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HOUSE BILL NO. 1452

Offered January 22, 2026

A BILL to amend the Code of Virginia by adding a section numbered 32.1-325.1:2, relating to Department of Medical Assistance Services; expedited review process for Medicaid service authorization requests; report.

Patrons—Anthony, Laufer, Cole, N.T., Henson and Schmidt

Referred to Committee on Health and Human Services

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-325.1:2 as follows:

§ 32.1-325.1:2. Expedited Medicaid service authorization process.

A. The Department shall, conditional on the receipt of all necessary approvals and the securing of federal financial participation pursuant to subsection D, establish an expedited review process for Medicaid service authorization requests involving time-sensitive, life-sustaining treatment when a delay in issuance of such service authorization would pose a significant risk to the health or safety of an individual. Such expedited review process shall include:

1. Review timeframes consistent with the level of medical urgency of the service authorization request;

2. Documentation and verification requirements;

3. Prioritization for hospital discharge planning, continuity of care, or emergency circumstances;

4. Criteria for ineligibility for expedited review; and

5. Any additional requirements or procedures determined necessary by the Department to implement the provisions of this section.

B. A service authorization request shall be eligible for expedited service authorization review pursuant to subsection A if the provider obtains a certification of medical urgency from a physician duly authorized to practice medicine in the Commonwealth or other licensed health care professional authorized to order or recommend treatment. The certification required pursuant to this subsection shall describe (i) the circumstances indicating medical urgency and (ii) the potential risk of harm associated with a delay in service authorization.

C. Implementation of the expedited review process established pursuant to subsection A shall not be construed to:

1. Guarantee approval of any request under review;

2. Create a new entitlement to coverage or payment;

3. Expand the scope of Medicaid benefits;

4. Alter existing medical necessity criteria;

5. Create a private cause of action; or

6. Require the Department to:

a. Accept incomplete or insufficient certifications of medical urgency required pursuant to subsection B;

b. Conduct new data collection, medical testing, or environmental monitoring;

c. Obtain or provide medical equipment; or

d. Engage consultants for implementation of this section.

D. The Department shall submit state plan amendments, apply for waivers, issue or amend guidance documents and provider manuals, and adopt or amend regulations as may be necessary to implement the provisions of this section and to secure federal financial participation for state Medicaid expenditures under the federal Medicaid program. The expedited review process established pursuant to subsection A shall be contingent on securing all necessary federal approvals and federal financial participation as may be necessary to implement the provisions of this section.

E. The Department shall report annually by November 1 to the House Committee on Appropriations, the Senate Committee on Finance and Appropriations, the House Committee on Health and Human Services, and the Senate Committee on Education and Health on the implementation of the expedited service authorization review process established pursuant to this section. Such report shall include:

1. The number of requests subject to expedited review;

2. Data on the timeframes for responding to requests;

3. The number of approvals and denials of requests, including primary reasons for denials;

4. Any barriers to implementation; and

5. Recommendations for improvement of the process.

2. That if the Department of Medical Assistance Services does not receive the necessary approval or federal financial participation from the Centers for Medicare and Medicaid Services to implement the

provisions of this act, then the provisions of this act shall expire on July 1, 2027.