2002 ANNUAL REPORT OF

The Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 27

COMMONWEALTH OF VIRGINIA
RICHMOND
2003

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

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April 21, 2003

TO: The Honorable Mark R. Warner, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the *Code of Virginia* (Title 30, Chapter 18, §§30-168 through 30-170) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 2002.

This 2002 Annual Report includes a summary of the Joint Commission's 2002 activities and legislative recommendations to the 2003 Session of the General Assembly. Copies of the legislation sponsored by the Joint Commission during the 2003 Session also are included. In addition to this annual report, final reports of the studies conducted were published or made available on the General Assembly website. These reports are also available from the Joint Commission staff office.

Sincerely,

Harvey B. Morgan
Chairman

Kim Snead
Executive Director

JOINT COMMISSION ON HEALTH CARE: 2002

Chairman
The Honorable Harvey B. Morgan

Vice Chairman
The Honorable William T. Bolling

The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Linda T. Puller
The Honorable Nick Rerras
The Honorable Kenneth W. Stolle
The Honorable William C. Wampler, Jr.
The Honorable Clifford L. Athey, Jr.
The Honorable Robert H. Brink
The Honorable L. Preston Bryant, Jr.
The Honorable Jeannemarie A. Devolites
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable S. Chris Jones
The Honorable Kenneth R. Melvin

Secretary of Health and Human Resources
The Honorable Jane H. Woods

Executive Director
Kim Snead

JOINT COMMISSION ON HEALTH CARE

Executive Director

Kim Snead

Senior Health Policy Analyst

April R. Kees

Office Manager

Mamie V. White

Access to the Internet

The Joint Commission's home page on the Internet is located at:
http://legis.state.va.us/jchc/jchchome.htm

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 2002.

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I. SUMMARY OF 2002 ACTIVITIES AND RELATED 2003 GENERAL ASSEMBLY ACTIONS

STATUTORY AUTHORITY

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

The Joint Commission is authorized in Title 30, Chapter 18, §30.168 through §30.170 of the *Code of Virginia*. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission endeavors to ensure that the greatest number of Virginians receives quality health care.

2002 JOINT COMMISSION ACTIVITIES

During 2002, the Joint Commission held seven meetings. An additional meeting was held in January 2003 after the 2003 Session of the General Assembly had convened. The following paragraphs summarize the proceedings of each meeting.

April 25th Meeting

Staff presented a final status report on the Joint Commission's 2002 legislation, an overview of the 2002 workplan, and a report on eye examinations prior to school enrollment.

May 30th Meeting

Staff presented a report on evaluating the personal maintenance allowance within the Medicaid elderly and disabled waiver program.

Patrick W. Finnerty, Director, Department of Medical Assistance Services, presented an update on the Family Access to Medical Insurance Security Plan and gave an update on other department initiatives.

June 20th Meeting

The June 20th meeting included five presentations:

Nancy K. Durrett, RN, MSN, Executive Director, Board of Nursing, Department of Health Professions, presented a report on Board of Nursing regulations regarding graduates of a foreign nursing school.

Grayson B. Miller, Jr., MD, Acting Deputy Director for Bioterrorism and Response with the Virginia Department of Health, presented a report on the Commonwealth's preparedness initiative.

Janet Lynch, Ph.D., CPHQ, Chief Quality Initiative Officer of the Virginia Health Quality Center, reported on the work of the Center's quality improvement initiatives and its 18 years as the federally-designated quality improvement organization for Virginia.

Becky Hartt Minor, MA, Chair, Virginia Cancer Plan Advisory Committee, and Diane Cole, MPH, Member of Virginia Cancer Plan Advisory Committee, presented the Virginia cancer plan initiatives for 2001 through 2005.

Tom Boshell, Senior Vice President of Marketing, Liberty Healthcare, reported on the treatment programs for sexually violent predators.

September 10th Meeting

An election of a new Chairman and Vice Chairman of the Joint Commission was held. Delegate Harvey B. Morgan was elected Chairman, and Senator William T. Bolling was elected Vice Chairman.

Staff presented a report on Virginia's Family Access to Medical Insurance Security Plan. Thomas F. Huff, Ph.D., VCU/Vice Provost for Life Sciences and

Peter Vallentyne, Ph.D., VCU/Professor of Philosophy, presented a report on the science and ethics of stem cell research.

October 8th Meeting

Three staff presentations were made regarding: (i) local health partnership authorities; (ii) Medicaid reimbursement for physicians, and (iii) reimbursement of noncontracting ancillary services providers.

Richardson Grinnan, MD, President, Virginia Health Information (VHI), presented VHI's annual report.

Delores A. Esser, Commissioner, Virginia Employment Commission, presented a report from the Virginia Workforce Council on nursing education.

Robert L. Wright, III, Bureau of Insurance, reported on long-term care insurance provisions.

Randolph L. Gordon, MD, MPH, Co-Chair, Virginia Center for Healthy Communities, and E. Sue Cantrell, MD, Director, Lenowisco Health District, presented a report on community-based health improvement initiatives.

November 6th Meeting

Phyllis Palmiero, Executive Director, State Council of Higher Education for Virginia, presented a report on increasing access to nursing education programs.

JoAnne Kirk Henry, Ed.D., RNCS, representing the Advisory Council on the Future of Nursing and the Virginia Partnership for Nursing, presented a report on the Virginia Partnership for Nursing.

Staff presented a report on emergency medical and mental health services in public schools. A "decision matrix" that summarized all of the issues addressed by the Joint Commission during 2002 was presented also. Commission members determined what actions to take in response to some of the issues contained in the "decision matrix." Staff were directed to draft legislation for introduction during the 2003 Session of the General Assembly and to make the drafted bills available for public comment.

A joint meeting of the Joint Commission and the Joint Commission on Behavioral Health Care was held.

December 10th Meeting

Staff continued the discussion of the "decision matrix" and Commission members made additional decisions regarding legislation to introduce during the 2003 Session of the General Assembly. Staff also reported on the follow-up issues from the November 6th meeting and reviewed the public comments received on the Joint Commission's draft legislative proposals. The Commission made decisions on proposed legislation, and adopted its package of legislative proposals and budgetary recommendations to be introduced during the 2003 Session.

January 9, 2003 Meeting

The Joint Commission members met to vote on budget language regarding the personal maintenance allowance for the Medicaid Elderly and Disabled Waiver.

SUBCOMMITTEE ACTIVITIES

In addition to the Joint Commission meetings summarized above, the Long-Term Care Subcommittee met to address long-term care and aging issues and the Child Health Insurance Subcommittee met to review child health insurance issues.

Long-Term Care Subcommittee

The Long-Term Care Subcommittee, originally established in 1997, continued during 2002. Delegate Hall chaired the Subcommittee; the other Subcommittee members were: Senators Martin and Puller, and Delegates Brink, Devolites, Hamilton, and Morgan.

The Long-Term Care Subcommittee met two times in 2002.

The first meeting was held on November 13, 2002 in the General Assembly Building. Julie A. Stanley, J.D., Assistant Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, presented a report on the development of Virginia's plan to address the provisions of the *Olmstead* Decision. Diana Thorpe, Director, Division of LTC & Quality Assurance, Department of Medical Assistance Services reported on the purchasing consortium for mattresses to prevent pressure ulcers. Bobbye Terry, Virginia

Association for Home Care; Eldon James, Virginia Association of Area Agencies on Aging; Mary Lynne Bailey, Virginia Health Care Association; Marcia Tetterton, Virginia Association of Nonprofit Homes for the Aging; and Carter Harrison, Alzheimer's Association of Virginia, presented information regarding the impact that additional budget reductions would have on long-term care services.

The second meeting was held on December 10, 2002 at the General Assembly Building. Secretary of Health and Human Resources, Jane H. Woods, presented a report on improvements in reporting adult abuse, exploitation, and neglect. Diana Thorpe presented information regarding home and community-based waivers. The meeting concluded with discussion about issues to be addressed in 2003.

Child Health Insurance Subcommittee

The Child Health Insurance Subcommittee was formed in order to review and make recommendations to the full Commission regarding the options presented in the staff study of FAMIS. The Subcommittee met on October 8th in the General Assembly Building. Delegate Hamilton chaired the Subcommittee; the other Subcommittee members were: Senators Bolling and Puller, and Delegates Athey, Brink, and Devolites.

JOINT COMMISSION ON HEALTH CARE FINAL REPORTS

During 2002, the Joint Commission conducted studies in response to seven legislative requests. These studies were presented in the form of "issue briefs" to the Commission during its 2002 meetings. The issue briefs and staff reports were posted on the Joint Commission's home page on the Internet to allow interested individuals to download the documents for review and comment.

Public comments were solicited on all of the staff reports, and a summary of the comments was presented to the Joint Commission members. Following the public comment period, all of the reports were finalized and put on the "Reports" website section of the General Assembly.

Figure 1 identifies each of the Joint Commission's 2002 final reports and indicates the authority for the study.

Figure 1
2002 Joint Commission on Health Care Reports to the General Assembly

Name of Study	Authority for Study	
Eye Examinations Prior to School Enrollment	Letter from House Education Committee (HB 571/HB 170)	RD 22, 2003
Personal Maintenance Allowance within the Medicaid Elderly and Disabled Waiver	Item 11 of the 2002-2004 Appropriations Act	RD 23, 2003
Local Health Partnership Authorities	HB 2060 (2001 Session)	RD 24, 2003
Reimbursement of Noncontracting Ancillary Services Providers	Letter from Senate Committee on Rules (SJR 125)	RD 25, 2003
Family Access to Medical Insurance Security Plan	Requested by JCHC member (SJR 90, SB 428/HB 1087, HB 332, HB 1086-1089)	RD 26, 2003
Emergency Medical and Mental Health Services in Public Schools	Requested by JCHC member (HJR 43)	RD 30, 2003
Medicaid Reimbursement of Physicians	Requested by JCHC member (SJR 38/HJR 42)	RD 32, 2003

Notes:
Except as noted, all joint resolution and bill numbers are from the 2002 General Assembly Session. Studies published as House/Senate documents are available from the Bill Room in the General Assembly Building. Studies published as JCHC Report Documents are available from the JCHC staff office or the General Assembly homepage under Legislative Studies: Reports to the General Assembly.

2003 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 2002, a package of legislative proposals (bills and budget amendments) was introduced during the 2003 Session of the General Assembly. The following paragraphs identify each bill, as enacted, and the final action taken by the General Assembly and the Governor. A copy of each bill, in the form signed by the Governor, is provided in Appendix A with the page numbers identified below.

Bills

(Unless otherwise noted, all of the following bills were approved by the General Assembly and signed by the Governor as described.)

SB 1068 — Extends the sunset provisions contained in the enabling language for local health partnership authorities from 2003 to 2006. The bill also would require any local health partnership authority to report on an annual basis any programmatic initiatives to the Joint Commission on Health Care. The bill also has technical amendments. (Appendix A, page 1)

SB 1091 — Requires dentists who are licensed as oral and maxillofacial surgeons to submit outpatient surgery data on procedures requiring certification under § 54.1-2709.1. (Appendix A, page 3)

SB 1218/ HB 2287 — Omnibus bill which includes the following provisions:

1. Establishes an umbrella program incorporating both Medicaid for medically-indigent children and the Family Access to Medical Insurance Security Plan in order to provide coordinated services to children enrolled in these programs. The Medicaid portion is named FAMIS Plus.
2. Codifies current practice by requiring the use of a single application to determine eligibility for both Medicaid coverage for children and FAMIS.
3. Extends coverage for certain community-based mental health services currently provided to children enrolled in FAMIS.
4. Reduces the waiting period from 6 to 4 months between the time that a child was covered by private health insurance and when eligibility for FAMIS can be established.
5. Amends the language authorizing cost-sharing within the FAMIS Plan to require nominal copayments, which shall not be less than those in effect on January 1, 2003. (Appendix A, pages 7 and 19)

Budget Amendment Requests

The JCHC introduced five budget amendment requests during the 2003 General Assembly Session. A brief description of each approved request is provided at Appendix B.

APPENDIX A

CHAPTER 70

An Act to amend and reenact §§ 32.1-122.10:001 and 32.1-122.10:002 of the Code of Virginia, and to amend and reenact the second enactment of Chapter 671 of the Acts of Assembly of 2001, relating to local health partnership authorities.

[S 1068]

Approved March 16, 2003

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-122.10:001 and 32.1-122.10:002 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-122.10:001. Purpose; one or more localities may create authority; advertisement and notice of hearing.

A. Communities lack the ability to coordinate, across jurisdictions, health partnership efforts between local governments and private providers of health care services, which leads to duplicative and inefficient services. Such public/private partnerships could (i) encourage the use of service delivery that otherwise might have required government funding or programs; (ii) allow governments to fully participate in such partnerships; (iii) maximize the willingness of individuals, agencies and private organizations to lend their expertise to help satisfy community needs; (iv) allow innovative funding mechanisms to leverage public funds; (v) allow appropriate information sharing to ensure the adequacy and quality of services delivered; (vi) provide liability protection for volunteers providing services under programs sponsored or approved by the authority; (vii) provide a mechanism to ensure that services provided in the community are necessary, appropriate, and provided by trained and supervised persons; and (viii) allow volunteers and others to focus their energies to achieve community health improvement. Health care services include, but are not limited to, treatment of and education about acute and chronic diseases, wellness and prevention activities that promote the health of communities, and access to services and activities.

B. The governing body of a locality may by ordinance or resolution, or the governing bodies of two or more localities may by concurrent ordinances or resolutions or by agreement, create a local health partnership authority which shall have as its purpose developing partnerships between public and private providers. ~~The name of the authority shall contain the word "authority."~~ The ordinance, resolution or agreement creating the authority shall not be adopted or approved until a public hearing has been held on the question of its adoption or approval. The authority shall be a public body politic and corporate.

C. The governing body of each participating locality shall cause to be advertised at least one time in a newspaper of general circulation in such locality a copy of the ordinance, resolution or agreement creating the authority, or a descriptive summary of the ordinance, resolution or agreement and a reference to the place where a copy of such ordinance, resolution or agreement can be obtained, and notice of the day, not less than ~~thirty~~ *30* days after publication of the advertisement, on which a public hearing will be held on the ordinance, resolution or agreement.

D. ~~To ensure that such authorities operate in an efficient manner and are accomplishing the goals set for them, a pilot project shall be instituted in Planning District 8 in a community health program that has been operating under the auspices of the Robert Wood Johnson and the Kellogg Foundations. The Joint Commission on Health Care shall monitor and provide technical advice to the authority and shall, by November 15, 2002, evaluate the program and make recommendations as to continuation of such an authority, the expansion to other areas of the state, and changes, if any, that are necessary to improve the program.~~

~~E.~~ No authority created pursuant to this article shall be exempt from any of the provisions of the Certificate of Public Need laws and regulations of the Commonwealth.

~~F.~~ *E.* No authority created pursuant to this article shall be allowed to issue bonds or other form of indebtedness.

F. Any authority created pursuant to this article shall report on programmatic initiatives on an annual basis to the Joint Commission on Health Care.

§ 32.1-122.10:002. Board of directors; expenses; officers; terms of office; quorum; annual report.

A. All powers, rights and duties conferred by this article, or other provisions of law, upon an authority shall be exercised by a board of directors. The participating localities in the local health partnership authority shall determine the composition of the membership of the board. At a minimum, the board shall be composed of one locally elected official, one representative of the health care industry, one representative of the business community, and one representative of the nongovernmental human services agencies from each participating locality *if such nongovernmental human services agencies exist*; and, sufficient citizen members to constitute the majority of the board, who shall not be employed by, nor board members of, nor financially linked to the partnering agencies, groups and corporations involved.

B. Each member of a board shall serve for a term of four years and may serve no more than two consecutive full terms. The creation of a vacancy on the board shall be filled in the same manner by the appointing locality, such position being filled for the unexpired term.

C. Members of the board of directors shall be reimbursed for actual expenses incurred in the performance of their duties from funds available to the board and according to policy determined by the board.

D. Each board shall elect from its membership a chairman, vice chairman and secretary/treasurer. The board shall appoint an executive director who shall discharge such functions as may be directed by the board. The authority shall employ such staff as may be appropriate to coordinate the work of the participating organizations in support of programs and services approved by each board. The executive director and staff shall be paid from funds received by the authority.

E. Each board, promptly following the close of the fiscal year, shall submit an annual report of the authority's activities of the preceding year to the governing body of each member locality and to the Joint Commission on Health Care. Each such report shall set forth a complete operating and financial statement covering the operation of the authority during such year.

2. That the second enactment of Chapter 671 of the Acts of Assembly of 2001 is amended and reenacted as follows:

2. That the provisions of this act shall expire on July 1, ~~2003~~ *2006*.

CHAPTER 466

An Act to amend and reenact §§ 32.1-276.3 and 32.1-276.6 of the Code of Virginia, relating to health care data reporting.

[S 1091]

Approved March 16, 2003

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-276.3 and 32.1-276.6 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-276.3. (Effective until July 1, 2008) Definitions.

As used in this chapter:

"Board" means the Board of Health.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1; (iii) a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; ~~or~~ (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2*; or (vii) any person licensed to practice dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain procedures pursuant to § 54.1-2709.1.* In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title, a hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1, a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services for the care and treatment of the mentally ill, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

"Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and registered oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-2709.1 or by a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and equipped for the provision of oral and maxillofacial surgery services to ambulatory patients.

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office *or oral and maxillofacial surgeon's office, as defined above.* Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians, and (ii) designed and equipped solely for the provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

§ 32.1-276.6. (Effective until July 1, 2008) Patient level data system continued; reporting requirements.

A. The Virginia Patient Level Data System is hereby continued, hereinafter referred to as the "System." Its purpose shall be to establish and administer an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions.

B. Every inpatient hospital shall submit to the Board patient level data as set forth in this subsection. Every general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title and every physician *and every oral and maxillofacial surgeon certified to perform certain procedures pursuant to § 54.1-2709.1* performing surgical procedures in his office shall also submit to the board outpatient surgical data as set forth in this subsection. *Every oral and maxillofacial surgeon certified to perform certain procedures pursuant to § 54.1-2709 shall submit to the Board outpatient surgical data as set forth in this subsection for only those procedures for which certification is required pursuant to § 54.1-2709.1.*

Any such hospital, facility ~~or~~, physician *or oral and maxillofacial surgeon, as defined in § 32.1-276.3,* may report the required data directly to the nonprofit organization cited in § 32.1-276.4. Unless otherwise noted, patient level data elements for hospital inpatients and patients having outpatient surgery shall include, where applicable and included on standard claim forms:

1. Hospital identifier;
2. Attending physician identifier (inpatient only);
3. Operating physician *or oral and maxillofacial surgeon* identifier;
4. Payor identifier;
5. Employer identifier *as required on standard claims forms*;
6. Patient identifier (all submissions);
7. Patient sex, race (inpatient only), date of birth (including century indicator), zip code, patient relationship to insured, employment status code, status at discharge, and birth weight for infants (inpatient only);
8. Admission type, source (inpatient only), date and hour, and diagnosis;
9. Discharge date (inpatient only) and status;
10. Principal and secondary diagnoses;
11. External cause of injury;

12. Co-morbid conditions existing but not treated;

13. Procedures and procedure dates;

14. Revenue center codes, units, and charges *as required on standard claims forms*; and

15. Total charges.

C. State agencies providing coverage for outpatient services shall submit to the Board patient level data regarding paid outpatient claims. Information to be submitted shall be extracted from standard claims forms and, where available, shall include:

1. Provider identifier;

2. Patient identifier;

3. Physician *or oral and maxillofacial surgeon* identifier;

4. Dates of service and diagnostic, procedural, demographic, pharmaceutical, and financial information; and

5. Other related information.

The Board shall promulgate regulations specifying the format for submission of such outpatient data. State agencies may submit this data directly to the nonprofit organization cited in § 32.1-276.4.

CHAPTER 71

An Act to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia, relating to children's health insurance.

[S 1218]

Approved March 16, 2003

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia are 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~~ *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 ~~twenty-one~~ *21*, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of ~~twenty-one~~ *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 payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of ~~twenty-one~~ *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;

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

9. 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;

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

11. 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;

12. A provision for payment of medical assistance which provides for payment for ~~forty-eight~~ *48* hours of inpatient treatment for a patient following a radical or modified radical mastectomy and ~~twenty-four~~ *24* hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of 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;

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

14. A provision for payment of medical assistance to (i) persons age ~~fifty~~ *50* and over and (ii) persons age ~~forty~~ *40* and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a ~~twelve~~ *12*-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age ~~thirty-five~~ *35* through ~~thirty-nine~~ *39*, one such mammogram biennially to persons age ~~forty~~ *40* through ~~forty-nine~~ *49*, and one such mammogram annually to persons age ~~fifty~~ *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;

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

17. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of ~~twenty-one~~ *21* years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable to the transplant procedure; (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;

18. 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;

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

20. 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 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~~ *65*. This provision shall include an expedited eligibility determination for such women*; and*

22. 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.

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 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 ~~eighteen~~ *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 ~~twenty-one~~ *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 Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

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

J. Except as provided in subsection 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. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325. (Delayed effective date - See notes) 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~~ *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 ~~twenty-one~~ *21*, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of ~~twenty-one~~ *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 ~~twenty-four~~ *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 ~~twenty-one~~ *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 ~~forty-eight~~ *48* hours of inpatient treatment for a patient following a radical or modified radical mastectomy and ~~twenty-four~~ *24* hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within ~~sixty~~ *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 ~~fifty~~ *50* and over and (ii) persons age ~~forty~~ *40* and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a ~~twelve~~ *12*-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age ~~thirty-five~~ *35* through ~~thirty-nine~~ *39*, one such mammogram biennially to persons age ~~forty~~ *40* through ~~forty-nine~~ *49*, and one such mammogram annually to persons age ~~fifty~~ *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 Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid

program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of ~~twenty-one~~ *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 or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; ~~and~~

22. (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~~ *65*. This provision shall include an expedited eligibility determination for such women*; and*

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.

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 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 ~~eighteen~~ *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 ~~twenty-one~~ *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 Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

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

J. Except as provided in subsection 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. Agreements made pursuant to this subsection shall comply with federal law and regulation.

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

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals~~, up to~~ *under* the age of ~~nineteen~~ *19* when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91(a) and (b) (1)); (iv) have been without health insurance for at least ~~six~~ *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.

B. Family Access to Medical Insurance Security Plan participants ~~whose incomes are above 150 percent of the federal poverty level~~ shall participate in cost sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family ~~at or~~ above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. ~~Cost-sharing~~ *The annual aggregate cost-sharing* for all eligible children in a family ~~between 100 percent and~~ *at or below* 150 percent of *the* federal poverty level ~~shall be limited to nominal copayments and the annual aggregate cost-sharing~~ shall not exceed 2.5 percent of the family's gross income. *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. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

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

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

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Family Access to Medical Insurance Security Plan shall include a provision allowing a child's application to be filed by a parent, legal guardian, authorized representative or any other adult caretaker relative with whom the child lives. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. *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. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

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

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

Security Plan and may assist families in completion of the applications.

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

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

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

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

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

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

CHAPTER 66

An Act to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia, relating to children's health insurance.

[H 2287]

Approved March 16, 2003

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia are 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~~ *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 ~~twenty-one~~ *21*, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of ~~twenty-one~~ *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 payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of ~~twenty-one~~ *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;

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

9. 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;

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

11. 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;

12. A provision for payment of medical assistance which provides for payment for ~~forty-eight~~ *48* hours of inpatient treatment for a patient following a radical or modified radical mastectomy and ~~twenty-four~~ *24* hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of 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;

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

14. A provision for payment of medical assistance to (i) persons age ~~fifty~~ *50* and over and (ii) persons age ~~forty~~ *40* and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a ~~twelve~~ *12*-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age ~~thirty-five~~ *35* through ~~thirty-nine~~ *39*, one such mammogram biennially to persons age ~~forty~~ *40* through ~~forty-nine~~ *49*, and one such mammogram annually to persons age ~~fifty~~ *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;

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

17. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of ~~twenty-one~~ *21* years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable to the transplant procedure; (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;

18. 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;

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

20. 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 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~~ *65*. This provision shall include an expedited eligibility determination for such women*; and*

22. 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.

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 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 ~~eighteen~~ *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 ~~twenty-one~~ *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 Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

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

J. Except as provided in subsection 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. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ 32.1-325. (Delayed effective date /- See notes) 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~~ *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 ~~twenty-one~~ *21*, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of ~~twenty-one~~ *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 ~~twenty-four~~ *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 ~~twenty-one~~ *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 ~~forty-eight~~ *48* hours of inpatient treatment for a patient following a radical or modified radical mastectomy and ~~twenty-four~~ *24* hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within ~~sixty~~ *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 ~~fifty~~ *50* and over and (ii) persons age ~~forty~~ *40* and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a ~~twelve~~ *12*-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age ~~thirty-five~~ *35* through ~~thirty-nine~~ *39*, one such mammogram biennially to persons age ~~forty~~ *40* through ~~forty-nine~~ *49*, and one such mammogram annually to persons age ~~fifty~~ *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 Health Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid

program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of ~~twenty-one~~ *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 or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss; ~~and~~

22. (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~~ *65*. This provision shall include an expedited eligibility determination for such women*; and*

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.

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 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 ~~eighteen~~ *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 ~~twenty-one~~ *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 Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

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

J. Except as provided in subsection 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. Agreements made pursuant to this subsection shall comply with federal law and regulation.

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

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals~~, up to the age of nineteen~~ *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; (iii) are not covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91(a) and (b) (1)); (iv) have been without health insurance for at least ~~six~~ *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.

B. Family Access to Medical Insurance Security Plan participants ~~whose incomes are above 150 percent of the federal poverty level~~ shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family ~~at or~~ above 150 percent of the federal poverty level shall not exceed five 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 ~~between 100 percent and~~ *at or below* 150 percent of *the* federal poverty level ~~shall be limited to nominal copayments and the annual aggregate cost-sharing~~ shall not exceed 2.5 percent of the family's gross income. *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. The Family Access to Medical Insurance Security Plan shall provide for benefits not included in the employer-sponsored health insurance benefit plan through supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

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

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

G. The Department of Medical Assistance Services may establish a centralized processing site for the administration of the program to include responding to inquiries, distributing applications and program information, and receiving and processing applications. The Family Access to Medical Insurance Security Plan shall include a provision allowing a child's application to be filed by a parent, legal guardian, authorized representative or any other adult caretaker relative with whom the child lives. The Department of Medical Assistance Services may contract with third-party administrators to provide any additional administrative services. Duties of the third-party administrators may include, but shall not be limited to, enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting, and such other services necessary for the administration of the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title XXI. *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. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

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

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

Security Plan and may assist families in completion of the applications.

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

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

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

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

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

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

APPENDIX B

2003 JCHC Budget Amendments

Description of Amendment	FY 2004 Request	Final Action
Funding to enable the Department of Medical Assistance Services to make proposed changes to FAMIS and FAMIS Plus. (Item 324#5h)	$1,674,950 GFs $2,524,500 NGFs	$57,070 GFs
Funding to enable the Department of Medical Assistance Services to increase the personal maintenance allowance for five Medicaid waivers from 100% to 150% of Supplemental Security Income (from $552 to $828 per month). (Items 325#19h and 325#3s)	$831,000,GFs $847,000 NGFs	*No funding was included in the approved budget.*
Language to authorize the Virginia Department for the Aging to request that the Department of Planning and Budget allow specific area agencies on aging to transfer up to 40% of their funds from one category of elderly services to another. (Items 303#1h and 303#1s)	Language only.	Language included.

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