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## SENATE BILL NO. 1158

Offered January 10, 2001

Prefiled January 10, 2001

*A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, and § 37.1-24.2 of the Code of Virginia, to amend the Code of Virginia by adding in Title 37.1 a chapter numbered 16, consisting of sections numbered 37.1-254 through 37.1-260, and to repeal §§ 2.1-812, 2.1-813, 2.1-814 and 37.1-23 of the Code of Virginia, relating to restructuring of the mental health care system.*

Patron—Hanger

Referred to Committee on Education and Health

**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 §37.1-24.2 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Title 37.1 a chapter numbered 16, consisting of sections numbered 37.1-254 through 37.1-260 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

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59 or Standards shall include any changes thereto within six months of the publication of such Guidelines  
60 or Standards or any official amendment thereto;

61 7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow  
62 transplants on behalf of individuals over the age of twenty-one who have been diagnosed with  
63 lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care  
64 provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone  
65 marrow transplant. Appeals of these cases shall be handled in accordance with the Department's  
66 expedited appeals process;

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

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

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

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

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

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

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

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

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

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

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

121 19. A provision for payment of medical assistance for community gero-psychiatric residential  
122 services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

175 F. When the services provided for by such plan are services which a clinical psychologist or a  
176 clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render  
177 in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical  
178 social worker or licensed professional counselor or licensed clinical nurse specialist who makes  
179 application to be a provider of such services, and thereafter shall pay for covered services as provided in  
180 the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists,  
181 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. 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, 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; and

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

20. *A provision for payment of medical assistance for community gero-psychiatric residential services.*

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 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.

§ 37.1-24.2. Separate facilities for geriatric patients; separate locations authorized.

(a) The Commissioner shall establish, within each state ~~hospital~~ mental health facility ~~which~~ that has resident geriatric patients, facilities for the care and treatment of geriatric patients. Such facilities shall be identified and designated as geriatric patient facilities and shall be separated in a reasonable manner from the remainder of the ~~hospital~~ facility.

(b) The ~~Board~~ Commissioner may in ~~its~~ his discretion, giving full consideration to needs and resources available, authorize the establishment of other geriatric facilities in locations apart from state ~~hospitals~~ mental health facilities.

## CHAPTER 16.

### RESTRUCTURING OF THE MENTAL HEALTH CARE SYSTEM.

§ 37.1-254. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Commissioner" means the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Fund" means the Mental Health, Mental Retardation and Substance Abuse Services Trust Fund.

"Net proceeds" means the gross amount received by the seller on account of the sale of any assets (i) less costs incurred on behalf of the seller in connection with such sale and (ii) if after the sale the sold assets will be used by an entity other than a state agency or instrumentality or a local governmental entity in a governmental activity and debt obligations financed any portion of the sold assets and any amount of such obligations is outstanding at the time of the sale, less the amount necessary to provide for the payment or redemption of the portion of such outstanding obligations that financed the sold assets (which amount shall be used to pay or redeem such obligations or shall be transferred to the third party issuer of the obligations for a use permitted in accordance with such obligations).

§ 37.1-255. Mental Health, Mental Retardation and Substance Abuse Services Trust Fund established; purpose.

There is hereby created in the state treasury a special nonreverting fund to be known as the Mental

428 *Health, Mental Retardation and Substance Abuse Services Trust Fund to enhance and ensure for the*  
429 *coming years the quality of care and treatment provided to consumers of the Commonwealth's mental*  
430 *health, mental retardation, and substance abuse services. The Fund shall be established on the books of*  
431 *the Comptroller. Notwithstanding the provisions of § 2.1-512, the Fund shall consist of the net proceeds*  
432 *of the sale of vacant buildings and land held by the Department of Mental Health, Mental Retardation*  
433 *and Substance Abuse Services. The Fund shall also consist of such moneys as shall be appropriated by*  
434 *the General Assembly and any private donations. Interest earned on moneys in the Fund shall remain in*  
435 *the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the*  
436 *end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the*  
437 *Fund shall be used solely for the purposes set forth in this chapter. Expenditures and disbursements*  
438 *from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written*  
439 *request signed by the Commissioner.*

440 *§ 37.1-256. Administration of Mental Health, Mental Retardation and Substance Abuse Services Trust*  
441 *Fund.*

442 *The Fund shall be administered by the Commissioner. Moneys in the Fund shall be used solely to*  
443 *provide mental health, mental retardation, and substance abuse services to enhance and ensure the*  
444 *quality of care and treatment provided by the Commonwealth to persons with mental health, mental*  
445 *retardation and substance abuse illnesses. Notwithstanding any other provision of law, the net proceeds*  
446 *from the sale of any vacant buildings and land shall first be used to (i) deliver mental health, mental*  
447 *retardation, and substance abuse services within the same service area as where such sold buildings*  
448 *and land were located to ensure the same level of mental health, mental retardation, and substance*  
449 *abuse care as before such sale and (ii) provide benefits to those persons who were employees of the*  
450 *Commonwealth and, as a result of such sale, are either no longer employed by the Commonwealth or*  
451 *are otherwise negatively affected by such sale. Such benefits shall include, but are not limited to,*  
452 *appropriate transitional benefits.*

453 *§ 37.1-257. Acute inpatient psychiatric care.*

454 *The Commissioner shall authorize the delivery of acute care inpatient psychiatric services in local*  
455 *community hospitals to the extent such services are available.*

456 *§ 37.1-258. Geriatric services.*

457 *A. The Commissioner shall provide for the transfer of consumers from geriatric inpatient mental*  
458 *health services in state mental health facilities to community gero-psychiatric residential services in*  
459 *accordance with the provisions of subsection B.*

460 *B. The Commissioner shall assure that each consumer receiving geriatric inpatient mental health*  
461 *services in a state mental health facility is clinically assessed individually for appropriateness of*  
462 *continued inpatient hospitalization. Consumers whose psychiatric and medical needs can be*  
463 *appropriately met in a community gero-psychiatric residential service, may, based on such assessment,*  
464 *be discharged to such a service, provided that the supports and services offered the consumer in the*  
465 *residential service shall be of appropriate quality and intensity to safeguard the consumers' health and*  
466 *well-being, and that an individual predischarge plan shall be developed in accordance with the*  
467 *provisions of § 37.1-197.1. The Commissioner shall assure that each state facility provides appropriate*  
468 *follow-up services for any consumer who is discharged pursuant to this subsection for a minimum of*  
469 *three months following discharge to monitor the delivery of medical and psychiatric services.*

470 *C. The Commissioner shall create a Gero-Psychiatric Behavioral Health Institute comprised of*  
471 *Department, state university medical school and academic program representatives to advance research,*  
472 *education and training in gero-psychiatric behavioral health treatment and pharmacology.*

473 *§ 37.1-259. Targeted facility restructuring.*

474 *The Commissioner shall have the authority to:*

475 *1. Close Southern Virginia Mental Health Institute, opened in 1977 and located in Danville, by July*  
476 *1, 2002.*

477 *2. Close Piedmont Geriatric Hospital, opened in 1967 and located in Burkeville, by July 1, 2006.*

478 *3. Close Catawba Hospital, opened in 1909 and located in Catawba, by July 1, 2006.*

479 *4. Close the inpatient geriatric services at Eastern State Hospital, opened in 1773 and located in*  
480 *Williamsburg, by July 1, 2004.*

481 *5. Relocate, by July 1, 2004, extended rehabilitation services from Eastern State Hospital to a site*  
482 *more central to the current geographical region served by Eastern State Hospital, provided that there is*  
483 *no reduction in the services for extended rehabilitation to consumers in that geographical region.*

484 *6. Operate DeJarnette Center, opened in 1932 and located in Staunton, as a public residential*  
485 *facility for youth who meet the criteria set forth in § 2.1-758.*

486 *§ 37.1-260. Duties and powers of the Commissioner relative to mental health care system*  
487 *restructuring and state mental health facility closures.*

488 *Notwithstanding any other provision of law, the Commissioner, with the approval of the Governor*  
489 *and the Secretary of Health and Human Resources, shall have the authority, for purposes of*



restructuring and closing mental health facilities, to make any necessary decisions and enter into any necessary contracts and other agreements that may have the effect of closing state facilities or programs or beds within state facilities; converting the use of facilities; changing the nature of the services currently provided in state mental health facilities; selling state facility land and buildings; or otherwise providing for the maximum protection, safety and appropriate care and treatment of consumers and the well-being of state facility employees.

2. That §§ 2.1-812, 2.1-813, 2.1-814 and 37.1-23 of the Code of Virginia are repealed.

3. That the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall review the requirements of the outstanding general obligation bonds for Dejarnette Center, Piedmont Geriatric Hospital and Catawba Hospital with regard to full implementation of the restructuring and closure of mental health facilities. In addition, the Commissioner shall develop an operational model to convert Dejarnette Center to a Comprehensive Services Act residential facility providing diagnosis, assessment and stabilization for children and adolescents served by the Comprehensive Services Act. The model shall be developed in collaboration with representatives of the Comprehensive Services Act program, local governments and other key stakeholders. The Commissioner shall report the status of the operational model to the Governor and to the Chairmen of the House Appropriations and Senate Finance Committees on or before September 30, 2001.

4. That the Board of Medical Assistance Services shall promulgate regulations to implement the provisions of this act within 280 days of its enactment.