

VIRGINIA STATE BUDGET

2019 Session

Budget Bill - HB1700 (Enrolled)

Bill Order » Office of Health and Human Resources » Item 303

Department of Medical Assistance Services

Item 303	First Year - FY2019	Second Year - FY2020
Medicaid Program Services (45600)	\$11,349,056,147 \$11,840,531,648	\$12,993,105,698 \$14,915,068,263
Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607)	\$123,671,762	\$110,694,442 \$81,678,750
Reimbursements for Behavioral Health Services (45608)	\$134,087,172 \$186,076,126	\$14,571,748 \$43,601,628
Reimbursements for Medical Services (45609)	\$8,816,333,481 \$8,994,264,674	\$9,247,571,707 \$9,664,682,683
Reimbursements for Long-Term Care Services (45610)	\$1,219,302,428 \$1,442,690,738	\$1,307,328,752 \$1,497,658,506
Payments for Healthcare Coverage for Low-Income Uninsured Adults (45611)	\$1,055,661,304 \$1,093,828,348	\$2,312,939,049 \$3,627,446,696
Fund Sources:		
General	\$4,693,022,530 \$4,875,329,958	\$4,775,531,889 \$4,988,700,277
Dedicated Special Revenue	\$752,219,143 \$675,249,477	\$1,070,819,016 \$1,062,068,926
Federal Trust	\$5,903,814,474 \$6,289,952,213	\$7,146,754,793 \$8,864,299,060

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.1. Out of this appropriation, \$61,835,881 the first year and ~~\$55,347,221~~ \$40,839,375 the second year from the general fund and \$61,835,881 the first year and ~~\$55,347,221~~ \$40,839,375 the second year from the federal trust fund is provided for reimbursement to the institutions within the Department of Behavioral Health and Developmental Services.

2. Out of this appropriation, \$18,969,647 the first year from the general fund is provided to cover any federal deferrals associated with payments made to Piedmont and Catawba hospitals. The Department of Planning and Budget shall unallot these funds and shall not allot the funds until the Department of Medical Assistance Services (DMAS) provides documentation of a federal deferral. The Department of Planning and Budget shall be authorized to transfer any unspent portion of this amount, along with first year appropriation in service area 45607 of this Item, to agency 793 (Mental Health Treatment Centers) should DMAS cease Medicaid payments to either Piedmont or Catawba hospitals.

B.1. Included in this appropriation is ~~\$71,773,601~~ \$44,675,958 the first year and ~~\$76,085,569~~ \$9,017,369 the second year from the general fund and ~~\$90,962,360~~ \$63,864,717 the first year and ~~\$95,874,328~~ \$28,206,128 the second year from nongeneral funds to reimburse the Virginia Commonwealth University Health System for indigent health care costs as reported by the hospital and adjusted by the department for indigent care savings related to Medicaid

expansion. 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 ~~\$43,354,550~~\$26,274,229 the first year and ~~\$45,391,756~~\$3,054,908 the second year from the general fund and ~~\$58,069,328~~\$40,989,007 the first year and ~~\$60,106,534~~\$17,769,686 the second year from nongeneral funds to reimburse the University of Virginia Health System for indigent health care costs as reported by the hospital and adjusted by the department for indigent care savings related to Medicaid expansion. 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 prior years. It also includes reductions associated with prior year indigent care reductions. However, the nongeneral funds are appropriated. In order to receive the nongeneral funds in excess of the amount of the general fund appropriated, the health systems shall certify the public expenditures.

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

C.1. The estimated revenue for the Virginia Health Care Fund is ~~\$371,395,190~~\$410,279,068 the first year and ~~\$365,695,190~~\$364,019,578 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. At least 30 days prior to the submission of any state plan or waiver amendment to the Centers for Medicare and Medicaid Services (CMS) *or change in the contracts with managed care organizations that may impact the capitation rates*, the Department of Medical Assistance Services (DMAS) shall provide written notification to the Director, Department of Planning and Budget as to the purpose of such change. This notice shall also assess whether the amendment will require any future state regulatory action or expenditure beyond that which is appropriated in this Act. *If the Department of Planning and Budget, after review of the proposed change, determines that it may likely result in a material fiscal impact on the general fund, for which no legislative appropriation has been provided, then the Department of Medical Assistance Services shall delay the proposed change until the General Assembly authorizes such action.*

F.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.

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.1.a. As of July 1, 2017, the Community Living (CL) waiver authorizes 11,302 slots.

b. As of July 1, 2017, the Family and Individuals Support (FIS) waiver authorizes 1,762 slots.

c. As of July 1, 2017, the Building Independence (BI) waiver authorizes 360 slots.

2. 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.

3. Upon approval by the Centers for Medicare and Medicaid Services of the application for renewal of the CL, FIS and BI waivers, 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.

4.a. The Department of Medical Assistance Services (DMAS) shall amend the CL waiver to add 189 new slots effective July 1, 2018 and an additional 195 slots effective July 1, 2019. An amount estimated at \$8,156,426 the first year and \$16,537,788 the second year from the general fund and \$8,156,426 the first year and \$16,537,788 the second year from nongeneral funds is provided to cover the anticipated costs of the new slots. These estimated amounts assumes that 60 of the additional slots in each year may be filled with individuals transitioning from facility care. DMAS shall seek federal approval for necessary changes to the CL waiver to add the additional slots.

b. The Department of Medical Assistance Services (DMAS) shall amend the FIS waiver to add 414 new slots effective July 1, 2018 and an additional 481 slots effective July 1, 2019. An amount estimated at \$6,347,617 the first year and \$13,720,427 the second year from the general fund and \$6,347,617 the first year and \$13,720,427 the second year from nongeneral funds is provided to cover the anticipated costs of the new slots. DMAS shall seek federal approval for necessary changes to the FIS waiver to add the additional slots.

c. The Department of Medical Assistance Services (DMAS) shall amend the BI waiver to add 40 new slots effective July 1, 2019. An amount estimated at \$257,680 the second year from the general fund and \$257,680 the second year from nongeneral funds is provided to cover the anticipated costs of the new slots. DMAS shall seek federal approval for necessary changes to the BI waiver to add the additional slots.

d. In addition to the new slots added in 4.a. and b., the Department of Medical Assistance Services (DMAS) shall amend the CL waiver to add 25 new slots effective July 1, 2018 and an additional 25 slots effective July 1, 2019. These slots shall be held as reserve capacity by the Department of Behavioral Health and Disability Services (DBHDS) to address emergency situations. An amount estimated at \$937,237 the first year and \$1,874,475 the second year from the general fund and \$937,237 the first year and \$1,874,475 the second year from nongeneral funds is provided to cover the anticipated costs of the emergency slots. DMAS shall seek federal approval for necessary changes to the CL waiver to add the additional slots. Beginning July 1, 2018, DBHDS shall provide a quarterly report on the use of the emergency slot provided in this paragraph.

e. In addition to the new slots added in 4.b., the Department of Medical Assistance Services shall amend the FIS waiver to add 326 new slots effective July 1, 2019 to address the Priority One waiting list. An amount estimated at \$5,000,000 from the general fund and \$5,000,000 from nongeneral funds the second year is provided to cover the anticipated costs of the additional slots.

f. The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Disability Services, shall separately track all costs, placements and services associated with the additional slots added in paragraphs I.4.a., I.4.b., and I.4.c. of this Item. By October 1 of each year, the department shall report this data to the Chairmen of the House Appropriations and Senate Finance Committees and the Director, Department of Planning and Budget.

J. 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 Director, Department of Planning and Budget by December 15 each year.

K. 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.

L. 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.

M.1. The Department of Medical Assistance Services shall have the authority to seek federal approval of changes to its Medallion 4.0 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.

N.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. N.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.

O. 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.

P. 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.

Q.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.

R.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 have authority to enact emergency regulations under [§ 2.2-4011](#) of the Administrative Process Act to effect these provisions.

S.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.

T. 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.

U. 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.

V.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, except as provided herein. If the agency does not render an informal fact-finding conference decision within 180 days of the receipt of the appeal request or, in the case of a joint agreement to stay the appeal decision as detailed below, within the time remaining after the stay expires and the appeal timeframes resume, 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. The Department of Medical Assistance Services and the provider may jointly agree to stay the deadline for the informal appeal decision or for the formal appeal recommended decision of the Hearing Officer for a period of up to sixty (60) days to facilitate settlement discussions. If the parties reach a resolution as reflected by a written settlement agreement within the sixty-day period, then the stay shall be extended for such additional time as may be necessary for review and approval of the settlement agreement in accordance § 2.2-514 of the 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.

W. 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.

X.1. 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.

2. 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.

Y. 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.

Z. 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.

AA. 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.

BB. 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.

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

DD. 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.

EE. 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 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.

b. 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 a, for individuals in need of behavioral health services to be effective July 1, 2019. 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.

FF. 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.

GG. 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.

HH. 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.

II. 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.

JJ.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.

vii. Clarify that settlement proposals may be tendered during the appeal process and that approval is subject to the requirements of § 2.2-514 of the Code of Virginia. The amended regulations shall develop a framework for the submission of the settlement proposal and state that the Department of Medical Assistance Services and the provider may jointly agree to stay the deadline for the informal appeal decision or for the formal appeal recommended decision of the Hearing Officer for a period of up to sixty (60) days to facilitate settlement discussions. If the parties reach a resolution as reflected by a written settlement agreement within the sixty-day period, then the stay shall be extended for such additional time as may be necessary for review and approval of the settlement agreement in accordance with law.

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.

KK. 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.

LL. 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.

MM.1. 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.

2. 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.

3. 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.

NN. 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.

OO. 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.

PP. 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.

QQ. 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.

RR. 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.

SS.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 EE.a. 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.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 undertaken 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.

TT. 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.

UU.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.

VV. 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.

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

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

3. The Department 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.

XX.1.a. 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.

b. The department shall adjust capitation payments to Medicaid managed care organizations for the purpose of securing access to Medicaid hospital services for the qualifying private hospital partners of Type One hospitals (consisting of state-owned teaching hospitals). The department shall revise its contracts with managed care organizations to incorporate these supplemental capitation payments and provider payment requirements. 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 approved by the Centers for Medicare and Medicaid Services (CMS). No payment shall be made without approval from CMS.

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 244.

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 XX.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 may transfer general fund to the department from 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 244 and Item 4-5.03.

c. Payments authorized in this subsection shall sunset after the effective date of a statewide supplemental payment for private acute care hospitals authorized in Item 3-5.16. For purposes of the upper payment limit, the department shall prorate the upper payment limit if the sunset date is mid-fiscal year. The department shall have the authority to implement this change prior to the completion of any regulatory process undertaken in order to effect such change.

7. The department shall amend the State plan for Medical Assistance to implement a supplemental inpatient and outpatient payment for Chesapeake Regional Hospital based on the difference between reimbursement with rates using an adjustment factor of 100% minus current authorized reimbursement subject to the inpatient and outpatient Upper Payment Limits for non-state government owned hospitals. The department shall include in its contracts with managed care organizations a minimum fee schedule for Chesapeake Regional Hospital consistent with rates using an adjustment factor of 100%. The department shall adjust capitation payments to Medicaid managed care organizations to fund this minimum fee schedule. Both the contract changes and capitation rate adjustments shall be compliant with 42 C.F.R. 438.6(c)(1)(iii) and subject to CMS approval. Prior to submitting the State Plan Amendment or making the managed care contract changes, Chesapeake Regional Hospital shall enter into an agreement with the department to transfer the non-federal share for these payments. The department shall have the authority to implement these reimbursement changes consistent with the effective date(s) approved by the Centers for Medicare and Medicaid (CMS). No payments shall be made without CMS approval.

8.a. There is hereby appropriated sum-sufficient nongeneral funds for the department to pay the state share of supplemental payments for nursing homes owned by Type One hospitals (consisting of state-owned teaching hospitals) as provided in the State Plan for Medical Assistance Services. The total supplemental payment 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. DMAS shall enter into a transfer agreement with any Type One hospital whose nursing home 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. 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 adjust capitation payments to Medicaid managed care organizations to fund a minimum fee schedule compliant with requirements in 42 C.F.R. § 438.6(c)(1)(iii) at a level consistent with the State Plan amendment authorized above for nursing homes owned by Type One hospitals. The department shall revise its contracts with managed care organizations to incorporate these supplemental capitation payments and provider

payment requirements. DMAS shall enter into a transfer agreement with any Type One hospitals whose nursing home 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. The department shall have the authority to implement these reimbursement changes consistent with the effective date approved by CMS. No payment shall be made without approval from CMS.

YY. 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.

ZZ. 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.

AAA.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 AAA.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.

BBB. 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.

CCC. 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.

DDD. 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.

EEE.1. Out of this appropriation, ~~\$1,450,000~~ \$1,400,000 the first year and ~~\$2,700,000~~ \$2,350,000 the second year from the general fund and ~~\$1,450,000~~ \$1,400,000 the first year and ~~\$2,700,000~~ \$2,250,000 the second year from nongeneral funds shall be used for supplemental payments to fund the second and third years of graduate medical education for 15 funded slots for residents who began their residencies in July 2017, the first and second years of graduate medical education of ~~14~~ 13 funded slots for residents beginning their residencies in July 2018, ~~and~~ the first year of graduate medical education of ~~25~~ 20 funded slots for residencies in July 2019, *and two one year post graduate fellowships in July 2019.*

2. The supplemental payment for each qualifying residency slot shall be \$100,000 annually minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be \$50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible. Supplemental payments shall be made for up to four years for each qualifying resident. Payments shall be made quarterly following the same schedule used for other medical education payments.

3. The Department of Medical Assistance Services shall submit a State Plan amendment based on the authorization in EEE.1. of this item to make supplemental payments for graduate medical education residency slots. 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.

4.a. Effective July 1, 2017, the department shall make supplemental payments to the following sponsoring institutions 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 2 psychiatry residencies.

b. Effective July 1, 2018, the department shall make supplemental payments to the following sponsoring institutions for the specified number of primary care residencies: Sentara Norfolk General (~~21 residencies~~ *residency*), *Maryview Hospital (1 residency)* and Carilion Medical Center (6 residencies). The department shall make supplemental payments to Carilion Medical Center for ~~2 psychiatry~~ *psychiatric* residencies and to Sentara Norfolk General for 1 OB/GYN residency, *and 2 psychiatric residencies, and 1 urology residency.*

c. Effective July 1, 2019, the department shall make supplemental payments to the following sponsoring institutions for the specified number of primary care residencies: Sentara Norfolk General (1 residency), Maryview Hospital (1 residency), Carilion Medical Center (6 residencies), Centra Health (2 residencies), and Riverside Regional Medical Center (2 residencies). The department shall make supplemental payments to Inova Fairfax Hospital for 1 General Surgery residency and to Carilion Medical Center for 2 psychiatric residencies. The department shall make supplemental payments to Sentara Norfolk General for 2 psychiatric residencies, 1 OB/GYN residency, and 2 urology residencies. The department shall make supplemental payments to the University of Virginia Health System for a one year fellowship in Addiction Medicine and to the Virginia Commonwealth University Health System for a one year fellowship in Addiction Medicine.

5. Preference shall be given for residency slots located in underserved areas. Applications for slots that involve multiple medical care providers collaborating in training residents and that involve providing residents the opportunity to train in underserved areas are encouraged. A majority of the new residency slots funded each year shall be for primary care. The department shall adopt criteria for primary care, high need specialties and underserved areas as developed by the Virginia Health Workforce Development Authority. Beginning July 1, 2018, the department shall also review and consider applications from non-hospital sponsoring institutions, such as Federally Qualified Health Centers (FQHCs).

6. If the number of qualifying residency slots exceeds the available number of supplemental payments, the Virginia Health Workforce Development Authority shall determine which new residency slots to fund based on priorities developed by the authority.

7. The sponsoring institution will be eligible for the supplemental payments as long as it maintains the number of residency slots in total and by category as a result of the increase. The sponsoring institutions must certify by June 1 each year that they continue to meet the criteria for the supplemental payments and report any changes during the year to the number of residents.

8. The department shall require all sponsoring institutions receiving Medicaid medical education funding to report annually by September 15 on the number of residents in total and by specialty/subspecialty. Medical education funding includes payments for graduate medical education (GME) and indirect medical education (IME).

9. The Virginia Health Workforce Authority shall study options to help institutions in underserved and rural areas acquire and maintain specialists and instructors vital to maximize the quality of residency programs and report to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2018.

FFF.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.

2. The Department of Medical Assistance Services shall have the authority to 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 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. Any amendments to the State Plan or waivers initiated under the provisions of this paragraph shall not exceed funding appropriated in this Act for this purpose. The department shall have the 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 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. Any amendments to the State Plan or waivers initiated under the provisions of this paragraph shall not exceed funding appropriated in this Act for this purpose. The department shall have the authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this Act.

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

GGG. The Department of Medical Assistance Services 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.

HHH. 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.

III. 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. 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.

III. 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.

KKK.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.

LLL.1. ~~Effective no later than January 1, 2019~~ *By October 1, 2019*, the Department of Medical Assistance Services is authorized to *shall* require consumer-directed aides providing personal care, respite care and companion services in the Medicaid Commonwealth Coordinated Care (CCC) Plus Waiver 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. Nothing stated above shall apply to respite services provided by a DBHDS licensed provider in a DBHDS licensed program site such as a group home, sponsored residential home, supervised living, supported living or similar facility/location licensed to provide respite, as allowed by the Centers for Medicare and Medicaid.

4. The department shall ensure that implementation of electronic visit verification complies with all requirements of the federal Centers of Medicare and Medicaid Services. The department shall have authority to implement these provisions prior to the completion of any regulatory process in order to effect such changes.

MMM. 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.

NNN. Effective July 1, 2019, the Department of Medical Assistance Services shall increase the rates for agency and consumer directed personal care, respite and companion services in the home and community based services waivers and Early Periodic Screening, and Diagnosis and Treatment (EPSDT) program by two percent. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

OOO. The Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, the Department of Social Services and other agencies as necessary, shall transfer appropriations across items, service areas and agencies within the budget to properly account for the costs and savings of the implementation of Medicaid coverage of newly eligible individuals pursuant to the Patient Protection and Affordable Care Act, including the Training, Education, Employment and Opportunity Program (TEEOP), consistent with the intent of the General Assembly.

PPP. For the period beginning September 1, 2016 until 180 days after publication and distribution of the Developmental Disabilities Waivers provider manual by the Department of Medical Assistance Services (DMAS), retraction of payment from Developmental Disabilities Waivers providers following an audit by DMAS or one of its contractors is only permitted when the audit points identified are supported by the Code of Virginia, regulations, DMAS general providers manuals, or DMAS Medicaid Memos in effect during the date of services being audited.

QQQ. The Department of Medical Assistance Services shall review of the rates paid to residential psychiatric treatment facilities and determine if those rates are appropriate for those facilities. The department shall require residential psychiatric treatment facilities to submit cost reports to be used to conduct its review. The department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2019.

RRR. The Department of Medical Assistance Services shall submit a report annually on all supplemental payments made to hospitals through the Medicaid program. This report shall include information for each hospital and by type of supplemental payment (Disproportionate Share Hospital, Graduate Medical Education, Indirect Medical Education, Upper Payment Limit program, and others). The report shall include total Medicaid payments from all sources and calculate the percent of overall payments that are supplemental payments. Furthermore, it shall include a description of each type of supplemental payment and the methodology used to calculate the payments. Each report shall reflect the data for the prior three fiscal years and shall be submitted to the Chairmen of the House Appropriations and Senate Finance Committees by September 1 each year.

SSS. Effective July 1, 2018, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to make the following changes. The department shall: (i) eliminate eligibility for Disproportionate Share Hospital (DSH) payments for Children's National Medical Center (CNMC); (ii) increase the annual indirect medical education (IME) payments for CNMC by the amount of DSH the hospital was eligible for in fiscal year 2018; and (iii) reduce the Type 2 DSH allocation by this same amount. The department shall have the authority to implement these changes effective July 1, 2018, and prior to completion of any regulatory action to effect such change.

TTT.1. The Department of Medical Assistance Services shall work with stakeholders to review and adjust medical necessity criteria for Medicaid-funded nursing services including private duty nursing, skilled nursing, and home health. The department shall adjust the medical necessity criteria to reflect advances in medical treatment, new technologies, and use of integrated care models including behavioral supports. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Titles XIX and XXI of the Social Security Act to include changes to services covered, provider qualifications, medical necessity criteria, and rates and rate methodologies for private duty nursing. The adjustments to these services shall meet the needs of members and

maintain budget neutrality by not requiring any additional expenditure of general fund beyond the current projected appropriation for such nursing services.

2. The department shall have authority to implement these changes to be effective July 1, 2019. The department shall also have authority to promulgate any emergency regulations required to implement these necessary changes within 280 days or less from the enactment dated of this act. The department shall submit a report and estimates of any projected cost savings to the Chairmen of the House Appropriations and Senate Finance Committees 30 days prior to implementation of such changes.

3. The department shall work with stakeholders to review changes to services covered, provider qualifications, rates and rate methodologies for private duty nursing services, and make recommendations to the Chairmen of the House Appropriations and Senate Finance Committees by December 15, 2018.

UUU. Effective July 1, 2018, the Department of Medical Assistance Services shall explore private sector technology based platforms and service delivery options to allow qualified, licensed providers to deliver the Consumer-Directed Agency with Choice model in the Commonwealth of Virginia. The department shall work with stakeholders to examine this model of care and assess the changes that would be required including the services covered, provider qualifications, medical necessity criteria, reimbursement methodologies and rates to implement the model. The department shall submit a report on its findings to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2018.

VVV. *Effective July 1, 2019, the department shall amend the State Plan for Medical Assistance to clarify payment rules for new nursing homes or renovations that qualify for mid-year rate adjustments, to include the following:*

1. For any facility whose Fair Rental Value report has less than 12 months of experience, the department shall develop an occupancy schedule that represents average statewide occupancy by month of operation for use in calculating the per diem rate in lieu of a minimum occupancy requirement or actual occupancy.

2. Any new beds or renovations placed in service between the reporting year and the rate year shall be treated as a mid-year rate adjustment. No new rate will be made after April 30. Rate updates that fall between May 1 and June 30 shall be effective July 1 of the same year.

3. The department shall annualize real estate taxes, property taxes and property insurance costs that do not represent a full year's cost.

4. Costs shall be based on currently available documentation at the time but are subject to audit. The department may use any reasonable method to estimate costs for which there is inadequate documentation. Any adjustments based on subsequent documentation or audit for a current rate year shall be applied beginning with the next rate year.

5. The department shall have 15 days from the date of the provider's submission to determine if the filing is complete for purposes of setting a rate for a new or renovated facility. The facility shall have 15 days from the date the filing is deemed incomplete to submit the required information. The deadline for setting the rate shall be extended for 30 days after the filing is deemed complete.

6. Providers may propose a phased renovation subject to approval by the department. The phased renovation may include reductions to available beds. Any modifications to the proposed renovation are also subject to approval by the department.

7. The department shall have the authority to implement these reimbursement changes effective July 1, 2019 and prior to the completion of any regulatory process undertaken in order to effect such change.

WWW. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance and any relevant waivers thereof to modify reimbursement for Hospice services provided to patients residing in facilities to include at least 100 percent of the relevant Medicaid facility rate for that individual, a component commonly referred to as "room and board." To the extent allowed under federal law and regulation, the Department shall further amend the State plan and/or relevant waivers thereof to pay this "room and board" rate in effect with no discount applied to the facility directly, thus eliminating the Hospice from its role in passing-through this facility payment to the facility. To the extent federal approval of this direct payment component is dependent on whether it is in the State Plan or in relevant waivers, the Department shall implement the direct payment where federal approval is achieved. The department shall have authority to implement these changes effective July 1, 2019 and prior to the completion of any regulatory process undertaken in order to effect such change.

XXX. Effective July 1, 2019, the Department of Medical Assistance Services shall increase the telehealth originating site facility fee to 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate. The department shall exempt Federally Qualified Health Centers and Rural Health Centers from this reimbursement change. The department shall have the authority to implement these changes prior to completion of any regulatory process undertaken in order to effect such change.

YYY.1. The Department of Medical Assistance Services shall work with the Department of Behavioral Health and Developmental Services and stakeholders to develop the continuum of evidence-based, trauma-informed, and cost-effective mental health services recommended by the University of Colorado Farley Center for Health Policy that will result in the best outcomes for Medicaid and FAMIS members. This continuum shall include community mental health rehabilitation services (including early intervention services) and integrated behavioral health in primary care and school settings.

2. The department shall develop the necessary waiver(s) and the State Plan amendments under Titles XIX and XXI of the Social Security Act to fulfill this item, including but not limited to, changes to the medical necessity criteria, services covered, provider qualifications, and reimbursement methodologies and rates for Community Mental Health and Rehabilitation Services. 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, provider qualifications, and rates and reimbursement methodologies. The department shall also work with its actuary to model the fiscal impact of the proposed continuum.

3. Prior to the submission of any state plan amendment or waivers to implement these changes, the Department of Medical Assistance Services and Department of Behavioral Health and Developmental Services shall submit a plan detailing the changes in provider rates, new services added and any other programmatic or cost changes to the Chairmen of the House Appropriations and Senate Finance Committees. The departments shall submit this report no later than December 1, 2019.

4. Upon approval of the 2020 General Assembly and the federal Centers for Medicare and Medicaid Services, the department shall have authority to implement these changes.

ZZZ. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase reimbursement for Critical Access Hospitals by using an adjustment factor or percent of cost reimbursement of 100% for inpatient operating and capital rates and outpatient rates effective July 1, 2019. The department shall have the authority to implement these changes effective July 1, 2019 and prior to completion of any regulatory action to effect such change.

AAAA. The Department of Medical Assistance Services shall pursue any and all alternatives and cost based reimbursement models to allow a private hospital in rural Southwest Virginia that has closed in the last five years to recoup capital startup costs and minimize operating losses for the next five years, including but not limited to optimizing federal matching dollars in accordance with federal law.

BBBB. The Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services shall recognize the Certified Employment Support Professional (CESP) and Association of Community Rehabilitation Educators (ACRE) certifications in lieu of competency requirements for supported employment staff in the Medicaid Community Living, Family and Individual Support and Building Independence Waiver programs and shall allow providers that are Department for the Aging and Rehabilitative Services vendors that hold a national three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) to be deemed qualified to meet employment staff competency requirements, provided the provider submits the results from their CARF surveys including recommendations received to the Department of Behavioral Health and Developmental Services so that the agency can verify that there are no recommendations for the standards that address staff competency.

CCCC. Effective July 1, 2019, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to increase the practitioner rates for primary care services by five percent and rates for Emergency Department services by one percent to reflect the equivalent of 70 percent of the 2018 Medicare rates. The department shall ensure through its contracts with managed care organizations that the rate increase is reflected in their rates to providers. The department shall have the authority to implement these reimbursement changes prior to the completion of the regulatory process.

DDDD. Effective July 1, 2019, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to create a separate service category for psychiatric services and to increase practitioner rates for psychiatric services by 21 percent to reflect the equivalent of 100 percent of the 2018 Medicare rates. All practitioners who bill these services shall receive new rates. The department shall have the authority to implement these reimbursement changes prior to the completion of the regulatory process.

EEEE. The Department of Medical Assistance Services shall develop a methodology for Disproportionate Share Hospital (DSH) payments that recognizes and creates incentives for private hospitals in providing medical services for individuals subject to temporary detention orders (TDOs). The methodology shall factor in utilization related to TDOs in the DSH methodology. The department shall have the authority to modify the State Plan for Medical Assistance and to implement the changes in the DSH methodology effective January 1, 2019 and prior to the completion of the regulatory process. The department shall report on the details of the methodology, and the potential impact on allocations to hospitals, to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2019.

FFFF. Notwithstanding any other provision of law, any unexpended general fund appropriation remaining in this item on the last day of each fiscal year shall revert to the general fund and shall not be reappropriated in the following fiscal year.

GGGG. The Department of Medical Assistance Services shall amend its contracts with managed care organizations to require written notification and training to agency-directed personal care providers at least 60 days prior to the implementation of all changes to Quality Management Review and prior authorization policies and processes consistent with state and federal regulations.