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HOUSE BILL NO. 1959

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Rules
on January 28, 2003)

(Patron Prior to Substitute—Delegate Hamilton)

A BILL to amend and reenact §§ 2.2-2818, 32.1-102.13, 32.1-276.9, 32.1-331.17, 32.1-351, 32.1-352, 37.1-48.2, 37.1-189.3, 38.2-5603, 38.2-5904, and 58.1-609.7 of the Code of Virginia, to amend and reenact the third enactment of Chapter 891 of the Acts of Assembly of 1998, the second enactment of Chapter 924 of the Acts of Assembly of 2000, the third enactments of Chapter 244 and Chapter 251 of the Acts of Assembly of 2001, and the second enactment of Chapter 465 of the Acts of Assembly of 2001; to amend the Code of Virginia by adding in Title 30 a chapter numbered 31, consisting of sections numbered 30-201 through 30-208; and to repeal Chapters 17 (§§ 30-165, 30-166, and 30-167), Chapter 18 (§§ 30-168, 30-169, and 30-170), and Chapter 20 (§§ 30-174 through 30-177) of Title 30 of the Code of Virginia, relating to the consolidation of the Joint Commission on Behavioral Health Care, the Joint Commission on Health Care and the Virginia Commission on Youth into the Commission on Youth, Family Services, and Health Care; study; report.

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 32.1-102.13, 32.1-122.10:001, 32.1-122.10:002, 32.1-276.9, 32.1-331.17, 32.1-351, 32.1-352, 37.1-48.2, 37.1-189.3, 38.2-5603, 38.2-5904, and 58.1-609.7 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Title 30 a chapter numbered 31, consisting of sections numbered 30-201 through 30-208 as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available ~~one~~ *1* screening mammogram to persons age ~~thirty-five~~*35* through ~~thirty-nine~~*39*, ~~one~~ *1* such mammogram biennially to persons age ~~forty~~ *40* through ~~forty-nine~~*49*, and ~~one~~ *1* such mammogram annually to persons age ~~fifty~~ *50* and over and may be limited to a benefit of ~~fifty~~ *50* dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean 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~~ *1* rad mid-breast, ~~two~~ *2* views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the

existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be 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. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within ~~six~~ *6* months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within ~~one~~ *1* business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with ~~one~~ *1* or more impartial health entities to review such decisions. Impartial health entities may include medical peer review organizations and independent utilization review companies. The Department shall adopt regulations to assure that the impartial health entity conducting the reviews has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an impartial health entity, the Department shall verify that the impartial health entity conducting the review of a denial of claims has no relationship or association with (i) the covered employee, (ii) the treating health care provider, or any of its employees or affiliates, (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age ~~three~~ *3* who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in ~~one~~ *1* of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least ~~one~~ *1* indication and the drug is recognized for treatment of the covered indication in ~~one~~ *1* of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the ~~two~~ *2* breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

12. Include coverage providing a minimum stay in the hospital of not less than ~~forty-eight~~ *48* hours for a patient following a radical or modified radical mastectomy and ~~twenty-four~~*24* hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age ~~fifty~~ *50* and over and (ii) to persons age ~~forty~~ *40* and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for ~~one~~ *1* PSA test in a ~~twelve~~*12*-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.

14. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

15. Include provisions allowing employees to continue receiving health care services for a period of up to ~~ninety~~ *90* days from the date of the primary care physician's notice of termination from any of the plan's provider panels. The plan shall notify any provider at least ~~ninety~~ *90* days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least ~~ninety~~ *90* days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be

reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

16. Include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the ~~Federal~~*federal* Food and Drug Administration.

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient" means a person covered under the plan established pursuant to this section.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

a. The National Cancer Institute;

b. An NCI cooperative group or an NCI center;

c. The FDA in the form of an investigational new drug application;

d. The federal Department of Veterans Affairs; or

e. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

Coverage under this section shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;

(2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the ~~noninvestigatonal~~*noninvestigational* alternative; and

(3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

17. Include coverage providing a minimum stay in the hospital of not less than ~~twenty-three~~ *23* hours for a covered employee following a laparoscopy-assisted vaginal hysterectomy and ~~forty-eight~~ *48* hours for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is appropriate.

18. (Effective until July 1, 2004) Include coverage for biologically based mental illness.

For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and ~~alcoholism~~ *alcohol* addiction.

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits,

copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage 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. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

21. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

22. Include coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing

Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Human Resource Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan shall include, in each planning district, at least ~~two~~ *2* health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

H. Any self-insured group health insurance plan established by the Department of Personnel that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii) other health care providers.

If the plan maintains ~~one~~ *1* or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescribing physician, the formulary drug is determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within ~~one~~ *1* business day of receipt of the request.

I. Any plan established in accordance with this section requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established in accordance with this section shall provide to all covered employees written notice of any benefit reductions during the contract period at least ~~thirty~~ *30* days before such reductions become effective.

K. No contract between a provider and any plan established in accordance with this section shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employee with similar medical conditions.

L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

The Ombudsman shall:

1. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

2. Answer inquiries from covered employees by telephone and electronic mail.

3. Provide to covered employees information concerning the state health plans.

4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.

6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered employees have access to the services provided by the Ombudsman and that

the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

9. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care by December 1 of each year.

M. The plan established in accordance with this section shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment.

N. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered expenses of each family member.

O. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least ~~thirty~~ *30* days following the death of such state employee.

CHAPTER 31.

COMMISSION ON YOUTH, FAMILY SERVICES, AND HEALTH CARE.

§ 30-201. Commission on Youth, Family Services, and Health Care; purpose.

The Commission on Youth, Family Services, and Health Care (the "Commission") is established in the legislative branch of state government. The purpose of the Commission is to study, report, and make recommendations to address the needs of and services to the Commonwealth's youth and their families and to ensure continuous improvement in all areas of publicly funded health care policy, management, financing, service delivery, regulation, and evaluation. For purposes of this chapter, the term health care shall include behavioral health care.

§ 30-202. Membership; terms; vacancies; chairman and vice chairman.

The Commission shall consist of 19 members that include 16 legislative members and 3 ex officio members. Members shall be appointed as follows: 9 members of the House of Delegates to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; 7 members of the Senate to be appointed by the Senate Committee on Privileges and Elections; and the Secretary of Health and Human Resources, the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, and the Director of the Department of Medical Assistance Services or their designees to serve ex officio with full voting privileges.

Legislative members and ex officio members of the Commission shall serve terms coincident with their terms of office. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Legislative members may be reappointed. Vacancies shall be filled in the same manner as the original appointments.

The Commission shall elect a chairman and vice chairman from among its membership, who shall be members of the General Assembly.

§ 30-203. Quorum; meetings; voting on recommendations.

A majority of the voting members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the voting members so request. The Commission may maintain offices and may hold meetings and functions at any place within the Commonwealth as it deems appropriate.

At the option of a majority of the members of the House of Delegates appointed to the Commission or a majority of the Senate members appointed to the Commission, no recommendation of the Commission shall be adopted without the approval of a majority of such members of the House of Delegates and a majority of such members of the Senate. For the purpose of this provision, a "majority" constitutes the majority of members present and voting at the meeting of the Commission.

§ 30-204. Compensation; expenses.

Legislative members of the Commission shall receive such compensation as provided in § 30-19.12.

All members shall be reimbursed for reasonable and necessary expenses incurred in the performance of their duties as provided in § 2.2-2825. However, all such compensation and expenses shall be paid from existing appropriations to the Commission or, if unfunded, shall be approved by the Joint Rules Committee.

§ 30-205. Powers and duties of the Commission.

The Commission shall have the following powers and duties:

1. Encourage the development of uniform policies and services to youth across the Commonwealth and provide a forum for continuing review and study of such services;

2. Endeavor to ensure that the Commonwealth as a provider and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care;

3. Encourage the development of uniform policies and services to ensure the availability of quality, affordable, and accessible health care services and provide a forum for continuing review and study of programs and services;

4. Examine the operations, management, jurisdiction, powers and interrelationships of any department, board, bureau, commission, authority, or other agency or governmental entity with any direct responsibility for services to youth and their families or the provision and delivery of health care in the Commonwealth;

5. Examine matters relating to youth, family, and health care services in other states and consult and exchange information with officers and agencies of other states with respect to such service problems of mutual concern;

6. Make recommendations and coordinate proposals and recommendations of all commissions and agencies as to legislation and budget amendments affecting services to youth and their families and the provision and delivery of health care; and

7. Undertake studies and gather information and data to accomplish its purpose and perform its duties and report its findings and recommendations annually to the General Assembly and the Governor as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The Commission shall make such further interim reports to the General Assembly and the Governor as it shall deem advisable or as shall be required by the General Assembly or the Governor.

§ 30-206. Staffing.

The Commission may appoint and employ and, at its pleasure, remove an executive director and such other persons as it deems necessary to assist it in carrying out its duties as set forth in this chapter. The Commission may employ experts who have special knowledge of the issues before it. The Commission may determine the duties of such staff and fix their salaries or compensation within the amounts appropriated thereof. If funds are not appropriated for staffing, the Joint Rules Committee shall determine the staffing support for the Commission. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

§ 30-207. Chairman's executive summary of activity and work of the Commission.

The chairman shall submit to the General Assembly and the Governor an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

§ 30-208. Sunset.

This chapter shall expire on July 1, 2007.

§ 32.1-102.13. Transition to elimination of medical care facilities certificate of public need.

A. Transition required. - A transition for elimination of the requirements for determination of need pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall begin on July 1, 2001, and shall be completed by July 1, 2004, as determined by the General Assembly.

B. Plan to be developed. - The deregulation required by this section shall be accomplished in accordance with a plan to be developed by the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care. The ~~Joint~~ Commission on *Youth, Family Services, and* Health Care shall work collaboratively with the Departments of Health, Medical Assistance Services, and Health Professions in conjunction with the implementation of the provisions of this section. The Departments of Health, Medical Assistance Services, and Health Professions shall provide technical assistance to the ~~Joint~~ Commission. All agencies of the Commonwealth shall provide assistance to the ~~Joint~~ Commission, upon request. The ~~Joint~~ Commission shall seek input from all classes of health care consumers, providers, and representatives of health care facilities in the performance of the duties of the ~~Joint~~ Commission ~~hereunder~~. The plan shall include recommendations for legislative and administrative consideration to carry out, in accordance with subsection A of this section, the elimination of the requirements for determination of need. ~~Such plan shall be submitted to the chairmen of the House Appropriations, Senate Finance, House Health, Welfare~~

~~and Institutions, and Senate Education and Health Committees on or before December 1, 2000, for review and approval by the 2001 Session of the General Assembly.~~

C. Components of the plan. - The plan for deregulation to be developed by the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care shall include, but need not be limited to, provisions for (i) meeting the health care needs of the indigent citizens of the Commonwealth, including access to care and provision for all health care providers to share in meeting such needs; (ii) meeting the health care needs of the uninsured citizens of the Commonwealth, including access to care; (iii) establishing licensure standards for the various deregulated services, including whether nationally recognized accreditation standards may be adopted, to protect the public health and safety and to promote the quality of services provided by deregulated medical facilities and projects; (iv) providing adequate oversight of the various deregulated services to protect the public health and safety; (v) providing for monitoring the effects of deregulation during the transition period and after full implementation of this section on the number and location of medical facilities and projects throughout the Commonwealth; (vi) determining the effect of deregulation of long-term care facilities and new hospitals with respect to the requirements for determination of need; (vii) determining the effect of deregulation on the unique mission of academic medical centers; (viii) determining the effect of deregulation on rural hospitals which are critical access hospitals; (ix) recommending a schedule for necessary statutory changes to implement the plan and for requiring, subject to approval of the General Assembly, that the appropriate regulatory boards promulgate regulations implementing the Commission's plan prior to any deregulation recommended in the plan.

D. Fiscal impact. - In developing the plan, the Commission shall also consider the impact of deregulation on state-funded health care financing programs and shall include an examination of the fiscal impact of such deregulation on the market rates paid by such financing programs for health care and long-term care services.

§ 32.1-276.9. (Effective until July 1, 2008) Confidentiality, subsequent release of data and relief from liability for reporting; penalty for wrongful disclosure; individual action for damages.

A. Patient level data collected pursuant to this chapter shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), shall be considered confidential, and shall not be disclosed other than as specifically authorized by this chapter; however, upon processing and verification by the nonprofit organization, all patient level data shall be publicly available, except patient, physician, and employer identifier elements, which may be released solely for research purposes if otherwise permitted by law and only if such identifier is encrypted and cannot be reasonably expected to reveal patient identities. No report published by the nonprofit organization, the Commissioner, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient. The nonprofit organization, in its discretion, may release physician and employer identifier information. Outpatient surgical charge data shall be made publicly available only pursuant to a review by the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care.

B. No person or entity, including the nonprofit organization contracting with the Commissioner, shall be held liable in any civil action with respect to any report or disclosure of information made under this article unless such person or entity has knowledge of any falsity of the information reported or disclosed.

C. Any disclosure of information made in violation of this chapter shall be subject to a civil penalty of not more than $5,000 per violation. This provision shall be enforceable upon petition to the appropriate circuit court by the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred. Any penalty imposed shall be payable to the Literary Fund. In addition, any person or entity who is the subject of any disclosure in violation of this article shall be entitled to initiate an action to recover actual damages, if any, or $500, whichever is greater, together with reasonable attorney's fees and court costs.

§ 32.1-331.17. Annual report to Commission.

The Committee shall report annually to the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care regarding its recommendations for prior authorization of drug products.

§ 32.1-351. Family Access to Medical Insurance Security Plan established.

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals, up to the age of ~~nineteen~~ *19*, when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet

the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91(a) and (b) (1)); (iv) have been without health insurance for at least ~~six~~ *6* months or meet the exceptions as set forth in the Virginia Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan.

B. Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed ~~five~~ *5* percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special education students.

D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this program does not substitute for private health insurance coverage.

F. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance.

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Family Access to Medical Insurance Security Plan shall include a provision allowing a child's application to be filed by a parent, legal guardian, authorized representative or any other adult caretaker relative with whom the child lives. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. In the event that an application is denied, the applicant shall be notified of any services available in his locality that can be accessed by contacting the local department of social services.

H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

The plan shall also include a provision to request the custodial parent's cooperation with the Commonwealth in securing medical and child support payments. However, such cooperation shall not be a condition of eligibility.

H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services

agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care and shall provide quarterly reports on enrollment, policies affecting enrollment, such as the exceptions that apply to the ~~six~~ *6* months' prior coverage limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and other topics.

J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state and federal appropriations and shall include appropriations of any funds that may be generated through the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall continue their eligibility under the Family Access to Medical Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages. Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in income status. Families may select among the options available pursuant to subsections D and F of this section.

M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing Administration as Virginia's State Children's Health Insurance Program.

§ 32.1-352. Virginia Family Access to Medical Insurance Security Plan Trust Fund.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Family Access to Medical Insurance Security Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any and all employer contributions which may be solicited or received by the Department of Medical Assistance Services, grants, donations, gifts, and bequests, or any and all moneys designated for the Fund, from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to subdivision A 4 of § 58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in § 38.2-4201 or § 38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to subsection D of § 38.2-4229.1. The State Corporation Commission shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Family Access to Medical Insurance Security Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely to

support the Virginia Family Access to Medical Insurance Security Plan in accordance with the requirements of Title XXI of the Social Security Act, as amended, the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33), and any conditions set forth in the appropriation act.

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care on the status of the Fund, the number of children served by this program, the costs of such services, and any issues related to the Virginia Family Access to Medical Insurance Security Plan that may need to be addressed.

§ 37.1-48.2. System restructuring; state and community consensus and planning team required.

A. For the purpose of considering any restructuring of the system of mental health services involving an existing state mental health facility, the Commissioner shall establish a state and community consensus and planning team consisting of Department staff and representatives of the jurisdictions served by the facility, including local government officials, consumers, family members of consumers, advocates, state facility employees, community services boards, public and private service providers, licensed hospitals, state-operated medical hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested citizens. In addition, the members of the House of Delegates and the Senate representing the jurisdictions served by the affected state facility may serve on the state and community consensus and planning team for that facility. Each state and community consensus and planning team, in collaboration with the Commissioner, shall develop a plan that addresses (i) the types, amounts, and locations of new and expanded community services that would be needed to successfully implement the closure or conversion of the facility to any use other than the provision of mental health services, including a ~~six~~*6*-year projection of the need for inpatient psychiatric beds and related community mental health services; (ii) the development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs; (iii) the creation of new and enhanced community services prior to the closure of the facility or its conversion to any use other than the provision of mental health services; (iv) the transition of state facility patients to community services in the locality of their residence prior to institutionalization or the locality of their choice; (v) the resolution of issues relating to the restructuring implementation process, including employment issues involving state facility employee transition planning and appropriate transitional benefits; and (vi) a ~~six~~ *6*-year projection comparing the cost of the current structure and the proposed structure.

B. The Commissioner shall ensure that each plan includes the following components:

1. A plan for community education;

2. A plan for the implementation of required community services, including state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas;

3. A plan for assuring the availability of adequate staff in the affected communities, including specific strategies for transferring qualified state facility employees to community services;

4. A plan for assuring the development, funding, and implementation of individualized discharge plans pursuant to § 37.1-197.1 for individuals discharged as a result of the closure or conversion of the facility to any use other than the provision of mental health services; and

5. A provision for suspending implementation of the plan if the total general funds appropriated to the Department for state facility and community services decrease in any year of plan implementation by more than ~~ten~~ *10* percent from the year in which the plan was approved by the General Assembly.

C. At least ~~nine~~ *9* months prior to any proposed facility closure or conversion of the facility to any use other than the provision of mental health services, the state and community consensus and planning team shall submit a plan to the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care and the Governor for review and recommendation.

D. The ~~Joint~~ Commission on *Youth, Family Services, and* Health Care shall make a recommendation to the General Assembly on the plan no later than ~~six~~ *6* months prior to the date of the proposed closure or conversion of the facility to any use other than the provision of mental health services.

E. Upon approval of the plan by the General Assembly and the Governor, the Commissioner shall ensure that the plan components required by subsection B are in place, and may thereafter perform all tasks necessary to implement the closure or conversion of the facility to any use other than the provision of mental health services.

F. Any funds saved by the closure or conversion of the facility to any use other than the provision of mental health services and not allocated to individualized services plans for patients being transferred or discharged as a result of the closure or conversion of the facility to any use other than the provision of mental health services shall be invested in the Mental Health, Mental Retardation and Substance Abuse Services Trust Fund established in Chapter 17 (§ 37.1-258 et seq.) of this title.

G. Nothing in this section shall prevent the Commissioner from leasing unused, vacant space to any

public or private organization or transferring such space pursuant to subsection H.

H. Concurrently with the development of a plan described in subsection A, the Commissioner, in consultation with the Chancellor of the Community College System or his designee, the President of Thomas Nelson Community College or his designee, and the President of the College of William and Mary or his designee, and with the advice of the state and community consensus and planning team, shall assess the impact and feasibility of using a portion of real property now occupied by Eastern State Hospital located in James City County for the placement of a new campus of Thomas Nelson Community College and the development of a Center for Excellence in Aging and Geriatric Health on the property. This assessment shall examine the potential future use of the property by Thomas Nelson Community College and the Center for Excellence in Aging and Geriatric Health and its long-term impact on services provided by Eastern State Hospital and community services boards located in Eastern State Hospital's catchment area. The Commissioner, after completion of the impact and feasibility assessment and of a plan described in subsection A and with the consent of the Governor, is authorized to transfer to Thomas Nelson Community College for its possession and use a portion of that real property currently occupied by the Eastern State Hospital and known generally as the Hancock Geriatric Treatment Center. Any such transfer shall only be made subject to the provision that Thomas Nelson Community College use the property for its general education mission that includes the placement and operation of a School of Allied Health Professions to offer health care degrees, including Licensed Practical Nurse programs and for the training of mental health care providers. Should the Commissioner decide to make such transfer of the property to Thomas Nelson Community College, the Department of General Services shall obtain an independent assessment of the property's value, which shall include appropriate consideration of the value of mental health training services to be provided by Thomas Nelson Community College, and funds equal to the assessed value of the property shall be deposited in the Mental Health, Mental Retardation and Substance Abuse Services Trust Fund subject to the appropriation act.

§ 37.1-189.3. Data reporting on youth and adolescents.

A. The Department shall collect and compile the following data:

1. The total number of licensed and staffed inpatient acute care psychiatric beds for children under the age of ~~fourteen~~*14* and adolescents ages ~~fourteen~~*14* through ~~seventeen~~*17*; and

2. The total number of licensed and staffed residential treatment beds, for children under the age of ~~fourteen~~*14* and adolescents ages ~~fourteen~~*14* through ~~seventeen~~*17* in residential facilities licensed pursuant to this chapter, exclusive of group homes.

B. The Department shall collect and compile data obtained from the community policy and management team pursuant to subdivision 15 of § 2.2-5206 and each operating community services board, administrative policy board, local government department with a policy-advisory board, or behavioral health authority pursuant to § 37.1-197.3. The Department shall ensure that the data reported is not duplicative.

C. The Department shall report this data on a quarterly basis to the Chairmen of the House Appropriations and Senate Finance Committees and the ~~Virginia Commission on Youth.~~ *Commission on Youth, Family Services, and Health Care.*

§ 38.2-5603. Role of the Commission on Youth, Family Services, and Health Care.

The ~~Joint~~ Commission on *Youth, Family Services, and* Health Care shall monitor the development of the Plan required in § 38.2-5601 and make recommendations to the designated agencies on modifications of the Plan. Periodic reports shall be provided to the Commission by the designated agencies as the Commission may require.

§ 38.2-5904. Office of the Managed Care Ombudsman established; responsibilities.

A. The Commission shall create within the Bureau of Insurance the Office of the Managed Care Ombudsman. The Office of the Managed Care Ombudsman shall promote and protect the interests of covered persons under managed care health insurance plans in the Commonwealth. All state agencies shall assist and cooperate with the Office of the Managed Care Ombudsman in the performance of its duties under this chapter. The definitions in § 32.1-137.7 shall have the same meanings ascribed to them in § 32.1-137.7 when used in this section.

B. The Office of the Managed Care Ombudsman shall:

1. Assist covered persons in understanding their rights and the processes available to them according to their managed care health insurance plan.

2. Answer inquiries from covered persons and other citizens by telephone, mail, electronic mail and in person.

3. Provide to covered persons and other citizens information concerning managed care health insurance plans and other utilization review entities upon request.

4. Develop information on the types of managed care health insurance plans available in the Commonwealth, including mandated benefits and utilization review procedures and appeals, and receive

and analyze the annual complaint data required to be filed by each health carrier providing a managed care health insurance plan, as provided in subsection C of § 38.2-5804.

5. Make available, either separately or through an existing Internet Web site utilized by the Bureau of Insurance, information as set forth in subdivision 4 and such additional information as may be deemed appropriate.

6. In conjunction with complaint and inquiry data maintained by the Bureau of Insurance, maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered persons in using the procedures and processes available to them from their managed care health insurance plan, including all utilization review appeals. Such assistance may require the review of insurance and health care records of a covered person, which shall be done only with that person's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered persons have access to the services provided through the Office of the Managed Care Ombudsman and that the covered persons receive timely responses from the representatives of the Office of the Managed Care Ombudsman to the inquiries.

9. Upon request to the Commission by any of the standing committees of the General Assembly having jurisdiction over insurance or health or the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care, provide to the Commission for dissemination to the requesting parties assessments of proposed and existing managed care health insurance laws and other studies of managed care health insurance plan issues.

10. Monitor changes in federal and state laws relating to health insurance.

11. Provide information to the Commission that will permit the Commission to report annually on the activities of the Office of the Managed Care Ombudsman to the standing committees of the General Assembly having jurisdiction over insurance and over health and to the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care. The Commission's report shall be filed by December 1 of each year, and shall include a summary of significant new developments in federal and state laws relating to health insurance each year.

12. Carry out activities as the Commission determines to be appropriate.

§ 58.1-609.7. Medical-related exemptions.

The tax imposed by this chapter or pursuant to the authority granted in §§ 58.1-605 and 58.1-606 shall not apply to the following:

1. Medicines, drugs, hypodermic syringes, artificial eyes, contact lenses, eyeglasses, eyeglass cases and contact lens storage containers when distributed free of charge, all solutions or sterilization kits or other devices applicable to the wearing or maintenance of contact lenses or eyeglasses when distributed free of charge, and hearing aids dispensed by or sold on prescriptions or work orders of licensed physicians, dentists, optometrists, ophthalmologists, opticians, audiologists, hearing aid dealers and fitters, nurse practitioners, physician assistants, and veterinarians; controlled drugs purchased for use by a licensed physician, optometrist, licensed nurse practitioner, or licensed physician assistant in his professional practice, regardless of whether such practice is organized as a sole proprietorship, partnership or professional corporation, or any other type of corporation in which the shareholders and operators are all licensed physicians, optometrists, licensed nurse practitioners, or licensed physician assistants engaged in the practice of medicine, optometry, or nursing, but excluding nursing homes, clinics, and similar corporations not otherwise exempt under this section; medicines and drugs purchased for use or consumption by a licensed hospital; and samples of prescription drugs and medicines and their packaging distributed free of charge to authorized recipients in accordance with the Federal Food, Drug and Cosmetic Act (21 U.S.C.A. § 301 et seq., as amended). Any veterinarian dispensing or selling medicines or drugs on prescription shall be deemed to be the user or consumer of all such medicines and drugs.

2. Wheelchairs and parts therefor, braces, crutches, prosthetic devices, orthopedic appliances, catheters, urinary accessories, other durable medical equipment and devices, and related parts and supplies specifically designed for those products; and insulin and insulin syringes, and equipment, devices or chemical reagents which may be used by a diabetic to test or monitor blood or urine, when such items or parts are purchased by or on behalf of an individual for use by such individual. Durable medical equipment is equipment ~~which~~*that* (i) can withstand repeated use, (ii) is primarily and customarily used to serve a medical purpose, (iii) generally is not useful to a person in the absence of illness or injury, and (iv) is appropriate for use in the home.

3. Drugs and supplies used in hemodialysis and peritoneal dialysis.

4. a. Ending July 1, 2003, tangible personal property for use or consumption by a nonprofit hospital or a nonprofit licensed nursing home.

b. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property for use or consumption by a nonprofit hospice. For purposes of this subdivision, "hospice" shall mean an

establishment caring for the needs of terminally ill patients.

5. Ending July 1, 2003, tangible personal property for use or consumption by community health centers exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established for the purpose of providing health care services for areas of the Commonwealth containing a medically underserved population as defined by 42 U.S.C. § 254 c (b) (3).

6. Special equipment installed on a motor vehicle when purchased by a handicapped person to enable such person to operate the motor vehicle.

7. Ending July 1, 2003, tangible nonmedical personal property purchased by a nonprofit organization organized exclusively for the purpose of providing housing and ancillary assistance for individuals suffering from leukemia or oncological diseases, for other ill individuals, and for the families of such individuals during periods of medical treatment of such individuals at any hospital in the Commonwealth.

8. Ending July 1, 2003, tangible personal property purchased by a voluntary health organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized exclusively for the purpose of providing direct therapeutic and rehabilitative services, such as speech therapy, physical therapy, and camping and recreational activities, to the children and adults of ~~this~~*the* Commonwealth regardless of the nature of their disease or socioeconomic position.

9. Special typewriters and computers and related parts and supplies specifically designed for those products used by handicapped persons to communicate when such equipment is prescribed by a licensed physician.

10. Ending July 1, 2003, tangible personal property purchased for use or consumption by health maintenance organizations licensed under Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 ~~which~~*that* are exempt from taxation under § 501 (c) (3) of the Internal Revenue Code.

11. Ending July 1, 2003, tangible personal property for use or consumption by a nonprofit, nonstock corporation ~~which~~*that* is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and ~~which~~*that* is organized under the laws of the Commonwealth exclusively for the purpose of conducting a clinic furnishing free health care services by licensed physicians and dentists.

12. Ending July 1, 2003, tangible personal property purchased for use or consumption by any nonprofit hospital, cooperative or nonprofit hospital corporation organized and operated for the sole purpose of providing services exclusively to nonprofit hospitals. This exemption shall not apply to any nonprofit hospital, cooperative or nonprofit hospital corporation providing services of any kind or to any extent to other than nonprofit hospitals.

13. From July 1, 1989, through June 30, 2001, tangible personal property purchased for use or consumption by a nonprofit high blood pressure center ~~which~~*that* is used exclusively to provide medical assistance to indigent persons diagnosed with hypertension.

14. Beginning July 1, 1989, and ending July 1, 2003, tangible personal property purchased for use or consumption by a tissue bank exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established for purposes of procuring, preserving, processing, allocating or distributing bones, organs, blood, skin and other human tissue to licensed physicians for clinical use.

15. a. Beginning July 1, 1998, (i) any nonprescription drugs and proprietary medicines purchased for the cure, mitigation, treatment, or prevention of disease in human beings and (ii) any samples of nonprescription drugs and proprietary medicines distributed free of charge by the manufacturer, including packaging materials and constituent elements and ingredients.

b. The terms "nonprescription drugs" and "proprietary medicines" shall be defined pursuant to regulations promulgated by the Department of Taxation. The exemption authorized in this subdivision shall not apply to cosmetics.

16. Beginning July 1, 1994, and ending July 1, 2003, tangible personal property purchased for use or consumption or sold by a volunteer medical services organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to provide reconstructive surgery and related health care to indigent children and young adults in developing countries and the United States.

17. Beginning July 1, 1995, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized exclusively for educational, scientific, and charitable purposes relating to the promotion of health within the boundaries of the Eighth Planning District established pursuant to § 15.2-4203, including (i) operating a medical clinic which shall provide services without charge or shall charge less than prevailing rates to those who are unable to obtain health care through conventional means and (ii) educating and providing information to the general public regarding the treatment and prevention of those conditions which commonly affect the poor.

18. Beginning July 1, 1995, and ending July 1, 2003, equipment and supplies purchased for use or consumption by a nonprofit charitable organization ~~which~~*that* is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and ~~which~~*that* is organized and operated exclusively for the purpose of

providing charitable, long-distance, advanced life-support, air ambulance services for low-income medical patients in the Commonwealth.

19. From July 1, 1995, through June 30, 2001, tangible personal property purchased for use or consumption by a nonprofit organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code, organized exclusively to provide medical and psychological evaluations and direct therapeutic and rehabilitative medical and psychological treatment and services to child-abuse victims within the boundaries of the Twenty-third Planning District established pursuant to § 15.2-4203.

20. Ending July 1, 2003, medical products and supplies, which are otherwise taxable, such as bandages, gauze dressings, incontinence products and wound-care products, when purchased by a Medicaid recipient through a Department of Medical Assistance Services provider agreement.

21. From July 1, 1995, through June 30, 2001, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to provide a comprehensive network of medical and psycho-social treatment to adults, on both an inpatient and outpatient basis, or to adolescent patients in a residential setting, within the boundaries of the Fifteenth Planning District established pursuant to § 15.2-4203.

22. Beginning July 1, 1996, and ending July 1, 2003, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized and operated primarily to benefit a medical college affiliated with a state university by providing support services to and conducting the professional practices of faculty members associated with such medical college.

23. Beginning July 1, 1997, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established at the initiative of the General Assembly and its ~~Joint~~ Commission on *Youth, Family Services, and* Health Care to increase access to primary and preventive health care for Virginia's uninsured and medically underserved citizens.

24. Beginning July 1, 1997, and ending July 1, 2003, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to coordinate and facilitate the delivery of health care services to the children, aged birth to ~~six~~ *6* years, of families whose incomes fall below the federal poverty level.

25. Beginning July 1, 1997, and ending July 1, 2003, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized and operated to initiate, promote, assist, develop, maintain, and conduct, directly or indirectly, studies, investigations and research relating to the treatment and prevention of birth defects.

26. Beginning July 1, 1997, and ending July 1, 2003, tangible personal property purchased for use or consumption by a foundation exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to promote quality health care and health care education in the Roanoke Valley by promoting health care research, providing health care education, and establishing scholarships for needy and deserving students who are pursuing health care careers.

27. Beginning July 1, 1997, and ending July 1, 2003, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to provide dental services within the boundaries of the Eighth Planning District established pursuant to § 15.2-4203 at reduced rates to the indigent by dentists and dental hygienists who volunteer their time.

28. Beginning July 1, 1995, and ending July 1, 2003, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to provide patient, family and community education programs about cancer as well as free community cancer screenings and to acquire, own and operate an out-patient medical facility for the provision of radiation therapy services to cancer patients.

29. Beginning July 1, 1998, and ending July 1, 2003, tangible personal property purchased for use or consumption by an organization exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and established to provide support and assistance to primary and secondary victims of Alzheimer's disease, their families, friends and communities; to facilitate community education of the disease; and to support research into its prevention.

30. Beginning July 1, 1998, and ending July 1, 2003, tangible personal property purchased for use or consumption by a corporation exempt from taxation under § 501 (c) (3) of the Internal Revenue Code ~~which~~*that* is organized exclusively to provide breast cancer support and outreach for the medically underserved, including free mammography programs.

31. Beginning July 1, 1998, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation organized under the laws of the Commonwealth ~~which~~*that* is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized for the purposes of developing a coordinated citizens' voluntary movement to work toward improved care and treatment of persons affected with kidney disease, and improving methods and services in research, prevention,

detection, diagnosis and treatment of kidney disease and disorders.

32. Beginning July 1, 2000, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation which is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to address the nationwide shortage of transplantable organs by promoting an increase in organ and tissue donation through campaigns in national print and broadcast media and community-based programs designed to educate the public about the virtues and benefits of organ and tissue donation.

33. Beginning July 1, 2000, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation ~~which~~*that* is exempt from federal income taxation pursuant to § 501 (c) (3) of the Internal Revenue Code and organized to provide medical services to individuals, regardless of economic status, with speech, hearing and language disorders, including such services as, but not limited to, evaluation, diagnosis and treatment.

34. Beginning July 1, 2000, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation located within the boundaries of the Twenty-Third District established pursuant to § 15.2-4203, exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to provide support services to terminally ill persons and their caregivers, including but not limited to, cancer information, bereavement care, transportation assistance, and time out for family members.

35. Beginning July 1, 2000, and ending July 1, 2003, tangible personal property purchased for use or consumption by a corporation exempt from taxation under § 501 (c) (3) of the Internal Revenue Code ~~which~~*that* is located within the boundaries of the Eighth Planning District established pursuant to § 15.2-4203 and organized to provide housing facilities and services specially designed to meet the physical, social and employment needs of the physically disabled and to promote their health, security and happiness in an effort to assist them in achieving social and economic self-sufficiency.

36. Effective retroactive to August 1, 1995, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit organization which is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to (i) foster the faith of students in healthcare graduate studies on the campus of the Medical College of Virginia, (ii) encourage and develop medical missions overseas, (iii) promote and support volunteer services in medical and dental care for the needy and homeless, and (iv) discourage out-of-wedlock teenage sexual activity.

37. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to improve health care in Grenada by (i) offering continuing medical and nursing education, (ii) providing medical supplies and equipment, and (iii) using donated funds and services of volunteer groups, professionals and corporations.

38. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to (i) make quality hospice care available to persons with life threatening illnesses, their families and those affected by death and dying, (ii) advocate effectively for patient comfort, dignity and choice, and (iii) be recognized as a leading resource in clinical, ethical, and spiritual issues of dying and grief.

39. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to improve the recovery and quality of life for survivors of brain injury and their families by providing outreach to more than 10,000 families annually in the form of information and referral assistance.

40. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to provide physical, psychological, social and spiritual care for terminally ill persons and their families.

41. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to (i) provide comprehensive reproductive and complementary health care services in settings that preserve and protect the essential privacy and rights of each individual, (ii) advocate public policies that guarantee these rights and ensure access to such services, and (iii) provide educational programs that enhance understanding of individual and societal implications of human sexuality.

42. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to support the charitable, scientific, and educational activities of a hospital by providing a comprehensive range of high quality health care services.

43. Beginning July 1, 2001, and ending July 1, 2003, tangible personal property purchased for use or consumption by a nonprofit corporation that is exempt from taxation under § 501 (c) (3) of the Internal Revenue Code and organized to identify and support innovative and creative health and quality of life improvements throughout the community in which it is located and in surrounding communities.

44. Beginning July 1, 2001, and ending July 1, 2002, tangible personal property purchased for use or consumption by a nonprofit organization exempt from federal income taxation pursuant to § 501 (c) (3) of the Internal Revenue Code and organized to improve access to primary health care for all Virginians by, including but not limited to, providing technical assistance to communities in developing not-for-profit primary care medical practices.

2. That the third enactment of Chapter 891 of the Acts of Assembly of 1998 is amended as follows:

3. That the Commissioner of the Department of Health shall report annually to the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care the status of this legislation, including, but not limited to (i) the criteria developed by which managed care health insurance plans are reviewed and evaluated; (ii) the number of quality assurance certificates issued by the Department; (iii) the number of quality assurance certificates denied by the Department and the reasons for the ~~denial~~*denials* ; (iv) the status of the periodic reviews for complaint investigations and compliance with the quality of care certificate standards established by this bill; and (v) the number and amount of civil penalties which were imposed during that year for noncompliance.

3. That the second enactment of Chapter 924 of the Acts of Assembly of 2000 is amended as follows:

2. That the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care shall, with the full cooperation of the Medical Society of Virginia, the Old Dominion Medical Society, the Board of Medicine, the Board of Nursing, and nurse practitioner associations, study nurse practitioner prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules III through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment. A preliminary report on this study shall be provided by the Commission to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by July 1, 2003. The Commission shall complete its work in time to submit its written findings and recommendations to ~~the Governor and~~ *the* 2004 General Assembly *and the Governor* as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

4. That the third enactments of Chapter 244 and Chapter 251 of the Acts of Assembly of 2001 is amended as follows:

3. That the Board of Nursing shall report annually to the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care on the number of people who utilized the provisions of subdivision 10 of § 54.1-3001 to practice nursing in the Commonwealth in the preceding year, and the number of those people who passed the licensing examination and remained eligible to practice nursing in the Commonwealth.

5. That the second enactment of Chapter 465 of the Acts of Assembly of 2001 is amended as follows:

2. That the ~~Joint~~ Commission on *Youth, Family Services, and* Health Care shall, with the full cooperation of the Medical Society of Virginia, the Old Dominion Medical Society, the Board of Medicine, the Board of Pharmacy, and physician assistant professional associations, study physician assistant prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules IV through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with physician assistant treatment. A preliminary report on this study shall be provided by the ~~Joint~~ Commission to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by July 1, 2004. The ~~Joint~~ Commission shall complete its work in time to submit its written findings and recommendations to the ~~Governor and~~ 2005 General Assembly *and the Governor* as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

6. That Chapters 17 (§§ 30-165, 30-166, and 30-167), 18 (§§ 30-168, 30-169, and 30-170), and 20 (§§ 30-174 through 30-177) of Title 30 of the Code of Virginia are repealed.

7. That whenever any reference is made in law or other provision approved by the General Assembly to the former Virginia Commission on Youth, the Joint Commission on Health Care, or the Joint Commission on Behavioral Health Care, such reference shall be construed to apply mutatis mutandis to the Commission on Youth, Family Services, and Health Care.