2014 Special Session I

# Budget Bill - HB5001 (Introduced)

Bill Order » Office of Health and Human Resources » Item 307

Department of Medical Assistance Services

| Item 307 | First Year - FY2013 | Second Year - FY2014 |
|---|---|---|
| **Medicaid Program Services (45600)** | **$7,610,298,210** | ~~**$8,061,586,025**~~ ***$8,001,607,601*** |
| Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607) | $263,128,981 | $263,128,981 |
| Reimbursements for Behavioral Health Services (45608) | $663,363,194 | ~~$725,639,169~~ *$696,565,922* |
| ~~Reimbursements for Professional and Institutional Medical Services (45609)~~ Reimbursements for Medical Services (45609) | $4,427,240,033 | ~~$4,682,278,063~~ *$4,705,330,084* |
| Reimbursements for Long-Term Care Services (45610) | $2,256,566,002 | ~~$2,390,539,812~~ *$2,336,582,614* |
| Fund Sources: | | |
| General | $3,401,990,672 | ~~$3,690,739,927~~ *$3,519,763,424* |
| Dedicated Special Revenue | $450,208,672 | ~~$370,765,117~~ *$461,883,222* |
| Federal Trust | $3,758,098,866 | ~~$4,000,080,981~~ *$4,019,960,955* |

Authority: Title 32.1, Chapters 9 and 10, Code of Virginia; P.L. 89-97, as amended, Title XIX, Social Security Act, Federal Code.

A. Out of this appropriation, $131,564,490 the first year and $131,564,490 the second year from the general fund and $131,564,490 the first year and $131,564,490 the second year from the federal trust fund is provided for reimbursement to the institutions within the Department of Behavioral Health and Developmental Services.

B.1. Included in this appropriation is $69,408,988 the first year and ~~$66,984,546~~ *$67,872,189* the second year from the general fund and $85,375,471 the first year and ~~$86,665,429~~ *$84,973,939* the second year from nongeneral funds to reimburse the Virginia Commonwealth University Health System for indigent health care costs. This funding is composed of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4.

2. Included in this appropriation is $37,921,346 the first year and ~~$38,172,887~~ *$39,128,622* the second year from the general fund and $48,940,486 the first year and ~~$51,955,177~~ *$51,160,627* the second year from nongeneral funds to reimburse the University of Virginia Health System for indigent health care costs. This funding is comprised of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4.

3. The general fund amounts for the state teaching hospitals have been reduced to mirror the general fund impact of no inflation for inpatient services, including DSH, GME and IME, for private hospitals plus an additional reduction for indigent care. However, the nongeneral funds are appropriated. In order to receive the nongeneral funds in excess of the amount of the general fund appropriated, the health systems shall certify the public expenditures.

4. The Department of Medical Assistance Service shall have the authority to increase Medicaid payments for Type One hospitals and physicians consistent with the appropriations to compensate for limits on disproportionate share hospital (DSH) payments to Type One hospitals that the department would otherwise make. In particular, the department shall have the authority to amend the State Plan for Medical Assistance to increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate as demonstrated by University of Virginia Health System and Virginia Commonwealth University Health System, to change reimbursement for Graduate Medical Education to cover costs for Type One hospitals, to case mix adjust the formula for indirect medical education reimbursement for HMO discharges for Type One hospitals and to increase the adjustment factor for Type One hospitals to 1.0. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

C.1. The estimated revenue for the Virginia Health Care Fund is $450,208,672 the first year and ~~$370,765,117~~ *$461,883,222* the second year, to be used pursuant to the uses stated in § 32.1-367, Code of Virginia.

2. Notwithstanding § 32.1-366, Code of Virginia, the State Comptroller shall deposit 41.5 percent of the Commonwealth's allocation of the Master Settlement Agreement with tobacco product manufacturers, as defined in § 3.2-3100, Code of Virginia, to the Virginia Health Care Fund.

3. Notwithstanding any other provision of law, the State Comptroller shall deposit 50 percent of the Commonwealth's allocation of the Strategic Contribution Fund payment pursuant to the Master Settlement Agreement with tobacco product manufacturers into the Virginia Health Care Fund.

4. Notwithstanding any other provision of law, revenues deposited to the Virginia Health Care Fund shall only be used as the state share of Medicaid unless specifically authorized by this act.

D. 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 Centers for Medicare and Medicaid Services 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 Centers for Medicare and Medicaid Services 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, Department of Medical Assistance Services, after consultation with the Attorney General, is authorized to pursue the alternative method.

E.1. The Director, 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 health care services and delivery systems, as may be permitted by Title XIX of the Social Security Act, which may provide less expensive alternatives to the State Plan for Medical Assistance.

2. The director shall promulgate such regulations as may be necessary to implement those programs which may be permitted by Titles XIX and XXI of the Social Security Act, in conformance with all requirements of the Administrative Process Act.

F. 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.

G. To the extent that appropriations in this Item are insufficient, the Department of Planning and Budget shall transfer general fund appropriation from Item 306 and 309, if available, to be used as state match for federal Title IX funds.

H. It is the intent of the General Assembly that the medically needy income limits for the Medicaid program are adjusted annually to account for changes in the Consumer Price Index.

I. It is the intent of the General Assembly that the use of the new atypical medications to treat seriously mentally ill Medicaid recipients should be supported by the formularies used to reimburse claims under the Medicaid fee-for-service and managed care plans.

J. The Department of Medical Assistance Services shall establish a program to more effectively manage those Medicaid recipients who receive the highest cost care. To implement the program, the department shall establish uniform criteria for the program, including criteria for the high cost recipients, providers and reimbursement, service limits, assessment and authorization limits, utilization review, quality assessment, appeals and other such criteria as may be deemed necessary to define the program. The department shall seek any necessary approval from the Centers for Medicare and Medicaid Services, and shall promulgate such regulations as may be deemed necessary to implement this program.

K. The Department of Medical Assistance Services and the Virginia Department of Health shall work with representatives of the dental community: to expand the availability and delivery of dental services to pediatric Medicaid recipients; to streamline the administrative processes; and to remove impediments to the efficient delivery of dental services and reimbursement thereof. The Department of Medical Assistance Services shall report its efforts to expand dental services to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget by December 15 each year.

L. The Department of Medical Assistance Services shall not require dentists who agree to participate in the delivery of Medicaid pediatric dental care services, or services provided to enrollees in the Family Access to Medical Insurance Security (FAMIS) Plan or any variation of FAMIS, to also deliver services to subscribers enrolled in commercial plans of the managed care vendor, unless the dentist is a willing participant in the commercial managed care plan.

M. The Department of Medical Assistance Services shall implement continued enhancements to the drug utilization review (DUR) program. The department shall continue the Pharmacy Liaison Committee and the DUR Board. The department shall continue to work with the Pharmacy Liaison Committee to implement initiatives for the promotion of cost-effective services delivery as may be appropriate. The department shall report on the Pharmacy Liaison Committee's and the DUR Board's activities to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later than December 15 each year of the biennium.

N.1. The Department of Medical Assistance Services shall have the authority to seek federal approval of changes to its MEDALLION waiver and its Medallion II waiver.

2. In order to conform the state regulations to the federally approved changes and to implement the provisions of this act, the department shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. The department shall implement these necessary regulatory changes to be consistent

with federal approval of the waiver changes.

O. The Department of Medical Assistance Services shall have the authority to seek federal approval of changes to its managed care waiver to limit the Primary Case Management program to localities of the state with only one participating managed care organization. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

P.1. The Department of Medical Assistance Services shall develop and pursue cost saving strategies internally and with the cooperation of the Department of Social Services, Virginia Department of Health, Office of the Attorney General, Comprehensive Services Act program, Department of Education, Department of Juvenile Justice, Department of Behavioral Health and Developmental Services, Virginia Department for the Aging, Department of the Treasury, University of Virginia Health System, Virginia Commonwealth University Health System Authority, Department of Corrections, federally qualified health centers, local health departments, local school divisions, community service boards, local hospitals, and local governments, that focus on optimizing Medicaid claims and cost recoveries. Any revenues generated through these activities shall be transferred to the Virginia Health Care Fund to be used for the purposes specified in this Item.

2. The Department of Medical Assistance Services shall retain the savings necessary to reimburse a vendor for its efforts to implement paragraph . P 1. of this Item. However, prior to reimbursement, the department shall identify for the Secretary of Health and Human Resources each of the vendor's revenue maximization efforts and the manner in which each vendor would be reimbursed. No reimbursement shall be made to the vendor without the prior approval of the above plan by the Secretary.

Q. The Department of Medical Assistance Services shall have the authority to pay contingency fee contractors, engaged in cost recovery activities, from the recoveries that are generated by those activities. All recoveries from these contractors shall be deposited to a special fund. After payment of the contingency fee any prior year recoveries shall be transferred to the Virginia Health Care Fund. Beginning November 1, 2011, and each year thereafter, the Director, Department of Medical Assistance Services shall report to the Chairmen of the House Appropriations and Senate Finance Committees the increase in recoveries associated with this program as well as the areas of audit targeted by contractors.

R. The Department of Medical Assistance Services in cooperation with the State Executive Council, shall provide semi-annual training to local Comprehensive Services Act teams on the procedures for use of Medicaid for residential treatment and treatment foster care services, including, but not limited to, procedures for determining eligibility, billing, reimbursement, and related reporting requirements. The department shall include in this training information on the proper utilization of inpatient and outpatient mental health services as covered by the Medicaid State Plan.

S.1. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, the Department of Medical Assistance Services, in consultation with the Department of Behavioral Health and Developmental Services, shall amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a Preferred Drug List. In developing the modifications, the department shall consider input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, and others, as appropriate.

2.a. The department shall utilize a Pharmacy and Therapeutics Committee to assist in the development and ongoing administration of the Preferred Drug List program. The Pharmacy and Therapeutics Committee shall be composed of 8 to 12 members, including the Commissioner, Department of Behavioral Health and Developmental Services, or his designee. Other members shall be selected or approved by the department. The membership shall include a ratio of physicians to pharmacists of 2:1 and the department shall ensure that at least one-half of the physicians and pharmacists are either direct providers or are employed with organizations that serve recipients for all segments of the Medicaid population. Physicians on the committee shall be licensed in Virginia, one of whom shall be a psychiatrist, and one of whom specializes in care for the aging. Pharmacists on the committee shall be

licensed in Virginia, one of whom shall have clinical expertise in mental health drugs, and one of whom has clinical expertise in community-based mental health treatment. The Pharmacy and Therapeutics Committee shall recommend to the department (i) which therapeutic classes of drugs should be subject to the Preferred Drug List program and prior authorization requirements; (ii) specific drugs within each therapeutic class to be included on the preferred drug list; (iii) appropriate exclusions for medications, including atypical anti-psychotics, used for the treatment of serious mental illnesses such as bi-polar disorders, schizophrenia, and depression; (iv) appropriate exclusions for medications used for the treatment of brain disorders, cancer and HIV-related conditions; (v) appropriate exclusions for therapeutic classes in which there is only one drug in the therapeutic class or there is very low utilization, or for which it is not cost-effective to include in the Preferred Drug List program; and (vi) appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens that have proven to be clinically effective. In developing and maintaining the preferred drug list, the cost effectiveness of any given drug shall be considered only after it is determined to be safe and clinically effective.

b. The Pharmacy and Therapeutics Committee shall schedule meetings at least semi-annually and may meet at other times at the discretion of the chairperson and members. At the meetings, the Pharmacy and Therapeutics committee shall review any drug in a class subject to the Preferred Drug List that is newly approved by the Federal Food and Drug Administration, provided there is at least thirty (30) days notice of such approval prior to the date of the quarterly meeting.

3. The department shall establish a process for acting on the recommendations made by the Pharmacy and Therapeutics Committee, including documentation of any decisions which deviate from the recommendations of the committee.

4. The Preferred Drug List program shall include provisions for (i) the dispensing of a 72-hour emergency supply of the prescribed drug when requested by a physician and a dispensing fee to be paid to the pharmacy for such supply; (ii) prior authorization decisions to be made within 24 hours and timely notification of the recipient and/or the prescribing physician of any delays or negative decisions; (iii) an expedited review process of denials by the department; and (iv) consumer and provider education, training and information regarding the Preferred Drug List prior to implementation, and ongoing communications to include computer access to information and multilingual material.

5. The Preferred Drug List program shall generate savings as determined by the department that are net of any administrative expenses to implement and administer the program.

6. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, to implement these changes, the Department of Medical Assistance Services shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. With respect to such state plan amendments and regulations, the provisions of § 32.1-331.12 et seq., Code of Virginia, shall not apply. In addition, the department shall work with the Department of Behavioral Health and Development Services to consider utilizing a Preferred Drug List program for its non-Medicaid clients.

7. The Department of Medical Assistance Services shall (i) exempt antidepressant, antianxiety and antipsychotic medications used for the treatment of mental illness from the Medicaid Preferred Drug List program through June 30, 2014; (ii) continually review utilization of behavioral health medications under the State Medicaid Program for Medicaid recipients; and (iii) ensure appropriate use of these medications according to federal Food and Drug Administration (FDA) approved indications and dosage levels. The department may also require retrospective clinical justification according to FDA approved indications and dosage levels for the use of multiple behavioral health drugs for a Medicaid patient. For individuals 18 years of age and younger who are prescribed three or more behavioral health drugs, the department may implement clinical edits that target inefficient, ineffective, or potentially harmful prescribing patterns in accordance with FDA-approved indications and dosage levels.

8. The Department of Medical Assistance Services shall ensure that in the process of developing the Preferred Drug

List, the Pharmacy and Therapeutics Committee considers the value of including those prescription medications which improve drug regimen compliance, reduce medication errors, or decrease medication abuse through the use of medication delivery systems that include, but are not limited to, transdermal and injectable delivery systems.

T.1. The Department of Medical Assistance Services may amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a specialty drug program. In developing the modifications, the department shall consider input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, the Pharmacy Liaison Committee, and others as appropriate.

2. In developing the specialty drug program to implement appropriate care management and control drug expenditures, the department shall contract with a vendor who will develop a methodology for the reimbursement and utilization through appropriate case management of specialty drugs and distribute the list of specialty drug rates, authorized drugs and utilization guidelines to medical and pharmacy providers in a timely manner prior to the implementation of the specialty drug program and publish the same on the department's website.

3. In the event that the Department of Medical Assistance Services contracts with a vendor, the department shall establish the fee paid to any such contractor based on the reasonable cost of services provided. The department may not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses cannot be based on the percentage of cost savings generated under the benefit management of services.

4. The department shall: (i) review, update and publish the list of authorized specialty drugs, utilization guidelines, and rates at least quarterly; (ii) implement and maintain a procedure to revise the list or modify specialty drug program utilization guidelines and rates, consistent with changes in the marketplace; and (iii) provide an administrative appeals procedure to allow dispensing or prescribing provider to contest the listed specialty drugs and rates.

5. The department shall report on savings and quality improvements achieved through the implementation measures for the specialty drug program to the Chairmen of the House Appropriations and Senate Finance Committees, the Joint Commission on Health Care, and the Department of Planning and Budget by November 1 of each year.

6. The department shall have authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act to effect these provisions.

U.1. The Department of Medical Assistance Services shall reimburse school divisions who sign an agreement to provide administrative support to the Medicaid program and who provide documentation of administrative expenses related to the Medicaid program 50 percent of the Federal Financial Participation by the department.

2. The Department of Medical Assistance Services shall retain five percent of the Federal Financial Participation for reimbursement to school divisions for medical and transportation services.

V. In the event that the Department of Medical Assistance Services decides to contract for pharmaceutical benefit management services to administer, develop, manage, or implement Medicaid pharmacy benefits, the department shall establish the fee paid to any such contractor based on the reasonable cost of services provided. The department may not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses cannot be based on the percentage of cost savings generated under the benefit management of services.

W. The Department of Medical Assistance Services, in cooperation with the Department of Social Services' Division of Child Support Enforcement (DSCE), shall identify and report third party coverage where a medical support order has required a custodial or noncustodial parent to enroll a child in a health insurance plan. The Department of Medical Assistance Services shall also report to the DCSE third party information that has been identified through their third party identification processes for children handled by DCSE.

X.1. Within the limits of this appropriation, the Department of Medical Assistance Services shall work with its contracted managed care organizations and fee-for-service health care providers to: (i) raise awareness among the providers who serve the Medicaid population about the health risks of chronic kidney disease; (ii) establish effective means of identifying patients with this condition; and (iii) develop strategies for improving the health status of these patients. The department shall work with the National Kidney Foundation to prepare and disseminate information for physicians and other health care providers regarding generally accepted standards of clinical care and the benefits of early identification of individuals at highest risk of chronic kidney disease.

2. The department shall request any clinical laboratory performing a serum creatinine test on a Medicaid recipient over the age of 18 years to calculate and report to the physician the estimated glomerular filtration rate (eGFR) of the patient and shall report it as a percent of kidney function remaining.

Y.1. Notwithstanding the provisions of § 32.1-325.1:1, Code of Virginia, upon identifying that an overpayment for medical assistance services has been made to a provider, the Director, Department of Medical Assistance Services shall notify the provider of the amount of the overpayment. Such notification of overpayment shall be issued within the earlier of (i) four years after payment of the claim or other payment request, or (ii) four years after filing by the provider of the complete cost report as defined in the Department of Medical Assistance Services' regulations, or (iii) 15 months after filing by the provider of the final complete cost report as defined in the Department of Medical Assistance Services' regulations subsequent to sale of the facility or termination of the provider.

2. Notwithstanding the provisions of § 32.1-325.1, Code of Virginia, the director shall issue an informal fact-finding conference decision concerning provider reimbursement in accordance with the State Plan for Medical Assistance, the provisions of § 2.2-4019, Code of Virginia, and applicable federal law. The informal fact-finding conference decision shall be issued within 180 days of the receipt of the appeal request. If the agency does not render an informal fact-finding conference decision within 180 days of the receipt of the appeal request, the decision is deemed to be in favor of the provider. An appeal of the director's informal fact-finding conference decision concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the State Plan for Medical Assistance provided for in § 32.1-325, Code of Virginia. Once a final agency case decision has been made, the director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the informal fact-finding conference decision or the final agency case decision. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313, Code of Virginia, from the date the Director's agency case decision becomes final.

Z. Any hospital that was designated a Medicare-dependent small rural hospital, as defined in 42 U.S.C. §1395ww (d) (5) (G) (iv) prior to October 1, 2004, shall be designated a rural hospital pursuant to 42 U.S.C. §1395ww (d) (8) (ii) (II) on or after September 30, 2004.

AA. The Department of Medical Assistance Services shall implement one or more Program for All Inclusive Care for the Elderly (PACE) programs.

BB. The Department of Medical Assistance Services shall amend its State Plan for Medical Assistance Services to develop and implement a regional model for the integration of acute and long-term care services. This model would be offered to elderly and disabled clients on a mandatory basis. The department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

CC.1. Contingent upon approval by the Centers for Medicare and Medicaid Services as part of the Money Follows the Person demonstration grant, the Department of Medical Assistance Services shall seek federal approval for necessary changes to home and community-based 1915(c) waivers to allow individuals transitioning from institutions to receive care in the community. The Department of Medical Assistance Services shall promulgate any necessary emergency regulations within 280 days or less from the enactment date of this act.

2. The Department of Medical Assistance Services shall amend the Individual and Family Developmental Disabilities Support (DD) Waiver to add up to 30 new slots (up to 15 each fiscal year) and the Intellectual Disabilities (ID) Waiver to add up to 220 new slots (up to 110 each fiscal year) which will be reserved for individuals transitioning out of institutional settings through the Money Follows the Person Demonstration. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the DD and ID waiver applications to add the additional slots.

DD. The Department of Medical Assistance Services shall have the authority to implement prior authorization and utilization review for community-based mental health services for children and adults. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

EE. The Department of Medical Assistance Services shall delay the last quarterly payment of certain quarterly amounts paid to hospitals, from the end of each state fiscal year to the first quarter of the following year. Quarterly payments that shall be delayed from each June to each July shall be Disproportionate Share Hospital payments, Indirect Medical Education payments, and Direct Medical Education payments. The department shall have the authority to implement this reimbursement change effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such change.

FF. The Department of Medical Assistance Services shall make the monthly capitation payment to managed care organizations for the member months of each month in the first week of the subsequent month. The department shall have the authority to implement this reimbursement schedule change effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such change.

GG. In every June the remittance that would normally be paid to providers on the last remittance date of the state fiscal year shall be delayed one week longer than is normally the practice. This change shall apply to the remittances of Medicaid and FAMIS providers. This change does not apply to providers who are paid a per-month capitation payment. The department shall have the authority to implement this reimbursement change effective upon passage of this act, and prior to the completion of any regulatory process undertaken in order to effect such change.

HH. Upon approval by the Centers for Medicare and Medicaid Services of the application for renewal of the Intellectual Disabilities Waiver, expeditious implementation of any revisions shall be deemed an emergency situation pursuant to § 2.2-4002 of the Administrative Process Act. Therefore, to meet this emergency situation, the Department of Medical Assistance Services shall promulgate emergency regulations to implement the provisions of this act.

II. The Department of Medical Assistance Services shall provide information to personal care agency providers regarding the options available to meet staffing requirements for personal care aides including the completion of provider-offered training or DMAS Personal Care Aide Training Curriculum.

JJ. The Department of Medical Assistance Services, in consultation with the Department of Behavioral Health and Developmental Services, shall amend the State Plan for Medical Assistance Services in order to comply with the payor of last resort requirements of Part C of the Individuals with Disabilities Education Act (IDEA) of 2004. The Department of Medical Assistance Services shall promulgate regulations to become effective within 280 days or

less from the enactment date of this act. The department shall implement these necessary regulatory changes to be consistent with federal requirements for the Part C program.

KK. The Department of Medical Assistance Services shall impose an assessment equal to 5.5 percent of revenue on all ICF-MR providers. The department shall determine procedures for collecting the assessment, including penalties for non-compliance. The department shall have the authority to adjust interim rates to cover new Medicaid costs as a result of this assessment.

LL. The Department of Medical Assistance Services shall make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The Department of Medical Assistance Services shall promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

MM. Notwithstanding Chapters 228 and 303 of the 2009 Virginia Acts of Assembly and § 32.1-323.2 of the Code of Virginia, the Department of Medical Assistance Services shall not add any slots to the Intellectual Disabilities Medicaid Waiver or the Individual and Family Developmental Disabilities and Support Medicaid Waiver other than those slots authorized to specifically to support the Money Follows the Person Demonstration, individuals who are exiting state institutions, any slots authorized under Chapters 724 and 729 of the 2011 Virginia Acts of Assembly or § 37.2-319, Code of Virginia, or authorized elsewhere in this act.

NN. The Department of Medical Assistance Services shall not adjust rates or the rate ceiling of residential psychiatric facilities for inflation.

OO.1. Effective July 1, 2010, the Department of Medical Assistance Services (DMAS) shall amend the State Plan for Medical Assistance to modify reimbursement for Durable Medical Equipment (DME) to:

a. Reduce reimbursement for DME that has a Durable Medical Equipment Regional Carrier (DMERC) rate from 100 percent of Medicare reimbursement level to 90 percent of the Medicare level.

b. Reduce fee schedule rates for DME and supplies by category-specific amounts as recommended in the November 1, 2009, Report on Durable Medical Equipment Reimbursement to the Senate Finance and House Appropriations Committees. The Department of Medical Assistance Services shall also modify the pricing of incontinence supplies from case to item, which is the industry standard.

c. Establish rates for additional procedure codes where benchmark rates are available.

d. Reimburse at cost plus 30 percent for any item not on the fee schedule. Cost shall be no more than the net manufacturer's charge to the provider, less shipping and handling.

e. Determine alternate pricing for any code that does not have a rate.

f. Limit service day reimbursement to intravenous and oxygen therapy equipment.

2. The department shall promulgate regulations to implement this amendment within 280 days or less from the enactment of this act. The department shall implement these reimbursement changes prior to the completion of the regulatory process.

PP. The Department of Medical Assistance Services shall have the authority to modify reimbursement for Durable Medical Equipment for incontinence supplies based on competitive bidding subject to approval by the Centers for Medicare and Medicaid Services (CMS). The department shall have the authority to promulgate regulations to become effective within 280 days or less from the enactment of this act.

QQ. The Department of Medical Assistance Services shall work with the Department of Behavioral Health and Developmental Services in consultation with the Virginia Association of Community Services Boards, the Virginia Network of Private Providers, the Virginia Coalition of Private Provider Associations, and the Association of Community Based Providers, to establish rates for the Intensive In-Home Service based on quality indicators and standards, such as the use of evidence-based practices.

RR. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:

a. In fulfillment of this Item, the department may seek any necessary federal authority through amendment to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to expand the current managed care program, Medallion II, to the Roanoke/Alleghany area by January 1, 2012, and far Southwest Virginia by July 1, 2012. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

b. In fulfillment of this Item, the department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to allow, on a pilot basis, foster care children, under the custody of the City of Richmond Department of Social Services, to be enrolled in Medicaid managed care (Medallion II) effective July 1, 2011. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

c. In fulfillment of this item, the department may seek federal authority to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. This service would be provided to adult EDCD waiver participants on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

d. In fulfillment of this item, the department may seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

e. In fulfillment of this item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate stakeholders, shall develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia

without compromising access to behavioral health services for vulnerable populations. Targeted case management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:

1. Improves value so that there is better access to care while improving equity.

2. Engages consumers as informed and responsible partners from enrollment to care delivery.

3. Provides consumer protections with respect to choice of providers and plans of care.

4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.

5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.

6. Improves quality, individual safety, health outcomes, and efficiency.

7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.

8. Builds upon current best practices in the delivery of behavioral health services.

9. Accounts for local circumstances and reflects familiarity with the community where services are provided.

10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.

11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.

12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.

13. Promotes availability of access to vital supports such as housing and supported employment.

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.

15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

f. The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph e, for individuals in need of behavioral health services not currently provided through managed care to be effective July 1, 2012. This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

g. The department may seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid. The Director of the Department of Medical Assistance Services, in consultation with the Secretary of Health and Human Resources, shall establish a stakeholder advisory committee to support implementation of dual-eligible care coordination systems. The advisory committee shall support the dual-eligible initiatives by identifying care coordination and quality improvement priorities, assisting in securing analytic and care management support resources from federal, private and other sources and helping design and communicate performance reports. The advisory committee shall include representation from health systems, health plans, long-term care providers, health policy researchers, physicians, and others with expertise in serving the aged, blind, and disabled, and dual-eligible populations. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

h. In fulfillment of this item, the department may seek the federal authority through amendment to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow for the implementation of a Health Home Program for Chronic Kidney Disease utilizing available funding included in the Patient Protection and Affordable Care Act of 2010 to be effective May 1, 2012. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

SS. The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

TT. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall seek federal authority to implement a pricing methodology to modify or replace the current pricing methodology for pharmaceutical products as defined in 12 VAC 30-80-40, including the dispensing fee, with an alternative methodology that is budget neutral or that creates cost savings. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

UU. The Department of Medical Assistance Services shall make programmatic changes to the recipient utilization (Client Medical Management) program in order ensure appropriate utilization, prevent abuse, and promote improved and cost efficient medical management of essential Medicaid client health care. The department shall consider all available options including, but not limited to, utilization review, program criteria, and client enrollment. The Department of Medical Assistance Services shall promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

VV. The Department of Medical Assistance Services shall mandate that payment rates negotiated between

participating Medicaid managed care organizations and out-of-network providers for emergency or otherwise authorized treatment shall be considered payment in full. In the absence of rates negotiated between the managed care organization and the out-of-network provider, these services shall be reimbursed at the Virginia Medicaid fees and/or rates and shall be considered payment in full. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

WW. The Department of Medical Assistance Services shall, contingent on federal approval, amend the Elderly and Disabled with Consumer Direction waiver to allow individuals in the waiver with special needs, who have a diagnosis of intellectual disability (ID), to receive respite services from a residential facility licensed for respite for individuals with ID. The department shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. The department shall implement these changes to be consistent with federal approval of the waiver changes.

XX. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to convert the current cost-based reimbursement methodology for outpatient hospitals to an Enhanced Ambulatory Patient Group (EAPG) methodology. Reimbursement for laboratory services shall be included in the new outpatient hospital reimbursement methodology. The new EAPG reimbursement methodology shall be implemented in a budget-neutral manner. The department shall have the authority to promulgate regulations to become effective within 280 days or less from the enactment of this act.

YY. The Department of Medical Assistance Services shall amend certain 1915 (c) home- and community-based waivers to cap agency and consumer directed personal care at 56 hours per week. The 1915 (c) waivers shall include the Elderly or Disabled with Consumer Direction, and HIV/AIDS Waivers. The department shall provide for individual exceptions to this limit using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

ZZ. The Department of Medical Assistance Services shall seek federal authority to move the family planning eligibility group from a demonstration waiver to the State Plan for Medical Assistance. The department shall seek approval of coverage under this new state plan option for individuals with income up to 200 percent of the federal poverty level. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

AAA. The Department of Medical Assistance Services (DMAS) shall have the authority to amend the State Plan for Medical Assistance to enroll and reimburse freestanding birthing centers accredited by the Commission for the Accreditation of Birthing Centers. Reimbursement shall be based on the Enhanced Ambulatory Patient Group methodology applied in a manner similar to the reimbursement methodology for ambulatory surgery centers. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

BBB. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to pay Medicare rates for primary care services performed by primary care physicians as mandated in §1202 of the federal Health Care and Education Reconciliation Act of 2010 (“HCERA”; P.L. 111-152). Primary care services are defined as certain evaluation and management (E&M) services and services related to immunization administration for vaccines and toxoids. Eligible physicians are defined as physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. The department shall have the authority to establish procedures to determine which providers meet the criteria. The rate increase shall be effective for a two-year period with dates of service beginning January 1, 2013, through December 31, 2014. As prescribed in HCERA, the department shall claim 100 percent federal matching funds for the difference in payments between the Medicaid

fee schedule effective July 1, 2009, and the Medicare rate effective January 1, 2013. HCERA also mandates that the increase be applied to Managed Care services. The department shall have authority to implement these reimbursement changes, including any requirements as a result of the federal rule implementing §1202 of HCERA and consistent with the State Plan Amendment approved by the Centers for Medicare and Medicaid Services, prior to the completion of any regulatory process undertaken in order to effect such change.

CCC.1. In response to the unfavorable outcome to an appeal by the Department of Medical Assistance Services in federal court regarding reimbursement for services furnished to Medicaid members in a residential treatment center or freestanding psychiatric hospital, the department shall have the authority to implement this paragraph.

2. Notwithstanding current regulations, the department shall have the authority to implement the amendment to the State Plan for Medical Assistance submitted by the department and as approved by the Centers for Medicare and Medicaid Services (CMS) effective April 1, 2010, until a new prospective reimbursement methodology is finalized. The department has the authority to recover payments, which have been disallowed by CMS, to providers for services furnished to Medicaid members in residential treatment centers or freestanding psychiatric hospitals for dates of service on or after April 1, 2010. Subject to approval of the State Plan Amendment by CMS, the department shall make supplemental payments to residential treatment centers or freestanding psychiatric hospitals so that they can reimburse providers for services furnished to Medicaid members in residential treatment centers or freestanding psychiatric hospitals for dates of service on or after April 1, 2010. The supplemental payment shall be determined based on the number of services furnished times the Medicaid rate. For claims after the effective date of this act, the department shall establish an interim rate for residential treatment centers and freestanding psychiatric facilities to cover the cost of reimbursing other providers. Providers shall submit information to DMAS on reimbursement paid to providers, which DMAS will settle.

3. The department shall develop a prospective payment methodology to be implemented as soon as practicable after the unfavorable federal court decision to reimburse residential treatment centers and freestanding psychiatric hospitals for services furnished by the facility and services furnished by other providers in and by the facility. The department shall revise reimbursement for services furnished Medicaid members in residential treatment centers and freestanding psychiatric hospitals to include professional, pharmacy and other services to be reimbursed separately as long as the services are in the plan of care developed by the residential treatment center or the freestanding psychiatric hospital and arranged by the residential treatment center or the freestanding psychiatric hospital. The department shall require residential treatment centers to include all services in the plan of care needed to meet the member's physical and psychological well-being while in the facility but may also include services in the community or as part of an emergency.

4. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days from the enactment of this act.

DDD. The Department of Medical Assistance Services may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to allow foster care children, on a regional basis to be determined by the department, to be enrolled in Medicaid managed care (Medallion II). The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

EEE. The Department of Medical Assistance Services shall have the authority to amend the State Plans under Title XIX and Title XXI of the Social Security Act in order to comply with the mandated provider screening provisions of the federal Affordable Care Act (P.L. 111-148 and 111-152). The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

FFF. The department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to develop and implement programmatic and system changes that allow expedited enrollment of Medicaid eligible recipients into Medicaid managed care, most

importantly for pregnant women. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

GGG.1. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate inflation adjustments in FY 2013 and FY 2014 for: (i) outpatient rehabilitation agency rates; and (ii) home health agency rates.

2. The department shall have the authority to implement these reimbursement changes effective July 1, 2012, and prior to completion of any regulatory process undertaken in order to effect such changes.

HHH. The Department of Medical Assistance Services shall amend the Children's Mental Health demonstration program to provide coverage of transition coordinator services for up to 15 months. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

III.1. The Department of Medical Assistance Services, related to appeals administered by and for the department, shall have authority to amend regulations to:

i. Utilize the method of transmittal of documentation to include email, fax, courier, and electronic transmission.

ii. Clarify that the day of delivery ends at normal business hours of 5:00 pm.

iii. Eliminate an automatic dismissal against DMAS for alleged deficiencies in the case summary that do not relate to DMAS's obligation to substantively address all issues specified in the provider's written notice of informal appeal. A process shall be added, by which the provider shall file with the informal appeals agent within 12 calendar days of the provider's receipt of the DMAS case summary, a written notice that specifies any such alleged deficiencies that the provider knows or reasonably should know exist. DMAS shall have 12 calendar days after receipt of the provider's timely written notification to address or cure any of said alleged deficiencies. The current requirement that the case summary address each adjustment, patient, service date, or other disputed matter identified in the provider's written notice of informal appeal in the detail set forth in the current regulation shall remain in force and effect, and failure to file a written case summary with the Appeals Division in the detail specified within 30 days of the filing of the provider's written notice of informal appeal shall result in dismissal in favor of the provider on those issues not addressed by DMAS.

iv. Clarify that appeals remanded to the informal appeal level via Final Agency Decision or court order shall reset the timetable under DMAS' appeals regulations to start running from the date of the remand.

v. Clarify the department's authority to administratively dismiss untimely filed appeal requests.

vi. Clarify the time requirement for commencement of the formal administrative hearing.

2. The Department of Medical Assistance Services shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

JJJ. The Department of Medical Assistance Services shall have the authority to amend the 1915(c) home-and-community-based Elderly or Disabled with Consumer-Direction waiver, subject to approval by the Centers for Medicare and Medicaid Services to incorporate the HIV/AIDS waiver. Pending CMS approval, the HIV/AIDS waiver will cease as of June 30, 2012. The department shall implement this change effective July 1, 2012, and prior to the completion of any regulatory process undertaken in order to effect such changes.

LLL. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to limit hospital inflation to 2.6 percent in fiscal year 2013 and 0 percent in fiscal year 2014. This shall apply to inpatient

hospital (including long-stay and freestanding psychiatric) operating, graduate medical education (GME) and disproportionate share hospital (DSH) rates. The department shall have the authority to implement these reimbursement changes effective July 1, 2012, and prior to completion of any regulatory process undertaken in order to effect such changes.

MMM. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate ceiling rebasing in fiscal year 2013, to increase rates and current ceilings for regular and specialized care nursing facilities by 2.2 percent in fiscal year 2013 and 2.2 percent in fiscal year 2014, and to increase ceilings an additional one percent in fiscal year 2013. The department shall have the authority to implement these reimbursement changes effective July 1, 2012, and prior to completion of any regulatory process undertaken in order to effect such changes.

NNN. Out of this appropriation, $3,187,405 from the general fund and $3,187,405 from nongeneral funds the first year and $3,527,562 from the general fund and $3,527,526 from nongeneral funds the second year shall be used to increase personal care reimbursement rates provided under community-based Medicaid waiver programs by one percent effective July 1, 2012.

OOO. The Department of Medical Assistance Services shall increase reimbursement rates for congregate care provided through Medicaid home- and community-based waivers by one percent effective July 1, 2012.

PPP. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the rate for Part C Early Intervention Targeted Case Management from $120 to $132 per month. The department shall have the authority to implement this reimbursement change effective July 1, 2012, and prior to the completion of any regulatory process undertaken in order to effect such change.

QQQ. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to set reimbursement rates for ground and air emergency transportation and neonatal transport at 40 percent of the Medicare Virginia urban rates in effect for calendar year 2011. The department shall have the authority to implement these reimbursement changes effective July 1, 2012, and prior to the completion of any regulatory process undertaken in order to effect such a change.

RRR. The Department of Medical Assistance Services shall amend the 1915 (c) home- and community-based Intellectual Disabilities waiver to add 75 slots effective July 1, 2012 and an additional 350 slots effective July 1, 2013.

SSS. The Department of Medical Assistance Services shall amend the Individual and Family Developmental Disabilities Support (DD) waiver to add 25 new slots effective July 1, 2012 and an additional 105 slots effective July 1, 2013. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the DD waiver to add the additional slots.

TTT. The Department of Medical Assistance Services shall have the authority to amend the Title XIX State Plan of Medical Assistance Services, the Virginia Plan for Title XXI of the Social Security Act and the Family Access to Medical Insurance Security Plan (FAMIS) MOMS waiver to include coverage of pregnant women who are lawfully residing in the United States and who are otherwise eligible for Medicaid services, pursuant to Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009. The department shall have the authority to promulgate emergency regulations to implement this change effective July 1, 2012.

UUU. Effective July 1, 2012, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to provide that the reimbursement floor for the nursing facility FRV “rental rate” shall be 8.5 percent in fiscal year 2013 and fiscal year 2014. The department shall have the authority to implement these reimbursement changes prior to the completion of any regulatory process undertaken in order to effect such change.

VVV. The Director of the Department of Medical Assistance Services, in consultation with the Secretary of Health and Human Resources and the Director of the Medicaid Fraud Control Unit within the Office of the Attorney General, shall develop a report containing recommendations to strengthen the prevention, detection, and prosecution of Medicaid fraud and abuse committed by recipients and service providers. To the extent feasible, the report shall provide estimates of the cost of implementing any new strategies to reduce and prevent Medicaid fraud and abuse as well as the potential cost savings that might be achieved. Specific consideration shall be given to enhancing the Commonwealth's ability, within federal law, of excluding or removing providers that are determined to pose a threat to the health and safety of recipients and/or to the fiscal integrity of the program. The report shall be provided to the Chairmen of the Senate Finance and House Appropriations Committees by December 1, 2012.

WWW. The Department of Medical Assistance Services shall develop a plan to strengthen its authority to use liens to recover the cost of providing long-term care services to Medicaid recipients. In developing the plan, the department shall survey other state Medicaid programs to determine the most effective strategies to impose Medicaid liens for estate recovery. The plan shall explain at what stage of the application process individuals will be notified about the department's use of liens to recover Medicaid costs. The plan shall also detail the additional resources that may be required to enforce lien authority and the potential cost-savings that might be achieved. The report shall be provided to the Chairmen of the Senate Finance and House Appropriations Committees by October 1, 2012.

XXX. The Department of Medical Assistance Services shall amend its regulations, subject to the federal Centers for Medicare and Medicaid Services approval, to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home- and community-based waiver enrollees. The department shall have the authority to promulgate emergency regulations to implement this change effective July 1, 2012.

YYY. The Department of Medical Assistance Services shall establish an advisory group of representatives of providers of home- and community-based care services to continue improvements in the audit process and procedures for home- and community-based utilization and review audits. The Department of Medical Assistance Services shall report on any revisions to the methodology for home- and community-based utilization and review audits, including progress made in addressing provider concerns and solutions to improve the process for providers while ensuring program integrity. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2012.

ZZZ. It is the intent of the General Assembly that the implementation and administration of the care coordination contract for behavioral health services be conducted in a manner that insures system integrity and engages private providers in the independent assessment process. In addition, it is the intent that in the provision of services that ethical and professional conflicts are avoided and that sound clinical decisions are made in the best interests of the individuals receiving behavioral health services. As part of this process, the department shall monitor the performance of the contract to ensure that these principles are met and that stakeholders are involved in the assessment, approval, provision, and use of behavioral health services provided as a result of this contract.

AAAA. 1. Notwithstanding the requirements of Code of Virginia § 2.2-4000, et seq., the Department of Medical Assistance Services shall amend the state plan and appropriate waivers under Title XIX of the Social Security Act to implement a process for administrative appeals of Medicaid/Medicare dual eligible recipients in accordance with terms of the Memorandum of Understanding between the department and the Centers for Medicare and Medicaid Services for the financial alignment demonstration program for dual eligible recipients. The department shall implement this change within 280 days or less from the enactment of this Appropriation Act.

2. The department shall report by November 1 of each year to the Governor, the Chairmen of the House Appropriations and Senate Finance Committees, and the Director, Department of Planning and Budget detailing implementation progress of the financial alignment demonstration waiver. This report shall include, but is not limited to, costs of implementation, projected cost savings, number of individuals enrolled, and any other

implementation issues that arise.

BBBB.1. Effective July 1, 2013, the Department of Medical Assistance Services shall have the authority, to establish a 25 percent higher reimbursement rate for congregate residential services for individuals with complex medical or behavioral needs currently residing in an institution and unable to transition to integrated settings in the community due to the need for services that cannot be provided within the maximum allowable rate, or individuals whose needs present imminent risk of institutionalization and enhanced waiver services are needed beyond those available within the maximum allowable rate. The department shall have authority to promulgate regulations to implement this change within 280 days or less from the enactment of this act.

2. The department, in cooperation with the Department of Behavioral Health and Developmental Services, shall report to the Governor, the Chairmen of the House Appropriations and Senate Finance Committees, and the Director, Department of Planning and Budget on the effectiveness of this rate increase in addressing the transition of institutionalized individuals to the community. This report shall include, but is not limited to, the number of individuals eligible for the higher reimbursement rate, whether they transitioned from an institution or were already receiving community services, and the costs to the Medicaid program. A report shall be due by February 1, 2014, that covers the first six months of FY 2014 and another report is due by August 1, 2014, that covers the last six months of FY 2014.

CCCC. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reduce the occupancy requirement for indirect operating and capital reimbursement for nursing facilities from 90 percent to 88 percent. The department shall have the authority to implement these reimbursement changes effective July 1, 2013, and prior to the completion of any regulatory process undertaken in order to effect such change.

DDDD. The Department of Medical Assistance Services shall not rebase hospital Disproportionate Share Hospital (DSH) amounts in FY 2014 and instead shall freeze DSH at the FY 2013 eligible providers and amounts. The department shall have the authority to implement these reimbursement changes effective July 1, 2013, and prior to the completion of any regulatory process undertaken in order to effect such change.

EEEE. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to allow for delivery of notices of program reimbursement or other items referred to in the regulations related to provider appeals by electronic means consistent with the Uniform Electronic Transactions Act. The department shall implement this change effective July 1, 2013, and prior to completion of any regulatory process undertaken in order to effect such changes.

FFFF. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to convert the current cost-based reimbursement methodology for nursing facility operating rates to a price-based methodology. The new price-based reimbursement methodology shall be implemented in a budget neutral manner. The department shall promulgate regulations to become effective within 280 days or less from the enactment of this act.

GGGG. The Department of Medical Assistance Services shall amend its State Plan under Title XIX of the Social Security Act to implement reasonable restrictions on the amount of incurred dental expenses allowed as a deduction from income for nursing facility residents. Such limitations shall include: (i) that routine exams and x-rays, and dental cleaning shall be limited to twice yearly; (ii) full mouth x-rays shall be limited to once every three years; and (iii) deductions for extractions and fillings shall be permitted only if medically necessary as determined by the department.

HHHH. Notwithstanding § 32.1-325, et seq. and § 32.1-351, et seq. of the Code of Virginia, and effective upon the availability of subsidized private health insurance offered through a Health Benefits Exchange in Virginia as articulated through the federal Patient Protection and Affordable Care Act (PPACA), the Department of Medical Assistance Services shall eliminate, to the extent not prohibited under federal law, Medicaid Plan First and FAMIS

Moms program offerings to populations eligible for said subsidized coverage in order to remove disincentives for subsidized private healthcare coverage through publicly-offered alternatives. To ensure, to the extent feasible, a smooth transition from public coverage, DMAS shall endeavor to phase out such coverage for existing enrollees once subsidized private insurance is available through a Health Benefits Exchange in Virginia. The department shall implement any necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

IIII. The Department of Medical Assistance Services shall have authority to amend the State Plans for Medical Assistance under Titles XIX and XXI of the Social Security Act, and any waivers thereof, to implement requirements of the federal Patient Protection and Affordable Care Act (PPACA) as it pertains to implementation of Medicaid and CHIP eligibility determination and case management standards and practices, including the Modified Adjusted Gross Income (MAGI) methodology. The department shall have authority to implement such standards and practices upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

JJJJ. Out of this appropriation, $800,000 the first year and $870,000 the second year from the general fund is provided for a contract with George Mason University for health innovation efforts as well as grants to public and private organizations for projects designed to reduce the rising cost of health care. The department shall provide a report on the allocation of funds to the Chairmen of the House Appropriations and Senate Finance Committee by September 30, 2013.

KKKK. Out of this appropriation, $754,854 from the general fund and $754,854 from nongeneral funds the second year shall be used to increase reimbursement rates by 5 percent for private duty nursing services provided under the Medicaid home- and community-based Technology Assisted waiver program. The department shall have the authority to implement this reimbursement change effective July 1, 2013, and prior to the completion of any regulatory process undertaken in order to effect such change.

LLLL. Out of this appropriation, $667,902 from the general fund and $667,902 from nongeneral funds the second year shall be used to increase reimbursement rates for adult day health services provided through Medicaid home- and community-based waiver programs by $10.00 per unit. The department shall have the authority to implement this reimbursement change effective July 1, 2013, and prior to the completion of any regulatory process undertaken in order to effect such change.

MMMM. Effective July 1, 2013, the Department of Medical Assistance Services shall establish a Medicaid Physician and Managed Care Liaison Committee including, but not limited to, representatives from the following organizations: the Virginia Academy of Family Physicians; the American Academy of Pediatricians – Virginia Chapter; the Virginia College of Emergency Physicians; the American College of Obstetrics and Gynecology – Virginia Section; Virginia Chapter, American College of Radiology; the Psychiatric Society of Virginia; the Virginia Medical Group Management Association; and the Medical Society of Virginia. The committee shall also include representatives from each of the department's contracted managed care organizations and a representative from the Virginia Association of Health Plans. The committee will work with the department to investigate the implementation of quality, cost-effective health care initiatives, to identify means to increase provider participation in the Medicaid program, to remove administrative obstacles to quality, cost-effective patient care, and to address other matters as raised by the department or members of the committee. The committee shall meet semi-annually, or more frequently if requested by the department or members of the committee. The department, in cooperation with the committee, shall report on the committee's activities annually to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later than October 1 each year.

NNNN. The Department of Medical Assistance Services shall establish a work group of representatives of providers of home- and community-based care services to continue improvements in the audit process and procedures for home- and community-based utilization and review audits. The Department of Medical Assistance Services shall

report on any revisions to the methodology for home- and community-based utilization and review audits, including progress made in addressing provider concerns and solutions to improve the process for providers while ensuring program integrity. In addition, the report shall include documentation of the past year's audits, a summary of the number of audits to which retractions were assessed and the total amount, the number of appeals received and the results of appeals. The report shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by December 1 of each year.

OOOO. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to calculate an indirect medical education (IME) factor for Virginia freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009. Total payments for IME in combination with other payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to. The department shall have the authority to implement these reimbursement changes effective July 1, 2013, and prior to completion of any regulatory process undertaken in order to effect such change.

PPPP. The Department of Medical Assistance Services shall realign the billable activities paid for individual supported employment provided under the Medicaid home- and community-based waivers to be consistent with job development and job placement services provided through employment services organizations that are reimbursed by the Department for Aging and Rehabilitative Services. The department shall have the authority to implement this reimbursement change effective July 1, 2013, and prior to the completion of any regulatory process undertaken in order to effect such change.

QQQQ. Effective July 1, 2013, the Department of Medical Assistance Services shall take the steps necessary to amend the Intellectual Disability Waiver and the Individual and Family Developmental Disabilities Support Waiver to change the unit of service for skilled and private duty nursing from the current one hour to one-quarter of an hour. The department shall implement this change using a methodology that is budget neutral.

RRRR.1. The Department of Medical Assistance Services shall seek federal authority through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to implement a comprehensive value-driven, market-based reform of the Virginia Medicaid/FAMIS programs. This reform shall be implemented in three phases as outlined in paragraphs 2, 3 and 4. The department shall have authority to implement necessary changes when feasible after federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

2. In the first phase of reform, the Department of Medical Assistance Services shall continue currently authorized reforms of the Virginia Medicaid/FAMIS service delivery model that shall, at a minimum, include (i) implementation of a Medicare-Medicaid Enrollee (dual eligible) Financial Alignment demonstration as evidenced by a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (CMS), signing of a three-way contract with CMS and participating plans, and approval of the necessary amendments to the State Plan for Medical Assistance and any waivers thereof; (ii) enhanced program integrity and fraud prevention efforts to include at a minimum: recovery audit contracting (RAC), data mining, service authorization, enhanced coordination with the Medicaid Fraud Control Unit (MFCU), and Payment Error Rate Measurement (PERM); (iii) inclusion of children enrolled in foster care in managed care; (iv) implementation of a new eligibility and enrollment information system for Medicaid and other social services; (v) improved access to Veterans services through creation of the Veterans Benefit Enhancement Program; and (vi) expedite the tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services.

3. In the second phase of reform, the Department of Medical Assistance Services shall implement value-based purchasing reforms for all recipients subject to a Modified Adjusted Gross Income (MAGI) methodology for program eligibility and any other recipient categories not excluded from the Medallion II managed care program. Such reforms shall, at a minimum, include the following: (i) the services and benefits provided are the types of services and benefits provided by commercial insurers and may include appropriate and reasonable limits on

services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services; (ii) reasonable limitations on non-essential benefits such as non-emergency transportation are implemented; and (iii) patient responsibility is required including reasonable cost-sharing and active patient participation in health and wellness activities to improve health and control costs.

To administer this reformed delivery model, the department is authorized to contract with qualified health plans to offer recipients a Medicaid benefit package adhering to these principles. Any coordination of non-traditional behavioral health services covered under contract with qualified health plans or through other means shall adhere to the principles outlined in paragraph RR. e. This reformed service delivery model shall be mandatory, to the extent allowed under the relevant authority granted by the federal government and shall, at a minimum, include (i) limited high-performing provider networks and medical/health homes; (ii) financial incentives for high quality outcomes and alternative payment methods; (iii) improvements to encounter data submission, reporting, and oversight; (iv) standardization of administrative and other processes for providers; and (v) support of the health information exchange.

The second phase of reform shall also include administrative simplification of the Medicaid program through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act and outline agreed upon parameters and metrics to provide maximum flexibility and expedited ability to develop and implement pilot programs to test innovative models that (i) leverage innovations and variations in regional delivery systems; (ii) link payment and reimbursement to quality and cost containment outcomes; or (iii) encourage innovations that improve service quality and yield cost savings to the Commonwealth.

4. In the third phase of reform, the Department of Medical Assistance Services shall seek reforms to include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems. The department shall begin designing the process and obtaining federal authority to transition all remaining Medicaid beneficiaries into a coordinated delivery system. A report shall be provided to the 2014 General Assembly regarding the progress of designing and implementing such reforms.

5. The Department of Medical Assistance Services shall provide a report to the Medicaid Innovation and Reform Commission on the specific waiver and/or State Plan changes that have been approved and status of implementing such changes, and associated cost savings or cost avoidance to Medicaid/FAMIS expenditures.

6.a. The Department shall seek the approval of the Medicaid Innovation and Reform Commission to amend the State Plan for Medicaid Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act. If the Medicaid Innovation and Reform Commission determines that the conditions in paragraphs 2, 3, 4, and 5 have been met, then the Commission shall approve implementation of coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act.

b. Upon approval by the Medicaid Innovation and Reform Commission, the department shall implement the provisions in paragraph 6.a. of this item by July 1, 2014, or as soon as feasible thereafter.

7.a. Contingent upon the expansion of eligibility in paragraph 6.a., there is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Health Reform and Innovation Fund, hereafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and any moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. For purposes of the Comptroller's preliminary and final annual reports required by § 2.2-813, however, all deposits to and disbursements from the Fund shall be accounted for as part of the general fund of the state treasury.

b. The Director of the Department of Medical Assistance Services, in consultation with the Director of the

Department of Planning and Budget, shall annually identify projected general fund savings attributable to enrollment of newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA, including behavioral health services, inmate health care, and indigent care. Beginning with development of the fiscal year 2015 budget, these projected savings shall be reflected in reduced appropriations to the affected agencies and the amounts deposited into the Fund net of any appropriation increases necessary to meet resulting programmatic requirements of the Department of Medical Assistance Services. Beginning in fiscal year 2015, funding to support health innovations described in Paragraph 3 shall be appropriated from the Fund not to exceed $3.5 million annually. Funding shall be distributed through health innovation grants to private and public entities in order to reduce the annual rate of growth in health care spending or improve the delivery of health care in the Commonwealth. When the department, in consultation with the Department of Planning and Budget, determines that the general fund expenses incurred from coverage of newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA exceed any associated savings, a percentage of the principle of the Fund as determined necessary by the department and the Department of Planning and Budget to cover the cost of the newly eligible population shall be reallocated to the general fund and appropriated to the department to offset the cost of this population. Principle shall be allocated on an annual basis for as long as funding is available.

8. In the event that the increased federal medical assistance percentages for newly eligible individuals included in 42 U.S.C. § 1396d(y)(1)[2010] of the PPACA is modified through federal law or regulation from the methodology in effect on January 1, 2014, resulting in a reduction in federal medical assistance as determined by the department in consultation with the Department of Planning and Budget, the Department of Medical Assistance Services shall disenroll and eliminate coverage for individuals who obtained coverage through 42 U.S.C. § 1396d(y)(1) [2010] of the PPACA. The disenrollment process shall include written notification to affected Medicaid beneficiaries, Medicaid managed care plans, and other providers that coverage will cease as soon as allowable under federal law from the date the department is notified of a reduction in Federal Medical Assistance Percentage.

9. There is hereby appropriated sum sufficient nongeneral funds for such costs as may be incurred to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act.

SSSS.1. The Director of the Department of Medical Assistance Services shall continue to make improvements in the provision of health and long-term care services under Medicaid/FAMIS that are consistent with evidence-based practices and delivered in a cost effective manner to eligible individuals.

2. In order to effect such improvements and ensure that reform efforts are cost effective relative to current forecasted Medicaid/FAMIS expenditure levels, the Department of Medical Assistance Services shall (i) develop a five-year consensus forecast of expenditures and savings associated with the Virginia Medicaid/FAMIS reform efforts by November 15 of each year in conjunction with the Department of Planning and Budget, and with input from the House Appropriations and Senate Finance Committees, and (ii) engage stakeholder involvement in meeting annual targets for quality and cost-effectiveness.

TTTT. Contingent upon the Commonwealth not receiving the expected revenue in fiscal year 2013 from the arbitration settlement with tobacco companies as part of the Master Settlement Agreement, the Director, Department of Planning and Budget, is authorized to appropriate from the unappropriated general fund balance in this act, and, if necessary, transfer general fund appropriation from the second year to the first year to backfill the shortage of up to $21,680,000 in general fund for the Medicaid program.