2015 Session

Budget Bill - HB1400 (Chapter 665)

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)	~~**$8,434,331,435**~~ ***$8,136,412,131***	~~**$8,661,642,748**~~ ***$8,494,567,407***
Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607)	~~$195,323,559~~ *$197,295,289*	~~$151,502,743~~ *$151,698,269*
Reimbursements for Behavioral Health Services (45608)	~~$714,458,456~~ *$687,767,790*	~~$737,933,976~~ *$789,996,961*
Reimbursements for Medical Services (45609)	~~$5,615,790,120~~ *$4,979,574,340*	~~$5,874,808,569~~ *$5,273,664,286*
Reimbursements for Long-Term Care Services (45610)	~~$1,908,759,300~~ *$2,271,774,712*	~~$1,897,397,460~~ *$2,279,207,891*
Fund Sources:		
General	~~$3,877,123,130~~ *$3,694,399,164*	~~$4,043,108,604~~ *$3,987,155,922*
Dedicated Special Revenue	~~$375,991,838~~ *$430,248,427*	~~$366,283,980~~ *$346,848,632*
Federal Trust	~~$4,181,216,467~~ *$4,011,764,540*	~~$4,252,250,164~~ *$4,160,562,853*

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~~ *$98,647,645* the first year and ~~$75,751,372~~ *$75,849,135* the second year from the general fund and ~~$97,661,779~~ *$98,647,644* the first year and ~~$75,751,371~~ *$75,849,134* 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~~ *$75,856,682* the first year and ~~$81,232,654~~ *$82,016,765* the second year from the general fund and ~~$91,856,828~~ *$91,101,458* the first year and ~~$99,297,231~~ *$98,731,727* 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~~ *$43,284,148* the first year and ~~$42,875,083~~ *$44,688,169* the second year from the general fund and ~~$53,760,229~~ *$54,386,197* the first year and ~~$56,391,794~~ *$57,112,685* 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 and FY 2016 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 ~~$375,991,838~~ *$430,248,427* the first year and ~~$366,283,980~~ *$346,848,632* 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 300 and 303, 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.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 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. 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.

P. 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.

Q. 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.

R.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.

S.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.

T.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.

U. 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.

V. 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.

W.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.

X.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.

Y. 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.

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

AA. 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.

BB.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.

CC. 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.

DD. 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.

EE. 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.

FF. 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.

GG. 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.

HH. 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.

II. 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.

JJ. 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.

KK. 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.

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

MM. 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.

NN. 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.

OO. 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.

2. There is hereby created in the state treasury a special nonreverting fund to be known as the Commonwealth Coordinated Care Pay for Performance 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. Moneys deposited to the fund shall be used solely for bonus payments to managed care organizations participating in the Commonwealth Coordinated Care program that meet the performance criteria of the pay for performance program specified in paragraph OO.e.1.

3. The department is authorized to implement a quality withhold program in the context of the initiative implemented pursuant to OO.e.1. Quality withhold funds, withheld from health plan capitation payments, shall be deposited in the fund created pursuant to OO.e.2. At the time and in the amounts determined by DMAS and Centers for Medicare and Medicaid Services, DMAS shall be authorized to make payments from the fund to health plans that meet quality performance measures stipulated in the Memorandum of Understanding and contract with health plans entered into pursuant to OO.e.1. Funds deposited in the fund may be used only for such payments.

4. The Department of Planning and Budget in collaboration with the Department of Medical Assistance services shall transfer general fund appropriation withheld from funds set aside in connection with a pay for performance program related to the dual eligible initiative pursuant to paragraph OO.e.1., to the fund.

PP. 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.

QQ. 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.

RR. 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.

SS. 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.

TT. 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.

UU. 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.

VV. 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.

WW. 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.

XX.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.

YY. 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.

ZZ. 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.

AAA. 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.

BBB.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.

CCC. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate hospital inflation for FY 2015 and FY 2016. 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.

DDD. The Department of Medical Assistance Services shall amend the 1915 (c) home- and community-based Intellectual Disabilities waiver to add 115 slots effective July 1, 2014 and an additional 410 slots effective July 1, 2015.

EEE. The Department of Medical Assistance Services shall amend the Individual and Family Developmental Disabilities Support (DD) waiver to add 15 new slots effective July 1, 2014 and an additional 40 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.

FFF. 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.

GGG. 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.

HHH. 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.

III. 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.

JJJ. 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.

KKK. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to convert the current cost-based payment methodology for nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology effective July 1, 2014. The new price-based payment methodology shall be implemented in a budget neutral manner.

1. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

a. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

b. The initial base year for calculating the cost per day is cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost per day by the raw Medicaid facility case-mix that corresponds to the base year by facility.

d. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the 4th quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by pro-rating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation.

e. Prices will be established for the following peer groups using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

1) Direct Peer groups

- Northern Virginia MSA

- Other MSAs

- Northern Rural

- Southern Rural

2) Indirect Peer Groups

- Northern Virginia MSA

- Rest of State – Greater than 60 Beds

- Other MSAs

- Northern Rural

- Southern Rural

- Rest of State – 60 Beds or Less

f. The price for each peer group shall be based on the following adjustment factors:

1) Direct - 105 percent of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

2) Indirect - 100.7 percent of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

g. Facilities with costs projected to the rate year below 95 percent of the price shall have an adjusted price equal to the price minus the difference between their cost and 95 percent of the unadjusted price. Adjusted prices will be established at each rebasing. New facilities after the base year shall not have an adjusted price until the next rebasing. The "spending floor" limits the potential gain of low cost facilities, thereby making it possible to implement higher adjustment factors for other facilities at less cost.

h. Individual claim payment for direct costs shall be based on each resident's Resource Utilization Group (RUG) during the service period times the facility direct price (similar to Medicare).

i. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGS to determine facility case mix for cost neutralization in determining the direct costs used in setting the price and for adjusting the claim payments for residents. The department may elect to transition from the RUG-III 34 Medicaid grouper to the RUG-IV 48 grouper in the following manner.

1) The department shall neutralize direct costs per day in the base year using the most current RUG grouper applicable to the base year.

2) The department shall utilize RUG-III 34 groups and weights in fiscal year 2015 for claim payments.

3) Beginning in fiscal year 2016, the department may elect to implement RUG-IV 48 Medicaid groups and weights for claim payments.

4) RUG-IV 48 weights used for claim payments will be normalized to RUG-III 34 weights as long as base year costs are neutralized by the RUG-III 34 group. In that the weights are not the same under RUG IV as under RUG III, normalization will insure that total payments in direct using the RUGs IV 48 weights will be the same as total payments in direct using the RUGs-III 34 grouper.

j. The department shall transition to the price-based methodology over a period of four years, blending the price-based rate described here with the cost-based rate based on current law with the following adjustments. The

facility cost-based operating rates shall be the direct and indirect rates for fiscal year 2015 based on facility case-mix neutral rates modeled after the law that would have been in effect in fiscal year 2015 absent this amendment and using base year data from calendar year 2011 inflated to the rate year. Based on a four-year transition, the rate will be based on the following blend:

1) Fiscal year 2015 - 25 percent of the price-based rate and 75 percent of the cost-based rate.

2) Fiscal year 2016 - 50 percent of the price-based rate and 50 percent of the cost-based rate.

3) Fiscal year 2017 - 75 percent of the price-based rate and 25 percent of the cost-based rate.

4) Fiscal year 2018 - 100 percent of the price-based (fully implemented).

During the first transition year for the period July 1, 2014 through October 31, 2014, DMAS shall case-mix adjust each direct cost component of the rates using the average facility case-mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim.

Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013 shall be determined based on the most recently settled cost data. If there is no settled cost report at the beginning of a fiscal year, then 100 percent of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013 shall be paid 100 percent of the price-based rate.

2. Prospective capital rates shall be calculated in the following manner.

a. Fair rental value per diem rates for the fiscal year shall be calculated for all freestanding nursing facilities based on the prior calendar year information aged to the fiscal year and using RS Means factors and rental rates corresponding to the fiscal year. There will be no separate calculation for beds subject to and not subject to transition.

b. The department shall develop a procedure for mid-year fair rental value per diem rate changes for nursing facilities that put into service a major renovation or new beds. A major renovation shall be defined as an increase in capital of $3,000 per bed. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the effective date and the new rate shall be effective at the beginning of the month following the end of the 60 days. The provider shall submit final documentation within 60 days of the new rate effective date and the department shall review final documentation and modify the rate if necessary effective 90 days after the implementation of the new rate. No mid-year rate changes shall be made for an effective date after April 30 of the fiscal year.

c. Effective July 1, 2014, the rental rate shall be 8.0 percent.

d. These FRV changes shall also apply to specialized care facilities.

e. The capital per diem rate for hospital-based nursing facilities shall be the last settled capital per diem.

3. Prospective Nurse Aide Training and Competency Evaluation Programs (NATCEP) rates shall be the Medicaid per diem rate in the base year inflated to the rate year based on inflation used in the operating rate calculations.

4. A prospective rate for criminal records checks shall be the per diem rate in the base year.

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

6. The department shall amend the State Plan for Medical Assistance to reimburse the price-based operating rate rather than the transition operating rate to any nursing facility whose licensed bed capacity decreased by at least 30 beds after 2011 and whose occupancy increased from less than 70 percent in 2011 to more than 80 percent in 2013. The department shall have the authority to implement this reimbursement change effective July 1, 2015, and prior to completion of any regulatory process in order to effect such change.

LLL. 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.

MMM. 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 and enrolled in 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.

NNN. 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.

OOO. 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.

PPP. 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.

QQQ. 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.

RRR. 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.

SSS. 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.

TTT.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 OO. c. 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. Upon federal approval, the department shall have authority to implement such pilot programs prior to the completion of the regulatory process.

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.

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.

I VETO THIS ITEM /s/ Terence R. McAuliffe (6/21/14) (Vetoed item is enclosed in brackets.)

[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. That notwithstanding any other provision of this act, or any other law, no general or nongeneral funds shall be appropriated or expended 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, unless included in an appropriation bill adopted by the General Assembly on or after July 1, 2014.

UUU.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.

VVV. 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.

WWW.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.

XXX. 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.

YYY. 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), P.L. 111-148, 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 and, notwithstanding the requirements of Code of Virginia § 2.2-4000, et seq., the process for administrative appeals of MAGI-related eligibility determinations. 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 changes.

ZZZ. The Department of Medical Assistance Services (DMAS) shall not change the unit of service or rate of reimbursement for Mental Health Skill-Building Services (MHSS) until the 2015 General Assembly has reviewed the impact of the December 1, 2013 emergency regulations that changed the eligibility and service description for Mental Health Skill-Building Services. DMAS and the Department of Behavioral Health and Developmental Services shall jointly prepare a report to be delivered by November 1, 2014 to the Chairmen of the House Appropriations and Senate Finance Committees. The report shall document the impact of the MHSS regulations implemented on December 1, 2013 and shall include an assessment of the fiscal impact, consumer and family impact, service delivery impact, and impact upon other agencies and facilities in Virginia.

AAAA. 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.

BBBB. 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.

CCCC. 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.

DDDD.1. There is hereby appropriated sum-sufficient nongeneral funds for the Department of Medical Assistance Services (DMAS) to pay the state share of supplemental payments for qualifying private hospital partners of Type One hospitals (consisting of state-owned teaching hospitals) as provided in the State Plan for Medical Assistance Services. Qualifying private hospitals shall consist of any hospital currently enrolled as a Virginia Medicaid provider and owned or operated by a private entity in which a Type One hospital has a non-majority interest. The supplemental payments shall be based upon the reimbursement methodology established for such payments in Attachments 4.19-A and 4.19-B of the State Plan for Medical Assistance Services. DMAS shall enter into a transfer agreement with any Type One hospital whose private hospital partner qualifies for such supplemental payments,

under which the Type One hospital shall provide the state share in order to match federal Medicaid funds for the supplemental payments to the private hospital partner. The department shall have the authority to implement these reimbursement changes consistent with the effective date in the State Plan amendment approved by CMS and prior to completion of any regulatory process in order to effect such changes.

2.*a.* The Department of Medical Assistance Services shall promulgate regulations to make supplemental payments to Medicaid physician providers with a medical school located in Eastern Virginia that is a political subdivision of the Commonwealth. The amount of the supplemental payment shall be based on the difference between the average commercial rate approved by the Centers for Medicare and Medicaid Services (CMS) and the payments otherwise made to physicians. ~~Funding for the state share for the Medicaid payments are authorized in Item 243.~~ The department shall have the authority to implement these reimbursement changes consistent with the effective date in the State Plan amendment approved by CMS and prior to completion of any regulatory process in order to effect such changes.

b. The department shall increase payments to Medicaid managed care organizations for the purpose of securing access to Medicaid physician services in Eastern Virginia, through higher rates to physicians affiliated with a medical school located in Eastern Virginia that is a political subdivision of the Commonwealth subject to applicable limits. The department shall revise its contracts with managed care organizations to incorporate these supplemental capitation payments, and provider payment requirements, subject to approval by CMS. No payment shall be made without approval from CMS.

c. Funding for the state share for these Medicaid payments is authorized in Item 243.

3. The Department of Medical Assistance Services (DMAS) shall have the authority to amend the State Plan for Medical Assistance Services (State Plan) to implement a supplemental Medicaid payment for local government-owned nursing homes. The total supplemental Medicaid payment for local government-owned nursing homes shall be based on the difference between the Upper Payment Limit of 42 CFR §447.272 as approved by CMS and all other Medicaid payments subject to such limit made to such nursing homes. There is hereby appropriated sum-sufficient funds for DMAS to pay the state share of the supplemental Medicaid payment hereunder. However, DMAS shall not submit such State Plan amendment to CMS until it has entered into an intergovernmental agreement with eligible local government-owned nursing homes or the local government itself which requires them to transfer funds to DMAS for use as the state share for the supplemental Medicaid payment each nursing home is entitled to and to represent that each has the authority to transfer funds to DMAS and that the funds used will comply with federal law for use as the state share for the supplemental Medicaid payment. If a local government-owned nursing home or the local government itself is unable to comply with the intergovernmental agreement, DMAS shall have the authority to modify the State Plan. The department shall have the authority to implement the reimbursement change consistent with the effective date in the State Plan amendment approved by CMS and prior to the completion of any regulatory process undertaken in order to effect such change.

4. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance Services to implement a supplemental payment for clinic services furnished by the Virginia Department of Health (VDH) effective July 1, 2015. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by the Centers for Medicare and Medicaid Services and all other Medicaid payments. VDH is required to transfer funds to the department funds already appropriated to VDH to cover the non-federal share of the Medicaid payments. The department shall have the authority to implement the reimbursement change effective July 1, 2015, and prior to the completion of any regulatory process undertaken in order to effect such changes.

EEEE. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to provide coverage for cessation services for tobacco users, including pharmacology, group and individual counseling, and other treatment services including the most current version of or an official update to the Clinical Health Guideline "Treating Tobacco Use and Dependence" published by the Public Health Service of the U.S. Department of Health and Human Services. These services shall be subject to copayment requirements. The department shall have

authority to implement this reimbursement change effective July 1, 2014 and prior to the 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 1915 (c) home- and community-based Elderly or Consumer-Direction (EDCD) waiver, Individual and Family Developmental Disabilities (DD) Support Waiver, Intellectual Disabilities (ID) waiver and Technology-Assisted (TECH) waiver, and associated regulations, to specify that transition services includes the first month's rent for qualified housing as an allowable cost. The department shall have authority to implement this reimbursement change effective July 1, 2014 and prior to the completion of any regulatory process undertaken in order to effect such changes.

GGGG. The Department of Medical Assistance Services shall have the authority to implement Section 1902(a)(10)(A)(i)(IX) of the federal Social Security Act to provide Medicaid benefits up until the age of 26 to individuals who are or were in foster care at least until the age of 18 in any state.

HHHH. Effective July 1, 2014 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 8.0 percent in fiscal year 2015 and fiscal year 2016. 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 changes.

IIII. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate nursing facility inflation for fiscal year 2016. This shall apply to nursing facility operating rates. 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 changes.

JJJJ. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate inflation for outpatient rehabilitation agencies and home health agencies for FY 2015 and FY 2016. The department shall have the authority to implement these reimbursement changes effective July 1, 2014, and prior to the completion of any regulatory process in order to effect such changes.

KKKK. The Department of Medical Assistance Services shall assess and report on the impact of the requirement that nurses providing private duty nursing services to individuals receiving services through the Technology Assisted Waiver program to have six months of work experience in order to be reimbursed through the Medicaid program. The assessment shall examine access to qualified nurses by individuals eligible for waiver services as well as hiring, turnover, and retention of nurses providing private duty nursing services through the waiver. The department shall provide a report on its findings by November 1, 2014, to the Chairmen of the House Appropriations and Senate Finance Committees.

LLLL.1. The Department of Medical Assistance Services shall amend the Medicaid demonstration project (Project Number 11-W-00297/3) to modify eligibility provided through the project to individuals with serious mental illness to be effective July 1, 2015. Income eligibility shall be modified to limit services to seriously mentally ill adults with effective household incomes up to 60 percent of the federal poverty level (FPL). All individuals enrolled in this Medicaid demonstration project with incomes between 61% and 100% of the Federal Poverty Level as of May 15, 2015 who continue to meet other program eligibility rules, shall maintain enrollment in the demonstration until their next eligibility renewal period or July 1, 2016, whichever comes first. Benefits shall include the following services: (i) primary care office visits including diagnostic and treatment services performed in the physician's office, (ii) outpatient specialty care, consultation, and treatment, (iii) outpatient hospital including observation and ambulatory diagnostic procedures, (iv) outpatient laboratory, (v) outpatient pharmacy, (vi) outpatient telemedicine, (vii) medical equipment and supplies for diabetic treatment, (viii) outpatient psychiatric treatment, (ix) mental health case management, (x) psychosocial rehabilitation assessment and psychosocial rehabilitation services, (xi) mental health crisis intervention, (xii) mental health crisis stabilization, (xiii) therapeutic or diagnostic injection, (xiv) behavioral telemedicine, (xv) outpatient substance abuse treatment services, and (xvi) intensive outpatient substance abuse treatment services. Care coordination, Recovery Navigation (peer supports), crisis line and prior authorization for services shall be provided

through the agency's Behavioral Health Services Administrator. 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.

2. The Department of Medical Assistance Services is authorized to amend the State Plan under Title XIX of the Social Security Act to add coverage for comprehensive dental services to pregnant women receiving services under the Medicaid program to include: (i) diagnostic, (ii) preventive, (iii) restorative, (iv) endodontics, (v) periodontics, (vi) prosthodontics both removable and fixed, (vii) oral surgery, and (viii) adjunctive general services.

3. The Department of Medical Assistance Services is authorized to amend the FAMIS MOMS and FAMIS Select demonstration waiver (No. 21-W-00058/3) for FAMIS MOMS enrollees to add coverage for dental services to align with pregnant women's coverage under Medicaid.

4. The Department of Medical Assistance Services is authorized to amend the State Plan under Title XXI of the Social Security Act to plan to allow enrollment for dependent children of state employees who are otherwise eligible for coverage.

5. 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.

MMMM. Out of this appropriation, $8,179,904 from the general fund and $8,179,904 from nongeneral funds the second year shall be used to increase rates by two percent for congregate residential services (except sponsored placement), 5.5 percent for in-home residential services, two percent for day support services and prevocational services, 10 percent for therapeutic consultation services, 15.7 percent for skilled nursing services in the Intellectual Disability and IFDDS waivers and six percent for EPSDT nursing to be equal to the private duty nursing rates in the Technology Assisted Waiver effective July 1, 2015.

2. The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on plans to redesign the Medicaid comprehensive Intellectual and Developmental Disability waivers prior to the submission of a request to the Centers for Medicare and Medicaid Services to amend the waivers. In developing the report, the departments shall include plans for the list of services to be included in each waiver; service limitations, provider qualifications, and proposed licensing regulatory changes; and proposed changes to the rate structure for services and the cost to implement such changes. In addition, the Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall report on how the individuals currently served in the existing waivers and those expected to transition to the community will be served in the redesigned waivers based on their expected level of need for services. The departments shall complete their work and submit the report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2015.

NNNN. The Department of Medical Assistance Services shall increase the rates for agency and consumer-directed personal and respite care services by two percent, effective July 1, 2015.

OOOO. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services to eliminate the requirement for pending, reviewing and reducing fees for emergency room claims for 99283 codes. The department shall have the authority to implement this reimbursement change effective July 1, 2015, and prior to the completion of any regulatory process undertaken in order to effect such change.

PPPP. 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 fiscal year 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, 2015, and prior to completion of any regulatory process undertaken in order to effect such change.

QQQQ.1. Notwithstanding § 32.1-330 of the Code of Virginia, the Department of Medical Assistance Services shall improve the preadmission screening process for individuals who will be eligible for long-term care services, as defined in the state plan for medical assistance. The community-based screening team shall consist of a licensed health care professional and a social worker who are employees or contractors of the Department of Health or the local department of social services, or other assessors contracted by the department. The department shall not contract with any entity for whom there exists a conflict of interest. For community-based screening for children, the screening shall be performed by an individual or entity with whom the department has entered into a contract for the performance of such screenings.

2. The department shall track and monitor all requests for screenings and report on those screenings that have not been completed within 30 days of an individual's request for screening. The screening teams and contracted entities shall use the reimbursement and tracking mechanisms established by the department.

3. The department shall report on the progress of meeting the requirements for completion of preadmission screenings within 30 days of an individual's request for screening, the implementation of the contract for screening children, and make recommendations for changes to improve the process to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2015.

4. The Department of Medical Assistance Services shall promulgate regulations to implement these provisions to be effective within 280 days of its enactment. The department may implement any changes necessary to implement these provisions prior to the promulgation of regulations undertaken in order to effect such changes.

RRRR.1. The Department of Medical Assistance Services (DMAS) shall provide quarterly reports beginning on July 1, 2015, to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the Commonwealth Coordinated Care program, including information on program enrollment, the ability of Medicare and Medicaid Managed Care Plans to ensure a robust provider network, resolution of provider concerns regarding the cost and technical difficulties in participating in the program, quality of care, and progress in resolving issues related to federal Medicare requirements which impede the efficient and effective delivery of care.

2. The Department of Medical Assistance Services (DMAS) shall require providers to use a National Provider Identifier number, effective July 1, 2015, in order to participate in the Commonwealth Coordinated Care program.

SSSS. The Department of Medical Assistance Services (DMAS) shall amend its July 1, 2016, managed care contracts in order to conform to the requirement pursuant to House Bill 1942 / Senate Bill 1262, passed during the 2015 Regular Session, for prior authorization of drug benefits. The Department shall report the necessary amendments to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2015.

TTTT. Notwithstanding 12VAC30-120-1600 et seq., a resident of a "safe, secure environment" as defined in 22VAC40-72-10 shall be deemed to have met the requirements of 12VAC30-120-1610 B for the purposes of the Alzheimer's Assisted Living Waiver.