2014 Special Session I

Budget Bill - HB5004 (Introduced)

Bill Order » Office of Health and Human Resources » Item 301

Department of Medical Assistance Services

Item 301	First Year - FY2015	Second Year - FY2016
Medicaid Program Services (45600)	**$8,495,724,272**	**$8,761,183,102**
Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607)	$195,323,559	$151,502,743
Reimbursements for Behavioral Health Services (45608)	$714,458,456	$737,933,976
Reimbursements for Medical Services (45609)	$5,653,402,865	$5,945,109,167
Reimbursements for Long-Term Care Services (45610)	$1,932,539,392	$1,926,637,216
Fund Sources:		
General	$3,924,798,676	$4,112,768,821
Dedicated Special Revenue	$371,235,653	$359,191,638
Federal Trust	$4,199,689,943	$4,289,222,643

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, $97,661,780 the first year and $75,751,372 the second year from the general fund and $97,661,779 the first year and $75,751,371 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 $76,612,053 the first year and $97,947,615 the second year from the general fund and $91,856,828 the first year and $99,297,231 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 $42,628,181 the first year and $55,299,598 the second year from the general fund and $53,760,229 the first year and $56,391,794 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 in FY 2015 for private hospitals reflected in paragraph CCC. of this Item. It also includes reductions for prior year inflation reductions and indigent care reductions. 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 $371,235,653 the first year and $359,191,638 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.

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.

E. 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.

F. To the extent that appropriations in this Item are insufficient, the Department of Planning and Budget shall transfer general fund appropriation from Item 300 and 303, if available, to be used as state match for federal Title IX funds.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L.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.

M.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, Department for Aging and Rehabilitative Services, 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.

2. The Department of Medical Assistance Services shall retain the savings necessary to reimburse a vendor for its efforts to implement paragraph. O.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.

N. 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. 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 by November 1 each year.

O. 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.

P.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) continually review utilization of behavioral health medications under the State Medicaid Program for Medicaid recipients; and (ii) 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.

Q.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.

R. 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.

S. 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.

T.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.

U.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.

V. 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.

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

X. 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.

Y.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.

Z. 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.

AA. 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.

BB. 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.

CC. 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.

DD. 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.

EE. 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.

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

GG. 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.

HH. 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.

II. 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 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.

b. 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.

c. 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.

d. 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.

e.1. 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.

JJ. 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.

KK. 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.

LL. 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.

MM. 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.

NN. 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.

OO. 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.

PP. 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.

QQ. 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, and consistent with the federal rule implementing § 1202 of HCERA and State Plan Amendment approved by the Centers for Medicare and Medicaid Services.

RR.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 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.

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

SS. 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.

TT. 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.

UU.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.

VV. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate hospital inflation for FY 2015. This shall apply to inpatient hospital operating rates (including long-stay and freestanding psychiatric), graduate medical education (GME) payments and disproportionate share hospital (DSH) payments. Similar reductions shall be made to the general fund share for Type One hospitals as reflected in Item 301 B. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process in order to effect such changes.

WW. The Department of Medical Assistance Services shall amend the 1915 (c) home- and community-based Intellectual Disabilities waiver to add 340 slots effective July 1, 2014 and an additional 360 slots effective July 1, 2015.

XX. 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, 2014 and an additional 25 slots effective July 1, 2015. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the DD

waiver to add the additional slots.

YY. 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.

ZZ. 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.

AAA. 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. 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.

BBB. 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.

CCC. 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.

DDD. 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.

EEE. 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.

FFF. 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.

GGG. 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.

HHH. 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.

III. 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.

JJJ. 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.

KKK. 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.

LLL. Effective July 1, 2014, the Department of Medical Assistance Services shall replace the AP-DRG grouper with the APR-DRG grouper for hospital inpatient reimbursement. The department shall develop budget neutral case rates and Virginia-specific weights for the APR-DRG grouper based on the FY 2011 base year. The department shall phase in the APR-DRG weights by blending in 50 percent of the full APR-DRG weights with 50 percent of FY 2014 AP-DRG weights in the first year and 75 percent of the full APR-DRG weights with 25 percent of the FY 2014 AP-DRG weights in the second year for each APR-DRG group and severity. FY 2014 AP-DRG weights shall be calculated as a weighted average FY 2014 AP-DRG weight for all claims in the base year that group to each APR-DRG group and severity. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process in order to effect such changes.

MMM.1. Effective July 1, 2014, the Department of Medical Assistance Services shall replace the current Disproportionate Share Hospital (DSH) methodology with the following methodology:

a) DSH eligible hospitals must have a total Medicaid Inpatient Utilization Rate equal to 14 percent or higher in the base year using Medicaid days eligible for Medicare DSH or a Low Income Utilization Rate in excess of 25 percent and meet other federal requirements. Eligibility for out of state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid NICU utilization equal to 14 percent or higher.

b) Each hospital's DSH payment shall be equal to the DSH per diem multiplied by each hospital's eligible DSH days in a base year. Days reported in provider fiscal years in state FY 2011 will be the base year for FY 2015 prospective DSH payments. DSH will be recalculated annually with an updated base year. DSH payments are subject to applicable federal limits.

c) Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric and rehabilitation days above 14 percent for each DSH hospital subject to special rules for out of state cost reporting hospitals. Eligible DSH days for out of state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14 percent times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out of state cost reporting hospitals who qualify for DSH but who have less than 12 percent Virginia Medicaid utilization shall be 50 percent of the days that would have otherwise been eligible DSH days.

d) Additional eligible DSH days are days that exceed 28 percent Medicaid utilization for Virginia Type Two hospitals (excluding Children's Hospital of the Kings Daughters).

e) The DSH per diem shall be calculated in the following manner:

a. The DSH per diem for Type Two hospitals is calculated by dividing the total Type Two DSH allocation by the sum of eligible DSH days for all Type Two DSH hospitals. For purposes of DSH, Type Two hospitals do not include Children's Hospital of the Kings Daughters (CHKD) or any hospital whose reimbursement exceeds its federal uncompensated care cost limit. The Type Two Hospital DSH allocation shall equal the amount of DSH paid to Type Two hospitals in state FY 2014 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

b. The DSH per diem for State Inpatient Psychiatric Hospitals is calculated by dividing the total State Inpatient Psychiatric Hospital DSH allocation by the sum of eligible DSH days. The State Inpatient Psychiatric Hospital DSH

allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

c. The DSH per diem for CHKD shall be three times the DSH per diem for Type Two hospitals.

d. The DSH per diem for Type One hospitals shall be 17 times the DSH per diem for Type Two hospitals.

2. Each year, the department shall determine how much Type Two DSH has been reduced as a result of the Affordable Care Act and adjust the percent of cost reimbursed for outpatient hospital reimbursement.

3. The department shall convene the Hospital Payment Policy Advisory Council at least once a year to consider additional changes to the DSH methodology.

4. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process in order to effect such changes.

NNN. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to pay rates for Durable Medical Equipment items subject to the Medicare competitive bidding program equal to the lower of the current DMERC minus 10 percent or the average of the Medicare competitive bid rates in Virginia markets. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process in order to effect such changes.

OOO. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to make a budget neutral change to the Mental Health Support Services rate from an hourly unit to a quarter hour unit. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process in order to effect such changes.

PPP. The Department of Medical Assistance Services shall have the authority to contract with other public and private entities to conduct the required screening process for the Individual and Family Developmental Disabilities Support waiver. 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 changes.

QQQ. The Department of Medical Assistance Services shall have authority to amend its regulations, subject to the federal Centers for Medicare and Medicaid Services approval, to strengthen all program requirements and policies of the consumer-directed services programs to ensure the health, safety and welfare of Medicaid home- and community-based waiver enrollees. The department shall submit a detailed report on proposed regulatory changes to the consumer-directed services programs and the issues and problems the department is attempting to resolve. The department shall submit the report to the Director, Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees at least 30 days prior to beginning the regulatory process.

RRR. Effective July 1, 2014, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reduce clinical laboratory fees by 12 percent. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process in order to effect such changes.

SSS. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the supplemental physician payments for practice plans affiliated with a freestanding children's hospital with more than 50 percent Medicaid inpatient utilization in FY 2009 to the maximum allowed by the Centers for Medicare and Medicaid Services. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to completion of any regulatory process undertaken in order to effect such change.