2018 Special Session I

Budget Bill - HB5001 (HB5001S1)

Department of Medical Assistance Services

Item 306	First Year - FY2017	Second Year - FY2018
Medicaid Program Services (45600)	**$9,306,605,828**	~~**$9,705,926,154**~~ ***$9,990,343,272***
Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607)	$142,690,148	$140,540,402
Reimbursements for Behavioral Health Services (45608)	$833,340,268	~~$892,215,342~~ *$671,487,348*
Reimbursements for Medical Services (45609)	$5,613,389,616	~~$5,820,956,424~~ *$7,413,741,830*
Reimbursements for Long-Term Care Services (45610)	$2,717,185,796	~~$2,852,213,986~~ *$1,764,573,692*
Fund Sources:		
General	$4,332,818,444	~~$4,605,674,894~~ *$4,651,424,296*
Dedicated Special Revenue	$399,790,186	~~$359,174,530~~ *$399,844,323*
Federal Trust	$4,573,997,198	~~$4,741,076,730~~ *$4,939,074,653*

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, $71,345,074 the first year and $70,270,201 the second year from the general fund and $71,345,074 the first year and $70,270,201 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 $64,271,600 the first year and ~~$66,307,880~~ *$67,031,489* the second year from the general fund and $81,753,552 the first year and ~~$85,496,639~~ *$86,220,247* 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 $39,565,488 the first year and ~~$40,676,066~~ *$42,165,481* the second year from the general fund and $52,701,218 the first year and ~~$55,390,844~~ *$56,880,258* 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 reduced and no inflation for inpatient services in FY 2017 and FY 2018 for private hospitals reflected in paragraph GGGG. 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 $399,790,186 the first year and ~~$359,174,530~~ *$399,677,948* 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. At least 30 days prior to the submission of an application for any new waiver of Title XIX or Title XXI of the Social Security Act, the Department of Medical Assistance Services shall notify the Chairmen of the House Appropriations and Senate Finance Committees of such pending application and provide information on the

purpose and justification for the waiver along with any fiscal impact. If the department receives an official letter from either Chairmen raising an objection about the waiver during the 30-day period, the department shall not submit the waiver application and shall request authority for such waiver as part of the normal legislative or budgetary process. If the department receives no objection, then the application may be submitted. Any waiver specifically authorized elsewhere in this item is not subject to this provision. Waiver renewals are not subject to the provisions of this paragraph.

3. 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, as needed, from Children's Health Insurance Program Delivery (44600) and Medical Assistance Services for Low Income Children (46600), if available, into this Item to be used as state match for federal Title XIX 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, meeting at least semi-

annually, to implement initiatives for the promotion of cost-effective services delivery as may be appropriate. The department shall solicit input from the Pharmacy Liaison Committee regarding pharmacy provisions in the development and enforcement of all managed care contracts. 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 3.0 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, Children's 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 Children's 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 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.

AA.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.

BB. 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.

CC. 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.

DD. 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.

EE. 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.

FF. 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.

GG. 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.

HH. The Department of Medical Assistance Services shall impose an assessment equal to 6.0 percent of revenue on all ICF-ID 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.

II. 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 to 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.

JJ. 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 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.

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

LL. 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.

MM. 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 3.0 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. 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.

NN. 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.

OO. 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 13 VAC 30- 80-40, including the dispensing fee, with an alternative methodology that is budget neutral or that creates a 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. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

PP. 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.

QQ. 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.

RR. 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.

SS. 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.

TT.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.

UU. 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 P.L. 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.

VV. 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.

WW.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.

I VETO THIS ITEM /s/ Terence R. McAuliffe (04/28/17) (Vetoed item is enclosed in brackets.)

[vii. Clarify that the informal appeals agent shall have the ability to close an informal appeal based on a settlement between the parties up to $250,000, notwithstanding § 2.2-514 of the Code of Virginia. For settlements of $250,000 or greater, such settlement shall be subject to § 2.2-514 of the Code of Virginia. **]**

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.

3. The Department of Medical Assistance Services shall convene a workgroup with representatives from the provider community, and the legal community, and the Office of Attorney General to develop a plan to avoid or adjust retractions or for non-material breaches of the Provider Participation Agreement when the provider has substantially complied with the Provider Participation Agreement. The plan shall include an assessment of any administrative financial impact that implementation of such plan would have on the department and an analysis of any implications for the department's efforts to combat fraud, waste, and abuse. The workgroup shall report on the status of this plan to the Chairmen of the House Appropriations and Senate Finance Committees no later than December 1, 2017.

XX. 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.

YY. 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.

ZZ. 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 include in the fall quarterly report required in paragraph AAAA. of this Item an annual update that details the implementation progress of the financial alignment demonstration. This update shall include, but is not limited to, costs of implementation, projected cost savings, number of individuals enrolled, and any other implementation issues that arise.

AAA. 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.

BBB. 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.

CCC. 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. Effective on and after July 1, 2017, the Direct Peer Group price percentage shall be increased to 106.8 percent.

2) Indirect - 100.7 percent of the peer group day-weighted median inflated cost per day for freestanding nursing facilities. Effective on and after July 1, 2017, the Indirect Peer Group price percentage shall be increased to 101.3 percent.

3) The department shall have the authority to implement these price percentage changes effective July 1, 2017 and prior to the completion of any regulatory process in order to effect such changes.

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.

7. Effective July 1, 2017, the department shall amend the State Plan for Medical Assistance to increase the direct and indirect operating rates under the nursing facility price based reimbursement methodology by 15 percent for nursing facilities where at least 80 percent of the resident population have one or more of the following diagnoses: quadriplegia, traumatic brain injury, multiple sclerosis, paraplegia, or cerebral palsy. In addition, a qualifying facility must have at least 90 percent Medicaid utilization and a case mix index of 1.15 or higher in fiscal year 2014. The department shall have the authority to implement this reimbursement methodology change for rates on or after July 1, 2017, and prior to completion of any regulatory process in order to effect such change.

8. Effective July 1, 2017 through June 30, 2020, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to pay nursing facilities located in the former Danville Metropolitan Statistical Area (MSA) the operating rates calculated for the Other MSA peer group. For purposes of calculating rates under the rebasing effective July 1, 2017, the department shall use the peer groups based on the existing regulations. For future rebasings, the department shall permanently move these facilities to the Other MSA peer group. The department shall have the authority to implement this reimbursement change effective July 1, 2017 and prior to completion of any regulatory process undertaken in order to effect such change.

DDD. 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.

EEE. 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.

FFF. 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.

GGG. 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 establish an Emergency Department Care Coordination work group comprised of representatives from the Committee, including the Virginia College of Emergency Physicians, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Academy of Family Physicians and the Virginia Association of Health Plans to review the following issues: (i) how to improve coordination of care across provider types of Medicaid "super utilizers"; (ii) the impact of primary care provider incentive funding on improved interoperability between hospital and provider systems; and (iii) methods for formalizing a statewide emergency department collaboration to improve care and treatment of Medicaid recipients and increase cost efficiency in the Medicaid program, including recognized best practices for emergency departments. 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.

HHH. 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.

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

in order to effect such change.

JJJ.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.

2. 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 MM. 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.

3. 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. DMAS 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.

~~4. As a condition on all appropriations in this act and 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, 2016.~~

4.a. Notwithstanding § 30-347, Code of Virginia, or any other provision of law, no later than 45 days upon the passage of House Bill 5001, the Department of Medical Assistance Services shall have the authority to (1) amend the State Plan for Medical 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 and (2) begin the process of implementing a § 1115 demonstration project to transform the Medicaid program for newly eligible individuals pursuant to the provisions of 4.a.(1) and eligible individuals enrolled in the existing Medicaid program. No later than 150 days from the passage of House Bill 5001, DMAS shall submit the § 1115 demonstration waiver application to CMS for approval. If the State Plan amendments are affirmatively approved by CMS prior to the submission of the waiver, Medicaid coverage for newly eligible individuals may be implemented. If the State Plan amendment becomes effective without affirmative action by CMS, coverage may begin upon submission of the completed § 1115 demonstration waiver application, per CMS notification, but no later than January 1, 2019. If the demonstration waiver cannot be completed by 150 days, despite a good faith effort to complete the application, the department may request an extension from the Chairmen of the House Appropriations and Senate Finance Committees. The department shall provide updates on the progress of the State Plan amendments and demonstration waiver applications to the Chairmen of the House Appropriations and Senate Finance Committees, or their designees, upon request, and provide for participation in discussions with CMS staff. The department shall respond to all requests for information from CMS on the State Plan amendments and demonstration waiver applications in a timely manner.

b. At least 10 days prior to the submission of the application for the waiver of Title XIX of the Social Security Act, the department shall notify the Chairmen of the House Appropriations and Senate Finance Committees of such pending application and provide a copy of the application. If the department receives an official letter from either Chairman raising an objection about the waiver during the 10-day period, the department shall make all reasonable

attempts to address the objection and modify the waiver(s). If the department receives no objection, then the application may be submitted. Any waiver specifically authorized elsewhere in this item is not subject to this provision. Waiver renewals are not subject to the provisions of this paragraph.

c. The Department of Medical Assistance Services shall include provisions to make referrals to job training, education and job placement assistance for all unemployed, able-bodied adult enrollees as allowed under current federal law or regulations through the State Plan amendments, contracts, or other policy changes. DMAS shall also include provisions to foster personal responsibility and prepare newly eligible enrollees for participation in commercial health insurance plans to include use of private health plans, premium support for employer-sponsored insurance, health and wellness accounts, appropriate utilization of hospital emergency room services, healthy behavior incentives, and enhanced fraud prevention efforts, among others through the State Plan amendments, contracts, or other policy changes.

d. The demonstration project shall be designed to empower individuals to improve their health and well-being and gain employer sponsored coverage or other commercial health insurance coverage, while simultaneously ensuring the program's long-term fiscal sustainability. The demonstration project shall include the following elements in the design:

(i) two pathways for eligible individuals with incomes between 100 percent and 138 percent of the federal poverty level, including income disregards, to obtain health care coverage: enrollment in an existing Medicaid managed care plan, or premium assistance for the purchase of employer-sponsored health insurance coverage if cost effective. The plans will provide a comprehensive benefit package consistent with private market plans, compliant with all mandated essential health benefits, and inclusive of current Medicaid covered mental health and addiction recovery and treatment services. The demonstration shall include (1) the development of a health and wellness account for eligible individuals, comprised of participant contributions and state funds to be used to fund the health insurance premiums and to ensure funds are available for the enrollee to cover out-of-pocket expenses for the deductible, with the ability to roll over the funds from the account into succeeding years if not fully used. The monthly premium amount for the enrollee shall be set on a sliding scale based on monthly income, not to exceed two percent of monthly income, nor be less than $1 per month; (2) provisions for demonstration coverage to begin on the first day of the month following receipt of the premium payment or enrollment due to treatment of an acute illness; (3) provisions for institution of a grace period for premium payment, followed by a waiting period before re-enrollment if the premium is not paid by the participant or if the participant does not maintain continuous coverage; and (4) provisions to recover premium payments owed to the Commonwealth through debt set-off collections;

(ii) provisions to enroll newly eligible individuals with incomes between 0 and 100 percent of the federal poverty level, including income disregards, in existing Medicaid managed care plans with existing Medicaid benefits or in employer-sponsored health insurance plans, if cost effective. Such newly eligible enrollees shall be subject to existing Medicaid cost sharing provisions;

(iii) cost-sharing for eligible enrollees with incomes between 100 percent and 138 percent of the federal poverty level, including income disregards, designed to promote healthy behaviors such as the avoidance of tobacco use, and to encourage personal responsibility and accountability related to the utilization of health care services such as the appropriate use of emergency room services. However, such individuals who also meet the exemptions listed in (iv) shall not be subject to premium and copayment requirements more stringent than existing Medicaid law or regulations. Enrollees who comply with provisions of the demonstration program, including healthy behavior provisions, may receive a decrease in their monthly premiums and copayments, not to exceed 50 percent.

(iv) the establishment of the Training, Education, Employment and Opportunity Program (TEEOP) for every able-bodied, working-age adult enrolled in the Medicaid program to enable enrollees to increase their health and well-being through community engagement leading to self-sufficiency. The TEEOP program shall not apply to: (1) children under the age of 18 or individuals under the age of 19 who are participating in secondary education; (2)

individuals age 65 years and older; (3) individuals who qualify for medical assistance services due to blindness or disability, including individuals who receive services pursuant to a § 1915 waiver; (4) individuals residing in institutions; (5) individuals determined to be medically frail; (6) individuals diagnosed with serious mental illness; (7) pregnant and postpartum women; (8) former foster children under the age of 26; (9) individuals who are the primary caregiver for a dependent, including a dependent child or adult dependent with a disability; and (10) individuals who already meet the work requirements of the TANF or SNAP programs. The TEEOP shall comply with guidance from CMS regarding such programs and may include other exemptions that may be necessary to achieve the TEEOP's goals of community engagement and improved health outcomes that are approved by CMS.

The TEEOP shall include provisions for gradually escalating participation in training, education, employment and community engagement opportunities through the program as follows:

a. beginning three months after enrollment, at least 20 hours per month;

b. beginning six months after enrollment, at least 40 hours per month;

c. beginning nine months after enrollment, at least 60 hours per month; and

d. beginning 12 months after enrollment, at least 80 hours per month;

The TEEOP shall also include provisions for satisfaction of the requirement for participation in training, education, employment and community engagement opportunities through participation in job skills training; job search activities in conformity with Virginia Employment and Commission guidelines; education related to employment; general education, including participation in a program of preparation for the General Education Development (GED) certification examination or community college courses leading to industry certifications or a STEM-H related degree or credential; vocational education and training; subsidized or unsubsidized employment; community work experience programs, community service or public service, excluding political activities, that can reasonably improve work readiness; or caregiving services for a non-dependent relative or other person with a chronic, disabling health condition. The department may waive the requirement for participation in employment in areas of the Commonwealth with unemployment rates equal to or greater than 150 percent of the statewide average; however, requirements related to training, education and other community engagement opportunities shall not be waived in any area of the Commonwealth.

The TEEOP shall work with Virginia Workforce Centers or One-Stops to provide services to Medicaid enrollees. Such services shall include career services for program enrollees, services to link enrollees with industry certification and credentialing programs, including the New Economy Workforce Credential Grant Program, and individualized case management services.

The TEEOP shall, to the extent allowed under federal law, utilize federal and state funding available through the Centers for Medicare and Medicaid Services, Temporary Assistance for Needy Families program, the Supplemental Nutrition Assistance Program, the Workforce Innovation and Opportunity Act, and other state and federal workforce development programs to support program enrollees.

Unless exempt, enrollees shall be ineligible to receive Medicaid benefits if, during any three months of the 12-month period beginning on the first day of enrollment, they fail to meet the TEEOP requirements and they will not be permitted to re-enroll until the end of such 12-month period, unless the failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control. However, enrollees shall be eligible to re-enroll in the program within such 12-month period upon demonstration of compliance with the TEEOP requirements.

(v) monitoring and oversight of the use of health care services to ensure appropriate utilization;

(vi) The Department of Medical Assistance Services shall develop a supportive employment and housing benefit targeted to high risk Medicaid beneficiaries with mental illness, substance use disorder, or other complex, chronic conditions who need intensive, ongoing support to obtain and maintain employment and stable housing.

e. The State Plan amendment and the demonstration waiver program shall include (i) systems for determining eligibility for participation in the program, (ii) provisions for disenrollment if federal funding is reduced or terminated, and (iii) provisions for monitoring, evaluating, and assessing the effectiveness of the waiver program in improving the health and wellness of program participants and furthering the objectives of the Medicaid program.

f. The department shall have the authority to promulgate emergency regulations to implement these changes within 280 days or less from the enactment date of House Bill 5001. The department shall have the authority to implement these changes prior to the completion of any regulatory process undertake in order to effect such changes.

5. 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 are 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 following the date the department is notified of a reduction in Federal Medical Assistance Percentage.

KKK.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.

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

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

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

Medicaid utilization or on total Medicaid NICU utilization equal to 14 percent or higher.

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

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

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

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

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

b. The DSH per diem for State Inpatient Psychiatric Hospitals is calculated by dividing the total State Inpatient Psychiatric Hospital DSH allocation by the sum of eligible DSH days. The State Inpatient Psychiatric Hospital DSH allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

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

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

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

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

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

NNN. The Department of Medical Assistance Services shall 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.

OOO. 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.

PPP.1. 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.

2. 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.

3. 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.

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.

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

RRR.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 the Centers for Medicare and Medicaid Services (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 CMS and the payments otherwise made to physicians. 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 247.

3.a. 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.

b. If by June 30, 2017, the Department of Medical Assistance Services has not secured approval from the Centers for Medicare and Medicaid Services to use a minimum fee schedule pursuant to 42 C.F.R. § 438.6(c)(1)(iii) for local government-owned nursing homes participating in Commonwealth Coordinated Care Plus (CCC Plus) at the same level as and in lieu of the supplemental Medicaid payments authorized in Section RRR.3.a., then DMAS shall: (i) exclude Medicaid recipients who elect to receive nursing home services in local government-owned nursing homes from CCC Plus; (ii) pay for such excluded recipient's nursing home services on a fee-for-service basis, including the related supplemental Medicaid payments as authorized herein; and (iii) prohibit CCC Plus contracted health plans from in any way limiting Medicaid recipients from electing to receive nursing home services from local government-owned nursing homes. The department may include in CCC Plus Medicaid recipients who elect to receive nursing home services in local government-owned nursing homes in the future when it has secured federal CMS approval to use a minimum fee schedule as described above.

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.

5. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the supplemental physician payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50 percent Medicaid inpatient utilization in fiscal year 2014 to the maximum allowed by the Centers for Medicare and Medicaid Services within the limit of the appropriation provided for this purpose. 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 Virginia Medicaid fee-for-service payments. The department shall have the authority to implement these reimbursement changes effective July 1, 2016, and prior to the completion of any regulatory process undertaken in order to effect such change."

6.a. The Department of Medical Assistance Services shall promulgate regulations to make supplemental Medicaid payments to the primary teaching hospitals affiliated with a Liaison Committee on Medical Education (LCME) accredited medical school located in Planning District 23 that is a political subdivision of the Commonwealth and an LCME accredited medical school located in Planning District 5 that has a partnership with a public university. The amount of the supplemental payment shall be based on the reimbursement methodology established for such payments in Attachments 4.19-A and 4.19-B of the State Plan for Medical Assistance and/or the department's contracts with managed care organizations. The department shall have the authority to implement these reimbursement changes consistent with the effective date in the State Plan amendment or the managed care contracts approved by the Centers for Medicare and Medicaid Services (CMS) and prior to completion of any regulatory process in order to effect such changes. No payment shall be made without approval from CMS.

b. Funding for the state share for these Medicaid payments is authorized in Item 247 and Item 4-5.03.

SSS. 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.

TTT. 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.

UUU. 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.

VVV. 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.

WWW. 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 in the first year, but shall not be substituted for published inflation factors in any subsequent scheduled rebasing of nursing facility 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.

XXX.1.a 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.

b. The Department of Medical Assistance Services shall amend the Medicaid demonstration project described in paragraph XXX 1 a to increase the income eligibility for adults with serious mental illness from 60 to 80 percent of the federal poverty level effective July 1, 2016 and from 80 to 100 percent of the federal poverty level effective October 1, 2017. Effective October 1, 2017, the department shall amend the Medicaid demonstration project to include the provision of addiction recovery and treatment services, including partial day hospitalization and residential treatment services. 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.

c. The Department of Medical Assistance Services, in cooperation with the Department of Social Services and the League of Social Service Executives, shall provide information and conduct outreach activities with the Department of Corrections and local and regional jails to increase access to the Medicaid demonstration waiver for individuals with serious mental illness who are preparing to be released from custody, or are under the supervision of state or local community corrections programs.

d. The Department of Medical Assistance Services, in cooperation with the Department of Social Services and the League of Social Service Executives, shall provide information and conduct outreach activities with the Department of Corrections and local and regional jails to increase access to the Medicaid demonstration waiver for individuals with serious mental illness who are preparing to be released from custody, or are under the supervision of state or local community corrections programs.

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.

YYY. 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.

ZZZ. 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.

AAAA.1. The Department of Medical Assistance Services (DMAS) shall provide quarterly reports , due within 30 days of a quarter's end, to the Governor, Director, Department of Planning and Budget and 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.

BBBB. 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.

CCCC.1. The Department of Medical Assistance Services shall adjust the rates and add new services in accordance with the recommendations of the provider rate study and the published formula for determining the SIS levels and tiers developed as part of the redesign of the Individual and Family Developmental Disabilities Support (DD), Day Support (DS), and Intellectual Disability (ID) Waivers. The department shall have the authority to adjust provider rates and units, effective July 1, 2016, in accordance with those recommendations with the exception that no rate changes for Sponsored Residential services shall take effect until January 1, 2017. The rate increase for skilled nursing services shall be 25 percent.

2. The Department of Medical Assistance Services shall have the authority to amend the Individual and Family Developmental Disabilities Support (DD), Day Support (DS), and Intellectual Disability (ID) Waivers, to initiate the following new waiver services effective July 1, 2016: Shared Living Residential, Supported Living Residential, Independent Living Residential, Community Engagement, Community Coaching, Workplace Assistance Services, Private Duty Nursing Services, Crisis Support Services, Community Based Crisis Supports, Center-based Crisis Supports, and Electronic Based Home Supports; and the following new waiver services effective July 1, 2017: Community Guide and Peer Support Services, Benefits Planning, and Non-medical Transportation. The rates and units for these new services shall be established consistent with recommendations of the provider rate study and the published formula for determining the SIS levels and tiers developed as part of the waiver redesign, with the

exception that private duty nursing rates shall be equal to the rates for private duty nursing services in the Assistive Technology Waiver and the EPSDT program. The implementation of these changes shall be developed in partnership with the Department of Behavioral Health and Developmental Services.

3. Out of this appropriation, $328,452 the first year and $656,903 the second year from the general fund and $328,452 the first year and $656,903 the second year from nongeneral funds shall be provided for a Northern Virginia rate differential in the family home payment for Sponsored Residential services. Effective January 1, 2017, the rates for Sponsored Residential services in the Intellectual Disability waiver shall include in the rate methodology a higher differential of 24.5 percent for Northern Virginia providers, in the family home payment as compared to the rest-of-state rate. The Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services shall, in collaboration with sponsored residential providers, the Virginia Network of Private Providers, the Virginia Association of Community Services Boards, the Virginia Sponsored Residential Provider Group, and family home providers, collect information and feedback related to payments to family homes and the extent to which changes in rates have impacted payments to the family homes statewide, and the increase or decrease in the capacity in each of the five geographic regions. The Department of Medical Assistance Services, in cooperation with the Department of Behavioral Health and Developmental Services, shall report the findings of this analysis to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2017.

4. For any state plan amendments or waiver changes to effectuate the provisions of paragraphs CCCC 1 and CCCC 2 above, the Department of Medical Assistance Services shall provide, prior to submission to the Centers for Medicare and Medicaid Services, notice to the Chairmen of the House Appropriations and Senate Finance Committees, and post such changes and make them easily accessible on the department's website.

5. The department shall have the authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such changes.

DDDD. The Department of Medical Assistance Services shall amend the 1915 (c) home-and-community based Community Living waiver to add 390 slots effective July 1, 2016 and an additional 180 slots effective July 1, 2017. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the waiver to add the additional slots.

EEEE.1. The Department of Medical Assistance Services shall amend the Family and Individual Support waiver to add 140 new slots effective July 1, 2016 and an additional 344 slots effective July 1, 2017. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the waiver to add the additional slots.

2. Effective July 1, 2016, the Department of Medical Assistance Services shall amend the Individual and Family Developmental Disabilities Support (DD) waiver to add 200 slots in fiscal year 2017 for individuals at the top of the chronological waiting list as of June 30, 2016.

3. Out of this appropriation, $632,040 the first year and $632,040 the second year from the general fund and $632,040 the first year and $632,040 the second year from nongeneral funds shall be used for up to 40 emergency reserve slots for emergencies, for individuals transferring between waivers and for individuals transitioning from an Intermediate Care Facility (ICF) or state nursing facility (SNF) to the community to ensure the health and safety of individuals in crisis. The Department of Medical Assistance Services shall amend the appropriate waiver to add up to 40 emergency reserve slots across the Intellectual Disability (ID) waiver, Individual and Family Developmental Disabilities Support (DD) waiver and Day Support (DS) waiver within the limits of this appropriation, effective July 1, 2016. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the ID, DD and DS waivers to add the additional emergency reserve slots.

FFFF.1. Out of this appropriation, $1,250,000 from the general fund and $1,250,000 from nongeneral funds the

second year shall be used to fund 25 new medical residency slots. The Department of Medical Assistance Services shall submit a State Plan amendment to make supplemental payments for new graduate medical education residency slots effective July 1, 2017. Supplemental payments shall be made for up to 25 new medical residency slots in fiscal year 2018. Of the 25 new residency slots, 13 shall be for primary care and 12 shall be for high need specialties. In addition, preference shall be given for residency slots located in underserved areas. The department shall adopt criteria for primary care, high need specialties and underserved areas developed by the Virginia Health Workforce Development Authority. The department shall make supplemental payments to the following hospitals for the specified number of primary care residencies: Sentara Norfolk General (2 residencies), Carilion Medical Center (6 residencies), Centra Lynchburg General Hospital (1 residency), Riverside Regional Medical Center (2 residencies), Bon Secours St. Francis Medical Center (2 residencies). The department shall make supplemental payments to Carilion Medical Center for two psychiatric residencies.The supplemental payment for each new qualifying residency slot shall be $100,000 annually minus any Medicare residency payment for which the hospital is eligible. Supplemental payments shall be made for up to four years for each new qualifying resident. The hospital will be eligible for the supplemental payments as long as the hospital maintains the number of residency slots in total and by category as a result of the increase in fiscal year 2018. Payments shall be made quarterly following the same schedule for other medical education payments. Subsequent to the award of a supplemental payment, the hospital must provide documentation annually by June 1 that they continue to meet the criteria for the supplemental payments and report any changes during the year to the number of residents. The department shall require all hospitals receiving medical education funding to report annually by June 1 on the number of residents in total and by specialty/subspecialty. The supplemental payments are subject to federal Centers for Medicare and Medicaid Services approval. 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.

2. Any remaining appropriation for this program at the end of the fiscal year shall be carried forward to the subsequent fiscal year to fund medical residency slots. The Department of Medical Assistance Services shall adjust the 2018-20 Medicaid forecast to include annual funding for the 25 residency slots as approved by the 2016 General Assembly.

3. Effective July 1, 2018, the department shall make supplemental payments to the following hospitals for the specified number of primary care residencies: Sentara Norfolk General (1 residency) and Carilion Medical Center (6 residencies). The department shall make supplemental payments to Carilion Medical Center for 2 psychiatry residencies and to Sentara Norfolk General for 1 OB/GYN residency.

GGGG. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to limit inflation to 50 percent of the inflation factor for fiscal year 2017 and eliminate inflation in fiscal year 2018. This shall apply to inpatient hospital operating rates (including long-stay and freestanding psychiatric hospitals), graduate medical education (GME) payments, disproportionate share hospital (DSH) payments and outpatient hospital rates. Similar reductions shall be made to the general fund share for Type One hospitals as reflected in paragraph B. of this Item. *The department shall make a full inflation adjustment payment in both FY 2017 and FY 2018 to Virginia freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009.* The department shall have the authority to implement these reimbursement changes effective July 1, 2016 and prior to the completion of any regulatory process in order to effect such changes.

HHHH. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to provide the full inflation factor for nursing facility and specialized care operating and NATCEP rates for FY2018. The department shall have the authority to implement these reimbursement changes effective July 1, 2017, and prior to the completion of any regulatory process in order to effect such changes.

IIII. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to limit inflation to 50 percent of the inflation factor for outpatient rehabilitation agencies and home health agencies for FY2018. The department shall have the authority to implement these reimbursement changes effective July 1, 2017, and prior to the completion of any regulatory process in order to effect such changes.

JJJJ. Effective July 1, 2016, the Department of Medical Assistance Services shall increase the rates for agency and consumer directed personal care, respite and companion services in the EDCD and ID/DD waivers and EPSDT program by two percent from current levels.

KKKK. Effective July 1, 2016, the Department of Medical Assistance Services shall increase the rates for private duty nursing in the Tech waiver and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program by 11.5 percent from current levels.

LLLL. Out of this appropriation, $79,505 from the general fund and $79,505 from the nongeneral fund the first year and $87,581 from the general fund and $87,581 from nongeneral funds the second year shall be used to increase reimbursement rates for adult day health services provided through Medicaid home- and community-based waiver programs by 2.5 percent effective July 1, 2016.

MMMM.1. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall amend the state plan for medical assistance and/or seek federal authority through an 1115 demonstration waiver, as soon as feasible, to provide coverage of inpatient detoxification, inpatient substance abuse treatment, residential detoxification, residential substance abuse treatment, and peer support services to Medicaid individuals in the Fee-for-Service and Managed Care Delivery Systems. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall make programmatic changes in the provision of all Substance Abuse Treatment Outpatient, Community Based and Residential Treatment services (group homes and facilities) for individuals with substance abuse disorders in order to ensure parity between the substance abuse treatment services and the medical and mental health services covered by the department and to ensure comprehensive treatment planning and care coordination for individuals receiving behavioral health and substance use disorder services. The department shall take action to ensure appropriate utilization and cost efficiency, and adjust reimbursement rates within the limits of the funding appropriated for this purpose based on current industry standards. The department shall consider all available options including, but not limited to, service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates for the following Medicaid services: substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse case management, opioid treatment, substance abuse day treatment, and substance abuse intensive outpatient. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance and any waivers thereof to include peer support services to children and adults with mental health conditions and/or substance use disorders. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria and provider qualifications. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

4. The Department of Medical Assistance Services shall, prior to the submission of any state plan amendment or waivers to implement paragraphs MMMM 1, MMMM 2, and MMMM 3, submit a plan detailing the changes in provider rates, new services added and any other programmatic changes to the Chairmen of the House Appropriation and Senate Finance Committees.

NNNN. The Department of Medical Assistances shall amend the State Plan for Medical Assistance to convert the specialized care rates to a prospective rate consistent with the existing cost-based methodology by adding inflation to the per diem costs subject to existing ceilings for direct, indirect and ancillary costs from the most recent settled

cost report prior to the state fiscal year for which the rates are being established. The same inflation adjustment shall apply to plant costs for specialized care facilities that do not have prospective capital rates that are based on fair rental value. The department shall use the state fiscal year rate methodology recently adopted for regular nursing facilities. Partial year inflation shall be applied to per diem costs if the provider fiscal year end is different than the state fiscal year. Ceilings shall also be maintained by state fiscal year. The department shall have the authority to implement these changes effective July 1, 2016, and prior to completion of any regulatory process to effect such changes.

OOOO. The Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, shall seek federal authority via a state plan amendment to cover low-dose computed tomography (LDCT) lung cancer screenings for high-risk adults. The department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this Act.

PPPP. The Department of Medical Assistance Services shall amend the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to reflect that no authority is provided for the payment of overtime for Medicaid-reimbursed consumer-directed personal assistance, respite and companion services. The Department shall implement the necessary regulatory changes and other necessary measures to be consistent with federal approval of any appropriate state plan and/or waiver changes, and prior to the completion of any regulatory process undertaken in order to effect such change."

QQQQ. The Department of Medical Assistance Services shall convene a work group of stakeholders, which shall include the Department for Aging and Rehabilitative Services, dementia service providers and dementia advocacy organizations to review the Alzheimer's Assisted Living (AAL) Waiver to determine if it can be modified to meet the 2014 Centers for Medicare and Medicaid Services Home and Community Based Services final rule requirements. If the waiver cannot be modified to meet the federal requirements, then the department shall create a plan that: (i) ensures current waiver recipients continue to receive services and (ii) addresses the service needs of the persons with dementia who are currently eligible for the AAL Waiver. The department shall report its plan and implementation recommendations to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2016.

RRRR. The Department of Medical Assistance Services shall not expend any appropriation for an approved Delivery System Reform Incentive Program (DSRIP) §1115 waiver unless the General Assembly appropriates the funding in the 2017 Session. The department shall notify the Chairmen of the House Appropriations and Senate Finance Committees within 15 days of any final negotiated waiver agreement with the Centers for Medicare and Medicaid Services.

SSSS. The Department of Medical Assistance Services shall seek federal authority through a State Plan Amendment under Title XIX of the Social Security Act to permit individuals to use certified appraisals conducted by appraisers licensed by the Virginia Real Estate Appraiser Board as an alternative to the use of the tax assessed value to establish the value of any non-commercial real property for purposes of Medicaid resource eligibility. The cost of the appraisal shall be borne by the applicant or his designee.

TTTT. Effective July 1, 2017, the Department of Medical Assistance Services shall amend the Building Independence waiver to add 60 slots in FY 2018.

UUUU. Effective July 1, 2017, the Department of Medical Assistance Services shall amend the managed care regulations to specify that all contracts with health plans in a Medicaid managed care delivery model, including long-term services and supports, require reimbursement to nursing facility and specialized care services at no less than the Medicaid established per diem rate for Medicaid covered days, using the department's methodologies, unless the managed care organization and the nursing facility or specialized care services provider mutually agree to an alternative payment. The department shall have authority to implement this provision prior to the completion of any regulatory process in order to effect such change.

VVVV. Omitted.

WWWW.1. The Department of Medical Assistance Services shall monitor the capacity available under the Upper Payment Limit (UPL) for all hospital supplemental payments and adjust payments accordingly when the UPL cap is reached. The department shall make an adjustment to stay under the UPL cap by reducing or eliminating as necessary supplemental payments to hospitals based on when the first supplemental payments were actually made so that the newest supplemental payments to hospitals would be impacted first and so on.

2. The Department of Medical Assistance Services shall have the authority to implement reimbursement changes deemed necessary to meet the requirements of this paragraph prior to the completion of any regulatory process in order to effect such changes.

XXXX. Effective upon enactment of this act, the Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall make sponsored residential services eligible for customized rates. The department may implement any changes necessary to implement this provision prior to the promulgation of regulations undertaken in order to effect such changes.

YYYY.1. Effective no later than January 1, 2019, the Department of Medical Assistance Services is authorized to require consumer-directed aides providing personal care, respite care and companion services in the Medicaid Elderly and Disabled with Consumer Direction (EDCD) and Developmental Disability waiver programs and the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program to utilize an Electronic Visit Verification (EVV) system. The department is authorized to contract with a vendor to provide access to an EVV system for use by consumer-directed aides.

2. For personal care, respite care and companion services agencies, the department shall work with the appropriate stakeholders to develop standards for electronic visit verification systems and certification requirements to ensure EVV systems used by such agencies meet all federal requirements and are capable of providing the necessary data the department may require.

3. The department shall ensure that implementation of electronic visit verification complies with all requirements of the federal Centers of Medicare and Medicaid Services.

ZZZZ. Effective July 1, 2017, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the formula for indirect medical education (IME) for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 as a substitute for DSH payments. The formula for these hospitals for indirect medical education for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers shall be identical to the formula for Type One hospitals. The IME payments shall continue to be limited such that total payments to freestanding children's hospitals with greater than 50 percent Medicaid utilization do not exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject,excluding third party reimbursement for Medicaid eligible patients. The department shall have the authority to implement these changes effective July 1, 2017, and prior to completion of any regulatory action to effect such changes.

AAAAA. Disproportionate Share Hospital payments shall not be reallocated to other eligible hospitals based on hospital non-participation in fiscal year 2018. The department shall have the authority to implement these changes effective upon the passage of this act and prior to the completion of any regulatory action to effect such change.