COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)

November 15, 2025

MEMORANDUM

TO: The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Supplemental Provider Payment Requirements Report

This report is submitted in compliance with Item 288.QQQQQ.1. of the 2025 Appropriations Act, which states:

Effective, January 1, 2026, the Department of Medical Assistance Services (DMAS) is authorized to establish objective and measurable performance measures for acute care hospitals that are receiving private acute care hospital enhanced payments authorized in § 3-5.15 of this act. These measures shall assess whether the additional payments improve services for Medicaid members. Specifically, DMAS shall include requirements to ensure access to care by Medicaid members through network adequacy requirements to prevent a hospital from reducing its service offerings in a manner that would have an adverse impact on Medicaid members in the community. In addition, DMAS shall include requirements to ensure improved coordination of care for behavioral health patients, including continued participation by hospitals in the acute bed registry. DMAS shall establish a process for measuring progress and may include a process to allow for corrective actions required for hospitals that do not achieve the specific performance measures established by DMAS. DMAS is authorized to measure progress toward these performance measures on a quarterly basis, unless DMAS determines that a specific measure is more appropriately measured on a longer timeframe. DMAS shall consult with impacted stakeholders in developing the performance measures and associated processes. A hospital that does not achieve the specific performance measures established by DMAS and is not able to fulfill the necessary corrective actions in the timeframe required by DMAS, shall lose eligibility for private acute care hospital enhanced payments for the associated period as determined by DMAS. DMAS shall submit a report to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees on the measures established and associated processes by November 15, 2025.

Should you have any questions or need additional information, please feel free to contact me at

(804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Supplemental Provider Payment Requirements Report

November 2025

Report Mandate:

Item 288.QQQQQ.1 of the 2025 Appropriation Act states: Effective, January 1, 2026, the Department of Medical Assistance Services (DMAS) is authorized to establish objective and measurable performance measures for acute care hospitals that are receiving private acute care hospital enhanced payments authorized in § 3-5.15 of this act. These measures shall assess whether the additional payments improve services for Medicaid members. Specifically, DMAS shall include requirements to ensure access to care by Medicaid members through network adequacy requirements to prevent a hospital from reducing its service offerings in a manner that would have an adverse impact on Medicaid members in the community. In addition, DMAS shall include requirements to ensure improved coordination of care for behavioral health patients, including continued participation by hospitals in the acute bed registry. DMAS shall establish a process for measuring progress and may include a process to allow for corrective actions required for hospitals that do not achieve the specific performance measures established by DMAS. DMAS is authorized to measure progress toward these performance measures on a quarterly basis, unless DMAS determines that a specific measure is more appropriately measured on a longer timeframe. DMAS shall consult with impacted stakeholders in developing the performance measures and associated processes. A hospital that does not achieve the specific performance measures established by DMAS and is not able to fulfill the necessary corrective actions in the timeframe required by DMAS, shall lose eligibility for private acute care hospital enhanced payments for the associated period as determined by DMAS. DMAS shall submit a report to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees on the measures established and associated processes by November 15, 2025.

Executive Summary

This report fulfills the mandate outlined in Item 288.QQQQQ.1 of the 2025 Appropriation Act, which directs Virginia's Department of Medical Assistance Services ("DMAS") to establish performance standards for acute care hospitals that are receiving private acute care hospital enhanced payments.

These standards are designed to ensure that supplemental payments lead to measurable improvements in Medicaid service delivery, particularly in access to care and behavioral health coordination. The following are the three performance measures selected by DMAS:

- Network Adequacy Safeguard for Critical Service Transitions
- Acute Bed Registry Attestation
- Substance Use Disorder - Screening, Brief Intervention and Referral to Treatment (SBIRT) and Training

This report outlines the framework for monitoring hospital compliance, including a phased corrective action process, and provides a roadmap for implementation leading up to the January 2026 launch. Through this report, DMAS affirms its commitment to transparency, accountability, and improved outcomes for Medicaid members.

The three core objectives of the performance measures:

- Improve services for Medicaid members;
- Ensure access to care, particularly through network adequacy safeguards; and
- Enhance coordination of care for behavioral health patients, including continued participation in the acute psychiatric bed registry.

To guide the development of these measures, DMAS is required to consult with impacted stakeholders and implement a process for monitoring compliance and enforcing corrective actions. Private acute care hospitals that fail to meet the established benchmarks and do not complete the required corrective actions within the designated timeframe will risk losing eligibility for enhanced payments for the applicable period.

Stakeholder Engagement Strategy

DMAS partnered with VHHA to engage private acute care hospitals, streamlining communication to the 63 private acute care hospitals affected by the changes. VHHA served as a liaison, communicating the goals and impacts of the performance measures and gathering recommendations for DMAS. DMAS reviewed and determined appropriateness and feasibility, making any needed adjustments that align with DMAS goals and objectives.

To aid understanding, DMAS developed and distributed a one-page summary of measure domains, compliance processes, legislative reporting requirements, and the implementation timeline for stakeholder review. As implementation continues, DMAS is actively identifying appropriate ways to engage private acute care hospitals throughout the implementation process.

Performance Measures

DMAS has finalized a set of performance measures to evaluate whether enhanced payments to private acute care hospitals result in improved services for Medicaid members in the specific areas outlined in the legislation (e.g., bed registry, network adequacy, and behavioral health coordination).

1. Network Adequacy Safeguard for Critical Service Transitions

Measure or Requirement: Hospitals are an essential component of access to care for Medicaid members, especially maternal care, care for children, and behavioral health. Therefore, to

ensure appropriate access, private acute care hospitals make strong efforts to contract with all DMAS contracted managed care organizations (MCOs), and if a contract is not in place, the private acute care hospitals will provide out-of-network access to Medicaid members at fee-for-service rates. For maternal care, all private acute care hospitals will engage in discussions with MCOs, DMAS, and other community providers to establish programs to ensure maternal access to care in the communities they serve, which may include services such as providing after-hours maternity care access.

Private acute care hospitals must also provide DMAS with at least 120 days' advanced written notice prior to eliminating or closing service delivery. For Labor and Delivery, Inpatient Behavioral Health, Pediatrics, Cardiology, Rehabilitation, and Oncology, hospitals will also be required to submit a transition report to DMAS that includes the following:

- Service utilization data for the affected area
- A description of a planned transition of and referral sources for the impacted services

Fulfilled Requirements of Item QQQQQ.1 of the 2025 Appropriation Act: DMAS "shall include requirements to ensure access to care by Medicaid members through network adequacy requirements to prevent a hospital from reducing its service offerings in a manner that would have an adverse impact on Medicaid members in the community".

Rationale for Measure or Requirement Selection: This measure is designed to safeguard access to essential services for Medicaid members by requiring hospitals to proactively plan for and mitigate the impact of service reductions or eliminations. It promotes continuity of care and ensures that hospitals remain accountable for maintaining adequate service levels in areas where Medicaid members depend heavily on acute care infrastructure. DMAS will also work with the Virginia Department of Health, Office of Licensure and Certification to assess the impact of these private acute care hospital service level changes on community access.

2. Acute Bed Registry Attestation

Measure or Requirement: Private acute care hospitals must certify their active participation in the acute psychiatric bed registry during each reporting period. This attestation confirms that hospitals are consistently updating and utilizing the registry to support behavioral health coordination.

Fulfilled Requirements of Item QQQQQ.1 of the 2025 Appropriation Act: DMAS "shall include requirements to ensure… continued participation by hospitals in the acute bed registry."

Rationale for Measure Selection: Participation in the acute psychiatric bed registry is essential for ensuring timely access to inpatient psychiatric services for Medicaid members. By requiring hospitals to attest to their ongoing use of the registry, DMAS promotes real-time tracking of bed

availability, facilitates efficient patient placement, reduces delays in care, and supports improved behavioral health outcomes. This measure reinforces hospitals' role in maintaining service coordination for Medicaid members with behavioral health needs. DMAS will work with the Department of Behavioral Health and Developmental Services to develop and/or review the process for compliance oversight.

3. Substance Use Disorder - Screening, Brief Intervention and Referral to Treatment (SBIRT) and Training

Measure or Requirement: Private acute care hospitals must submit a regular report detailing their implementation of SBIRT. The report will require hospitals to submit the number of staff trained in SBIRT procedures. This report confirms that hospitals are actively training eligible staff who can identify people who use substances or those at risk of substance misuse and addiction, supporting workforce development, and improving care transitions for individuals with substance use disorders. This will also lead to SBIRT billing code and rate review, to monitor outcomes for members. DMAS will work with private acute care hospitals to develop appropriate timelines and reporting.

Fulfilled Requirements of Item QQQQQ.1 of the 2025 Appropriation Act: DMAS shall "include requirements to ensure improved coordination of care for behavioral health patients."

Rationale for Measure Selection: Coordinated care across the care continuum is essential for improving outcomes in behavioral health. By ensuring seamless transitions between providers and service settings, hospitals can reduce gaps in care and enhance patient engagement. Coordinated care also helps reduce unnecessary readmissions and promotes sustainable, long-term outcomes for Medicaid members. SBIRT is an evidence-based practice for screening, brief intervention, and referral to treatment used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Integrating SBIRT can lead to earlier detection of substance use issues, reduce related healthcare expenses, and improve patient outcomes by ensuring timely access to appropriate care. This also supports the training of staff in the hospitals to support this screening framework.

Evaluation and Monitoring Framework

To ensure accountability and continuous improvement, DMAS will implement a structured evaluation and monitoring framework for the established performance measures and requirements. DMAS is still finalizing the measure specifications and reporting mechanisms and timeline, which will inform the timing of performance reviews and may trigger corrective action if gaps in compliance are identified. As part of its initial approach, DMAS developed a Corrective Action Plan (CAP) framework to monitor compliance and address performance gaps. Key activities associated with the CAP framework include:

- **Scheduled Deadlines**: DMAS will establish regular reporting deadlines in advance (e.g., quarterly or as needed).
- **Initial Review**: DMAS will review data submissions and issue written notice of non-compliance for late or insufficient submissions to private acute care hospitals, as needed.
- **Hospital Response Window**: The hospitals will have a designated period to respond with corrections. The designated period may vary depending on the severity of the non-compliance.
- **Secondary Review**: DMAS will review the hospital's response and determine whether the issue is resolved.
    - If resolved, no further action is needed. DMAS will track the issue to ensure it is addressed in future submission cycles.
    - If unresolved, a formal CAP must be submitted.
- **CAP Submission**: Hospitals will have a designated period to submit a CAP using technical guidance provided by DMAS, which may vary based on the severity of the issue.
- **CAP Approval**: DMAS will review the CAP and either approve the CAP or request resubmission.
- **Monitoring and Check-ins**: DMAS will actively monitor CAP implementation and establish an agreed-upon check-in schedule.
- **Payment Contingency**: No payments will be issued until the CAP is approved and the area of non-compliance is corrected as verified by DMAS.

This framework allows for early intervention, structured support, and continuous monitoring to help PAC hospitals meet performance expectations while maintaining alignment with the goals. DMAS will finalize timelines and distribute them to hospitals prior to implementation. Technical assistance will also be provided to the hospitals during implementation and ongoing submissions. If included in future arrangements, critical access hospitals may require a separate compliance process tailored to their specific circumstances given their distinct operational constraints and more limited resources.

Implementation Roadmap

DMAS will begin preparations for these new performance standards in 2026. This includes refining compliance and CAP processes, developing data collection tools, and providing guidance to meet expectations. The implementation of the performance measures follows a phased approach:

- **June - November 2025**: DMAS engaged stakeholders, selected measures, and submitted the report to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees.
- **November 2025 - June 2026**: DMAS will work with prepare private acute care hospitals for implementation of the new performance standards.
- **July 2026 and on**: DMAS will conduct reviews to monitor compliance and enforce corrective actions as needed.

Through this work, DMAS affirms its commitment to advancing a program that delivers measurable value, strengthens hospital accountability, and, most importantly, improves the health and well-being of the Virginians it serves.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 1.7 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.