2006 Special Session I

Budget Bill - HB5002 (Chapter 3)

Department of Medical Assistance Services

Item 302	First Year - FY2007	Second Year - FY2008
Medicaid Program Services (45600)	**$5,029,321,523**	**$5,383,254,608**
Reimbursements to State-Owned Mental Health and Mental Retardation Facilities (45607)	$210,412,730	$203,128,980
Reimbursements for Mental Health and Mental Retardation Services (45608)	$308,967,227	$330,046,469
Reimbursements for Professional and Institutional Medical Services (45609)	$3,136,324,142	$3,403,935,759
Reimbursements for Long-Term Care Services (45610)	$1,373,617,424	$1,446,143,400
Fund Sources:		
General	$2,293,923,508	$2,463,598,873
Dedicated Special Revenue	$311,694,578	$323,427,897
Federal Trust	$2,423,703,437	$2,596,227,838

Authority: Title 32.1, Chapters 9 and 10, Code of Virginia; P.L. 89-87, as amended, Title XIX, Social Security Act, Federal Code.

A. It is the intent of the General Assembly to develop and cause to be developed appropriate, fiscally responsible methods for addressing the issues related to the cost and funding of long-term care. It is the further intent of the General Assembly to promote home-based and community-based care for individuals who are determined to be in need of nursing facility care.

B.1. The Director of the Department of Medical Assistance Services shall seek the necessary waivers from the United States Department of Health and Human Services to authorize the Commonwealth to cover health care services and delivery systems, as may be permitted by Title XIX of the Social Security Act, which may provide less expensive alternatives to the State Plan for medical assistance.

2. The Director shall promulgate such regulations as may be necessary to implement those programs which may be permitted by Titles XIX and XXI of the Social Security Act, in conformance with all requirements of the Administrative Process Act.

C.1. The appropriation includes $105,206,365 the first year from the general fund and $105,206,365 from the federal trust fund and $101,564,490 the second year from the general fund and $101,564,490 from the federal trust fund for reimbursement to the institutions within the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Department of Mental Health, Mental Retardation and Substance Abuse Services

shall be reimbursed for the federal share of general salary scale adjustments approved by the General Assembly.

2. The appropriation includes the first year $183,765,651 from the general fund and $183,765,651 from the federal trust fund, and the second year $201,291,404 from the general fund and $201,291,404 from the federal trust fund for estimated reimbursements for services provided to individuals on the Mental Retardation Waiver or the Mental Retardation Day Support Waiver.

D. Out of this appropriation, the Department of Medical Assistance Services shall provide coverage of intensive assisted living care to residents of licensed Adult Care Residences who are Auxiliary Grant recipients. Individuals entitled to benefits under this section are not entitled to benefits under Item 304.

E. 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 of the Department of Medical Assistance Services, after consultation with the Attorney General, is authorized to pursue the alternative method.

F.1. Included in this appropriation is $59,243,568 from the general fund and $59,243,568 from nongeneral funds in the first year and $62,037,416 from the general fund and $62,037,416 from nongeneral funds in the second year to reimburse the Virginia Commonwealth University Health System for indigent health care costs and Medicaid losses. 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.

2. Included in this appropriation is $35,298,153 from the general fund and $35,298,153 from nongeneral funds in the first year and $38,000,957 from the general fund and $38,000,957 from nongeneral funds in the second year to reimburse the University of Virginia Health System for indigent health care costs and Medicaid losses. 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.

G. The Department shall establish a program to more effectively manage those Medicaid recipients who receive the highest cost care. To implement the program, the Department shall establish uniform criteria for the program, including criteria for the high cost recipients, providers and reimbursement, service limits, assessment and authorization limits, utilization review, quality assessment, appeals and other such criteria as may be deemed necessary to define the program. The Department shall seek any necessary approval from the Centers for Medicare and Medicaid Services, and shall promulgate such regulations as may be deemed necessary to implement this program.

H. The Department of Medical Assistance Services and the Virginia Department of Health shall work with representatives of the dental community: to expand the availability and delivery of dental services to pediatric Medicaid recipients; to streamline the administrative processes; and to remove impediments to the efficient delivery of dental services and reimbursement thereof. The Department of Medical Assistance Services shall report its efforts to expand dental services to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget by December 15 each year.

I. The Department of Medical Assistance Services shall implement continued enhancements to the prospective

drug utilization review (pro-DUR) program. The Department shall continue the Pharmacy Liaison Committee and the pro-DUR Committee. The Department shall continue to work with the Pharmacy Liaison Committee to implement initiatives for the promotion of cost-effective services delivery as may be appropriate. The Department shall report on the Pharmacy Liaison Committee's and the pro-DUR Committee'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.

J. 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.

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. It is the intent of the General Assembly that the use of the new atypical medications to treat seriously mentally ill Medicaid recipients should be supported by the formularies used to reimburse claims under the Medicaid fee-for-service and managed care plans.

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

2. In order to conform the state regulations to the federally approved changes and to implement the provisions of this act, the Department shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. The Department shall implement these necessary regulatory changes to be consistent with federal approval of the waiver changes.

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, Comprehensive Services Act program, Department of Education, Department of Juvenile Justice, Department of Mental Health, Mental Retardation and Substance Abuse Services, Virginia Department for the Aging, 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.

2. The Department shall track revenues and submit a status report on the successful implementation of any strategies to the Department of Planning and Budget by October 15 in each year of the biennium. The report shall include revenues generated for both the department and other agencies.

3. Whenever feasible the affected agency shall either (i) administratively transfer to the Department the general fund appropriation needed to implement the proposed savings initiative and the estimated general fund savings related to the initiative or (ii) the Department of Medical Assistance Services reimbursement to the affected agency shall be limited to the federal share of the Medicaid reimbursement, with the affected agency responsible for providing the state share; the affected agency shall still be responsible for transferring to the Department the estimated savings related to the initiative. In cases where the above options are not feasible, the Medicaid savings paid by the identified service providers pursuant to these strategies shall be recovered and deposited into the state treasury as nongeneral fund revenue or as an expenditure refund. Any revenues generated through these activities shall be deposited into the Virginia Health Care Fund to be used for the purposes specified in this Item.

O. The Department of Medical Assistance Services shall retain the savings necessary to reimburse a vendor for its

efforts resulting from the Department's Request for Proposals, issued on August 30, 2001, and titled Maximizing Federal Reimbursement. However, prior to reimbursement, the Department shall identify for the Secretary of Health and Human Resources each of the vendor's revenue maximization efforts and the manner in which each vendor would be reimbursed. No reimbursement shall be made to the vendor without the prior approval of the above plan by the Secretary.

P. The Department of Medical Assistance Services in cooperation with the State Executive Council, shall provide semi-annual training to local Comprehensive Services Act teams on the procedures for use of Medicaid for residential treatment and treatment foster care services, including, but not limited to, procedures for determining eligibility, billing, reimbursement, and related reporting requirements. The Department shall include in this training information on the proper utilization of inpatient and outpatient mental health services as covered by the Medicaid State Plan. The Department shall report annually, by June 30, to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget on the results of the training program. The report shall include the number of local team representatives attending formal training programs offered by the Department; the number of technical assistance requests responded to by the Department; and the type and amounts of training materials made available to the local teams.

Q. The Department of Medical Assistance Services shall discontinue efforts to seek approval for a Research and Demonstration 1115 Waiver for the management of chronic care conditions of elderly and disabled persons through the Virginia Area Agencies on Aging using funds previously allocated for elderly case management under the department of Medical Assistance Services' State Plan. The department shall amend the State Plan for Medical Assistance Services to restore elderly case management services as a state plan service. The department shall promulgate emergency regulations to become effective within 280 days or less from the enactment date of this act. The department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

R. Contingent upon approval by the Centers for Medicare and Medicaid Services to implement a new Independence Plus Home and Community Based Services Waiver, the Department of Medical Assistance Services shall promulgate emergency regulations to become effective within 280 days or less from the enactment date of this act. The department shall implement these necessary regulatory changes to be consistent with federal approval of the waiver application developed by the department and stakeholders. In the event a recipient of a waiver slot under the Independence Plus Home and Community Based Services Waiver exits the program, funding for the slot shall revert to the waiver program from which the recipient came.

S.1. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, the Department of Medical Assistance Services, in consultation with the Department of Mental Health, Mental Retardation and Substance Abuse 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 of the Department of Mental Health, Mental Retardation and Substance Abuse 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 quarterly 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 Mental Health, Mental Retardation, and Substance Abuse Services to consider utilizing a Preferred Drug List program for its non-Medicaid clients.

7. The Department of Medical Assistance Services shall exempt antidepressant and antianxiety medications used for the treatment of mental illness from the Medicaid Preferred Drug List program.

8. The department shall provide to the Governor; the House Committees on Appropriations, and Health, Welfare and Institutions; the Senate Committees on Finance, and Education and Health; and the Joint Commission on Health Care a report on the Preferred Drug List (PDL) Program no later than November 1 of each year. The report shall include the direct savings attributed to the PDL for the prior fiscal year, an estimated savings of the program for the next fiscal year, and the cost to administer the PDL. The report shall also include an analysis of the impact of the program on patient health including, but not limited to, hospitalizations and emergency outpatient visits.

T. 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.

U. Contingent upon approval by the Centers for Medicare and Medicaid Services, the Department of Medical Assistance Services shall implement coverage for an additional level of Residential Treatment for Children and Adolescents. The state match will be obtained from Comprehensive Services Act funds. The Department shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. The Department shall implement these necessary regulatory changes to be consistent with federal approval of the State Plan amendment.

V. 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.

W. The Department of Medical Assistance Services shall develop, in conjunction with affected constituents, a waiver pursuant to §1915(c) of the Social Security Act (42 U.S.C. 1396n) from the Centers for Medicaid and Medicare Services to establish a home and community-based care waiver for persons with Alzheimer's disease and related dementias (“Alzheimer's/Dementia Assisted Living Waiver”). The Alzheimer's/Dementia Assisted Living Waiver shall be for those individuals who meet the functional criteria for admission to a nursing facility, who have a diagnosis of Alzheimer's disease or a related dementia, and who are eligible to receive an Auxiliary Grant. The waiver enrollment for the first year of such program shall be limited to an enrollment of 200 individuals who choose to move to an assisted living facility. The agency shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act.

X. Within the limits of this appropriation, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services to implement a Medicaid Buy-in Program on January 1, 2007. The program shall be designed to include cost sharing provisions. At the time of enrollment in the program, the individual must either be a current Medicaid recipient or meet the income, asset and eligibility requirements for the Medicaid-covered group for individuals age 65 or older, blind or disabled who have incomes that do not exceed 80 percent of the federal poverty income guidelines. The agency shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act.

Y.1. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to modify the reimbursement methodology used to reimburse for generic drug products. The new methodology shall reimburse for the product cost based on a Maximum Allowable Cost list to be established by the department. Such amendments shall be effective within 280 days or less from the enactment of this act.

2. In developing the maximum allowable cost (MAC) reimbursement rate for generic pharmaceuticals, the department shall: (i) publish the factors used to set state MAC rates, including the identity of the reference product used to set the MAC rate; the GCN number of the reference product; the factor by which the MAC rate exceeds the reference product price, which shall be not less than 110 percent of the lowest-published wholesale acquisition cost for products widely available for purchase in the state, and included in national pricing compendia; and the identity and date of the published compendia used to determine the reference product and set the MAC rate; (ii) identify three different suppliers that are able to supply the product and from whom pharmacies are able to purchase sufficient quantities of the drug. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the FDA's most recent version of the “Orange Book"; (iii) identify that the use of a MAC rate is lower than the Federal Upper Limit (FUL) for the drug, or the development of a MAC rate that does not have a FUL will not result in the use of higher-cost innovator brand name or single source drugs in the Medicaid program; and (iv) distribute the list of state MAC rates to pharmacy providers in a timely manner prior to the implementation of MAC rates and subsequent modifications.

3. The department shall: (i) review and update the list of MAC rates at least quarterly; (ii) implement and maintain a procedure to eliminate products from the list, or modify MAC rates, consistent with changes in the marketplace; and (iii) provide an administrative appeals procedure to allow a dispensing provider to contest a listed MAC rate.

4. The department shall report on savings achieved through the implementation of the Maximum Allowable Cost rates for generic pharmacy products in the Medicaid pharmacy program to the Chairmen of the House Appropriations and Senate Finance Committees, the Joint Commission on Health Care, and the Department of Planning and Budget by January 1 of each year.

Z. Out of this appropriation, the dedicated special fund appropriation for Medical Assistance Services includes $311,694,578 the first year and $323,427,897 the second year from the Virginia Health Care Fund.

AA. 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.

BB. The Department of Medical Assistance Services, in cooperation with the Department of Social Services' Division of Child Support Enforcement, shall identify and initiate third party recovery actions where there is a medical support order requiring a noncustodial parent to contribute to the medical cost of a child who is enrolled in the Medicaid or Family Access to Medical Insurance Security (FAMIS) Programs.

CC. In developing a long-term disease state management program, the Department of Medical Assistance Services shall consider including initiatives which positively impact health care costs in children and adults with asthma and other chronic diseases.

DD.1. The Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance Services governing Medicaid reimbursement for nursing facilities effective July 1, 2006. The provision to increase the ceilings by $3 per day shall be deleted. In its place, the department shall amend the State Plan to eliminate administrator salary limits, medical director salary limits and management fee limits, except when the administrator, medical director or contracted management firm is a related party, and set the indirect care ceiling at 106.13 percent of the day weighted median of base year cost. In addition, $3 per resident day, adjusted for inflation from FY 2006, multiplied times Medicaid utilization and allocated proportionately between direct and indirect cost, shall be added to facility specific cost per day used to set prospective rates to the extent those facility specific costs are from a cost reporting period that includes any days before July 1, 2005. This amendment to the State Plan shall become effective within 280 days from enactment of this act.

2. In addition to the changes in paragraph DD.1. in this Item, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance Services governing Medicaid reimbursement for nursing facilities to set the direct care ceiling at 117 percent and the indirect care ceiling at 107 percent of the day weighted median of base year cost, effective July 1, 2006. Out of this appropriation, $3,904,150 from the general fund and $3,904,150 from nongeneral funds the first year and $4,036,891 from the general fund and $4,036,891 from nongeneral funds in the second year is provided to increase the ceilings. This amendment to the State Plan shall become effective within 280 days from enactment of this act.

3. The Department of Medical Assistance Services shall implement the reimbursement change in paragraph DD.2. in this item on July 1, 2006, or on the date of this enactment, whichever is later. The Department shall have authority to implement this reimbursement change prior to the completion of any regulatory process undertaken in order to effect such change.

EE. To maintain the funding levels for indigent care, the Department of Medical Assistance Services shall have the authority to amend the State Plan of Medical Assistance to increase payments to physicians who are faculty affiliated with Type I hospitals or related universities. The amount of the total payment shall be up to the upper payment limit for these services as permitted by federal Medicaid law and regulation. Contingent upon federal approval, the Department of Medical Assistance Services shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

FF.1. Within the limits of this appropriation, the Department of Medical Assistance Services shall work with its contracted managed care organizations and fee-for-service health care providers to: (i) raise awareness among the providers who serve the Medicaid population about the health risks of chronic kidney disease; (ii) establish effective means of identifying patients with this condition; and (iii) develop strategies for improving the health status of these patients. The Department shall work with the National Kidney Foundation to prepare and disseminate information for physicians and other health care providers regarding generally accepted standards of clinical care and the benefits of early identification of individuals at highest risk of chronic kidney disease.

2. Effective July 1, 2006, the Department shall request any clinical laboratory performing a serum creatinine test on a Medicaid recipient over the age of 18 years to calculate and report to the physician the estimated glomerular filtration rate (eGFR) of the patient and shall report it as a percent of kidney function remaining. The Department shall provide a status report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by January 1, 2007 on its efforts to increase reporting of the eGFR rate to physicians and, to the extent feasible, that clinical laboratories are complying with the requested reporting.

GG.1. The Director of the Department of Planning and Budget is authorized to transfer amounts, as needed, from Medicaid Program Services (program 45600) to Administrative and Support Services (program 49900) to fund administrative expenditures associated with contracts between the Department of Medical Assistance Services and companies providing disease state and chronic care management programs services for Medicaid recipients. The Department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

2. The department shall report on its efforts to contract for and implement disease state management programs in the Medicaid program by November 1 of each year of the biennium, to the Chairmen of the Senate Finance and House Appropriations Committees and the Department of Planning and Budget. The report shall include estimates of savings that may result from such programs.

HH.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 of the Department of Medical Assistance Services shall notify the provider of the amount of the overpayment. Such notification of overpayment shall be issued within the earlier of (i) four years after payment of the claim or other payment request, or (ii) four years after filing by the provider of the complete cost report as defined in the Department of Medical Assistance Services' regulations, or (iii) 15 months after filing by the provider of the final complete cost report as defined in the Department of Medical Assistance Services' regulations subsequent to sale of the facility or termination of the provider.

2. Notwithstanding the provisions of § 32.1-325.1, Code of Virginia, the Director shall issue an informal fact-finding conference decision concerning provider reimbursement in accordance with the State Plan for Medical Assistance, the provisions of § 2.2-4019, Code of Virginia, and applicable federal law. The informal fact-finding conference decision shall be issued within 180 days of the receipt of the appeal request. If the agency does not render an informal fact-finding conference decision within 180 days of the receipt of the appeal request, the decision is deemed to be in favor of the provider. An appeal of the Director's informal fact-finding conference decision concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the State Plan for Medical Assistance provided for in § 32.1-325, Code of Virginia. Once a final agency case decision has been made, the Director shall undertake full recovery of such

overpayment whether or not the provider disputes, in whole or in part, the informal fact-finding conference decision or the final agency case decision. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313, Code of Virginia, from the date the Director's agency case decision becomes final.

II. 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.

JJ.1. The Department of Medical Assistance Service shall amend the State Plan for Medical Assistance Services to modify the delivery system of pharmaceutical products to include a specialty drug program. In developing the modifications, the department shall consider input from physicians, pharmacists, pharmaceutical manufacturers, patient advocates, the Pharmacy Liaison Committee, and others as appropriate.

2. In developing the specialty drug program to implement appropriate care management and control drug expenditures, the department shall contract with a vendor who will develop a methodology for the reimbursement and utilization through appropriate case management of specialty drugs and distribute the list of specialty drug rates, authorized drugs and utilization guidelines to medical and pharmacy providers in a timely manner prior to the implementation of the specialty drug program and publish the same on the department's website.

3. In the event that the Department of Medical Assistance Services contracts with a vendor, the Department shall establish the fee paid to any such contractor based on the reasonable cost of services provided. The Department may not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses cannot be based on the percentage of cost savings generated under the benefit management of services.

4. The department shall: (i) review, update and publish the list of authorized specialty drugs, utilization guidelines, and rates at least quarterly; (ii) implement and maintain a procedure to revise the list or modify specialty drug program utilization guidelines and rates, consistent with changes in the marketplace; and (iii) provide an administrative appeals procedure to allow dispensing or prescribing provider to contest the listed specialty drugs and rates.

5. The department shall report on savings and quality improvements achieved through the implementation measures for the specialty drug program to the Chairmen of the House Appropriations and Senate Finance Committees, the Joint Commission on Health Care, and the Department of Planning and Budget by November 1 of each year.

6. The department shall have authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act to effect these provisions.

KK. The Department of Medical Assistance Services shall amend the State Plan of Medical Assistance Services to increase the physician/practitioner reimbursement fees in the following manner: evaluation and management procedures, as defined by the American Medical Association's annual publication of the Current Procedural Terminology manual, excluding hospital emergency department visits, provided to children under the age of twenty-one shall be increased by five percent effective July 1, 2006, and by five percent effective July 1, 2007; reimbursement fees for obstetrical/gynecological services which were increased on September 1, 2004, shall not be increased; all other physician rates shall be increased three percent effective July 1, 2007. The Department of Medical Assistance Services shall implement these reimbursement changes on July 1, 2006, or on the date of this enactment, whichever is later. The Department shall have authority to implement these reimbursement changes prior to the completion of any regulatory process undertaken in order to effect such change.

LL. The Department of Medical Assistance Services shall amend the Medicaid Mental Retardation Waiver, and any related state regulations, to add 110 new slots which will be reserved for children under the age of 6. The Department of Medical Assistance Services shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

MM. The Department of Medical Assistance Services shall amend all §1915(c) home and community-based care waivers, excluding the AIDS Waiver, and any related state regulations to set patient pay requirements at 165 percent of Supplemental Security Income for individuals enrolled in the waivers. The Department of Medical Assistance Services shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

NN. The Department of Medical Assistance Services has the authority to implement cost-based reimbursement for special education health services furnished by school division providers effective July 1, 2006. School division providers shall file annual cost reports for these services and the department shall settle reimbursement to actual costs. Reimbursement to school divisions shall continue to be subject to the provisions of § 32.1-326.3(A)(1) of the Code of Virginia that only the federal share shall be reimbursed for special education health services and that local governments fund the state match for special education health services provided by school divisions. The Department shall have the authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act to effect this provision.

OO. The Department of Medical Assistance Services shall increase adult day health care reimbursement rates provided under Medicaid home and community based waiver programs by five percent effective January 1, 2007.

PP.1. The Department of Medical Assistance Services shall amend the State Plan of Medical Assistance Services governing Medicaid reimbursements for hospitals to set the adjustment factor for Type 2 hospitals equal to 78 percent, effective July 1, 2006.

2. The Department of Medical Assistance Services shall implement this reimbursement change on July 1, 2006, or on the date of this enactment, whichever is later. The Department shall have authority to implement this reimbursement change prior to the completion of any regulatory process undertaken in order to effect such change.

QQ. The Department of Medical Assistance Services shall work with representatives of the nursing home provider associations to develop a revised cost-reporting methodology which improves the timeliness and efficiency of the current process. A specific goal of such an enhanced process would be to decrease by one year the look-back period used within the biennial cost ceiling rebase determination. The department shall report its findings and recommendations to the Governor and the Chairman of the House Appropriations and Senate Finance Committees by September 1, 2006.

RR. The Department of Medical Assistance Services shall amend the Day Support Home- and Community-based Waiver to include supported employment as a service option.

SS. The Department of Medical Assistance Services shall have the authority to amend the State Plan of Medical Assistance Services to implement modifications to the Medicaid program to comply with the mandated provisions of the federal Deficit Reduction Omnibus Reconciliation Act of 2005. This authorization shall apply only to those provisions the states are required to implement within 280 days of enactment of this Appropriation Act. The Department shall have the authority to enact emergency regulations under § 2.2-4011 of the Administrative Process Act to effect this provision. The Department shall notify the Chairmen of the House Appropriations and Senate Finance Committees no less than 30 days prior to the submission of amendments to the State Plan of Medical Assistance Services.

TT. The Department of Medical Assistance Services, in cooperation with the Department of Mental Health, Mental

Retardation and Substance Abuse Services, the Virginia Association of Community Services Boards, the ARC of Virginia, and other stakeholders, shall jointly review the current Medicaid home- and community-based waiver for persons with mental retardation to determine how the waiver program can be improved to provide a person-centered, individualized support focus. In conducting the review, the Department shall assess the need to upgrade availability of therapeutic behavioral consultation, skilled nursing, medical and other specialized supports for individuals who are served through the waiver. Also, the Department shall review successful models of waiver-funded community supports used by other states to serve individuals with mental retardation for potential application to Virginia. The Department shall report on its review of the waiver program including recommendations for changes and cost implications by December 1, 2006, to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees.

UU. Effective July 1, 2006, the Department of Medical Assistance Services shall amend the home- and community-based care waivers for mental retardation services and developmental disabilities to ensure that applied behavioral analysis for individuals with autism or autistic spectrum disorders and positive behavioral supports for individuals with severe behavioral difficulties are covered under therapeutic consultation services. Out of the amounts appropriated in this item, $84,000 from the general fund and $84,000 from nongeneral funds the first year and $84,000 from the general fund and $84,000 from nongeneral funds the second year is provided for these services through the waiver program.

VV. Out of this appropriation, $2,570,823 the second year from the general fund and $2,570,823 the second year from nongeneral funds shall be used to increase personal care reimbursement rates provided under community-based Medicaid waiver programs by three percent, effective July 1, 2007.

WW. Out of this appropriation, $722,177 the first year and $765,507 the second year from the general fund and $722,177 the first year and $765,507 the second year from nongeneral funds shall be used to increase reimbursement rates for skilled nursing services provided through the Medicaid technology assisted home- and community-based waiver program and the HIV/AIDS Home and Community-based Care Waiver program by five percent, effective July 1, 2006.

XX. Out of this appropriation, $17,355,007 the first year and $17,355,007 the second year from the general fund and $17,355,007 the first year and $17,355,007 the second year from nongeneral funds shall be used to increase reimbursement rates paid to providers delivering unique services provided through the Mental Retardation, Individual and Family Developmental Disabilities Support or Day Support Home and Community-based Waiver Programs (but not provided in other waiver programs) by five percent effective July 1, 2006. Reimbursement rates paid to providers of congregate residential group home services for individuals in the Mental Retardation Home and Community-based Waiver Program shall be increased by 10 percent, effective July 1, 2006. The increase does not apply to personal care and related services, nursing services or services that are either fixed price or determined through individual consideration.

YY. Out of this appropriation, $656,209 the first year and $1,030,965 the second year from the general fund and $656,209 the first year and $1,030,965 the second year from nongeneral funds is provided for additional slots in the Medicaid Individual and Family Developmental Disabilities (DD) Support Waiver.

ZZ.1. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall develop a long-range blueprint for the development and implementation of an integrated acute and long-term care system. This plan shall: (i) explain how the various community and state level stakeholders will be involved in the development and implementation of the new program model(s); (ii) describe the various steps for development and implementation of the program model(s), including a review of other states' models, funding, populations served, services provided, education of clients and providers, and location of programs; (iii) describe how the existing system is funded and how integration will impact funding; and (iv) describe the evaluation methods that will be used to ensure that the program provides access, quality, and consumer satisfaction.

2. The Department of Medical Assistance Services shall report on its plan for integrating acute and long-term care services to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by December 15, 2006.

AAA. The Department of Medical Assistance Services shall implement one or more Program for All Inclusive Care for the Elderly (PACE) programs by July 2007. Out of this appropriation, $1,500,000 the first year from the general fund is provided to make grants of up to $250,000 per site for start-up funds for potential PACE programs. The grant funds may be used for staffing, development of business plans, and other start-up activities. To be eligible for grant funding, organizations must submit the following documentation to the Department of Medical Assistance Services no later than September 1, 2006: (i) completion of a market assessment that demonstrates sufficient potential PACE participants to develop a PACE program; (ii) demonstration of partnerships with acute care hospitals, nursing facilities, and other potential partners; (iii) designation of an adult day health care center from which to operate a PACE program; and (iv) identification of funding partners to sustain a PACE project.

BBB. The Department of Medical Assistance Services shall amend its State Plan for Medical Assistance Services to develop and implement a regional model for the integration of acute and long-term care services no later than July 2007. This model would be offered to elderly and disabled clients on a voluntary basis. The Department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

CCC. The Director of the Department of Medical Assistance Services shall seek the necessary waiver from the United States Centers for Medicare and Medicaid Services to expand eligibility for Medicaid coverage of family planning services to individuals with a family income up to 133 percent of the federal poverty level. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions. The Department of Medical Assistance Services shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.