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HOUSE BILL NO. 1592

House Amendments in [] — January 22, 2001

A BILL to amend and reenact § 32.1-325 as it is effective and as it may become effective, of the Code of Virginia, relating to medical assistance services.

Patron Prior to Engrossment—Delegate Callahan

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325 as it is effective and as it may become effective, of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. (For effective date — See note) 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, breast cancer, myeloma, or leukemia and have been determined by the treating health care

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59 provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone
60 marrow transplant. Appeals of these cases shall be handled in accordance with the Department's
61 expedited appeals process;

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

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

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

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

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

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

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

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

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

98 17. A provision for payment of medical assistance services for liver, heart and lung transplantation
99 procedures for individuals over the age of twenty-one years when (i) there is no effective alternative
100 medical or surgical therapy available with outcomes that are at least comparable to the transplant
101 procedure; (ii) the transplant procedure and application of the procedure in treatment of the specific
102 condition have been clearly demonstrated to be medically effective and not experimental or
103 investigational; (iii) prior authorization by the Department of Medical Assistance Services has been
104 obtained; (iv) the patient-selection criteria of the specific transplant center where the surgery is proposed
105 to be performed has been used by the transplant team or program to determine the appropriateness of
106 the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond
107 to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii)
108 the transplant is likely to prolong the patient's life and restore a range of physical and social functioning
109 in the activities of daily living;

110 18. A provision for payment of medical assistance for colorectal cancer screening, specifically
111 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in
112 appropriate circumstances radiologic imaging, in accordance with the most recently published
113 recommendations established by the American College of Gastroenterology, in consultation with the
114 American Cancer Society, for the ages, family histories, and frequencies referenced in such
115 recommendations; and

116 19. A provision for payment of medical assistance for custom ocular prostheses [*following the*
117 *medically necessary removal of an eye*].

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

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

121 2. Initiate such cost containment or other measures as are set forth in the appropriation act.
 122 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the
 123 provisions of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

182 the cost of providing medical assistance under the plan to their parents.

183 H. The Department of Medical Assistance Services shall:

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

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

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

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

202 § 32.1-325. (Delayed effective date — See notes) Board to submit plan for medical assistance
203 services to Secretary of Health and Human Services pursuant to federal law; administration of plan;
204 contracts with health care providers.

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

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

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

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

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

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

236 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
237 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
238 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
239 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
240 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
241 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
242 children which are within the time periods recommended by the attending physicians in accordance with
243 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, breast cancer, myeloma, or leukemia 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, two views of each breast;

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;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of twenty-one years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

305 19. A provision for payment of medical assistance for colorectal cancer screening, specifically
306 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in
307 appropriate circumstances radiologic imaging, in accordance with the most recently published
308 recommendations established by the American College of Gastroenterology, in consultation with the
309 American Cancer Society, for the ages, family histories, and frequencies referenced in such
310 recommendations; and

311 20. *A provision for payment of medical assistance for custom ocular prostheses [following the*
312 *medically necessary removal of an eye] .*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

365 F. When the services provided for by such plan are services which a clinical psychologist or a
366 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.

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