2018 Special Session I

Budget Bill - HB5002 (Chapter 2)

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

Department of Medical Assistance Services

Item 307	First Year - FY2019	Second Year - FY2020
Administrative and Support Services (49900)	**$282,112,859**	**$281,299,207**
General Management and Direction (49901)	$271,558,406	$270,744,754
Administrative Support for the Family Access to Medical Insurance Security Plan (49932)	$10,554,453	$10,554,453
Fund Sources:		
General	$75,722,124	$77,451,857
Special	$2,305,332	$2,334,320
Federal Trust	$204,085,403	$201,513,030

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

A.1. By November 1 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit a forecast of Medicaid expenditures, upon which the Governor's budget recommendations will be based, for the current and subsequent two years to the Chairmen of the House Appropriations and Senate Finance Committees. In addition to the expenditure forecast, the Department of Medical Assistance Services shall provide a breakout that shows forecasted expenditures by caseload/utilization, inflation, and policy changes. An enrollment forecast for the same forecast period shall also be submitted with the expenditure forecast.

2. The forecast shall be based upon current state and federal laws and regulations. The forecast shall only include expenditures for medical services in Program 45600 and shall exclude administrative expenditures. Rebasing and inflation estimates that are required by existing law or regulation for any Medicaid provider shall be included in the forecast. The forecast shall also include an estimate of projected increases or decreases in managed care costs, including estimates regarding changes in managed care rates for the three-year period. In preparing for each year's forecast of the managed care portions of the budget, the department shall submit to its actuarial contractor a letter, with a copy sent to the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees. This letter shall document the department's request for a point estimate of the rate of increase in rates, based on application of actuarial principals and methodologies and information available at the time of the forecast, that the contractor estimates will occur in the years being forecast, and shall specify the population groupings for which estimates are requested. The department shall request that the contractor reply in writing with a copy to all parties copied on the department's letter.

3. The Department of Planning and Budget and the Department of Medical Assistance Services shall convene a meeting on or before October 15 of each year with the appropriate staff from the House Appropriations and Senate Finance Committees to review current trends and the assumptions used in the Medicaid forecast prior to its finalization. The departments shall provide at this meeting a complete list of all policy and manual adjustments along with the estimated amounts of each adjustment by fiscal year that will be included in the Medicaid forecast

due November 1.

B.1. The Department of Medical Assistance Services shall submit monthly expenditure reports of the Medicaid program by service that shall compare expenditures to the official Medicaid forecast, adjusted to reflect budget actions from each General Assembly Session. The monthly report shall be submitted to the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees within 20 days after the end of each month.

2. The Department of Medical Assistance Services shall submit a quarterly report summarizing managed care encounter data by service category in a format similar to the report in paragraph B.1. This quarterly report shall be submitted to the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees no later than 30 days after the end of each quarter.

3. The Department of Medical Assistance Services shall track expenditures for the prior fiscal year that ended on June 30, that includes the expenditures associated with changes in services and eligibility made in the Medicaid and FAMIS programs adopted by the General Assembly in the past session(s). Expenditures related to changes in services and eligibility adopted in a General Assembly Session shall be included in the report for five fiscal years beginning from the first year the policy impacted expenditures in the Medicaid and FAMIS programs. The department shall report the expenditures of each funding change separately and show the impact by fiscal year. The report shall be submitted to the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees by October 1 of each year.

C.1. It is the intent of the General Assembly that the Department of Medical Assistance Services provide more data regarding Medicaid and other programs operated by the department on their public website. The department shall create a central website that consolidates data and statistical information to make the information more readily available to the general public. At a minimum the information included on such website shall include monthly enrollment data, expenditures by service, and other relevant data.

2. No later than June 30, 2018, the department shall make Medicaid and other agency data stored in the agency's data warehouse available through the department's website that includes, at a minimum, interactive tools for the user to select, display, manipulate and export requested data.

D. The Department of Medical Assistance Services shall notify the Director, Department of Planning and Budget, and the Chairmen of the House Appropriations and Senate Finance Committees at least 30 days prior to any change in capitated rates for managed care companies. The notification shall include the amount of the rate increase or decrease, and the projected impact on the state budget.

E.1. Effective January 1, 2018, the Department of Medical Assistance Services shall include in all its contracts with managed care organizations (MCOs) the following:

a. A provision requiring the MCOs to return one-half of the underwriting gain in excess of three percent of Medicaid premium income up to 10 percent. The MCOs shall return 100 percent of the underwriting gain above 10 percent.

b. A requirement for detailed financial and utilization reporting. The reported data shall include: (i) income statements that show expenses by service category; (ii) balance sheets; (iii) information about related-party transactions; and (iv) information on service utilization metrics.

c. Upon the inclusion of behavioral health care in managed care, behavioral health-specific metrics to identify undesirable trends in service utilization.

d. Upon the inclusion of behavioral health care in managed care, a report on their policies and processes for

identifying behavioral health providers who provide inappropriate services and the number of such providers that are disenrolled.

2. For rate periods effective January 1, 2018 and thereafter, the Department of Medical Assistance Services shall direct its actuary as part of the rate setting process to:

a. Identify potential inefficiencies in the Medallion program and adjust capitation rates for expected efficiencies. The department is authorized to phase-in this adjustment over time based on the portion of identified inefficiencies that MCOs can reasonably reduce each year.

b. Monitor medical spending for related-party arrangements and adjust historical medical spending when deemed necessary to ensure that capitation rates do not cover excessively high spending as compared to benchmarks. Related-party arrangements shall mean those in which there is common ownership or control between the entities, and shall not include Medicaid payments otherwise authorized in this item.

c. Adjust capitation rates in the Medallion program to account for a portion of expected savings from required initiatives.

d. Allow negative historical trends in medical spending to be carried forward when setting capitation rates.

e. Annually rebase administrative expenses per member per month for projected enrollment changes.

f. Annually incorporate findings on unallowable administrative expenses from audits of MCOs into its calculations of underwriting gain and administrative loss ratios for the purposes of ongoing financial monitoring, including enforcement of the underwriting gain cap.

g. Adjust calculations of underwriting gain and medical loss ratio by classifying as profit medical spending that is excessively high due to related-party arrangements.

3. The Department of Medical Assistance Services shall report to the General Assembly on spending and utilization trends within Medicaid managed care, with detailed population and service information and include an analysis and report on the underlying reasons for these trends, the agency's and MCOs' initiatives to address undesirable trends, and the impact of those initiatives. The report shall be submitted each year by September 1.

4. The Department of Medical Assistance Services shall develop a proposal for cost sharing requirements based on family income for individuals eligible for long-term services and supports through the optional 300 percent of Supplemental Security Income eligibility category and submit the proposal to the Centers for Medicare and Medicaid Services to determine if such a proposal is feasible. No cost sharing requirements shall be implemented unless approved by the General Assembly.

F. The Department of Medical Assistance Services, to the extent permissible under federal law, shall enter into an agreement with the Department of Behavioral Health and Developmental Services to share Medicaid claims and expenditure data on all Medicaid-reimbursed mental health, intellectual disability and substance abuse services, and any new or expanded mental health, intellectual disability retardation and substance abuse services that are covered by the State Plan for Medical Assistance. The information shall be used to increase the effective and efficient delivery of publicly funded mental health, intellectual disability and substance abuse services.

G. The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall convene a stakeholder workgroup, to meet at least once annually, with representatives of the Virginia Association of Community Services Boards, the Virginia Network of Private Providers, the Virginia Association of Centers for Independent Living, Virginia Association of Community Rehabilitation Programs (VaACCSES), the disAbility Law Center of Virginia, the ARC of Virginia, and other

stakeholders including representative family members, as deemed appropriate by the Department of Medical Assistance Services. The workgroup shall: (i) review data from the previous year on the distribution of the SIS levels and tiers by region and by waiver; (ii) review the process, information considered, scoring, and calculations used to assign individuals to their levels and reimbursement tiers; (iii) review the communication which informs individuals, families, providers, case managers and other appropriate parties about the SIS tool, the administration, and the opportunities for review to ensure transparency; and (iv) review other information as deemed necessary by the workgroup. The department shall report on the results and recommendations of the workgroup to the General Assembly by October 1 of each year.

H.1. The Department of Medical Assistance Services (DMAS) shall take actions to improve the reliability of Medicaid eligibility screenings for long-term services and supports, including: (i) validation of the children's criteria used with the Uniform Assessment Instrument to determine eligibility for Medicaid long-term services and supports, and (ii) design and implementation of an inter-rater reliability test for the pre-admission screening process.

2. The department shall work with relevant stakeholders to (i) assess whether hospital screening teams are making appropriate recommendations regarding placement in institutional care or home and community-based care; (ii) determine whether hospitals should have a role in the screening process; and (iii) determine what steps must be taken to ensure the Uniform Assessment Instrument is implemented consistently and does not lead to unnecessary institutional placements.

3. The department shall report to the General Assembly by December 1 on steps taken to address the risks associated with hospital screenings, including any statutory or regulatory changes needed to improve such screenings.

I. The Department of Medical Assistance Services (DMAS) shall collect and provide to the Office of Children's Services (OCS) all information and data necessary to ensure the continued collection of local matching dollars associated with payments for Medicaid eligible services provided to children through the Children's Services Act as required in Item 282, C.2. of this Act. This information and data shall be collected by DMAS and provided to OCS on a monthly basis.

J. The Departments of Medical Assistance Services (DMAS) and Social Services (DSS) shall collaborate with the League of Social Services Executives, and other stakeholders to analyze and report data that demonstrates the accuracy, efficiency, compliance, quality of customer service, and timeliness of determining eligibility for the Medicaid, CHIP and Governor's Access Program (GAP) programs. Based on this collaboration, the departments shall develop meaningful performance metrics on data in agency systems that shall be used to monitor eligibility trends, address potential compliance problem areas and implement best practices. DMAS shall maintain on its website a public dashboard on eligibility performance that includes performance metrics developed through collaborative efforts as well as the performance of local departments of social services and any centralized eligibility-processing unit. Effective August 1, 2018 this dashboard shall be updated for the previous quarter and 30 days following the end of each quarter thereafter.

K. In addition to any regional offices that may be located across the Commonwealth, any statewide, centralized call center facility that operates in conjunction with a brokerage transportation program for persons enrolled in Medicaid or the Family Access to Medical Insurance Security plan shall be located in Norton, Virginia.

L. The Department of Medical Assistance Services shall, to the extent possible, require web-based electronic submission of provider enrollment applications, revalidations and other related documents necessary for participation in the fee-for-service program under the State Plans for Title XIX and XXI of the Social Security Act.

M. The Department of Medical Assistance Services, in collaboration with the Department of Social Services, shall require Medicaid eligibility workers to search for unreported assets at the time of initial eligibility determination

and renewal, using all currently available sources of electronic data, including local real estate property databases and the Department of Motor Vehicles for all Medicaid applicants and recipients whose assets are subject to an asset limit under Medicaid eligibility requirements.

N.1. The Department of Medical Assistance Services shall require eligibility workers to verify income, using currently available Virginia Employment Commission data, for applicants and recipients who report no earned or unearned income. The Department shall, at the earliest date feasible but no later than October 1, 2017, require all Medicaid eligibility workers to apply the same protocols when verifying income for all applicants and recipients, including those who report no earned or unearned income.

2. The Department shall amend the Virginia Medicaid application, upon approval of the federal Centers for Medicare and Medicaid, to require a Medicaid applicant to opt out if such applicant does not want to grant permission to the state to use his federal tax returns for the purposes of renewing eligibility. The Department shall implement the necessary regulatory changes and other necessary measures to be consistent with federal approval of any appropriate state plan changes, and prior to the completion of any regulatory process undertaken in order to effect such change.

O.1. The Department of Medical Assistance Services shall report on the operations and costs of the Medicaid call center (also known as the Cover Virginia Call Center). This report shall include number of calls received on a monthly basis, the purpose of the call, the number of applications for Medicaid submitted through the call center, and the costs of the contract. The department shall submit the report by August 15 of each year to the Director, Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance Committees.

2. Out of this appropriation, $3,283,004 the first year and $3,283,004 the second year from the general fund and $9,839,000 the first year and $9,839,000 the second year from nongeneral funds is provided for the enhanced operation of the Cover Virginia Call Center as a centralized eligibility processing unit (CPU) that shall be limited to processing Medicaid applications received from the Federally Facilitated Marketplace, telephonic applications through the call center, or electronically submitted Medicaid-only applications. The department shall report the number of applications processed on a monthly basis and payments made to the contractor to the Director, Department of Planning and Budget and the Chairman of the House Appropriations and Senate Finance Committees. The report shall be submitted no later than 30 days after the end of each quarter of the fiscal year.

3. The Secretary of Health and Human Resources shall convene an interagency workgroup of the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), and the Department of Planning and Budget (DPB) and representatives of the Virginia League of Social Services Executives to assess the programmatic, operational and fiscal impact of consolidating the Cover Virginia call center with the call center operated by DSS to determine if more efficient and cost effective services can be achieved, prior to the reprocurement of the Cover Virginia call center contract. The workgroup shall develop an implementation plan and funding adjustments, that may be needed, to implement a consolidated call center. The Secretary shall report on the results of the assessment and any recommendations to the Chairmen of the House Appropriations and Senate Finance Committee by September 1, 2019.

P.1. Out of this appropriation, $5,835,000 the first year and $5,835,000 the second year from the general fund and $52,515,000 the first year and $52,515,000 the second year from nongeneral funds shall be provided to replace the Medicaid Management Information System.

2. Within 30 days of awarding a contract or contracts related to the replacement project, the Department of Medical Assistance Services shall provide the Chairmen of the House Appropriations and Senate Finance Committees, and the Director, Department of Planning and Budget, with a copy of the contract including costs.

3. Beginning July 1, 2016, the Department of Medical Assistance Services shall provide annual progress reports that

must include a current project summary, implementation status, accounting of project expenditures and future milestones. All reports shall be submitted to the Chairmen of House Appropriations and Senate Finance Committees, and Director, Department of Planning and Budget.

Q. 1. Out of this appropriation, $1,675,000 the first year and $1,675,000 the second year from special funds is appropriated to the Department of Medical Assistance Services (DMAS) for the disbursement of civil money penalties (CMP) levied against and collected from Medicaid nursing facilities for violations of rules identified during survey and certification as required by federal law and regulation. Based on the nature and seriousness of the deficiency, the Agency or the Centers for Medicare and Medicaid Services may impose a civil money penalty, consistent with the severity of the violations, for the number of days a facility is not in substantial compliance with the facility's Medicaid participation agreement. Civil money penalties collected by the Commonwealth must be applied to the protection of the health or property of residents of nursing facilities found to be deficient. Penalties collected are to be used for (1) the payment of costs incurred by the Commonwealth for relocating residents to other facilities; (2) payment of costs incurred by the Commonwealth related to operation of the facility pending correction of the deficiency or closure of the facility; and (3) reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or individuals used by the facility to provide services to residents. These funds are to be administered in accordance with the revised federal regulations and law, 42 CFR 488.400 and the Social Security Act § 1919(h), for Enforcement of Compliance for Long-Term Care Facilities with Deficiencies. Any special fund revenue received for this purpose, but unexpended at the end of the fiscal year, shall remain in the fund for use in accordance with this provision.

2. Of the amounts appropriated in Q.1. of this Item, up to $175,000 the first year and $175,000 the second year from special funds may be used for the costs associated with administering CMP funds.

3. Of the amounts appropriated in Q.1. of this Item, up to $1,000,000 the first year and $1,000,000 the second year from the special funds may be used for special projects that benefit residents and improve the quality of nursing Facilities.

4. By October 1 of each year, the department shall provide an annual report of the previous fiscal year that includes the amount of revenue collected and spending activities to the Chairmen of the House Appropriations and Senate Finance Committees and the Director, Department of Planning and Budget.

5. No spending or activity authorized under the provisions of paragraph Q. of this Item shall necessitate general fund spending or require future obligations to the Commonwealth.

6. The department shall maintain CMP special fund balance of at least $1.0 million to address emergency situations in Virginia's nursing facilities.

R. Out of this appropriation, $100,000 the first year and $100,000 the second year from the general fund shall be provided to contract with the Virginia Center for Health Innovation for research, development and tracking of innovative approaches to healthcare delivery.

S.1. Out of this appropriation, $40,332 the first year and $69,320 the second year from special funds and $295,764 the first year and $266,776 the second year from federal funds shall be used to contract with Vision to Learn, a non-profit organization, to provide vision exams and corrective lenses and frames, if necessary, to school age children enrolled in Title I schools where at least 51 percent of the student body qualifies for free or reduced lunch. Vision to Learn will provide services through a mobile eye clinic, and must have a formalized agreement with targeted schools being serviced. The Department of Medical Assistance Services (DMAS) shall reimburse Vision to Learn for services provided to children that do not have another source of payment. The department shall reimburse for services rendered at the standard fee-for-service reimbursement rates.

2. Federal trust funds for these services will be accessed through the Children's Health Insurance Program (CHIP)

Health Services Initiative allowed by Section 2015(a)(1)(D)(ii)) of the Social Security Act and 42 CFR 457.10. The department is authorized to match federal trust funds with local public and private contributions for the purpose of reimbursing Vision to Learn for eye exams and corrective lenses and frames, if necessary, to school age children.

3. The funding of these services is contingent on continued federal funding for the Children's Health Insurance Program (CHIP), and is further limited by the availability of CHIP administrative funds. This language should not be construed as authorizing a new Medicaid or CHIP benefit, or as creating a new entitlement.

T. The Director, the Department of Medical Assistance Services, shall include language in all managed care contracts, for all department programming, requiring the plan sponsor to report quarterly, for all quarters through the one ending June 30, 2019, to the department for all pharmacy claims; the amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. In the event there is a difference between these amounts, the plan sponsor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data and information provided by the plan sponsor shall be kept secure; and notwithstanding any other provision of law, the department shall maintain the confidentiality of the proprietary information and not share or disclose the proprietary information contained in the report or data collected with persons outside the department. Only those department employees involved in collecting, securing and analyzing the data for the purpose of preparing the report shall have access to the proprietary data.

U. The Department of Medical Assistance Services shall, prior to the end of each fiscal quarter, determine and properly reflect in the accounting system whether pharmacy rebates received in the quarter are related to fee-for-service or managed care expenditures and whether or not the rebates are prior year recoveries or expenditure refunds for the current year. All pharmacy rebates for the quarter determined to be prior year revenue shall be deposited to the Virginia Health Care Fund before the end of the fiscal quarter. The department shall create and use a separate revenue source code to account for pharmacy rebates in the Virginia Health Care Fund.

V.1. Effective with the development of the 2020-2022 biennium, it is the intent of the General Assembly that there is hereby established an annual Medicaid state spending target for each fiscal year. The Joint Subcommittee for Health and Human Resources Oversight shall establish the annual target by September 15 of each year for the following two fiscal years. The target shall take into account the following: a 10-year rolling average of Medicaid expenditures by eligibility category and utilization of services, a 20-year rolling average of general fund revenue growth, and for policy decisions adopted by General Assembly during the previous Session which impact Medicaid spending.

2. In the event of an economic recession, the Joint Subcommittee may take into consideration enrollment and spending trends experienced during previous recessions in establishing the targets.

3. It is the intent of the General Assembly that the Governor abide by the spending target for Medicaid state spending, as established by the Joint Subcommittee, in developing the introduced budget each year and shall notify the Chairmen of the House Appropriations and Senate Finance Committees in the event the target cannot be met, along with the reason it cannot be met.