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## HOUSE BILL NO. 1405

House Amendments in [ ] — February 14, 2000

*A BILL to amend and reenact § 32.1-325 of the Code of Virginia, relating to medical assistance services.*

Patrons—Christian, Almand, Baskerville, Brink, Crittenden, Darner, Day, Drake, Grayson, Hall, Hamilton, Jones, D.C., Jones, J.C., Plum, Rhodes, Spruill, Van Landingham and Van Yahres;  
Senators: Couric, Howell and Mims

Referred to Committee on Appropriations

**Be it enacted by the General Assembly of Virginia:****1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:**

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma, ~~or~~ breast cancer, *myeloma*, [ *or leukemia or a diagnosed condition for which high dose*

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60 *chemotherapy and bone marrow transplant is the appropriate treatment* ] and have been determined by  
61 the treating health care provider to have a performance status sufficient to proceed with such high-dose  
62 chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with  
63 the Department's expedited appeals process;

64 8. A provision identifying entities approved by the Board to receive applications and to determine  
65 eligibility for medical assistance;

66 9. A provision for breast reconstructive surgery following the medically necessary removal of a  
67 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been  
68 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

69 10. A provision for payment of medical assistance for annual pap smears;

70 11. A provision for payment of medical assistance services for prostheses following the medically  
71 necessary complete or partial removal of a breast for any medical reason;

72 12. A provision for payment of medical assistance which provides for payment for forty-eight hours  
73 of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four  
74 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection  
75 for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as  
76 requiring the provision of inpatient coverage where the attending physician in consultation with the  
77 patient determines that a shorter period of hospital stay is appropriate;

78 13. A requirement that certificates of medical necessity for durable medical equipment and any  
79 supporting verifiable documentation shall be signed, dated, and returned by the physician and in the  
80 durable medical equipment provider's possession within sixty days from the time the ordered durable  
81 medical equipment and supplies are first furnished by the durable medical equipment provider;

82 14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons  
83 age forty and over who are at high risk for prostate cancer, according to the most recent published  
84 guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal  
85 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this  
86 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate  
87 specific antigen;

88 15. A provision for payment of medical assistance for low-dose screening mammograms for  
89 determining the presence of occult breast cancer. Such coverage shall make available one screening  
90 mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons  
91 age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The  
92 term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically  
93 for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film  
94 and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each  
95 breast; and

96 16. A provision, when in compliance with federal law and regulation and approved by the Health  
97 Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible  
98 students when such services qualify for reimbursement by the Virginia Medicaid program and may be  
99 provided by school divisions.

100 B. In preparing the plan, the Board shall:

101 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided  
102 and that the health, safety, security, rights and welfare of patients are ensured.

103 2. Initiate such cost containment or other measures as are set forth in the appropriation act.

104 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the  
105 provisions of this chapter.

106 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations  
107 pursuant to § 9-6.14:7.1, the potential fiscal impact of such regulation on local boards of social services.  
108 For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis  
109 with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall  
110 include the projected costs/savings to the local boards of social services to implement or comply with  
111 such regulation and, where applicable, sources of potential funds to implement or comply with such  
112 regulation.

113 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in  
114 accordance with 42 C.F.R. § 488.400 et seq., "Enforcement of Compliance for Long-Term Care  
115 Facilities With Deficiencies."

116 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for  
117 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,  
118 regardless of any other provision of this chapter, such amendments to the state plan for medical  
119 assistance services as may be necessary to conform such plan with amendments to the United States  
120 Social Security Act or other relevant federal law and their implementing regulations or constructions of  
121 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health

and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by subsection I of this

183 section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

184 § 32.1-325. (Delayed effective date) Board to submit plan for medical assistance services to Secretary  
185 of Health and Human Services pursuant to federal law; administration of plan; contracts with health care  
186 providers.

187 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to  
188 time and submit to the Secretary of the United States Department of Health and Human Services a state  
189 plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and  
190 any amendments thereto. The Board shall include in such plan:

191 1. A provision for payment of medical assistance on behalf of individuals, up to the age of  
192 twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as  
193 child-placing agencies by the Department of Social Services or placed through state and local subsidized  
194 adoptions to the extent permitted under federal statute;

195 2. A provision for determining eligibility for benefits for medically needy individuals which  
196 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount  
197 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial  
198 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value  
199 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender  
200 value of such policies has been excluded from countable resources and (ii) the amount of any other  
201 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of  
202 meeting the individual's or his spouse's burial expenses;

203 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically  
204 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the  
205 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used  
206 as the principal residence and all contiguous property. For all other persons, a home shall mean the  
207 house and lot used as the principal residence, as well as all contiguous property, as long as the value of  
208 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the  
209 definition of home as provided here is more restrictive than that provided in the state plan for medical  
210 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and  
211 lot used as the principal residence and all contiguous property essential to the operation of the home  
212 regardless of value;

213 4. A provision for payment of medical assistance on behalf of individuals up to the age of  
214 twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of  
215 twenty-one days per admission;

216 5. A provision for deducting from an institutionalized recipient's income an amount for the  
217 maintenance of the individual's spouse at home;

218 6. A provision for payment of medical assistance on behalf of pregnant women which provides for  
219 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most  
220 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American  
221 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards  
222 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and  
223 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the  
224 children which are within the time periods recommended by the attending physicians in accordance with  
225 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines  
226 or Standards shall include any changes thereto within six months of the publication of such Guidelines  
227 or Standards or any official amendment thereto;

228 7. A provision for the payment for family planning services on behalf of women who were  
229 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such  
230 family planning services shall begin with delivery and continue for a period of twenty-four months, if  
231 the woman continues to meet the financial eligibility requirements for a pregnant woman under  
232 Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion  
233 services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

234 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow  
235 transplants on behalf of individuals over the age of twenty-one who have been diagnosed with  
236 lymphoma, ~~or~~ breast cancer, *myeloma*, [ *or leukemia or a diagnosed condition for which high-dose*  
237 *chemotherapy and bone marrow transplant is the appropriate treatment* ] and have been determined by  
238 the treating health care provider to have a performance status sufficient to proceed with such high-dose  
239 chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with  
240 the Department's expedited appeals process;

241 9. A provision identifying entities approved by the Board to receive applications and to determine  
242 eligibility for medical assistance;

243 10. A provision for breast reconstructive surgery following the medically necessary removal of a  
244 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been

obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast; and

17. A provision, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. In such amendments which are in

306 conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the  
307 next regular session of the General Assembly unless enacted into law.

308 D. The Director of Medical Assistance Services is authorized to:

309 1. Administer such state plan and receive and expend federal funds therefor in accordance with  
310 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to  
311 the performance of the Department's duties and the execution of its powers as provided by law.

312 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other  
313 health care providers where necessary to carry out the provisions of such state plan. Any such agreement  
314 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is  
315 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new  
316 agreement or contract. Such provider may also apply to the Director for reconsideration of the  
317 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

318 3. Refuse to enter into or renew an agreement or contract with any provider which has been  
319 convicted of a felony.

320 4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a  
321 principal in a professional or other corporation when such corporation has been convicted of a felony.

322 E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his  
323 interest in a convicted professional or other corporation, the Director shall, upon request, conduct a  
324 hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's  
325 participation in the conduct resulting in the conviction.

326 The Director's decision upon reconsideration shall be consistent with federal and state laws. The  
327 Director may consider the nature and extent of any adverse impact the agreement or contract denial or  
328 termination may have on the medical care provided to Virginia Medicaid recipients.

329 F. When the services provided for by such plan are services which a clinical psychologist or a  
330 clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render  
331 in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical  
332 social worker or licensed professional counselor or licensed clinical nurse specialist who makes  
333 application to be a provider of such services, and thereafter shall pay for covered services as provided in  
334 the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists,  
335 licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at  
336 rates based upon reasonable criteria, including the professional credentials required for licensure.

337 G. The Board shall prepare and submit to the Secretary of the United States Department of Health  
338 and Human Services such amendments to the state plan for medical assistance services as may be  
339 permitted by federal law to establish a program of family assistance whereby children over the age of  
340 eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward  
341 the cost of providing medical assistance under the plan to their parents.

342 H. The Department of Medical Assistance Services shall:

343 1. Include in its provider networks and all of its health maintenance organization contracts a  
344 provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one  
345 who have special needs and who are Medicaid eligible, including individuals who have been victims of  
346 child abuse and neglect, for medically necessary assessment and treatment services, when such services  
347 are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and  
348 neglect, or a provider with comparable expertise, as determined by the Director.

349 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an  
350 exception, with procedural requirements, to mandatory enrollment for certain children between birth and  
351 age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse  
352 Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20  
353 U.S.C. § 1471 et seq.).

354 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible  
355 recipients with special needs. The Board shall promulgate regulations regarding these special needs  
356 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special  
357 needs as defined by the Board.

358 J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement  
359 Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by subsection I of this  
360 section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

361 **2. That the Board shall promulgate regulations to implement the provisions of this act to be**  
362 **effective within 280 days of its enactment.**

363 **[ 3. That the provisions of this act shall not become effective unless an appropriation effectuating**  
364 **the purposes of this act is included in the 2000 Appropriation Act, passed during the 2000 Session**  
365 **of the General Assembly and signed into law by the Governor. ]**