1998 Session

Budget Bill - SB29 (Introduced)

Bill Order » Office of Health and Human Resources » Item 322

Department of Medical Assistance Services

Item 322 (Not set out)

	First Year - FY1997	Second Year - FY1998
Medical Assistance Services (Medicaid) (45600)	**$2,256,387,779**	**$2,321,357,441**
Nonmandatory Mental Health and Mental Retardation Services (45607)	$195,334,717	$188,406,773
Nonmandatory Mental Health, Mental Retardation and Substance Abuse Community Based Services (45608)	$111,145,265	$122,616,760
Professional and Institutional Services (45609)	$1,913,267,375	$1,972,362,332
Mental Illness Services (45610)	$36,640,422	$37,971,576
Fund Sources:		
General	$1,095,936,346	$1,126,328,546
Special	$50,000	$50,000
Federal Trust	$1,160,401,433	$1,194,978,895

Authority: P.L. 89-87, as amended, Title XIX, Social Security Act, Federal Code; Title 32.1, Chapters 9 and 10 Code of Virginia.

A. It is the intent of the General Assembly to develop and cause to be developed appropriate, fiscally responsible methods for addressing the issues related to the cost and funding of long-term care. It is the further intent of the General Assembly to promote home-based and community-based care for individuals who are determined to be in need of nursing facility care.

B. The Director of the Department of Medical Assistance Services shall seek the necessary waivers from the United States Department of Health and Human Services to authorize the Commonwealth to cover a range of non-institutional, long-term care services which may provide less expensive alternatives to institutional care.

C.1. The appropriation includes $94,874,270 the first year from the general fund and $100,460,447 from the federal trust fund and $91,414,966 the second year from the general fund and $96,991,807 from the federal trust fund for reimbursement to the institutions within the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall be reimbursed for the federal share of general salary scale adjustments approved by the General Assembly.

2. The appropriation includes for the first year $25,074,028 from the general fund and $26,550,490 from the federal trust fund, and for the second year $25,799,662 from the general fund and $27,373,591 from the federal trust fund for reimbursement to the Department of Mental Health, Mental Retardation and Substance Abuse Services for the Mental Retardation Waiver. The appropriation also includes for the first year $28,909,199 from the general fund

and $30,611,548 from the federal trust fund and for the second year $33,693,990 from the general fund and $35,749,517 from the federal trust fund for reimbursement to the Department of Mental Health, Mental Retardation and Substance Abuse Services for the "State Plan Option" community mental health and mental retardation services.

3. The Board of Medical Assistance Services shall promulgate regulations, subject to approval by the Health Care Financing Administration (HCFA), to grant the skilled nursing facilities of the Department of Mental Health, Mental Retardation and Substance Abuse Services an exception to routine cost limits normally required by HCFA in connection with Medicaid payments to institutional providers.

D. The State Board of Medical Assistance Services shall develop amendments to the State Plan for Medical Assistance and seek the Health Care Financing Administration's approval to provide that:

1. Effective July 1, 1996, the Virginia Medicaid program will change the preauthorization requirement for incontinence supplies from greater than three cases per month to greater than two cases per month. Also effective July 1, 1996, the rates paid by the Virginia Medicaid program for all items of durable medical equipment shall be reduced by 4.5 percent, except that no adjustment shall be made in the rates paid for nutritional supplements.

2.a. The Department of Medical Assistance Services, in cooperation with affected provider groups, shall conduct a study: (i) to determine the distribution and identity of costs of providing specialized care services; (ii) to develop a payment methodology with flexibility in rates based upon varying levels of care, varying lengths of stay, and varying costs in different areas of the state; and (iii) to develop a payment methodology that encourages delivery of quality specialized care services through the use of appropriate financial incentives. The study shall conclude and the Department of Medical Assistance Services shall establish appropriate rates for specialized care services . The Department shall promulgate regulations, to be effective July 1, 1997, to implement such rates and to implement other appropriate changes in service limits, program category criteria, utilization control methods, and provider contract standards consistent with the recommendations of the study.

b. The Department of Medical Assistance Services, in establishing rates for specialized care services, shall not reduce rates or the relevant parts of the Medicaid base budget for nursing facilities below the actual savings or appropriate cost for specialized care services determined by the study referenced in paragraph a.

c. The Department of Medical Assistance Services shall submit to the Chairmen of the House Appropriations and Senate Finance Committees a report by October 1, 1996, regarding the results of the study pursuant to paragraph a., the methodology determined to establish specialized care rates, the rates determined for specialized care, and the expected achievement of savings.

d. This section is not applicable to payment methodologies for specialized care services in long-stay hospitals.

3. The Department of Medical Assistance Services shall amend its regulations governing nursing home reimbursement to be effective July 1, 1997, to implement an adjustment to the nursing home operating rate for the additional reasonable costs of care of nursing home residents who are victims of traumatic brain injuries. This rate adjustment shall be applicable only to residents with traumatic brain injuries and related behavioral problems to be defined in regulation, and who are in a unit of a nursing home that meets the criteria of a traumatic brain injury unit, also to be established in regulation. Among these criteria shall be the condition that a traumatic brain injury unit must be a unit of not less than 20 beds.

4.a. Effective on or after July 1, 1996, the Department of Medical Assistance Services shall implement the following: continued enhancements to the prospective drug utilization review (pro-DUR) program; application of the pro-DUR to the long-term care community; and expanded implementation of a disease state management program. The Department shall establish a Medicaid Pharmacy Liaison Committee composed of representatives from the following organizations: Community Pharmacy, Long-Term Care/Consultant Pharmacy, the Virginia

Pharmacists Association, the Virginia Association of Chain Drug Stores, and the Pharmaceutical Research and Manufacturers of America. The Committee will work with the Pharmacy Division of the Department and the Prior Authorization Advisory Committee, both in the implementation of the above initiatives and to investigate the implementation of additional quality, cost-effective health care initiatives. The Department, in cooperation with the Committee, shall report on their progress annually to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees.

b. The Department shall study, in collaboration with the Medicaid Pharmacy Liaison Committee, the adequacy of current reimbursement rates as they relate to cognitive services provided by pharmacists.

5. Effective on or after July 1, 1996, the Virginia Medical Assistance Program shall provide expanded state plan option services for community-based mental health, mental retardation, and substance abuse services to be provided by Community Services Boards.

6. The Department of Medical Assistance Services shall promulgate regulations, to be effective July 1, 1997, to implement consumer-driven personal assistance services to Virginians who are eligible to participate in the Department of Rehabilitative Services' personal assistance program and who are determined to be at-risk of nursing home placement in the near future. The regulations shall set forth the target populations, freedom of choice and appeal rights, program criteria, the assessment and authorization process, the range of services to be provided, provider eligibility and enrollment, quality assurance procedures and utilization control, and the role of the fiscal agent and reimbursement. The Department shall follow the procedures of Article 2 of the Administrative Process Act as set forth in §9-6.14:7.1, Code of Virginia, in promulgating regulations to implement these services for other Virginians who may be eligible for the program.

7. The Board of Medical Assistance Services shall promulgate regulations, which shall be effective July 1, 1997, to amend the state plan for medical assistance to reimburse licensed clinical psychologists, licensed clinical social workers and licensed professional counselors, as required by Virginia Code § 32.1-325.

8. Effective on July 1, 1997, the Department of Medical Assistance Services shall expand coverage of school-based health services for children with special education needs to include up to two meetings annually for the purposes of developing the Individualized Education Program and skilled nursing sessions provided by or under the supervision of a registered nurse.

E. Out of this appropriation, the Department of Medical Assistance Services shall provide coverage of intensive assisted living care to residents of licensed Adult Care Residences who are Auxiliary Grant recipients. The per diem reimbursement shall not exceed $180 per person per month. Individuals entitled to benefits under this section are not entitled to benefits under Item 324.

F. Effective on and after July 1, 1996, the Virginia Medical Assistance Program shall provide coverage of investigations by local health departments to determine the source of lead contamination . Out of this appropriation funding shall be provided for the screening and treatment of Medicaid-eligible children who have been diagnosed with elevated blood levels. Only costs that are eligible for federal funding participation in accordance with current federal regulations shall be covered. Payments for environmental investigations under this section shall be limited to no more than two visits per residence.

G. It is the intent of the General Assembly that upon the repeal of Title XIX of the Social Security Act and enactment of Title XXI of the Social Security Act, which is expected to establish state MediGrant programs, or upon passage and signature of any federal legislation that makes or permits reductions in funds or services in the Medicaid program, the Board of Medical Assistance Services shall develop a plan for providing Medicaid assistance to the poor, in compliance with the federal changes. Prior to the development of such plan, the Department shall conduct a public education program to explain the federal changes to the recipient community, and shall include a mechanism for obtaining public input. The Department's plan shall be presented to the Chairmen of the House

Appropriations Committee, the House Health, Welfare and Institutions Committee, the Senate Finance Committee, the Senate Committee on Education and Health, the Commission on Federal Block Grant Programs, and the Joint Commission on Health Care by October 1, 1996, if federal changes are approved by that date. No changes in the current Medicaid state plan, related to these federal changes, shall be made prior to the 1997 General Assembly's approval of the Department's plan.

H. Out of this appropriation, $50,000 in Special Fund Revenue is appropriated in each year of the biennium to the Department of Medical Assistance Services for the administration of the disbursement of civil money penalties levied against and collected from Medicaid nursing facilities for violations of rules identified during survey and certification as required by federal law and regulation. Based on the nature and seriousness of the deficiency, the Agency or the Health Care Financing Administration may impose a civil money penalty, consistent with the severity of the violations, for the number of days a facility is not in substantial compliance with the facility's Medicaid participation agreement. Civil money penalties collected by the Commonwealth must be applied to the protection of the health or property of residents of nursing facilities found to be deficient. Penalties collected are to be used for (1) the payment of costs incurred by the Commonwealth for relocating residents to other facilities; (2) payment of costs incurred by the Commonwealth related to operation of the facility pending correction of the deficiency or closure of the facility; and (3) reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or individuals used by the facility to provide services to residents. These funds are to be administered in accordance with the revised federal regulations and law, 42 CFR 488.400 and the Social Security Act § 1919(h), for Enforcement of Compliance for Long-Term Care Facilities with Deficiencies. Any Special Fund Revenue received for this purpose, but unexpended at the end of the fiscal year, shall remain in the fund for use in accordance with this provision.

I. Effective on and after July 1, 1996, the State Plan for Medical Assistance shall provide for a co-payment of $6 from all Medicaid recipients for use of a hospital emergency room except that no co-payment shall be required from Medicaid recipients who are under 21 years of age, recipients who are seeking treatment for a pregnancy-related service, and recipients who are seeking treatment for a bona fide emergency.

J. 1. Effective July 1, 1996, the Board of Medical Assistance Services shall adopt regulations necessary to implement a fully prospective reimbursement system for hospital inpatient services. Reimbursement rates for most inpatient services shall be based on a Diagnosis Related Groups (DRG) methodology. The Board shall revise and promulgate its regulations, to be effective July 1, 1997, governing its appeals and utilization control measures (preauthorization and utilization review) so as to make them consistent with a prospective DRG reimbursement methodology. A schedule for the transition from the current reimbursement methodology to the fully prospective DRG methodology shall be established in the regulations. The regulations shall include provisions that: (i) eliminate the 21-day cap on length of stay for adults for those services to be governed under a prospective, case-based payment methodology; and (ii) recalibrate (evaluate and adjust the weights assigned to cases) and rebase (review and update as appropriate the cost basis on which the base rate is developed) the DRG system at least every other year. As it develops regulations to implement the new reimbursement methodology, the Department shall consult with affected provider groups.

2. The Director of the Department shall appoint a Medicaid Hospital Payment Policy Advisory Council to develop recommendations to the Board on such issues as: update/inflation factors, incorporation of capital and medical education costs, rebasing/recalibration mechanisms, and timing/final design of outpatient prospective payment systems. The Advisory Council shall include four hospital/health system representatives nominated by the Virginia Hospital and Healthcare Association, two senior Department staff, and one representative each from the Department of Planning and Budget and the Joint Commission on Health Care.

K. Effective on and after July 1, 1996, the Department of Medical Assistance Services shall implement a fully prospective reimbursement system for outpatient rehabilitation services. This reimbursement system shall use an Ambulatory Patient Groups (APG) methodology. The Board of Medical Assistance Services shall issue such regulations as are necessary for implementation of the reimbursement methodologies.

L.1. The Department of Medical Assistance Services shall delay the expansion of the MEDALLION II managed care, capitated program into the Northern Virginia region until May 1, 1997.

2.a. With the aid of an outside party that has expertise in services for the mental health, mental retardation, and substance abuse populations, the Department, working jointly with the Department of Mental Health, Mental Retardation and Substance Abuse Services, Community Services Boards, providers, consumers and family members, local governments and health maintenance organizations in the Northern Virginia region, shall develop alternative patient-focused models for the inclusion of the mentally disabled population in a mandatory managed care product. One of the alternative models shall provide for the administration, delivery and funding for behavioral health care to be separate from all other health care. The analysis of each model should include the advantages and disadvantages of the model, both financial and administrative, for the population involved and for Virginia's publicly funded mental health system and implementation strategies for each. The workplan for the effort and an interim and final report shall be submitted to the Joint Commission Studying the Publicly Funded Mental Health System and to the Chairmen of the following committees: House Appropriations; House Health, Welfare and Institutions; Senate Finance; Senate Education and Health; and the Joint Commission on Health Care. The Department of Medical Assistance Services shall submit an interim report by September 1, 1996, and the final report by December 18, 1996.

b. The Department of Medical Assistance Services shall expand MEDALLION II managed care in Northern Virginia. In doing so; (i) the Department shall retain fee-for-service reimbursement for all outpatient mental health treatment services provided by physicians, practitioners and clinics, with limited exceptions which the Department may find necessary to ensure appropriate care by managed care providers; (ii) mental health, mental retardation, and substance abuse rehabilitation services shall continue to be provided by Community Services Boards; and (iii) persons receiving services under the mental retardation waiver program shall be excluded from mandatory managed care. Services exempted from managed care, specified in L.2.b.(i),(ii), and (iii) of this item, shall be subject to revision upon completion of recommendations from the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation, and Substance Abuse Services and approval of the General Assembly. The Director of the Department of Medical Assistance Services shall seek the necessary waiver from the Health Care Financing Administration to effect this policy and shall promulgate the necessary regulations, which shall be effective November 1, 1997.

3. The Department of Medical Assistance Services shall submit a quarterly report of the status of the MEDALLION II program to the Chairmen of the following committees: House Appropriations, House Health, Welfare and Institutions, Senate Finance, Senate Education and Health, the Joint Commission on Health Care, and the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation, and Substance Abuse Services. Each report shall include a status report and recommendation regarding the following issues related to MEDALLION II: (i) assurance of provider compliance with marketing requirements; (ii) participation of public health care providers in capitated plans; (iii) prevention of adverse risk selection against high-cost clients; (iv) coordination of services for at-risk, frail, and disabled recipients; (v) quality assurance procedures in general, and in particular, for aged, blind, and disabled clients; (vi) progress on development of appropriate policies for Medicaid funding of graduate medical education programs and disproportionate share hospitals; and (vii) the provision of Medicaid-funded behavioral health care. The reports shall be submitted quarterly beginning July 1, 1997.

4. The Department of Medical Assistance Services shall evaluate the feasibility of expanding the MEDALLION II program to include medically underserved areas in the Tidewater region and surrounding areas. The Department shall submit a report of its findings and recommendations to the Chairmen of the following committees: House Appropriations; House Health, Welfare and Institutions; Senate Finance; Senate Education and Health; and the Joint Commission on Health Care by October 1, 1996. It is the intent of the General Assembly that the Department shall not further expand into the Tidewater region until May 1, 1997, and shall incorporate the findings of the models being constructed for Northern Virginia, as specified in paragraph 2 above.

5. In addition to the quarterly report, the Department of Medical Assistance Services shall contract for an independent evaluation of the MEDALLION II program in the Tidewater area after its first six months of operation. The evaluation shall specifically include the following criteria: (i) a consumer satisfaction survey stratified by population group; (ii) preliminary fiscal impact analyses including costs and savings to the Medicaid program and costs and margins to the contracting health maintenance organizations; (iii) determination of the reliability and completeness of patient encounter data; (iv) enrollment and disenrollment figures and apparent patterns; (v) provider and consumer complaints logged and the Department's responses; and (vi) health maintenance organizations affiliations with public providers. The results and recommendations from the evaluation shall be reported to the Chairmen of the following committees: House Appropriations; House Health, Welfare and Institutions; Senate Finance; Senate Education and Health; and the Joint Commission on Health Care by September 1, 1996.

6. It is the intent of the General Assembly that other than as specified in paragraphs L.1. and L.4. above, the Department shall not expand the program beyond the current Tidewater localities.

7. Emergency care provided to a member of a Medicaid managed care, capitated program by a non-participating provider in the member's managed care network will be reimbursed according to the current Medicaid fee schedule. This reimbursement shall be considered payment in full.

M. If any part, section, subsection, paragraph, clause, or phrase of this item or the application thereof is declared by the United States Department of Health and Human Services or the Health Care Financing Administration to be in conflict with a federal law or regulation, such decisions shall not affect the validity of the remaining portions of this item, which shall remain in force as if this item had passed without the conflicting part, section, subsection, paragraph, clause, or phrase. Further, if the United States Department of Health and Human Services or the Health Care Financing Administration determines that the process for accomplishing the intent of a part, section, subsection, paragraph, clause, or phrase of this item is out of compliance or in conflict with federal law and regulation and recommends another method of accomplishing the same intent, the Director of the Department of Medical Assistance Services, after consultation with the Attorney General, is authorized to pursue the alternative method.

N. The Department of Medical Assistance Services shall provide coverage of hospice services through the Medicaid Hospice Benefit at current funding levels, or higher if necessary to meet patient needs. The Department shall provide guidelines to MEDALLION II health maintenance organizations (HMOs) for hospice patient referral from an HMO to a licensed and certified Medicaid or Medicare hospice provider. These guidelines will be in addition to the current Medicaid hospice admission criteria and will include considerations of medical appropriateness, and patient and family choice.

O. Under MEDALLION II and OPTIONS, managed care plans shall be marketed to recipients, and recipients shall be enrolled in such plans, exclusively through an independent marketing broker paid by the Department of Medical Assistance Services. The independent marketing broker shall be known as the Medicaid Managed Care Health Benefits Manager, whose duties shall include: (i) outreach and education to assure that recipients understand the choices among managed care plans that are available to them; (ii) enrollment of recipients in the managed care plan of their choice; (iii) education to assure that recipients understand their rights and responsibilities under the terms of their chosen managed care plan and under the Medicaid program; and (iv) operation and documentation of a toll-free recipient service hotline to receive and resolve recipient complaints.

P. Included in this appropriation is $40,886,011 from the general fund and $43,293,546 from nongeneral funds the first year and $40,869,175 from the general fund and $43,310,382 from nongeneral funds the second year for Medicaid payments for the University of Virginia Medical Center. In the event that additional funding is available through projected balances in the Department of Medical Assistance Services' budget, the cited amounts may be increased.

Q. Included in this appropriation is $71,560,979 from the general fund and $75,774,781 from nongeneral funds the first year and $71,531,511 from the general fund and $75,804,249 from nongeneral funds the second year for Medicaid payments for the Medical College of Virginia Hospitals Authority. In the event that additional funding is available through projected balances in the Department of Medical Assistance Services' budget, the cited amounts may be increased.

R. The Department of Medical Assistance Services and the Department of Social Services, in cooperation with local departments of social services, shall study the cost to the local departments of social services for administering the Department of Medical Assistance Services' regulations on guardianship. A report shall be provided to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 1997.

S. The Department of Medical Assistance Services shall amend its regulations governing the coverage of anorexiant drugs, to be effective July 1, 1997, to allow for coverage of anorexiant drugs for recipients: (i) who meet the strict disability standards for obesity established by the Social Security Administration, and (ii) whose condition is certified as life-threatening by the treating physician. Coverage of the anorexiant drug for the above reasons shall be subject to prior authorization.

T. The Department of Medical Assistance Services shall conduct an analysis of the cost of services in the personal care program, including the cost of compliance with criminal records checks and hepatitis B vaccines. To conduct this analysis, the Department may require all or a sample of providers to submit financial reports which identify the cost of services provided by these agencies. Results of the analysis shall be reported to the Governor and to the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 1997.

U. The Department of Medical Assistance Services shall study the availability of dentists accepting Medicaid payments. The study shall include identification of geographic areas of the state with the greatest shortages and recommendations for improving access to dental care for Medicaid recipients. The report shall be provided to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 1997.

V.1. The following is the policy of the Commonwealth with respect to aliens in accordance with §411(d) of Public Law 104-193.

2. Through June 30, 1997, alien coverage under the State Plan for Medical Assistance will remain as it was on August 21, 1996. Beginning on July 1, 1997, the State Plan for Medical Assistance will include all optional groups of aliens as permitted under Public Law 104-193 who arrived in the United States prior to August 22, 1996. All aliens who arrived in the United States on or after August 22, 1996, shall be eligible after June 30, 1997, only for services mandated by Public Law 104-193.

3. All aliens receiving Medicaid and residing in long-term institutional facilities or participating in home and community-based waivers on June 30, 1997, who are eligible for full Medicaid benefits on June 30, 1997, will continue to be eligible for full Medicaid benefits after June 30, 1997, at state expense if federal financial participation is not available.

4. The Department shall promulgate regulations to be effective July 1, 1997, to implement the foregoing policy.

W. The Department shall provide full medical assistance services to noncitizens ineligible for Medicaid because of alienage pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law No. 104-193, who: (i) are under age 19, and (ii) would be eligible for full Medicaid benefits if the alien requirements prior to the passage of Public Law No. 104-193 were still in effect.