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SENATE BILL NO. 763

Offered January 24, 2000

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, and §§ 60.2-116 and 60.2-612 of the Code of Virginia, and to amend the Code of Virginia by adding sections numbered 32.1-330.1:01 and 60.2-602.1, relating to the Textile Workers Relief Act of 2000.

Patrons—Reynolds, Bolling, Byrne, Colgan, Couric, Edwards, Hawkins, Houck, Howell, Lambert, Marsh, Marye, Maxwell, Miller, K.G., Miller, Y.B., Norment, Potts, Puckett, Puller, Saslaw, Ticer and Whipple

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, and §§ 60.2-116 and 60.2-612 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 32.1-330.1:01 and 60.2-602.1 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 and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

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

9. A provision for breast reconstructive surgery following the medically necessary removal of a 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;

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

11. 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;

12. 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;

13. 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;

14. 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;

15. 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, *and* two views of each breast; ~~and~~

16. 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*; and*

17. A provision, in compliance with 42 USC 1396a (u) of Title XIX of the United States Social Security Act, as amended, to provide for medical assistance services eligibility for qualified COBRA continuation beneficiaries.

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

§ 32.1-325. (Delayed effective date) 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 the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. 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;

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

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

10. A provision for breast reconstructive surgery following the medically necessary removal of a 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~~,~~ *and* 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*; and*

18. A provision, in compliance with 42 USC 1396a (u) of Title XIX of the United States Social Security Act, as amended, to provide for medical assistance services eligibility for qualified COBRA continuation beneficiaries.

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. 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 receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and 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 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 section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-330.1:01. State Program for Displaced Virginia Workers.

A. From such funds as appropriated for this purpose, the Board of Medical Assistance Services shall

develop, implement, and administer the State Program for Displaced Virginia Workers to provide at least twenty-four months coverage for individuals and their families who are eligible for NAFTA transitional adjustment assistance pursuant to 19 USC § 2331 and its implementing regulations.

B. The Board shall promulgate any necessary regulations for implementation of this program including, but not limited to:

1. Financial eligibility criteria, as set forth in the appropriation act, allowing for a maximum family income of at least 200 percent of federal poverty level;

2. Allowable resources, as set forth in the appropriation act, which may not exceed twice the maximum amount of resources that an individual may have and obtain benefits under the Virginia Medicaid program as established in regulation and the state plan for medical assistance services and approved by the Health Care Financing Administration;

3. A provision requiring that costs incurred for medical care or any other type of remedial care shall not be taken into account when determining income;

4. The amount, duration, and scope of medical services covered by the Program; and

5. Application forms and the manner of distribution of such forms and publicizing the availability of the Program.

C. The Board's regulations shall not prohibit eligibility for displaced workers meeting the criteria established in this section because of eligibility to elect COBRA continuation coverage.

D. The services available under the Program shall not exceed in amount, duration or scope those available to recipients of medical assistance services as established in the state plan for medical assistance pursuant to § 32.1-325 of this code.

E. For the purpose of linking essential services to displaced workers and their families and ameliorating, to the extent possible, the effects of loss of income and benefits, the Board shall establish an aggressive outreach mechanism for recently displaced workers in Virginia.

§ 60.2-116. Reciprocal agreements.

A. Subject to the approval of the Governor, the Commission is hereby authorized to enter into arrangements with the appropriate agencies of other states or the federal government whereby individuals performing services in this and other states for a single employing unit under circumstances not specifically provided for in §§ 60.2-212 through 60.2-219, or under similar provisions in the unemployment compensation laws of such other states, shall be deemed to be engaged in employment performed entirely within this Commonwealth or within one of such other states. Such arrangements may set forth terms whereby the potential right to benefits accumulated under the unemployment compensation laws of one or more states or under such a law of the federal government, or both, may constitute the basis for the payment of benefits through a single appropriate agency of any state under terms which the Commission finds will be fair and reasonable as to all affected interests and will not result in any substantial loss to the fund.

B. Subject to the approval of the Governor, the Commission is also authorized to enter into arrangements with the appropriate agencies of other states or of the federal government:

1. a. Whereby wages or services, upon the basis of which an individual may become entitled to benefits under the unemployment compensation law of another state or of the federal government, shall be deemed to be wages for employment by employers for the purposes of §§ 60.2-602, *60.2-602.1*, 60.2-606, 60.2-607, 60.2-609, 60.2-610, 60.2-611, subdivision 1 of § 60.2-612 and §§ 60.2-614 through 60.2-617, provided such other state agency or agency of the federal government has agreed to reimburse the fund for such portion of benefits paid under this title upon the basis of such wages or services as the Commission finds will be fair and reasonable as to all affected interests; and

b. Whereby the Commission will reimburse other state or federal agencies charged with the administration of unemployment compensation laws with such reasonable portion of benefits, paid under the law of any such other states or of the federal government upon the basis of employment or wages for employment by employers, as the Commission finds will be fair and reasonable as to all affected interests.

2. Reimbursements so payable under subdivision 1 b of this subsection shall be deemed to be benefits for the purposes of §§ 60.2-300 through 60.2-304, but no reimbursement so payable shall be charged against any employer's account for the purposes of §§ 60.2-526 through 60.2-531. The Commission is hereby authorized to make to other state or federal agencies and receive from such other state or federal agencies, reimbursements from or to the fund, in accordance with arrangements pursuant to this section.

C. Subject to the approval of the Governor, the Commission is also authorized to enter into arrangements with the appropriate agencies of other states or of the federal government:

1. Whereby the Commission may deduct, in accordance with the provisions of § 60.2-633, from unemployment benefits otherwise payable to an individual an amount equal to any overpayment made to such individual under an unemployment benefit program of the United States or of any other state, and

not previously recovered. The amount so deducted shall be paid to the jurisdiction under whose program such overpayment was made and in accordance with the arrangement between the Commission and the jurisdiction.

2. Whereby the United States agrees to allow the Commission to recover from unemployment benefits otherwise payable to an individual under an unemployment benefit program of the United States any overpayments made by the Commission to such individual under this title and not previously recovered, in accordance with the same procedures that apply under subdivision 1 of this subsection.

3. The amendments made by this subsection shall apply to recoveries made on or after July 1, 1987, and shall apply with respect to overpayments made before, on, or after such date.

§ 60.2-602.1. Weekly benefit calculations for certain high-unemployment localities.

A. This section shall apply to eligible employees whose residence or last place of employment is in a county, city or town with an unemployment rate of not less than ten percent as of January 1, 2000, as calculated by the Commission.

B. For claims filed on or after the effective date of this section, an eligible individual's weekly benefit amount shall equal the amount of total wages paid to the individual for the two quarters of his base period in which such total wages were highest, divided by 35, and if the quotient is not a whole dollar, rounded to the next lower whole dollar; however, the maximum weekly benefit amount shall be $332.

C. The maximum total amount of benefits payable to any individual during any benefit year shall not exceed the lesser of (i) the maximum total benefit for the individual or (ii) the total benefit amount for the individual. The total benefit amount for an individual shall be determined by (i) dividing the individual's base period wages by the amount of total wages paid to the individual for the two quarters of his base period in which such total wages were highest, and (ii) using the quotient to determine the applicable durational factor as follows:

If the quotient equals or exceeds	*but is not*	*the durational factor is:*
1.0000	*1.0714*	*12*
1.0714	*1.1428*	*13*
1.1428	*1.2142*	*14*
1.2142	*1.2856*	*15*
1.2856	*1.3570*	*16*
1.3570	*1.4285*	*17*
1.4285	*1.5000*	*18*
1.5000	*1.5714*	*19*
1.5714	*1.6428*	*20*
1.6428	*1.7142*	*21*
1.7142	*1.7856*	*22*
1.7856	*1.8570*	*23*
1.8570	*1.9285*	*24*
1.9285	*2.000*	*25*
2.0000		*26*

The total benefit amount for an individual shall be the product obtained by multiplying the

applicable durational factor by the individual's weekly benefit amount. The maximum total benefit for an individual is twenty-six times such individual's weekly benefit amount, except when benefits are paid pursuant to the provisions of § 60.2-610 or § 60.2-611. Such determination shall be based only upon wages paid for insured work during such individual's base period. The Commission shall maintain a separate account for each individual who is paid wages for insured work. After the expiration of each calendar quarter the Commission shall credit each individual's account with the wages paid to him for insured work in such calendar quarter.

§ 60.2-612. Benefit eligibility conditions.

An unemployed individual shall be eligible to receive benefits for any week only if the Commission finds that:

1. He has, in the highest two quarters of earnings within his base period, been paid wages in employment for employers that are ~~equal to~~ not less than ~~the lowest amount appearing in Column A of the "Benefit Table" appearing in § 60.2-602 on the line which extends through Division C and on which in Column B of the "Benefit Table" appears his weekly benefit amount~~*$2,500*. Such wages shall be earned in not less than two quarters.

2. a. His total or partial unemployment is not due to a labor dispute in active progress or to shutdown or start-up operations caused by such dispute which exists (i) at the factory, establishment, or other premises, including a vessel, at which he is or was last employed, or (ii) at a factory, establishment or other premises, including a vessel, either within or without this Commonwealth, which (a) is owned or operated by the same employing unit which owns or operates the premises at which he is or was last employed and (b) supplies materials or services necessary to the continued and usual operation of the premises at which he is or was last employed. This subdivision shall not apply if it is shown to the satisfaction of the Commission that:

(1) He is not participating in or financing or directly interested in the labor dispute; and

(2) He does not belong to a grade or class of workers of which, immediately before the commencement of the labor dispute, there were members employed at the premises, including a vessel, at which the labor dispute occurs, any of whom are participating in or financing or directly interested in the dispute.

b. If separate branches of work which are commonly conducted as separate businesses at separate premises are conducted in separate departments of the same premises, each such department shall, for the purposes of this subdivision, be deemed to be a separate factory, establishment or other premises. Membership in a union, or the payment of regular dues to a bona fide labor organization, however, shall not alone constitute financing a labor dispute.

3. He is not receiving, has not received or is not seeking unemployment benefits under an unemployment compensation law of any other state or of the United States; however, if the appropriate agency of such other state or of the United States finally determines that he is not entitled to such unemployment benefits, this subdivision shall not apply.

4. He is not on a bona fide paid vacation. If an individual is paid vacation pay for any week in an amount less than the individual's weekly benefit amount his eligibility for benefits shall be computed under the provisions of § 60.2-603.

5. He has registered for work and thereafter has continued to report at an employment office in accordance with such regulations as the Commission may prescribe. The Commission may, by regulation, waive or alter either or both of the requirements of this subdivision for certain types of cases when it finds that compliance with such requirements would be oppressive, or would be inconsistent with the purposes of this title.

6. He has made a claim for benefits in accordance with regulations the Commission may prescribe.

7. a. He is able to work, is available for work, and is actively seeking and unable to obtain suitable work. Every claimant who is totally unemployed shall report to the Commission the names of employers contacted each week in his effort to obtain work. This information may be subject to employer verification by the Commission through a program designed for that purpose. The Commission may determine that registration by a claimant with the Virginia State Job Service may constitute a valid employer contact and satisfy the search for work requirement of this subsection in labor market areas where job opportunities are limited. The Commission may determine that an individual, whose usual and customary means of soliciting work in his occupation is through contact with a single hiring hall which makes contacts with multiple employers on behalf of the claimant, meets the requirement that he be actively seeking and unable to obtain suitable work by contacting that hiring hall alone. In areas of high unemployment, as determined by the Commission, the Commission has the authority to adjust the requirement that he be actively seeking and unable to obtain suitable work.

b. An individual who leaves the normal labor market area of the individual for the major portion of any week is presumed to be unavailable for work within the meaning of this section. This presumption may be overcome if the individual establishes to the satisfaction of the Commission that the individual

has conducted a bona fide search for work and has been reasonably accessible to suitable work in the labor market area in which the individual spent the major portion of the week to which the presumption applies.

c. An individual whose type of work is such that it is performed by individuals working two or more shifts in a twenty-four-hour period shall not be deemed unavailable for work if the individual is currently enrolled in classes of higher education, provided that the enrollment would only limit the individual's availability for one shift and the individual is otherwise available to work any of the other shifts.

8. He has given notice of resignation to his employer and the employer subsequently made the termination of employment effective immediately, but in no case to exceed two weeks for which he would have worked had the employee separated from employment on the date of termination as given in the notice; provided, that the claimant could not establish good cause for leaving work pursuant to § 60.2-618 and was not discharged for misconduct as provided in § 60.2-618.

9. ~~Beginning January 6, 1991, he has served a waiting period of one week during which he was eligible for benefits under this section in all other respects and has not received benefits, except that only one waiting week shall be required of such individual within any benefit year.~~

~~10.~~ He is not imprisoned or confined in jail.

~~10~~*11*. He participates in reemployment services, such as job search assistance services, if he has been determined to be likely to exhaust regular benefits and need reemployment services pursuant to a profiling system established by the Commission, unless the Commission determines that (i) such claimant has completed such services or (ii) there is good cause for such claimant's failure to participate in such services.

2. That the provisions of this act, except those amending section 32.1-325 of the Code of Virginia, shall expire on July 1, 2003.

3. That an emergency exists and this act is in force from its passage.