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SENATE BILL NO. 1216

Offered January 8, 2003

Prefiled January 8, 2003

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

Patrons—Newman and Reynolds; Delegate: Byron

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

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

§ 32.1-325. (For effective date /- See note) Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

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

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

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

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

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

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

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

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with

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59 lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care
60 provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone
61 marrow transplant. Appeals of these cases shall be handled in accordance with the Department's
62 expedited appeals process;

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

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

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

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

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

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

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

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

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

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

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

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

118 20. A provision for payment for medical assistance for infant hearing screenings and all necessary
119 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the
120 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 or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; and

21. (For effective date - See note) 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 sixty-five. This provision shall include an expedited eligibility determination for such women.

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, 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 which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

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

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

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

3. Refuse to enter into or renew an agreement or contract with any provider which has been

182 convicted of a felony.

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

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

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

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

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

205 H. The Department of Medical Assistance Services shall:

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

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

217 3. *Prepare and submit to the Centers for Medicare and Medicaid Services, as soon as such waiver*
218 *template shall become available, an application for a new waiver for home- and community-based*
219 *services that is cost effective and expands consumer-directed care to the maximum extent allowable*
220 *under federal law and regulation while protecting the health and safety of recipients. Such waiver shall*
221 *provide for a fiscal agent to handle tax issues and payment of personal attendants on the part of*
222 *recipients. The waiver application shall provide recipients with flexible choices and personal*
223 *independence in so far as possible and shall include provisions for family members to deliver the*
224 *covered services when consistent with and not prohibited by federal law and regulation.*

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

229 J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public
230 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by
231 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law
232 and regulation.

233 § 32.1-325. (Delayed effective date /- See notes) Board to submit plan for medical assistance services
234 to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts
235 with health care providers

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

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

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

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

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

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

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

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of twenty-four months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

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

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

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

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

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

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

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the

305 durable medical equipment provider's possession within sixty days from the time the ordered durable
306 medical equipment and supplies are first furnished by the durable medical equipment provider;

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

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

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

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

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

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

343 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
344 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the
345 United States Food and Drug Administration, and as recommended by the national Joint Committee on
346 Infant Hearing in its most current position statement addressing early hearing detection and intervention
347 programs. Such provision shall include payment for medical assistance for follow-up audiological
348 examinations as recommended by a physician or audiologist and performed by a licensed audiologist to
349 confirm the existence or absence of hearing loss; and

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

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

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

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

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

366 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations

pursuant to § 2.2-4007, 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 which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

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

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

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

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

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

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 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 recipients.

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

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of

428 eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward
429 the cost of providing medical assistance under the plan to their parents.

430 H. The Department of Medical Assistance Services shall:

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

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

442 3. *Prepare and submit to the Centers for Medicare and Medicaid Services, as soon as such waiver*
443 *template shall become available, an application for a new waiver for home- and community-based*
444 *services that is cost effective and expands consumer-directed care to the maximum extent allowable*
445 *under federal law and regulation while protecting the health and safety of recipients. Such waiver shall*
446 *provide for a fiscal agent to handle tax issues and payment of personal attendants on the part of*
447 *recipients. The waiver application shall provide recipients with flexible choices and personal*
448 *independence in so far as possible and shall include provisions for family members to deliver the*
449 *covered services when consistent with and not prohibited by federal law and regulation.*

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

454 J. Except as provided in subsection A 1 of § 2.2-4345, the provisions of the Virginia Public
455 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by
456 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law
457 and regulation.