2010 Session

Budget Bill - HB30 (Introduced)

Item 297

	First Year - FY2011	Second Year - FY2012
Medicaid Program Services (45600)	**$6,806,326,159**	**$7,272,405,030**
Reimbursements to State-Owned Mental Health and Mental Retardation Facilities (45607)	$203,128,981	$263,128,981
Reimbursements for Mental Health and Mental Retardation Services (45608)	$564,798,970	$624,977,080
Reimbursements for Professional and Institutional Medical Services (45609)	$4,169,558,131	$4,512,840,177
Reimbursements for Long-Term Care Services (45610)	$1,868,840,077	$1,871,458,792
Fund Sources:		
General	$2,832,173,282	$3,426,891,382
Dedicated Special Revenue	$286,422,750	$288,638,249
Federal Trust	$3,687,730,127	$3,556,875,399

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, 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. The appropriation includes $99,663,148 the first year from the general fund and $125,768,085 from the federal trust fund and $131,564,490 the second year from the general fund and $131,564,490 from the federal trust fund for reimbursement to the institutions within the Department of Behavioral Health and Developmental Services.

D. If any part, section, subsection, paragraph, clause, or phrase of this Item or the application thereof is declared by the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services to be in conflict with a federal law or regulation, such decisions shall not affect the validity of the remaining portions of this Item, which shall remain in force as if this Item had passed without the conflicting part, section, subsection, paragraph, clause, or phrase. Further, if the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services determines that the process for accomplishing the intent of a part, section, subsection, paragraph, clause, or phrase of this Item is out of compliance or in conflict with federal law and regulation and recommends another method of accomplishing the same intent, the Director, Department of Medical Assistance Services, after consultation with the Attorney General, is authorized to pursue the alternative method.

E.1. Included in this appropriation is $68,737,040 from the general fund and $72,805,362 from nongeneral funds in the first year and $74,003,983 from the general fund and $78,727,642 from nongeneral funds in the second year to reimburse the Virginia Commonwealth University Health System for indigent health care costs. This funding is comprised of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4. In order to receive the nongeneral funds in excess of the amount of the general fund appropriated, the Virginia Commonwealth University Health System shall certify the public expenditure.

2. Included in this appropriation is $40,867,418 from the general fund and $43,475,976 from nongeneral funds in the first year and $44,224,177 from the general fund and $47,046,997 from nongeneral funds in the second year to reimburse the University of Virginia Health System for indigent health care costs. This funding is comprised of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4. In order to receive the nongeneral funds in excess of the amount of the general fund appropriated, the University of Virginia University Health System shall certify the public expenditure.

F. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L.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.

M. 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 Behavioral Health and Developmental 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. 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.

N. The Department of Medical Assistance Services shall retain the savings necessary to reimburse a vendor for its efforts to implement paragraph M 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 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.

P.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 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 Behavioral Health and Development Services to consider utilizing a Preferred Drug List program for its non-Medicaid clients.

7. 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.

Q. 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.

R. 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.

S.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) if publicly available, 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 two 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 conduct an analysis of the fiscal impact of the implementation of "Average Manufacturer Price" (AMP), as required by the federal Deficit Reduction Act of 2005, Public Law 109-171. Upon the later of April 15, 2008, or 90 days after the effective date of the regulation that the United States Secretary of Health and Human Services must promulgate under Section 6001(c)(3) of the 'Deficit Reduction Act of 2005,' Pub. L. No. 109-171, the department shall report to the Governor and the chairmen of the Senate Finance and House Appropriations Committees the amount of savings anticipated in the Medicaid Forecast as a result of this change in federal law. In the event that anticipated pharmacy savings exceed the amount of savings assumed in the Medicaid Forecast, the department shall make recommendations concurrently with the report regarding the adjustment of pharmacy dispensing fees based on the impact of changes in local pharmacy reimbursements.

T.1. The estimated revenue for the Virginia Health Care Fund is $292,001,874 the first year and $294,242,812 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. Out of this appropriation, the dedicated special fund appropriation for Medicaid Program Services includes $290,022,750 the first year and $292,238,249 the second year from the Virginia Health Care Fund.

5. Out of the amounts estimated in paragraph T.1., $1,979,124 the first year and $2,004,563 the second year is appropriated in Item 296 to be used as state match for the Children's Health Insurance Program.

U. 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.

V. 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.

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

2. 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.

X. The Director, 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.

Y.1. Notwithstanding the provisions of § 32.1-325.1:1, Code of Virginia, upon identifying that an overpayment for medical assistance services has been made to a provider, the Director, Department of Medical Assistance Services shall notify the provider of the amount of the overpayment. Such notification of overpayment shall be issued within the earlier of (i) four years after payment of the claim or other payment request, or (ii) four years after filing by the provider of the complete cost report as defined in the Department of Medical Assistance Services' regulations, or (iii) 15 months after filing by the provider of the final complete cost report as defined in the Department of Medical Assistance Services' regulations subsequent to sale of the facility or termination of the provider.

2. Notwithstanding the provisions of § 32.1-325.1, Code of Virginia, the director shall issue an informal fact-finding conference decision concerning provider reimbursement in accordance with the State Plan for Medical Assistance, the provisions of § 2.2-4019, Code of Virginia, and applicable federal law. The informal fact-finding conference decision shall be issued within 180 days of the receipt of the appeal request. If the agency does not render an informal fact-finding conference decision within 180 days of the receipt of the appeal request, the decision is deemed to be in favor of the provider. An appeal of the director's informal fact-finding conference

decision concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the State Plan for Medical Assistance provided for in § 32.1-325, Code of Virginia. Once a final agency case decision has been made, the director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the informal fact-finding conference decision or the final agency case decision. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313, Code of Virginia, from the date the Director's agency case decision becomes final.

Z. 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.

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

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

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

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

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

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

BB. 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.

CC. The Department of Medical Assistance Services shall have the authority to amend the State Plan of Medical Assistance Services, the Virginia Plan for Title XXI of the Social Security Act and the Family Access the Medical Insurance Security Plan to implement modifications to the Medicaid program to comply with the mandated

provisions of the federal Children's Health Insurance Program Reauthorization Act of 2009. 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.

DD. 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.

EE. The Department of Medical Assistance Services shall implement one or more Program for All Inclusive Care for the Elderly (PACE) programs.

FF. The Department of Medical Assistance Services shall amend its State Plan for Medical Assistance Services to develop and implement a regional model for the integration of acute and long-term care services. This model would be offered to elderly and disabled clients on a mandatory basis. The department shall promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

GG.1. The Director, 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.

2. The Department of Medical Assistance Services shall, if feasible and consistent with federal requirements, seek the necessary waiver from the Centers for Medicare and Medicaid Services to expand eligibility for Medicaid coverage of family planning services to individuals with a family income above 133 percent of the federal poverty level up to an eligibility level that will not compromise federal budget neutrality for the waiver, but not to exceed 200 percent of the federal poverty level.

HH.1. Contingent upon approval by the Centers for Medicare and Medicaid Services as part of the Money Follows the Person demonstration grant, the Department of Medical Assistance Services shall seek federal approval for necessary changes to home and community-based 1915(c) waivers to allow individuals transitioning from institutions to receive care in the community. The Department of Medical Assistance Services shall promulgate any necessary emergency regulations within 280 days or less from the enactment date of this act.

2. The Department of Medical Assistance Services shall amend the Individual and Family Developmental Disabilities Support (DD) Waiver to add 30 new slots (15 each fiscal year) and the Intellectual Disabilities (ID) Waiver to add 220 new slots (110 each fiscal year) which will be reserved for individuals transitioning out of institutional settings through the Money Follows the Person Demonstration. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the DD and ID waiver applications to add the additional slots.

II. The Department of Medical Assistance Services shall have the authority to amend the managed care waiver to

allow the department to enroll adoption assistance recipients into managed care organizations as defined in 12 VAC 30-120-360 through 12 VA 30-120-420. In addition, the department shall have the authority to amend the State Plans for Titles XIX (Medical Assistance) and XXI (Family Access to Medical Insurance Security Plan – FAMIS) of the Social Security Act, as required by applicable statute and regulations to provide managed care services to adoption assistance recipients. The Department of Medical Assistance Services shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

JJ. The Department of Medical Assistance Services shall be authorized, in collaboration with the Virginia Commonwealth University Health System (VCUHS), to seek a waiver from the Centers for Medicare and Medicaid Services (CMS) to permit use of Disproportionate Share Hospital (DSH) funds to allow the VCUHS (Hospital and Physician Practice) to continue the existing partnership with community physicians and with any community hospitals who are providing less costly health care services to eligible indigent patients for VCUHS. As part of the waiver application process the parties shall develop estimates of the cost of the program to the state and federal governments, and shall report the findings to the Governor and to the Chairman of the House Appropriations and the Senate Finance Committees. If the Director, Department of Planning and Budget, determines that the waiver program would not require additional state funds, the program shall be implemented upon receiving CMS approval. If additional state funding is needed, the program shall not be implemented until such funding is authorized through the budget process.

KK. 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.

LL. The Department of Medical Assistance Services shall have the authority to seek federal approval of changes to its managed care waiver to limit the Primary Case Management program to localities of the state with only one participating managed care organization. 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.

MM. Effective July 1, 2009, the department shall have the authority to amend the State Plan for Medical Assistance to eliminate reimbursement for hospital acquired conditions in a manner similar to the Medicare initiative implemented October 1, 2008. The department shall have the authority to implement this reimbursement change effective July 1, 2009, and prior to the completion of any regulatory process undertaken in order to effect such change. The department shall also revise its medical necessity criteria to be consistent with Medicare national coverage determinations as part of the overall Medicare initiative.

NN. 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.

OO. 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.

PP. 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.

QQ. Upon approval by the Centers for Medicare and Medicaid Services of the application for renewal of the Mental Retardation Waiver, expeditious implementation of any revisions shall be deemed an emergency situation pursuant to § 2.2-4002 of the Administrative Process Act. Therefore, to meet this emergency situation, the Department of Medical Assistance Services shall promulgate emergency regulations to implement the provisions of this act.

RR. The Department of Medical Assistance Services, to the extent permissible under federal law, shall enter into an agreement with local Healthy Families sites so that qualifying funds may be used at the discretion of each site for obtaining matching nongeneral funds when available.

SS. The Department of Medical Assistance Services shall provide information to personal care agency providers regarding the options available to meet staffing requirements for personal care aides including the completion of provider-offered training or DMAS Personal Care Aide Training Curriculum.

TT. 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 in order to comply with the payor of last resort requirements of Part C of the Individuals with Disabilities Education Act (IDEA) of 2004. The Department of Medical Assistance Services shall promulgate 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 requirements for the Part C program.

UU. The Department of Medical Assistance Services shall impose an assessment equal to 5.5 percent of revenue on all ICF-MR 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. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and any extension thereof through subsequent federal legislation.

VV. The Department of Medical Assistance Services shall eliminate supplemental coverage of regular and intensive assisted living services. The department shall implement this change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

WW. The Department of Medical Assistance Services shall amend the 1915 (c) home- and-community based waivers and the Children's Mental Health demonstration grant to decrease the annual respite care hours from 720 to 240. The 1915 (c) waivers shall include the Alzheimer's Assisted Living, Day Support, Elderly or Disabled with Consumer Direction, Individual and Family Developmental Disabilities Support, Intellectual Disabilities, Technology Assisted, and HIV/AIDs Waivers. The department shall implement this change effective January 1, 2011, and prior to the completion of any regulatory process undertaken in order to effect such change.

XX. The Department of Medical Assistance Services shall amend the Children's Mental Health demonstration grant program eligibility requirements in order to permit a child to be evaluated as a separate assistance unit of one, regardless of whether the child is living in the home with a parent or guardian, or siblings. The department shall implement this change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

YY. 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 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.

ZZ. 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 under the Mental Retardation Medicaid Waiver (now referred to as the Intellectual Disabilities Waiver) or the Individual and Family Developmental Disabilities and Support Medicaid Waiver in either the first or second year, other than those slots authorized to specifically support the Money Follows the Person Demonstration or individuals who are exiting Southeastern Virginia Training Center or other state institutions.

AAA. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate the incentive plan for long-stay hospitals. The department shall also eliminate the inflation increase for rates in FY 2011 and FY 2012 and freeze ceilings in FY 2011 and FY 2012 at the same level as the ceilings for long stay hospitals with fiscal year ends of June 30, 2010. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

BBB.1. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to make the following changes:

a. Rebase hospital DRG weights, case rates, psych and rehab per diem rates except that 2008 base year costs shall only be increased 2.58 percent. Operating rates in FY 2012 shall not be increased by inflation. The department shall not replace through other payment mechanisms the losses of Type One hospitals from this limitation on base year cost increases unless the provider is able to transfer the state share or certify the public expenditures.

b. Revise the inpatient hospital Medicaid utilization percent from 15 percent to 14 percent to determine DSH eligibility and rebase regular DSH reimbursement for all hospitals but reduce the final calculation by a uniform percentage such that total expenditures in FY 2011 do not exceed expenditures in FY 2010 separately for Type 1 and Type 2 hospitals. The department shall calculate the reduction prior to implementing other changes to DSH eligibility. DSH payments in FY 2012 shall not be increased by inflation.

c. Eliminate the FY 2011 and FY 2012 adjustments for inflation for graduate medical education per resident amounts. The department shall not replace through other payment mechanisms the losses of Type One hospitals from this limitation on base year cost increases unless the provider is able to transfer the state share or certify the public expenditures.

2. The department shall have the authority to implement these reimbursement changes effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

CCC. Effective July 1, 2010, through June 30, 2012, the Department of Medical Assistance Services shall freeze rates for freestanding psychiatric hospitals at the FY 2010 level. The department shall have the authority to implement these reimbursement changes effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

DDD. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate the adjustment for inflation of nursing facility and specialized care operating rates for days of service in FY 2011 and FY 2012 and to freeze nursing facility and specialized care ceilings in FY 2011 and FY 2012 at the same level as the ceilings for nursing facilities with fiscal year ends of June 30, 2010. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

EEE. Effective July 1, 2010, the Department of Medical Assistance Services shall not adjust rates or the rate ceiling of residential psychiatric facilities for inflation.

FFF. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate the FY 2011 and FY 2012 inflation adjustment for home health agencies. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

GGG. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate the FY 2011 and FY 2012 inflation adjustment for outpatient rehabilitation agencies. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

HHH. The Department of Medical Assistance Services shall have the authority to amend the 1915 (c) home-and-community-based Elderly or Disabled with Consumer Direction Waiver to place a moratorium on new enrollments in this waiver effective January 1, 2011, other than those slots authorized to specifically support the Money Follows the Person Demonstration or individuals who are exiting Southeastern Virginia Training Center or other state institutions. The provisions of this paragraph expire on January 1, 2012. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and any extension thereof through subsequent federal legislation, and prior to the completion of any regulatory process undertaken in order to effect such change.

III. The Department of Medical Assistance Services shall have the authority to amend the 1915 (c) home-and-community-based Intellectual Disabilities Waiver to place a moratorium on new enrollments in this waiver effective January 1, 2011, other than those slots authorized to specifically support the Money Follows the Person Demonstration or individuals who are exiting Southeastern Virginia Training Center or other state institutions. The provisions of this paragraph expire on January 1, 2012. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and any extension thereof through subsequent federal legislation, and prior to the completion of any regulatory process undertaken in order to effect such change.

JJJ. The Department of Medical Assistance Services shall have the authority to amend the 1915 (c) home-and-community-based Day Support Waiver to place a moratorium on new enrollments in this waiver effective January 1, 2011, other than those slots authorized to specifically support the Money Follows the Person Demonstration or individuals who are exiting Southeastern Virginia Training Center or other state institutions. The provisions of this paragraph expire on January 1, 2012. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009(P.L. 111-5) and any extension thereof through subsequent federal legislation, and prior to the completion of any regulatory process undertaken in order to effect such change.

KKK. The Department of Medical Assistance Services shall have the authority to amend the 1915 (c) home-and-community-based Individual and Family Developmental Disabilities Support Waiver to place a moratorium on new enrollments in this waiver effective January 1, 2011, other than those slots authorized to specifically support the Money Follows the Person Demonstration or individuals who are exiting Southeastern Virginia Training Center or other state institutions. The provisions of this paragraph expire on January 1, 2012. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and any extension thereof through subsequent federal legislation, and prior to the completion of any regulatory process undertaken in order to effect such change.

LLL. The Department of Medical Assistance Services shall have the authority to amend the 1915 (c) home-and-community-based Alzheimer's Assisted Living Waiver to place a moratorium on new enrollments in this waiver effective January 1, 2011, other than those slots authorized to specifically support the Money Follows the Person Demonstration or individuals who are exiting Southeastern Virginia Training Center or other state institutions. The provisions of this paragraph expire on January 1, 2012. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and any extension thereof through subsequent federal legislation, and prior to the completion of any regulatory process undertaken in order to effect such change.

MMM. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to eliminate additional Indirect Medical Education (IME) payments based on NICU utilization (described in 12 VAC 30-70-291.D) or NICU days (described in 12 VAC 30-70-291.E) . IME payments to Virginia hospitals shall remain unchanged. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

NNN. Effective July 1, 2010, the Department of Medical Assistance Services shall reduce the rates for home and community based care waiver services by five percent, except for skilled nursing rates for services delivered to recipients in the Technology Assisted Waiver. Other than the specific exemption above, these rate reductions apply to these services whether provided to waiver recipients or to any other Medicaid or FAMIS eligible individuals.

OOO. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to remove optional coverage for services by providers enrolled as podiatrists. The department shall implement this change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

PPP. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to remove optional coverage of adult vision services. The department shall implement this change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

QQQ. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to establish annual limits for adult rehabilitation services, including physical therapy, occupational therapy, and speech therapy, provided in all settings by all providers for which states have discretion under applicable federal law. The department shall have authority to promulgate regulations to become effective within 280 days or less from the enactment date of this act.

RRR. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reduce the income limit for eligibility under the 300 percent Supplemental Security Income (SSI) eligibility group to 275 percent of the SSI payment level. The department shall implement this change effective January 1, 2011, or on the earliest date thereafter when it is determined that such change will not jeopardize the increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and any extension thereof through subsequent federal legislation, and prior to the completion of any regulatory process undertaken in order to effect such change.

SSS. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to decrease the maximum reimbursement for pharmaceutical products to the Average Wholesale Price minus 13.1 percent. Such amendment shall become effective July 1, 2010.

TTT. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to establish a threshold for out-of-state cost reporting hospitals to qualify for disproportionate share hospital payments. In addition to meeting all other requirements, out-of-state cost reporting hospitals must have

Virginia Medicaid utilization in the base year of at least 12 percent of total Medicaid days. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.

UUU. Effective July 1, 2010, the Department of Medical Assistance Services (DMAS) shall amend the State Plan for Medical Assistance to modify reimbursement for Durable Medical Equipment (DME) to:

a. Reduce reimbursement for DME that has a Durable Medical Equipment Regional Carrier (DMERC) rate from 100 percent of Medicare reimbursement level to 90 percent of the Medicare level.

b. Reduce fee schedule rates for DME and supplies by category-specific amounts as recommended in the November 1, 2009, Report on Durable Medical Equipment Reimbursement to the Senate Finance and House Appropriations Committees. The Department of Medical Assistance Services shall also modify the pricing of incontinence supplies from case to item, which is the industry standard.

c. Establish rates for additional procedure codes where benchmark rates are available.

d. Reimburse at cost plus 30 percent for any item not on the fee schedule. Cost shall be no more than the net manufacturer's charge to the provider, less shipping and handling.

e. Determine alternate pricing for any code that does not have a rate.

f. Limit service day reimbursement to intravenous and oxygen therapy equipment.

2. The department shall promulgate regulations to implement this amendment within 280 days or less from the enactment of this act.

VVV. The Department of Medical Assistance Services (DMAS) shall have the authority to modify reimbursement for Durable Medical Equipment for incontinence supplies based on competitive bidding subject to approval by the Centers for Medicare and Medicaid Services (CMS). The department shall have the authority to promulgate regulations to become effective within 280 days or less from the enactment of this act.

WWW. Effective July 1, 2010, the Department of Medical Assistance Services (DMAS) shall amend the State Plan for Medical Assistance to modify the limit on incontinence supplies prior to requiring prior authorization. The department shall have the authority to implement this reimbursement change effective July 1, 2010, and prior to the completion of any regulatory process undertaken in order to effect such change.