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HOUSE BILL NO. 345

Offered January 13, 2010

Prefiled January 11, 2010

A BILL to amend and reenact §§ 2.2-213.1, 2.2-511, 2.2-617, 2.2-2648, 2.2-2649, 2.2-3705.6, 2.2-4002, 2.2-4025, 2.2-4345, 19.2-389, 20-49.8, 20-88.02, 20-108.2, 22.1-274.02, 23-38.93, 23-50.16, 23-77.3, 24.2-411.2, 26-17.4, 32.1-27.1, 32.1-111.2, 32.1-111.6:1, 32.1-122.07, 32.1-123, 32.1-127, 32.1-127.01, 32.1-132, 32.1-137, 32.1-138, 32.1-138.2, 32.1-138.3, 32.1-162.8, 32.1-276.4, 32.1-276.5:1, 32.1-323.1, 32.1-325 through 32.1-325.2, 32.1-326.1 through 32.1-327, 32.1-330.1, 32.1-330.3, 32.1-331.12, 32.1-331.13, 32.1-346, 32.1-347, 32.1-351, 32.1-353.2, 32.1-353.3, 32.1-366, 32.1-367, 32.1-369, 37.2-837, 37.2-1024, 38.2-226.2, 38.2-508.3, 38.2-1318, 38.2-2201, 38.2-3405.1, 38.2-3407.12, 38.2-3407.15, 38.2-3408, 38.2-3430.2, 38.2-3431, 38.2-3541, 38.2-4300, 38.2-4306, 38.2-4319, 38.2-4320, 38.2-4320.1, 38.2-5009, 38.2-5509, 38.2-5803, 38.2-5804, 38.2-6007, 54.1-2523, 54.1-2709.2, 54.1-2910.1, 54.1-3411.1, 55-19.5, 58.1-609.10, 63.2-608, 63.2-616, 63.2-1606, 63.2-1805, 63.2-1900, 63.2-1905, 63.2-1954.1, 63.2-2200, 63.2-2201, and 65.2-101 of the Code of Virginia and to repeal § 32.1-323.2 of the Code of Virginia, relating to withdrawing from the Medicaid program.

Patron—Marshall, R.G.

Referred to Committee on Appropriations

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-213.1, 2.2-511, 2.2-617, 2.2-2648, 2.2-2649, 2.2-3705.6, 2.2-4002, 2.2-4025, 2.2-4345, 19.2-389, 20-49.8, 20-88.02, 20-108.2, 22.1-274.02, 23-38.93, 23-50.16, 23-77.3, 24.2-411.2, 26-17.4, 32.1-27.1, 32.1-111.2, 32.1-111.6:1, 32.1-122.07, 32.1-123, 32.1-127, 32.1-127.01, 32.1-132, 32.1-137, 32.1-138, 32.1-138.2, 32.1-138.3, 32.1-162.8, 32.1-276.4, 32.1-276.5:1, 32.1-323.1, 32.1-325 through 32.1-325.2, 32.1-326.1 through 32.1-327, 32.1-330.1, 32.1-330.3, 32.1-331.12, 32.1-331.13, 32.1-346, 32.1-347, 32.1-351, 32.1-353.2, 32.1-353.3, 32.1-366, 32.1-367, 32.1-369, 37.2-837, 37.2-1024, 38.2-226.2, 38.2-508.3, 38.2-1318, 38.2-2201, 38.2-3405.1, 38.2-3407.12, 38.2-3407.15, 38.2-3408, 38.2-3430.2, 38.2-3431, 38.2-3541, 38.2-4300, 38.2-4306, 38.2-4319, 38.2-4320, 38.2-4320.1, 38.2-5009, 38.2-5509, 38.2-5803, 38.2-5804, 38.2-6007, 54.1-2523, 54.1-2709.2, 54.1-2910.1, 54.1-3411.1, 55-19.5, 58.1-609.10, 63.2-608, 63.2-616, 63.2-1606, 63.2-1805, 63.2-1900, 63.2-1905, 63.2-1954.1, 63.2-2200, 63.2-2201, and 65.2-101 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-213.1. Secretary of Health and Human Resources and Commissioner of Insurance to develop long-term care public information campaign.

A. In order to respond to the burgeoning population of seniors in the Commonwealth, the Secretary of Health and Human Resources and the Commissioner of Insurance shall develop a public information campaign to inform the citizens of the Commonwealth of (i) the impending crisis in long-term care, (ii) ~~the effect of the impending crisis on the Virginia Medicaid program and on the finances of families and their estates,~~ ~~(iii)~~ innovative alternatives and combinations of institutional and community-based long-term care services, and ~~(iv)~~ *(iii)* the requirements for long-term care insurance certificates and policies and the meaning of terminology used in such certificates and policies.

B. The Secretary of Health and Human Resources and the Commissioner of Insurance shall enlist the assistance of the Board of Health and the Commissioner of Health, in the exercise of their responsibilities set forth in Title 32.1 to protect, implement, and preserve the public health, in disseminating the information concerning long-term care to the public.

§ 2.2-511. Criminal cases.

A. Unless specifically requested by the Governor to do so, the Attorney General shall have no authority to institute or conduct criminal prosecutions in the circuit courts of the Commonwealth except in cases involving (i) violations of the Alcoholic Beverage Control Act (§ 4.1-100 et seq.), (ii) violation of laws relating to elections and the electoral process as provided in § 24.2-104, (iii) violation of laws relating to motor vehicles and their operation, (iv) the handling of funds by a state bureau, institution, commission or department, (v) the theft of state property, (vi) violation of the criminal laws involving child pornography and sexually explicit visual material involving children, (vii) the practice of law without being duly authorized or licensed or the illegal practice of law, (viii) violations of § 3.2-4212 or 58.1-1008.2, (ix) with the concurrence of the local attorney for the Commonwealth, violations of the Virginia Computer Crimes Act (§ 18.2-152.1 et seq.), (x) with the concurrence of the local attorney for the Commonwealth, violations of the Air Pollution Control Law (§ 10.1-1300 et seq.), the Virginia Waste Management Act (§ 10.1-1400 et seq.), and the State Water Control Law (§ 62.1-44.2 et seq.),

(xi) with the concurrence of the local attorney for the Commonwealth, violations of Chapters 2 (§ 18.2-18 et seq.), 3 (§ 18.2-22 et seq.), and 10 (§ 18.2-434 et seq.) of Title 18.2, if such crimes relate to violations of law listed in clause (x) of this subsection, (xii) with the concurrence of the local attorney for the Commonwealth, criminal violations by ~~Medicaid~~ *medical assistance* providers or their employees in the course of doing business, or violations of Chapter 13 (§ 18.2-512 et seq.) of Title 18.2, in which cases the Attorney General may leave the prosecution to the local attorney for the Commonwealth, or he may institute proceedings by information, presentment or indictment, as appropriate, and conduct the same, (xiii) with the concurrence of the local attorney for the Commonwealth, violations of Article 9 (§ 18.2-246.1 et seq.) of Chapter 6 of Title 18.2, (xiv) with the concurrence of the local attorney for the Commonwealth, assisting in the prosecution of violations of §§ 18.2-186.3 and 18.2-186.4, (xv) with the concurrence of the local attorney for the Commonwealth, assisting in the prosecution of violations of § 18.2-46.2, 18.2-46.3, or 18.2-46.5 when such violations are committed on the grounds of a state correctional facility, and (xvi) with the concurrence of the local attorney for the Commonwealth, assisting in the prosecution of violations of Article 10 (§ 18.2-246.6 et seq.) of Chapter 6 of Title 18.2.

In all other criminal cases in the circuit courts, except where the law provides otherwise, the authority of the Attorney General to appear or participate in the proceedings shall not attach unless and until a petition for appeal has been granted by the Court of Appeals or a writ of error has been granted by the Supreme Court. In all criminal cases before the Court of Appeals or the Supreme Court in which the Commonwealth is a party or is directly interested, the Attorney General shall appear and represent the Commonwealth. In any criminal case in which a petition for appeal has been granted by the Court of Appeals, the Attorney General shall continue to represent the Commonwealth in any further appeal of a case from the Court of Appeals to the Supreme Court.

B. The Attorney General shall, upon request of a person who was the victim of a crime and subject to such reasonable procedures as the Attorney General may require, ensure that such person is given notice of the filing, of the date, time and place and of the disposition of any appeal or habeas corpus proceeding involving the cases in which such person was a victim. For the purposes of this section, a victim is an individual who has suffered physical, psychological or economic harm as a direct result of the commission of a crime; a spouse, child, parent or legal guardian of a minor or incapacitated victim; or a spouse, child, parent or legal guardian of a victim of a homicide. Nothing in this subsection shall confer upon any person a right to appeal or modify any decision in a criminal, appellate or habeas corpus proceeding; abridge any right guaranteed by law; or create any cause of action for damages against the Commonwealth or any of its political subdivisions, the Attorney General or any of his employees or agents, any other officer, employee or agent of the Commonwealth or any of its political subdivisions, or any officer of the court.

§ 2.2-617. Definitions.

As used in this chapter, unless the context requires otherwise:

"Federal statute" means a federal statute that is in accord with the United States Constitution imposing mandates on state or local governments, which may include, but is not limited to, the following:

1. The Safe Drinking Water Act, 42 U.S.C. § 300f, et seq., as amended;
2. The Clean Air Act, 42 U.S.C. § 7401, et seq., as amended;
3. The Federal Water Pollution Control Act, 33 U.S.C. § 1251, et seq., as amended;
4. The Solid Waste Disposal Act, 42 U.S.C. § 3251, et seq., as amended;
5. The Resource Conservation and Recovery Act of 1976, 42 U.S.C. § 6901, et seq., as amended;
6. The Comprehensive Environmental Response, Compensation, and Liability Act of 1980, 42 U.S.C. § 9601, et seq., as amended;
7. The Superfund Amendments and Reauthorization Act of 1986, P.L. 99-499, as amended;
8. The Endangered Species Act of 1973, 16 U.S.C. § 1531, et seq., as amended;
9. The Asbestos School Hazard Abatement Statute, 20 U.S.C. § 4011, et seq., as amended;
10. The Brady Handgun Violence Prevention Act of 1993, P.L. 101-336, as amended;
11. The Commercial Motor Vehicle Safety Act of 1986, 49 U.S.C. § 2501, et seq., as amended;
12. The Family and Medical Leave Act of 1993, P.L. 103-3, as amended;
13. The Emergency Planning and Community Right-to-Know Act, P.L. 99-145 and 99-499, as amended;
14. The Federal, State, and Local Partnership for Education Improvement Program, 20 U.S.C. § 1751, et seq., as amended;
15. The National Voter Registration Act of 1993, P.L. 103-31, as amended;
16. The Federal School Lunch Program and School Breakfast Program, 42 U.S.C. §§ 1751 and 1773, P.L. 101-336, as amended;
17. ~~The Federal Social Services and Medicaid Requirements, 42 U.S.C. § 1396, et seq., as amended;~~
~~18~~*17*. The Federal Highway Safety Programs; and

~~19~~*18*. The Intermodal Surface Transportation Efficiency Act of 1991, P.L. 102-240, as amended.

§ 2.2-2648. State Executive Council for Comprehensive Services for At-Risk Youth and Families; membership; meetings; powers and duties.

A. The State Executive Council for Comprehensive Services for At-Risk Youth and Families (the Council) is established as a supervisory council, within the meaning of § 2.2-2100, in the executive branch of state government.

B. The Council shall consist of one member of the House of Delegates to be appointed by the Speaker of the House and one member of the Senate to be appointed by the Senate Committee on Rules; the Commissioners of Health, of Behavioral Health and Developmental Services, and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Juvenile Justice; the Director of the Department of Medical Assistance Services; the Governor's Special Advisor on Children's Services, to serve as an ex officio non-voting member; the chairman of the state and local advisory team established pursuant to § 2.2-5202; three local government representatives to include a member of a county board of supervisors or a city council and a county administrator or city manager, to be appointed by the Governor; one public provider, to be appointed by the Governor; two private provider representatives from facilities that maintain membership in an association of providers for children's or family services and receives funding as authorized by the Comprehensive Services Act (§ 2.2-5200 et seq.), to be appointed by the Governor, who may appoint from nominees recommended by the Virginia Coalition of Private Provider Associations; and a parent representative. The parent representative shall be appointed by the Governor for a term not to exceed three years and shall not be an employee of any public or private program that serves children and families. The Governor's appointments shall be for a term not to exceed three years and shall be limited to no more than two consecutive terms, beginning with appointments after July 1, 2009. Appointments of legislative members shall be for terms coincident with their terms of office. Legislative members shall not be included for the purposes of constituting a quorum.

C. The Council shall be chaired by the Secretary of Health and Human Resources or a designated deputy who shall be responsible for convening the council. The Council shall meet, at a minimum, quarterly, to oversee the administration of this article and make such decisions as may be necessary to carry out its purposes. Legislative members shall receive compensation as provided in § 30-19.12 and nonlegislative citizen members shall receive compensation for their services as provided in §§ 2.2-2813 and 2.2-2825.

D. The Council shall have the following powers and duties:

1. Hire and supervise a director of the Office of Comprehensive Services for At-Risk Youth and Families;

2. Appoint the members of the state and local advisory team in accordance with the requirements of § 2.2-5201;

3. Provide for the establishment of interagency programmatic and fiscal policies developed by the Office of Comprehensive Services for At-Risk Youth and Families, which support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.), through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;

4. Provide for a public participation process for programmatic and fiscal guidelines and dispute resolution procedures developed for administrative actions that support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.). The public participation process shall include, at a minimum, 60 days of public comment and the distribution of these guidelines and procedures to all interested parties;

5. Oversee the administration of and consult with the Virginia Municipal League and the Virginia Association of Counties about state policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

6. Provide for the administration of necessary functions that support the work of the Office of Comprehensive Services for At-Risk Youth and Families;

7. Review and take appropriate action on issues brought before it by the Office of Comprehensive Services for At-Risk Youth and Families, Community Policy and Management Teams (CPMTs), local governments, providers and parents;

8. Advise the Governor and appropriate Cabinet Secretaries on proposed policy and operational changes that facilitate interagency service development and implementation, communication and cooperation;

9. Provide administrative support and fiscal incentives for the establishment and operation of local comprehensive service systems;

10. Oversee coordination of early intervention programs to promote comprehensive, coordinated service delivery, local interagency program management, and co-location of programs and services in communities. Early intervention programs include state programs under the administrative control of the

state executive council member agencies;

11. Oversee the development and implementation of a mandatory uniform assessment instrument and process to be used by all localities to identify levels of risk of Comprehensive Services Act (CSA) youth;

12. Oversee the development and implementation of uniform guidelines to include initial intake and screening assessment, development and implementation of a plan of care, service monitoring and periodic follow-up, and the formal review of the status of the youth and the family;

13. Oversee the development and implementation of uniform guidelines for documentation for CSA-funded services;

14. Review and approve a request by a CPMT to establish a collaborative, multidisciplinary team process for referral and reviews of children and families pursuant to § 2.2-5209;

15. Oversee the development and implementation of mandatory uniform guidelines for utilization management; each locality receiving funds for activities under the Comprehensive Services Act shall have a locally determined utilization management plan following the guidelines or use of a process approved by the Council for utilization management, covering all CSA-funded services;

16. Oversee the development and implementation of uniform data collection standards and the collection of data, utilizing a secure electronic client-specific database for CSA-funded services, which shall include, but not be limited to, the following client specific information: (i) children served, including those placed out of state; (ii) individual characteristics of youths and families being served; (iii) types of services provided; (iv) service utilization including length of stay; (v) service expenditures; (vi) provider identification number for specific facilities and programs identified by the state in which the child receives services; (vii) a data field indicating the circumstances under which the child ends each service; and (viii) a data field indicating the circumstances under which the child exits the Comprehensive Services Act program. All client-specific information shall remain confidential and only non-identifying aggregate demographic, service, and expenditure information shall be made available to the public;

17. Oversee the development and implementation of a uniform set of performance measures for evaluating the Comprehensive Services Act program, including, but not limited to, the number of youths served in their homes, schools and communities. Performance measures shall be based on information: (i) collected in the client-specific database referenced in subdivision 16, (ii) from the mandatory uniform assessment instrument referenced in subdivision 11, and (iii) from available and appropriate client outcome data that is not prohibited from being shared under federal law and is routinely collected by the state child-serving agencies that serve on the Council. If provided client-specific information, state child serving agencies shall report available and appropriate outcome data in clause (iii) to the Office of Comprehensive Services for At-Risk Youth and Families. Outcome data submitted to the Office of Comprehensive Services for At-Risk Youth and Families shall be used solely for the administration of the Comprehensive Services Act program. Applicable client outcome data shall include, but not be limited to: (a) permanency outcomes by the Virginia Department of Social Services, (b) recidivism outcomes by the Virginia Department of Juvenile Justice, and (c) educational outcomes by the Virginia Department of Education. All client-specific information shall remain confidential and only non-identifying aggregate outcome information shall be made available to the public;

18. Oversee the development and distribution of management reports that provide information to the public and CPMTs to help evaluate child and family outcomes and public and private provider performance in the provision of services to children and families through the Comprehensive Services Act program. Management reports shall include total expenditures on children served through the Comprehensive Services Act program as reported to the Office of Comprehensive Services for At-Risk Youth and Families by state child-serving agencies on the Council and shall include, but not be limited to: (i) client-specific payments for inpatient and outpatient mental health services, treatment foster care services and residential services made through the ~~Medicaid~~ *medical assistance* program and reported by the Virginia Department of Medical Assistance Services and (ii) client-specific payments made through the Title IV-E foster care program reported by the Virginia Department of Social Services. The Office of Comprehensive Services shall provide client-specific information to the state agencies for the sole purpose of the administration of the Comprehensive Services Act program. All client-specific information shall remain confidential and only non-identifying aggregate demographic, service, expenditure, and outcome information shall be made available to the public;

19. Establish and oversee the operation of an informal review and negotiation process with the Director of the Office of Comprehensive Services and a formal dispute resolution procedure before the State Executive Council, which include formal notice and an appeals process, should the Director or Council find, upon a formal written finding, that a CPMT failed to comply with any provision of this Act. "Formal notice" means the Director or Council provides a letter of notification, which communicates the Director's or the Council's finding, explains the effect of the finding, and describes the appeal process, to the chief administrative officer of the local government with a copy to the chair of

the CPMT. The dispute resolution procedure shall also include provisions for remediation by the CPMT that shall include a plan of correction recommended by the Council and submitted to the CPMT. If the Council denies reimbursement from the state pool of funds, the Council and the locality shall develop a plan of repayment;

20. Deny state funding to a locality where the CPMT fails to provide services that comply with the Comprehensive Services Act (§ 2.2-5200 et seq.), in accordance with subdivision 19;

21. Biennially publish and disseminate to members of the General Assembly and community policy and management teams a state progress report on comprehensive services to children, youth and families and a plan for such services for the next succeeding biennium. The state plan shall:

a. Provide a fiscal profile of current and previous years' federal and state expenditures for a comprehensive service system for children, youth and families;

b. Incorporate information and recommendations from local comprehensive service systems with responsibility for planning and delivering services to children, youth and families;

c. Identify and establish goals for comprehensive services and the estimated costs of implementing these goals, report progress toward previously identified goals and establish priorities for the coming biennium;

d. Report and analyze expenditures associated with children who do not receive pool funding and have emotional and behavioral problems;

e. Identify funding streams used to purchase services in addition to pooled, ~~Medicaid~~ *medical assistance*, and Title IV-E funding; and

f. Include such other information or recommendations as may be necessary and appropriate for the improvement and coordinated development of the state's comprehensive services system; and

22. Oversee the development and implementation of mandatory uniform guidelines for intensive care coordination services for children who are at risk of entering, or are placed in, residential care through the Comprehensive Services Act program. The guidelines shall: (i) take into account differences among localities, (ii) specify children and circumstances appropriate for intensive care coordination services, (iii) define intensive care coordination services, and (iv) distinguish intensive care coordination services from the regular case management services provided within the normal scope of responsibility for the child-serving agencies, including the community services board, the local school division, local social services agency, court service unit, and Department of Juvenile Justice. Such guidelines shall address: (a) identifying the strengths and needs of the child and his family through conducting or reviewing comprehensive assessments including, but not limited to, information gathered through the mandatory uniform assessment instrument; (b) identifying specific services and supports necessary to meet the identified needs of the child and his family, building upon the identified strengths; (c) implementing a plan for returning the youth to his home, relative's home, family-like setting, or community at the earliest appropriate time that addresses his needs, including identification of public or private community-based services to support the youth and his family during transition to community-based care; and (d) implementing a plan for regular monitoring and utilization review of the services and residential placement for the child to determine whether the services and placement continue to provide the most appropriate and effective services for the child and his family.

§ 2.2-2649. Office of Comprehensive Services for At-Risk Youth and Families established; powers and duties.

A. The Office of Comprehensive Services for At-Risk Youth and Families is hereby established to serve as the administrative entity of the Council and to ensure that the decisions of the council are implemented. The director shall be hired by and subject to the direction and supervision of the Council pursuant to § 2.2-2648.

B. The director of the Office of Comprehensive Services for At-Risk Youth and Families shall:

1. Develop and recommend to the state executive council programs and fiscal policies that promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels;

2. Develop and recommend to the Council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

3. Develop and provide for the consistent oversight for program administration and compliance with state policies and procedures;

4. Provide for training and technical assistance to localities in the provision of efficient and effective services that are responsive to the strengths and needs of troubled and at-risk youths and their families;

5. Serve as liaison to the participating state agencies that administratively support the Office and that provide other necessary services;

6. Provide an informal review and negotiation process pursuant to subdivision D 19 of § 2.2-2648;

7. Implement, in collaboration with participating state agencies, policies, guidelines and procedures adopted by the State Executive Council;

8. Consult regularly with the Virginia Municipal League, the Virginia Coalition of Private Provider Associations, and the Virginia Association of Counties about implementation and operation of the Comprehensive Services Act (§ 2.2-5200 et seq.);

9. Hire appropriate staff as approved by the Council;

10. Identify, disseminate, and provide annual training for CSA staff and other interested parties on best practices and evidence-based practices related to the Comprehensive Services Program;

11. Perform such other duties as may be assigned by the State Executive Council;

12. Develop and implement uniform data collection standards and collect data, utilizing a secure electronic database for CSA-funded services, in accordance with subdivision D 16 of § 2.2-2648;

13. Develop and implement a uniform set of performance measures for the Comprehensive Services Act program in accordance with subdivision D 17 of § 2.2-2648;

14. Develop, implement, and distribute management reports in accordance with subdivision D 18 of § 2.2-2648;

15. Report to the Council all expenditures associated with serving children who receive pool-funded services. The report shall include expenditures for (i) all services purchased with pool funding; (ii) treatment, foster care case management, and residential care funded by ~~Medicaid~~ *medical assistance*; and (iii) child-specific payments made through the Title IV-E program;

16. Report to the Council on the nature and cost of all services provided to the population of at-risk and troubled children identified by the State Executive Council as within the scope of the CSA program;

17. Develop and distribute model job descriptions for the position of Comprehensive Services Act Coordinator and provide technical assistance to localities and their coordinators to help them to guide localities in prioritizing coordinator's responsibilities toward activities to maximize program effectiveness and minimize spending; and

18. Develop and distribute guidelines, approved by the State Executive Council, regarding the development and use of multidisciplinary teams, in order to encourage utilization of multidisciplinary teams in service planning and to reduce Family Assessment and Planning Team caseloads to allow Family Assessment and Planning Teams to devote additional time to more complex and potentially costly cases.

C. The director of the Office of Comprehensive Services, in order to provide support and assistance to the Comprehensive Policy and Management Teams (CPMTs) and Family Assessment and Planning Teams (FAPTs) established pursuant to the Comprehensive Services Act for At-Risk Youth and Families (§ 2.2-5200 et seq.), shall:

1. Develop and maintain a web-based statewide automated database, with support from the Department of Information Technology or its successor agency, of the authorized vendors of the Comprehensive Services Act (CSA) services to include verification of a vendor's licensure status, a listing of each discrete CSA service offered by the vendor, and the discrete CSA service's rate determined in accordance with § 2.2-5214; and

2. Develop, in consultation with the Department of General Services, CPMTs, and vendors, a standardized purchase of services contract, which in addition to general contract provisions when utilizing state pool funds will enable localities to specify the discrete service or services they are purchasing for the specified client, the required reporting of the client's service data, including types and numbers of disabilities, mental health and mental retardation diagnoses, or delinquent behaviors for which the purchased services are intended to address, the expected outcomes resulting from these services and the performance timeframes mutually agreed to when the services are purchased.

§ 2.2-3705.6. Exclusions to application of chapter; proprietary records and trade secrets.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Proprietary information gathered by or for the Virginia Port Authority as provided in § 62.1-132.4 or 62.1-134.1.

2. Financial statements not publicly available filed with applications for industrial development financings in accordance with Chapter 49 (§ 15.2-4900 et seq.) of Title 15.2.

3. Confidential proprietary records, voluntarily provided by private business pursuant to a promise of confidentiality from a public body, used by the public body for business, trade and tourism development or retention; and memoranda, working papers or other records related to businesses that are considering locating or expanding in Virginia, prepared by a public body, where competition or bargaining is involved and where, if such records are made public, the financial interest of the public body would be adversely affected.

4. Information that was filed as confidential under the Toxic Substances Information Act (§ 32.1-239 et seq.), as such Act existed prior to July 1, 1992.

5. Fisheries data that would permit identification of any person or vessel, except when required by court order as specified in § 28.2-204.

6. Confidential financial statements, balance sheets, trade secrets, and revenue and cost projections

provided to the Department of Rail and Public Transportation, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Surface Transportation Board or the Federal Railroad Administration with respect to data provided in confidence to the Surface Transportation Board and the Federal Railroad Administration.

7. Confidential proprietary records related to inventory and sales, voluntarily provided by private energy suppliers to the Department of Mines, Minerals and Energy, used by that Department for energy contingency planning purposes or for developing consolidated statistical information on energy supplies.

8. Confidential proprietary information furnished to the Board of Medical Assistance Services or the ~~Medicaid~~ *Medical Assistance* Prior Authorization Advisory Committee pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

9. Proprietary, commercial or financial information, balance sheets, trade secrets, and revenue and cost projections provided by a private transportation business to the Virginia Department of Transportation and the Department of Rail and Public Transportation for the purpose of conducting transportation studies needed to obtain grants or other financial assistance under the Transportation Equity Act for the 21st Century (P.L. 105-178) for transportation projects, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Surface Transportation Board or the Federal Railroad Administration with respect to data provided in confidence to the Surface Transportation Board and the Federal Railroad Administration. However, the exemption provided by this subdivision shall not apply to any wholly owned subsidiary of a public body.

10. Confidential information designated as provided in subsection F of § 2.2-4342 as trade secrets or proprietary information by any person who has submitted to a public body an application for prequalification to bid on public construction projects in accordance with subsection B of § 2.2-4317.

11. a. Memoranda, staff evaluations, or other records prepared by the responsible public entity, its staff, outside advisors, or consultants exclusively for the evaluation and negotiation of proposals filed under the Public-Private Transportation Act of 1995 (§ 56-556 et seq.) or the Public Private Education Facilities and Infrastructure Act of 2002 (§ 56-575.1 et seq.), where (i) if such records were made public prior to or after the execution of an interim or a comprehensive agreement, § 56-573.1:1 or 56-575.17 notwithstanding, the financial interest or bargaining position of the public entity would be adversely affected, and (ii) the basis for the determination required in clause (i) is documented in writing by the responsible public entity; and

b. Records provided by a private entity to a responsible public entity, affected jurisdiction, or affected local jurisdiction pursuant to the provisions of the Public-Private Transportation Act of 1995 or the Public-Private Education Facilities and Infrastructure Act of 2002, to the extent that such records contain (i) trade secrets of the private entity as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.); (ii) financial records of the private entity, including balance sheets and financial statements, that are not generally available to the public through regulatory disclosure or otherwise; or (iii) other information submitted by the private entity, where, if the records were made public prior to the execution of an interim agreement or a comprehensive agreement, the financial interest or bargaining position of the public or private entity would be adversely affected. In order for the records specified in clauses (i), (ii) and (iii) to be excluded from the provisions of this chapter, the private entity shall make a written request to the responsible public entity:

~~1.~~ *(1)* Invoking such exclusion upon submission of the data or other materials for which protection from disclosure is sought;

~~2.~~ *(2)* Identifying with specificity the data or other materials for which protection is sought; and

~~3.~~ *(3)* Stating the reasons why protection is necessary.

The responsible public entity shall determine whether the requested exclusion from disclosure is necessary to protect the trade secrets or financial records of the private entity. To protect other records submitted by the private entity from disclosure, the responsible public entity shall determine whether public disclosure prior to the execution of an interim agreement or a comprehensive agreement would adversely affect the financial interest or bargaining position of the public or private entity. The responsible public entity shall make a written determination of the nature and scope of the protection to be afforded by the responsible public entity under this subdivision. Once a written determination is made by the responsible public entity, the records afforded protection under this subdivision shall continue to be protected from disclosure when in the possession of any affected jurisdiction or affected local jurisdiction.

Except as specifically provided in subdivision 11 a, nothing in this subdivision shall be construed to authorize the withholding of (a) procurement records as required by § 56-573.1:1 or 56-575.17; (b) information concerning the terms and conditions of any interim or comprehensive agreement, service contract, lease, partnership, or any agreement of any kind entered into by the responsible public entity

and the private entity; (c) information concerning the terms and conditions of any financing arrangement that involves the use of any public funds; or (d) information concerning the performance of any private entity developing or operating a qualifying transportation facility or a qualifying project.

For the purposes of this subdivision, the terms "affected jurisdiction," "affected local jurisdiction," "comprehensive agreement," "interim agreement," "qualifying project," "qualifying transportation facility," "responsible public entity," and "private entity" shall mean the same as those terms are defined in the Public-Private Transportation Act of 1995 or in the Public-Private Education Facilities and Infrastructure Act of 2002.

12. Confidential proprietary information or trade secrets, not publicly available, provided by a private person or entity to the Virginia Resources Authority or to a fund administered in connection with financial assistance rendered or to be rendered by the Virginia Resources Authority where, if such information were made public, the financial interest of the private person or entity would be adversely affected, and, after June 30, 1997, where such information was provided pursuant to a promise of confidentiality.

13. Trade secrets, as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.), or confidential proprietary records that are not generally available to the public through regulatory disclosure or otherwise, provided by a (a) bidder or applicant for a franchise or (b) franchisee under Chapter 21 (§ 15.2-2100 et seq.) of Title 15.2 to the applicable franchising authority pursuant to a promise of confidentiality from the franchising authority, to the extent the records relate to the bidder's, applicant's, or franchisee's financial capacity or provision of new services, adoption of new technologies or implementation of improvements, where such new services, technologies or improvements have not been implemented by the franchisee on a nonexperimental scale in the franchise area, and where, if such records were made public, the competitive advantage or financial interests of the franchisee would be adversely affected.

In order for trade secrets or confidential proprietary information to be excluded from the provisions of this chapter, the bidder, applicant, or franchisee shall (i) invoke such exclusion upon submission of the data or other materials for which protection from disclosure is sought, (ii) identify the data or other materials for which protection is sought, and (iii) state the reason why protection is necessary.

No bidder, applicant, or franchisee may invoke the exclusion provided by this subdivision if the bidder, applicant, or franchisee is owned or controlled by a public body or if any representative of the applicable franchising authority serves on the management board or as an officer of the bidder, applicant, or franchisee.

14. Documents and other information of a proprietary nature furnished by a supplier of charitable gaming supplies to the Department of Agriculture and Consumer Services pursuant to subsection E of § 18.2-340.34.

15. Records and reports related to Virginia apple producer sales provided to the Virginia State Apple Board pursuant to § 3.2-1215.

16. Trade secrets, as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.) of Title 59.1, submitted by CMRS providers as defined in § 56-484.12 to the Wireless Carrier E-911 Cost Recovery Subcommittee created pursuant to § 56-484.15, relating to the provision of wireless E-911 service.

17. Records submitted as a grant or loan application, or accompanying a grant or loan application, to the Innovation and Entrepreneurship Investment Authority pursuant to Article 3 (§ 2.2-2233.1 et seq.) of Chapter 22 of Title 2.2 or to the Commonwealth Health Research Board pursuant to Chapter 22 (§ 23-277 et seq.) of Title 23 to the extent such records contain proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical, technological, or scholarly issues, when such information has not been publicly released, published, copyrighted, or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

18. Confidential proprietary records and trade secrets developed and held by a local public body (i) providing telecommunication services pursuant to § 56-265.4:4 and (ii) providing cable television services pursuant to Article 1.1 (§ 15.2-2108.2 et seq.) of Chapter 21 of Title 15.2, to the extent that disclosure of such records would be harmful to the competitive position of the locality. In order for confidential proprietary information or trade secrets to be excluded from the provisions of this chapter, the locality in writing shall (i) invoke the protections of this subdivision, (ii) identify with specificity the records or portions thereof for which protection is sought, and (iii) state the reasons why protection is necessary.

19. Confidential proprietary records and trade secrets developed by or for a local authority created in accordance with the Virginia Wireless Service Authorities Act (§ 15.2-5431.1 et seq.) to provide qualifying communications services as authorized by Article 5.1 (§ 56-484.7:1 et seq.) of Chapter 15 of Title 56, where disclosure of such information would be harmful to the competitive position of the authority, except that records required to be maintained in accordance with § 15.2-2160 shall be released.

20. Trade secrets as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.) or financial records of a business, including balance sheets and financial statements, that are not generally available to the public through regulatory disclosure or otherwise, provided to the Department of Minority Business Enterprise as part of an application for (i) certification as a small, women-owned, or minority-owned business in accordance with Chapter 14 (§ 2.2-1400 et seq.) of this title or (ii) a claim made by a disadvantaged business or an economically disadvantaged individual against the Capital Access Fund for Disadvantaged Businesses created pursuant to § 2.2-2311. In order for such trade secrets or financial records to be excluded from the provisions of this chapter, the business shall (a) invoke such exclusion upon submission of the data or other materials for which protection from disclosure is sought, (b) identify the data or other materials for which protection is sought, and (c) state the reasons why protection is necessary.

21. Documents and other information of a proprietary or confidential nature disclosed by a carrier to the State Health Commissioner pursuant to § 32.1-276.5:1.

22. Trade secrets, as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.), including, but not limited to, financial records, including balance sheets and financial statements, that are not generally available to the public through regulatory disclosure or otherwise, and revenue and cost projections supplied by a private or nongovernmental entity to the Inspector General of the Virginia Department of Transportation for the purpose of an audit, special investigation, or any study requested by the Inspector General's Office in accordance with law.

In order for the records specified in this subdivision to be excluded from the provisions of this chapter, the private or nongovernmental entity shall make a written request to the Department:

~~1~~*a*. Invoking such exclusion upon submission of the data or other materials for which protection from disclosure is sought;

~~2~~*b*. Identifying with specificity the data or other materials for which protection is sought; and

~~3~~*c*. Stating the reasons why protection is necessary.

The Inspector General of the Virginia Department of Transportation shall determine whether the requested exclusion from disclosure is necessary to protect the trade secrets or financial records of the private entity. The Virginia Department of Transportation shall make a written determination of the nature and scope of the protection to be afforded by it under this subdivision.

§ 2.2-4002. Exemptions from chapter generally.

A. Although required to comply with § 2.2-4103 of the Virginia Register Act (§ 2.2-4100 et seq.), the following agencies shall be exempted from the provisions of this chapter, except to the extent that they are specifically made subject to §§ 2.2-4024, 2.2-4030 and 2.2-4031:

1. The General Assembly.

2. Courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

3. The Department of Game and Inland Fisheries in promulgating regulations regarding the management of wildlife and for all case decisions rendered pursuant to any provisions of Chapters 2 (§ 29.1-200 et seq.), 3 (§ 29.1-300 et seq.), 4 (§ 29.1-400 et seq.), 5 (§ 29.1-500 et seq.), and 7 (§ 29.1-700 et seq.) of Title 29.1.

4. The Virginia Housing Development Authority.

5. Municipal corporations, counties, and all local, regional or multijurisdictional authorities created under this Code, including those with federal authorities.

6. Educational institutions operated by the Commonwealth, provided that, with respect to § 2.2-4031, such educational institutions shall be exempt from the publication requirements only with respect to regulations that pertain to (i) their academic affairs, (ii) the selection, tenure, promotion and disciplining of faculty and employees, (iii) the selection of students, and (iv) rules of conduct and disciplining of students.

7. The Milk Commission in promulgating regulations regarding (i) producers' licenses and bases, (ii) classification and allocation of milk, computation of sales and shrinkage, and (iii) class prices for producers' milk, time and method of payment, butterfat testing and differential.

8. The Virginia Resources Authority.

9. Agencies expressly exempted by any other provision of this Code.

10. The Department of General Services in promulgating standards for the inspection of buildings for asbestos pursuant to § 2.2-1164.

11. The State Council of Higher Education for Virginia, in developing, issuing, and revising guidelines pursuant to § 23-9.6:2.

12. The Commissioner of Agriculture and Consumer Services in adopting regulations pursuant to subsection B of § 3.2-6002 and in adopting regulations pursuant to § 3.2-6023.

13. The Commissioner of Agriculture and Consumer Services and the Board of Agriculture and Consumer Services in promulgating regulations pursuant to subsections B and D of § 3.2-3601,

subsection B of § 3.2-3701, § 3.2-4002, subsections B and D of § 3.2-4801, §§ 3.2-5121 and 3.2-5206, and subsection A of § 3.2-5406.

14. The Board of Optometry when specifying therapeutic pharmaceutical agents, treatment guidelines, and diseases and abnormal conditions of the human eye and its adnexa for TPA-certification of optometrists pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of Title 54.1.

15. The Virginia War Memorial Foundation.

16. The Virginia ~~Medicaid~~ *Medical Assistance* Prior Authorization Advisory Committee in making recommendations to the Board of Medical Assistance Services regarding prior authorization for prescription drug coverage pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

17. The State Board of Education, in developing, issuing, and revising guidelines pursuant to § 22.1-203.2.

18. The Virginia Racing Commission, (i) when acting by and through its duly appointed stewards or in matters related to any specific race meeting or (ii) in promulgating technical rules regulating actual live horse racing at race meetings licensed by the Commission.

19. The Virginia Small Business Financing Authority.

20. The Virginia Economic Development Partnership Authority.

21. The Board of Agriculture and Consumer Services in adopting, amending or repealing regulations pursuant to subsection A (ii) of § 59.1-156.

22. The Insurance Continuing Education Board pursuant to § 38.2-1867.

23. The Board of Health in promulgating the list of diseases that shall be reported to the Department of Health pursuant to § 32.1-35 and in adopting, amending or repealing regulations pursuant to subsection C of § 35.1-14 that incorporate the Food and Drug Administration's Food Code pertaining to restaurants or food service.

24. The nonprofit, nonstock corporation established by the Commissioner of Agriculture and Consumer Services pursuant to subdivision B 5 of § 3.2-102.

25. (Expires December 31, 2010) The Secretary of Natural Resources in setting a date of closure for the Chesapeake Bay purse seine fishery for Atlantic menhaden for reduction purposes pursuant to § 28.2-1000.2.

26. The Board of Pharmacy when specifying special subject requirements for continuing education for pharmacists pursuant to § 54.1-3314.1.

B. Agency action relating to the following subjects shall be exempted from the provisions of this chapter:

1. Money or damage claims against the Commonwealth or agencies thereof.

2. The award or denial of state contracts, as well as decisions regarding compliance therewith.

3. The location, design, specifications or construction of public buildings or other facilities.

4. Grants of state or federal funds or property.

5. The chartering of corporations.

6. Customary military, naval or police functions.

7. The selection, tenure, dismissal, direction or control of any officer or employee of an agency of the Commonwealth.

8. The conduct of elections or eligibility to vote.

9. Inmates of prisons or other such facilities or parolees therefrom.

10. The custody of persons in, or sought to be placed in, mental, penal or other state institutions as well as the treatment, supervision, or discharge of such persons.

11. Traffic signs, markers or control devices.

12. Instructions for application or renewal of a license, certificate, or registration required by law.

13. Content of, or rules for the conduct of, any examination required by law.

14. The administration of pools authorized by Chapter 47 (§ 2.2-4700 et seq.) of this title.

15. Any rules for the conduct of specific lottery games, so long as such rules are not inconsistent with duly adopted regulations of the State Lottery Board, and provided that such regulations are published and posted.

16. Orders condemning or closing any shellfish, finfish, or crustacea growing area and the shellfish, finfish or crustacea located thereon pursuant to Article 2 (§ 28.2-803 et seq.) of Chapter 8 of Title 28.2.

17. Any operating procedures for review of child deaths developed by the State Child Fatality Review Team pursuant to § 32.1-283.1.

18. The regulations for the implementation of the Health Practitioners' Monitoring Program and the activities of the Health Practitioners' Monitoring Program Committee pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.

19. The process of reviewing and ranking grant applications submitted to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Chapter 3.1 (§ 51.5-12.1 et seq.) of Title 51.5.

20. Loans from the Small Business Environmental Compliance Assistance Fund pursuant to Article 4 (§ 10.1-1197.1 et seq.) of Chapter 11.1 of Title 10.1.

21. The Virginia Breeders Fund created pursuant to § 59.1-372.

22. The types of pari-mutuel wagering pools available for live or simulcast horse racing.

23. The administration of medication or other substances foreign to the natural horse.

C. Minor changes to regulations published in the Virginia Administrative Code under the Virginia Register Act, Chapter 41 (§ 2.2-4100 et seq.) of this title, made by the Virginia Code Commission pursuant to § 30-150, shall be exempt from the provisions of this chapter.

§ 2.2-4025. Exemptions operation of this article; limitations.

A. This article shall not apply to any agency action that (i) is placed beyond the control of the courts by constitutional or statutory provisions expressly precluding court review, (ii) involves solely the internal management or routine of an agency, (iii) is a decision resting entirely upon an inspection, test, or election save as to want of authority therefor or claim of arbitrariness or fraud therein, (iv) is a case in which the agency is acting as an agent for a court, or (v) encompasses matters subject by law to a trial de novo in any court.

B. The provisions of this article, however, shall apply to case decisions regarding the grant or denial of Temporary Assistance for Needy Families, ~~Medicaid~~ *medical assistance*, food stamps, general relief, auxiliary grants, or state-local hospitalization. However, no appeal may be brought regarding the adequacy of standards of need and payment levels for public assistance and social services programs. Notwithstanding the provisions of § 2.2-4027, the review shall be based solely upon the agency record, and the court shall be limited to ascertaining whether there was evidence in the agency record to support the case decision of the agency acting as the trier of fact. If the court finds in favor of the party complaining of agency action, the court shall remand the case to the agency for further proceedings. The validity of any statute, regulation, standard or policy, federal or state, upon which the action of the agency was based shall not be subject to review by the court. No intermediate relief shall be granted under § 2.2-4028.

§ 2.2-4345. Exemptions from competitive sealed bidding and competitive negotiation for certain transactions; limitations.

A. The following public bodies may enter into contracts without competitive sealed bidding or competitive negotiation:

1. ~~The Director of the Department of Medical Assistance Services for special services provided for eligible recipients pursuant to subsection H of § 32.1-325, provided that the Director has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public, or would constitute an imminent threat to the health or welfare of such recipients. The writing shall document the basis for this determination.~~

~~2.~~ The State Health Commissioner for the compilation, storage, analysis, evaluation, and publication of certain data submitted by health care providers and for the development of a methodology to measure the efficiency and productivity of health care providers pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1, if the Commissioner has made a determination in advance, after reasonable notice to the public and set forth in writing, that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public. The writing shall document the basis for this determination. Such agreements and contracts shall be based on competitive principles.

~~3~~*2*. The Virginia Code Commission when procuring the services of a publisher, pursuant to §§ 30-146 and 30-148, to publish the Code of Virginia or the Virginia Administrative Code.

4*3*. The Department of Alcoholic Beverage Control for the purchase of alcoholic beverages.

~~5~~*4*. The Department for the Aging, for the administration of elder rights programs, with (i) nonprofit Virginia corporations granted tax-exempt status under § 501(c)(3) of the Internal Revenue Code with statewide experience in Virginia in conducting a state long-term care ombudsman program or (ii) designated area agencies on aging.

~~6~~5. The Department of Health for (a) child restraint devices, pursuant to § 46.2-1097; (b) health care services with Virginia corporations granted tax-exempt status under § 501(c)(3) of the Internal Revenue Code and operating as clinics for the indigent and uninsured that are organized for the delivery of primary health care services in a community (i) as federally qualified health centers designated by the Health Care Financing Administration or (ii) at a reduced or sliding fee scale or without charge; or (c) contracts with laboratories providing cytology and related services if competitive sealed bidding and competitive negotiations are not fiscally advantageous to the public to provide quality control as prescribed in writing by the Commissioner of Health.

~~7~~*6*. Virginia Correctional Enterprises, when procuring materials, supplies, or services for use in and support of its production facilities, provided the procurement is accomplished using procedures that ensure as efficient use of funds as practicable and, at a minimum, includes obtaining telephone quotations. Such procedures shall require documentation of the basis for awarding contracts under this section.

~~8~~*7*. The Virginia Baseball Stadium Authority for the operation of any facilities developed under the provisions of Chapter 58 (§ 15.2-5800 et seq.) of Title 15.2, including contracts or agreements with respect to the sale of food, beverages and souvenirs at such facilities.

~~9~~*8*. With the consent of the Governor, the Jamestown-Yorktown Foundation for the promotion of tourism through marketing with private entities provided a demonstrable cost savings, as reviewed by the Secretary of Education, can be realized by the Foundation and such agreements or contracts are based on competitive principles.

~~10~~9. The Chesapeake Hospital Authority in the exercise of any power conferred under Chapter 271, as amended, of the Acts of Assembly of 1966; provided that it does not discriminate against any person on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, or disability in the procurement of goods and services.

~~11~~*10*. Richmond Eye and Ear Hospital Authority, any authorities created under Chapter 53 (§ 15.2-5300 et seq.) of Title 15.2 and any hospital or health center commission created under Chapter 52 (§ 15.2-5200 et seq.) of Title 15.2 in the exercise of any power conferred under their respective authorizing legislation; provided that these entities shall not discriminate against any person on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, or disability in the procurement of goods and services.

~~12~~*11*. The Patrick Hospital Authority sealed in the exercise of any power conferred under the Acts of Assembly of 2000; provided that it does not discriminate against any person on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, or disability in the procurement of goods and services.

~~13~~*12*. Public bodies for insurance or electric utility services if purchased through an association of which it is a member if the association was formed and is maintained for the purpose of promoting the interest and welfare of and developing close relationships with similar public bodies, provided such association has procured the insurance or electric utility services by use of competitive principles and provided that the public body has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding and competitive negotiation are not fiscally advantageous to the public. The writing shall document the basis for this determination.

~~14~~*13*. Public bodies administering public assistance and social services programs as defined in § 63.2-100, community services boards as defined in § 37.2-100, or any public body purchasing services under the Comprehensive Services Act for At-Risk Youth and Families (§ 2.2-5200 et seq.) or the Virginia Juvenile Community Crime Control Act (§ 16.1-309.2 et seq.) for goods or personal services for direct use by the recipients of such programs if the procurement is made for an individual recipient. Contracts for the bulk procurement of goods or services for the use of recipients shall not be exempted from the requirements of § 2.2-4303.

~~15~~*14*. The Eastern Virginia Medical School in the exercise of any power conferred pursuant to Chapter 471, as amended, of the Acts of Assembly of 1964.

B. No contract for the construction of any building or for an addition to or improvement of an existing building by any local government or subdivision of local government for which state funds of not more than $30,000 in the aggregate or for the sum of all phases of a contract or project either by appropriation, grant-in-aid or loan, are used or are to be used for all or part of the cost of construction shall be let except after competitive sealed bidding or after competitive negotiation as provided under of subsection D of § 2.2-4303. The procedure for the advertising for bids or for proposals and for letting of the contract shall conform, mutatis mutandis, to this chapter.

§ 19.2-389. Dissemination of criminal history record information.

A. Criminal history record information shall be disseminated, whether directly or through an intermediary, only to:

1. Authorized officers or employees of criminal justice agencies, as defined by § 9.1-101, for purposes of the administration of criminal justice and the screening of an employment application or review of employment by a criminal justice agency with respect to its own employees or applicants, and dissemination to the Virginia Parole Board, pursuant to this subdivision, of such information on all state-responsible inmates for the purpose of making parole determinations pursuant to subdivisions 1, 2, 3, and 5 of § 53.1-136 shall include collective dissemination by electronic means every 30 days;

2. Such other individuals and agencies that require criminal history record information to implement a state or federal statute or executive order of the President of the United States or Governor that expressly refers to criminal conduct and contains requirements or exclusions expressly based upon such conduct, except that information concerning the arrest of an individual may not be disseminated to a noncriminal justice agency or individual if an interval of one year has elapsed from the date of the arrest and no disposition of the charge has been recorded and no active prosecution of the charge is pending;

3. Individuals and agencies pursuant to a specific agreement with a criminal justice agency to provide services required for the administration of criminal justice pursuant to that agreement which shall

specifically authorize access to data, limit the use of data to purposes for which given, and ensure the security and confidentiality of the data;

4. Individuals and agencies for the express purpose of research, evaluative, or statistical activities pursuant to an agreement with a criminal justice agency that shall specifically authorize access to data, limit the use of data to research, evaluative, or statistical purposes, and ensure the confidentiality and security of the data;

5. Agencies of state or federal government that are authorized by state or federal statute or executive order of the President of the United States or Governor to conduct investigations determining employment suitability or eligibility for security clearances allowing access to classified information;

6. Individuals and agencies where authorized by court order or court rule;

7. Agencies of any political subdivision of the Commonwealth for the conduct of investigations of applicants for public employment, permit, or license whenever, in the interest of public welfare or safety, it is necessary to determine under a duly enacted ordinance if the past criminal conduct of a person with a conviction record would be compatible with the nature of the employment, permit, or license under consideration;

8. Public or private agencies when authorized or required by federal or state law or interstate compact to investigate (i) applicants for foster or adoptive parenthood or (ii) any individual, and the adult members of that individual's household, with whom the agency is considering placing a child or from whom the agency is considering removing a child due to abuse or neglect, on an emergency, temporary, or permanent basis pursuant to §§ 63.2-901.1 and 63.2-1505, subject to the restriction that the data shall not be further disseminated to any party other than a federal or state authority or court as may be required to comply with an express requirement of law;

9. To the extent permitted by federal law or regulation, public service companies as defined in § 56-1, for the conduct of investigations of applicants for employment when such employment involves personal contact with the public or when past criminal conduct of an applicant would be incompatible with the nature of the employment under consideration;

10. The appropriate authority for purposes of granting citizenship and for purposes of international travel, including but not limited to, issuing visas and passports;

11. A person requesting a copy of his own criminal history record information as defined in § 9.1-101 at his cost, except that criminal history record information shall be supplied at no charge to a person who has applied to be a volunteer with (i) a Virginia affiliate of Big Brothers/Big Sisters of America; (ii) a volunteer fire company or volunteer rescue squad; (iii) the Volunteer Emergency Families for Children; (iv) any affiliate of Prevent Child Abuse, Virginia; (v) any Virginia affiliate of Compeer; or (vi) any board member or any individual who has been offered membership on the board of a Crime Stoppers, Crime Solvers or Crime Line program as defined in § 15.2-1713.1;

12. Administrators and board presidents of and applicants for licensure or registration as a child welfare agency as defined in § 63.2-100 for dissemination to the Commissioner of Social Services' representative pursuant to § 63.2-1702 for the conduct of investigations with respect to employees of and volunteers at such facilities, caretakers, and other adults living in family day-care homes or homes approved by family day-care systems, and foster and adoptive parent applicants of private child-placing agencies, pursuant to §§ 63.2-1719 through 63.2-1721, subject to the restriction that the data shall not be further disseminated by the facility or agency to any party other than the data subject, the Commissioner of Social Services' representative or a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination;

13. The school boards of the Commonwealth for the purpose of screening individuals who are offered or who accept public school employment and those current school board employees for whom a report of arrest has been made pursuant to § 19.2-83.1;

14. The State Lottery Department for the conduct of investigations as set forth in the State Lottery Law (§ 58.1-4000 et seq.), and the Department of Agriculture and Consumer Services for the conduct of investigations as set forth in Article 1.1:1 (§ 18.2-340.15 et seq.) of Chapter 8 of Title 18.2;

15. Licensed nursing homes, hospitals and home care organizations for the conduct of investigations of applicants for compensated employment in licensed nursing homes pursuant to § 32.1-126.01, hospital pharmacies pursuant to § 32.1-126.02, and home care organizations pursuant to § 32.1-162.9:1, subject to the limitations set out in subsection E;

16. Licensed homes for adults, licensed district homes for adults, and licensed adult day-care centers for the conduct of investigations of applicants for compensated employment in licensed homes for adults pursuant to § 63.2-1720, in licensed district homes for adults pursuant to § 63.1-189.1, and in licensed adult day-care centers pursuant to § 63.2-1720, subject to the limitations set out in subsection F;

17. The Alcoholic Beverage Control Board for the conduct of investigations as set forth in § 4.1-103.1;

18. The State Board of Elections and authorized officers and employees thereof in the course of

conducting necessary investigations with respect to registered voters, limited to any record of felony convictions;

19. The Commissioner of Behavioral Health and Developmental Services for those individuals who are committed to the custody of the Commissioner pursuant to §§ 19.2-169.2, 19.2-169.6, 19.2-176, 19.2-177.1, 19.2-182.2, 19.2-182.3, 19.2-182.8, and 19.2-182.9 for the purpose of placement, evaluation, and treatment planning;

20. Any alcohol safety action program certified by the Commission on the Virginia Alcohol Safety Action Program for (i) assessments of habitual offenders under § 46.2-360, (ii) interventions with first offenders under § 18.2-251, or (iii) services to offenders under § 18.2-51.4, 18.2-266, or 18.2-266.1;

21. Residential facilities for juveniles regulated or operated by the Department of Social Services, the Department of Education, or the Department of Behavioral Health and Developmental Services for the purpose of determining applicants' fitness for employment or for providing volunteer or contractual services;

22. The Department of Behavioral Health and Developmental Services and facilities operated by the Department for the purpose of determining an individual's fitness for employment pursuant to departmental instructions;

23. Pursuant to § 22.1-296.3, the governing boards or administrators of private or religious elementary or secondary schools which are accredited by a statewide accrediting organization recognized, prior to January 1, 1996, by the State Board of Education or a private organization coordinating such records information on behalf of such governing boards or administrators pursuant to a written agreement with the Department of State Police;

24. Public and nonprofit private colleges and universities for the purpose of screening individuals who are offered or accept employment;

25. Executive directors of community services boards or the personnel director serving the community services board for the purpose of determining an individual's fitness for employment pursuant to §§ 37.2-506 and 37.2-607;

26. Executive directors of behavioral health authorities as defined in § 37.2-600 for the purpose of determining an individual's fitness for employment pursuant to §§ 37.2-506 and 37.2-607;

27. The Commissioner of the Department of Social Services for the purpose of locating persons who owe child support or who are alleged in a pending paternity proceeding to be a putative father, provided that only the name, address, demographics and social security number of the data subject shall be released;

28. Authorized officers or directors of agencies licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 by the Department of Behavioral Health and Developmental Services for the purpose of determining if any applicant who accepts employment in any direct consumer care position has been convicted of a crime that affects their fitness to have responsibility for the safety and well-being of persons with mental illness, mental retardation and substance abuse pursuant to §§ 37.2-416, 37.2-506, and 37.2-607;

29. The Commissioner of the Department of Motor Vehicles, for the purpose of evaluating applicants for a motor carrier certificate or license subject to the provisions of Chapters 20 (§ 46.2-2000 et seq.) and 21 (§ 46.2-2100 et seq.) of Title 46.2;

30. The chairmen of the Committees for Courts of Justice of the Senate or the House of Delegates for the purpose of determining if any person being considered for election to any judgeship has been convicted of a crime;

31. Heads of state agencies in which positions have been identified as sensitive for the purpose of determining an individual's fitness for employment in positions designated as sensitive under Department of Human Resource Management policies developed pursuant to § 2.2-1201.1. Dissemination of criminal history record information to the agencies shall be limited to those positions generally described as directly responsible for the health, safety and welfare of the general populace or protection of critical infrastructures;

32. The Office of the Attorney General, for all criminal justice activities otherwise permitted under subdivision A 1 and for purposes of performing duties required by the Civil Commitment of Sexually Violent Predators Act (§ 37.2-900 et seq.);

33. Shipyards, to the extent permitted by federal law or regulation, engaged in the design, construction, overhaul, or repair of nuclear vessels for the United States Navy, including their subsidiary companies, for the conduct of investigations of applications for employment or for access to facilities, by contractors, leased laborers, and other visitors;

34. Any employer of individuals whose employment requires that they enter the homes of others, for the purpose of screening individuals who apply for, are offered, or have accepted such employment;

35. Public agencies when and as required by federal or state law to investigate (i) applicants as providers of adult foster care and home-based services or (ii) any individual with whom the agency is considering placing an adult on an emergency, temporary, or permanent basis pursuant to § 63.2-1601.1,

subject to the restriction that the data shall not be further disseminated by the agency to any party other than a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination, subject to limitations set out in subsection G;

36. The Department of Medical Assistance Services, or its designee, for the purpose of screening individuals who, through contracts, subcontracts, or direct employment, volunteer, apply for, are offered, or have accepted a position related to the provision of transportation services to enrollees in the ~~Medicaid Program or the~~ Family Access to Medical Insurance Security (FAMIS) Program, or any other program administered by the Department of Medical Assistance Services;

37. The State Corporation Commission for the purpose of investigating individuals who are members, senior officers, directors, and principals of an applicant for licensure as a mortgage lender or mortgage broker, or a licensed mortgage lender or mortgage broker for the purpose of investigating individuals applying for a position of employment in which the individual may have access to or process personal identifying or financial information from a member of the public, pursuant to Chapter 16 (§ 6.1-408 et seq.) of Title 6.1. Notwithstanding any other provision of law, if an application for a mortgage lender or mortgage broker license is denied based in whole or in part on information obtained from the Central Criminal Records Exchange pursuant to § 6.1-414, the Commissioner of Financial Institutions or his designee may disclose such information to the applicant or its designee;

38. The Department of Professional and Occupational Regulation for the purpose of investigating individuals for initial licensure pursuant to § 54.1-2106.1; and

39. Other entities as otherwise provided by law.

Upon an ex parte motion of a defendant in a felony case and upon the showing that the records requested may be relevant to such case, the court shall enter an order requiring the Central Criminal Records Exchange to furnish the defendant, as soon as practicable, copies of any records of persons designated in the order on whom a report has been made under the provisions of this chapter.

Notwithstanding any other provision of this chapter to the contrary, upon a written request sworn to before an officer authorized to take acknowledgments, the Central Criminal Records Exchange, or the criminal justice agency in cases of offenses not required to be reported to the Exchange, shall furnish a copy of conviction data covering the person named in the request to the person making the request; however, such person on whom the data is being obtained shall consent in writing, under oath, to the making of such request. A person receiving a copy of his own conviction data may utilize or further disseminate that data as he deems appropriate. In the event no conviction data is maintained on the data subject, the person making the request shall be furnished at his cost a certification to that effect.

B. Use of criminal history record information disseminated to noncriminal justice agencies under this section shall be limited to the purposes for which it was given and may not be disseminated further.

C. No criminal justice agency or person shall confirm the existence or nonexistence of criminal history record information for employment or licensing inquiries except as provided by law.

D. Criminal justice agencies shall establish procedures to query the Central Criminal Records Exchange prior to dissemination of any criminal history record information on offenses required to be reported to the Central Criminal Records Exchange to ensure that the most up-to-date disposition data is being used. Inquiries of the Exchange shall be made prior to any dissemination except in those cases where time is of the essence and the normal response time of the Exchange would exceed the necessary time period. A criminal justice agency to whom a request has been made for the dissemination of criminal history record information that is required to be reported to the Central Criminal Records Exchange may direct the inquirer to the Central Criminal Records Exchange for such dissemination. Dissemination of information regarding offenses not required to be reported to the Exchange shall be made by the criminal justice agency maintaining the record as required by § 15.2-1722.

E. Criminal history information provided to licensed nursing homes, hospitals and to home care organizations pursuant to subdivision 15 of subsection A shall be limited to the convictions on file with the Exchange for any offense specified in §§ 32.1-126.01, 32.1-126.02, and 32.1-162.9:1.

F. Criminal history information provided to licensed assisted living facilities, licensed district homes for adults, and licensed adult day-care centers pursuant to subdivision 16 of subsection A shall be limited to the convictions on file with the Exchange for any offense specified in § 63.1-189.1 or 63.2-1720.

G. Criminal history information provided to public agencies pursuant to subdivision 35 of subsection A shall be limited to the convictions on file with the Exchange for any offense specified in § 63.2-1719.

H. Upon receipt of a written request from an employer or prospective employer, the Central Criminal Records Exchange, or the criminal justice agency in cases of offenses not required to be reported to the Exchange, shall furnish at the employer's cost a copy of conviction data covering the person named in the request to the employer or prospective employer making the request; provided that the person on whom the data is being obtained has consented in writing to the making of such request and has presented a photo-identification to the employer or prospective employer. In the event no conviction data

is maintained on the person named in the request, the requesting employer or prospective employer shall be furnished at his cost a certification to that effect. The criminal history record search shall be conducted on forms provided by the Exchange.

§ 20-49.8. Judgment or order; costs; birth record.

A. A judgment or order establishing parentage may include any provision directed against the appropriate party to the proceeding, concerning the duty of support, including an equitable apportionment of the expenses incurred on behalf of the child from the date the proceeding under this chapter was filed with the court against the alleged parent or, if earlier, the date an order of the Department of Social Services entered pursuant to Title 63.2 and directing payment of support was delivered to the sheriff or process server for service upon the obligor. The judgment or order may be in favor of the natural parent or any other person or agency who incurred such expenses provided the complainant exercised due diligence in the service of the respondent. The judgment or order may also include provisions for the custody and guardianship of the child, visitation privileges with the child, or any other matter in the best interest of the child. In circumstances where the parent is outside the jurisdiction of the court, the court may enter a further order requiring the furnishing of bond or other security for the payment required by the judgment or order. The judgment or order may direct either party to pay the reasonable and necessary unpaid expenses of the mother's pregnancy and delivery or equitably apportion the unpaid expenses between the parties. However, when the Commonwealth, through ~~the Medicaid~~ *a medical assistance* program, has paid such expenses, the court may order reimbursement to the Commonwealth for such expenses.

B. A determination of paternity made by any other state shall be given full faith and credit, whether established through voluntary acknowledgment or through administrative or judicial process; provided, however, that, except as may otherwise be required by law, such full faith and credit shall be given only for the purposes of establishing a duty to make payments of support and other payments contemplated by subsection A.

C. For each court determination of parentage made under the provisions of this chapter, a certified copy of the order or judgment shall be transmitted to the State Registrar of Vital Records by the clerk of the court within ~~thirty~~ *30* days after the order becomes final. Such order shall set forth the full name and date and place of birth of the person whose parentage has been determined, the full names of both parents, including the maiden name, if any, of the mother and the name and address of an informant who can furnish the information necessary to complete a new birth record. In addition, when the State Registrar receives a document signed by a man indicating his consent to submit to scientifically reliable genetic tests, including blood tests, to determine paternity and the genetic test results affirming at least a ~~ninety-eight~~ *98* percent probability of paternity, a new birth record shall be completed as provided in § 32.1-261. When the State Registrar receives a copy of a judgment or order for a person born outside of this Commonwealth, such order shall be forwarded to the appropriate registration authority in the state of birth or the appropriate federal agency.

§ 20-88.02. Transfer of assets to qualify for assistance; liability of transferees.

A. As used in this section, "uncompensated value" means the aggregate amount by which the fair market value of all property or resources, including fractional interests, transferred by any transferor after the effective date of and subject to this section, exceeds the aggregate consideration received for such property or resources.

B. Within ~~thirty~~ *30* months prior to the date on which any person receives benefits from any program of public assistance or social services as defined in § 63.2-100, if such person has transferred any property or resources resulting in uncompensated value, the transferee of such property or resources shall be liable to repay the Commonwealth for benefits paid on behalf of the transferor up to the amount of that uncompensated value less $25,000.

C. In their discretion, the heads of the agencies which administer the appropriate program or programs of public assistance may petition the circuit court having jurisdiction over the property or over the transferee for an order requiring repayment. That order shall continue in effect, as the court may determine, for so long as the transferor receives public assistance or until the uncompensated value is completely repaid. With respect to all transfers subject to this section, a rebuttable presumption is created that the transferee acted with the intent and for the purpose of assisting the transferor to qualify for public assistance. If the presumption is rebutted, this section shall not apply and the petition shall be dismissed.

D. After reasonable investigation, the agency or agencies administering the program of public assistance shall not file any petition, and no court shall order payments under subsection B of this section if it is determined that: (i) the uncompensated value of the property transferred is $25,000 or less, (ii) that the property transferred was the home of the transferor at the time of the transfer and the transferor or any of the following individuals reside in the home: the transferor's spouse, any natural or adopted child of the transferor under the age of ~~twenty-one~~ *21* years or any natural or adopted child of the transferor, regardless of age, who is blind or disabled as defined by the federal Social Security Act

~~or~~ ~~the~~ ~~Virginia~~ ~~Medicaid~~ ~~Program~~, or (iii) the transferee is without financial means or that such payment would work a hardship on the transferee or his family. If the transferee does not fully cooperate with the investigating agency to determine the nature and extent of the hardship, there shall be a rebuttable presumption that no hardship exists.

§ 20-108.2. Guideline for determination of child support; quadrennial review by Child Support Guidelines Review Panel; executive summary.

A. There shall be a rebuttable presumption in any judicial or administrative proceeding for child support under this title or Title 16.1 or 63.2, including cases involving split custody or shared custody, that the amount of the award which would result from the application of the guidelines set forth in this section is the correct amount of child support to be awarded. In order to rebut the presumption, the court shall make written findings in the order as set out in § 20-108.1, which findings may be incorporated by reference, that the application of the guidelines would be unjust or inappropriate in a particular case as determined by relevant evidence pertaining to the factors set out in § 20-108.1. The Department of Social Services shall set child support at the amount resulting from computations using the guidelines set out in this section pursuant to the authority granted to it in Chapter 19 (§ 63.2-1900 et seq.) of Title 63.2 and subject to the provisions of § 63.2-1918.

B. For purposes of application of the guideline, a basic child support obligation shall be computed using the schedule set out below. For combined monthly gross income amounts falling between amounts shown in the schedule, basic child support obligation amounts shall be extrapolated. However, unless one of the following exemptions applies where the sole custody child support obligation as computed pursuant to subdivision G 1 is less than $65 per month, there shall be a presumptive minimum child support obligation of $65 per month payable by the payor parent. Exemptions from this presumptive minimum monthly child support obligation shall include: parents unable to pay child support because they lack sufficient assets from which to pay child support and who, in addition, are institutionalized in a psychiatric facility; are imprisoned for life with no chance of parole; are medically verified to be totally and permanently disabled with no evidence of potential for paying child support, including recipients of Supplemental Security Income (SSI); or are otherwise involuntarily unable to produce income. "Number of children" means the number of children for whom the parents share joint legal responsibility and for whom support is being sought.

SCHEDULE OF MONTHLY BASIC CHILD SUPPORT OBLIGATIONS

COMBINED MONTHLY GROSS INCOME	ONE CHILD	TWO CHILDREN	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN	SIX CHILDREN
0-599	65	65	65	65	65	65
600	110	111	113	114	115	116
650	138	140	142	143	145	146
700	153	169	170	172	174	176
750	160	197	199	202	204	206
800	168	226	228	231	233	236
850	175	254	257	260	263	266
900	182	281	286	289	292	295
950	189	292	315	318	322	325
1000	196	304	344	348	351	355
1050	203	315	373	377	381	385
1100	210	326	402	406	410	415
1150	217	337	422	435	440	445
1200	225	348	436	465	470	475
1250	232	360	451	497	502	507
1300	241	373	467	526	536	542
1350	249	386	483	545	570	576
1400	257	398	499	563	605	611
1450	265	411	515	581	633	645
1500	274	426	533	602	656	680
1550	282	436	547	617	672	714
1600	289	447	560	632	689	737
1650	295	458	573	647	705	754
1700	302	468	587	662	721	772

1041	1750	309	479	600	676	738	789
1042	1800	315	488	612	690	752	805
1043	1850	321	497	623	702	766	819
1044	1900	326	506	634	714	779	834
1045	1950	332	514	645	727	793	848
1046	2000	338	523	655	739	806	862
1047	2050	343	532	666	751	819	877
1048	2100	349	540	677	763	833	891
1049	2150	355	549	688	776	846	905
1050	2200	360	558	699	788	860	920
1051	2250	366	567	710	800	873	934
1052	2300	371	575	721	812	886	948
1053	2350	377	584	732	825	900	963
1054	2400	383	593	743	837	913	977
1055	2450	388	601	754	849	927	991
1056	2500	394	610	765	862	940	1006
1057							
1058	2550	399	619	776	874	954	1020
1059	2600	405	627	787	886	967	1034
1060	2650	410	635	797	897	979	1048
1061	2700	415	643	806	908	991	1060
1062	2750	420	651	816	919	1003	1073
1063	2800	425	658	826	930	1015	1085
1064	2850	430	667	836	941	1027	1098
1065	2900	435	675	846	953	1039	1112
1066	2950	440	683	856	964	1052	1125
1067	3000	445	691	866	975	1064	1138
1068	3050	450	699	876	987	1076	1152
1069	3100	456	707	886	998	1089	1165
1070	3150	461	715	896	1010	1101	1178
1071	3200	466	723	906	1021	1114	1191
1072	3250	471	732	917	1032	1126	1205
1073	3300	476	740	927	1044	1139	1218
1074	3350	481	748	937	1055	1151	1231
1075	3400	486	756	947	1067	1164	1245
1076	3450	492	764	957	1078	1176	1258
1077	3500	497	772	967	1089	1189	1271
1078							
1079	3550	502	780	977	1101	1201	1285
1080	3600	507	788	987	1112	1213	1298
1081	3650	512	797	997	1124	1226	1311
1082	3700	518	806	1009	1137	1240	1326
1083	3750	524	815	1020	1150	1254	1342
1084	3800	530	824	1032	1163	1268	1357
1085	3850	536	834	1043	1176	1283	1372
1086	3900	542	843	1055	1189	1297	1387
1087	3950	547	852	1066	1202	1311	1402
1088	4000	553	861	1078	1214	1325	1417
1089	4050	559	871	1089	1227	1339	1432
1090	4100	565	880	1101	1240	1353	1448
1091	4150	571	889	1112	1253	1367	1463
1092	4200	577	898	1124	1266	1382	1478
1093	4250	583	907	1135	1279	1396	1493
1094	4300	589	917	1147	1292	1410	1508
1095	4350	594	926	1158	1305	1424	1523
1096	4400	600	935	1170	1318	1438	1538
1097	4450	606	944	1181	1331	1452	1553

1098	4500	612	954	1193	1344	1467	1569
1099							
1100	4550	618	963	1204	1357	1481	1584
1101	4600	624	972	1216	1370	1495	1599
1102	4650	630	981	1227	1383	1509	1614
1103	4700	635	989	1237	1395	1522	1627
1104	4750	641	997	1247	1406	1534	1641
1105	4800	646	1005	1257	1417	1546	1654
1106	4850	651	1013	1267	1428	1558	1667
1107	4900	656	1021	1277	1439	1570	1679
1108	4950	661	1028	1286	1450	1582	1692
1109	5000	666	1036	1295	1460	1593	1704
1110	5050	671	1043	1305	1471	1605	1716
1111	5100	675	1051	1314	1481	1616	1728
1112	5150	680	1058	1323	1492	1628	1741
1113	5200	685	1066	1333	1502	1640	1753
1114	5250	690	1073	1342	1513	1651	1765
1115	5300	695	1081	1351	1524	1663	1778
1116	5350	700	1088	1361	1534	1674	1790
1117	5400	705	1096	1370	1545	1686	1802
1118	5450	710	1103	1379	1555	1697	1815
1119	5500	714	1111	1389	1566	1709	1827
1120							
1121	5550	719	1118	1398	1576	1720	1839
1122	5600	724	1126	1407	1587	1732	1851
1123	5650	729	1133	1417	1598	1743	1864
1124	5700	734	1141	1426	1608	1755	1876
1125	5750	739	1148	1435	1619	1766	1888
1126	5800	744	1156	1445	1629	1778	1901
1127	5850	749	1163	1454	1640	1790	1913
1128	5900	753	1171	1463	1650	1801	1925
1129	5950	758	1178	1473	1661	1813	1937
1130	6000	763	1186	1482	1672	1824	1950
1131	6050	768	1193	1491	1682	1836	1962
1132	6100	773	1201	1501	1693	1847	1974
1133	6150	778	1208	1510	1703	1859	1987
1134	6200	783	1216	1519	1714	1870	1999
1135	6250	788	1223	1529	1724	1882	2011
1136	6300	792	1231	1538	1735	1893	2023
1137	6350	797	1238	1547	1745	1905	2036
1138	6400	802	1246	1557	1756	1916	2048
1139	6450	807	1253	1566	1767	1928	2060
1140	6500	812	1261	1575	1777	1940	2073
1141							
1142	6550	816	1267	1583	1786	1949	2083
1143	6600	820	1272	1590	1794	1957	2092
1144	6650	823	1277	1597	1801	1965	2100
1145	6700	827	1283	1604	1809	1974	2109
1146	6750	830	1288	1610	1817	1982	2118
1147	6800	834	1293	1617	1824	1990	2127
1148	6850	837	1299	1624	1832	1999	2136
1149	6900	841	1304	1631	1839	2007	2145
1150	6950	845	1309	1637	1847	2016	2154
1151	7000	848	1315	1644	1855	2024	2163
1152	7050	852	1320	1651	1862	2032	2172
1153	7100	855	1325	1658	1870	2041	2181

1154	7150	859	1331	1665	1878	2049	2190
1155	7200	862	1336	1671	1885	2057	2199
1156	7250	866	1341	1678	1893	2066	2207
1157	7300	870	1347	1685	1900	2074	2216
1158	7350	873	1352	1692	1908	2082	2225
1159	7400	877	1358	1698	1916	2091	2234
1160	7450	880	1363	1705	1923	2099	2243
1161	7500	884	1368	1712	1931	2108	2252
1162							
1163	7550	887	1374	1719	1938	2116	2261
1164	7600	891	1379	1725	1946	2124	2270
1165	7650	895	1384	1732	1954	2133	2279
1166	7700	898	1390	1739	1961	2141	2288
1167	7750	902	1395	1746	1969	2149	2297
1168	7800	905	1400	1753	1977	2158	2305
1169	7850	908	1405	1758	1983	2164	2313
1170	7900	910	1409	1764	1989	2171	2320
1171	7950	913	1414	1770	1995	2178	2328
1172	8000	916	1418	1776	2001	2185	2335
1173	8050	918	1423	1781	2007	2192	2343
1174	8100	921	1428	1787	2014	2198	2350
1175	8150	924	1432	1793	2020	2205	2357
1176	8200	927	1437	1799	2026	2212	2365
1177	8250	929	1441	1804	2032	2219	2372
1178	8300	932	1446	1810	2038	2226	2380
1179	8350	935	1450	1816	2045	2232	2387
1180	8400	937	1455	1822	2051	2239	2395
1181	8450	940	1459	1827	2057	2246	2402
1182	8500	943	1464	1833	2063	2253	2410
1183							
1184	8550	945	1468	1839	2069	2260	2417
1185	8600	948	1473	1845	2076	2266	2425
1186	8650	951	1478	1850	2082	2273	2432
1187	8700	954	1482	1856	2088	2280	2440
1188	8750	956	1487	1862	2094	2287	2447
1189	8800	959	1491	1868	2100	2294	2455
1190	8850	962	1496	1873	2107	2300	2462
1191	8900	964	1500	1879	2113	2307	2470
1192	8950	967	1505	1885	2119	2314	2477
1193	9000	970	1509	1891	2125	2321	2484
1194	9050	973	1514	1896	2131	2328	2492
1195	9100	975	1517	1901	2137	2334	2498
1196	9150	977	1521	1905	2141	2339	2503
1197	9200	979	1524	1909	2146	2344	2509
1198	9250	982	1527	1914	2151	2349	2514
1199	9300	984	1531	1918	2156	2354	2520
1200	9350	986	1534	1922	2160	2359	2525
1201	9400	988	1537	1926	2165	2365	2531
1202	9450	990	1541	1930	2170	2370	2536
1203	9500	993	1544	1935	2175	2375	2541
1204							
1205	9550	995	1547	1939	2179	2380	2547
1206	9600	997	1551	1943	2184	2385	2552
1207	9650	999	1554	1947	2189	2390	2558
1208	9700	1001	1557	1951	2194	2396	2563
1209	9750	1003	1561	1956	2198	2401	2569
1210	9800	1006	1564	1960	2203	2406	2574

9850	1008	1567	1964	2208	2411	2580
9900	1010	1571	1968	2213	2416	2585
9950	1012	1574	1972	2218	2421	2590
10000	1014	1577	1977	2222	2427	2596

For gross monthly income between $10,000 and $20,000, add the amount of child support for $10,000 to the following percentages of gross income above $10,000:

ONE CHILD	TWO CHILDREN	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN	SIX CHILDREN
3.1%	5.1%	6.8%	7.8%	8.8%	9.5%

For gross monthly income between $20,000 and $50,000, add the amount of child support for $20,000 to the following percentages of gross income above $20,000:

ONE CHILD	TWO CHILDREN	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN	SIX CHILDREN
2%	3.5%	5%	6%	6.9%	7.8%

For gross monthly income over $50,000, add the amount of child support for $50,000 to the following percentages of gross income above $50,000:

ONE CHILD	TWO CHILDREN	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN	SIX CHILDREN
1%	2%	3%	4%	5%	6%

C. For purposes of this section, "gross income" means all income from all sources, and shall include, but not be limited to, income from salaries, wages, commissions, royalties, bonuses, dividends, severance pay, pensions, interest, trust income, annuities, capital gains, social security benefits except as listed below, workers' compensation benefits, unemployment insurance benefits, disability insurance benefits, veterans' benefits, spousal support, rental income, gifts, prizes or awards.

If a parent's gross income includes disability insurance benefits, it shall also include any amounts paid to or for the child who is the subject of the order and derived by the child from the parent's entitlement to disability insurance benefits. To the extent that such derivative benefits are included in a parent's gross income, that parent shall be entitled to a credit against his or her ongoing basic child support obligation for any such amounts, and, if the amount of the credit exceeds the parent's basic child support obligations, the credit may be used to reduce arrearages.

Gross income shall be subject to deduction of reasonable business expenses for persons with income from self-employment, a partnership, or a closely held business. "Gross income" shall not include:

1. Benefits from public assistance and social services programs as defined in § 63.2-100;

2. Federal supplemental security income benefits;

3. Child support received; or

4. Income received by the payor from secondary employment income not previously included in "gross income," where the payor obtained the income to discharge a child support arrearage established by a court or administrative order and the payor is paying the arrearage pursuant to the order. "Secondary employment income" includes but is not limited to income from an additional job, from self-employment, or from overtime employment. The cessation of such secondary income upon the payment of the arrearage shall not be the basis for a material change in circumstances upon which a modification of child support may be based.

For purposes of this subsection: (i) spousal support received shall be included in gross income and spousal support paid shall be deducted from gross income when paid pursuant to an order or written agreement and (ii) one-half of any self-employment tax paid shall be deducted from gross income.

Where there is an existing court or administrative order or written agreement relating to the child or children of a party to the proceeding, who are not the child or children who are the subject of the present proceeding, then there is a presumption that there shall be deducted from the gross income of the party subject to such order or written agreement, the amount that the party is actually paying for the support of a child or children pursuant to such order or agreement.

Where a party to the proceeding has a natural or adopted child or children in the party's household or primary physical custody, and the child or children are not the subject of the present proceeding, there is a presumption that there shall be deducted from the gross income of that party the amount as shown on the Schedule of Monthly Basic Child Support Obligations contained in subsection B that represents that party's support obligation based solely on that party's income as being the total income available for the natural or adopted child or children in the party's household or primary physical custody, who are not the subject of the present proceeding. Provided, however, that the existence of a party's financial responsibility for such a child or children shall not of itself constitute a material change in circumstances for modifying a previous order of child support in any modification proceeding. Any adjustment to gross income under this subsection shall not create or reduce a support obligation to an

amount which seriously impairs the custodial parent's ability to maintain minimal adequate housing and provide other basic necessities for the child, as determined by the court.

In cases in which retroactive liability for support is being determined, the court or administrative agency may use the gross monthly income of the parties averaged over the period of retroactivity.

D. Except for good cause shown or the agreement of the parties, in addition to any other child support obligations established pursuant to this section, any child support order shall provide that the parents pay in proportion to their gross incomes, as used for calculating the monthly support obligation, any reasonable and necessary unreimbursed medical or dental expenses that are in excess of $250 for any calendar year for each child who is the subject of the obligation. The method of payment of those expenses shall be contained in the support order. Each parent shall pay his respective share of expenses as those expenses are incurred. Any amount paid under this subsection shall not be adjusted by, nor added to, the child support calculated in accordance with subsection G. For the purposes of this section, medical or dental expenses shall include but not be limited to eyeglasses, prescription medication, prosthetics, orthodontics, and mental health or developmental disabilities services, including but not limited to services provided by a social worker, psychologist, psychiatrist, counselor, or therapist.

E. Any costs for health care coverage as defined in § 63.2-1900 and dental care coverage, when actually being paid by a parent or that parent's spouse, to the extent such costs are directly allocable to the child or children, and which are the extra costs of covering the child or children beyond whatever coverage the parent or that parent's spouse providing the coverage would otherwise have, shall be added to the basic child support obligation. Where the court orders that a custodial parent enroll a child in health care coverage sponsored by the Department of Social Services, the Department shall deduct the cost of the coverage prior to disbursement of the child support payment in accordance with § 63.2-1954.1.

F. Any child-care costs incurred on behalf of the child or children due to employment of the custodial parent shall be added to the basic child support obligation. Child-care costs shall not exceed the amount required to provide quality care from a licensed source. When requested by the noncustodial parent, the court may require the custodial parent to present documentation to verify the costs incurred for child care under this subsection. Where appropriate, the court shall consider the willingness and availability of the noncustodial parent to provide child care personally in determining whether child-care costs are necessary or excessive. Upon the request of either party, and upon a showing of the tax savings a party derives from child-care cost deductions or credits, the court shall factor actual tax consequences into its calculation of the child-care costs to be added to the basic child support obligation.

G. 1. Sole custody support. The sole custody total monthly child support obligation shall be established by adding (i) the monthly basic child support obligation, as determined from the schedule contained in subsection B, (ii) costs for health care coverage to the extent allowable by subsection E, (iii) cash medical support in cases where the child is a recipient of ~~Medicaid or~~ the Family Access to Medical Insurance Security Plan as set forth in clause (ii) of the definition of cash medical support in § 63.2-1900, and (iv) work-related child-care costs and taking into consideration all the factors set forth in subsection B of § 20-108.1. The total monthly child support obligation shall be divided between the parents in the same proportion as their monthly gross incomes bear to their monthly combined gross income. The monthly obligation of each parent shall be computed by multiplying each parent's percentage of the parents' monthly combined gross income by the total monthly child support obligation.

However, the monthly obligation of the noncustodial parent shall be reduced by the cost for health care coverage to the extent allowable by subsection E when paid directly by the noncustodial parent or that parent's spouse. Unreimbursed medical and dental expenses shall be calculated and allocated in accordance with subsection D.

2. Split custody support. In cases involving split custody, the amount of child support to be paid shall be the difference between the amounts owed by each parent as a noncustodial parent, computed in accordance with subdivision 1, with the noncustodial parent owing the larger amount paying the difference to the other parent. Unreimbursed medical and dental expenses shall be calculated and allocated in accordance with subsection D.

For the purpose of this section and § 20-108.1, split custody shall be limited to those situations where each parent has physical custody of a child or children born of the parents, born of either parent and adopted by the other parent or adopted by both parents. For the purposes of calculating a child support obligation where split custody exists, a separate family unit exists for each parent, and child support for that family unit shall be calculated upon the number of children in that family unit who are born of the parents, born of either parent and adopted by the other parent or adopted by both parents. Where split custody exists, a parent is a custodial parent to the children in that parent's family unit and is a noncustodial parent to the children in the other parent's family unit.

3. Shared custody support.

(a) Where a party has custody or visitation of a child or children for more than 90 days of the year, as such days are defined in subdivision G 3 (c), a shared custody child support amount based on the

ratio in which the parents share the custody and visitation of any child or children shall be calculated in accordance with this subdivision. The presumptive support to be paid shall be the shared custody support amount, unless a party affirmatively shows that the sole custody support amount calculated as provided in subdivision G 1 is less than the shared custody support amount. If so, the lesser amount shall be the support to be paid. For the purposes of this subsection, the following shall apply:

(i) Income share. "Income share" means a parent's percentage of the combined monthly gross income of both parents. The income share of a parent is that parent's gross income divided by the combined gross incomes of the parties.

(ii) Custody share. "Custody share" means the number of days that a parent has physical custody, whether by sole custody, joint legal or joint residential custody, or visitation, of a shared child per year divided by the number of days in the year. The actual or anticipated "custody share" of the parent who has or will have fewer days of physical custody shall be calculated for a one-year period. The "custody share" of the other parent shall be presumed to be the number of days in the year less the number of days calculated as the first parent's "custody share." For purposes of this calculation, the year may begin on such date as is determined in the discretion of the court, and the day may begin at such time as is determined in the discretion of the court. For purposes of this calculation, a day shall be as defined in subdivision G 3 (c).

(iii) Shared support need. "Shared support need" means the presumptive guideline amount of needed support for the shared child or children calculated pursuant to subsection B of this section, for the combined gross income of the parties and the number of shared children, multiplied by 1.4.

(iv) Sole custody support. "Sole custody support" means the support amount determined in accordance with subdivision G 1.

(b) Support to be paid. The shared support need of the shared child or children shall be calculated pursuant to subdivision G 3 (a) (iii). This amount shall then be multiplied by the other parent's custody share. To that sum for each parent shall be added the other parent's or that parent's spouse's cost of health care coverage to the extent allowable by subsection E, plus the other parent's work-related child-care costs to the extent allowable by subsection F. This total for each parent shall be multiplied by that parent's income share. The support amounts thereby calculated that each parent owes the other shall be subtracted one from the other and the difference shall be the shared custody support one parent owes to the other, with the payor parent being the one whose shared support is the larger. Unreimbursed medical and dental expenses shall be calculated and allocated in accordance with subsection D.

(c) Definition of a day. For the purposes of this section, "day" means a period of 24 hours; however, where the parent who has the fewer number of overnight periods during the year has an overnight period with a child, but has physical custody of the shared child for less than 24 hours during such overnight period, there is a presumption that each parent shall be allocated one-half of a day of custody for that period.

(d) Minimum standards. Any calculation under this subdivision shall not create or reduce a support obligation to an amount which seriously impairs the custodial parent's ability to maintain minimal adequate housing and provide other basic necessities for the child. If the gross income of either party is equal to or less than 150 percent of the federal poverty level promulgated by the U.S. Department of Health and Human Services from time to time, then the shared custody support calculated pursuant to this subsection shall not be the presumptively correct support and the court may consider whether the sole custody support or the shared custody support is more just and appropriate.

(e) Support modification. When there has been an award of child support based on the shared custody formula and one parent consistently fails to exercise custody or visitation in accordance with the parent's custody share upon which the award was based, there shall be a rebuttable presumption that the support award should be modified.

(f) In the event that the shared custody support calculation indicates that the net support is to be paid to the parent who would not be the parent receiving support pursuant to the sole custody calculation, then the shared support shall be deemed to be the lesser support.

H. The Secretary of Health and Human Resources shall ensure that the guideline set out in this section is reviewed by October 31, 2001, and every four years thereafter, by the Child Support Guidelines Review Panel, consisting of 15 members comprised of four legislative members and 11 nonlegislative citizen members. Members shall be appointed as follows: three members of the House Committee for Courts of Justice, upon the recommendation of the chairman of such committee, 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; one member of the Senate Committee for Courts of Justice, upon the recommendation of the chairman of such committee, to be appointed by the Senate Committee on Rules; and one representative of a juvenile and domestic relations district court, one representative of a circuit court, one representative of the Department of Social Services' Division of Child Support Enforcement, three members of the Virginia State Bar, two custodial parents,

two noncustodial parents, and one child advocate, upon the recommendation of the Secretary of Health and Human Resources, to be appointed by the Governor. The Panel shall determine the adequacy of the guideline for the determination of appropriate awards for the support of children by considering current research and data on the cost of and expenditures necessary for rearing children, and any other resources it deems relevant to such review. The Panel shall report its findings to the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports before the General Assembly next convenes following such review.

Legislative members shall serve terms coincident with their terms of office. Nonlegislative citizen members shall serve at the pleasure of the Governor. All members may be reappointed. Appointments to fill vacancies, other than by expiration of a term, shall be made for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

Legislative members shall receive such compensation as provided in § 30-19.12, and nonlegislative citizen members shall receive such compensation for the performance of their duties as provided in § 2.2-2813. All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the costs of compensation and expenses of the members shall be provided by the Department of Social Services.

The Department of Social Services shall provide staff support to the Panel. All agencies of the Commonwealth shall provide assistance to the Panel, upon request.

The chairman of the Panel shall submit to the Governor and the General Assembly a quadrennial executive summary of the interim activity and work of the Panel no later than the first day of 2006 regular session of the General Assembly and every four years thereafter. 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.

§ 22.1-274.02. Certain memorandum of agreement required.

A. The Superintendent of Public Instruction or his designee and the Director of the Department of Medical Assistance Services or his designee shall develop and execute a memorandum of agreement relating to special education health services. This memorandum of agreement shall be revised on a periodic basis; however, the agreement shall, at a minimum, be revised and executed within six months of the inauguration of a new governor in order to maintain policy integrity.

B. The agreement shall include, but need not be limited to, (i) requirements for regular and consistent communications and consultations between the two departments and with school division personnel and officials and school board representatives; (ii) a specific and concise description and history of the federal Individuals with Disabilities Education Act (IDEA), a summary of school division responsibilities pursuant to the Individuals with Disabilities Education Act, and a summary of any corresponding state law which influences the scope of these responsibilities; (iii) a specific and concise summary of the then-current Department of Medical Assistance Services regulations regarding the special education health services; (iv) assignment of the specific responsibilities of the two state departments for the operation of special education health services; (v) a schedule of issues to be resolved through the regular and consistent communications process, including, but not limited to, ways to integrate and coordinate care between the Department of Medical Assistance Services' managed care providers and special education health services providers; (vi) a process for the evaluation of the services which may be delivered by school divisions participating as special education health services providers pursuant to ~~Medicaid~~ *medical assistance*; (vii) a plan and schedule to reduce the administrative and paperwork burden of ~~Medicaid~~ *medical assistance* participation on school divisions in Virginia; and (viii) a mechanism for informing primary care providers and other case management providers of those school divisions that are participating as ~~Medicaid~~ *medical assistance* providers and for identifying such school divisions as ~~Medicaid~~ *medical assistance* providers that are available to receive referrals to provide special education health services.

C. The Board of Education shall cooperate with the Board of Medical Assistance Services in developing a form to be included with the Individualized Education Plan (IEP) that shall be accepted by the Department of Medical Assistance Services as the plan of care (POC) and in collecting the data necessary to establish separate and specific ~~Medicaid~~ *medical assistance* rates for the IEP meetings and other services delivered by school divisions to students.

The POC form shall (i) be consistent with the plan of care required by the Department of Medical Assistance Services of other ~~Medicaid~~ *medical assistance* providers, (ii) allow for written updates, (iii) be used by all school divisions participating as ~~Medicaid~~ *medical assistance* providers of special education health services, (iv) document the student's progress, and (v) be integrated and coordinated with the Department of Medical Assistance Services' managed care providers.

D. The Department of Education shall prepare, upon consultation with the Department of Medical Assistance Services, a consent form which (i) is separate from the IEP, (ii) includes a statement noting that such form is not part of the student's IEP, (iii) includes a release to authorize billing of school-based health services delivered to the relevant student by the school division, and (iv) shall be

used by all school divisions participating in ~~Medicaid~~ *medical assistance* reimbursement. This consent form shall be made available to the parents upon conclusion of the IEP meeting. The release shall allow for billing of school-based health services by Virginia school divisions to ~~the Virginia Medicaid program and other~~ *any medical assistance* programs operated by the Department of Medical Assistance Services.

E. The Department of Education and the Department of Medical Assistance Services shall also develop a cost-effective, efficient, and appropriate process to allow school divisions access to eligibility data for students for whom consent has been obtained.

§ 23-38.93. Educational policies of the Commonwealth; other requirements.

A. For purposes of §§ 2.2-5004, 23-1.01, 23-1.1, 23-2, 23-2.1, 23-2.1:1, 23-3, 23-4.2, 23-4.3, 23-4.4, 23-7.1:02, 23-7.4, 23-7.4:1, 23-7.4:2, 23-7.4:3, 23-7.5, 23-8.2:1, 23-9.1, 23-9.2, 23-9.2:3, 23-9.2:3.03, 23-9.2:3.1 through 23-9.2:5, 23-9.6:1.01, and Chapter 4.9 (§ 23-38.75 et seq.), each covered institution shall remain a public institution of higher education of the Commonwealth following its conversion to a covered institution governed by this chapter, and shall retain the authority granted and any obligations required by such provisions. In addition, each covered institution shall retain the authority, and any obligations related to the exercise of such authority, that is granted to institutions of higher education pursuant to Chapter 1.1 (§ 23-9.3 et seq.); Chapter 3 (§ 23-14 et seq.); Chapter 3.2 (§ 23-30.23 et seq.); Chapter 3.3 (§ 23-30.39 et seq.); Chapter 4 (§ 23-31 et seq.); Chapter 4.01 (§ 23-38.10:2 et seq.); Chapter 4.1 (§ 23-38.11 et seq.); Chapter 4.4 (§ 23-38.45 et seq.); ~~Chapter 4.4:1 (§ 23-38.53:1 et seq.);~~ Chapter 4.4:2 (§ 23-38.53:4 et seq.); Chapter 4.4:3 (§ 23-38.53:11); Chapter 4.4:4 (§ 23-38.53:12 et seq.); Chapter 4.5 (§ 23-38.54 et seq.); ~~Chapter 4.7 (§ 23-38.70 et seq.);~~ Chapter 4.8 (§ 23-38.72 et seq.); and Chapter 4.9 (§ 23-38.75 et seq.).

B. State government-owned or operated and state-owned teaching hospitals that are a part of a covered institution as of the institution's effective date of the initial Management Agreement shall continue to be characterized as state government-owned or operated and state-owned teaching hospitals for purposes of payments under the State Plan for ~~Medicaid~~ *Medical Assistance* Services adopted pursuant to § 32.1-325 ~~et seq.~~, provided that the covered institution commits to serve indigent and medically indigent patients, in which event the Commonwealth, through the Department of Medical Assistance Services, shall, subject to the appropriation in the appropriation act in effect, continue to reimburse the full cost of the provision of care, treatment, health-related and educational services to indigent and medically indigent patients and continue to treat hospitals that were part of a covered institution and that were Type One Hospitals prior to the institution's effective date of the initial Management Agreement as Type One Hospitals for purposes of such reimbursement.

§ 23-50.16. Operations of Medical Center.

A. In enacting this section, the General Assembly recognizes that the ability of Virginia Commonwealth University to provide medical and health sciences education and related research is dependent upon the maintenance of high-quality teaching hospitals and related health care and health maintenance facilities, collectively referred to in this section as the Medical Center, and that the maintenance of a medical center serving such purposes requires specialized management and operation that permit the Medical Center to remain economically viable and to participate in cooperative arrangements reflective of changes in health care delivery.

B. Without limiting the powers provided in §§ 23-50.8 and 23-50.10, Virginia Commonwealth University may create, own in whole or in part or otherwise control corporations, partnerships, insurers or other entities whose activities will promote the operations of the Medical Center and its mission, may cooperate or enter into joint ventures with such entities and government bodies and may enter into contracts in connection therewith. Without limiting the power of Virginia Commonwealth University to issue bonds, notes, guarantees, or other evidence of indebtedness under subsection C in connection with such activities, no such creation, ownership or control shall create any responsibility of the University, the Commonwealth or any other agency thereof for the operations or obligations of any entity or in any way make the University, the Commonwealth, or any other agency thereof responsible for the payment of debt or other obligations of such entity. All such interests shall be reflected on the financial statements of the Medical Center.

C. Notwithstanding the provisions of Chapter 3 (§ 23-14 et seq.) of this title, Virginia Commonwealth University may issue bonds, notes, guarantees, or other evidence of indebtedness without the approval of any other governmental body subject to the following provisions:

1. Such debt is used solely for the purpose of paying not more than ~~fifty~~ *50* percent of the cost of capital improvements in connection with the operation of the Medical Center or related issuance costs, reserve funds, and other financing expenses, including interest during construction or acquisition and for up to one year thereafter;

2. The only revenues of the University pledged to the payment of such debt are those derived from the operation of the Medical Center and related health care and educational activities, and there are pledged therefor no general fund appropriation and special ~~Medicaid~~ *medical assistance* disproportionate

share payments for indigent and medically indigent patients who are not eligible for ~~the Virginia Medicaid Program~~ *a medical assistance program*;

3. Such debt states that it does not constitute a debt of the Commonwealth or a pledge of the faith and credit of the Commonwealth;

4. Such debt is not sold to the public;

5. The total principal amount of such debt outstanding at any one time does not exceed ~~twenty-five~~ *$25* million ~~dollars~~;

6. The Treasury Board has approved the terms and structure of such debt;

7. The purpose, terms, and structure of such debt are promptly communicated to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees; and

8. All such indebtedness is reflected on the financial statements of the Medical Center.

Subject to meeting the conditions set forth above, such debt may be in such form and have such terms as the board of visitors may provide and shall be in all respects debt of the University for the purposes of §§ 23-23, 23-25, and 23-26.

§ 23-77.3. Operations of Medical Center.

A. In enacting this section, the General Assembly recognizes that the ability of the University of Virginia to provide medical and health sciences education and related research is dependent upon the maintenance of high quality teaching hospitals and related health care and health maintenance facilities, collectively referred to in this section as the Medical Center, and that the maintenance of a Medical Center serving such purposes requires specialized management and operation that permit the Medical Center to remain economically viable and to participate in cooperative arrangements reflective of changes in health care delivery.

B. Notwithstanding the provisions of § 32.1-124 exempting hospitals and nursing homes owned or operated by an agency of the Commonwealth from state licensure, the Medical Center shall be, for so long as the Medical Center maintains its accreditation by the Joint Commission on Accreditation of Health Care Organizations or any successor in interest thereof, deemed to be licensed as a hospital for purposes of other law relating to the operation of hospitals licensed by the Board of Health. The Medical Center shall not, however, be deemed to be a licensed hospital to the extent any law relating to licensure of hospitals specifically excludes the Commonwealth or its agencies. As an agency of the Commonwealth, the Medical Center shall, in addition, remain (i) exempt from licensure by the Board of Health pursuant to § 32.1-124 and (ii) subject to the Virginia Tort Claims Act (§ 8.01-195.1 et seq.). Further, this subsection shall not be construed as a waiver of the Commonwealth's sovereign immunity.

C. Without limiting the powers provided in this chapter, the University of Virginia may create, own in whole or in part or otherwise control corporations, partnerships, insurers or other entities whose activities will promote the operations of the Medical Center and its mission, may cooperate or enter into joint ventures with such entities and government bodies and may enter into contracts in connection therewith. Without limiting the power of the University of Virginia to issue bonds, notes, guarantees, or other evidence of indebtedness under subsection D in connection with such activities, no such creation, ownership or control shall create any responsibility of the University, the Commonwealth or any other agency thereof for the operations or obligations of any such entity or in any way make the University, the Commonwealth, or any other agency thereof responsible for the payment of debt or other obligations of such entity. All such interests shall be reflected on the financial statements of the Medical Center.

D. Notwithstanding the provisions of Chapter 3 (§ 23-14 et seq.) of this title, the University of Virginia may issue bonds, notes, guarantees, or other evidence of indebtedness without the approval of any other governmental body subject to the following provisions:

1. Such debt is used solely for the purpose of paying not more than 50 percent of the cost of capital improvements in connection with the operation of the Medical Center or related issuance costs, reserve funds, and other financing expenses, including interest during construction or acquisitions and for up to one year thereafter;

2. The only revenues of the University pledged to the payment of such debt are those derived from the operation of the Medical Center and related health care and educational activities, and there are pledged therefor no general fund appropriation and special ~~Medicaid~~ *medical assistance* disproportionate share payments for indigent and medically indigent patients who are not eligible for ~~the Virginia Medicaid Program~~ *a medical assistance program*;

3. Such debt states that it does not constitute a debt of the Commonwealth or a pledge of the faith and credit of the Commonwealth;

4. Such debt is not sold to the public;

5. The total principal amount of such debt outstanding at any one time does not exceed $25 million;

6. The Treasury Board has approved the terms and structure of such debt;

7. The purpose, terms, and structure of such debt are promptly communicated to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees; and

8. All such indebtedness is reflected on the financial statements of the Medical Center.

Subject to meeting the conditions set forth above, such debt may be in such form and have such terms as the board of visitors may provide and shall be in all respects debt of the University for the purposes of §§ 23-23, 23-25, and 23-26.

§ 24.2-411.2. State-designated voter registration agencies.

A. The following agencies are designated as voter registration agencies in compliance with the National Voter Registration Act (42 U.S.C. § 1973gg et seq.) and shall provide voter registration opportunities at their state, regional, or local offices, depending upon the point of service:

1. Agencies whose primary function is to provide public assistance, including agencies that provide benefits under the Temporary Assistance for Needy Families program; Special Supplemental Food Program for Women, Infants, and Children; ~~Medicaid~~ ~~program;~~ or Food Stamps program;

2. Agencies whose primary function is to provide state-funded programs primarily engaged in providing services to persons with disabilities;

3. Armed Forces recruitment offices; and

4. The regional offices of the Department of Game and Inland Fisheries and the offices of the Virginia Employment Commission in the Northern Virginia Planning District 8.

B. The Secretary of the State Board of Elections, with the assistance of the Office of the Attorney General, shall compile and maintain a list of the specific agencies covered by subdivisions A 1 and A 2 that, in the legal opinion of the Attorney General, must be designated to meet the requirements of the National Voter Registration Act. The Secretary of the State Board of Elections shall notify each agency of its designation and thereafter notify any agency added to or deleted from the list.

C. At each voter registration agency, the following services shall be made available on the premises of the agency:

1. Distribution of mail voter registration forms provided by the State Board of Elections;

2. Assistance to applicants in completing voter registration application forms, unless the applicant refuses assistance; and

3. Receipt of completed voter registration application forms.

D. A voter registration agency, which provides service or assistance in conducting voter registration, shall make the following services available on the premises of the agency:

1. Distribution with each application for its service or assistance, or upon admission to a facility or program, and with each recertification, readmission, renewal, or change of address form, of a voter registration application prescribed by the State Board of Elections that complies with the requirements of the National Voter Registration Act (42 U.S.C. § 1973gg et seq.).

2. Provision, as part of the voter registration process, of a form that includes:

a. The question: "If you are not registered to vote where you live now, would you like to apply to register to vote here today?"

b. If the agency provides public assistance, the statement: "Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency."

c. Boxes for the applicant to check to indicate whether the applicant would like to register, declines to register to vote, or is already registered (failure to check any box being deemed to constitute a declination to register for purposes of subdivision 2 a), together with the statement (in close proximity to the boxes and in prominent type): "IF YOU DO NOT CHECK ANY BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME."

d. The statement: "If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek help or accept help is yours. You may fill out the application form in private."

e. The statement: "If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the State Board of Elections." The statement shall include the address and telephone number of the State Board.

f. The following statement accompanying the form which features prominently in boldface capital letters: "WARNING: INTENTIONALLY MAKING A MATERIALLY FALSE STATEMENT ON THIS FORM CONSTITUTES THE CRIME OF ELECTION FRAUD, WHICH IS PUNISHABLE UNDER VIRGINIA LAW AS A FELONY. VIOLATORS MAY BE SENTENCED TO UP TO 10 YEARS IN PRISON, OR UP TO 12 MONTHS IN JAIL AND/OR FINED UP TO $2,500."

3. Provision to each applicant who does not decline to register to vote of the same degree of assistance with regard to the completion of the voter registration application as is provided by the office with regard to the completion of its own applications, unless the applicant refuses assistance.

E. If a voter registration agency designated under subsection A of this section provides services to a person with a disability at the person's home, the agency shall provide the voter registration services as provided for in this section.

F. A person who provides services at a designated voter registration agency shall not:

1. Seek to influence an applicant's political preference;

2. Display any material indicating the person's political preference or party allegiance;

3. Make any statement to an applicant or take any action the purpose or effect of which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits; or

4. Disclose, except as authorized by law for official use, the social security number, or any part thereof, of any applicant for voter registration.

Any person who is aggrieved by a violation of this subsection may provide written notice of the violation to the State Board of Elections. The Board shall be authorized to cooperate with the agency to resolve the alleged violation. Nothing contained in this subsection shall prohibit an aggrieved person from filing a complaint in accordance with § 24.2-1019 against a person who commits any election law offense enumerated in §§ 24.2-1000 through 24.2-1016.

G. A completed voter registration application shall be transmitted as directed by the State Board of Elections not later than five business days after the date of receipt.

H. Each state-designated voter registration agency shall maintain such statistical records on the number of applications to register to vote as requested by the State Board of Elections.

§ 26-17.4. Conservators, guardians of minors' estates, committees, trustees under § 37.2-1016 and receivers.

A. Within six months from the date of the qualification, conservators, guardians of minors' estates, committees, and trustees under § 37.2-1016 shall exhibit before the commissioner of accounts a statement of all money and other property which such fiduciary has received, or become chargeable with, or has disbursed within four months from the date of qualification.

B. After the first account of the fiduciary has been filed and settled, the second and subsequent accounts for each succeeding ~~twelve-month~~ *12-month* period will be due within four months from the last day of the ~~twelve-month~~ *12-month* period commencing on the terminal date of the preceding account unless the commissioner of accounts extends the period for filing upon reasonable cause.

C. For fiduciaries acting on behalf of ~~Medicaid~~ *medical assistance* recipients, the fees charged by the commissioners of accounts under subsection A or B shall not exceed ~~twenty-five dollars~~ *$25*.

§ 32.1-27.1. Additional civil penalty or appointment of a receiver.

A. In addition to the remedies provided in § 32.1-27, the civil penalties set forth in this section may be imposed by the circuit court for the city or county in which the facility is located as follows:

1. A civil penalty for a Class I violation shall not exceed the lesser of $25 per licensed or certified bed or $1,000 for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

2. A civil penalty for a Class II violation shall not exceed the lesser of $5 per licensed or certified bed or $250 per day for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

In the event federal law or regulations require a civil penalty in excess of the amounts set forth above for Class I or Class II violations, then the lowest amounts required by such federal law or regulations shall become the maximum civil penalties under this section. The date of notification under this section shall be deemed to be the date of receipt by the facility of written notice of the alleged Class I or Class II violation, which notice shall include specifics of the violation charged and which notice shall be hand delivered or sent by overnight express mail or by registered or certified mail, return receipt requested.

All civil penalties received pursuant to this subsection shall be paid into a special fund of the Department for the cost of implementation of this section, to be applied to the protection of the health or property of residents or patients of facilities that the Commissioner or the United States Secretary of Health and Human Services finds in violation, including payment for the costs for relocation of patients, maintenance of temporary management or receivership to operate a facility pending correction of a violation, and for reimbursement to residents or patients of lost personal funds.

B. In addition to the remedies provided in § 32.1-27 and the civil penalties set forth in subsection A of this section, the Commissioner may petition the circuit court for the jurisdiction in which any nursing home or certified nursing facility as defined in § 32.1-123 is located for the appointment of a receiver in accordance with the provisions of this subsection whenever such nursing home or certified nursing facility shall (i) receive official notice from the Commissioner that its license has been or will be revoked or suspended, or that its Medicare ~~or~~ ~~Medicaid~~ certification has been or will be cancelled or revoked; or (ii) receive official notice from the United States Department of Health and Human Services or the Department of Medical Assistance Services that its provider agreement has been or will be revoked, cancelled, terminated or not renewed; or (iii) advise the Department of its intention to close or not to renew its license or Medicare ~~or~~ ~~Medicaid~~ provider agreement less than ~~ninety~~ *90* days in advance; or (iv) operate at any time under conditions which present a major and continuing threat to the health, safety, security, rights or welfare of the patients, including the threat of imminent abandonment

by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (v) the Department is unable to make adequate and timely arrangements for relocating all patients who are receiving medical assistance under this chapter ~~and Title XIX of the Social Security Act~~ in order to ensure their continued safety and health care.

Upon the filing of a petition for appointment of a receiver, the court shall hold a hearing within ~~ten~~ *10* days, at which time the Department and the owner or operator of the facility may participate and present evidence. The court may grant the petition if it finds any one of the conditions identified in (i) through (iv) above to exist in combination with the condition identified in (v) and the court further finds that such conditions will not be remedied and that the patients will not be protected unless the petition is granted.

No receivership established under this subsection shall continue in effect for more than 180 days without further order of the court, nor shall the receivership continue in effect following the revocation of the nursing home's license or the termination of the certified nursing facility's Medicare ~~or Medicaid~~ provider agreement, except to enforce any post-termination duties of the provider as required by the provisions of the Medicare ~~or Medicaid~~ provider agreement.

The appointed receiver shall be a person licensed as nursing home administrator in the Commonwealth pursuant to Title 54.1 or, if not so licensed, shall employ and supervise a person so licensed to administer the day-to-day business of the nursing home or certified nursing facility.

The receiver shall have (i) such powers and duties to manage the nursing home or certified nursing facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all patients and the right to refuse to admit new patients during the receivership, (ii) the power to receive, conserve, protect and disburse funds, including Medicare ~~and Medicaid~~ payments on behalf of the owner or operator of the nursing home or certified nursing facility, (iii) the power to execute and avoid executory contracts, (iv) the power to hire and discharge employees, and (v) the power to do all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the patients from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have been substantially eliminated or remedied, or (ii) all patients in the nursing home or certified nursing facility have been relocated. Within ~~thirty~~ *30* days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the nursing home or certified nursing facility from Medicare~~, Medicaid~~ and other patient care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the nursing home or certified nursing facility which existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts which result in injuries to persons or damage to property at the nursing home or certified nursing facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or of any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

§ 32.1-111.2. Exemptions from provisions of this article.

The following entities are exempted from the provisions of this article:

1. Emergency medical service agencies based outside the Commonwealth, except that any such agency receiving a person who is sick, injured, wounded, incapacitated or helpless within the Commonwealth for transportation to a location within the Commonwealth shall comply with the provisions of this article;

2. Emergency medical service agencies operated by the United States government; and

3. Wheelchair interfacility transport services and wheelchair interfacility transport service vehicles that are engaged, whether or not for profit, in the business, service, or regular activity of and exclusively used for transporting wheelchair bound passengers between medical facilities in the Commonwealth when no ancillary medical care or oversight is necessary. However, such services and vehicles shall

comply with Department of Medical Assistance Services regulations regarding the transportation of ~~Medicaid~~ *medical assistance* recipients to covered services.

§ 32.1-111.6:1. Commissioner of Health to issue certain emergency medical services permits or licenses.

The Commissioner of Health shall issue permits or licenses for emergency medical services agencies and vehicles as needed to ensure compliance with federal regulations relating to reimbursement of ambulance services pursuant to Medicare ~~and~~ ~~Medicaid~~.

§ 32.1-122.07. Authority of Commissioner for certain health planning activities; rural health plan; designation as a rural hospital.

A. The Commissioner, with the approval of the Board, is authorized to make application for federal funding and to receive and expend such funds in accordance with state and federal regulations.

B. The Commissioner shall administer section 1122 of the United States Social Security Act if the Commonwealth has made an agreement with the United States Secretary of Health and Human Services pursuant to such section.

C. In compliance with the provisions of the Balanced Budget Act of 1997, P.L. 105-33, and any amendments to such provisions, the Commissioner shall submit to the appropriate regional administrator of the Centers for Medicare & Medicaid Services (CMS) an application to establish a Medicare Rural Hospital Flexibility Program in Virginia.

D. The Commissioner shall develop and the Board of Health shall approve a rural health care plan for the Commonwealth to be included with the application to establish a Medicare Rural Hospital Flexibility Program. In cooperation and consultation with the Virginia Hospital and Health Care Association, the Medical Society of Virginia, representatives of rural hospitals, and experts within the Department of Health on rural health programs, the plan shall be developed and revised as necessary or as required by the provisions of the Balanced Budget Act of 1997, P.L. 105-33, and any amendments to such provisions. In the development of the plan, the Commissioner may also seek the assistance of the regional health planning agencies. The plan shall verify that the Commonwealth is in the process of designating facilities located in Virginia as critical access hospitals, shall note that the Commonwealth wishes to certify facilities as "necessary providers" of health care in rural areas, and shall describe the process, methodology, and eligibility criteria to be used for such designations or certifications. Virginia's rural health care plan shall reflect local needs and resources and shall, at minimum, include, but need not be limited to, a mechanism for creating one or more rural health networks, ways to encourage rural health service regionalization, and initiatives to improve access to health services, including hospital services, for rural Virginians.

E. Notwithstanding any provisions of this chapter or the Board's regulations to the contrary, the Commissioner shall, in the rural health care plan, (i) use as minimum standards for critical access hospitals, the certification regulations for critical access hospitals promulgated by the Centers for Medicare & Medicaid Services (CMS) pursuant to Title XVIII of the Social Security Act, as amended; and (ii) authorize critical access hospitals to utilize a maximum of ~~ten~~ *10* beds among their inpatient hospital beds as swing beds for the furnishing of services of the type which, if furnished by a nursing home or certified nursing facility, would constitute skilled care services without complying with nursing home licensure requirements or retaining the services of a licensed nursing home administrator. Such hospital shall include, within its plan of care, assurances for the overall well-being of patients occupying such beds.

F. Nothing herein or set forth in Virginia's rural health care plan shall prohibit any hospital designated as a critical access hospital from leasing the unused portion of its facilities to other health care organizations or reorganizing its corporate structure to facilitate the continuation of the nursing home beds that were licensed to such hospital prior to the designation as a critical access hospital. The health care services delivered by such other health care organizations shall not be construed as part of the critical access hospital's services or license to operate.

G. Any medical care facility licensed as a hospital shall be considered a rural hospital on and after September 30, 2004, pursuant to 42 U.S.C. § 1395ww(d)(8)(E)(ii)(II), if (i) the hospital is located in an area defined as rural by federal statute or regulation; (ii) the Board of Health defines, in regulation, the area in which the hospital is located as a rural health area or the hospital as a rural hospital; or (iii) the hospital was designated, prior to October 1, 2004, as a Medicare-dependent small rural health hospital, as defined in 42 U.S.C. § 1395ww(d)(5)(G)(iv).

§ 32.1-123. Definitions.

As used in this article unless a different meaning or construction is clearly required by the context or otherwise:

"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare ~~or~~ ~~Medicaid~~ provider, or both, pursuant to § 32.1-137.

"Class I violation" means failure of a nursing home or certified nursing facility to comply with one or more requirements of state or federal law or regulations which creates a situation that presents an immediate and serious threat to patient health or safety.

"Class II violation" means a pattern of noncompliance by a nursing home or certified nursing facility with one or more federal conditions of participation which indicates delivery of substandard quality of care but does not necessarily create an immediate and serious threat to patient health and safety. Regardless of whether the facility participates in Medicare ~~or Medicaid~~, the federal conditions of participation shall be the standards for Class II violations.

"Hospital" means any facility licensed pursuant to this article in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, rehabilitation, chronic disease, short-term, long-term, outpatient surgical, and inpatient or outpatient maternity hospitals.

"Immediate and serious threat" means a situation or condition having a high probability that serious harm or injury to patients could occur at any time, or already has occurred, and may occur again, if patients are not protected effectively from the harm, or the threat is not removed.

"Inspection" means all surveys, inspections, investigations and other procedures necessary for the Department of Health to perform in order to carry out various obligations imposed on the Board or Commissioner by applicable state and federal laws and regulations.

"Nursing home" means any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.

"Nonrelated" means not related by blood or marriage, ascending or descending or first degree full or half collateral.

"Substandard quality of care" means deficiencies in practices of patient care, preservation of patient rights, environmental sanitation, physical plant maintenance, or life safety which, if not corrected, will have a significant harmful effect on patient health and safety.

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII ~~and Title XIX~~ of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.) of this chapter.

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to assure the environmental protection and the life safety of its patients and employees and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; and (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare & Medicaid Services (CMS)~~, particularly 42 C.F.R. § 482.45~~. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential

donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (i) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (ii) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be based on Joint Commission on Accreditation of Healthcare Organizations' standards;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is a registered sex offender, if the home or facility anticipates the potential

patient will have a length of stay greater than three days or in fact stays longer than three days; and

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot which is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

§ 32.1-127.01. Regulations to authorize certain sanctions and guidelines.

The regulations established pursuant to § 32.1-127 shall authorize the Commissioner to initiate court proceedings against nursing homes and certified nursing facilities, except for facilities or units certified as facilities for the mentally retarded. Such proceedings may be initiated by themselves or in conjunction with the administrative sanctions provided in § 32.1-135.

The Board shall promulgate guidelines for the Commissioner to determine when the imposition of administrative sanctions or initiation of court proceedings as specified in § 32.1-27.1, or both, are appropriate in order to ensure prompt correction of violations involving noncompliance with requirements of state or federal law or regulation as discovered on any inspection conducted by the Department of Health pursuant to the provisions of this article or the provisions of Title XVIII ~~or Title XIX~~ of the Social Security Act or as discovered on any inspection conducted by the Department of Medical Assistance Services ~~pursuant to Title XIX of the Social Security Act~~.

§ 32.1-132. Alterations or additions to hospitals and nursing homes; when new license required; use of inpatient hospital beds for furnishing skilled care services.

A. Any person who desires to make any substantial alteration or addition to or any material change in any hospital or nursing home shall, before making such change, alteration or addition, submit the proposal therefor to the Commissioner for his approval. The Commissioner shall review the proposal to determine compliance with applicable statutes and regulations of the Board and as soon thereafter as reasonably practicable notify the person that the proposal is or is not approved.

B. If any such alteration, addition or change has the effect of changing the bed capacity or classification of the hospital or nursing home, the licensee shall obtain a new license for the remainder of the license year before beginning operation of additional beds or in the new classification.

C. Notwithstanding any provision of state law to the contrary, any hospital, after sending such written notice as may be required by the Commissioner, may utilize, for a period not to exceed ~~thirty~~ *30* days for any one patient, a maximum of ~~ten~~ *10* percent of its inpatient hospital beds as swing beds for the furnishing of services of the type which, if furnished by a nursing home or certified nursing facility, would constitute skilled care services without complying with nursing home licensure requirements or retaining the services of a licensed nursing home administrator. Such hospital shall amend its plan of care and implement its plan as amended to ensure the overall well-being of patients occupying such beds. Only those hospitals which qualify under § 1883 of Title XVIII ~~and § 1913 of Title XIX~~ of the Social Security Act and are certified as skilled nursing facilities may be reimbursed for such services for Medicare ~~and Medicaid~~ patients.

§ 32.1-137. Certification of medical care facilities under Title XVIII of Social Security Act.

The Board shall constitute the sole agency of the Commonwealth to enter into contracts with the United States government for the certification of medical care facilities under Title XVIII of the United States Social Security Act and any amendments thereto ~~and with the Virginia Department of Medical Assistance Services for the certification of medical care facilities under Title XIX of the United States Social Security Act and any amendments thereto~~.

§ 32.1-138. Enumeration; posting of policies; staff training; responsibilities devolving on guardians, etc.; exceptions; certification of compliance.

A. The governing body of a nursing home facility required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter, through the administrator of such facility, shall cause to be promulgated policies and procedures to ensure that, at the minimum, each patient admitted to such facility:

1. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during his stay, of his rights and of all rules and regulations governing patient conduct and responsibilities;

2. Is fully informed, prior to or at the time of admission and during his stay, of services available in the facility and of related charges, including any charges for services not covered under Titles XVIII or XIX of the United States Social Security Act or not covered by the facility's basic per diem rate;

3. Is fully informed in summary form of the findings concerning the facility in federal Centers for Medicare & Medicaid Services surveys and investigations, if any;

4. Is fully informed by a physician, physician assistant, or nurse practitioner of his medical condition unless medically contraindicated as documented by a physician, physician assistant, or nurse practitioner in his medical record and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

5. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act, and is given reasonable advance notice as provided in § 32.1-138.1 to ensure orderly transfer or discharge, and such actions are documented in his medical record;

6. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient and as a citizen and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

7. May manage his personal financial affairs, or may have access to records of financial transactions made on his behalf at least once a month and is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with state law;

8. Is free from mental and physical abuse and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time or when necessary to protect the patient from injury to himself or to others;

9. Is assured confidential treatment of his personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of his transfer to another health care institution or as required by law or third-party payment contract;

10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. May associate and communicate privately with persons of his choice and send and receive his personal mail unopened, unless medically contraindicated as documented by his physician in his medical record;

13. May meet with and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated as documented by his physician, physician assistant, or nurse practitioner in his medical record;

14. May retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other patients and unless medically contraindicated as documented by his physician, physician assistant, or nurse practitioner in his medical record;

15. If married, is assured privacy for visits by his or her spouse and if both are inpatients in the facility, is permitted to share a room with such spouse unless medically contraindicated as documented by the attending physician, physician assistant, or nurse practitioner in the medical record; and

16. Is fully informed, as evidenced by the written acknowledgment of the resident or his legal representative, prior to or at the time of admission and during his stay, that he should exercise whatever due diligence he deems necessary with respect to information on any sexual offenders registered pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, including how to obtain such information. Upon request, the nursing home facility shall assist the resident, prospective resident, or the legal representative of the resident or prospective resident in accessing this information and provide the resident, prospective resident, or the legal representative of the resident or prospective resident with printed copies of the requested information.

B. All established policies and procedures regarding the rights and responsibilities of patients shall be printed in at least 12-point type and posted conspicuously in a public place in all nursing home facilities required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter. These policies and procedures shall include the name and telephone number of the complaint coordinator in the Division of Licensure and Certification of the Virginia Department of Health, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies of such policies and procedures shall be given to patients upon admittance to the facility and made

available to patients currently in residence, to any guardians, next of kin, or sponsoring agency or agencies, and to the public.

C. The provisions of this section shall not be construed to restrict any right that any patient in residence has under law.

D. Each facility shall provide appropriate staff training to implement each patient's rights included in subsection A hereof.

E. All rights and responsibilities specified in subsection A hereof and § 32.1-138.1 as they pertain to (i) a patient adjudicated incapacitated in accordance with state law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who is unable to communicate with others shall devolve to such patient's guardian, next of kin, sponsoring agency or agencies, or representative payee, except when the facility itself is representative payee, selected pursuant to section 205(j) of Title II of the United States Social Security Act.

F. Nothing in this section shall be construed to prescribe, regulate, or control the remedial care and treatment or nursing service provided to any patient in a nursing institution to which the provisions of § 32.1-128 are applicable.

G. It shall be the responsibility of the Commissioner to insure that the provisions of this section and the provisions of § 32.1-138.1 are observed and implemented by nursing home facilities. Each nursing home facility to which this section and § 32.1-138.1 are applicable shall certify to the Commissioner that it is in compliance with the provisions of this section and the provisions of § 32.1-138.1 as a condition to the issuance or renewal of the license required by Article 1 (§ 32.1-123 et seq.) of this chapter.

§ 32.1-138.2. Certain contract provisions prohibited.

No contract or agreement for nursing home care shall contain any provisions which restrict or limit the ability of a resident to apply for and receive ~~Medicaid~~ *medical assistance* or which require a specified period of residency prior to applying for ~~Medicaid~~ *medical assistance*. The resident may be required to notify the facility when an application for ~~Medicaid~~ *medical assistance* has been made. No contract or agreement may require a deposit or other prepayment from ~~Medicaid~~ *medical assistance* recipients. No contract or agreement shall contain provisions authorizing the facility to refuse to accept retroactive ~~Medicaid~~ *medical assistance* benefits.

§ 32.1-138.3. Third party guarantor prohibition.

Any facility certified under Title XVIII or XIX of the United States Social Security Act shall not require a third party guarantee of payment to the facility as a condition of admission or of expedited admission to, or continued stay in, the facility. This section shall not be construed to prevent a facility from requiring an individual who has legal access to a resident's income or resources which are available to pay for care in the facility to sign a contract without incurring personal financial liability except for breach of the duty to provide payment from the resident's income or resources for such care.

For purposes of this section, the resident's income or resources shall include any amount deemed to be income or resources of the resident for purposes of ~~Medicaid~~ *medical assistance* eligibility and any resources transferred by the resident to a third party if the transfer disqualifies the resident from ~~Medicaid~~ *medical assistance* coverage for nursing facility services.

§ 32.1-162.8. Exemptions from article.

The provisions of this article shall not be applicable to:

1. A natural person who provides services to a patient or individual on an individual basis if such person is (i) acting alone under a medical plan of care and is licensed to provide such services pursuant to Title 54.1 or (ii) retained by the individual or by another individual acting on the individual's behalf.

2. Any organization providing only housekeeping, chore or beautician services.

3. Any home care organization located in the Commonwealth that is:

a. Certified by the Department of Health under provisions of Title XVIII ~~or~~ ~~Title~~ ~~XIX~~ of the Social Security Act;

b. Approved for payments for home health or personal care by the Department of Medical Assistance Services;

c. Accredited by the Joint Commission on Accreditation for Health Organizations, the National League of Nursing or the National Home Caring Council; or

d. Licensed for hospice services under Article 7 (§ 32.1-162.1 et seq.) of this chapter.

§ 32.1-276.4. Agreements for certain data services.

A. The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to this chapter and for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Such nonprofit organization shall be governed by a board of directors composed of representatives of state government, including the Commissioner, and the consumer, health care provider, and business communities. Of the health care provider representatives, there shall be an equal number of hospital, nursing home, physician

and health plan representatives. The articles of incorporation of such nonprofit organization shall require the nomination of such board members by organizations and associations representing those categories of persons specified for representation on the board of directors.

B. In addition to providing for the compilation, storage, analysis, and evaluation services described in subsection A, any contract or agreement with a nonprofit, tax-exempt health data organization made pursuant to this section shall require the board of directors of such organization to:

1. Develop and disseminate other health care cost and quality information designed to assist businesses and consumers in purchasing health care and long-term care services;

2. Prepare and make public summaries, compilations, or other supplementary reports based on the data provided by health care providers pursuant to this chapter;

3. Collect, compile, and publish Health Employer Data and Information Set (HEDIS) information or reports or other quality of care or performance information sets approved by the Board, pursuant to § 32.1-276.5, and submitted by health maintenance organizations or other health care plans;

4. Jointly determine with the Board of Medicine any data concerning safety services and quality health care services rendered by physicians to ~~Medicaid~~ *medical assistance* recipients that should be identified, collected, and disseminated. The board of directors shall further determine jointly with the Board of Medicine the costs of requiring physicians to identify, submit, or collect such information and identify sufficient funding sources to appropriate to physicians for the collection of the same. No physician shall be required to collect or submit safety and quality of health care services information that is already identified, collected, or submitted under this chapter; or for which funds for collection are not appropriated;

5. Maintain the confidentiality of data as set forth in § 32.1-276.9;

6. Submit a report to the Board, the Governor, and the General Assembly no later than October 1 of each year for the preceding fiscal year. Such report shall include a certified audit and provide information on the accomplishments, priorities, and current and planned activities of the nonprofit organization;

7. Submit, as appropriate, strategic plans to the Board, the Governor, and the General Assembly recommending specific data projects to be undertaken and specifying data elements that will be required from health care providers. In developing strategic plans, the nonprofit organization shall incorporate similar activities of other public and private entities to maximize the quality of data projects and to minimize the cost and duplication of data projects. In its strategic plans, the nonprofit organization shall also evaluate the continued need for and efficacy of current data initiatives, including the use of patient level data for public health purposes. The nonprofit organization shall submit the first such strategic plan to the Board, the Governor, and the General Assembly by October 1, 1996. Such initial plan shall include recommendations for measuring quality of care for all health care providers and for funding all data projects undertaken pursuant to this chapter. The approval of the General Assembly shall be required prior to the implementation of any recommendations set forth in a strategic plan submitted pursuant to this section;

8. Competitively bid or competitively negotiate all aspects of all data projects, if feasible.

C. Except as provided in subdivision A 2 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Commissioner authorized by this section. Funding for services provided pursuant to any such contract or agreement shall come from general appropriations and from fees determined pursuant to § 32.1-276.8.

§ 32.1-276.5:1. Disclosures of contractual arrangements to be made publicly available.

A. In order to advance transparency in health care and provide patients and families with better information on which to judge value among their treatment options, the Commissioner shall negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for an annual survey of carriers offering private group health insurance policies, which are subject to HEDIS reporting, to determine the reimbursement that is paid for a minimum of 25 most frequently reported health care services which may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases. Each carrier shall report the average reimbursement paid for a specific service from all providers and provider types, to include hospitals, outpatient or ambulatory surgery centers and physician offices. The survey shall also include, when available, the average reimbursement rates for the same services provided for reimbursement by fee-for-service Medicare~~and Medicaid~~. The survey shall be managed by the Commissioner to insure that when such information is reported it will provide the aggregate information so that readers will be able to determine the average amount of reimbursement paid for specific healthcare services. No provider, facility or carrier specific reimbursement information shall be included in the public survey reports. Such specific information shall be deemed proprietary and shall not be disclosed to the public; only the Commissioner will have access to the underlying survey data. The public survey reports shall be made available to the public through an Internet Website operated by the contracting organization.

The Commissioner, in conjunction with stakeholders working through the non-profit organization,

shall work to (i) incorporate existing service quality data and guidance to the price information to further assist informed consumer choice to the extent it is practical and consistent with generally accepted national guidelines, and (ii) seek over time to display price and quality information for episodes of care in a manner which is consistent with generally accepted national guidelines.

B. The information acquired in the survey and provided to the Commissioner shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 21 of § 2.2-3705.6.

§ 32.1-323.1. Department to submit forecast of expenditures.

By November 15 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit an estimate of ~~Medicaid~~ *medical assistance* expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and to the Senate Committees on Finance and Education and Health, and to the Joint Legislative Audit and Review Commission.

§ 32.1-325. Board to develop plan for medical assistance services; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare~~,~~ *and* amend from time to time ~~and submit to the Secretary of the United States Department of Health and Human Services~~ a state plan for medical assistance services ~~pursuant to Title XIX of the United States Social Security Act and any amendments thereto~~. The Board ~~shall~~ *may* include in such plan~~:~~ *such provisions as it deems appropriate to care for medically needy citizens of the Commonwealth.*

~~1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;~~

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

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

~~4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;~~

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

~~6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;~~

~~7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman~~

continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

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

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

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

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

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician, physician assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 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 PSA test in a 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;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

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

20. A provision for payment of medical assistance for custom ocular prostheses;

~~21. A provision for payment for medical assistance 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 provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;~~

~~22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;~~

~~23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for both programs; and~~

~~24. A provision, when authorized by and in compliance with federal law, to establish a public-private long-term care partnership program between the Commonwealth of Virginia and private insurance companies that shall be established through the filing of an amendment to the state plan for medical assistance services by the Department of Medical Assistance Services. The purpose of the program shall be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for such services through encouraging the purchase of private long-term care insurance policies that have been designated as qualified state long-term care insurance partnerships and may be used as the first source of benefits for the participant's long-term care. Components of the program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and applicable federal guidelines.~~

B. In preparing the plan, the Board shall:

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

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

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

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

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

6. 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 recipient of medical assistance services, 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 recipients such corrective information as may be required to electronically process a prescription claim.

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

~~In the event conforming amendments to the state plan for medical assistance services are adopted, the~~

Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

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

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

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

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

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

E*D*. In any case in which a Medicaid *medical assistance* agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

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

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

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

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

3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of health care services under Medicaid and the Family Access to Medical Insurance Security Plan established under § 32.1-351.

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

J*G*. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by

subsection ~~I of this section~~ *F*. ~~Agreements made pursuant to this subsection shall comply with federal law and regulation.~~

§ 32.1-325.01. Certain term life insurance considered resources.

When making eligibility determinations for institutional or community-based care to be paid for by the Department, the Department shall consider as an uncompensated transfer all resources that are used by an applicant to purchase any term life insurance policy that does not have a benefit payable at death that will equal or exceed twice the sum of all premiums paid for such policy if such policy was purchased within ~~thirty~~ *30* months prior to the date of application for assistance.

The provisions of this section shall not apply to term life insurance policies for pre-need funerals pursuant to § 54.1-2820, except that any benefits paid under such policy in excess of such actual expenses shall be subject to recovery by the Department of Medical Assistance Services for ~~Medicaid~~ *medical assistance* payments made on behalf of the deceased insured. The provisions of this section shall not apply to any term life insurance policies purchased prior to the effective date of this law.

§ 32.1-325.02. Determinations of assets; disclaimers of interests to be considered uncompensated transfers of assets for medical assistance eligibility purposes under certain circumstances.

A. When determining eligibility for medical assistance services, "assets" means, in regard to an individual, all income and resources of the individual and the individual's spouse, including, but not limited to, any income or resources which the individual or such individual's spouse is or becomes entitled to, but does not receive, because of any action by such individual or such individual's spouse, or by a person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or such individual's spouse, or by any person, including any court or administrative body, acting at the direction of or upon the request of the individual or such individual's spouse.

B. For the sole purpose of determining eligibility for medical assistance services as provided in this title, Chapter 5 (§ 63.2-500 et seq.) of Title 63.2, and the regulations of the Department of Medical Assistance Services, any disclaimer of succession pursuant to Chapter 8.1 (§ 64.1-196.1 et seq.) of Title 64.1 shall be considered an uncompensated transfer of assets equal to the value of any interest disclaimed by any person who would, by reason of the disclaimer of succession, retain ~~Medicaid~~ *medical assistance* eligibility or become eligible for medical assistance within (i) 36 months of the date that the disclaimer instrument is filed with a court of competent jurisdiction when the disclaimer instrument relates to any property other than property passed through a trust or (ii) 60 months of the date that the disclaimer instrument is filed with a court of competent jurisdiction when the disclaimer instrument relates to payments from a trust or portions of a trust.

§ 32.1-325.03. Legal presence required for certain state and local public benefits; exceptions; definitions; proof of legal presence.

A. In addition to meeting the existing eligibility requirements of the benefits applied for, no person who is not a United States Citizen or legally present in the United States shall receive medical services under this chapter, except for the following:

1. ~~Medicaid~~*Medical assistance* benefits for those residing in long-term institutional facilities or participating in home and community based waivers on June 30, 1997, who were eligible for full ~~Medicaid~~ *medical assistance* benefits shall continue to be eligible for ~~Medicaid~~ *medical assistance* benefits at state expense ~~if federal financial participation is not available~~;

2. ~~Medicaid~~ *Medical assistance* benefits for those who because of alien requirements pursuant to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) (i) are under the age of 19 years and (ii) would be eligible for full ~~Medicaid~~ *medical assistance* benefits if the alien requirements prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 were still in effect. However, such person upon reaching the age of 19 years shall comply with the provisions of this section; and

3. State or local public benefits that are mandated by Federal Law pursuant to 8 U.S.C. § 1621.

B. The determination of eligibility for public benefits as provided in this chapter shall be subject to the provisions of § 63.2-503.1, as applicable.

§ 32.1-325.1. Adverse initial determination of overpayment; appeals of agency determinations.

A. The Director shall make an initial determination as to whether an overpayment has been made to a provider in accordance with the state plan for medical assistance~~,~~ *and* the provisions of § 2.2-4019 ~~and applicable federal law~~. The initial determination shall be issued within 180 days of the receipt of the appeal request. If the agency does not render a decision within 180 days, the decision is deemed to be in favor of the provider.

B. An appeal of the Director's initial determination concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the state plan for medical assistance provided for in § 32.1-325. The hearing officer appointed pursuant to § 2.2-4024 shall conduct the appeal and submit a recommended decision to the Director within 120 days of the

agency's receipt of the appeal request. The Director shall consider the parties' exceptions and issue the final agency case decision within ~~sixty~~ *60* days of receipt of the hearing officer's recommended decision. If the Director does not render a final agency case decision within ~~sixty~~ *60* days of the receipt of the hearing officer's recommended decision, the decision is deemed to be in favor of the provider. The Director shall adopt the hearing officer's recommended decision unless to do so would be an error of law or Department policy. Any final agency case decision in which the Director rejects a hearing officer's recommended decision shall state with particularity the basis for rejection. Prior to a final agency case decision issued in accordance with § 2.2-4023, the Director may not undertake recovery of any overpayment amount paid to the provider through offset or other means. Once a final determination of overpayment has been made, the Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial or the final determination of overpayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the Director's determination becomes final. Nothing in § 32.1-313 shall be construed to require interest payments on any portion of overpayment other than the unpaid balance referenced herein.

C. The burden of proof in informal and formal administrative appeals is on the provider. The agency shall reimburse a provider for reasonable and necessary attorneys' fees and costs associated with an informal or formal administrative appeal if the provider substantially prevails on the merits of the appeal and the agency's position is not substantially justified, unless special circumstances would make an award unjust. In any case in which a provider has recovered attorneys' fees and costs associated with an informal or formal administrative appeal, the provider shall not be entitled to recover those same attorneys' fees and costs in a subsequent judicial proceeding.

D. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). In any case in which a final determination of overpayment has been reversed in a subsequent judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest, within ~~thirty~~ *30* days of the subsequent judicial order.

§ 32.1-325.1:1. Definitions; recovery of overpayment for medical assistance services.

A. For the purposes of this section, the following definitions shall apply:

"Agreement" means any contract executed for the delivery of services to recipients of medical assistance pursuant to subdivision ~~D~~ *C* 2 of § 32.1-325.

"Successor in interest" means any person as defined in § 1-230 having stockholders, directors, officers, or partners in common with a health care provider for which an agreement has been terminated.

"Termination" means (i) the cessation of operations by a provider, (ii) the sale or transfer of the provider, (iii) the reorganization or restructuring of the health care provider, or (iv) the termination of an agreement by either party.

B. The Director of Medical Assistance Services shall collect by any means available to him at law any amount owed to the Commonwealth because of overpayment for medical assistance services. Upon making an initial determination that an overpayment has been made to the provider pursuant to § 32.1-325.1, the Director shall notify the provider of the amount of the overpayment. Such initial determination shall be made within the earlier of (i) four years, or (ii) 15 months after filing of the final cost report by the provider subsequent to sale of the facility or termination of the provider. The provider shall make arrangements satisfactory to the Director to repay the amount due. If the provider fails or refuses to make arrangements satisfactory to the Director for such repayment or fails or refuses to repay the Commonwealth for the amount due for overpayment in a timely manner, the Director may devise a schedule for reducing the ~~Medicaid~~ *medical assistance* reimbursement due to any successor in interest.

C. In any case in which the Director is unable to recover the amount due for overpayment pursuant to subsection B, he shall not enter into another agreement with the responsible provider or any person who is the transferee, assignee, or successor in interest to such provider unless (i) he receives satisfactory assurances of repayment of all amounts due or (ii) the agreement with the provider is necessary in order to ensure that ~~Medicaid~~ *medical assistance* recipients have access to the covered services rendered by the provider.

Further, to the extent consistent with ~~federal and~~ state law, the Director shall not enter into any agreement with a provider having any stockholder possessing a material financial interest, partner, director, officer, or owner in common with a provider which has terminated a previous agreement for participation in the medical assistance services program without making satisfactory arrangements to repay all outstanding ~~Medicaid~~ *medical assistance* overpayment.

D. The provisions of this section shall not apply to successors in interest with respect to transfer of a medical care facility pursuant to contracts entered into before February 1, 1990.

§ 32.1-325.2. Department is payor of last resort.

A. Insurers, including group health plans as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, self-insured plans, health services plans, service benefit plans, health maintenance organizations, managed care organizations, pharmacy benefits managers, or other parties that are, by

statute, contract, or agreement legally responsible for payment of a claim for a health care item or service, are prohibited from including any clause in health care contracts which would exclude enrolling an individual or in making any payment for benefits to the individual or on the individual's behalf for health care when the individual is eligible for medical assistance.

B. The Department of Medical Assistance Services shall be the payor of last resort to any insurer, including a group health plan as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a health services plan, a service benefit plan, a health maintenance organization, a managed care organization, a pharmacy benefits manager, or other party that is, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service for persons eligible for medical assistance in the Commonwealth. ~~The above entities, as a condition of doing business in the Commonwealth, shall comply with the requirements set forth in 42 U.S.C. 1396a(a) (25) (I) (i)-(iv).~~

C. To the extent the Department of Medical Assistance Services has made payment for medical services where a third party has a legal obligation to make payment for such services, the Commonwealth shall automatically acquire all rights to such payment from the third party.

D. To the extent the Department of Medical Assistance Services is permitted by law to obtain recoveries from third parties, actions at law for such recoveries shall be decided under the same laws, rules and standards including applicable bases of liability and defenses as would apply if the individual receiving the services had brought the action directly; provided that nothing herein shall affect the sovereign immunity of the Commonwealth.

E. The term "insurer" as used herein shall be deemed to include without limitation "insurance carriers."

§ 32.1-326.1. Department to operate program of estate recovery.

In accordance with applicable federal law and regulations, ~~including those under Title XIX of the Social Security Act,~~ the Department shall operate a program of estate recovery for all persons who receive payments or on whose behalf payments are made for ~~Medicaid-financed~~ nursing facility care by the Department. The amount recovered from the estate of a deceased recipient shall not exceed the amount of total ~~Medicaid~~ *medical assistance* payments made on behalf of such recipient.

§ 32.1-326.2. Pilot school/community health centers.

The Department of Medical Assistance Services, in cooperation with the Department of Education, shall, consistent with the biennium budget cycle, examine and may revise the funding and components of the pilot school/community health centers. Any revisions shall be designed to maximize access to health care for poor children, and to improve the funding by making use of every possible, cost-effective means, ~~Medicaid~~ *medical assistance* reimbursement or program. Any revisions shall be focused on prevention of large costs for acute or medical care and may include, but not be limited to:

1. Funding sources and means of distribution for the state match which will clearly demonstrate that local governments are not funding the state match for these centers.

2. The benefits and drawbacks of allowing school divisions to provide services to disabled students as ~~Medicaid~~ *medical assistance* providers.

3. The appropriate credentials of the providers of care in the school health centers, e.g., licensure by the Board of Education and compliance with federal requirements or licensure by a regulatory board within the Department of Health Professions.

4. Utilization of the individualized education plan, when signed by a physician, as the plan of care authorizing services.

5. Delivery of medically necessary services, such as rehabilitation services, psychiatric and psychological evaluations and therapy, transportation, and nursing.

6. Payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, with proper medical oversight, in consultation with the students' primary care physicians.

7. The role of the Medallion and Options programs in regard to the school health centers and flexibility for school divisions regarding any required referrals.

Any funds necessary to support revisions to the school/community health center projects shall be included in the budget estimates for the departments, as appropriate.

§ 32.1-326.3. Special education health services; memorandum of agreement between the Department of Education and the Department of Medical Assistance Services.

A. The Department of Medical Assistance Services, in cooperation with the Department of Education, shall, consistent with the biennium budget cycle, examine and revise, as necessary, the regulations relating to the funding and components of special education services.

Any revisions shall be designed to maximize access to health care for poor children who are eligible for medical assistance services and are disabled and have been identified as eligible for special education, and to assist school divisions in the funding of medically necessary related services by making use of every possible, cost-effective means, ~~Medicaid~~ *medical assistance* reimbursement or other

program administered by the Department of Medical Assistance Services, including, but not limited to, the State Children's Health Insurance Plan pursuant to Title XXI of the United States Social Security Act, as approved by the federal Health Care Financing Administration at the time. Any revisions shall be based on the flexibility allowed to the states and be focused on avoiding large costs for acute or medical care and increasing children's access to health care, and shall include, but need not be limited to:

1. Rates for services which shall clearly identify that only the federal share shall be reimbursed for the special education health services and shall demonstrate that local governments are funding the state match for the special education health services provided by school divisions.

2. The benefits and drawbacks of allowing school divisions to provide services as ~~Medicaid~~*medical assistance* providers to disabled students.

3. The appropriate credentials of the providers of care, in compliance with federal requirements and with the approval of the Health Care Financing Administration, for special education health services; e.g., licensure by the Board of Education and licensure by the appropriate health regulatory board within the Department of Health Professions.

4. Delivery of medically necessary related services for special education students who are eligible for medical assistance services.

The services shall be limited to those services which are required by the student's Individualized Education Plan (IEP), shall be covered under the then-current state plan for medical assistance services, and may be provided, consistent with federal law and as approved by the Health Care Financing Administration, by a school division participating as a special education health services provider. Such services shall include, but need not be limited to, speech therapy, including such services when delivered by school speech-language pathologists licensed by the Board of Audiology and Speech-Language Pathology or those individuals who are directly supervised, at least ~~twenty-five~~ *25* percent of the time, by such licensed speech-language pathologists; physical therapy; occupational therapy; psychiatric and psychological evaluations and therapy, including such services when delivered by school psychologists-limited licensed by the Board of Psychology; transportation between the student's home, the school or other site where health-related services are to be provided on those days when the student is scheduled to receive such services at the school or such other site; and skilled nursing services, such as health assessments, screening activities, nursing appraisals, nursing assessments, nursing procedures, medication assessment, medication monitoring, and medication administration.

5. The role of the Medallion, Medallion II, Options or other managed care programs in regard to the special education health services and coordination with school divisions regarding any required referrals.

B. Any funds necessary to support revisions to the special education health services shall be included in the budget estimates for the departments, as appropriate.

C. The Director of the Department of Medical Assistance Services or his designee and the Superintendent of Public Instruction or his designee shall develop and execute a memorandum of agreement relating to special education health services. This memorandum of agreement shall be revised on a periodic basis; however, the agreement shall, at a minimum, be revised and executed within six months of the inauguration of a new governor in order to maintain policy integrity.

D. The agreement shall include, but need not be limited to, (i) requirements for regular and consistent communications and consultations between the two departments and with school division personnel and officials and school board representatives; (ii) a specific and concise description and history of the federal Individuals with Disabilities Education Act (IDEA), a summary of school division responsibilities pursuant to the Individuals with Disabilities Education Act, and a summary of any corresponding state law which influences the scope of these responsibilities; (iii) a specific and concise summary of the then-current Department of Medical Assistance Services regulations regarding the special education health services; (iv) assignment of the specific responsibilities of the two state departments for the operation of special education health services; (v) a schedule of issues to be resolved through the regular and consistent communications process, including, but not limited to, ways to integrate and coordinate care between the Department of Medical Assistance Services' managed care providers and special education health services providers; (vi) a process for the evaluation of the services which may be delivered by school divisions participating as special education health services providers pursuant to ~~Medicaid~~ *the medical assistance program*; (vii) a plan and schedule to reduce the administrative and paperwork burden of ~~Medicaid~~ *medical assistance* participation on school divisions in Virginia; and (viii) a mechanism for informing primary care providers and other case management providers of those school divisions that are participating as ~~Medicaid~~ *medical assistance* providers and for identifying such school divisions as ~~Medicaid~~ *medical assistance* providers that are available to receive referrals to provide special education health services.

E. The Board of Medical Assistance Services shall cooperate with the Board of Education in developing a form to be included with the Individualized Education Plan (IEP) that shall be accepted by the Department of Medical Assistance Services as the plan of care (POC) and in collecting the data

necessary to establish separate and specific ~~Medicaid~~ *medical assistance* rates for the IEP meetings and other services delivered by school divisions to students.

The POC form shall (i) be consistent with the plan of care required by the Department of Medical Assistance Services of other ~~Medicaid~~ *medical assistance* providers, (ii) allow for written updates, (iii) be used by all school divisions participating as ~~Medicaid~~ *medical assistance* providers of special education health services, (iv) document the student's progress, and (v) be integrated and coordinated with the Department of Medical Assistance Services' managed care providers.

F. The Department of Medical Assistance Services shall consult with the Department of Education in preparing a consent form which (i) is separate from the IEP, (ii) includes a statement noting that such form is not part of the student's IEP, (iii) includes a release to authorize billing of school-based health services delivered to the relevant student by the school division, and (iv) shall be used by all school divisions participating in ~~Medicaid~~ *medical assistance* reimbursement. This consent form shall be made available to the parents upon conclusion of the IEP meeting. The release shall allow for billing of school-based health services by Virginia school divisions to the ~~Virginia~~ ~~Medicaid~~ *medical assistance* program ~~and other programs~~ operated by the Department of Medical Assistance Services.

G. The Department of Medical Assistance Services and the Department of Education shall also develop a cost-effective, efficient, and appropriate process to allow school divisions access to eligibility data for students for whom consent has been obtained.

H. The Board of Medical Assistance Services shall, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, also (i) include, in its regulations which provide for reimbursement of school divisions participating in ~~Medicaid~~ *the medical assistance program* as special education health services providers, a provision for reimbursement of mental health services delivered by licensed school psychologists-limited and a provision for reimbursement for services rendered to ~~Medicaid-~~eligible students of speech-language pathology services delivered by school speech-language pathologists or those individuals who are directly supervised, at least ~~twenty-five~~ *25* percent of the time, by such licensed speech-language pathologists; (ii) revise the limitations, established pursuant to relevant regulations and Virginia's state plan for medical assistance services, on services delivered by school divisions participating in ~~Medicaid~~ *the medical assistance program* as special education health services providers~~, in effect on January 1, 1999~~, for physical therapy, occupational therapy, and speech, hearing, and language disorders when such services are rendered to children who are eligible for special education services and have IEPs requiring such services; (iii) cooperate with the Board of Education in developing a form to be included with the IEP that shall be accepted by the Department of Medical Assistance Services as the plan of care when signed by a physician or, when under such physician's supervision, his designee; (iv) cooperate with the Board of Education in collecting the data necessary to establish separate and specific rates for the IEP services delivered by school divisions to students with disabilities who are eligible for special education and for medical assistance services; and (v) analyze the data necessary for such rates and establish new rates for reimbursement of IEP meetings based on such data.

I. Services delivered by school divisions as participating providers in the ~~Medicaid~~ *medical assistance* program ~~or any other program~~ operated by the Department of Medical Assistance Services shall not include any family planning, pregnancy or abortion services.

§ 32.1-327. Claim against indigent's estate for payments made.

In accordance with applicable federal law and regulations, ~~including those under Title XIX of the Social Security amendments of 1965,~~ the Department may make claim against the estate of an indigent or medically indigent person for the amount of any medical assistance payments made on his behalf by the Department. The Department may waive its claim if it determines that enforcement of the claim would result in substantial hardship to the heirs or dependents of the individual against whose estate the claim exists.

§ 32.1-330.1. Department to implement premium assistance program for HIV-positive individuals.

The Board of Medical Assistance Services shall from funds eligible for this purpose from Title II of the Ryan White Comprehensive AIDS Resources Emergency CARE Act (42 U.S.C. § 300ff-21 et seq.) or other funds appropriated or made available for this purpose, implement, and may promulgate any necessary regulations for implementation of, a premium assistance program for HIV-positive individuals which shall have, at minimum, the following characteristics:

1. Payment of health insurance premiums for individuals who are not eligible for ~~Medicaid~~ *medical assistance* and who can document (i) HIV infection and inability to continue working for medical reasons and (ii) eligibility to continue their employer's group policy pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985;

2. Financial eligibility criteria allowing a maximum income of no more than 250 percent of the federal poverty guidelines and countable liquid assets of no more than $10,000 in value;

3. Funds eligible under Title II of the Ryan White CARE Act shall not be used toward copayments

and deductible payments; and

4. Coverage of family members, if the HIV-infected person's policy is the sole source of health insurance.

§ 32.1-330.3. Operation of a pre-PACE plan or PACE plan; oversight by Department of Medical Assistance Services.

A. Operation of a pre-PACE plan or PACE plan that participates in the medical assistance services program must be in accordance with a prepaid health plan contract or other PACE contract consistent with Chapter 6 of Title IV of the federal Balanced Budget Act of 1997 with the Department of Medical Assistance Services.

1. As used in this section, "pre-PACE" means of or associated with long-term care prepaid health plans (i) authorized by the ~~United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act (42 U.S.C. § 1396b et seq.) and the~~ state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

2. As used in this section, "PACE" means of or associated with long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804, 1997, pursuant to Title XVIII ~~and Title XIX~~ of the United States Social Security Act (42 U.S.C. § 1395eee et seq.), and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and pre-PACE and PACE enrollees in the event that a pre-PACE or PACE provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

C. During the pre-PACE or PACE period, the plan shall have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a plan for handling insolvency approved by the Department of Medical Assistance Services.

D. The pre-PACE or PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

The required arrangements to cover expenses shall be in accordance with the PACE Protocol as published by On Lok, Inc. in cooperation with the United States Health Care Financing Administration, as of April 14, 1995, or any successor protocol that may be agreed upon between the United States Health Care Financing Administration and On Lok, Inc.

Appropriate arrangements to cover expenses shall include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit or parental guarantees.

E. Enrollment in a ~~pre-PACE or~~ PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to ~~Title XIX or~~ Title XVIII of the United States Social Security Act~~, respectively~~.

F. Full disclosure shall be made to all individuals in the process of enrolling in the pre-PACE or PACE plan that services are not guaranteed beyond a thirty-day period.

G. The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for the Aging, and a pre-PACE or PACE provider.

Article 4.

~~Medicaid~~ *Medical Assistance* Prior Authorization Advisory Committee.

§ 32.1-331.12. Definitions.

As used in this article:

"Board" means the Board of Medical Assistance Services.

"Committee" means the ~~Medicaid~~ *Medical Assistance* Prior Authorization Advisory Committee established pursuant to this article.

"Department" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the Board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq.).

§ 32.1-331.13. Medical Assistance Prior Authorization Advisory Committee; membership.

The Board shall amend the state plan and promulgate regulations to establish the ~~Medicaid~~ *Medical Assistance* Prior Authorization Advisory Committee, composed of ~~eleven~~ *11* members to be appointed by the Board. Five members shall be physicians, at least three of whom shall care for a significant number of ~~Medicaid~~ *medical assistance* patients; four shall be pharmacists, two of whom shall be community pharmacists; one member shall be a consumer of mental health services; and one member shall be a ~~Medicaid~~ *medical assistance* recipient. A quorum for action of the Committee shall consist of six members. The members shall serve at the pleasure of the Board, and vacancies shall be filled in the same manner as the original appointment. The Board shall consider nominations made by The Medical Society of Virginia, the Old Dominion Medical Society, the Psychiatric Society of Virginia, the Virginia Pharmaceutical Association, the Virginia Alliance for the Mentally Ill and the Virginia Mental Health Consumers Association when making appointments to the Committee.

The Committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the Board, the Director, or any two members of the Committee. The Department shall provide appropriate staffing to the Committee.

§ 32.1-346. Director to establish standards; reimbursement of services.

A. The Director shall prescribe regulations setting forth the amount, duration and scope of medical services covered by the Program which shall be uniform in all localities. Such services shall consist only of inpatient and outpatient hospital services, services rendered in free-standing ambulatory surgical centers and local public health clinics by providers who have signed agreements to participate in the State/Local Hospitalization Program and are enrolled providers in the Medical Assistance Program. Services covered under the Program shall not exceed in amount, duration or scope those available to recipients of Medical Assistance Services as provided in the State Plan for Medical Assistance pursuant to Chapter 10 (§ 32.1-323 et seq.) ~~of this title~~. Subject to the above, the Board may modify such coverage so long as uniformity of coverage is maintained throughout the Commonwealth.

B. Reimbursement for services under this Program shall be equal to that of the Medical Assistance Program pursuant to Chapter 10 of this title as follows:

1. The reimbursement rate per visit for outpatient hospital services shall be the same as that established by the Department of Medical Assistance Services for an intermediate office visit for an established patient;

2. The inpatient hospital reimbursement rate shall be consistent with the ~~Medicaid~~ *medical assistance* inpatient rate methodology. However, no disproportionate share or medical education adjustment for SLH inpatient hospital reimbursement shall be provided;

3. Inpatient hospital stays for adults shall be limited to ~~twenty-one~~ *21* days of covered hospitalization within ~~sixty~~ *60* days for the same or similar diagnosis. The ~~sixty day~~ *60-day* period shall begin with the initial hospital admission. Only ~~twenty-one~~ *21* total medically necessary days shall be covered whether incurred for one or more hospital stays, in the same or multiple hospitals, during the ~~sixty day~~ *60-day* period. Inpatient hospital admissions on Friday and Saturday shall not be covered except in cases of medical emergencies. Reimbursement of inpatient hospital days on behalf of individuals up to the age of ~~twenty-one~~ *21* shall be for medically necessary stays in excess of ~~twenty-one~~ *21* days as provided in the State Plan for Medical Assistance Services;

4. The hospital emergency room reimbursement rate per visit shall be the same as that rate established by the Department of Medical Assistance Services for an intermediate level, established patient emergency department visit; and

5. The outpatient surgical rate for hospitals and ambulatory surgical centers shall be the same as the rates established by the Department of Medical Assistance Services for the facility component for ambulatory surgical centers.

C. Procedures identified by the Department of Medical Assistance Services as outpatient surgical procedures shall be performed in an outpatient setting unless the inpatient care was medically necessary and outpatient surgery could not be safely performed, the surgical procedure was performed with other surgical procedures requiring inpatient admission or adequate outpatient facilities were not available.

D. Acceptance of payment for services by a provider under this Program shall constitute payment in full.

§ 32.1-347. Eligibility for Program; duty of the Department of Social Services and local welfare or social services agencies; data required.

A. The Board of Medical Assistance Services shall promulgate regulations to establish uniform eligibility criteria by defining those persons who will qualify for payment for medical care under the Program. Such criteria shall include, but not be limited to, the following:

1. To be eligible, a person shall have net countable income, determined in accordance with the Board of Medical Assistance Services' regulations, equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations, except that

localities which in fiscal year 1989 used an income level higher than 100 percent of the federal nonfarm poverty level may continue to use the same income level; and

2. To be eligible, a person shall have net countable resources, determined in accordance with the Board of Medical Assistance Services' regulations, equal to or less than the then current resource standards of the federal Supplemental Security Income Program.

Further, as a condition of eligibility, the Department of Medical Assistance Services shall require all legally competent applicants and recipients to assign to the Commonwealth any and all rights to third party benefits, whether contractual or otherwise, including medical support or payments, to which the applicants and recipients may be entitled. All applicants and recipients shall also agree to cooperate with the Department in obtaining such third party benefits. Such an assignment shall not preclude a court from apportioning sums which would be subject to the provisions of § 8.01-66.9.

B. Eligibility under this Program shall be determined by the Department of Social Services through the local boards of welfare or social services upon application for assistance under this program from residents of such localities. The eligibility criteria established by the Board pursuant to this section shall be used in processing all such applications. The local departments of welfare or social services shall certify to the applicant and Department of Medical Assistance Services within ~~thirty~~ *30* days of receipt of each application whether the person applying meets such criteria.

C. Administrative appeal of adverse eligibility decisions shall be conducted by the Department using the procedures applicable to applicants for ~~Medicaid~~ *medical assistance* benefits under the State Plan for Medical Assistance pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title.

D. The State/Local Hospitalization Program shall be established in the books of the Comptroller so as to segregate the amounts appropriated and the amounts contributed thereto by the localities. No portion of the State/Local Hospitalization Program shall be used for a purpose other than that described in this chapter. Any state funds remaining at the end of the fiscal year shall not revert to the general fund but shall remain in the State/Local Hospitalization Program to be used as an offset to the calculated local share for the following year. Any local share money remaining at the end of the fiscal year or the biennium shall remain in the locality's account under the State/Local Hospitalization Program to be used by the Department as an offset to the calculated local share for the following year.

§ 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 under the age of 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~~ *the state plan developed pursuant to § 32.1-325*; (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 four 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. Eligible children, residing in Virginia, whose family income does not exceed 200 percent of the federal poverty level during the enrollment period shall receive 12 continuous months of coverage as permitted by Title XXI of the Social Security Act.

B. Family Access to Medical Insurance Security Plan participants 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 above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. The annual aggregate cost-sharing for all eligible children in a family at or below 150 percent of the federal poverty level shall not exceed 2.5 percent of the family's gross income. The nominal copayments for all eligible children in a family shall not be less than those in effect on January 1, 2003. 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. The mental health services required herein shall include intensive in-home services, case management services, day treatment, and 24-hour emergency response. The services shall be

provided in the same manner and with the same coverage and service limitations as they are provided to children under the State Plan for Medical Assistance Services.

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.

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. All eligible individuals, insofar as feasible, shall be enrolled in health maintenance organizations.

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. A single application form shall be used to determine eligibility for ~~Title XIX or~~ Title XXI of the Social Security Act, as amended~~, and outreach, enrollment, re-enrollment and services delivery shall be coordinated with the FAMIS Plus program pursuant to § 32.1-325~~. 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. 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 Health Care.

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 Centers for Medicare & Medicaid Services as Virginia's State Children's Health Insurance Program.

§ 32.1-353.2. Definitions.

As used in this chapter:

"Board" means the Board of Medical Assistance Services.

"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare ~~or Medicaid~~ provider, ~~or both,~~ pursuant to Title XVIII ~~and Title XIX~~ of the United States Social Security Act, as amended, and § 32.1-137.

"Civil money penalty funds" means those funds collected by the Department of Medical Assistance Services for enforcement of certified nursing facility remedies ~~pursuant to Title XIX of the Social Security Act~~.

"Director" means the Director of the Department of Medical Assistance Services.

§ 32.1-353.3. Authorization to expend civil money penalty funds.

A. The Department of Medical Assistance Services, as administrator of the state ~~Medicaid~~ *medical services* program, maintains a fund comprised of civil money penalties received from nursing facilities as a result of enforcement of federal survey requirements. Pursuant to federal regulations, such funds shall be used for the protection of the health or property of certified nursing facility residents.

B. In addition to the remedies specified in subsection A, the Director shall establish a Nursing Facility Quality Improvement Program in compliance with all applicable federal and state regulations designed to improve the health, safety, and welfare of residents in nursing facilities. The Director shall develop the Nursing Facility Quality Improvement Program in cooperation with affected state agencies, representatives of the nursing facility provider community, and advocacy groups.

§ 32.1-366. Virginia Health Care Fund established.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Health Care Fund, hereafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and any moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. For purposes of the Comptroller's preliminary and final annual reports required by § 2.2-813, however, all deposits to and disbursements from the Fund shall be accounted for as part of the general fund of the state treasury.

B. All revenue received by the Commonwealth pursuant to the provisions of (i) §§ 58.1-1001 and 58.1-1018, (ii) Article 2.1 (§ 58.1-1021.01 et seq.) of Chapter 10 of Title 58.1, and (iii) § 3.2-4203 shall be paid into the state treasury and deposited to the Fund. The Comptroller shall also deposit 40 percent of the Commonwealth's allocation pursuant to the Master Settlement Agreement with tobacco product manufacturers, as defined in § 3.2-3100, to the Fund. The Fund shall also consist of all recoveries received during a fiscal year resulting from expenditures incurred in the ~~Medicaid~~ *medical assistance* program during a prior fiscal year or years to the extent that such amounts represent recoveries of state funds that would otherwise be deposited to the general fund of the state treasury.

§ 32.1-367. Uses of Virginia Health Care Fund.

Moneys deposited to the Fund shall be used solely for the provision of health care services. Such moneys shall be appropriated as provided in the general appropriation act. Health care services include, but are not limited to, ~~Medicaid~~ *medical assistance* payments, disease diagnosis, prevention and control, and community health services.

§ 32.1-369. Uses of Breast and Cervical Cancer Prevention and Treatment Fund.

Moneys deposited to the Breast and Cervical Cancer Prevention and Treatment Fund shall be used to support the treatment of breast and cervical cancer for women under ~~Medicaid pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, P.L. 106-354~~ *medical assistance*. Up to 10 percent of the Fund may be used annually to conduct screening activities for breast and cervical cancer under the Every Woman's Life Program administered by the Virginia Department of Health.

§ 37.2-837. Discharge from state hospitals or training centers, conditional release, and trial or home visits for consumers.

A. Except for a state hospital consumer held upon an order of a court for a criminal proceeding, the

director of a state hospital or training center may discharge, after the preparation of a discharge plan:

1. Any consumer in a state hospital who, in his judgment, (a) is recovered, (b) does not have a mental illness, or (c) is impaired or not recovered but whose discharge will not be detrimental to the public welfare or injurious to the consumer;

2. Any consumer in a state hospital who is not a proper case for treatment within the purview of this chapter; or

3. Any consumer in a training center who chooses to be discharged or, if the consumer lacks the mental capacity to choose, whose legally authorized representative chooses for him to be discharged. Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no consumer at a training center who is enrolled in ~~Medicaid~~ *medical assistance* shall be discharged if the consumer or his legally authorized representative on his behalf chooses to continue receiving services in a training center.

For all individuals discharged, the discharge plan shall be formulated in accordance with the provisions of § 37.2-505 by the community services board or behavioral health authority that serves the city or county where the consumer resided prior to admission or by the board or authority that serves the city or county where the consumer or his legally authorized representative on his behalf chooses to reside immediately following the discharge. The discharge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals, training centers, and community services boards or behavioral health authorities, and shall identify (i) the services, including mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the consumer will require upon discharge into the community and (ii) the public or private agencies that have agreed to provide these services. If the individual will be housed in an assisted living facility, as defined in § 63.2-100, the discharge plan shall identify the facility, document its appropriateness for housing and capacity to care for the consumer, contain evidence of the facility's agreement to admit and care for the consumer, and describe how the community services board or behavioral health authority will monitor the consumer's care in the facility.

B. The director may grant a trial or home visit to a consumer in accordance with regulations adopted by the Board. The state facility granting a trial or home visit to a consumer shall not be liable for his expenses during the period of that visit. Such liability shall devolve upon the relative, conservator, person to whose care the consumer is entrusted while on the trial or home visit, or the appropriate local department of social services of the county or city in which the consumer resided at the time of admission pursuant to regulations adopted by the State Board of Social Services.

C. Any consumer who is discharged pursuant to subdivision A 2 shall, if necessary for his welfare, be received and cared for by the appropriate local department of social services. The provision of public assistance or social services to the consumer shall be the responsibility of the appropriate local department of social services as determined by regulations adopted by the State Board of Social Services. Expenses incurred for the provision of public assistance to the consumer who is receiving 24-hour care while in an assisted living facility licensed pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2 shall be the responsibility of the appropriate local department of social services of the county or city in which the consumer resided at the time of admission.

§ 37.2-1024. Estate planning.

A. In the order appointing a conservator entered pursuant to § 37.2-1009 or in a separate proceeding brought on petition, the court may authorize a conservator to: (i) make gifts from income and principal not necessary for the incapacitated person's maintenance to those persons to whom the incapacitated person would, in the judgment of the court, have made gifts if he had been of sound mind or (ii) disclaim property as provided in Chapter 8.1 (§ 64.1-196.1 et seq.) of Title 64.1. A guardian ad litem shall be appointed to represent the interest of the incapacitated person, and reasonable notice of the hearing shall be given to the incapacitated person and to all persons who would be heirs or distributees of the incapacitated person, if he were dead as of the date of the filing of the petition, or beneficiaries under any known will of the incapacitated person. The court may authorize the hearing to proceed without notice to any beneficiary who would not be substantially affected by the proposed gift or disclaimer. The court shall determine the amounts, recipients, and proportions of any gifts of the estate and the advisability of any disclaimer after considering: (i) the size and composition of the estate; (ii) the nature and probable duration of the incapacity; (iii) the effect of the gifts or disclaimers on the estate's financial ability to meet the incapacitated person's foreseeable health, medical care, and maintenance needs; (iv) the incapacitated person's estate plan; (v) prior patterns of assistance or gifts to the proposed donees; (vi) the tax effect of the proposed gifts or disclaimers; (vii) the effect of any transfer of assets or disclaimer on the establishment or retention of eligibility for medical assistance services; and (viii) other factors that the court may deem relevant.

B. The conservator may make a gift, not to exceed $100 to each donee in a calendar year and not to exceed a total of $500 per calendar year from such income and principal, without the requirements of a

court-appointed guardian ad litem, of notification to the incapacitated person or to any person who would be an heir or distributee of the incapacitated person, if he were dead, or a beneficiary under any known will of the incapacitated person, and of a court hearing. Prior to the making of such a gift, the conservator must consider conditions (i) through (viii) as set forth in subsection A of this section and must also find that the incapacitated person has shown a history of giving the same or a similar gift to a specific donee for the previous three years prior to the appointment of the conservator.

C. The conservator may transfer assets of an incapacitated person or an incapacitated person's estate into an irrevocable trust where the transfer has been designated solely for burial of the incapacitated person or spouse of the incapacitated person ~~in accordance with conditions set forth in subdivision A 2 of § 32.1-325~~. The conservator also may contractually bind an incapacitated person or an incapacitated person's estate by executing a preneed funeral contract, described in Chapter 28 (§ 54.1-2800 et seq.) of Title 54.1, for the benefit of the incapacitated person.

D. A conservator may exercise the incapacitated person's power to revoke or amend a trust or to withdraw or demand distribution of trust assets only with the approval of the court for good cause shown, unless the trust instrument expressly provides otherwise.

§ 38.2-226.2. Provisions of title not applicable to certain long-term care health plans.

A. This title shall not apply to pre-PACE long-term care health plans (i) authorized by ~~the United States Health Care Financing Administration pursuant to § 1903 (m) (2) (B) of Title XIX of the United States Social Security Act (42 U.S.C. § 1396b et seq.) and~~ the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. This title shall not apply to PACE long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804, 1997, pursuant to Title XVIII ~~and Title XIX~~ of the United States Social Security Act (42 U.S.C. § 1395eee et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

C. Enrollment in a ~~pre-PACE or~~ PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to ~~Title XIX or~~ Title XVIII of the United States Social Security Act~~, respectively~~.

§ 38.2-508.3. Consideration of medical assistance eligibility prohibited.

A. No person shall, in determining the eligibility of an individual for coverage under an individual or group accident and sickness policy, health services plan or health maintenance organization contract, consider the eligibility of such individual for medical assistance ~~("Medicaid")~~ from this Commonwealth or from any other state.

B. No person shall, in determining benefits payable to, or on behalf of an individual covered under an individual or group accident and sickness policy, health services plan or health maintenance organization contract, take into account the eligibility of such individual for medical assistance ~~("Medicaid")~~ from this Commonwealth or from any other state.

§ 38.2-1318. Examinations; how conducted.

A. Whenever the Commission examines the affairs of any person, as set forth in § 38.2-1317, it may appoint as examiners one or more competent persons.

1. To the extent practicable, the examiners shall be regular employees of the Commission.

2. No examiner may be appointed by the Commission if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this article; however, this section shall not be construed to automatically preclude an examiner from being:

a. A policyholder or claimant under an insurance policy;

b. A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

c. An investment owner in shares of regulated diversified investment companies; or

d. A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

3. Notwithstanding the requirements of this subsection, the Commission may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals or firms who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this article.

B. The examiners shall be instructed as to the scope of the examination, and, in conducting the examination, the examiner shall observe, to the extent practicable, those guidelines and procedures set forth in the Examiners' Handbook, or any successor publications, adopted by the NAIC and such other guidelines or procedures as the Commission may deem appropriate.

C. Every company or person from whom information is sought, its officers, directors, and agents shall provide the examiners convenient access at all reasonable hours to its books, records, files, securities, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined or those of any person, including any affiliates or subsidiaries of the person examined, that are relevant to the examination.

1. The officers, directors, employees and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

2. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the Commission's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to § 38.2-1040.

D. For the purpose of any investigation or proceeding under this article, the Commission or any individual designated by it may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of any books, papers, correspondence, memoranda, agreements or other documents or records which the Commission determines are relevant to the examination.

E. In connection with any examination, the Commission may retain attorneys, appraisers, independent actuaries, independent certified public accountants, security analysts or other professionals and specialists as examiners; the cost of which shall be borne by the company which is the subject of the examination.

F. Nothing contained in this article shall be construed to limit the Commission's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the provisions of this title.

G. Nothing contained in this article shall be construed to limit the Commission's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commission may deem appropriate.

H. Whenever the Commission examines the affairs of any person providing benefits pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended, as set forth in § 38.2-1317, nothing contained in this article shall be construed to limit the Commission's authority to consult with the Department of Medical Assistance Services about such person before taking any action as a result of services the person provides pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended.

§ 38.2-2201. Provisions for payment of medical expense and loss of income benefits.

A. Upon request of an insured, each insurer licensed in this Commonwealth issuing or delivering any policy or contract of bodily injury or property damage liability insurance covering liability arising from the ownership, maintenance or use of any motor vehicle shall provide on payment of the premium, as a minimum coverage (i) to persons occupying the insured motor vehicle; and (ii) to the named insured and, while resident of the named insured's household, the spouse and relatives of the named insured while in or upon, entering or alighting from or through being struck by a motor vehicle while not occupying a motor vehicle, the following health care and disability benefits for each accident:

1. All reasonable and necessary expenses for medical, chiropractic, hospital, dental, surgical, ambulance, prosthetic and rehabilitation services, and funeral expenses, resulting from the accident and incurred within three years after the date of the accident, up to $2,000 per person; however, if the insured does not elect to purchase such limit the insurer and insured may agree to any other limit;

2. If the person is usually engaged in a remunerative occupation, an amount equal to the loss of income incurred after the date of the accident resulting from injuries received in the accident up to $100 per week during the period from the first workday lost as a result of the accident up to the date the person is able to return to his usual occupation. However, the period shall not extend beyond one year from the date of the accident; and

3. An expense described in subdivision 1 shall be deemed to have been incurred:

a. If the insured is directly responsible for payment of the expense;

b. If the expense is paid by (i) a health care insurer pursuant to a negotiated contract with the health care provider or (ii) ~~Medicaid or~~ Medicare, where the actual payment with reference to the medical bill rendered by the provider is less than or equal to the provider's usual and customary fee, in the amount of the actual payment; however, if the insured is required to make a payment in addition to the actual payment by the health care insurer or ~~Medicaid or~~ Medicare, the amount shall be increased by the payment made by the insured;

c. If no medical bill is rendered or specific charge made by a health care provider to the insured, an insurer, or any other person, in the amount of the usual and customary fee charged in that community for the service rendered.

B. The insured has the option of purchasing either or both of the coverages set forth in subdivisions 1 and 2 of subsection A of this section. Either or both of the coverages, as well as any other medical expense or loss of income coverage under any policy of automobile liability insurance, shall be payable to the covered injured person notwithstanding the failure or refusal of the named insured or other person entitled to the coverage to give notice to the insurer of an accident as soon as practicable under the terms of the policy, except where the failure or refusal prejudices the insurer in establishing the validity of the claim.

C. In any policy of personal automobile insurance in which the insured has purchased coverage under subsection A of this section, every insurer providing such coverage arising from the ownership, maintenance or use of no more than four motor vehicles shall be liable to pay up to the maximum policy limit available on every motor vehicle insured under that coverage if the health care or disability expenses and costs mentioned in subsection A of this section exceed the limits of coverage for any one motor vehicle so insured.

§ 38.2-3405.1. Commonwealth's right to certain accident and sickness benefits.

A. The Department of Medical Assistance Services shall be entitled to direct reimbursement under any accident and sickness insurance policy, health services plan, or health maintenance organization contract for covered services or items to the extent that payment has been made by the Department of Medical Assistance Services on behalf of an individual covered under such policy, plan, or contract for such services or items.

B. No insurer, health services plan, or health maintenance organization shall impose upon the Department of Medical Assistance Services or any state agency, which has been assigned or has otherwise acquired the rights of an individual eligible for medical assistance ~~("Medicaid")~~ and covered for health benefits by the insurance policy, health services plan, or health maintenance organization contract, any requirements that are different from requirements applicable to an agent or assignee of any other individual so covered.

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract

holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), ~~Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid),~~ 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee (and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in this Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the

carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or § 38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) ~~thirty~~ *30* percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is

subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), ~~Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid),~~ 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C.

L. This section shall apply to group health benefit plans issued or renewed by carriers in this Commonwealth on or after July 1, 1998.

M. Nothing in this section shall operate to limit any rights or obligations arising under §§ 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312 or § 38.2-4312.1.

N. If any provision of this section or its application to any person or circumstance is held invalid for

any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any other application of this section which shall be given effect without the invalid provision or application, and for this purpose the provisions of this section are declared severable.

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), ~~Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid),~~ 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (CHAMPUS); or (ii) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of

payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will

be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. If any provision of this section, or the application thereof to any person or circumstance, is held invalid or unenforceable, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid or unenforceable provision or application, and to that end the provisions of this section are severable.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

§ 38.2-3408. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.

A. If an accident and sickness insurance policy provides reimbursement for any service that may be legally performed by a person licensed in this Commonwealth as a chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, marriage and family therapist or licensed acupuncturist, reimbursement under the policy shall not be denied because the service is rendered by the licensed practitioner.

B. If an accident and sickness insurance policy provides reimbursement for a service that may be legally performed by a licensed pharmacist, reimbursement under the policy shall not be denied because the service is rendered by the licensed pharmacist provided that (i) the service is performed for an insured for a condition under the terms of a collaborative agreement, as defined in § 54.1-3300, between a pharmacist and the physician with whom the insured is undergoing a course of treatment or (ii) the service is for the administration of vaccines for immunization. Notwithstanding the provisions of § 38.2-3407, the insurer may require the pharmacist, any pharmacy or provider that may employ such pharmacist, or the collaborating physician to enter into a written agreement with the insurer as a condition for reimbursement for such services. In addition, reimbursement to pharmacists acting under the terms of a collaborative agreement under this subsection shall not be subject to the provisions of § 38.2-3407.7.

C. This section shall not apply to ~~Medicaid~~ *medical assistance*, or any state fund.

§ 38.2-3430.2. Definitions.

A. The terms defined in § 38.2-3431 that are used in this article shall have the meanings set forth in that section.

B. For purposes of this article:

"Eligible individual" means an individual:

1. (i) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months and (ii) whose most recent prior creditable coverage was under individual health insurance coverage, a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan;

2. Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of Title XVIII of the Social Security Act, or (iii) a state plan ~~under Title XIX of such Act, or any successor program~~, and does not have other health insurance coverage;

3. With respect to whom the most recent coverage within the coverage period described in subdivision 1 was not terminated based on a factor described in subdivision B 1 or B 2 of § 38.2-3430.7 relating to nonpayment of premiums or fraud;

4. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage;

5. Who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program; and

6. In the case where individual health insurance coverage is the most recent creditable coverage, the coverage was nonrenewed by the health insurance issuer under the conditions allowed in subdivision C 2 of § 38.2-3430.7, in which case the aggregate period of creditable coverage required is reduced to twelve months.

For the purposes of determining the aggregate of the periods of creditable coverage under subdivision B 1 (i) of this section, a period of creditable coverage shall not be counted with respect to enrollment of an individual under a health benefit plan if, after such period, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage or was not serving a waiting period for coverage under a group health plan, or for group health insurance coverage or was in an affiliation period.

§ 38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual and any portion of the premium is paid by the employer, provided that the health insurance issuer providing individual coverage under such circumstances shall be registered as a health insurance issuer in the small group market under this article, and shall have offered small employer group insurance to the employer in the manner required under this article; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting period if any and affiliation period if applicable imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f) (1) of such section insofar as it relates to pediatric vaccines;

2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

"Community rate" means the average rate charged for the same or similar coverage to all small employer groups with the same area, age and gender characteristics. This rate shall be based on the health insurance issuer's combined claims experience for all groups within its small employer market.

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);

4. ~~Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;~~

~~5~~*4*. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

~~6~~*5*. A medical care program of the Indian Health Service or of a tribal organization;

~~7~~*6*. A state health benefits risk pool;

~~8~~*7*. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

~~9~~*8*. A public health plan (as defined in federal regulations);

~~10~~*9*. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)); or

~~11~~*10*. Individual health insurance coverage.

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

3. In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection C of this section.

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g) (1) of the Social Security Act (42 U.S.C. § 1395ss (g) (1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance;

~~Medicaid~~ *medical assistance* coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b) (2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or through a health insurance issuer.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any

placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16) (B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16) (B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Rating period" means the 12-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer or through a health insurance issuer.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means, with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. The Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. The Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to § 2.2-2503. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, subject to the provisions of § 38.2-3432.2. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:

1. Such plan may include cost containment and cost sharing features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, subject to the limitations set forth in §§ 38.2-3407 and 38.2-4209 and Chapter 43 (§ 38.2-4300 et seq.) of this title; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; co-payment, co-insurance, deductible or other cost sharing arrangement as those terms are defined in § 38.2-3407.12; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage

for health maintenance organizations shall be actuarial equivalents of these plans for health insurance issuers.

2. No law requiring the coverage or offering of coverage of a benefit or provider pursuant to § 38.2-3408 or § 38.2-4221 shall apply to the essential or standard health care plan or riders thereof.

3. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan, subject to the provisions of § 38.2-3432.2.

4. All essential and standard benefit plans issued to small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A health insurance issuer shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a health insurance issuer, disapprove the continued use by the health insurance issuer of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

5. No health insurance issuer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:

a. From a small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a health insurance issuer offering group health insurance coverage from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the health insurance issuer being declared an impaired insurer.

A health insurance issuer offering group health insurance coverage that does not offer coverage pursuant to subdivision 5 b may not offer coverage to small employers until the Commission determines that the health insurance issuer is no longer impaired.

6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the provisions of subdivision C 5 of this section and shall fairly market the essential and standard health benefit plans to all small employers in their service area of the Commonwealth. A health insurance issuer offering group health insurance coverage that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's service area.

7. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:

a. To small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas;

c. To small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the later of 180 days after closure to new applications or the date on which the health maintenance organization notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 6 of this subsection apply.

8. In order to ensure the broadest availability of health benefit plans to small employers, the

Commission shall set market conduct and other requirements for health insurance issuers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each health insurance issuer offering group health insurance coverage with the Commission of its intention to offer health insurance coverage in the small group market under this article;

b. Publication by the Commission of a list of all health insurance issuers who offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurance issuers that no health benefit plan may be sold to a small employer by a health insurance issuer not so identified as a health insurance issuer in the small group market;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

d. To the extent deemed to be necessary to ensure the fair distribution of small employers among carriers, periodic reports by health insurance issuers about plans issued to small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to small employers. Health insurance issuers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by health insurance issuers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a 12-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient.

§ 38.2-3541. Conversion or continuation on termination of eligibility.

Each group hospital policy, group medical and surgical policy or group major medical policy delivered or issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain, subject to the policyholder's selection, one of the options set forth in this section. These options shall apply if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage, prior to that person becoming eligible for Medicare or ~~Medicaid~~ *medical assistance* benefits unless such termination is due to termination of the group policy under circumstances in which the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting conditions under the replacement coverage or plan.

1. Option 1: To have the insurer issue him, without evidence of insurability, an individual accident and sickness insurance policy in the event that the insurer is not exempt under § 38.2-3416 and offers such policy, subject to the following requirements:

a. The application for the policy shall be made, and the first premium paid to the insurer within ~~thirty-one~~ *31* days after the termination;

b. The premium on the policy shall be at the insurer's then customary rate applicable: (i) to such policies, (ii) to the class of risk to which the person then belongs, and (iii) to his or her age on the effective date of the policy;

c. The policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;

d. The benefits under the policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;

e. The policy shall extend coverage to the same family members that were insured under the group policy; and

f. Coverage under this option shall be effected in such a way as to result in continuous coverage during the ~~thirty-one-day~~ *31-day* period for such insured.

2. Option 2: To have his present coverage under the policy continued for a period of ~~ninety~~ *90* days immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

a. The application for the extended coverage is made to the group policyholder and the total premium for the ~~ninety-day~~ *90-day* period is paid to the group policyholder prior to the termination;

b. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy; and

c. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility.

§ 38.2-5009. Commission awards for birth-related neurological injuries; notice of award.

A. Upon determining (i) that an infant has sustained a birth-related neurological injury and (ii) that obstetrical services were delivered by a participating physician at the birth or that the birth occurred in a participating hospital, the Commission shall make an award providing compensation for the following items relative to such injury:

1. Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, therapeutic, nursing, attendant, residential and custodial care and service, medications, supplies, special equipment or facilities, and related travel, such expenses to be paid as they are incurred. Reimbursement may be provided for nursing and attendant care that is provided by a relative or legal guardian of a Program beneficiary so long as that care is beyond the scope of child care duties and services normally and gratuitously provided by family members to uninjured children. However, such expenses shall not include:

a. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses of medical and hospital services under this subdivision shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

In order to provide coverage for expenses of medical and hospital services under this subdivision, the Commission, in all cases where a comparative analysis of the costs, including the effects on the infant's family's health insurance coverage, and benefits indicates that such action is more cost-effective than awarding payment of medical and hospital expenses, shall (i) require the claimant to purchase private health insurance providing coverage for such expenses, provided that the premium or other costs of such coverage shall be paid by the Fund; (ii) require the claimant to participate in the~~State Medicaid Program~~ *state medical assistance program*, the Children's Health Insurance Program or other state or federal health insurance program for which the infant is eligible; or (iii) if the Commission determines that it would be unreasonably burdensome to require the claimant to purchase private health insurance and that the infant is ineligible for a health insurance program described in clause (ii), to make an award providing compensation for the cost of private accident and sickness insurance for the infant.

2. Loss of earnings from the age of 18 are to be paid in regular installments beginning on the eighteenth birthday of the infant. An infant found to have sustained a birth-related neurological injury shall be conclusively presumed to have been able to earn income from work from the age of 18 through the age of 65, if he had not been injured, in the amount of 50 percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector. Payments shall be calculated based on the Commonwealth's reporting period immediately preceding the 18th birthday of the claimant child, and subsequently adjusted based upon the succeeding annual reports of the Commonwealth. The provisions of § 65.2-531 shall apply to any benefits awarded under this subdivision.

3. Reasonable expenses incurred in connection with the filing of a claim under this chapter, including reasonable attorneys' fees, which shall be subject to the approval and award of the Commission.

A copy of the award shall be sent immediately by registered or certified mail to the parties.

B. The amendments to this section enacted pursuant to Chapter 535 of the Acts of Assembly of 1990 shall be retroactively effective in all cases arising prior to July 1, 1990, that have been timely filed and are not yet final.

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of the Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than $50,000 nor more than $500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and

physician care, outpatient medical services, laboratory and radiologic services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) of this title. In the case of a health maintenance organization that has contracted with the Commonwealth to furnish basic health services to recipients of medical assistance ~~under Title XIX of the United States Social Security Act~~ pursuant to § 38.2-4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325.

"Copayment" means an amount an enrollee is required to pay in order to receive a specific health care service.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate or individual or group agreement or contract issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in the Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least 90 percent of total costs of health care services.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Limited health care services" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Net worth" or "capital and surplus" means the excess of total admitted assets over the total liabilities of the health maintenance organization, provided that surplus notes shall be reported and accounted for in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practice and procedures manuals.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees

and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee, or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.

§ 38.2-4306. Evidence of coverage and charges for health care services.

A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section. Any evidence of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended, is excluded from the provisions of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature, or both;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee;

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment; and

g. Any right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.

B. Pursuant to this subsection:

1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission. Any schedule of charges or amendment to the schedule of charges for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended, is excluded from the provisions of this subsection.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee in a group health plan shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within 30 days after notice of the disapproval. If the Commission does not disapprove any form within 30 days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional 30 days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1,

§ 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.15, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4320. Authority of Commonwealth to contract with health maintenance organizations.

This Commonwealth is authorized to enter into contracts with health maintenance organizations on behalf of its employees and the citizens of the Commonwealth, including contracts to furnish health care services to recipients of medical assistance ~~under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq~~.

§ 38.2-4320.1. Explanation of benefits for health maintenance organization enrollees who are recipients of medical assistance services or covered by the Family Access to Medical Insurance Security (FAMIS) Plan.

In the case of any health maintenance organization that has contracted with the Virginia Department of Medical Assistance Services to provide health care services to recipients of medical assistance services ~~pursuant to Title XIX of the Social Security Act, as amended~~, or to individuals who are covered by the Family Access to Medical Insurance Security (FAMIS) Plan developed pursuant to Title XXI of the Social Security Act, as amended, the requirements for furnishing an explanation of benefits to current or former members and their respective health care providers shall be as authorized and directed in the standards prescribed in the state plan for medical assistance services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 and the FAMIS Plan pursuant to Chapter 13 (§ 32.1-351 et seq.) of Title 32.1. The requirements for an explanation of benefits otherwise addressed in this title shall not

apply to such health maintenance organization when contracting to deliver such services to the extent that the statutory requirements differ from the standards of the Department of Medical Assistance Services.

§ 38.2-5509. Supplemental provisions; rules; exemption.

A. The provisions of this Act are supplemental to any other provisions of the laws of this Commonwealth, and shall not preclude or limit any other powers or duties of the Commission, the Commissioner of Insurance, or any of the Commission's employees or agents under such laws, including, but not limited to, the provisions of §§ 38.2-1038 and 38.2-1040, or §§ 38.2-4316 A 7 and 38.2-4317, and Chapter 15 (§ 38.2-1500 et seq.) and any regulations issued thereunder.

B. The Commission may adopt reasonable rules necessary for the implementation of this Act.

C. The Commission may exempt from the application of this Act any domestic property and casualty insurer which:

1. Writes direct business only in this Commonwealth;

2. Writes direct annual premiums of $2 million or less; and

3. Assumes no reinsurance in excess of five percent of direct premium written.

D. The Commission may exempt from the application of this Act an insurer organized and operating under the laws of this Commonwealth and licensed pursuant to the provisions of Chapter 25 (§ 38.2-2500 et seq.) of this title.

E. The Commission may exempt from the application of this Act a domestic health organization that writes direct business only in this Commonwealth and assumes no reinsurance in excess of five percent of direct premium written, and either (i) writes direct annual premiums of two million dollars or less for comprehensive medical coverages or (ii) is licensed pursuant to Chapter 45 and covers less than 2,000 lives. As used in this subsection, "comprehensive medical coverages" means contracts providing basic health care services and Medicare ~~and Medicaid~~ risk coverages or policies providing hospital, surgical, major medical, *and* Medicare ~~risk and Medicaid~~ risk coverages. Medicare supplement need not be included and premiums for administrative services shall not be included.

§ 38.2-5803. Disclosures and representations to enrollees.

A. The following shall be provided to the MCHIP's covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and shall be made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers. Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and receive a printed copy of such list.

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.

4. Notice that the MCHIP is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice included within the evidence of coverage, providing substantially the following: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice shall also provide the toll-free telephone number, mailing address, and electronic mail address of the Office of the Managed Care Ombudsman. This section shall not apply to evidences of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended.

B. The following shall apply to MCHIPs that require a covered person to select a primary care physician with respect to the offer of basic health care services by the MCHIP:

1. At the time of enrollment each covered person shall have the right to select a primary care physician from among the health carrier's affiliated primary care physicians for the MCHIP, subject to availability.

2. Any covered person who is dissatisfied with his primary care physician shall have the right to select another primary care physician from among the affiliated primary care physicians, subject to availability. The health carrier may impose a reasonable waiting period for this transfer.

§ 38.2-5804. Complaint system.

A. A health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1 and shall include the following:

1. A record of the complaints shall be maintained for no less than five years.

2. Such health carrier shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and electronic mail address of the Office of the Managed Care Ombudsman, and shall also specify any required limits imposed by or on behalf of the MCHIP. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse decisions pursuant to § 32.1-137.15.

B. The Commission, in cooperation with the State Health Commissioner, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this chapter shall be assessed by the State Health Commissioner pursuant to provisions in Title 32.1 and the regulations promulgated thereunder. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of this title, shall be assessed by the Commission.

C. The health carrier for each MCHIP shall submit to the Office of the Managed Care Ombudsman and the State Health Commissioner an annual complaint report in a form prescribed by the Commission and the Board of Health. The complaint report shall include (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the grievance or complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the MCHIP's affiliated providers.

D. The provisions of this section shall not apply to plans administered by the Department of Medical Assistance Services that provide benefits pursuant to ~~Title XIX or~~ Title XXI of the Social Security Act, as amended.

E. The provisions of Chapter 5 (§ 38.2-500 et seq.) of this title shall apply to the health carrier, its MCHIPs, and evidence of coverage and representations thereto, except to the extent that the Commission determines that the nature of the health carrier, its MCHIP, and evidences of coverage and representations thereto render any of the provisions clearly inappropriate.

§ 38.2-6007. Disclosure.

A. Before asking a viator or insured to sign any document, a licensee under this chapter shall provide the respective viator or insured, or both, with a copy of the disclosure document described in this subsection. The viatical settlement provider or viatical settlement broker shall provide the viator with an additional copy of the disclosures, with the application, no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall provide the following information:

1. There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

2. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.

3. Proceeds of the viatical settlement could be subject to the claims of creditors.

4. Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for ~~Medicaid~~ *medical assistance* or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

5. The viator has the right to rescind a viatical settlement contract for 15 calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in subsection C of § 38.2-6008. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans, and loan interest to the viatical settlement provider or viatical settlement purchaser.

6. Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

7. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.

8. Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used unless one is developed by the Commission.

9. The disclosure document shall contain the following language: "All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an

insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

10. The insured may be contacted by either the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

B. A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and the viatical settlement provider or viatical settlement broker, and provide the following information:

1. The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

2. The name, address, and telephone number of the viatical settlement provider;

3. The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits;

4. State the name, business address, and telephone number of the independent third party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

5. If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.

C. If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

§ 54.1-2523. Confidentiality of data; disclosure of information; discretionary authority of Director.

A. All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring program pursuant to this chapter and any material relating to the operation or security of the program shall be confidential and shall be exempt from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 15 of § 2.2-3705.5. Further, the Director shall only have discretion to disclose any such information as provided in subsections B and C.

B. Upon receiving a request for information in accordance with the Department's regulations and in compliance with applicable federal law and regulations, the Director shall disclose the following:

1. Information relevant to a specific investigation of a specific recipient or of a specific dispenser or prescriber to an agent designated by the superintendent of the Department of State Police to conduct drug diversion investigations pursuant to § 54.1-3405.

2. Information relevant to an investigation or inspection of or allegation of misconduct by a specific person licensed, certified, or registered by or an applicant for licensure, certification, or registration by a health regulatory board; information relevant to a disciplinary proceeding before a health regulatory board or in any subsequent trial or appeal of an action or board order to designated employees of the Department of Health Professions; or to designated persons operating the Health Practitioners' Monitoring Program pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of this title.

3. Information relevant to the proceedings of any investigatory grand jury or special grand jury that has been properly impaneled in accordance with the provisions of Chapter 13 (§ 19.2-191 et seq.) of Title 19.2.

4. Information relevant to a specific investigation of a specific dispenser or specific prescriber to an agent of the United States Drug Enforcement Administration with authority to conduct drug diversion investigations.

C. In accordance with the Department's regulations and applicable federal law and regulations, the Director may, in his discretion, disclose:

1. Information in the possession of the program concerning a recipient who is over the age of 18 to that recipient.

2. Information on a specific recipient to a prescriber, as defined in this chapter, for the purpose of establishing the treatment history of the specific recipient when such recipient is either under care and treatment by the prescriber or the prescriber is initiating treatment of such recipient. In a manner

specified by the Director in regulation, notice shall be given to patients that information may be requested by the prescriber from the Prescription Monitoring Program.

3. Information on a specific recipient to a dispenser for the purpose of establishing a prescription history to assist the dispenser in determining the validity of a prescription in accordance with § 54.1-3303 when the recipient is seeking a covered substance from the dispenser or the facility in which the dispenser practices. In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the dispenser from the Prescription Monitoring Program.

4. Information relevant to an investigation or regulatory proceeding of a specific dispenser or prescriber to other regulatory authorities concerned with granting, limiting or denying licenses, certificates or registrations to practice a health profession when such regulatory authority licenses such dispenser or prescriber or such dispenser or prescriber is seeking licensure by such other regulatory authority.

5. Information relevant to an investigation relating to a specific dispenser or prescriber who is a participating provider in the Virginia ~~Medicaid~~ *medical assistance* program or information relevant to an investigation relating to a specific recipient who is currently eligible for and receiving or who has been eligible for and has received medical assistance services to the ~~Medicaid~~ *Medical Assistance* Fraud Control Unit of the Office of the Attorney General or to designated employees of the Department of Medical Assistance Services, as appropriate.

6. Information relevant to determination of the cause of death of a specific recipient to the designated employees of the Office of the Chief Medical Examiner.

7. Information for the purpose of bona fide research or education to qualified personnel; however, data elements that would reasonably identify a specific recipient, prescriber, or dispenser shall be deleted or redacted from such information prior to disclosure. Further, release of the information shall only be made pursuant to a written agreement between such qualified personnel and the Director in order to ensure compliance with this subdivision.

D. The Director may enter into agreements for mutual exchange of information among prescription monitoring programs in other jurisdictions, which shall only use the information for purposes allowed by this chapter.

E. This section shall not be construed to supersede the provisions of § 54.1-3406 concerning the divulging of confidential records relating to investigative information.

F. Confidential information that has been received, maintained or developed by any board or disclosed by the board pursuant to subsection A shall not, under any circumstances, be available for discovery or court subpoena or introduced into evidence in any medical malpractice suit or other action for damages arising out of the provision of or failure to provide services. However, this subsection shall not be construed to inhibit any investigation or prosecution conducted pursuant to Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2.

§ 54.1-2709.2. Registration and certain data required.

The Board of Dentistry shall require all oral and maxillofacial surgeons to annually register with the Board and to report and make available the following information:

1. The names of medical schools or schools of dentistry attended and dates of graduation;

2. Any graduate medical or graduate dental education at any institution approved by the Accreditation Council for Graduation Medical Education, the Commission on Dental Accreditation, American Dental Association;

3. Any specialty board certification or eligibility for certification as approved by the Commission on Dental Accreditation, American Dental Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any insurance plans accepted, managed care plans in which the oral and maxillofacial surgeon participates, and hospital affiliations, including specification of any privileges granted by the hospital;

6. Any appointments, within the most recent 10-year period, of the oral and maxillofacial surgeon to a dental school faculty and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location of any primary and secondary practice settings and the approximate percentage of the oral and maxillofacial surgeon's time spent practicing in each setting;

8. The access to any translating service provided to the primary practice setting of the oral and maxillofacial surgeon;

9. The status of the oral and maxillofacial surgeon's participation in the Virginia ~~Medicaid~~ ~~Program~~ *medical assistance program*;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2709.3, and 54.1-2709.4 that results in a suspension or

revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action; and

11. Other information related to the competency of oral and maxillofacial surgeons as specified in the regulations of the Board.

The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request by a consumer, of such information relating to an oral and maxillofacial surgeon. The regulations promulgated by the Board shall provide for reports to include all paid claims in categories indicating the level of significance of each award or settlement.

§ 54.1-2910.1. Certain data required.

A. The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

1. The names of the schools of medicine, osteopathy, or podiatry and the years of graduation;

2. Any graduate medical, osteopathic, or podiatric education at any institution approved by the Accreditation Council for Graduation Medical Education, the American Osteopathic Association or the Council on Podiatric Medical Education;

3. Any specialty board certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Multiple Specialties in Podiatry, or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any hospital affiliations;

6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;

8. The access to any translating service provided to the primary and secondary practice settings of the doctor;

9. The status of the doctor's participation in the Virginia ~~Medicaid~~ ~~Program~~ *medical assistance program*;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;

11. Conviction of any felony; and

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than $10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months.

D. This section shall not apply to any person licensed pursuant to §§ 54.1-2928.1, 54.1-2933.1, 54.1-2936, and 54.1-2937 or to any person holding an inactive license to practice medicine, osteopathy, or podiatry.

§ 54.1-3411.1. Prohibition on returns, exchanges, or re-dispensing of drugs; exceptions.

A. Drugs dispensed to persons pursuant to a prescription shall not be accepted for return or exchange for the purpose of re-dispensing by any pharmacist or pharmacy after such drugs have been removed from the pharmacy premises from which they were dispensed except:

1. In a hospital with an on-site hospital pharmacy wherein drugs may be returned to the pharmacy in accordance with practice standards;

2. In such cases where official compendium storage requirements are assured and the drugs are in manufacturers' original sealed containers or in sealed individual dose or unit dose packaging that meets official compendium class A or B container requirements, or better, and such return or exchange is consistent with federal law; or

3. When a dispensed drug has not been out of the possession of a delivery agent of the pharmacy.

B. The Board of Pharmacy shall promulgate regulations to establish a Prescription Drug Donation Program for accepting unused previously dispensed prescription drugs that meet the criteria set forth in subdivision A2, for the purpose of re-dispensing such drugs to indigent patients, either through hospitals, or through clinics organized in whole or in part for the delivery of health care services to the indigent. Such program shall not authorize the donation of Schedule II-V controlled substances if so prohibited by federal law. No drugs shall be re-dispensed unless the integrity of the drug can be assured.

C. Unused prescription drugs dispensed for use by persons eligible for coverage under ~~Title XIX or~~ Title XXI of the Social Security Act, as amended, may be donated pursuant to this section unless such donation is prohibited.

D. A pharmaceutical manufacturer shall not be liable for any claim or injury arising from the storage, donation, acceptance, transfer, or dispensing of any drug provided to a patient, or any other activity undertaken in accordance with a drug distribution program established pursuant to this section.

E. Nothing in this section shall be construed to create any new or additional liability, or to abrogate any liability that may exist, applicable to a pharmaceutical manufacturer for its products separately from the storage, donation, acceptance, transfer, or dispensing of any drug provided to a patient in accordance with a drug distribution program established pursuant to this section.

§ 55-19.5. Provision in certain trust void.

A. Except as provided in subsection B, a provision in any inter vivos trust created for the benefit of the grantor which provides directly or indirectly for the suspension, termination or diversion of the principal, income or other beneficial interest of the grantor in the event that he should apply for medical assistance or require medical, hospital, or nursing care or long-term custodial, nursing or medical care shall be against public policy and ineffective as against the Commonwealth. The assets of the trust, both principal and interest, shall be distributed as though no such application had been made. The provisions of this subsection shall apply without regard to the irrevocability of the trust or the purpose for which the trust was created.

B. Subsection A shall not apply to any trust with a corpus of $25,000 or less. If the corpus of any such trust exceeds $25,000, $25,000 of the trust shall be exempt from the provisions of subsection A. However, if the grantor has created more than one trust as described in subsection A, the $25,000 exemption shall be prorated among the trusts. Further, if the grantor made uncompensated transfers, as defined in § 20-88.02, within ~~thirty~~ *30* months of applying for ~~Medicaid~~ *medical assistance* benefits and no payments were ordered pursuant to subsection D of § 20-88.02, the $25,000 exemption under this subsection shall not apply.

C. The exemption provided by subsection B shall not apply to any trust created on or after August 11, 1993.

D. To the extent any trust created between August 11, 1993, and July 1, 1994 would but for subsection C be entitled to the exemption provided by subsection B, the grantor may revoke such trust notwithstanding any irrevocability in the terms of such trust. Nothing contained in this subsection shall be construed to authorize the grantor to effect the vested rights of any beneficiary of such trust without the express written consent of such beneficiary.

E. The provisions of subsection A shall not apply to an irrevocable inter vivos trust to the extent it is created for the purpose of paying the grantor's funeral and burial expenses and is funded in an amount and manner allowable as a resource in determining eligibility for medical assistance benefits. In the event any amount remains in the trust upon payment of the funeral or burial arrangements provided to or on behalf of such individual, the Commonwealth shall receive all amounts remaining in such trust up to an amount equal to the total medical assistance paid on behalf of the individual.

F. For purposes of this section, medical assistance and medical assistance benefits shall mean benefits payable under the State Plan for Medical Assistance.

§ 58.1-609.10. Miscellaneous 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. Artificial or propane gas, firewood, coal or home heating oil used for domestic consumption. "Domestic consumption" means the use of artificial or propane gas, firewood, coal or home heating oil by an individual purchaser for other than business, commercial or industrial purposes. The Tax Commissioner shall establish by regulation a system for use by dealers in classifying individual purchases for domestic or nondomestic use based on the principal usage of such gas, wood, coal or oil. Any person making a nondomestic purchase and paying the tax pursuant to this chapter who uses any

portion of such purchase for domestic use may, between the first day of the first month and the fifteenth day of the fourth month following the year of purchase, apply for a refund of the tax paid on the domestic use portion.

2. An occasional sale, as defined in § 58.1-602. A nonprofit organization that is eligible to be granted an exemption on its purchases pursuant to § 58.1-609.11, and that is otherwise eligible for the exemption pursuant to this subdivision, shall be exempt pursuant to this subdivision on its sales of 1) food, prepared food and meals and 2) tickets to events that include the provision of food, prepared food and meals, so long as such sales take place on less than 24 occasions in a calendar year.

3. Tangible personal property for future use by a person for taxable lease or rental as an established business or part of an established business, or incidental or germane to such business, including a simultaneous purchase and taxable leaseback.

4. Delivery of tangible personal property outside the Commonwealth for use or consumption outside of the Commonwealth. Delivery of goods destined for foreign export to a factor or export agent shall be deemed to be delivery of goods for use or consumption outside of the Commonwealth.

5. Tangible personal property purchased with food coupons issued by the United States Department of Agriculture under the Food Stamp Program or drafts issued through the Virginia Special Supplemental Food Program for Women, Infants, and Children.

6. Tangible personal property purchased for use or consumption in the performance of maintenance and repair services at Nuclear Regulatory Commission-licensed nuclear power plants located outside the Commonwealth.

7. Beginning July 1, 1997, and ending July 1, 2006, a professional's provision of original, revised, edited, reformatted or copied documents, including but not limited to documents stored on or transmitted by electronic media, to its client or to third parties in the course of the professional's rendition of services to its clientele.

8. (Effective until July 1, 2010) School lunches sold and served to pupils and employees of schools and subsidized by government; school textbooks sold by a local board or authorized agency thereof; and school textbooks sold for use by students attending a nonprofit college or other institution of learning, when sold (i) by such institution of learning or (ii) by any other dealer, when such textbooks have been certified by a department or instructor of such institution of learning as required textbooks for students attending courses at such institution.

8. (Effective July 1, 2010) School lunches sold and served to pupils and employees of schools and subsidized by government; school textbooks sold by a local board or authorized agency thereof; and school textbooks sold for use by students attending a college or other institution of learning, when sold (i) by such institution of learning or (ii) by any other dealer, when such textbooks have been certified by a department or instructor of such institution of learning as required textbooks for students attending courses at such institution.

9. 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; medicines and drugs purchased for use or consumption by a licensed hospital, nursing home, clinic, or similar corporation not otherwise exempt under this section; 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). With the exceptions of those medicines and drugs used for agricultural production animals that are exempt to veterinarians under subdivision 1 of § 58.1-609.2, 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.

10. 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 that 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 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.

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

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

13. 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.

14. a. (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.

15. Tangible personal property withdrawn from inventory and donated to (i) an organization exempt from taxation under § 501(c)(3) of the Internal Revenue Code or (ii) the Commonwealth, any political subdivision of the Commonwealth, or any school, agency, or instrumentality thereof.

16. Tangible personal property purchased by nonprofit churches that are exempt from taxation under § 501(c)(3) of the Internal Revenue Code, or whose real property is exempt from local taxation pursuant to the provisions of § 58.1-3606, for use (i) in religious worship services by a congregation or church membership while meeting together in a single location and (ii) in the libraries, offices, meeting or counseling rooms or other rooms in the public church buildings used in carrying out the work of the church and its related ministries, including kindergarten, elementary and secondary schools. The exemption for such churches shall also include baptistries; bulletins, programs, newspapers and newsletters that do not contain paid advertising and are used in carrying out the work of the church; gifts including food for distribution outside the public church building; food, disposable serving items, cleaning supplies and teaching materials used in the operation of camps or conference centers by the church or an organization composed of churches that are exempt under this subdivision and which are used in carrying out the work of the church or churches; and property used in caring for or maintaining property owned by the church including, but not limited to, mowing equipment; and building materials installed by the church, and for which the church does not contract with a person or entity to have installed, in the public church buildings used in carrying out the work of the church and its related ministries, including, but not limited to worship services; administrative rooms; and kindergarten, elementary, and secondary schools.

17. Medical products and supplies, which are otherwise taxable, such as bandages, gauze dressings, incontinence products and wound-care products, when purchased by a ~~Medicaid~~ *medical assistance* recipient through a Department of Medical Assistance Services provider agreement.

18. Beginning July 1, 2007, and ending July 1, 2012, multifuel heating stoves used for heating an individual purchaser's residence. "Multifuel heating stoves" are stoves that are capable of burning a wide variety of alternative fuels, including, but not limited to, shelled corn, wood pellets, cherry pits, and olive pits.

19. Fabrication of animal meat, grains, vegetables, or other foodstuffs when the purchaser (i) supplies the foodstuffs and they are consumed by the purchaser or his family, (ii) is an organization exempt from taxation under § 501(c)(3) or (c)(4) of the Internal Revenue Code, or (iii) donates the foodstuffs to an organization exempt from taxation under § 501(c)(3) or (c)(4) of the Internal Revenue Code.

20. Beginning July 1, 2010 and ending June 30, 2020, computer equipment purchased or leased for the processing, storage, retrieval, or communication of data, including but not limited to servers, routers, connections, and other enabling hardware, provided that such computer equipment is purchased or leased for use in a data center that (a) is located in a Virginia locality, (b) results in a new capital investment on or after July 1, 2009 of at least $150 million, and (c) results in the creation on or after July 1, 2009 of at least 50 new jobs associated with the operation or maintenance of the data center provided that such jobs pay at least one and one half times the prevailing average wage in that locality. Prior to claiming such exemption, any qualifying person claiming the exemption must enter into a memorandum of understanding with the Virginia Economic Development Partnership Authority that at a minimum provides the details for determining the amount of capital investments made and the number of new jobs created, the timeline for achieving the capital investment and new job goals, the repayment obligations should those goals not be achieved, and any conditions under which repayment by the qualifying person claiming the exemption may be required. In addition, the exemption shall apply to any such computer equipment purchased or leased to upgrade, supplement, or replace computer equipment purchased or leased in the initial investment. The exemption shall not apply to any computer software otherwise taxable under Chapter 6 of Title 58.1, Code of Virginia that is sold or leased separately from the computer equipment, nor shall it apply to general building improvements or fixtures.

§ 63.2-608. Virginia Initiative for Employment Not Welfare (VIEW).

A. The Department shall establish and administer the Virginia Initiative for Employment Not Welfare (VIEW) to reduce long-term dependence on welfare, to emphasize personal responsibility and to enhance opportunities for personal initiative and self-sufficiency by promoting the value of work. The Department shall endeavor to develop placements for VIEW participants that will enable participants to develop job skills that are likely to result in independent employment and that take into consideration the proficiency, experience, skills and prior training of a participant.

VIEW shall recognize clearly defined responsibilities and obligations on the part of public assistance recipients and shall include a written agreement of personal responsibility requiring parents to participate in work activities while receiving TANF, earned-income disregards to reduce disincentives to work, and a limit on TANF financial assistance.

VIEW shall require all able-bodied recipients of TANF who do not meet an exemption to participate in a work activity. VIEW shall require eligible TANF recipients to participate in unsubsidized, partially subsidized or fully subsidized employment or other allowable TANF work activity as defined by federal law and enter into an agreement of personal responsibility.

B. To the maximum extent permitted by federal law, and notwithstanding other provisions of Virginia law, the Department and local departments may, through applicable procurement laws and regulations, engage the services of public and private organizations to operate VIEW and to provide services incident to such operation.

C. All VIEW participants shall be under the direction and supervision of a case manager.

D. The Department shall ensure that participants are assigned to one of the following work activities within 90 days after the approval of TANF assistance:

1. Unsubsidized private-sector employment;

2. Subsidized employment, as follows:

a. The Department shall conduct a program in accordance with this section that shall be known as the Full Employment Program (FEP). FEP replaces TANF with subsidized employment. Persons not able to find unsubsidized employment who are otherwise eligible for TANF may participate in FEP unless exempted by this chapter. FEP shall assign participants to subsidized wage-paying private-sector jobs designed to increase the participants' self-sufficiency and improve their competitive position in the workforce.

b. Participants in FEP shall be placed in full-time employment when appropriate and shall be paid by the employer at an hourly rate not less than the federal or state minimum wage, whichever is higher. At no point shall a participant's spendable income received from wages and tax credits be less than the value of TANF received prior to the work placement.

c. Every employer subject to the Virginia unemployment insurance tax shall be eligible for assignment of FEP participants, but no employer shall be required to utilize such participants. Employers shall ensure that jobs made available to FEP participants are in conformity with § 3304 (a) (5) of the Federal Unemployment Tax Act. FEP participants cannot be used to displace regular workers.

d. FEP employers shall:

(i) Endeavor to make FEP placements positive learning and training experiences;

(ii) Provide on-the-job training to the degree necessary for the participants to perform their duties;

(iii) Pay wages to participants at the same rate that they are paid to other employees performing the same type of work and having similar experience and employment tenure;

(iv) Provide sick leave, holiday and vacation benefits to participants to the same extent and on the same basis that they are provided to other employees performing the same type of work and having similar employment experience and tenure;

(v) Maintain health, safety and working conditions at or above levels generally acceptable in the industry and no less than those in which other employees perform the same type of work;

(vi) Provide workers' compensation coverage for participants;

(vii) Encourage volunteer mentors from among their other employees to assist participants in becoming oriented to work and the workplace; and

(viii) Sign an agreement with the local department outlining the employer requirements to participate in FEP. All agreements shall include notice of the employer's obligation to repay FEP reimbursements in the event the employer violates FEP rules.

e. As a condition of FEP participation, employers shall be prohibited from discriminating against any person, including program participants, on the basis of race, color, sex, national origin, religion, age, or disability;

3. Part-time or temporary employment;

4. Community work experience, as follows:

a. The Department and local departments shall work with other state, regional and local agencies and governments in developing job placements that serve a useful public purpose as provided in § 482 (f) of the Social Security Act, as amended. Placements shall be selected to provide skills and serve a public

function. VIEW participants shall not displace regular workers.

b. The number of hours per week for participants shall be determined by combining the total dollar amount of TANF and food stamps and dividing by the minimum wage with a maximum of a work week of 32 hours, of which up to 12 hours of employment-related education and training may substitute for work experience employment; or

5. Any other allowable TANF work activity as defined by federal law.

E. Notwithstanding the provisions of subsections A and D, if a local department determines that a VIEW participant is in need of job skills and would benefit from immediate job skills training, it may place the participant in a general educational development (GED) program or a career and technical education program targeted at skills required for particular employment opportunities. Eligible participants include those with problems related to obtaining and retaining employment, such as participants (i) with less than a high school education, (ii) whose reading or math skills are at or below the eighth grade level, (iii) who have not retained a job for a period of at least six months during the prior two years, or (iv) who are in a treatment program for a substance abuse problem or are receiving services through a family violence treatment program. The VIEW participant may continue in a GED program or career and technical education program for as long as the local department determines he is progressing satisfactorily and to the extent permitted by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), as amended.

F. Participants may be reevaluated after a period determined by the local department and reassigned to another work component. In addition, the number of hours worked may be reduced by the local department so that a participant may complete additional training or education to further his employability.

G. Local departments shall be authorized to sanction parents up to the full amount of the TANF grant for noncompliance, unless good cause exists.

H. VIEW participants shall not be assigned to projects that require that they travel unreasonable distances from their homes or remain away from their homes overnight without their consent.

Any injury to a VIEW participant arising out of and in the course of community work experience shall be covered by the participant's existing ~~Medicaid~~ *medical assistance* coverage. If a community work experience participant is unable to work due to such an accident, his status shall be reviewed to determine whether he is eligible for an exemption from the limitation on TANF financial assistance.

A community work experience participant who becomes incapacitated for 30 days or more shall be eligible for TANF financial assistance for the duration of the incapacity, if otherwise eligible.

The Board shall adopt regulations providing for the accrual of paid sick leave or other equivalent mechanism for community work experience participants.

§ 63.2-616. Provision of public assistance and social services.

Local departments may combine community resources to assist the families of persons who may be in need because of the limitations on TANF financial assistance and may arrange for appropriate care of needy families where the limitation on TANF financial assistance as a result of the birth of an additional child or the two-year limit on TANF financial assistance is executed. Public assistance and social services may be provided that include, but are not limited to, help for families in obtaining donated food and clothing, continuation of food stamps for adults and children who are otherwise eligible, child care, and ~~Medicaid~~ *medical assistance* coverage for adults and children who are otherwise eligible for ~~Medicaid~~ *medical assistance*.

§ 63.2-1805. Admissions and discharge.

A. The Board shall adopt regulations:

1. Governing admissions to assisted living facilities;

2. Requiring that each assisted living facility prepare and provide a statement, in a format prescribed by the Department, to any prospective resident and his legal representative, if any, prior to admission and upon request, that discloses information, fully and accurately in plain language, about the (i) services; (ii) fees, including clear information about what services are included in the base fee and any fees for additional services; (iii) admission, transfer, and discharge criteria, including criteria for transfer to another level of care within the same facility or complex; (iv) general number and qualifications of staff on each shift; (v) range, frequency, and number of activities provided for residents; and (vi) ownership structure of the facility;

3. Establishing a process to ensure that each resident admitted or retained in an assisted living facility receives appropriate services and periodic independent reassessments and reassessments when there is a significant change in the resident's condition in order to determine whether a resident's needs can continue to be met by the facility and whether continued placement in the facility is in the best interests of the resident;

4. Governing appropriate discharge planning for residents whose care needs can no longer be met by the facility;

5. Addressing the involuntary discharge of residents;

6. Requiring that residents are informed of their rights pursuant to § 63.2-1808 at the time of admission;

7. Establishing a process to ensure that any resident temporarily detained in a facility pursuant to §§ 37.2-809 through 37.2-813 is accepted back in the assisted living facility if the resident is not involuntarily admitted pursuant to §§ 37.2-814 through 37.2-819; and

8. Requiring that each assisted living facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report.

B. If there are observed behaviors or patterns of behavior indicative of mental illness, mental retardation, substance abuse, or behavioral disorders, as documented in the uniform assessment instrument completed pursuant to § 63.2-1804, the facility administrator or designated staff member shall ensure that an evaluation of the individual is or has been conducted by a qualified professional as defined in regulations. If the evaluation indicates a need for mental health, mental retardation, substance abuse, or behavioral disorder services, the facility shall provide (i) a notification of the resident's need for such services to the authorized contact person of record when available and (ii) a notification of the resident's need for such services to the community services board or behavioral health authority established pursuant to Title 37.2 that serves the city or county in which the facility is located, or other appropriate licensed provider. The Department shall not take adverse action against a facility that has demonstrated and documented a continual good faith effort to meet the requirements of this subsection.

C. The Department shall not order the removal of a resident from an assisted living facility if (i) the resident, the resident's family, the resident's physician, and the facility consent to the resident's continued stay in the assisted living facility and (ii) the facility is capable of providing, obtaining, or arranging for the provision of necessary services for the resident, including, but not limited to, home health care and/or hospice care.

D. Notwithstanding the provisions of subsection C above, assisted living facilities shall not admit or retain an individual with any of the following conditions or care needs:

1. Ventilator dependency.

2. Dermal ulcers III and IV, except those stage III ulcers that are determined by an independent physician to be healing.

3. Intravenous therapy or injections directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia or as permitted in subsection E.

4. Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.

5. Psychotropic medications without appropriate diagnosis and treatment plans.

6. Nasogastric tubes.

7. Gastric tubes except when the individual is capable of independently feeding himself and caring for the tube or as permitted in subsection E.

8. An imminent physical threat or danger to self or others is presented by the individual.

9. Continuous licensed nursing care (seven-days-a-week, 24-hours-a-day) is required by the individual.

10. Placement is no longer appropriate as certified by the individual's physician.

11. Maximum physical assistance is required by the individual as documented by the uniform assessment instrument and the individual meets ~~Medicaid~~ *medical assistance* nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance, unless the individual's independent physician determines otherwise. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument.

12. The assisted living facility determines that it cannot meet the individual's physical or mental health care needs.

13. Other medical and functional care needs that the Board determines cannot be met properly in an assisted living facility.

E. Except for auxiliary grant recipients, at the request of the resident in an assisted living facility and when his independent physician determines that it is appropriate, (i) care for the conditions or care needs defined in subdivisions D 3 and D 7 may be provided to the resident by a licensed physician, a licensed nurse or a nurse holding a multistate licensure privilege under a physician's treatment plan, or a home care organization licensed in Virginia or (ii) care for the conditions or care needs defined in subdivision D 7 may also be provided to the resident by facility staff if the care is delivered in accordance with the regulations of the Board of Nursing for delegation by a registered nurse, 18 VAC 90-20-420 et seq.

The Board shall adopt regulations to implement the provisions of this subsection.

F. In adopting regulations pursuant to subsections A, B, C, D, and E the Board shall consult with the

Departments of Health and Behavioral Health and Developmental Services.

§ 63.2-1606. Protection of aged or incapacitated adults; mandated and voluntary reporting.

A. Matters giving reason to suspect the abuse, neglect or exploitation of adults shall be reported immediately upon the reporting person's determination that there is such reason to suspect. Medical facilities inspectors of the Department of Health are exempt from reporting suspected abuse immediately while conducting federal inspection surveys in accordance with § 1864 of Title XVIII ~~and~~ ~~Title~~ ~~XIX~~ of the Social Security Act, as amended, of certified nursing facilities as defined in § 32.1-123. Reports shall be made to the local department or the adult protective services hotline in accordance with requirements of this section by the following persons acting in their professional capacity:

1. Any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, with the exception of persons licensed by the Board of Veterinary Medicine;

2. Any mental health services provider as defined in § 54.1-2400.1;

3. Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, unless such personnel immediately reports the suspected abuse, neglect or exploitation directly to the attending physician at the hospital to which the adult is transported, who shall make such report forthwith;

4. Any guardian or conservator of an adult;

5. Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity;

6. Any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to, companion, chore, homemaker, and personal care workers; and

7. Any law-enforcement officer.

B. The report shall be made in accordance with subsection A to the local department of the county or city wherein the adult resides or wherein the adult abuse, neglect or exploitation is believed to have occurred or to the adult protective services hotline. Nothing in this section shall be construed to eliminate or supersede any other obligation to report as required by law. If a person required to report under this section receives information regarding abuse, neglect or exploitation while providing professional services in a hospital, nursing facility or similar institution, then he may, in lieu of reporting, notify the person in charge of the institution or his designee, who shall report such information, in accordance with the institution's policies and procedures for reporting such matters, immediately upon his determination that there is reason to suspect abuse, neglect or exploitation. Any person required to make the report or notification required by this subsection shall do so either orally or in writing and shall disclose all information that is the basis for the suspicion of adult abuse, neglect or exploitation. Upon request, any person required to make the report shall make available to the adult protective services worker and the local department investigating the reported case of adult abuse, neglect or exploitation any information, records or reports which document the basis for the report. All persons required to report suspected adult abuse, neglect or exploitation shall cooperate with the investigating adult protective services worker of a local department and shall make information, records and reports which are relevant to the investigation available to such worker to the extent permitted by state and federal law. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure; such reports may, however, be disclosed to the Adult Fatality Review Team as provided in § 32.1-283.5 and, if reviewed by the Team, shall be subject to all of the Team's confidentiality requirements.

C. Any financial institution staff who suspects that an adult has been exploited financially may report such suspected exploitation to the local department of the county or city wherein the adult resides or wherein the exploitation is believed to have occurred or to the adult protective services hotline. For purposes of this section, financial institution staff means any employee of a bank, savings institution, credit union, securities firm, accounting firm, or insurance company.

D. Any person other than those specified in subsection A who suspects that an adult is an abused, neglected or exploited adult may report the matter to the local department of the county or city wherein the adult resides or wherein the abuse, neglect or exploitation is believed to have occurred or to the adult protective services hotline.

E. Any person who makes a report or provides records or information pursuant to subsection A, C or D, or who testifies in any judicial proceeding arising from such report, records or information, or who takes or causes to be taken with the adult's or the adult's legal representative's informed consent photographs, video recordings, or appropriate medical imaging of the adult who is subject of a report shall be immune from any civil or criminal liability on account of such report, records, information, photographs, video recordings, appropriate medical imaging or testimony, unless such person acted in bad faith or with a malicious purpose.

F. An employer of a mandated reporter shall not prohibit a mandated reporter from reporting directly to the local department or to the adult protective services hotline. Employers whose employees are

mandated reporters shall notify employees upon hiring of the requirement to report.

G. Any person 14 years of age or older who makes or causes to be made a report of adult abuse, neglect, or exploitation that he knows to be false shall be guilty of a Class 4 misdemeanor. Any subsequent conviction of this provision shall be a Class 2 misdemeanor.

H. Any person who fails to make a required report or notification pursuant to subsection A shall be subject to a civil penalty of not more than $500 for the first failure and not less than $100 nor more than $1,000 for any subsequent failures. Civil penalties under subdivision A 7 shall be determined by a court of competent jurisdiction, in its discretion. All other civil penalties under this section shall be determined by the Commissioner or his designee. The Board shall establish by regulation a process for imposing and collecting civil penalties, and a process for appeal of the imposition of such penalty pursuant to § 2.2-4026 of the Administrative Process Act.

I. Any mandated reporter who has reasonable cause to suspect that an adult died as a result of abuse or neglect shall immediately report such suspicion to the appropriate medical examiner and to the appropriate law-enforcement agency, notwithstanding the existence of a death certificate signed by a licensed physician. The medical examiner and the law-enforcement agency shall receive the report and determine if an investigation is warranted. The medical examiner may order an autopsy. If an autopsy is conducted, the medical examiner shall report the findings to law enforcement, as appropriate, and to the local department or to the adult protective services hotline.

J. No person or entity shall be obligated to report any matter if the person or entity has actual knowledge that the same matter has already been reported to the local department or to the adult protective services hotline.

K. All law-enforcement departments and other state and local departments, agencies, authorities and institutions shall cooperate with each adult protective services worker of a local department in the detection, investigation and prevention of adult abuse, neglect and exploitation.

§ 63.2-1900. Definitions.

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

"Administrative order" or "administrative support order" means a noncourt-ordered legally enforceable support obligation having the force and effect of a support order established by the court.

"Assignment of rights" means the legal procedure whereby an individual assigns support rights to the Commonwealth on behalf of a dependent child or spouse and dependent child.

"Authorization to seek or enforce a support obligation" means a signed authorization to the Commonwealth to seek or enforce support on behalf of a dependent child or a spouse and dependent child or on behalf of a person deemed to have submitted an application by operation of law.

"Cash medical support" means (i) the proportional amount the court or the Department shall order both parents to pay toward reasonable and necessary unreimbursed medical or dental expenses pursuant to subsection D of § 20-108.2 and (ii) where the child is a recipient of ~~Medicaid~~ *medical assistance* or the Family Access to Medical Insurance Security Plan and other health care coverage is not available or accessible to either parent at a reasonable cost, the court or the Department shall order the noncustodial parent to pay to the Department 2.5 percent of his gross income, to be prorated as agreed to by the Department and the Department of Medical Assistance Services.

"Court order" means any judgment or order of any court having jurisdiction to order payment of support or an order of a court of comparable jurisdiction of another state ordering payment of a set or determinable amount of support moneys.

"Custodial parent" means the natural or adoptive parent with whom the child resides; a stepparent or other person who has physical custody of the child and with whom the child resides; or a local board that has legal custody of a child in foster care.

"Debt" means the total unpaid support obligation established by court order, administrative process or by the payment of public assistance and owed by a noncustodial parent to either the Commonwealth or to his dependent(s).

"Department-sponsored health care coverage" means any health care coverage that the Department may make available through a private contractor for children receiving child support services from the Department.

"Dependent child" means any person who meets the eligibility criteria set forth in § 63.2-602, whose support rights have been assigned or whose authorization to seek or enforce a support obligation has been given to the Commonwealth and whose support is required by Titles 16.1 and 20.

"Employee" means any individual receiving income.

"Employer" means the source of any income.

"Financial institution" means a depository institution, an institution-affiliated party, any federal credit union or state credit union including an institution-affiliated party of such a credit union, and any benefit association, insurance company, safe deposit company, money market mutual fund, or similar entity authorized to do business in this Commonwealth.

"Financial records" includes, but is not limited to, records held by employers showing income, profit

sharing contributions and benefits paid or payable and records held by financial institutions, broker-dealers and other institutions and entities showing bank accounts, IRA and separate contributions, gross winnings, dividends, interest, distributive share, stocks, bonds, agricultural subsidies, royalties, prizes and awards held for or due and payable to a responsible person.

"Foreign support order" means any order issued outside of the Commonwealth by a court or tribunal as defined in § 20-88.32.

"Health care coverage" means any plan providing hospital, medical or surgical care coverage for dependent children provided such coverage is available and can be obtained by a parent, parents, or a parent's spouse at a reasonable cost.

"Income" means any periodic form of payment due an individual from any source and shall include, but not be limited to, income from salaries, wages, commissions, royalties, bonuses, dividends, severance pay, payments pursuant to a pension or retirement program, interest, trust income, annuities, capital gains, social security benefits, workers' compensation benefits, unemployment insurance benefits, disability insurance benefits, veterans' benefits, spousal support, net rental income, gifts, prizes or awards.

"Mistake of fact" means an error in the identity of the payor or the amount of current support or arrearage.

"Net income" means that income remaining after the following deductions have been taken from gross income: federal income tax, state income tax, federal income compensation act benefits, any union dues where collection thereof is required under federal law, and any other amounts required by law.

"Noncustodial parent" means a responsible person who is or may be obligated under Virginia law for support of a dependent child or child's caretaker.

"Obligee" means (i) an individual to whom a duty of support is or is alleged to be owed or in whose favor a support order has been issued or a judgment determining parentage has been rendered, (ii) a state or political subdivision to which the rights under a duty of support or support order have been assigned or that has independent claims based on financial assistance provided to an individual obligee, or (iii) an individual seeking a judgment determining parentage of the individual's child.

"Obligor" means an individual, or the estate of a decedent, who (i) owes or is alleged to owe a duty of support, (ii) is alleged but has not been adjudicated to be a parent of a child, or (iii) is liable under a support order.

"Payee" means any person to whom spousal or child support is to be paid.

"Reasonable cost" pertaining to health care coverage for dependent children means available, in an amount not to exceed five percent of the parents' combined gross income, and accessible through employers, unions or other groups, or Department-sponsored health care coverage, without regard to service delivery mechanism; unless the court deems otherwise in the best interests of the child or by agreement of the parties.

§ 63.2-1905. Establishment of State Case Registry.

The Department shall keep and maintain a State Case Registry (Registry) that contains case records of services provided by the Division of Child Support Enforcement, as well as each support order established or modified in the Commonwealth. Records contained in this Registry shall be promptly updated, maintained, and regularly monitored, and shall include (i) information on administrative actions and administrative and judicial proceedings and orders relating to paternity establishment and support; (ii) information obtained from comparison with federal, state or local sources of information; (iii) information on support collections and distributions; and (iv) any other relevant information. The Supreme Court of Virginia shall report information concerning judicial proceedings and orders relating to paternity and support to the Department. The Department shall be permitted to disseminate Registry information for information comparisons with other state and federal agencies, and as may be required pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) and any regulations adopted thereto. Such information comparison activities shall include the following: (a) Federal Case Registry of Child Support Orders, (b) Federal Parent Locator Service, (c) Temporary Assistance for Needy Families ~~and~~ ~~Medicaid~~, and (d) intrastate and interstate information comparisons.

§ 63.2-1954.1. Distribution of collections including Department-sponsored health care coverage.

Where the Department receives child support payments pursuant to an order that includes Department-sponsored health care coverage, the Department shall deduct the health care cost from the support payment before distribution of the balance of the support payment to the custodial parent. The Department shall forward the cost of the health care coverage to the plan provider. If the payment is insufficient to cover both the monthly child support obligation and either the monthly cost of the Department-sponsored health care coverage or cash medical support in cases where the child is a recipient of ~~Medicaid~~ *medical assistance* or the Family Access to Medical Insurance Security Plan as set forth in clause (ii) of the definition of cash medical support in § 63.2-1900, the child support payment

shall be paid first. The Department shall establish regulations to address insufficient health care coverage payments.

§ 63.2-2200. Definitions.

As used in this chapter, unless the context requires otherwise:

"Activities of daily living" or "ADLs" means bathing, dressing, toileting, transferring, bowel control, bladder control, and eating/feeding.

"Assistance" means aid that is required to be provided by another person in order to safely complete the activity.

"Care for a mentally or physically impaired person" means assistance with the activities of daily living provided to such person when the person has been screened and has been found to be eligible, in accordance with relevant state regulations, for placement and ~~Medicaid~~ *medical assistance* reimbursement for services in an assisted-living facility or a nursing home or for receiving community-based long-term care services.

"Caregiver" means an adult who is a single person with a Virginia adjusted gross income of not more than $50,000, or married and the combined Virginia adjusted gross income of both spouses is not more than $75,000 who provides care for a mentally or physically impaired person within the Commonwealth. A caregiver shall be either related by blood, marriage, or adoption to, or the legally appointed guardian of, the mentally or physically impaired person for whom he is caring.

"Fund" means the Virginia Caregivers Grant Fund established by § 63.2-2202.

"Mentally or physically impaired person" means a person who is a resident of Virginia that requires assistance with two or more activities of daily living during more than half the year.

§ 63.2-2201. Caregivers Grant Program established.

A. From January 1, 2000, through December 31, 2010, any caregiver who provides care for a mentally or physically impaired person shall be eligible to receive an annual caregivers grant in the amount of $500. The grants under this chapter shall be paid from the Fund, as provided in this chapter, to the caregiver during the calendar year immediately following the calendar year in which the care for a mentally or physically impaired person was provided. The total amount of grants to be paid under this chapter for any year shall not exceed the amount appropriated by the General Assembly to the Fund for payment to caregivers for such year.

B. Only one grant shall be allowed annually for each mentally or physically impaired person receiving care under the provisions of this section. Multiple caregivers providing care to the same mentally or physically impaired person shall be eligible to share the $500 grant as mutually agreed. However, only one caregiver may submit a grant application for the person. A caregiver providing care to more than one eligible person shall submit a separate grant application for each person receiving care.

C. The mentally or physically impaired person being cared for may live in the caregiver's home or in his own home but shall not be receiving ~~Medicaid~~ *medical assistance*-reimbursed community long-term care services, other than on a temporary or periodic basis, or living in a nursing home or other assisted living facility where assistance with ADLs is already provided and the cost of such assistance is included in the monthly bill or rental fee.

§ 65.2-101. Definitions.

As used in this title:

"Average weekly wage" means:

1. a. The earnings of the injured employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury, divided by 52; but if the injured employee lost more than seven consecutive calendar days during such period, although not in the same week, then the earnings for the remainder of the 52 weeks shall be divided by the number of weeks remaining after the time so lost has been deducted. When the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee earned wages shall be followed, provided that results fair and just to both parties will be thereby obtained. When, by reason of a shortness of time during which the employee has been in the employment of his employer or the casual nature or terms of his employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury was being earned by a person of the same grade and character employed in the same class of employment in the same locality or community.

b. When for exceptional reasons the foregoing would be unfair either to the employer or employee, such other method of computing average weekly wages may be resorted to as will most nearly approximate the amount which the injured employee would be earning were it not for the injury.

2. Whenever allowances of any character made to an employee in lieu of wages are a specified part of the wage contract, they shall be deemed a part of his earnings. For the purpose of this title, the average weekly wage of the members of the Virginia National Guard, the Virginia Naval Militia and the Virginia State Defense Force, registered members on duty or in training of the United States Civil

Defense Corps of this Commonwealth, volunteer firefighters engaged in firefighting activities under the supervision and control of the Department of Forestry, and forest wardens shall be deemed to be such amount as will entitle them to the maximum compensation payable under this title; however, any award entered under the provisions of this title on behalf of members of the National Guard, the Virginia Naval Militia or their dependents, or registered members on duty or in training of the United States Civil Defense Corps of this Commonwealth or their dependents, shall be subject to credit for benefits paid them under existing or future federal law on account of injury or occupational disease covered by the provisions of this title.

3. Whenever volunteer firefighters, volunteer lifesaving or volunteer rescue squad members, volunteer law-enforcement chaplains, auxiliary or reserve police, auxiliary or reserve deputy sheriffs, volunteer emergency medical technicians, members of volunteer search and rescue organizations, volunteer members of community emergency response teams, and volunteer members of medical reserve corps are deemed employees under this title, their average weekly wage shall be deemed sufficient to produce the minimum compensation provided by this title for injured workers or their dependents. For the purposes of workers' compensation insurance premium calculations, the monthly payroll for each volunteer firefighter or volunteer lifesaving or volunteer rescue squad member shall be deemed to be $300.

4. The average weekly wage of persons, other than those covered in subdivision 3 of this definition, who respond to a hazardous materials incident at the request of the Department of Emergency Management shall be based upon the earnings of such persons from their primary employers.

"Award" means the grant or denial of benefits or other relief under this title or any rule adopted pursuant thereto.

"Change in condition" means a change in physical condition of the employee as well as any change in the conditions under which compensation was awarded, suspended, or terminated which would affect the right to, amount of, or duration of compensation.

"Client company" means any person that enters into an agreement for professional employer services with a professional employer organization.

"Coemployee" means an employee performing services pursuant to an agreement for professional employer services between a client company and a professional employer organization.

"Commission" means the Virginia Workers' Compensation Commission as well as its former designation as the Virginia Industrial Commission.

"Employee" means:

1. a. Every person, including aliens and minors, in the service of another under any contract of hire or apprenticeship, written or implied, whether lawfully or unlawfully employed, except (i) one whose employment is not in the usual course of the trade, business, occupation or profession of the employer or (ii) as otherwise provided in subdivision 2 of this definition.

b. Any apprentice, trainee, or retrainee who is regularly employed while receiving training or instruction outside of regular working hours and off the job, so long as the training or instruction is related to his employment and is authorized by his employer.

c. Members of the Virginia National Guard and the Virginia Naval Militia, whether on duty in a paid or unpaid status or when performing voluntary service to their unit in a nonduty status at the request of their commander.

Income benefits for members of the National Guard or Naval Militia shall be terminated when they are able to return to their customary civilian employment or self-employment. If they are neither employed nor self-employed, those benefits shall terminate when they are able to return to their military duties. If a member of the National Guard or Naval Militia who is fit to return to his customary civilian employment or self-employment remains unable to perform his military duties and thereby suffers loss of military pay which he would otherwise have earned, he shall be entitled to one day of income benefits for each unit training assembly or day of paid training which he is unable to attend.

d. Members of the Virginia State Defense Force.

e. Registered members of the United States Civil Defense Corps of this Commonwealth, whether on duty or in training.

f. Except as provided in subdivision 2 of this definition, all officers and employees of the Commonwealth, including (i) forest wardens; (ii) judges, clerks, deputy clerks and employees of juvenile and domestic relations district courts and general district courts; and (iii) secretaries and administrative assistants for officers and members of the General Assembly employed pursuant to § 30-19.4 and compensated as provided in the general appropriation act, who shall be deemed employees of the Commonwealth.

g. Except as provided in subdivision 2 of this definition, all officers and employees of a municipal corporation or political subdivision of the Commonwealth.

h. Except as provided in subdivision 2 of this definition, (i) every executive officer, including president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the

charter and bylaws of a corporation, municipal or otherwise and (ii) every manager of a limited liability company elected or appointed in accordance with the articles of organization or operating agreement of the limited liability company.

i. Policemen and firefighters, sheriffs and their deputies, town sergeants and their deputies, county and city commissioners of the revenue, county and city treasurers, attorneys for the Commonwealth, clerks of circuit courts and their deputies, officers and employees, and electoral board members appointed in accordance with § 24.2-106, who shall be deemed employees of the respective cities, counties and towns in which their services are employed and by whom their salaries are paid or in which their compensation is earnable. However, notwithstanding the foregoing provision of this subdivision, such individuals who would otherwise be deemed to be employees of the city, county, or town in which their services are employed and by whom their salaries are paid or in which their compensation is earnable shall be deemed to be employees of the Commonwealth while rendering aid outside of the Commonwealth pursuant to a request, approved by the Commonwealth, under the Emergency Management Assistance Compact enacted pursuant to § 44-146.28:1.

j. Members of the governing body of any county, city or town in the Commonwealth, whenever coverage under this title is extended to such members by resolution or ordinance duly adopted.

k. Volunteers, officers and employees of any commission or board of any authority created or controlled by a local governing body, or any local agency or public service corporation owned, operated or controlled by such local governing body, whenever coverage under this title is authorized by resolution or ordinance duly adopted by the governing board of any county, city, town, or any political subdivision thereof.

l. Except as provided in subdivision 2 of this definition, volunteer firefighters, volunteer lifesaving or rescue squad members, volunteer law-enforcement chaplains, auxiliary or reserve police, auxiliary or reserve deputy sheriffs, volunteer emergency medical technicians, members of volunteer search and rescue organizations, volunteer members of regional hazardous materials emergency response teams, volunteer members of community emergency response teams, and volunteer members of medical reserve corps, who shall be deemed employees of (i) the political subdivision or state institution of higher education in which the principal office of such volunteer fire company, volunteer lifesaving or rescue squad, volunteer law-enforcement chaplains, auxiliary or reserve police force, auxiliary or reserve deputy sheriff force, volunteer emergency medical technicians, volunteer search and rescue organization, regional hazardous materials emergency response team, community emergency response team, or medical reserve corps is located if the governing body of such political subdivision or state institution of higher education has adopted a resolution acknowledging those persons as employees for the purposes of this title or (ii) in the case of volunteer firefighters or volunteer lifesaving or rescue squad members, the companies or squads for which volunteer services are provided whenever such companies or squads elect to be included as an employer under this title.

m. (1) Volunteer firefighters, volunteer lifesaving or rescue squad members, volunteer law-enforcement chaplains, auxiliary or reserve police, auxiliary or reserve deputy sheriffs, volunteer emergency medical technicians, members of volunteer search and rescue organizations and any other persons who respond to an incident upon request of the Department of Emergency Management, who shall be deemed employees of the Department of Emergency Management for the purposes of this title.

(2) Volunteer firefighters when engaged in firefighting activities under the supervision and control of the Department of Forestry, who shall be deemed employees of the Department of Forestry for the purposes of this title.

n. Any sole proprietor, shareholder of a stock corporation having only one shareholder, member of a limited liability company having only one member, or all partners of a business electing to be included as an employee under the workers' compensation coverage of such business if the insurer is notified of this election. Any sole proprietor, shareholder or member or the partners shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this title.

When any partner or sole shareholder, member or proprietor is entitled to receive coverage under this title, such person shall be subject to all provisions of this title as if he were an employee; however, the notices required under §§ 65.2-405 and 65.2-600 of this title shall be given to the insurance carrier, and the panel of physicians required under § 65.2-603 shall be selected by the insurance carrier.

o. The independent contractor of any employer subject to this title at the election of such employer provided (i) the independent contractor agrees to such inclusion and (ii) unless the employer is self-insured, the employer's insurer agrees in writing to such inclusion. All or part of the cost of the insurance coverage of the independent contractor may be borne by the independent contractor.

When any independent contractor is entitled to receive coverage under this section, such person shall be subject to all provisions of this title as if he were an employee, provided that the notices required under §§ 65.2-405 and 65.2-600 are given either to the employer or its insurance carrier.

However, nothing in this title shall be construed to make the employees of any independent contractor the employees of the person or corporation employing or contracting with such independent

contractor.

p. The legal representative, dependents and any other persons to whom compensation may be payable when any person covered as an employee under this title shall be deceased.

q. Jail officers and jail superintendents employed by regional jails or jail farm boards or authorities, whether created pursuant to Article 3.1 (§ 53.1-95.2 et seq.) or Article 5 (§ 53.1-105 et seq.) of Chapter 3 of Title 53.1, or an act of assembly.

r. AmeriCorps members who receive stipends in return for volunteering in local, state and nonprofit agencies in the Commonwealth, who shall be deemed employees of the Commonwealth for the purposes of this title.

s. Food Stamp recipients participating in the work experience component of the Food Stamp Employment and Training Program, who shall be deemed employees of the Commonwealth for the purposes of this title.

t. Temporary Assistance for Needy Families recipients not eligible for ~~Medicaid~~ *medical assistance* participating in the work experience component of the Virginia Initiative for Employment Not Welfare Program, who shall be deemed employees of the Commonwealth for the purposes of this title.

2. "Employee" shall not mean:

a. Officers and employees of the Commonwealth who are elected by the General Assembly, or appointed by the Governor, either with or without the confirmation of the Senate. This exception shall not apply to any "state employee" as defined in § 51.1-124.3 nor to Supreme Court Justices, judges of the Court of Appeals, judges of the circuit or district courts, members of the Workers' Compensation Commission and the State Corporation Commission, or the Superintendent of State Police.

b. Officers and employees of municipal corporations and political subdivisions of the Commonwealth who are elected by the people or by the governing bodies, and who act in purely administrative capacities and are to serve for a definite term of office.

c. Any person who is a licensed real estate salesperson, or a licensed real estate broker associated with a real estate broker, if (i) substantially all of the salesperson's or associated broker's remuneration is derived from real estate commissions, (ii) the services of the salesperson or associated broker are performed under a written contract specifying that the salesperson is an independent contractor, and (iii) such contract includes a provision that the salesperson or associated broker will not be treated as an employee for federal income tax purposes.

d. Any taxicab or executive sedan driver, provided the Commission is furnished evidence that such individual is excluded from taxation by the Federal Unemployment Tax Act.

e. Casual employees.

f. Domestic servants.

g. Farm and horticultural laborers, unless the employer regularly has in service more than two full-time employees.

h. Employees of any person, firm or private corporation, including any public service corporation, that has regularly in service less than three employees in the same business within this Commonwealth, unless such employees and their employers voluntarily elect to be bound by this title. However, this exemption shall not apply to the operators of underground coal mines or their employees. An executive officer who is not paid salary or wages on a regular basis at an agreed upon amount and who rejects coverage under this title pursuant to § 65.2-300 shall not be included as an employee for purposes of this subdivision.

i. Employees of any common carrier by railroad engaging in commerce between any of the several states or territories or between the District of Columbia and any of the states or territories and any foreign nation or nations, and any person suffering injury or death while he is employed by such carrier in such commerce. This title shall not be construed to lessen the liability of any such common carrier or to diminish or take away in any respect any right that any person so employed, or the personal representative, kindred or relation, or dependent of such person, may have under the act of Congress relating to the liability of common carriers by railroad to their employees in certain cases, approved April 22, 1908, or under §§ 8.01-57 through 8.01-62 or § 56-441.

j. Employees of common carriers by railroad who are engaged in intrastate trade or commerce. However, this title shall not be construed to lessen the liability of such common carriers or take away or diminish any right that any employee or, in case of his death, the personal representative of such employee of such common carrier may have under §§ 8.01-57 through 8.01-61 or § 56-441.

k. Except as provided in subdivision 1 of this definition, a member of a volunteer fire-fighting, lifesaving or rescue squad when engaged in activities related principally to participation as a member of such squad whether or not the volunteer continues to receive compensation from his employer for time away from the job.

l. Except as otherwise provided in this title, noncompensated employees and noncompensated directors of corporations exempt from taxation pursuant to § 501 (c) (3) of Title 26 of the United States

Code (Internal Revenue Code of 1954).

m. Any person performing services as a sports official for an entity sponsoring an interscholastic or intercollegiate sports event or any person performing services as a sports official for a public entity or a private, nonprofit organization which sponsors an amateur sports event. For the purposes of this subdivision, "sports official" includes an umpire, referee, judge, scorekeeper, timekeeper or other person who is a neutral participant in a sports event. This shall not include any person, otherwise employed by an organization or entity sponsoring a sports event, who performs services as a sports official as part of his regular employment.

"Employer" includes (i) any person, the Commonwealth or any political subdivision thereof and any individual, firm, association or corporation, or the receiver or trustee of the same, or the legal representative of a deceased employer, using the service of another for pay and (ii) any volunteer fire company or volunteer lifesaving or rescue squad electing to be included and maintaining coverage as an employer under this title. If the employer is insured, it includes his insurer so far as applicable.

"Executive officer" means (i) the president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the charter and bylaws of a corporation and (ii) the managers elected or appointed in accordance with the articles of organization or operating agreement of a limited liability company. However, such term does not include noncompensated officers of corporations exempt from taxation pursuant to § 501 (c) (3) of Title 26 of the United States Code (Internal Revenue Code of 1954).

"Filed" means hand delivered to the Commission's office in Richmond or any regional office maintained by the Commission; sent by telegraph, electronic mail or facsimile transmission; or posted at any post office of the United States Postal Service by certified or registered mail. Filing by first-class mail, telegraph, electronic mail or facsimile transmission shall be deemed completed only when the application actually reaches a Commission office.

"Injury" means only injury by accident arising out of and in the course of the employment or occupational disease as defined in Chapter 4 (§ 65.2-400 et seq.) of this title and does not include a disease in any form, except when it results naturally and unavoidably from either of the foregoing causes. Such term shall not include any injury, disease or condition resulting from an employee's voluntary:

1. Participation in employer-sponsored off-duty recreational activities which are not part of the employee's duties; or

2. Use of a motor vehicle that was provided to the employee by a motor vehicle dealer as defined by § 46.2-1500 and bears a dealer's license plate as defined by § 46.2-1550 for (i) commuting to or from work or (ii) any other nonwork activity.

Such term shall include any injury, disease or condition:

1. Arising out of and in the course of the employment of (a) an employee of a hospital as defined in § 32.1-123; (b) an employee of a health care provider as defined in § 8.01-581.1; (c) an employee of the Department of Health or a local department of health; (d) a member of a search and rescue organization; or (e) any person described in clauses (i) through (iv), (vi), and (ix) of subsection A of § 65.2-402.1 otherwise subject to the provisions of this title; and

2. Resulting from (a) the administration of vaccinia (smallpox) vaccine, Cidofivir and derivatives thereof, or Vaccinia Immune Globulin as part of federally initiated smallpox countermeasures, or (b) transmission of vaccinia in the course of employment from an employee participating in such countermeasures to a coemployee of the same employer.

"Professional employer organization" means any person that enters into a written agreement with a client company to provide professional employer services.

"Professional employer services" means services provided to a client company pursuant to a written agreement with a professional employer organization whereby the professional employer organization initially employs all or a majority of a client company's workforce and assumes responsibilities as an employer for all coemployees that are assigned, allocated, or shared by the agreement between the professional employer organization and the client company.

"Staffing service" means any person, other than a professional employer organization, that hires its own employees and assigns them to a client to support or supplement the client's workforce. It includes temporary staffing services that supply employees to clients in special work situations such as employee absences, temporary skill shortages, seasonal workloads, and special assignments and projects.

2. That § 32.1-323.2 of the Code of Virginia is repealed.

3. That provisions of this act shall become effective upon the passage of federal health care reform measures before the end of the fiscal year 2010-2011 that substantially diminish the Commonwealth's authority to administer medical assistance through the Medicaid program, according to the Attorney General. Upon passage of federal health care reform, the Director of the Department of Medical Assistance Services shall request the Attorney General to review such legislation and issue an official advisory opinion as to whether such reform substantially

diminishes the state's authority in administering medical services through the Medicaid program through one or more of the following measures: a reduced ability to serve the state's children through the SCHIP program rather than through Medicaid, requirements to cover individuals at higher income levels than currently required, increased federal review of reimbursements made to Medicaid providers, additional mandates of services currently allowed under the Medicaid program at the state's option, additional federal review of managed care networks, additional federal review of Medicaid eligibility determinations, and any other measure that, in the opinion of the Attorney General, substantially reduces the state's authority in administering medical assistance through the Medicaid program.