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**HOUSE BILL NO. 1979**

Offered January 10, 2001

Prefiled January 10, 2001

*A BILL to amend and reenact § 32.1-325 of the Code of Virginia, as it is currently effective and as it may become effective, relating to Medicaid eligibility.*

\_\_\_\_\_  
Patron—Orrock

\_\_\_\_\_  
Referred to Committee on Health, Welfare and Institutions

**Be it enacted by the General Assembly of Virginia:**

**1. That § 32.1-325 of the Code of Virginia, as it is currently effective and as it may become effective, 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, 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; and

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.

116 19. *A provision for determining eligibility for benefits for medically needy individuals that disregards*  
117 *from countable resources any gift of property by an individual that is accepted by Virginia Outdoors*  
118 *Foundation pursuant to Chapter 18 (§ 10.1-1800 et seq.) of Title 10.1. Such gift of property shall not be*  
119 *considered an uncompensated transfer of assets for Medicaid eligibility purposes.*

120 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

182 permitted by federal law to establish a program of family assistance whereby children over the age of  
183 eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward  
184 the cost of providing medical assistance under the plan to their parents.

185 H. The Department of Medical Assistance Services shall:

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

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

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

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

204 § 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human  
205 Services pursuant to federal law; administration of plan; contracts with health care providers

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

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

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

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

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

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

237 6. A provision for payment of medical assistance on behalf of pregnant women which provides for  
238 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most  
239 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American  
240 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards  
241 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and  
242 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the  
243 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, 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

305 patient's life and restore a range of physical and social functioning in the activities of daily living; and

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

312 20. *A provision for determining eligibility for benefits for medically needy individuals that disregards*  
313 *from countable resources any gift of property by an individual that is accepted by Virginia Outdoors*  
314 *Foundation pursuant to Chapter 18 (§ 10.1-1800 et seq.) of Title 10.1. Such gift of property shall not be*  
315 *considered an uncompensated transfer of assets for Medicaid eligibility purposes.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

365 The Director's decision upon reconsideration shall be consistent with federal and state laws. The  
366 Director may consider the nature and extent of any adverse impact the agreement or contract denial or

367 termination may have on the medical care provided to Virginia Medicaid recipients.

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

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

381 H. The Department of Medical Assistance Services shall:

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

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

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

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