2012 Special Session I

Budget Bill - HB1300 (Chapter 2)

Department of Medical Assistance Services

Item 297	First Year - FY2011	Second Year - FY2012
Medicaid Program Services (45600)	**$7,160,120,878**	~~**$7,139,707,037**~~ ***$6,973,579,404***
~~Reimbursements to State-Owned Mental Health and Mental Retardation Facilities (45607)~~ Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities (45607)	$224,399,339	$263,128,981
~~Reimbursements for Mental Health and Mental Retardation Services (45608)~~ Reimbursements for Mental Health and Intellectual Disability Services (45608)	$598,893,173	~~$627,627,297~~ *$649,700,120*
Reimbursements for Professional and Institutional Medical Services (45609)	$4,351,704,930	~~$4,168,256,945~~ *$3,912,061,731*
Reimbursements for Long-Term Care Services (45610)	$1,985,123,436	~~$2,080,693,814~~ *$2,148,688,572*
Fund Sources:		
General	$2,700,712,247	~~$3,346,720,741~~ *$3,234,635,900*
Dedicated Special Revenue	$285,993,227	~~$297,592,267~~ *$281,579,144*
Federal Trust	$4,173,415,404	~~$3,495,394,029~~ *$3,457,364,360*

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 $90,410,493 the first year from the general fund and $133,988,844 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 $63,991,631 from the general fund and $72,805,362 from nongeneral funds in the first year and ~~$69,559,795~~ *$70,540,096* from the general fund and ~~$78,727,642~~ *$79,707,943* from nongeneral funds in the second year to reimburse the Virginia Commonwealth University Health System for indigent health care costs. This funding is composed of disproportionate share hospital (DSH) payments, indirect medical education (IME) payments, and any Medicaid profits realized by the Health System. Payments made from the federal DSH fund shall be made in accordance with 42 USC 1396r-4. 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. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act, the reduction of $4,445,409 from the general fund the first year shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

2. Included in this appropriation is $38,212,827 from the general fund and $43,475,976 from nongeneral funds in the first year and ~~$41,568,366~~ *$40,331,858* from the general fund and ~~$47,046,997~~ *$45,810,489* 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. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage established under the American Recovery and Reinvestment Act, the reduction of $2,654,591 from the general fund the first year shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

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 semi-annually and may meet at other times at the discretion of the chairperson and members. At the meetings, the Pharmacy and Therapeutics committee shall review any drug in a class subject to the Preferred Drug List that is newly approved by the Federal Food and Drug Administration, provided there is at least thirty (30) days notice of such approval prior to the date of the quarterly meeting.

3. The department shall establish a process for acting on the recommendations made by the Pharmacy and Therapeutics Committee, including documentation of any decisions which deviate from the recommendations of the Committee.

4. The Preferred Drug List program shall include provisions for (i) the dispensing of a 72-hour emergency supply of the prescribed drug when requested by a physician and a dispensing fee to be paid to the pharmacy for such supply; (ii) prior authorization decisions to be made within 24 hours and timely notification of the recipient and/or the prescribing physician of any delays or negative decisions; (iii) an expedited review process of denials by the department; and (iv) consumer and provider education, training and information regarding the Preferred Drug List prior to implementation, and ongoing communications to include computer access to information and multilingual material.

5. The Preferred Drug List program shall generate savings as determined by the department that are net of any administrative expenses to implement and administer the program.

6. Notwithstanding § 32.1-331.12 et seq., Code of Virginia, to implement these changes, the Department of Medical Assistance Services shall promulgate emergency regulations to become effective within 280 days or less from the

enactment of this act. With respect to such state plan amendments and regulations, the provisions of § 32.1-331.12 et seq., Code of Virginia, shall not apply. In addition, the department shall work with the Department of Behavioral Health and Development Services to consider utilizing a Preferred Drug List program for its non-Medicaid clients.

7. The Department of Medical Assistance Services shall (i) exempt antidepressant, antianxiety and antipsychotic medications used for the treatment of mental illness from the Medicaid Preferred Drug List program; (ii) continually review utilization of behavioral health medications under the State Medicaid Program for Medicaid recipients; and (iii) ensure appropriate use of these medications according to federal Food and Drug Administration (FDA) approved indications and dosage levels. The department may also require retrospective clinical justification according to FDA approved indications and dosage levels for the use of multiple behavioral health drugs for a Medicaid patient. For individuals 18 years of age and younger who are prescribed three or more behavioral health drugs, the department may implement clinical edits that target inefficient, ineffective, or potentially harmful prescribing patterns in accordance with FDA-approved indications and dosage levels. The department shall report on the utilization and cost of drugs exempted under the provisions of this paragraph to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2010.

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 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 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 $287,743,698 the first year and ~~$299,596,830~~ *$283,583,707* 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 $285,993,227 the first year and ~~$297,592,267~~ *$281,579,144* the second year from the Virginia Health Care Fund.

5. Out of the amounts estimated in paragraph T.1., $1,750,471 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 up to 30 new slots (up to 15 each fiscal year) and the Intellectual Disabilities (ID) Waiver to add up to 220 new slots (up to 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.1. 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.

2. Notwithstanding paragraph NN.1. in this Item, the department shall pay, in the last quarter of the first year, the last quarterly hospital payment amounts of that year that are for Indirect Medical Education and Direct Medical Education. Disproportionate Share Hospital payments shall be paid as directed in paragraph NN.1.

OO.1. 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.

2. Notwithstanding paragraph OO.1. in this Item, the department shall pay in June of 2011 the monthly capitation payment to managed care organizations for the member months of June 2011.

PP. 1. 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.

2. Notwithstanding paragraph PP.1. in this Item, the department shall pay the final remittance of June 2011 in the first year.

3. The Department of Planning and Budget is authorized to transfer amounts, as needed, between this Item and Items 295, 296, and 299 to address the changes in appropriation necessary to fund the programs impacted by a suspension of the final weekly remittance payment delay as required in paragraph PP. of this Item.

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 July 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 certain 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 480. 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, and HIV/AIDs Waivers. The department shall implement this change effective July 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.1. Notwithstanding Chapters 228 and 303 of the 2009 Virginia Acts of Assembly and § 32.1-323.2 of the Code of Virginia, and paragraph ZZ.2. of this item, 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.

2. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the Department of Medical Assistance Services shall amend the 1915 (c) home- and community-based Intellectual Disabilities waiver to add 250 slots effective July 1, 2010 to address the community waiting list. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

3. The Department of Medical Assistance Services shall amend the 1915 (c) home- and community-based

Intellectual Disabilities waiver to add 30 waiver slots for Medicaid recipients who are exiting Southeastern Virginia Training Center according to the following schedule: 15 waiver slots effective July 1, 2010 and 15 additional waiver slots effective July 1, 2011.

4. The Department of Medical Assistance Services shall amend the 1915 (c) home- and community-based Intellectual Disabilities waiver to add 275 slots effective July 1, 2011.

5. The Department of Medical Assistance Services shall amend the Individual and Family Developmental Disabilities Support (DD) Waiver to add 150 new slots effective July 1, 2011. The Department of Medical Assistance Services shall seek federal approval for necessary changes to the DD applications to add the additional slots.

AAA.1. 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. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year amounts reduced in this paragraph related to elimination of the incentive plan shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

2. No additional changes shall be made to the incentive plan effective October 1, 2010.

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 after 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.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. Eliminate the adjustment for inflation of nursing facility and specialized care operating rates for days of service in fiscal year 2011 and fiscal year 2012 and to freeze nursing facility and specialized care ceilings in fiscal year 2011 and fiscal year 2012 at the same level as the ceilings for nursing facilities with fiscal years end of June 30, 2010.

b. Further reduce nursing facility direct and indirect care payment rates and specialized care operating rates by three percent below the rates that otherwise would have been in effect after application of paragraph DDD.1.a. in fiscal year 2011 .

c. Provide that the floor for the nursing facility FRV "rental rate" shall be 8.75 percent in fiscal year 2011 and 8.0 percent in fiscal year 2012.

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. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reductions in paragraph DDD.1.b. and paragraph DDD.1.c. shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

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

2. Effective July 1, 2010, the Department of Medical Assistance Services shall reduce reimbursements to residential psychiatric facilities to achieve an additional savings in the first year of $1,321,092 general fund and $1,667,128 nongeneral fund and in the second year of $1,985,800 general fund and $1,985,800 nongeneral fund. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in paragraph EEE.2. shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

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.

MMM.1. Effective July 1, 2010 through Jun 30, 2011, 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), except for hospitals with greater than 50 percent overall Medicaid utilization, or NICU days (described in 12 VAC 30-70-291.E). The amount of IME to be apportioned

among the remaining hospitals that qualify under 12 VAC 30-70-291.D shall be $1,900,000 total funds the first year. 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.

2. Effective July 1, 2011, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance governing Medicaid reimbursements for hospitals to provide an increase in Indirect Medical Education payments for non-state owned hospitals that have Medicaid Neonatal Intensive Care Unit (NICU) utilization greater than 4,500 Medicaid NICU inpatient days using base year 2003 data, as reported to the Department as of March 1, 2005. Out of this appropriation, $250,000 from the general fund and $250,000 from nongeneral funds the second year shall be provided for this purpose. The department shall have the authority to implement this reimbursement change effective July 1, 2011, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. Effective July 1, 2011, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to provide for an additional IME payment not to exceed $200,000 for all Type Two hospitals who had Medicaid NICU utilization in excess of 50 percent as reported to the Department as of March 1, 2004, have total Medicaid utilization under 50 percent and who do not otherwise receive an additional IME payment. The department shall have the authority to implement this reimbursement change effective July 1, 2011, and prior to the completion of any regulatory process undertaken in order to effect such change.

4. Freestanding children's hospitals are not eligible for the Indirect Medical Education payments included in subparagraphs 2 and 3.

NNN.1. 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.

2. Effective July 1, 2011, the Department of Medical Assistance Services shall reduce the rates for home and community-based care waiver services by one percent below the rates effective October 1, 2010, 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.

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.

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. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

TTT.1. 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. Out-of-state cost reporting hospitals that do not meet the 12 percent threshold shall be compensated at 50 percent of the rate that they otherwise would have received under the current payment methodology as modified in this Act. 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.

2. 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 indirect medical education 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. *The department shall implement these reimbursement changes prior to the completion of the regulatory process.*

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.

XXX. The Department of Medical Assistance Services shall work with the Department of Behavioral Health and Developmental Services and the Virginia Association of Community Services Boards to establish rates for the Intensive In-Home Service based on quality indicators and standards, such as the use of evidence-based practices.

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ZZZ. Effective January 1, 2011, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reimburse out-of-state non-cost reporting hospitals who treat Virginia Medicaid recipients inpatient operating rates that are the lesser of: (i) the amount they would be reimbursed by their state Medicaid program; or (ii) the current payment based on the statewide average operating rate. The department shall have the authority to implement this change effective January 1, 2011, and prior to the completion of any regulatory process undertaken in order to effect such change. If there is an extension through June 30, 2011, of increased Federal Medical Assistance Percentage under the American Recovery and reinvestment Act (P.P. 111-5), the change authorized in this paragraph shall become effective July 1, 2011.

AAAA.1. Effective July 1, 2010, the hospital adjustment factor for acute care and rehabilitation inpatient services for Type Two hospitals shall be 75 percent of cost and the adjustment factor for psychiatric inpatient hospital services for Type Two hospitals shall be 81 percent of cost. Corresponding changes shall be made to the hospital adjustment factors for Type One hospitals. The department shall not replace through other payment mechanisms the losses of Type One hospitals from this reduction unless the provider is able to transfer the state share or certify the public expenditures. 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.

3. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

4. No additional changes shall be made to adjustment factors effective October 1, 2010.

BBBB.1. Effective July 1, 2010, the Department of Medical Assistance Services shall reduce reimbursement for hospital outpatient services from 80 percent of cost to 77 percent of cost for Type Two hospitals and from 94.2 percent of operating cost to 91.2 percent and from 90 percent of capital cost to 87 percent for Type One hospitals. The department shall not replace through other payment mechanisms the losses Type One hospitals experience from this reduction unless the provider is able to transfer the state share or certify the public expenditures. 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."

2. Effective July 1, 2011, the Department of Medical Assistance Services shall reduce reimbursement for hospital outpatient services from 77 percent of cost to 76 percent of cost for Type Two hospitals and from 91.2 percent of operating cost to 90.2 percent and from 87 percent of capital cost to 86 percent for Type One hospitals. The department shall not replace through other payment mechanisms the losses Type One hospitals experience from this reduction unless the provider is able to transfer the state share or certify the public expenditures.

3. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the

American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

CCCC.1. Effective July 1, 2010, the Department shall reduce by 3 percent rates determined under RBRVS in 12 VAC 30-80-190 at the same time as the annual update.

2. Effective July 1, 2011, the Department shall calculate the annual update to rates determined under RBRVS in 12 VAC 30-80-190 as if the reduction in subparagraph 1 had not been taken. The department shall have the authority to implement these reimbursement changes effective July 1, 2011, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

DDDD.1. Effective July 1, 2010, the Department of Medical Assistance Services shall reduce the rates for dental services by 3.0 percent.

3. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

4. No additional changes shall be made to dental rates effective October 1, 2010.

EEEE.1. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to decrease the dispensing fee paid to pharmacists from $3.75 to $3.50 per prescription per month. Such amendments to the State Plan shall become effective July 1, 2011.

2. No additional changes shall be made to the dispensing fee effective October 1, 2010.

GGGG. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reductions in paragraph WW., HHH., III., JJJ., KKK., LLL. and NNN. shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK in this item.

HHHH.1. Effective July 1, 2010, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reduce hospital capital reimbursement from 75 percent of cost to 72 percent of cost for Type Two hospitals, except that Type Two Hospitals with greater than 50 percent Virginia Medicaid utilization shall be reduced from 80 percent of cost to 77 percent of cost, and from 100 percent of cost to 97 percent of cost for Type One hospitals. The department shall not replace through other payment mechanisms the losses of Type One hospitals from this reduction unless the provider is able to transfer the state share or certify the public expenditures. 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.

2. Effective July 1, 2011, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to reduce hospital capital reimbursement from 72 percent of cost to 71 percent of cost for Type Two hospitals, except that Type Two Hospitals with greater than 50 percent Virginia Medicaid utilization shall be reduced from 77 percent of cost to 76 percent of cost, and from 97 percent of cost to 96 percent of cost for Type

One hospitals. The department shall not replace through other payment mechanisms the losses of Type One hospitals from this reduction unless the provider is able to transfer the state share or certify the public expenditures.

3. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the first year reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

IIII. Effective July 1, 2011, the Department of Medical Assistance Services shall retain five percent of the Federal Financial Participation for reimbursement to school divisions for medical and transportation services. This reimbursement will cover the department's costs in assisting school divisions in submitting cost reports.

JJJJ.1. Effective July 1, 2010, the Department of Medical Assistance Services shall reduce rates for mental health therapeutic day treatment services by three percent and require prior authorization of services. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the reduction in paragraph JJJJ1. shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

2. Effective July 1, 2011, the Department of Medical Assistance Services shall reduce rates for mental health therapeutic day treatment services by four percent below the rates in effect on June 30, 2010.

KKKK. The Governor shall have authority to direct that the reduction or funding, contingent on an extension through June 30, 2011, of increased Federal Medical Assistance Percentage, be imposed, either partially or in full, as he deems necessary in order to ensure that the costs to the Commonwealth of contingent restorations in various items within this act do not exceed the amount of funding available from an extension of the increased Federal Medical Assistance Percentage.

LLLL.1. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to establish a supplemental physician payment for practice plans affiliated with a freestanding children's hospital with more than 50 percent Medicaid inpatient utilization in FY 2009 based on the difference between the upper payment limit approved by the Centers for Medicare and Medicaid Services minus $400,000 and the reimbursement otherwise payable to physicians effective July 1, 2011. The department shall have the authority to implement these reimbursement changes effective July 1, 2011, and prior to completion of any regulatory process undertaken in order to effect such change.

MMMM.1. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:

a. In fulfillment of this Item, the department may seek any necessary federal authority through amendment to the

State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to expand the current managed care program, Medallion II, to the Roanoke/Alleghany area by January 1, 2012, and far Southwest Virginia by July 1, 2012. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

b. In fulfillment of this Item, the department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to allow, on a pilot basis, foster care children, under the custody of the City of Richmond Department of Social Services, to be enrolled in Medicaid managed care (Medallion II) effective July 1, 2011. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

c. In fulfillment of this item, the department may seek federal authority to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. This service would be provided to adult EDCD waiver participants on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

d. In fulfillment of this item, the department may seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services ~~effective January 1, 2012~~. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

e. In fulfillment of this item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate stakeholders, shall develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Targeted case management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:

1. Improves value so that there is better access to care while improving equity.

2. Engages consumers as informed and responsible partners from enrollment to care delivery.

3. Provides consumer protections with respect to choice of providers and plans of care.

4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.

5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.

6. Improves quality, individual safety, health outcomes, and efficiency.

7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.

8. Builds upon current best practices in the delivery of behavioral health services.

9. Accounts for local circumstances and reflects familiarity with the community where services are provided.

10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.

11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.

12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.

13. Promotes availability of access to vital supports such as housing and supported employment.

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.

15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

f. The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph e, for individuals in need of behavioral health services not currently provided through managed care to be effective July 1, 2012. This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

g. The department may seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid ~~to be effective April 1, 2012~~. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

h. In fulfillment of this item, the department may seek the federal authority through amendment to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow for the implementation of a Health Home Program for Chronic Kidney Disease utilizing available funding included in the Patient Protection and Affordable Care Act of 2010 to be effective May 1, 2012. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

NNNN. Effective July 1, 2011, the Department of Medical Assistance Services shall have the authority to amend the State Plan under Title XIX of the Social Security Act to eliminate the five dollar per month/per member unit dose fee for members residing in a nursing facility. The department shall have the authority to implement this change prior to the completion of any regulatory process undertaken in order to effect such change.

OOOO.1. Effective July 1, 2011, the Department of Medical Assistance Services shall amend the State Plans under Title XIX and XXI of the Social Security Act to develop five regional pilot programs in coordination with community services boards or behavioral health authorities to improve the care of children who are in need of community mental health rehabilitative services, ensure appropriate utilization of services, measure outcomes and increase the cost effectiveness of services provided. The pilot programs shall be established in regions with high utilization of such services, as defined by service volume and expenditures. The pilot programs shall include provisions for children to be evaluated by a licensed or licensed-eligible mental health professional of the community services boards or behavioral health authorities in order to access community mental health rehabilitative services. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

2. The Director, Department of Planning and Budget is authorized to transfer amounts, as needed, from Medicaid Program Services (45600), Medical Assistance Services for Low Income Children (46600) and Children's Health Insurance Program Delivery (44600), to Administrative and Support Services (49900), to fund administrative expenditures associated with contracts between the department and community services boards and/or their organization providing assessment services for Medicaid and FAMIS recipients in need of community mental health rehabilitative services.

PPPP.1. The Department of Medical Assistance Services shall make programmatic changes in the provision of Intensive In-Home and Therapeutic Day Treatment in order to implement new quality service model(s) for these services. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

2. The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act.

3. No less than 30 days prior to implementing the changes authorized in this paragraph, the Director of Medical Assistance Services shall report to the Chairmen of the House Appropriations and Senate Finance Committees the specific programmatic changes that will be made for intensive in-home and residential services including an estimate of the fiscal impact of the proposed changes.

QQQQ. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall seek federal authority to implement a cost neutral (relative to the current method) pricing methodology to modify or replace the current maximum reimbursement of Average Wholesale Price for pharmaceutical products as defined in 12 VAC 30-80-40. 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.

RRRR. The Department of Medical Assistance Services shall make programmatic changes to the recipient utilization (Client Medical Management) program in order ensure appropriate utilization, prevent abuse, and promote improved and cost efficient medical management of essential Medicaid client health care. The department shall consider all available options including, but not limited to, utilization review, program criteria, and client enrollment. 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.

SSSS. The Department of Medical Assistance Services shall mandate that payment rates negotiated between participating Medicaid managed care organizations and out-of-network providers for emergency or otherwise authorized treatment shall be considered payment in full. In the absence of rates negotiated between the managed care organization and the out-of-network provider, these services shall be reimbursed at the Virginia Medicaid fees and/or rates and shall be considered payment in full. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

TTTT. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to specify that the documentation requirements for the signing and dating of medical records by health care providers shall be a mandatory condition of Medicaid reimbursement. The department shall have authority to promulgate emergency regulations to implement these changes within 280 days or less from the enactment date of this act.

UUUU. 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 include early intervention case management. The Department of Medical Assistance Services shall promulgate regulations to become effective within 280 days or less from the enactment date of this act.

VVVV. The Department of Medical Assistance Services shall have the authority to pay contingency fee contractors, engaged in cost recovery activities, from the recoveries that are generated by those activities. All recoveries from these contractors shall be deposited to a special fund. After payment of the contingency fee any prior year recoveries shall be transferred to the Virginia Health Care Fund. Beginning November 1, 2011 and each year thereafter, the Director of Medical Assistance Services shall report to the Chairmen of the House Appropriations and Senate Finance Committees the increase in recoveries associated with this program as well as the areas of audit targeted by contractors.

WWWW. The Department of Medical Assistance Services shall, contingent on federal approval, amend the Elderly and Disabled with Consumer Direction waiver to allow individuals in the waiver with special needs, who have a diagnosis of intellectual disability (ID), to receive respite services from a children's residential facility licensed for respite for children with ID. 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 changes to be consistent with federal approval of the waiver changes.

XXXX. Effective July 1, 2011, the Department of Medical Assistance Services shall reduce rates for Residential Level A and B services by 8 percent below the rates in effect on January 31, 2010.

YYYY. ~~Effective January 1, 2012, the~~ *The* Department of Medical Assistance Services shall have the authority to amend the State Plan for Medical Assistance to convert the current cost-based reimbursement methodology for outpatient hospitals to an Enhanced Ambulatory Patient Group (EAPG) methodology. Reimbursement for laboratory services shall be included in the new outpatient hospital reimbursement methodology. The new EAPG reimbursement methodology shall be implemented in a budget-neutral manner. The department shall have the authority to ~~implement this action effective January 1, 2012, and shall~~ promulgate regulations to become effective within 280 days or less from the enactment of this act.

AAAAA. The Department of Medical Assistance Services shall consult with representatives of providers of home- and community-based care services concerning audits of such providers, and shall evaluate the effectiveness and appropriateness of the audit methodology. The Department shall submit a report on this evaluation to the Governor and to the Chairmen of the House Appropriations Committee and the Senate Finance Committee by November 1, 2011.

BBBBB. The Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services, in consultation with appropriate stakeholders and national experts, shall research and

work to improve and/or develop Medicaid waivers for individuals with intellectual disabilities and developmental disabilities that will increase efficiency and cost effectiveness, enable more individuals to be served, strengthen the delivery of person-centered supports, enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice, and provide viable community alternatives to institutional placement. This initiative shall include a review of the current Intellectual Disabilities (ID), Day Support and Individual and Family Developmental Disabilities Supports (IFDDS) waivers to identify any improvements to these waivers that will achieve these same outcomes. The Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services shall report on the proposed waiver changes and associated costs to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2011.

CCCCC. The Department of Medical Assistance Services shall amend certain 1915 (c) home- and community-based waivers to cap agency and consumer directed personal care at 56 hours per week, 52 weeks per year, for a total of 2,920 hours per year. The 1915 (c) waivers shall include the Elderly or Disabled with Consumer Direction, and HIV/AIDS Waivers. The Department shall provide for individual exceptions to this limit using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

DDDDD. Notwithstanding Item 297 GG of this act, the department shall seek federal authority to move the family planning eligibility group from a demonstration waiver to the State Plan for Medical Assistance, effective April 2011. The department shall seek approval of coverage under this new state plan option for individuals with income up to 200 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 shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

EEEEE. Effective July 1, 2011, the Department of Medical Assistance Services (DMAS) shall have the authority to amend the State Plan for Medical Assistance to enroll and reimburse freestanding birthing centers accredited by the Commission for the Accreditation of Birthing Centers. Reimbursement shall be based on the Enhanced Ambulatory Patient Group methodology applied in a manner similar to the reimbursement methodology for ambulatory surgery centers. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.