2023 Special Session I

Budget Bill - HB6001 (Introduced)

Bill Order » Office of Health and Human Resources » Item 308

Department of Medical Assistance Services

Item 308	First Year - FY2023	Second Year - FY2024
Administrative and Support Services (49900)	**$295,873,698**	**$288,261,699**
General Management and Direction (49901)	$276,561,140	$269,574,963
Administrative Support for the Family Access to Medical Insurance Security Plan (49932)	$16,812,558	$16,186,736
CHIP Health Services Initiatives (49936)	$2,500,000	$2,500,000
Fund Sources:		
General	$74,373,559	$72,923,062
Special	$7,329,800	$7,329,800
Dedicated Special Revenue	$8,969,112	$8,781,954
Federal Trust	$205,201,227	$199,226,883

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

A.1.a. Notwithstanding any other provision of law, by November 1 of each year, the Department of Medical Assistance Services (DMAS) shall prepare and submit a forecast of Medicaid expenditures, upon which the Governor's budget recommendations will be based, for the current and subsequent two years to the Director, Department of Planning and Budget (DPB) and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees.

b. The forecast shall be based on current state and federal laws and regulations.

c. The forecast shall reflect only expenditures for medical services provided in Program 45600 and shall exclude service area 45606, service area 45607, and administrative expenditures.

d. Rebasing and inflation estimates that are required by existing law or regulation for any Medicaid provider shall be included in the forecast.

e. The forecast shall include a projection of the increases or decreases in managed care costs, including the rates that will be reflected in the upcoming July 1 contracts as well as changes in managed care rates for a three-year period including the current year.

f. In preparing for each year's forecast of the managed care portions of the budget, DMAS shall submit to its actuarial contractor a letter of request, with a copy sent to the Director, DPB and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees. This letter shall document the department's request for a point estimate of managed care rates and changes in rates, based on the application of actuarial

principals and methodologies and information available at the time of the forecast. The letter also shall require that the contractor reflect the years being forecasted, and shall specify the population groupings for which estimates are requested. The department shall request that the contractor reply in writing with a copy to all parties copied on the department's letter of request.

2. In addition to the November 1 forecast submission, DMAS shall provide: 1) a separate accounting of forecasted expenditures by caseload/utilization, inflation and policy changes; and 2) an enrollment forecast for the same period of the forecast.

3. In the development and execution of the official forecast, DMAS shall collaborate with staff from the Department of Planning and Budget (DPB), House Appropriations Committee and Senate Finance and Appropriations Committee. Further, DMAS shall consult with DPB and money committee staff throughout the year, as necessary, to review any issues that may influence the current or upcoming forecasts. Upon request from such staff, DMAS shall provide the information necessary to evaluate factors that may affect the Medicaid forecast; including, but not limited to, program utilization, enrollment, lump sum payments, and rate changes. At a minimum, DMAS shall provide such staff with program updates within 30 days after the end of each General Assembly session and fiscal year. By October 15 of each year, DMAS shall make a preliminary forecast of Medicaid expenditures available for review to staff from DPB and the House Appropriations and Senate Finance and Appropriations Committees. DMAS shall consider feedback generated from this review in the official November 1 forecast.

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

2. The Department of Medical Assistance Services shall prepare a quarterly report summarizing managed care expenditures by program and service category through the most recent quarter with three months of runout. The report shall summarize the data by service date for each quarter in the current fiscal year and the previous two fiscal years and update prior quarter expenditures. The department shall publish the report on the department's website no later than 30 days after the end of each quarter and shall notify the Department of Planning and Budget and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees.

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

4. The Department of Medical Assistance Services shall convene a meeting each quarter with the Secretary of Finance, Secretary of Health and Human Resources, or their designees, and appropriate staff from the Department of Planning and Budget, House Appropriations and Senate Finance and Appropriations Committees, and Joint Legislative Audit and Review Commission to explain any material differences in expenditures compared to the official Medicaid forecast, adjusted to reflect budget actions from each General Assembly Session. The main purpose of each meeting shall be to review and discuss the most recent Medicaid expenditures to determine the program's financial status. If necessary, the department shall provide options to bring expenditures in line with available resources. At each quarterly meeting, the department shall provide an update on any changes to the managed care programs, or contracts with managed care organizations, that includes detailed information and

analysis on any such changes that may have an impact on the capitation rates or overall fiscal impact of the programs, including changes that may result in savings. In addition, the department shall report on utilization and other trends in the managed care programs. During each fiscal year, the meetings for each quarter shall be held in July, October, December, and April to review the previous three month period.

C. The Department of Medical Assistance Services shall report a detailed accounting, annually, of the agency's organization and operations. This report shall include an organizational chart that shows all full- and part-time positions (by job title) employed by the agency as well as the current management structure and unit responsibilities. The report shall also provide a summary of organization changes implemented over the previous year. The report shall be made available on the department's website by August 15 of each year.

D. The Department of Medical Assistance Services shall, within 15 days of receiving a deferral of federal grant funds, or release of a deferral, or a disallowance letter, notify the Director, Department of Planning and Budget, and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees of such deferral action or disallowance. The notice shall include the amount of the deferral or disallowance and a detailed explanation of the federal rationale for the action. Any federal documentation received by the department shall be attached to the notification.

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

2. The department shall make Medicaid and other agency data stored in the agency's data warehouse available through the department's website that includes, at a minimum, interactive tools for the user to select, display, manipulate and export requested data.

3. The Department of Medical Assistance Services shall post on its website the complete State Plan for Medical Assistance along with all amendments in an easily searchable format to be accessible to the public.

4. Within five days of any submission of a State Plan amendment to the Centers for Medicare and Medicaid Services, the Department of Medical Assistance Services shall post such submission on its website. The department shall also post any federal approval documents once the State Plan amendment is approved.

5. The department shall publish a document on its website, updated annually, that lists all policy changes, including their fiscal impact, for the Medicaid program for the preceding fiscal year.

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

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

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

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

transactions; and (iv) information on service utilization metrics.

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

d. Upon the inclusion of behavioral health care in managed care, a report on their policies and processes for identifying behavioral health providers who provide inappropriate services and the number of such providers that are disenrolled.

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

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

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

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

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

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

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

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

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

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

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

I. The Department of Medical Assistance Services, in collaboration with the Department of Behavioral Health and Developmental Services, shall convene a stakeholder workgroup, to meet at least once annually, with representatives of the Virginia Association of Community Services Boards, the Virginia Network of Private Providers, the Virginia Association of Centers for Independent Living, Virginia Association of Community Rehabilitation Programs (VaACCSES), the disAbility Law Center of Virginia, the ARC of Virginia, and other stakeholders including representative family members, as deemed appropriate by the Department of Medical Assistance Services. The workgroup shall: (i) review data from the previous year on the distribution of the SIS levels and tiers by region and by waiver; (ii) review the process, information considered, scoring, and calculations used to assign individuals to their levels and reimbursement tiers; (iii) review the communication which informs individuals, families, providers, case managers and other appropriate parties about the SIS tool, the administration, and the opportunities for review to ensure transparency; and (iv) review other information as deemed necessary by the workgroup. The department shall report on the results and recommendations of the workgroup to the General Assembly by October 1 of each year.

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

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

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

M. The Department of Medical Assistance Services, in collaboration with the Department of Social Services, shall require Medicaid eligibility workers to search for unreported assets at the time of initial eligibility determination and renewal, using all currently available sources of electronic data, including local real estate property databases and the Department of Motor Vehicles for all Medicaid applicants and recipients whose assets are subject to an asset limit under Medicaid eligibility requirements.

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

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

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

2. Out of this appropriation, $3,283,004 the first year and $3,283,004 the second year from the general fund and $9,839,000 the first year and $9,839,000 the second year from nongeneral funds is provided for the enhanced operation of the Cover Virginia Call Center as a centralized eligibility processing unit (CPU) that shall be limited to processing Medicaid applications received from the Federally Facilitated Marketplace, telephonic applications through the call center, or electronically submitted Medicaid-only applications. The department shall report the number of applications processed on a monthly basis and payments made to the contractor to the Director, Department of Planning and Budget and the Chairman of the House Appropriations and Senate Finance and Appropriations Committees. The report shall be submitted no later than 60 days after the end of each quarter of the fiscal year.

P. Out of this appropriation, $15,462,264 the first year and $15,462,264 the second year from the general fund and $62,407,632 the first year and $62,407,632 the second year from nongeneral funds shall be provided to maintain and operate the Medicaid Enterprise System.

Q.1. Out of this appropriation, $6,035,000 the first year and $6,035,000 the second year from special funds is appropriated to the Department of Medical Assistance Services (DMAS) for the disbursement of civil money penalties (CMP) levied against and collected from Medicaid nursing facilities for violations of rules identified during survey and certification as required by federal law and regulation. Based on the nature and seriousness of the deficiency, the agency or the Centers for Medicare and Medicaid Services may impose a civil money penalty, consistent with the severity of the violations, for the number of days a facility is not in substantial compliance with the facility's Medicaid participation agreement. Civil money penalties collected by the Commonwealth must be applied to the protection of the health or property of residents of nursing facilities found to be deficient. Penalties collected are to be used for (1) the payment of costs incurred by the Commonwealth for relocating residents to other facilities; (2) payment of costs incurred by the Commonwealth related to operation of the facility pending correction of the deficiency or closure of the facility; and (3) reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or individuals used by the facility to provide services to residents. These funds are to be administered in accordance with the revised federal regulations and law, 42 CFR 488.400 and the Social Security Act § 1919(h), for Enforcement of Compliance for Long-Term Care Facilities with Deficiencies. Any special fund revenue received for this purpose, but unexpended at the end of the fiscal year, shall remain in the fund for use in accordance with this provision.

2. Of the amounts appropriated in Q.1. of this Item, up to $225,000 the first year and $225,000 the second year from special funds may be used for the costs associated with administering CMP funds.

3. Of the amounts appropriated in Q.1. of this Item, up to $2,310,000 the first year and $2,310,000 the second year from the special funds may be used for special projects that benefit residents and improve the quality of nursing Facilities.

4. Out of the amounts appropriated in Q.1. of this item, $3,500,000 the first year and $3,500,000 the second year from special funds shall be used for a quality improvement program addressing nursing facility capacity building. The program design may be based on the results of the Virginia Gold Quality Improvement Program pilot project, to include peer mentoring, job-related and interpersonal skills training, and work-related benefits. The Department of Medical Assistance Services shall seek approval from the Centers for Medicare & Medicaid Services (CMS) to implement the program.

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

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

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

8. The Department of Medical Assistance Services is authorized to administratively request up to $2,000,000 of additional special fund appropriation for special projects if 1) the appropriated amounts in Q.3. are insufficient; and 2) such projects and costs are approved by the Centers for Medicare and Medicaid Services (CMS) for the Civil Money Penalty Reinvestment State Plan. The Department of Planning Budget shall approve such requests provided the required conditions are met.

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

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

T. Out of this appropriation, $87,500 the first year and $87,500 the second year from the general fund and $262,500 the first year and $262,500 second year from nongeneral funds shall be provided for support of the All Payer Claims Database operated by Virginia Health Information. This appropriation is contingent on federal approval of an Operational Advanced Planning Document.

U. Out of this appropriation, $875,000 the first year and $875,000 the second year from the general fund and $1,625,000 the first year and $1,625,000 the second year from nongeneral funds is provided for the Department of Medical Assistance Services to amend the State Plan and any waivers under Title XXI to fund $2,500,000 annually for three Poison Control centers serving Virginia as part of a Health Services Initiative. The department shall have the authority to promulgate emergency regulations to implement these amendments within 280 days or less from the enactment of this act.

V. Notwithstanding any other provision of law, the Department of Medical Assistance Services (DMAS) shall have the authority to adjust the date of any agency payments should doing so allow the agency to maximize federal reimbursement. This language shall only apply to the extent that any impacted payments or reimbursements are allowable and appropriate under state and federal rules.

W.1. Out of amounts appropriated in the items for this agency, $598,763 the first year and $598,763 the second year from the general fund and $823,476 the first year and $823,476 the second year from nongeneral funds is provided to support seven appeals staff positions that will respond to additional appeals and ensure regulatory compliance.

2. The Department of Medical Assistance Services shall amend regulations to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of

documents and decision deadlines for de novo client hearings. The department shall have the authority to promulgate emergency regulations to implement these amendments within 280 days or less from the enactment of this Act.

X. Out of this appropriation, $447,700 the first year and $447,700 the second year from the general fund and $1,212,666 the first year and $1,212,666 the second year from nongeneral funds is provided to implement the Virginia Facilitated Enrollment Program.

Y. Out of this appropriation, $1,319,515 the first year and $1,319,515 the second year from the general fund and $3,798,129 the first year and $3,798,129 the second year from federal funds is provided to support the Emergency Department Care Coordination Program (EDCC) as allowed by the Centers for Medicare and Medicaid Services. The Department of Medical Assistance Services, in cooperation with the Virginia Department of Health, shall establish a work group comprised of the EDCC contractor, the Virginia Health Information, Medicaid and commercial managed care organizations, health systems with emergency departments and emergency department physicians to optimize the use of the system and any enhancements to the system to facilitate communication and collaboration among physicians, other healthcare providers and other clinical and care management personnel about patients receiving services in hospital emergency departments for the purpose of improving the quality of care.

Z. Effective July 1, 2021, the Department of Medical Assistance Services shall implement an orientation program for Doula service providers.

AA. Out of this appropriation, $90,000 the first year and $90,000 the second year from the general fund and $90,000 the first year and $90,000 the second year from federal funds shall be used by the agency to hire a full time employee in the provider reimbursement division. This employee shall have the actuarial and accounting experience necessary to provide ongoing expertise on nursing facility reimbursement and rate methodology issues.

BB. Out of this appropriation, $300,000 the first year and $300,000 the second year from the general fund and $300,000 the first year and $300,000 the second year from federal funds shall be used by the agency to hire five additional full-time employees to augment existing staff in the agency's finance division. Specifically, the Department of Medical Assistance Services shall hire three additional positions in the budget division, one additional position in the fiscal division and one additional position in the provider reimbursement division. The agency shall inform the Director, Department of Planning and Budget once these positions are hired. In addition, these positions shall be highlighted in the agency's annual organizational report.

CC.1. The Department of Medical Assistance Services, in conjunction with relevant stakeholders, shall convene a workgroup to develop a plan for a neurobehavioral science unit and a waiver program for individuals with brain injury and neuro-cognitive disorders. The neurobehavioral science unit shall be considered as one of the alternative institutional placements for individuals needing these waiver services. The workgroup shall make recommendations in the plan related to relevant service definitions, administrative structure, eligibility criteria, reimbursement rates, evaluation, and estimated annual costs to reimburse for neurobehavioral institutional care and administration of the waiver program. The department shall include a rate methodology that supports institutional costs and waiver services.

2. The department shall submit a report which outlines the recommendations for a neurobehavioral science unit, waiver program, and the service methodology to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 1, 2022.

DD. The Department of Medical Assistance Services and the Department of Planning and Budget shall evaluate the impact of merging the Commonwealth Care Coordinated Plus and Medallion 4.0 managed care programs to identify administrative cost savings and efficiencies that will result from combining the two programs and contracts. The departments shall develop a plan to achieve savings of at least $1.0 million a year and shall report

that plan to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by no later than October 1, 2022.

EE.1. The Department of Medical Assistance Services is authorized to begin the reprocurement of the Commonwealth's managed care service delivery system with an implementation date no earlier than July 1, 2024.

2. In development of a single managed care contract with the selected managed care organizations, the department shall not include the following services, which shall remain in fee-for-service: (i) dental services; (ii) developmental disability waiver services; (iii) and other services currently excluded from the managed care contracts. DMAS shall not include any new services in the contract unless explicitly authorized by the General Assembly.

3. The department shall ensure that the cost of any programmatic and/or contractual changes are fully accounted for in the Appropriation Act. Contract and program changes associated with this reprocurement shall not create any future funding commitments unless authorized by the General Assembly.

4.The department shall have its contracted actuary review the new managed care contract and report on all program changes as compared to the existing contract and estimate any fiscal impact of such changes no later than 30 days prior to the effective date of the contract.