid inmate payment exclusion that otherwise restricts Medicaid coverage of services for individuals while incarcerated. Section 5121 of the CAA, 2023 requires states to cover screenings and diagnostic services for eligible juveniles, as well as TCM services during this transitional period out of incarceration. Services must be provided to Medicaid-eligible individuals under age 21, CHIP (FAMIS) enrolled children, and individuals up to age 26 in the Medicaid former foster youth eligibility group.

Given the complexity associated with implementing Section 5121, CMS has stated that the attestation SPA review framework will aim to balance CMS' regulatory requirements, general oversight requirements, and the statutory effective date of January 1, 2025. The framework for reviewing SPAs will be based on states' readiness to fully implement Section 5121. States will be determined as either fully ready, partially ready, or not ready to implement Section 5121. States determined partially ready or not ready to implement will be given additional time to work toward full readiness. In the interim, states determined partially ready will be allowed to claim for services in carceral facilities that are ready to participate.

Following internal review, the project was sent to DPB and the Tribal Programs for review on 2/25/25. The SPA was submitted to CMS for review on 3/28/25. CMS issued an RAI (request for additional information) on 6/16/25 and DMAS submitted responses on 7/11/25. The SPA was

approved by CMS on 7/21/25. Coordination of the corresponding regulatory action is forthcoming.

(18) Tribal Provider Reimbursement: The state plan is being amended to make the following changes to tribal provider reimbursement:

• Clarify that tribal clinics cannot be reimbursed at the facility rate (all inclusive rate, or AIR) for non-clinic services, including pharmacy, dental, transportation, and 1915(c) waiver services.
• Clarify that tribal FQHCs cannot be reimbursed at the AIR for pharmacy, transportation, and 1915(c) waiver services. Dental services provided by Tribal FQHCs are reimbursed through the Alternative Payment Methodology (APM) established in the Medicaid State Plan at Att. 4.19-B, pages 4.6-4.7.
• Clarify the definition of the per visit rate for purposes of reimbursement at the AIR, specifying that it is a bundled, all-inclusive encounter rate and must not be unbundled and billed as separate encounter claims.
• Specify that an Indian Health Service, tribal or urban Indian organization, including a Tribal 638 facility that operates a retail pharmacy, must enroll separately as a pharmacy provider, and that payment for pharmacy services shall align with an existing pharmacy payment methodology and shall not be at the AIR. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.

The state plan is also being amended to make a change needed to reflect new federal requirements for Medicaid reimbursement to tribal clinics, clarifying that these services include professional services furnished at the clinic by or under the direction of a physician, or services furnished outside the clinic, by clinic personnel under the direction of a physician. Following internal review, the project was sent to DPB and the Tribal Programs for review on 12/20/24. The SPA was submitted to CMS for review on 5/15/25. CMS issued DMAS an RAI on 8/4/25 and DMAS is currently coordinating responses.

(19) Update to Non-Covered Drugs: This SPA will align state plan language related to covered outpatient drugs with current law (Section 1927 of the Social Security Act) and current DMAS practice. Following internal review, the project was sent to DPB and the Tribal Programs for review on 2/26/25. DPB approved the SPA on 3/5/25; the SPA was submitted to HHR for review on 3/13/25 and subsequently approved; and the project was submitted to CMS for review on 3/28/25. DMAS held a conf. call with CMS on 4/17/25 to discuss the project. CMS forwarded recommended changes to the state plan page on 4/23/25. Following internal review, DMAS submitted SPA page revisions to CMS on 5/22/25. The SPA was approved by CMS on 6/11/25. Coordination of the corresponding regulatory action is forthcoming.

***(20) DD Waiver Telehealth Update:** This regulatory project will allow DMAS to add telehealth as a service option for individuals receiving DD waiver services, pursuant to the 2021 Appropriation Act, Item 313#18h, and the 2024 Appropriation Act, Item 288.UUUU. DMAS submitted 1915c waiver amendments to CMS that were approved on June 12, 2023, and June 18, 2024, and this regulatory action will incorporate those same changes in the Virginia Administrative Code. The project is currently circulating for internal review.

2024 General Assembly

(01) Repeal of Case Management Services for Recipients of Auxiliary Grants: This regulatory action repeals the regulations associated with case management services for assisted living facility residents receiving auxiliary grants. DMAS has not provided this service for over ten years, so the regulations are outdated and need to be repealed to align with DMAS' current practices. DMAS submitted a SPA to CMS to remove the outdated case management language from the state plan. The SPA was approved on September 11, 2024, and this regulatory action will also align the Virginia Administrative Code with State Plan language. Following internal review, the reg project was submitted to the OAG for review on 11/19/24. The OAG approved the project on 2/21/25 and subsequently, the project was submitted to DPB for review on 2/24/25.

***(02) Licensed Behavior Analysts — Credentialed Addiction Treatment Professionals:** The state plan is being amended to add Licensed Behavior Analysts (LBAs) to the definition of "Credentialed Addiction Treatment Professional." LBAs are not currently recognized by DMAS in the Addiction and Recovery Treatment Services (ARTS) program as practitioners because behavior analysts provide a broad spectrum of behavioral health services. Behavioral Analysis does, however, include a subspeciality directed at treating substance use disorders. Adding LBAs to the definition of a "Credentialed Addiction Treatment Professional," and recognizing them as a provider type under the ARTS program, helps address the shortage of available credentialed addiction treatment professionals in Virginia. Following internal and oversight agency review, the SPA was submitted to CMS on 9/4/24 and approved on 9/11/24. The corresponding regulatory project was reviewed/approved internally and submitted to the OAG on 2/6/25. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall. DMAS received inquiries from the OAG on 10/6/25.

(03) EPSDT Therapeutic Group Homes: In accordance with the 2024 Appropriations Act, Item 288.EEEEE, this SPA establishes a per diem rate to therapeutic group homes that provide services to youth with an intellectual or developmental disability in addition to a behavioral health diagnosis. Group homes that provide this higher level of service are called "Early and Periodic Screening, Diagnosis, and Treatment" (or EPSDT) Therapeutic Group Homes. The per diem rate for these facilities shall be increased by 50%, effective July 1, 2024. Following internal and oversight agency review, the SPA was submitted to CMS on 6/18/24 and approved on 9/5/24. The corresponding regulatory project is forthcoming.

(04) Supplemental Payments to Private Hospitals for Physician Services: In accordance with the Item 288.OO.9.a-c of the 2024 Appropriations Act, this SPA makes 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. Following internal and oversight agency review, the SPA was submitted to CMS for review on 11/8/24. CMS placed the SPA in a RAI status on 1/15/25. DMAS forwarded a draft response to CMS on 1/22/25.

(05) Adult Dental and 2024 Updates: This regulatory project (formerly entitled Adult Dental) adds language to the Virginia Administrative Code to implement a comprehensive dental benefit for adults, in accordance with a mandate from the General Assembly. Following internal review, the fast-track project was submitted to the OAG for review on 4/25/24.

(06) Substance Use Disorder: This regulatory action will align the Virginia Administrative Code (VAC) with DMAS' current practices. Specifically, this action will:

- Update the terminology of the Preferred Office Based Opioid Treatment (OBOT) to Preferred Office Based Addiction Treatment (OBAT) in 12 VAC 30-130-5020 and 12 VAC30-130-5040. In accordance with the 2021 Appropriations Act, Item 313.PPPPP, DMAS already expanded the substance use disorder service called OBOT (which had been available only to individuals with a primary diagnosis of opioid use disorder) to individuals with a substance-related or addictive disorder. DMAS updated the terminology in other sections of the VAC in a previous regulatory action, but inadvertently missed the references in 12 VAC 30-130-5020 and 12 VAC30-130-5040.
- Clarify requirements for the Substance Use Care Coordination as well as the role of the licensed practical nurse (LPN) in the opioid treatment program (OTP) setting to align with current practices. LPNs are permitted to provide onsite medication administration treatment during the induction phase.
- Clarify the size of SUD counseling groups to align with current practice. The group size is limited to a maximum of 12 individuals, but this may be exceed based on the clinical determination of a Credentialed Addiction Treatment Professional (CATP).
- Update provider licensing references for SUD services (ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0) to reflect current DBHDS requirements and DMAS current practices.

The project is currently circulating for internal review.

2023 General Assembly

(01) FAMIS Plan Update: This regulatory action is intended to make technical program updates, in addition to reducing the overall regulatory burden on the public in accordance with Executive Order 19. The primary advantage of these changes is that they update the regulations to align with current practices and remove outdated and unnecessary language from the Virginia Administrative Code (VAC). Following internal review, the project was forwarded to the OAG for review on 12/26/23. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(02) Pharmacists as Providers: In accordance with SB 1538 of the 2023 General Assembly, the state plan is being revised to provide reimbursement to a pharmacist, pharmacy technician, or pharmacy intern when services are (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to services and treatment in accordance with § 54.1-3303.1. Following internal review, the SPA was submitted to CMS on 10/16/23 and approved by CMS on

12/20/23. Following internal review, the corresponding regulatory project was submitted to the OAG for review on 4/25/25.

(03) State-Based Exchange: This state plan amendment explains that The Virginia General Assembly passed legislation creating the Health Benefit Exchange Division within the State Corporation Commission to oversee Virginia's transition to a Virginia State Based Exchange (SBE). The SBE is expected to go live in November, 2023. One element of this project is that DMAS must file a SPA to reflect the presence of the SBE in Virginia.

The SPA notes that the exchange will:
"… conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the SBE. The SBE will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost sharing (if applicable) or assigning a benefit package. These functions will be performed by the single state agency. The SBE also refers individuals to the single state agency for determination if potentially eligible for non-MAGI Medicaid (e.g. ABD or limited coverage) or if potentially eligible for MAGI coverage but the exchange was unable to make a full determination. The SBE will not be handling appeals." Following internal review, the SPA was submitted to CMS for review on 5/12/23. The SPA was approved on 8/7/23. Following internal review, the project was forwarded to the OAG for review on 5/15/24.

***(04) Electronic Visit Verification (EVV) for Home Health:** The purpose of this SPA is to incorporate changes to the state plan text in accordance with the requirements of the Social Security *Act* (SSA) § 1903(l) regarding EVV as applicable to home health care services across all mandates of the SSA and the *Cures Act*. Virginia is in compliance with section 12006 of the 21st Century CURES Act, which required states to implement EVV for personal care services by January 1, 2020. Section 12006 of the CURES Act requires states to implement EVV for Home Health Care Services (HHCS) by January 1, 2023. Virginia applied for and received a one-year Good Faith Effort (GFE) exemption for HHCS. As a result, Virginia implemented EVV for Home Health Care Services on July 1, 2023. Following internal review, the SPA was submitted to CMS on 8/28/23 and approved on 10/26/23. The corresponding regulatory project was submitted to the OAG on 1/17/24 for review. DMAS received OAG comments on 2/13/24, 2/16/24, 3/8/24, 4/8/24, 4/24/24, and 4/26/24 and DMAS responded to all inquiries and addressed the requested edits. A conference call with the OAG was held on 4/23/24. DMAS submitted additional revisions to the OAG on 4/24/24. More OAG questions were received on 4/26/24. Revisions were sent to the OAG for review on 5/7/24 and 5/14/24. Additional OAG comments were received on 7/22/24. DMAS coordinated responses and subsequently participated in a conf. call w/ OCL staff on 8/1/24 to discuss the project. DMAS forwarded responses to the OAG for review on 8/13/24. DMAS requested a project status update on 9/19/24. The OAG forwarded questions and requested edits on 2/19/25 and 10/3/25. DMAS is coordinating a response.

2022 General Assembly

(01) Post Eligibility Special Earnings: The 2022 Appropriations Act, Item 304.ZZ, requires DMAS to adjust the post eligibility special earnings allowance for individuals in the Commonwealth Coordinated Care Plus (CCC Plus), Community Living (CL), Family and

Individual Support (FIS), and Building Independence (BI) waiver programs to incentivize employment for individuals receiving waiver services. The purpose of this action is to incentivize employment for individuals receiving DD waiver services by allowing a percentage of earned income to be disregarded when calculating an individual's contribution to the cost of their waiver services when earning income. This enables individuals enrolled in the DD waiver to keep more of their income, without losing financial eligibility for the waiver. This does not result in new individuals being added to the DD waiver. The project was submitted to the OAG for review on 2/7/23. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(02) Medicaid Enterprise System: The purpose of this final exempt regulatory action is to make technical updates to several of the agency's regulations to reflect the Department's transition of several key information management functions handled through the Virginia Medicaid Management Information System (VAMMIS) to a new technology platform called the Medicaid Enterprise System (MES). The MES replaced the department's VAMMIS on April 4, 2022. The reg project was posted to the Town Hall on 3/7/23 for OAG review.

(03) Third Party Liability Update: This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA was submitted to CMS on 6/27/22 and approved on 7/25/22. Following internal review, the corresponding fast-track project was submitted to the OAG for review on 12/13/22. Revised regs were sent to the OAG for review on 5/30/23. Minor revisions were made to the regs and updated regs were forwarded to the OAG for review on 10/24/23. The project was approved by the OAG on 12/27/24 and submitted to DPB for review. DPB approved the project on 2/5/25 and the regs were also submitted to HHR for review on 2/5/25.

2021 General Assembly

***(01) Private Duty Nursing Services Under EPSDT:** This regulatory action updates the Virginia Administrative Code to include the following items related to private duty nursing, in accordance with a mandate from the 2021 General Assembly: services covered, provider qualifications, medical necessity criteria**,** and rates. This regulation establishes the regulatory framework for individuals with the need for high-intensity medical care. Having regulations in place (rather than just language in Medicaid manuals) helps ensure that the rules are clear and transparent, and that they are applied equally across providers, and across members. This reg action includes a service description, a list of service components, provider qualifications, and service limits (which includes references to the documents needed to establish medical necessity). Following internal review, the regs were submitted to the OAG on 8/6/21 and then to DPB on 4/6/22. After edits were made to the regulations, the project was re-submitted to the OAG on 4/26/22 and sent to DPB on 5/18/22. The project was forwarded to the Secretary's Office for review on 6/1/22. Following additional internal revisions, the regulations were sent back to HHR on 8/1/22. The reg action was forwarded to the Gov's Ofc. on 9/25/23; to the Register on 10/5/23; and was published in the Register on 10/23/23. The 30-day public comment period ended on 11/22/23 and the emergency regulation is effective beginning 10/6/23 through 4/5/25. The corresponding fast-track project, following internal review, was submitted to the OAG on 3/18/24 for review. On 5/16/25, the OAG

requested minor edits. DMAS submitted those revisions, via the Town Hall, to the OAG on 5/29/25. DMAS submitted updated budget language to the OAG on 11/10/25. The OAG approved the project on 11/19/25 and the project was moved to DPB review. DPB requested a conf. w/ DMAS on 12/3/25. A meeting is forthcoming.

***(02) School Services:** The purpose of this SPA is to adhere to the 2021 Appropriations Act, Items 313.EEEE and VVVV, which require DMAS to make changes to the state plan. These changes will: 1) increase the rates for psychiatric services by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates; and 2) increase supplemental physician payments for a freestanding children's hospital serving children in Planning District 8. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by CMS and all other Virginia Medicaid fee-for-service payments. The project was submitted to CMS on 10/18/21. The request for additional information (RAI) for this project was received from CMS on 1/4/22. DMAS' RAI response was sent to CMS on 3/30/22. The SPA was approved by CMS on 9/26/23. Following internal review, the corresponding regulatory action was forwarded to the OAG on 2/29/24. DMAS received comments/questions from the OAG and forwarded responses on 9/16/25. DMAS input edits in the RIS system and re-submitted the project to the OAG on 10/9/25.

(03) Clarifications for Durable Medical Equipment and Supplies – Revisions: This state plan amendment proposes to amend a previous SPA. DMAS previously submitted SPA 20-011 entitled "Clarifications for Durable Medical Equipment and Supplies" which was approved by CMS on October 20, 2020. Following the approval of SPA 20-011, CMS discovered duplicative wording and the necessity to re-categorize a heading on multiple pages, and also requested that DMAS submit a new SPA to revise the text on those pages. There is no change to the content or meaning of the state plan text as a result of the change. Following internal review, and the submission of the DPB and Tribal Programs notifications, the SPA was forwarded to HHR for review on 3/8/21. The SPA was approved by CMS on 5/24/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 8/26/21. The project was re-submitted to the OAG for review on 8/11/22. Additional revisions were posted to the Town Hall on 4/16/24. DMAS is awaiting further direction.

2020 General Assembly

(01) Preadmission Screening and Resident Review (PASRR) Update: In responding to the legislative mandate of the General Assembly, the purpose of this regulatory action is to establish regulatory requirements for (i) allowing qualified nursing facility staff to complete the LTSS screening for an individual who applies for or requests LTSS, and who is receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital; and (ii) protecting an individual's choice for institutional or community based services and choice of provider. Following internal review, the project was submitted to the OAG for review on 1/5/21. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/14/21. Additional revisions were submitted on 4/28/21. The project was submitted to DPB for review on 6/16/21 and to HHR on 6/29/21. The regs were forwarded to the Governor on 11/20/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21; published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until

8/15/23. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22. DMAS received inquiries from the OAG on 12/16/22, 1/3/23, 1/9/23, 1/25/23, 2/9/23, 2/13/23, 3/2/23, and 3/13/23. DMAS submitted responses to the multiple OAG requests for edits and is awaiting further direction. On 6/15/23, DMAS requested an emergency reg extension and notified the OSHHR of the request. On 6/20/23, the Gov.'s Ofc. approved extending the emergency regulation until 2/14/24. On 4/17/24, the OAG posed additional questions and DMAS submitted responses on 4/25/24. On 5/1/24, DMAS forwarded revised regulations and informed the OAG that the revisions are available for review. Revisions were made to the project on 5/29/25 and an updated agency background document was uploaded to the Town Hall.

(02) 90-Day Prescriptions: The recent Medicaid Disaster Relief SPA allowed DMAS to provide 90-day prescriptions to Medicaid members (excluding Schedule II drugs), however, that SPA will end on the last day of the federal-declared emergency period. DMAS is filing a SPA to allow for the provision of a maximum of a 90-day supply for select maintenance drugs dispensed to Medicaid members (excluding Schedule II drugs) after the end of the federal emergency period. The 90-day supply will be available to Medicaid members after the member has received two (2) fills of 34 days or less of the drug. Following internal review, the SPA was filed with CMS on 11/9/20 and approved on 12/10/20. Following internal review, the corresponding regulatory action was submitted to OAG on 1/28/21. Status inquiries were forwarded to the OAG on 7/1/21, 8/10/21, 8/24/21, 9/14/21, 1/25/22, 3/9/22, 4/13/22, and 7/12/22. The project's economic impact form was uploaded to the Town Hall on 9/30/22.

Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.