2005 ANNUAL REPORT OF

The Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 110

COMMONWEALTH OF VIRGINIA
RICHMOND
2006

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Delegate Harvey B. Morgan
Chairman

Kim Snead
Executive Director

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July 11, 2006

TO: The Honorable Timothy M. Kaine, Governor of Virginia

and

Members of the Virginia 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, 2005.

This 2005 Annual Report includes a summary of the Joint Commission's 2005 activities and legislative recommendations to the 2006 Session of the General Assembly. In addition, executive summaries of the studies completed in 2005 are included. The final reports of the completed studies 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

JOINT COMMISSION ON HEALTH CARE: 2005

Chairman
The Honorable Harvey B. Morgan

Vice Chairman
The Honorable William C. Mims

The Honorable Harry B. Blevins
The Honorable R. Edward Houck
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Linda T. Puller
The Honorable Nick Rerras
The Honorable William C. Wampler, Jr.
The Honorable Clifford L. Athey, Jr.
The Honorable Robert H. Brink
The Honorable Benjamin L. Cline
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable R. Steven Landes
The Honorable Kenneth R. Melvin
The Honorable John M. O'Bannon, III
The Honorable John J. Welch, III

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

Executive Director
Kim Snead

JOINT COMMISSION ON HEALTH CARE

Executive Director
Kim Snead

Principal Health Policy Analyst
April R. Kees

Senior Health Policy Analyst
Catherine W. Harrision

Intern
A. Ridgely Minter

Office Manager
Mamie White Jones

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 2005.

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I. SUMMARY OF 2005 ACTIVITIES AND RELATED 2006 GENERAL ASSEMBLY ACTIONS

STATUTORY AUTHORITY

The Joint Commission on Health Care (JCHC) was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032 to continue the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session). On July 1, 2003, the responsibilities of the Joint Commission on Behavioral Health Care were assumed by JCHC.

The Joint Commission is authorized in Title 30, Chapter 18, §30.168 through §30.170 of the *Code of Virginia*. The purpose of the Joint Commission as stated in *Code* §30.168 is "to study, report and make recommendations on all areas of health care provisions, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care."

2005 JOINT COMMISSION ACTIVITIES

In keeping with its statutory mandate, the Joint Commission completed studies; considered the comments of advocates, industry representatives, and other interested parties; and introduced legislation to advance the quality of health care, long-term care and behavioral health care in the Commonwealth.

Five meetings of the Joint Commission were held; including a meeting in January 2006 before the 2006 General Assembly Session convened. The agenda for each meeting is shown on the following pages.

Agenda for May 4, 2004

I. Call to Order
Delegate Harvey B. Morgan, Chairman

II. Overview of Agenda
Kim Snead, Executive Director

III. Status of Legislation and Proposed Workplan for 2005
Kim Snead

Agenda for September 13, 2005

I. Call to Order
Delegate Harvey B. Morgan, Chairman

II. Overview of Agenda
Kim Snead, Executive Director

III. Report on Medicaid Preferred Drug List and Medicaid Disease Management Program
Wayne Turnage, Director of Policy and Research
Department of Medical Assistance Services

IV. Update on Family Access to Medical Insurance Security (FAMIS)
Linda L. Nablo, Director of the Division of Child Health Insurance
Department of Medical Assistance Services

V. Report of the Prince William Health Partnership Authority
Kim Snead
Margaret K. Goldberger, FACHE, Executive Director
Prince William Health Partnership Authority

VI. Staff Study on Medicaid Asset Transfer Allowances
Catherine W. Harrison, Health Policy Analyst

VII. Staff Follow-Up on Healthy Lives Prescription Assistance
Catherine W. Harrison, Health Policy Analyst

VIII. Staff Study on Licensing of Dietitians
April Kees, Senior Health Policy Analyst

Agenda for October 25, 2005

I. Call to Order
Delegate Harvey B. Morgan, Chairman

II. Overview of Agenda and Public Comments
Kim Snead, Executive Director

III. Virginia Health Information Initiatives
Novel Martin, President, VHI Board of Directors

IV. Request for JCHC Study of Follow-Up Services for Preterm Newborns
Kim Snead
Susan G. Brown, M.D., Henrico Doctors' Hospital

V. Plan to Provide Access to MHMRSAS Services for Children, Adolescents and their Families (Budget Item 330-F)
Brian L. Meyer, Ph.D., Chair
Child and Family Behavioral Health Policy and Planning Committee
Mary Ann Discenza, Division of Child and Family Services
Department of Mental Health, Mental Retardation and Substance Abuse Services

VI. Report on Plan for Proton Beam Therapy Center in Hampton Roads
Dr. William R. Harvey, President, Hampton University

VII. Update on Study of Issues Affecting Women's Obstetrical and Gynecological Health
Jeffrey Lake, Deputy Commissioner for Community Health Services
Department of Health

VIII. JLARC Study on Medicaid Reimbursement Rates for Home and Community-Based Care Services (Budget Item 21.E)
Kimberly A. Sarte, Project Leader
Joint Legislative Audit and Review Commission

IX. Staff Study on Impact of Federal Funding for HIV/AIDS Prevention and Treatment on Virginia's System of Care (Budget Item 11.B)
Catherine W. Harrison, Health Policy Analyst

X. Staff Study on Mental Health Needs and Treatment of Minority Individuals (SJR 25 - 2004)
Kim Snead

Agenda for November 10, 2005

I. Call to Order
Delegate Harvey B. Morgan, Chairman

II. Decision Matrix/Summary of Comments

Agenda for January 10, 2006

I. Call to Order
Delegate Harvey B. Morgan, Chairman

II. Discussion of Changes in Proposed Legislation and Budget Amendments
Kim Snead, Executive Director

III. Identification of Patrons for Legislation
Delegate Harvey B. Morgan

SUBCOMMITTEE ACTIVITIES

The Joint Commission on Health Care has established two standing subcommittees – the Long-Term Care Subcommittee and the Behavioral Health Care Subcommittee.

Long-Term Care Subcommittee

The Long-Term Care Subcommittee, originally established in 1997, continued during 2005 with Delegate Hamilton as the Chairman.

Long-Term Care Subcommittee

Delegate Phillip A. Hamilton, Chairman
Delegate Robert H. Brink
Delegate Benjamin L. Cline
Delegate Franklin P. Hall
Delegate R. Steven Landes
Delegate John M. O'Bannon, III
Delegate John J. Welch, III
Delegate Harvey B. Morgan (ex-officio)

Senator Harry B. Blevins
Senator R. Edward Houck
Senator Benjamin J. Lambert, III
Senator Stephen H. Martin
Senator Linda T. Puller

The Long-Term Care Subcommittee held four meetings in 2005. The meeting agendas included the following reports:

Long-Term Care Subcommittee Agenda for June 14, 2005

I. Call to Order
Delegate Phillip A. Hamilton, Chairman

II. Overview of Agenda
April Kees, Senior Health Policy Analyst

III. Overview of 2005 LTC Studies and Proposed Subcommittee Workplan
April Kees

IV. Report on Assisted Living Facility/Community Service Board Model
Mary Ann Bergeron, Executive Director
Va. Association of Community Services Boards

V. Review of Provisions in the Assisted Living Facility Legislation
April Kees

VI. Update on SCHEV Initiatives Related to Ensuring an Adequate Supply of Nurses in Virginia (HB 2818, 2003)
April Kees

Long-Term Care Subcommittee Agenda for July 21, 2005

I. Call to Order
Delegate Phillip A. Hamilton, Chairman

II. Overview of Agenda
April Kees, Senior Health Policy Analyst

III. PACE: Connecting Care and Community for Virginia's Elderly
The Honorable Jane H. Woods, Secretary of Health and Human Resources
Peter Fitzgerald, National PACE Association
David Abraham, Sentara Life Care
Jay Barton, PACE of the Blue Ridge
Diana Wallace, Appalachian Agency for Senior Citizens
Cheryl Cooper, Jefferson Area Board of Aging
John Tucker, Northern Virginia PACE Planning Committee
Marilyn Maxwell, Mountain Empire Older Citizens

IV. Update on Virginia's Olmstead Plan
April Kees

V. Incentives for Purchasing Long-Term Care Insurance
April Kees

VI. Overview of Health Savings Accounts
April Kees

Long-Term Care Subcommittee Agenda for October 25, 2005

I. Call to Order
Delegate Phillip A. Hamilton, Chairman

II. Overview of Agenda
April Kees, Senior Health Policy Analyst

III. Nursing Home Quality Initiative Related to Pain Management
Joy Hogan Rozman, President and CEO, Virginia Health Quality Center

IV. Staff Study on Geriatricians
April Kees

V. State Initiatives Related to Medicaid
April Kees

VI. Status Update on Assisted Living Facilities
April Kees

Long-Term Care Subcommittee Agenda for November 10, 2005

I. Call to Order
Delegate Phillip A. Hamilton, Chairman

II. Decision Matrix/Summary of Comments
April Kees, Senior Health Policy Analyst

Behavioral Health Care Subcommittee

The Behavioral Health Care Subcommittee was established in July 2003 with Senator Martin as Chairman.

Behavioral Health Care Subcommittee

Senator Stephen H. Martin, Chairman

Senator Harry B. Blevins	Delegate Robert H. Brink
Senator R. Edward Houck	Delegate Franklin P. Hall
Senator William C. Mims	Delegate R. Steven Landes
Senator Linda T. Puller	Delegate John M. O'Bannon, III
Senator William C. Wampler, Jr.	Delegate Harvey B. Morgan (ex officio)

The Behavioral Health Care Subcommittee held four meetings during 2005 and one meeting in 2006. The meeting agendas included the following reports:

Behavioral Health Care Subcommittee Agenda for May 4, 2005

I. Call to Order
Senator Stephen H. Martin, Chairman

II. Overview of Agenda
Kim Snead, Executive Director

III. Proposed Workplan for 2005
Kim Snead

Behavioral Health Care Subcommittee Agenda for July 21, 2005

I. Call to Order
Senator Stephen H. Martin, Chairman

II. Overview of Agenda
Kim Snead, Executive Director

III. Programs for Students with Autism in Chesterfield County Schools
Kathy Beasly, Instructional Specialist and Amy Petin, Teacher

IV. Results of Mental Health Screening in Juvenile Secure Detention
Scott Reiner, Department of Juvenile Justice

V. The Courtland Center Program Central VA Community Services
Linda Edwards, Courtland Center Director and
Chris Webb, Administrator of the Blue Ridge Regional Jail Service

VI. Health Planning Region IV Mental Health Services for Jail Inmates
Lynda Hyatt, Ph.D., Clinical Director, Health Planning Region IV Jail Services Team

VII. Offender Re-Entry Pilot Program
Prison Re-Entry Project 8/06 - 6/09
Forensic Prison Re-Entry Project
Mary Ann Bergeron, Director, Va. Association of Community Services Boards

VIII. Behavioral Health Services Provided by Community Health Centers
Richard Shinn, Director of Public Affairs, Va. Primary Care Association

IX. Behavioral Health Services Provided by Free Clinics
Mara Servaites, Program Manager, Va. Association of Free Clinics

Behavioral Health Care Subcommittee Agenda for September 13, 2005

I. Call to Order
Senator Stephen H. Martin, Chairman

II. Overview of Agenda
Kim Snead, Executive Director

III. Report on Activities of the Office of the Inspector General
James W. Stewart, III, Inspector General

IV. Report on Integrated Strategic Plan
James S. Reinhard, MD, Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services

V. Report on Relinquishing Custody to Access Behavioral Health Treatment
Raymond R. Ratke, Deputy Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services

VI. Plan for Suicide Prevention Across the Lifespan
James M. Martinez, Jr., Director of Mental Health Services
Department of Mental Health, Mental Retardation and Substance Abuse Services

VII. Staff Study on the Needs of Patients Found Not Guilty by Reason of Insanity
Kim Snead

Behavioral Health Care Subcommittee Agenda for November 10, 2005

I. Call to Order
Senator Stephen H. Martin, Chairman

II. Decision Matrix/Summary of Comments

Behavioral Health Care Subcommittee Agenda for January 11, 2006

I. Call to Order
Senator Stephen H. Martin, Chairman

II. Discussion of Budget Amendment Recommendations Related to Forensic Behavioral Health Care Initiatives

JOINT COMMISSION ON HEALTH CARE
FINAL REPORTS

During 2005, the Joint Commission conducted six staff studies. The study presentations and staff reports were posted on the Joint Commission's Internet home page to allow interested individuals to download the documents for review and comment. Public comments were solicited on all of the staff reports, and summaries of the comments were presented to the Joint Commission members. Following the public comment period, all of the reports were posted on the "Reports to the General Assembly" website section of the Legislative Information System.

The Joint Commission's 2005 studies are shown below:

Joint Commission on Health Care Reports to the General Assembly
2005

Name of Study	Authority for Study	Document Number
Mental Health Needs and Treatment of Young Minority Adults	SJR 24 (2004)	SD 4
Needs of Patients Found Not Guilty by Reason on Insanity	SJR 324 (2005)	SD 5
Federal Funding for HIV/AIDS Prevention and Treatment on Virginia's System of Care	Appropriations Act -- Item 11.B Regular Session, 2005	HD 6
Medicaid Asset Transfer Allowances	Chairman's Request (HB 2601)	RD 93
Healthy Lives Prescription Assistance	Study Update	RD 95
Licensing of Dietitians	Chairman's Request (HB 455)	RD 97

Notes:
Except as noted, joint resolutions and bills are from the 2005 General Assembly Session. JCHC reports are published as House/Senate or Report documents. These documents may be accessed from the General Assembly Homepage under Legislative Studies: Reports to the General Assembly or requested from the Bill Room in the General Assembly Building.

2006 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 2005, a package of legislative proposals (legislation and budget amendments) was introduced during the 2006 Session of the General Assembly.

Bills and Resolutions

The following paragraphs identify each bill or resolution as introduced. A copy of each approved bill or resolution is provided in Appendix A with the page numbers identified below.

HB 786/ SB 287 **Long-Term Care Tax Credits.**
Amend Title 58.1 to replace the current income tax deduction with a tax credit of 10 percent of the premium paid for qualifying long-term care insurance contracts. Both bills were amended to provide a one-time tax credit of 15 percent of the long-term care premiums paid within the tax year. Any unused tax credit amounts may be carried over for the next five taxable years, but the credit may not exceed the cost of 15 percent of the premium charged for the first 12 months of long-term care insurance coverage. In addition, the tax deduction for premiums paid on long-term care insurance remains in effect, but either the credit or the deduction may be claimed within a tax filing. HB 786 and SB 287 were approved as amended and appear as *2006 Acts of Assembly* Chapters 599 and 570 respectively.

HB 787/ SB 252 **Local Health Partnership Authorities.**
Amend *Code* § 32.1-122.10:001 to remove the sunset clause on the establishment/continuation of health partnership authorities. HJR 787 was tabled. SB 252 was approved and appears as *2006 Acts of Assembly* Chapter 368.

HB 788/ SB 438 **Joint Commission on Health Care Sunset.**
Amend *Code* § 30.1-170 to remove the sunset clause for the Joint Commission on Health Care. Both bills were amended to extend the sunset date to July 1, 2010. HB 788 and SB 438 were approved and appear as *2006 Acts of Assembly* Chapters 113 and 178 respectively.

HB 789/ SB 251 **Compensation of Expert Witness.**
Amend *Code* § 19.2-175 to remove the language which prohibits compensation to psychiatrists, clinical psychologists and other experts who are employed by the Commonwealth (except for experts employed by the University of Virginia and Virginia Commonwealth University) to provide professional services in trials involving an insanity defense or after conviction in a case in which the offense indicates sexual

abnormality. Compensation is limited to services provided during non-state hours and approved as being outside the scope of state employment. Both bills were approved and appear as *2006 Acts of Assembly* Chapters 114 and 170 respectively.

HB 790/ SB 250 **Extension of Time a NGRI Acquittee May Receive Inpatient Treatment in a State Hospital without Having His Conditional Release Revoked.** Amend *Code* § 19.2-182.10 to increase the time from 30 to 60 days that an acquittee may be in the DMHMRSAS Commissioner's custody "for inpatient treatment pursuant to revocation proceedings" but be subsequently placed on conditional release with the Court's approval "as if revocation had not taken place." Both bills were approved and appear as *2006 Acts of Assembly* Chapters 199 and 225 respectively.

HB 791/ SB 289 **Clarification that Voluntary Admission to a State Hospital Does Not Automatically Result in Revocation of Conditional Release.** Amend *Code* §§ 19.2-182.8 and 19.2-182.9 to clarify that voluntary admission to a State hospital does not automatically result in revocation of conditional release for acquittees. Both bills were approved and appear as *2006 Acts of Assembly* Chapters 343 and 370 respectively.

SB 288 **Expedited Court Consideration.** Amends *Code* §§ 19.2-182.8 to add language to require a hearing on revocation of conditional release to be scheduled on an expedited basis and given priority over other civil matters by the Court. SB 288 was approved and appears as *2006 Acts of Assembly* Chapter 369.

HJR 96/ SJR 125 **Autism.** Encourage the Board and the Department of Education; the Board and the Department of Mental Health, Mental Retardation and Substance Abuse Services; and other relevant entities to take certain actions to improve the education and treatment of individuals with autism spectrum disorders. Both resolutions were adopted by the General Assembly.

HJR 97/ SJR 122 **JLARC Asset Transfer Study.** Request that the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission monitor changes in the federal restrictions on sheltering assets to qualify for Medicaid long-term care services. Both resolutions were adopted by the General Assembly.

Budget Amendment Requests

During the 2006 General Assembly Session, 14 budget amendments were introduced in each chamber of the General Assembly on behalf of JCHC. The actions taken on the budget amendments are shown on the next two pages.

	JCHC Budget Amendments	Joint Conference Committee Amendments
1 VDH 289#1h/1s	**$265,110 GFs per year** to expand the **HIV resistance testing** program.	
2 VDH 293#2h/2s	~~$175,000~~ **$125,000 GFs per year** to support the **outpatient surgical data system** and the distribution of additional **VHI reports to consumers.**	293#1c $125,000 GFs per year
3 DMAS 302#5h/5s	**$3.7 million GFs &NGFs in FY 2007 and $3.9 million GFs & NGFs in FY 2008** to increase the **personal maintenance allowance from 150% to 300% of SSI for HCBS Medicaid waivers.**	302#16c $250,000 GFs and $250,000 NGFs per year to increase PMA to 165% SSI
4 DMHMRSAS 312#1h/1s	**$400,000 GFs per year** to **replicate the ALF/RBHA Project.**	
5 DMHMRSAS 312#2h/2s	**$2.5 million per year to replicate Ethel's II.**	
6 DMAS 302#3h/3s	**$1.5 million for FY 2007** to provide start-up funds for up to **six grants for PACE projects.**	302#21c $1.5 million GFs FY 2007 start-up funding for ≤ to 6 PACE programs; *DMAS to develop and report plan for integrating acute and LTC systems; DMAS may implement regional model integrating acute and LTC services.*
7 DMHMRSAS 311#1h/1s	**$344,000 GFs per year** to provide **4 two-year fellowships** to the appropriate academic health centers (with payback clauses) in child psychiatry and **four 1-year internships in child psychology.**	
8 DMHMRSAS 311#2h/2s	**$1.25 million GFs per year** for **training for BHC clinicians** of children and adolescents **and for** such **health care practitioners** as pediatricians and PC physicians.	

	JCHC Budget Amendments	Joint Conference Committee Amendments
9 DMHMRSAS 312#3h/12s	**$4 million GFs per year** to continue funding 2 projects and provide funding for 6 additional **projects to serve youth who have/at risk for juvenile justice involvement.**	
10 DMHMRSAS	**$240,000 GFs in FY 2007 and $480,000 GFs in FY 2008** to add **MH services for juveniles in an additional 4 local detention facilities each year.**	
11 DMHMRSAS 312#4h/4s	**$1.8 million GFs per year** to establish **MH Demonstration Projects in 20 middle schools.**	
12 DMHMRSAS 312#5h/5s	**$250,000 GFs per year** to implement and evaluate MH services provided within community health centers.	
13 DMHMRSAS 312#6h/6s	**$235,000 GFs per year** to allow **CSBs to contract with free clinics** to provide MH services for low-income, uninsured adults.	
14 DMHMRSAS 312#7h/7s	**$1,106,000 GFs in FY 2007 and $1,012,660 GFs in FY 2008** to establish and evaluate 2 offender re-entry demonstration projects.	
15 DMHMRSAS 311#3h/3s	**$2.2 million to fund mental health initiatives to divert from or provide services to jail inmates** (Including $450,000 per year for Chesterfield Day Reporting and $200,000 in FY 2007 and $150,000 in FY 2008 for New River Valley CIT)	311#10c $500,000 GFs per year for community programs to divert or provide services for individuals released from jail 391#1c $338,063 GFs in FY 2007 for Chesterfield Day Reporting Program 391#4c $150,000 GFs in FY 2007 for New River Valley CIT **$1,488,063 total**

II. EXECUTIVE SUMMARIES OF 2005 JCHC REPORTS

MENTAL HEALTH NEEDS AND TREATMENT OF YOUNG MINORITY ADULTS

EXECUTIVE SUMMARY

Senate Joint Resolution 25 (2004) directed the Joint Commission on Health Care to "study the mental health needs and treatment of young minority adults in the Commonwealth" and to submit findings and recommendations to the Governor and the General Assembly by the first day of the 2006 session. SJR 25 requires the Joint Commission on Health Care in conducting the study to:

- Estimate the "number of mentally disabled young adults by gender, age, and racial and ethnic classification, in the geographic regions of the Commonwealth."
- Identify the "prevailing mental health and emotional disorders and their etiology among minority young adults [and]...the mental health needs of minority citizens, particularly minority young adults in Virginia."
- Determine the "number of racial and ethnic minority persons who receive mental health treatment...and the facilities providing such care."
- Ascertain whether "mental health providers are trained to provide culturally competent mental health treatment" and the level of need for such treatment in Virginia.
- Review "federal and state laws and regulations...and identify the...extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services, and mental health treatment for mentally disabled young adults" and recommend ways to provide information to allow family members to obtain services and treatment without resorting to involuntary commitment.

A study workgroup was established and met during 2004 and 2005. The workgroup included representatives of community health centers, community services boards, free clinics, indigent defense attorneys, the Psychiatric Society of Virginia, Hampton University, Virginia Commonwealth University and such state agencies as the Department of Health and the Department of Mental Health,

Mental Retardation and Substance Abuse Services. Contacts will continue to be made to involve additional workgroup members.

A detailed study workplan was developed; however, it was the consensus of the workgroup that the study will require one to two more years to address adequately the study issues. JCHC voted to continue the study of the mental health needs and access to treatment of minority individuals in Virginia by including the study on the 2006 workplan for the Joint Commission on Health Care.

NEEDS OF INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY OR INCOMPETENT TO STAND TRIAL

EXECUTIVE SUMMARY

Authority for the Study

SJR 324 (2005) requested the Joint Commission on Health Care (JCHC) through its Behavioral Health Care Subcommittee to study the needs of individuals found not guilty by reason of insanity (NGRI) or incompetent to stand trial (IST). (It should be noted that SJR 324 originally requested a study by the Joint Legislative Audit and Review Commission, but the resolution was amended to direct the study to the Behavioral Health Care Subcommittee of the Joint Commission on Health Care.)

Background

Virginia is one of 24 states that have adopted a version of the McNaughten standard in allowing a NGRI defense. As noted in the *Report of the Virginia State Crime Commission SJR 381 Not Guilty by Reason of Insanity*, RD 31 (2004):

"To establish an insanity defense, the defendant must show that he did not know the difference between right and wrong or that he did not understand the nature and consequences of his acts." Once a defendant has been acquitted by being found NGRI, *the Code of VA* § 19.2-182.2 requires the acquittee to be placed in temporary custody of the DMHMRSAS Commissioner for evaluation. Within 45 days, DMHMRSAS must make a recommendation to the committing Court to:

- Release without conditions
- Release with conditions
- Commit for inpatient hospitalization.

The Court subsequently holds a civil hearing to determine the disposition. Acquittees committed by the Court are placed in the custody of the DMHMRSAS Commissioner. A DMHMRSAS fact sheet on the NGRI system notes that "restriction of liberties of acquittees is based on identified risks and clinical treatment needs [with] gradual increases in freedom based on successful completion of the previous, more restrictive level of privileges."

Study Findings

As of June 30, 2004, there were 222 NGRI acquittees held within a State hospital – 209 felon and 13 misdemeanant acquittees. DMHMRSAS reports that

the "number of NGRI admissions has been increasing which decreases the number of short-term acute beds available given longer lengths of stay than most civilly committed individuals." DMHMRSAS reported that the median length of stay between State hospital admission and the first conditional release was 35.7 months for felon acquittees and 12.7 months for misdemeanant acquittees. Given the intention not to increase the number of State hospital beds, the bed space that is available becomes quite valuable.

Issues related to the NGRI study were discussed during meetings of the Forensic Services Work Group (convened by DMHMRSAS). In addition, an ad hoc workgroup was convened by JCHC staff to develop recommendations regarding the study provisions of SJR 324 including to:

- Determine appropriate treatment of acquittees
- Review/revise diagnostic categories as possible NGRI defense
- Examine discharge alternative to expedite return to community
- Provide coordination when release conditions are violated but hospitalization is not required
- Determine needs and impact of persons found incompetent to stand trial on mental health system.

The workgroup developed a number of recommendations which seek to facilitate appropriate treatment and eventual release of acquittees into the community. However, the workgroup also determined that a number of more complex issues could not be studied adequately within the one-year timeframe.

Options and Public Comments

The following options were proposed and public comments received regarding the options. The options that were approved by JCHC are shown in bold text.

Option I: Continue to address NGRI issues related to community- and hospital-based programs by including the review of Virginia's NGRI system on the Behavioral Health Care Subcommittee's workplan for 2006.
All 5 comments received supported Option I.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.
Alan Reynolds
Steven Shoon
Bill Whittig, Ed.D., LCSW

Option II: Introduce legislation to amend the *Code of Virginia*, Title 19.2 Chapter 11.1 to clarify that voluntary admissions to State hospitals do not have to result in revocation of conditional release for NGRI acquittees.
Four comments were received in support of Option II.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.
Alan Reynolds
Steven Shoon

Option III: Introduce legislation to amend the *Code of Virginia*, Title 19.2 Chapter 11 to remove language prohibiting psychiatrists and clinical psychologists who are employed by the Commonwealth from being paid for completing evaluations.
Two comments were received in support of Option III.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.

Option IV: Introduce budget amendment to increase funding of the Discharge Assistance Plan to be used to facilitate release of NGRI acquittees into the community.
Two comments were received in support of Option IV.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.

Option V: Introduce legislation to amend the *Code of Virginia*, Title 19.2 Chapter 11.1 to increase the time from 30 to ~~45~~ 60 days that an acquittee is allowed to be involuntarily committed to a State hospital without automatically having his conditional release revoked.
Three comments were received in support of Option V. VACSB recommended an increase from 30 to 60 days "in light of the amount of necessary court paperwork and the ongoing workload" a recommendation that DMHMRSAS staff indicated as an acceptable change in the recommendation. Mr. Alan Reynolds recommended increasing the time to 180 days noting that the longer timeframe "would allow an acquittee to avoid an overextended stay in the custody of the Commissioner, and it's the equivalent of the standard involuntary commitment order." This much longer timeframe could be reviewed if a second year study is initiated.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.
Alan Reynolds

Option VI: Introduce legislation and accompanying budget amendment to amend the *Code of Virginia*, Title 19.2 Chapter 11 to either increase or remove the

limitation on the fees paid psychiatrists and clinical psychologists for completing competency evaluations and to provide funding for the fee increase.
Two comments were received in support of Option VI.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.

Option VII: Introduce a budget amendment to provide funding for competency restoration treatment and follow-up competency evaluations for adult defendants who do not require hospitalization.
Two comments were received in support of Option VII.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.

Option VIII: Introduce legislation to amend the *Code of Virginia*, Title 19.2 Chapter 11.1 so that consideration of violations of conditional release may be considered by the Court on an expedited basis.
Two comments were received in support of Option VIII.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.

Option IX: Continue to consider and support initiatives designed to divert individuals with behavioral health care needs from the criminal justice system and to provide treatment for individuals who are not diverted.
Three comments were received in support of Option IX.
Virginia Association of Community Services Boards
Thomas L. Hafemeister, J.D., Ph.D.
Steven Shoon

FEDERAL FUNDING FOR HIV/AIDS PREVENTION AND TREATMENT PROGRAMS IN VIRGINIA

EXECUTIVE SUMMARY

Authority for Study

Appropriations Act, Item 11 B (2005 Regular Session) directed the Joint Commission on Health Care to conduct a study on federal funding to Virginia's HIV/AIDS prevention and treatment programs. Specifically, the Commission was charged with analyzing recent federal funding trends regarding the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and additional sources of federal funding provided to the Commonwealth for the prevention and treatment of HIV/AIDS.

Background on HIV/AIDS

Acquired Immunodeficiency Syndrome (AIDS) was first reported in the U.S. in 1981. The next year, the first case of AIDS in Virginia was reported. AIDS is caused by the Human Immunodeficiency Virus (HIV), which progressively destroys the body's ability to fight infections and certain cancers by effectively killing or damaging cells in the human immune system. Although no cure has been found, treatment is available. Prescription medications play a pivotal role in treating HIV/AIDS. Highly active antiretroviral therapy (HAART) is the common term for the use of three or more FDA approved drugs for treatment and is a key component of disease treatment.

From 1999 to 2003, the number of individuals living in the U.S. with AIDS increased 30 percent. During this same time period, the Centers for Disease Control (CDC) reported a 3 percent decrease in AIDS-related deaths, while the number of AIDS diagnoses increased 4 percent. The CDC estimates that by the end of 2003, 1,039,000 to 1,185,000 individuals were infected with HIV in the United States. Of those individuals, it was estimated that 24 to 27 percent were undiagnosed and unaware of their HIV status. In Virginia, approximately 17,000 people are known to be living with HIV/AIDS. The Virginia Department of Health estimates that another 5,000 individuals in Virginia are unaware of their HIV positive status.

Medicaid Coverage for Individuals Living with HIV/AIDS

Medicaid receives the largest portion of federal spending for providing services to individuals with HIV/AIDS. An individual living with HIV/AIDS may qualify for Medicaid if he meets the qualifications of a particular group (low-income children, parents meeting specific income thresholds, pregnant women, the elderly, and individuals with disabilities) and his income and resources fall below required limits.

Medicaid state plans must provide certain mandatory services to individuals who qualify as categorically needy individuals. Examples of mandatory services that are important to individuals living with HIV/AIDS include inpatient hospital services, physician services, and certain forms of long-term care. States may also choose to provide optional services. Examples of optional services important to individuals living with HIV/AIDS that are available through Virginia's Medicaid program include prescription drug coverage and rehabilitative services. In addition, Virginia provides home and community-based care to individuals with HIV/AIDS through its AIDS Waiver. In FY 2004, 274 individuals received services through the AIDS Waiver. The cost of services provided outside of the waiver to AIDS Waiver participants totaled $6,117,320, with over 60% of this amount a result of pharmacy expenditures. The cost of waiver services totaled $608,497, with the average cost per recipient totaling $2,221.

Centers for Disease Control (CDC) Funding

Part of CDC's mission includes funding activities related to HIV surveillance, research, prevention, and evaluation through local, state, national and international levels. Programs involving epidemiology and surveillance are critical to producing the data necessary to target the delivery of HIV prevention and treatment services.

The Virginia HIV/AIDS surveillance program receives funding from CDC to collect federally-mandated HIV/AIDS infection data. In FY 2005, VDH received $467,556 in federal funding, which is less than the $478,460 received by VDH in 1997. As funding is decreasing, data collection demands are increasing. The CDC has developed Incidence and Resistance Projects in which data on new cases of HIV infection and data on HIV drug resistant infections in newly diagnosed HIV cases are to be collected. To expand the Resistance Project with state funds, $265,110 GFs are needed.

Preventing HIV infection has proven to be more cost-effective than treating an individual with HIV/AIDS. However, federal funding for prevention efforts in Virginia peaked in 2001 at just over $5.2 million. Since that time, funding has decreased by $152,000 or 3 percent (to just under $5.05 million in 2005). In addition, VDH is anticipating another 3 percent reduction in the coming year. As a result of decreased federal funding, several programs have been altered to ensure that funds are appropriated to provide the greatest impact in addition to preserving community-based services to high-risk populations. State funding in the amount of $285,000 GFs are needed to offset the loss of federal HIV prevention dollars. Of the proposed state funding, $150,000 would address federal rescissions in 2004-2006. The remaining $135,000 of the $285,000 would restore service funds redirected to rent, salary increases, and other administrative costs at the Virginia Department of Health.

In 2003, CDC initiated a new program, the Advancing HIV Prevention Initiative (AHP). The program is designed to reduce barriers to early diagnosis of HIV infection, access to care, and prevention services for individuals living with HIV. VDH must redirect existing funds to meet the objectives of the AHP initiative. New technology has assisted in the attainment of AHP goals. However, the cost of this new technology prohibits its expansion. For example, oral fluid testing requires no needles and may be conducted directly in the community. Rapid testing allows individuals to receive test results in as little as 20 minutes. VDH has established pilot sites using both testing methods but expansion is difficult due to the cost. To address the demands created by AHP, $164,000 GFs are needed.

Health Resources and Services Administration Funding

The Health Resources and Services Administration (HRSA) administers funding provided under the Ryan White Comprehensive AIDS Resources Emergency Act (RWCA). Funding under RWCA was established to provide a safety net for uninsured, low-income individuals who had no other access to care. As a result, funds may only be used as the payer of last resort. The program is the largest federal program designed to provide services for individuals living with HIV/AIDS. RWCA was enacted in 1990, amended and reauthorized in 1996 and 2000, and is being considered for reauthorization.

The following chart displays RWCA funding streams in Virginia.

Funding Stream	Description	Recipients in Virginia	2005 Award
Title I	Provides emergency assistance to severely affected urban areas	Norfolk EMA North. & parts of NW region (DC EMA)	$4,726,063 $4,164,593
Title II	Funds services to provide medications, health care, etc.	State of Va. VDH administers	$22,679,750
Title III	Funds primary care	6 providers statewide	$2,463,520
Title IV	Enhances client access to care & research for women & children	2 providers statewide	$858,391

RWCA Title II. Title II funds are designed to improve the quality, availability, and organization of health care and support services for individuals and families living with HIV. In Virginia, Title II funds support five regional care consortia and the AIDS Drug Assistance Program (ADAP).

The five regional care consortia supported by Title II funding provide client needs assessments, service gap identification, and needed service provision. Federal funds were originally designed to support a system of short-term access to acute care services. For RWCA's FY 2005 (4/1/05 – 3/31/06), Virginia received $5,543,229 in base funding. This was a 6.5% decrease in base funding from the previous year even though there has been an increasing demand for services. VDH estimates that $500,000 GFs are needed to stabilize access to primary care in Northern Virginia alone.

ADAP is designed to provide medications for the treatment of HIV/AIDS to individuals who have limited or no coverage from private insurance or Medicaid. ADAP-earmarked funds have been the fastest growing component of the RWCA appropriation. However, expenditures in Virginia's program have increased 23.8% from FY 2003 to FY 2004. In FY 2005, Virginia was awarded $16,782,217 for ADAP. In addition, Virginia was determined to be a state with a severe need, and, as such, qualified for $1.6 million in ADAP supplemental funds. This federal funding requires a 4:1 federal/state match. Due to increasing program expenditures and longer client enrollment periods, VDH estimates that $4,300,000 GFs are needed to offset the projected shortfall in ADAP funding.

Implementation of the Medicare Part D prescription drug benefit on January 1, 2006 may affect the Virginia ADAP participants who are Medicare beneficiaries. Ten percent of Virginia ADAP participants receive Medicare and will be required to enroll in Medicare Part D. The cost-sharing requirements of Part D will be a difficult change for some ADAP participants, especially if their income is over 150%FPL.

VDH has investigated several methods to assist Part D beneficiaries, including using ADAP funds to cover out-of-pocket costs for Part D beneficiaries and creating a new State Pharmaceutical Assistance Program (SPAP). Creating a new SPAP would allow state funds to count towards Part D beneficiaries' out-of-pocket costs, without affecting access to catastrophic drug coverage. It is estimated that $500,000 GFs are needed to create and implement the program.

Approximately $21 million of the current Title II award requires a federal/state match of 2:1. If this match is not met, federal funding will be decreased. In the past, Department of Corrections' (DOC) expenditures have been used to meet the match. Recently, DOC revised HIV services and medication contracts and realized savings resulting in a reduced state match; thus jeopardizing Virginia's access to federal Title II funding.

RWCA Title III. Title III provides direct grants to community-based primary health care clinics and public health providers. Funds are distributed through a competitive grant process, with six providers receiving grants in Virginia totaling $2,611,181 for FY 2004 and $2,463,520 for FY 2005. Title III serves as an important vehicle for targeting HIV-related medical services to underserved communities of color and rural areas. HRSA has begun capping the number of Title III providers in the state. Subsequent funding shifts have caused a reduction in funding for the Roanoke area. The estimated annual cost to maintain HIV-related primary care services in Southwest Virginia is $577,000 GFs.

Options and Public Comments

A number of public comments addressed issues other than the proposed options. Six individuals commented regarding the length of the public comment period. The comments received expressed concern that the eight days given for public comment did not provide an adequate time frame for the issue brief to be circulated and commented on by the general public. One commenter did not address any of the specific options, but expressed the importance of community planning and services.

The following options were proposed and public comments received regarding those options. It should be noted that only comments which specifically addressed support for an option were counted as supporting that option. Staff did not attempt to make a judgment call with regard to support. The options that were approved by JCHC are shown in bold text.

Option I: Take no action.
Thirteen comments in opposition to Option I were received.
Robert Atkins.
Fairfax County Department of Health.
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Jan Gordon Oellerich.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Virginia Department of Health.
Virginia Organizations Responding to AIDS.
Whitman-Walker Clinic.

Option II: Introduce a budget amendment (language and funding) to expand the HIV resistance testing program.
a) **$265,110 GFs per year of the 2006-2008 biennium;** or
b) other level of funding.
Option II received twelve supportive comments.
Robert Atkins.
Fairfax County Department of Health.
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Edward Strickler, Jr.
Virginia Department of Health.
Virginia Organizations Responding to AIDS.

Option III: Introduce a budget amendment (language and funding) to cover federal rescissions in prevention funding.
a) $285,000 GFs; or
b) other funding level.
Fourteen comments supported Option III. Nine of the supportive comments favored (b) with a higher funding amount.
Robert Atkins.
Fairfax County Department of Health.
Bob Kenney.
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Edward Strickler, Jr.
Virginia Department of Health.
Virginia Organizations Responding to AIDS.
Whitman-Walker Clinic.

Option IV: Introduce a budget amendment (language and funding) to cover the federal unfunded mandate, Advancing HIV Prevention Initiative.
a) $164,000 GFs; or
b) other amount of funding.
Twelve comments in support of Option IV were received. Seven of those comments supported (b) with greater funding.
Robert Atkins.
Fairfax County Department of Health.
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Edward Strickler, Jr.
Virginia Department of Health.
Virginia Organizations Responding to AIDS.

Option V: Introduce a budget amendment (language and funding) to stabilize access to HIV primary care services statewide ~~in Northern and Southwest Virginia.~~

a) ~~$1,077,000 GFs (NOVA $500,000, SWVA $577,000); or~~

b) different amount of funding.

Eighteen comments were received in support of Option V. Of those comments, twelve supported additional funding.

Robert Atkins.
Debby Dimon.
Fairfax County Department of Health.
David Hoover
Bob Kenney.
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Jan Gordon Oellerich.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Southwest/Piedmont HIV Care Consortium.
Edward Strickler, Jr.
Virginia Department of Health.
Virginia Organizations Responding to AIDS.
Whitman-Walker Clinic.

Option VI: Introduce a budget amendment (language and funding) to provide additional funding to offset projected ADAP shortfall.

a) $4,300,000 GFs;

b) $3,800,000 GFs ($4.3 million offset by SPAP of $500,000); or

c) other funding level.

Sixteen comments supporting Option VI were received, with one comment specifically supporting funding level (b).

Robert Atkins.
Debby Dimon.
Fairfax County Department of Health.
David Hoover
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Nicolette Solan Pegler.

John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Southwest/Piedmont HIV Care Consortium.
Edward Strickler, Jr.
Virginia Organizations Responding to AIDS.
Whitman-Walker Clinic.

Option VII: Introduce a budget amendment (funding and language) to create a SPAP to serve former ADAP Medicare Part D eligible clients.
a) $500,000 GFs; or
b) other amount of funding.
Option VII received fifteen supportive comments. Of those fifteen, one comment supported (b) in an amount higher than $500,000.
Robert Atkins.
Debby Dimon.
Fairfax County Department of Health.
David Hoover
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Edward Strickler, Jr.
Virginia Department of Health.
Virginia Organizations Responding to AIDS.
Whitman-Walker Clinic.

Option VIII: Introduce a resolution, encouraging the Virginia Commonwealth University School of Dentistry to investigate and if appropriate apply for funding under the RWCA Dental Reimbursement Program and the Community Based Dental Partnership Program.
Fourteen comments were received supporting Option VIII. Several comments suggested directing VCU to apply for funding.
Robert Atkins.
Debby Dimon.
Fairfax County Department of Health.
Bob Kenney.
Northern Virginia AIDS Ministry.

Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Jan Gordon Oellerich.
Nicolette Solan Pegler.
John Ruthinoski.
Ronald Scheraga.
Blaine Sheffer.
Edward Strickler, Jr.
Virginia Organizations Responding to AIDS.

Option IX: Continue to monitor activities involving RWCA and federal funding by including the issues on the JCHC workplan for 2006.
Thirteen comments were received in support of Option IX.
Arlington Department of Human Services.
Robert Atkins.
Debby Dimon.
Fairfax County Department of Health.
Northern Virginia AIDS Ministry.
Northern Virginia HIV Consortium.
Northern Virginia HIV Consortium Persons with AIDS Committee.
Jan Gordon Oellerich.
Nicolette Solan Pegler.
John Ruthinoski.
Blaine Sheffer.
Edward Strickler, Jr.
Virginia Organizations Responding to AIDS.

In addition to supporting Option IX, several comments included suggestions on what JCHC should explore for next year. The following was submitted by Susan R. Rowland, Executive Director of Virginia Organizations Responding to AIDS:

> *In the next year, the JCHC should review information on:*
> • *The results of work undertaken within the Northern Virginia region to improve the efficient use of public funds in providing treatment services. A project is currently underway in Northern Virginia, requested by the Northern Virginia AIDS Ministry and funded by the Washington AIDS Foundation. Similar support should be made available to providers in all regions of the state in order to maximize public funding for treatment services.*
> • *Virginia's Medicaid Plan and the trends in services provided to persons living with HIV/AIDS under the Plan, compared to services available in other states. As*

Ryan White CARE Act funds are diminished, the state's Medicaid Plan provides another option for sharing the cost of care with federal sources.

- *Virginia's HIV/AIDS Health Insurance Premium Assistance Program, operated by the Department of Medical Assistance Services. This program is designed to assist persons who are at risk of loosing private health insurance coverage due to loss of income.*
- *The impact upon Virginia of changes to the Ryan White CARE Act as a result of the expect reauthorization of the Act by Congress this year. The RWCA is authorized for just 5 years at a time, and the Act's authorization expired on September 30, 2005. Reauthorization is expected shortly, and a number of significant revisions are proposed. The JCHC should be informed of these changes, along with the expected impacts upon Virginia's system of prevention and treatment services.*

Furthermore, VDH, DMAS, the teaching hospitals, and other major medical care providers that operate programs targeting treatment to persons living with HIV/AIDS should regularly report to the JCHC on the status of prevention and treatment services. Such regular reporting would allow the Commission's members to react proactively with appropriate policy and budgetary responses, assuring that Virginia stays in front of the HIV-virus, and is not driven to higher rates of infection as already seen in other states.

MEDICAID ASSET TRANSFERS
EXECUTIVE SUMMARY

Authority for Study

House Bill 2601 (2005) would have permitted the Department of Medical Assistance Services, when appropriate and practicable, to seek a waiver of the Social Security Act under Section 1115 to create more restrictive asset transfer limits than those currently allowed under federal law or regulations. Ultimately, the bill was left in the Senate Finance Committee. However, upon the request of members of the Joint Commission on Health Care, a study was conducted to review a variety of the issues raised by HB 2601.

Medicaid Long-Term Care

Nationally, Medicaid is the largest purchaser of nursing facility services with $51 billion covered by this federal-state program in 2003. According to the Virginia Department of Medical Assistance Services' (DMAS) Statistical Record, annual expenditures for nursing facility services reached $547,287,699 in 2003. Just over 76% of these expenditures were for individuals classified as aged.

The improper transfer of assets to gain access to Medicaid payment for long-term care services is an issue that has received national attention. Beginning in 1980 with the Boren-Long Amendments, the federal government enacted legislation designed to curb abuse of the Medicaid system. National studies have come to varying conclusions about the prevalence of inappropriate asset transfers.

Current Issues Involving Sheltering Assets in Virginia

Interviews with State personnel revealed three major methods that Medicaid applicants are using to shelter assets in Virginia including: increased use of annuities, life estates, and savings bonds. Although the exact number of inappropriate asset transfers is not readily available, anecdotal evidence suggests they are becoming a more pervasive issue. DMAS is currently going through the regulatory process to strengthen regulations regarding the use of annuities to shelter assets. Options for curbing the use of life estates and savings bonds to shelter assets are currently being reviewed.

A number of proposals have been discussed at the national and state levels to help curb the abuse of Medicaid asset transfers. One proposal involves placing additional restrictions on Medicaid asset transfers. A second proposal is to expand estate recovery programs. Proposals for imposing additional restrictions on Medicaid asset transfers have focused most often on increasing the look-back period, changing the start date of the penalty period, or altering the formula used to determine the length of the penalty period.

Look-Back Period. Currently, states have a look-back period of 36 months (60 months for trusts) in which to examine a Medicaid applicant's financial transactions to determine if unallowable asset transfers have occurred. Several organizations, including the Medicaid Commission and the National Governor's Association, have proposed increasing the length of the look-back period from three to five years. The CMS Office of the Actuary estimates that this change would save less than $100 million over five years.

Penalty Period. If an individual makes an improper transfer during the look-back period, they are assessed a penalty period in which they do not qualify for Medicaid payment of long-term care services. The penalty period is calculated by dividing the uncompensated value of assets transferred during the look-back period by the average monthly cost of private pay nursing facility services at the time of application for Medicaid. At the present time, the first day of the month in which the asset transfer occurred (provided that the date does not occur during an existing penalty period) is the start date for the penalty period. Proposals have been made to change that start date from the date of the asset transfer to either the date of application for Medicaid long-term care services or the nursing home admission date. In addition, it has been suggested that the formula used to determine the penalty period be altered by using the average monthly cost of Medicaid nursing facility services instead of the average monthly cost of private pay nursing facility services. This change would dramatically increase the length of the penalty period.

Estate Recovery Programs. Since the inception of the Medicaid program, states have been allowed to recover assets from the estates of deceased Medicaid recipients who were over the age of 65 when they received benefits and who had no surviving spouse, minor child, or adult disabled child. The passage of the *Omnibus Reconciliation Act of 1993* required states to implement estate recovery programs.

Under Virginia's Medicaid estate recovery program, adjustments or recoveries for services Medicaid has covered may be recovered from the estate of

a permanently institutionalized individual or from a recipient age 55 or older for payments covering nursing facility services, home and community-based services, and related hospital and prescription drug services.

Methods for reducing the cost of Medicaid long-term care services for the federal and state governments have received attention also. Two methods include encouraging individuals to use reverse mortgages and to purchase long-term care insurance.

Reverse Mortgages. Home Equity Conversion Mortgages (HECM) are the most common type of reverse mortgage. With an HECM, a lender advances money to a homeowner who must be age 62 or older. The money may be provided in a series of fixed monthly payments, a line of credit from which the borrower may draw from, or a combination of these methods. Payments do not need to be made on the loan as long as the individual remains living in the home. The loan balance collected by the lender includes any accrued interest, other charges, and the amounts paid out. Funds from reverse mortgages can be used to pay for long-term care services. However, restrictions regarding eligibility for reverse mortgages, including maximum initial loan amounts, mean that reverse mortgages are not a viable option for some individuals.

Long-Term Care Insurance Tax Incentives. Governments on both the federal and state level recognize the potential for savings if individuals purchase adequate long-term care coverage. As a result, numerous pieces of legislation across the country have been proposed to encourage the purchase of these plans. According to the National Conference of State Legislators, 26 states have long-term care insurance tax incentives in place. Maine offers both a tax credit and a deduction. Sixteen states, including Virginia, offer a tax deduction. Another nine states offer a tax credit.

Long-Term Care Partnerships. The Long-Term Care Partnership program allows individuals to access state Medicaid long-term care programs and not deplete their assets if they have purchased certain approved long-term care insurance policies. California, Connecticut, Indiana, and New York are the only states that have LTC Partnerships in operation. Nineteen states, including Virginia, have enacted some form of enabling legislation to create the program in their state, but the *Omnibus Reconciliation Act (OBRA) of 1993* has restricted the ability of states to create LTC Partnerships.

In response to positive outcomes from the four states with Partnership programs and growing concerns over Medicaid long-term care budgets, a variety

of stakeholders have expressed strong support for removing the restrictions imposed by OBRA 1993. The National Governor's Association and the National Conference of State Legislators have called for the repeal of federal restrictions. In addition, the President included language in his 2006 budget that would provide authority for states to implement LTC Partnership programs; and, several bills have been introduced in Congress that would lift federal restrictions.

Options and Public Comments

The following options were proposed and public comments received regarding those options. The Options that were approved by JCHC are shown in bold text.

Option I: Take no action.
No comments were received addressing Option I.

Option II: Introduce legislation to provide a tax credit for employers who offer long-term care insurance to their employees.
Six comments in support of Option II were received. Jill Hanken, in explaining the Virginia Poverty Law Center's support of Option II, stated:

> *I support this option as a way to encourage broader use of long term care insurance. Long term care insurance remains a relatively new product that has not reached a broad enough audience. Tax incentives are an important mechanism for encouraging more employers to offer and more consumers to purchase coverage.*

Option III: Introduce legislation to provide a tax credit rather than a tax deduction for long-term care insurance.
This issue was addressed during the Long-Term Care Subcommittee meeting and resulted in the introduction of legislation to provide a one-time tax credit (of 15 percent of the insurance premiums paid within the tax year) for individuals who purchase long-term care insurance.
Option III received six supportive comments. Christopher McCarthy, on behalf of the Elder Law Section of the Virginia Bar Association, commented in support of Option III stating:

> *We support this option. A taxpayer will be more motivated to purchase a policy if an immediate benefit will be available.*

Option IV: Introduce a budget amendment (language and funding) to create a grant program for individuals purchasing long-term care insurance to be administered through the Virginia Department for the Aging. VDA would work with stakeholders to develop eligibility criteria for participation in the program. Concerns over the ability and applicability of VDA administering this potential program were raised by VDA. Another six comments in support of Option IV were received. Eldon James commented for the VAAAA in support of Option IV and in opposition to Option V:

> *We support this option. Cost is a deterrent, especially for those of low and moderate income. A grant program, similar to what was intended when the Caregivers' Grant Program was created, would make it more financially possible foe lower or middle income households to purchase this coverage. We see this as consistent with the recommendation in Option VI.*

Option V: Introduce legislation authorizing DMAS to apply for a waiver to implement more restrictive asset transfer restrictions.
Six comments in opposition to Option V were received. Mary Lynne Bailey, representing the Virginia Health Care Association, stated in opposition to Option V:

> *As you are aware, there is considerable interest among national organizations and in Congress for the federal government to address additional restrictions on asset transfers to make it more difficult for individuals to transfer assets in order to qualify for Medicaid long term care services. Because of this federal interest, VHCA believes the Joint Commission should not pursue Option V (Introduce legislation authorizing the Department of Medical Assistance Services to apply for a waiver to implement more restrictive asset transfer restriction.)*

Option VI: Introduce a resolution or send a letter from the JCHC encouraging members of Congress to pass legislation authorizing the further implementation of Long-Term Care Partnership programs in other states.
Option VI solicited seven supportive comments. Dana Steger commented on behalf of the Virginia Association of Non-Profit Homes for the Aging (VANHA) to support Option VI:

> *VANHA supports option VI, introducing a resolution or sending a letter from the JCHC to encourage members of Congress to pass legislation authorizing the further implementation of Long-Term Care Partnership programs in other states.*

Option VII: Continue to monitor the actions of Congress regarding additional asset transfer restrictions, reverse mortgages, and Long-Term Care Partnership programs, in addition to monitoring the activities in Virginia involving annuities, life estates, and bonds by including the issues on the JCHC workplan for 2006. Seven comments in support of Option VII were received. Susan Ward commented in support of Option VII on behalf of the Virginia Hospital and Healthcare Association (VHHA) and stated:

> *The VHHA supports Option VII, suggesting that the commission continue to monitor the actions of Congress regarding additional asset transfer restrictions, reverse mortgages and Long-Term Care Partnership programs in addition to monitoring Virginia activities regarding annuities, life estates and bonds.*
>
> *The Medicaid program is a necessary but an expensive program, requiring a growing level of resources to serve those in need. Given its cost and importance, we believe that Medicaid eligibility and transfer-of-asset policies should be examined to ensure that they incorporate the concept of recipient personal responsibility and that they direct Medicaid resources to those who truly qualify for benefits. This is best done in the context of federal Medicaid reform to ensure that policies uniformly address difficult issues such as long-term care providers' exposure when individuals whom they are serving lose benefits for illegally transferring assets but have no resources to pay for needed nursing home care.*

Option VIII: Introduce a resolution requesting JLARC to conduct a study to determine the extent of the use of asset transfers to shelter assets in order to qualify for Medicaid long-term care.

Five comments were received in support of Option VIII. Cynthia Pritchard explained the Multiple Sclerosis Virginia Consumer Action Network's (MSVACAN) support for Option VIII by stating:

> *We support this option. The information in the 1993 JLARC report is dated and does not reflect the current environment in Virginia because of policy and programmatic changes that have occurred over the past 12 years.*

HEALTHY LIVES PRESCRIPTION ASSISTANCE PROGRAM
EXECUTIVE SUMMARY

Authority for Study

House Bill 2225 and Senate Bill 1341, identical bills, enacted during the 2003 General Assembly Session amended the *Code of Virginia* to establish the Healthy Lives Prescription Assistance Fund under the auspices of the Secretary of Health and Human Resources to "accept appropriations, donations, grants, and in-kind contributions to develop and implement programs that will enhance current prescription programs for citizens of the Commonwealth who are without insurance or the ability to pay for prescription drugs and to develop innovative programs to make such prescription drugs more available." In addition, HB 2225 and SB 1341 included a second enactment clause that requires the Joint Commission on Health Care to prepare a Plan "to provide prescription drug benefits for low-income senior citizens and persons with disabilities...."

To develop recommendations for the Plan, a diverse group of interested parties, representing advocacy groups, health care providers and associations, pharmaceutical manufacturers, state agencies, and the Secretary of Health and Human Resources participated in workgroup meetings during the summer of 2003. Based on recommendations from this group, JCHC on November 12, 2003 unanimously approved a two-phased design for the Healthy Lives Prescription Plan.

Phase I included such activities as informing seniors and their families regarding the existence of pharmaceutical discount cards and affiliating with opportunities that currently exist in the community to provide assistance in filling out applications.

Implementation of Phase II included the following activities:

- Monitoring the actions of Congress regarding a Medicare prescription drug benefit;
- Examining what other states are doing to assist seniors;

- Encouraging Virginia-based initiatives such as The Pharmacy Connection;
- Continuing to develop partnerships with community-based entities such as pharmacies, faith-based organizations, human service agencies, and advocacy associations; and
- Analyzing potential legislation to increase the income limits for Medicaid eligibility in Virginia.

During the 2005 General Assembly Session, three joint resolutions and three budget amendments were introduced by the Joint Commission to provide information about and funding for prescription assistance programs. HJR 701 to encourage the Department for the Aging and the Department of Health to include information about "wrap-around" coverage offered by some private pharmaceutical companies, and
HJR 702/SJR 363 to encourage distribution of information about prescription assistance programs through the Mission of Mercy program were adopted by the General Assembly. Likewise, the three budget amendments to provide prescription assistance funding to benefit low-income Virginians through programs offered by the Virginia Health Care Foundation, free clinics, and community health centers were included in the 2005 budget approved by the General Assembly.

In November 2005, JCHC voted to focus on addressing the implementation of Medicare Part D and its effect on Virginia's senior and disabled citizens. This decision was based on several factors. First, the Healthy Lives Prescription Assistance Fund had received no funding. Second, passage of the Medicare Prescription Drug, Improvement and Modernization Act in establishing Medicare Part D had addressed the needs of many Virginians who had previously lacked prescription coverage. Third, several JCHC-introduced budget amendments, to increase funding for prescription assistance to uninsured Virginians by $950,000 per year, were included in the budget approved during the 2005 General Assembly Session. Consequently, this is the final report of the Joint Commission on Health Care regarding the Healthy Lives Prescription Assistance Plan.

LICENSING OF DIETITIANS
EXECUTIVE SUMMARY

Authority for Study

House Bill 455 (HB 455) was introduced by Delegate McQuigg during the 2004 General Assembly Session. The bill was carried over to the 2005 Session. During the 2005 Session, HB 455 passed the House with an amendment but was passed by in the Senate Education and Health Committee with a letter. The letter was sent to the Joint Commission to review the issue. HB 455 would have required dietitians to be licensed by the Board of Medicine.

Background

A number of previous studies have addressed the issue of licensure for dietitians. House Joint Resolution 150 of the 1986 Session requested a study on the need to regulate dietitians and nutritionists. The study was conducted by the Council on Health Regulatory Boards. The Council had the responsibility to consider and evaluate health care professions and occupations to consider whether they should be regulated and the degree of regulation necessary. The Council had six formal criteria for evaluating whether a profession should be regulated. The main criterion was: "The unregulated practice of an occupation will harm or endanger the health, safety, and welfare of the public. The potential for harm is recognizable and not remote or dependent on tenuous argument." The conclusion of this study was that dietitians and nutritionists did not require regulation at that time. The Council indicated that safeguards were available including enforcement of: laws against the unlicensed practice of medicine, the Virginia Consumer Protection Act, and the statutes and regulations governing the various health occupations and professions.

House Bill 312 of the 1994 General Assembly Session would have established licensure for dietitians and nutritionists. The Bill was vetoed by the Governor when his amendment to reenact the bill in the 1995 Session was not accepted. The Governor directed the Department of Health Professions (DHP) to examine the issue. The Department had seven criteria to evaluate whether a profession should be regulated. These criteria concern risk for harm to the consumer, specialized skills and training, autonomous practice, scope of practice, economic impact, alternatives to regulation, and least restrictive regulation. The first criterion is the most fundamental test according to DHP. This criterion "pertains to the risk of harm to the public's health, safety, or welfare resulting

from the unregulated practice of the profession." There must not be other less restrictive means of redress. The Department found that the first criterion had not been met and that there were "existing mechanisms in place to afford consumer protection and redress without state regulation of dieticians and nutritionists."

Current Status in Virginia

HB 2191 of the 1995 Session set *out the minimum educational and training requirements for a person to hold himself out to be a "dietitian" or "nutritionist."*

Section 54.1-2731 of the *Code of Virginia* implements these provisions.

A. No person shall hold himself out to be or advertise or permit to be advertised that such person is a dietitian or nutritionist unless such person:

1. Has (i) received a baccalaureate or higher degree in nutritional sciences, community nutrition, public health nutrition, food and nutrition, dietetics or human nutrition from a regionally accredited college or university and (ii) satisfactorily completed a program of supervised clinical experience approved by the Commission on Dietetic Registration of the American Dietetic Association;

2. Has active registration through the Commission on Dietetic Registration of the American Dietetic Association;

3. Has an active certificate of the Certification Board for Nutrition Specialists by the Board of Nutrition Specialists;

4. Has an active accreditation by the Diplomats or Fellows of the American Board of Nutrition;

5. Has a current license or certificate as a dietitian or nutritionist issued by another state; or

6. Has the minimum requisite education, training and experience determined by the Board of Health Professions appropriate for such person to hold himself out to be, or advertise or allow himself to be advertised as, a dietitian or nutritionist.

The restrictions of this section apply to the use of the terms "dietitian" and "nutritionist" as used alone or in any combination with the terms "licensed," "certified," or "registered," as those terms also imply a minimum level of education, training and competence.

B. Any person who willfully violates the provisions of this section shall be guilty of a Class 3 misdemeanor.

The *Code of Virginia* also states that:

Nothing in this chapter shall preclude or affect in any fashion the ability of any person to provide any assessment, evaluation, advice, counseling, information or services of any nature that are otherwise allowed by law, whether or not such services are provided in connection with the marketing and sale of products.

Title 18, 75-30-10 of the *Virginia Administrative Code* also gives the following requirements:

- Requirements for use of title of dietitian or nutritionist.
- In addition to the criteria established in §54.1-2731 of the *Code of Virginia*, a person may hold himself out to be a dietitian or nutritionist who has met the following requirements:

  Section 54.1-2731 of the *Code of Virginia* implements these provisions.

  A. No person shall hold himself out to be or advertise or permit to be advertised that such person is a dietitian or nutritionist unless such person:

  1. Has (i) received a baccalaureate or higher degree in nutritional sciences, community nutrition, public health nutrition, food and nutrition, dietetics or human nutrition from a regionally accredited college or university and (ii) satisfactorily completed a program of supervised clinical experience approved by the Commission on Dietetic Registration of the American Dietetic Association;

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  3. Has an active certificate of the Certification Board for Nutrition Specialists by the Board of Nutrition Specialists;

  4. Has an active accreditation by the Diplomats or Fellows of the American Board of Nutrition;

  5. Has a current license or certificate as a dietitian or nutritionist issued by another state; or

  6. Has the minimum requisite education, training and experience determined by the Board of Health Professions appropriate for such person to hold himself out to be, or advertise or allow himself to be advertised as, a dietitian or nutritionist.

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- Requirements for use of title of dietitian or nutritionist.
- In addition to the criteria established in §54.1-2731 of the *Code of Virginia*, a person may hold himself out to be a dietitian or nutritionist who has met the following requirements:

  1. Has a baccalaureate degree with a major in foods and nutrition or dietetics or has equivalent hours of food and nutrition course work;

  2. Has two years of work experience in nutrition or dietetics concurrent with or subsequent to such degree; and

  3. Is employed by or under contract to a governmental agency.

Overview of Regulation of Dietitians and Nutritionist in Other States

The forms of regulation used by various states include.

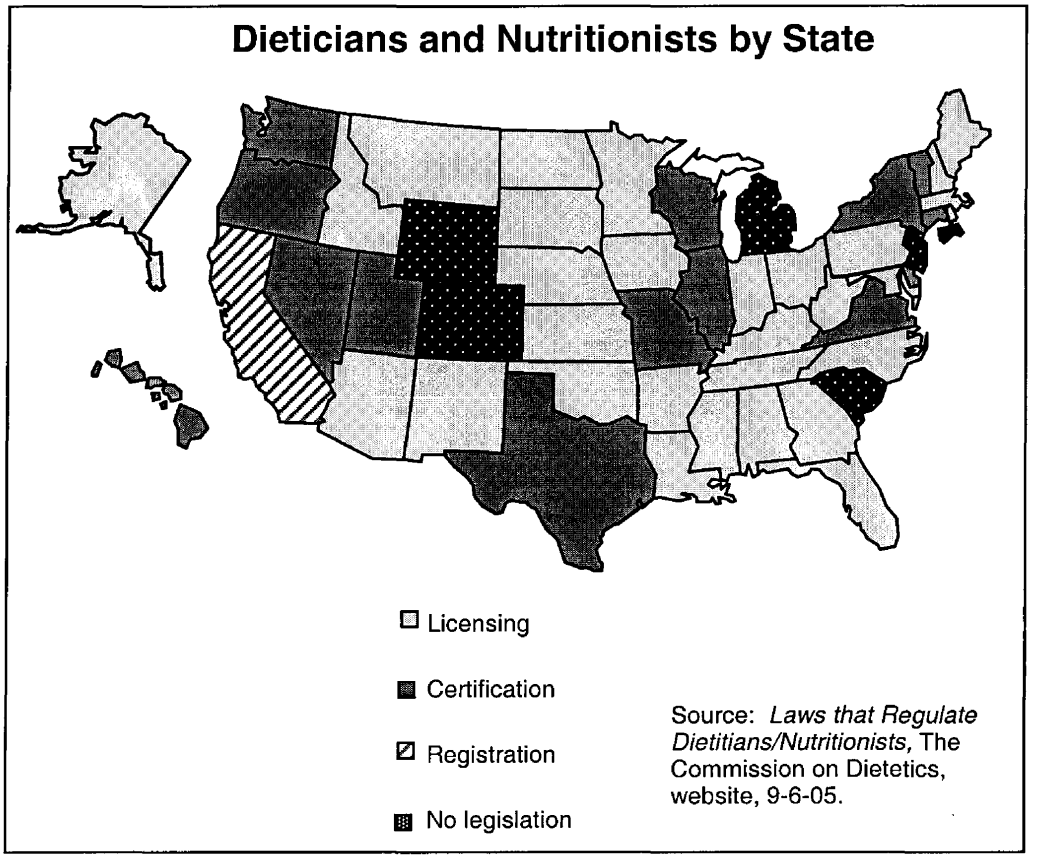
Licensing *- statutes include an explicitly defined scope of practice, and performance of the profession is illegal without first obtaining a license from the state.*

Statutory certification *— limits use of particular titles to persons meeting predetermined requirements, while persons not certified can still practice the occupation or profession.*

Registration *— is the least restrictive form of state regulation. As with certification, unregistered persons are permitted to practice the profession. Typically, exams are not given and enforcement of the registration requirement is minimal.*

The figure below illustrates dietician/nutritionist regulation by state.

- 29 states, the District of Columbia, and Puerto Rico license dietitians and/or nutritionists.
    - 20 mention both dietitians and nutritionists.
- 14 states require certification of dietitians and/or nutritionists.
- California requires registration of dietitians.



Fifteen states license both dieticians and nutritionists. Nebraska licenses medical nutrition therapists. Colorado has twice reviewed the proposal to regulate dieticians and the Department of Regulatory Agencies (DORA) recommended against licensing or regulating dietitians. DORA's review of other states found very few complaints regarding dietitians and related fields.

Provisions of HB 455

HB 455 defined the practice of dietetics as follows:

The "practice of dietetics" is defined as the integration and application of principles derived from the sciences of nutrition, biochemistry, food, physiology, management and behavioral and social sciences to achieve and maintain health through the provision of nutrition care services...."

Licensure requirements in HB 455 included giving the Board of Medicine the authority to establish the criteria for licensure. The bill listed the following criteria:

(a) at least a bachelors degree in human nutrition, nutrition education, foods and nutrition, food systems management, dietetics, or public health nutrition or a related field from an accredited college that meets the requirements of the Commission on Dietetic Registration;

(b) at least 900 hours of supervised experience approved by the Commission on Dietetic Registration;

(c) passage of the examination for registration administered by the Commission on Dietetic Registration or current registration with the Commission on Dietetic Registration; and

(d) documentation that the applicant for licensure has not had his license or certification as a dietitian suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

To limit the impact to certain businesses exemptions were included in HB 455. The list of exemptions includes the following:

(1) any student performing activities related to an educational program under the supervision of a licensed dietitian or any person completing the supervised practice required for licensure;

(2) a registered dietetic technician working under the supervision and direction of a licensed dietitian;

(3) a government employee or a person under contract to the government acting within the scope of such employment or contract;

(4) any health professional licensed or certified under this title when engaging in the profession for which he is licensed or any person working under the supervision of such a professional;

(5) a certified teacher employed by or under contract to any public or private elementary or secondary school or institution of higher education;

(6) any person with management responsibility for food service department policies, procedures, or outcomes in any food service department in any program or facility licensed by the Commonwealth;

(7) any person who does not hold himself out to be a dietitian who furnishes general nutrition information on food, food products, or dietary supplements or explains to customers about food, food products, or dietary supplements in connection with marketing and distribution of food or food products; or

(8) any person who provides weight control, wellness, or exercise services involving nutrition provided the program has been reviewed by a licensed dietitian, no change is initiated without prior approval of the dietitian, and consultation is available from a licensed dietitian.

Arguments Made by Interested Parties

The public discussion concerning HB 455 was one that was debated by a number of parties on both sides of the licensure issue. Some proponents of the legislation include:

- American Dietetic Association
- Virginia Dietetic Association (proposing legislation that only requires licensure of dieticians who provide medical nutrition therapy.)
- Virginia Nutritionists Association (proposing legislation that would also license nutritionists.)
- Other Nutritionist Group-Herondorf (proposing legislation that would also license nutritionists).

Examples of their arguments for licensure include concerns such as the unregulated practice of providing nutritional advice is a threat to public safety and anecdotal evidence of harm to consumers.

Some opponents of the legislation include:

- Health Food Stores
- Weight Loss Clinics
- Other regulated health professionals
- Native American healers
- Certified Natural Health Professionals
- National Association of Nutrition Professionals.

Examples of their arguments against licensure include limitations on the freedom of speech and the ability to engage in a profession, the creation of a monopoly, and undue financial burden.

OPTIONS AND PUBLIC COMMENTS

The following options were proposed and public comments received regarding the options. JCHC voted to approve Option I to take no action.

Option I: Take no action.

Option II: Introduce legislation that would license dietitians.

Option III: Introduce legislation that would license dietitians & nutritionists.

Option IV: Introduce legislation that would require licensure for dieticians who provide medical nutrition therapy.

Option V: Introduce legislation that would require licensure for dieticians and nutritionists who provide medical nutrition therapy.

Option VI: Request that the Department of Health Professions conduct another thorough review of the issue.

The following table summarizes the public comments that were received on each Policy Option. Option I (to take no action) was supported by the largest number of commenters (374). Option IV (to require licensure for dietitians who provide medical nutrition therapy) was supported by 304 commenters. Option V (to require licensure for dietitians and nutritionists who provide medical nutrition therapy) was supported by 225 commenters. (Note that 221 of these commenters actually commented in support of both Options IV and V.) One commenter proposed an additional policy option that included specific language for a proposed bill.

Policy Option	Number of Comments in Support
I	374*
II	2
III	2
IV	304
V	225
VI	0
*Comments that stated opposition to HB 455 or the licensing of dietitians were interpreted as Option I (Take No Action). Only one individual explicitly supported Option I.	

Some other issues that may be considered as part of any legislation on the issue:

- How to define dietitian, nutritionist, or any other provider that would be included in the legislation.
- Education and practice requirements.
- Other credentials or registration that may be required.
- Grandfathering.
- Appropriate exemptions.
- Reciprocity with other states.

APPENDIX A

Joint Commission on Health Care
2006 Legislation

Bills

HB 786/ SB 287 **Long-Term Care Tax Credits.** **1/15**

Amend Title 58.1 to replace the current income tax deduction with a tax credit of 10 percent of the premium paid for qualifying long-term care insurance contracts. Both bills were amended to provide a one-time tax credit of 15 percent of the long-term care premiums paid within the tax year. Any unused tax credit amounts may be carried over for the next five taxable years, but the credit may not exceed the cost of 15 percent of the premium charged for the first 12 months of long-term care insurance coverage. In addition, the tax deduction for premiums paid on long-term care insurance remains in effect, but either the credit or the deduction may be claimed within a tax filing. HB 786 and SB 287 were approved as amended and appear as *2006 Acts of Assembly* Chapters 599 and 570 respectively.

HB 787/ SB 252 **Local Health Partnership Authorities.** **6/14**

Amend *Code* § 32.1-122.10:001 to remove the sunset clause on the establishment/continuation of health partnership authorities. HJR 787 was tabled. SB 252 was approved and appears as *2006 Acts of Assembly* Chapter 368.

HB 788/ SB 438 **Joint Commission on Health Care Sunset.** **7/23**

Amend *Code* § 30.1-170 to remove the sunset clause for the Joint Commission on Health Care. Both bills were amended to extend the sunset date to July 1, 2010. HB 788 and SB 438 were approved and appear as *2006 Acts of Assembly* Chapters 113 and 178 respectively.

HB 789/ SB 251 **Compensation of Expert Witness.** **8/13**

Amend *Code* § 19.2-175 to remove the language which prohibits compensation to psychiatrists, clinical psychologists

and other experts who are employed by the Commonwealth (except for experts employed by the University of Virginia and Virginia Commonwealth University) to provide professional services in trials involving an insanity defense or after conviction in a case in which the offense indicates sexual abnormality. Compensation is limited to services provided during non-state hours and approved as being outside the scope of state employment. Both bills were approved and appear as *2006 Acts of Assembly* Chapters 114 and 170 respectively.

HB 790/ SB 250 **Extension of Time a NGRI Acquittee May Receive Inpatient Treatment in a State Hospital without Having His Conditional Release Revoked.** 9/12

Amend *Code* § 19.2-182.10 to increase the time from 30 to 60 days that an acquittee may be in the DMHMRSAS Commissioner's custody "for inpatient treatment pursuant to revocation proceedings" but be subsequently placed on conditional release with the Court's approval "as if revocation had not taken place." Both bills were approved and appear as *2006 Acts of Assembly* Chapters 199 and 225 respectively.

HB 791/ SB 289 **Clarification that Voluntary Admission to a State Hospital Does Not Automatically Result in Revocation of Conditional Release.** 10/21

Amend *Code* §§ 19.2-182.8 and 19.2-182.9 to clarify that voluntary admission to a State hospital does not automatically result in revocation of conditional release for acquittees. Both bills were approved and appear as *2006 Acts of Assembly* Chapters 343 and 370 respectively.

SB 288 **Expedited Court Consideration.** 20

Amends *Code* §§ 19.2-182.8 to add language to require a hearing on revocation of conditional release to be scheduled on an expedited basis and given priority over other civil matters by the Court. SB 288 was approved and appears as *2006 Acts of Assembly* Chapter 369.

Resolutions

HJR 96/ SJR 125	**Autism.** Encourage the Board and the Department of Education; the Board and the Department of Mental Health, Mental Retardation and Substance Abuse Services; and other relevant entities to take certain actions to improve the education and treatment of individuals with autism spectrum disorders. Both resolutions were adopted by the General Assembly.	**24/28**
HJR 97/ SJR 122	**JLARC Asset Transfer Study.** Request that the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission monitor changes in the federal restrictions on sheltering assets to qualify for Medicaid long-term care services. Both resolutions were adopted by the General Assembly.	**26/27**

VIRGINIA ACTS OF ASSEMBLY -- 2006 SESSION

CHAPTER 599

An Act to amend and reenact § 58.1-322 of the Code of Virginia and to amend the Code of Virginia by adding in Article 3 of Chapter 3 of Title 58.1 a section numbered 58.1-339.11, relating to individual income tax deductions and credits for the cost of long-term care insurance premiums.

[H 786]

Approved April 5, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 58.1-322 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 3 of Chapter 3 of Title 58.1 a section numbered 58.1-339.11 as follows:

§ 58.1-322. Virginia taxable income of residents.

A. The Virginia taxable income of a resident individual means his federal adjusted gross income for the taxable year, which excludes combat pay for certain members of the Armed Forces of the United States as provided in § 112 of the Internal Revenue Code, as amended, and with the modifications specified in this section.

B. To the extent excluded from federal adjusted gross income, there shall be added:

1. Interest, less related expenses to the extent not deducted in determining federal income, on obligations of any state other than Virginia, or of a political subdivision of any such other state unless created by compact or agreement to which Virginia is a party;

2. Interest or dividends, less related expenses to the extent not deducted in determining federal taxable income, on obligations or securities of any authority, commission, or instrumentality of the United States, which the laws of the United States exempt from federal income tax but not from state income taxes;

3. Unrelated business taxable income as defined by § 512 of the Internal Revenue Code;

4. The amount of a lump sum distribution from a qualified retirement plan, less the minimum distribution allowance and any amount excludable for federal income tax purposes that is excluded from federal adjusted gross income solely by virtue of an individual's election to use the averaging provisions under § 402 of the Internal Revenue Code; and

5. through 8. [Repealed.]

9. The amount required to be included in income for the purpose of computing the partial tax on an accumulation distribution pursuant to § 667 of the Internal Revenue Code.

C. To the extent included in federal adjusted gross income, there shall be subtracted:

1. Income derived from obligations, or on the sale or exchange of obligations, of the United States and on obligations or securities of any authority, commission, or instrumentality of the United States to the extent exempt from state income taxes under the laws of the United States including, but not limited to, stocks, bonds, treasury bills, and treasury notes, but not including interest on refunds of federal taxes, interest on equipment purchase contracts, or interest on other normal business transactions.

2. Income derived from obligations, or on the sale or exchange of obligations of this Commonwealth or of any political subdivision or instrumentality of the Commonwealth.

3. [Repealed.]

4. Benefits received under Title II of the Social Security Act and other benefits subject to federal income taxation solely pursuant to § 86 of the Internal Revenue Code.

4a. Through December 31, 2000, the same amount used in computing the federal credit allowed under § 22 of the Internal Revenue Code by a retiree under age 65 who qualified for such retirement on the basis of permanent and total disability and who is a qualified individual as defined in § 22 (b) (2) of the Internal Revenue Code; however, any person who claims a deduction under subdivision 5 of subsection D of this section may not also claim a subtraction under this subdivision.

4b. For taxable years beginning on or after January 1, 2001, up to $20,000 of disability income, as defined in § 22 (c) (2) (B) (iii) of the Internal Revenue Code; however, any person who claims a deduction under subdivision 5 of subsection D of this section may not also claim a subtraction under this subdivision.

5. The amount of any refund or credit for overpayment of income taxes imposed by the Commonwealth or any other taxing jurisdiction.

6. The amount of wages or salaries eligible for the federal Targeted Jobs Credit which was not deducted for federal purposes on account of the provisions of § 280C (a) of the Internal Revenue Code.

7, 8. [Repealed.]

9. [Expired.]

10. Any amount included therein less than $600 from a prize awarded by the State Lottery

Department.

11. The wages or salaries received by any person for active and inactive service in the National Guard of the Commonwealth of Virginia, not to exceed the amount of income derived from 39 calendar days of such service or $3,000, whichever amount is less; however, only those persons in the ranks of O3 and below shall be entitled to the deductions specified herein.

12. Amounts received by an individual, not to exceed $1,000 in any taxable year, as a reward for information provided to a law-enforcement official or agency, or to a nonprofit corporation created exclusively to assist such law-enforcement official or agency, in the apprehension and conviction of perpetrators of crimes. This provision shall not apply to the following: an individual who is an employee of, or under contract with, a law-enforcement agency, a victim or the perpetrator of the crime for which the reward was paid, or any person who is compensated for the investigation of crimes or accidents.

13. [Repealed.]

14. [Expired.]

15., 16. [Repealed.]

17. For taxable years beginning on and after January 1, 1995, the amount of "qualified research expenses" or "basic research expenses" eligible for deduction for federal purposes, but which were not deducted, on account of the provisions of § 280C (c) of the Internal Revenue Code and which shall be available to partners, shareholders of S corporations, and members of limited liability companies to the extent and in the same manner as other deductions may pass through to such partners, shareholders, and members.

18. For taxable years beginning on or after January 1, 1995, all military pay and allowances, not otherwise subtracted under this subsection, earned for any month during any part of which such member performed military service in any part of the former Yugoslavia, including the air space above such location or any waters subject to related naval operations, in support of Operation JOINT ENDEAVOR as part of the NATO Peace Keeping Force. Such subtraction shall be available until the taxpayer completes such service.

19. For taxable years beginning on and after January 1, 1996, any income received during the taxable year derived from a qualified pension, profit-sharing, or stock bonus plan as described by § 401 of the Internal Revenue Code, an individual retirement account or annuity established under § 408 of the Internal Revenue Code, a deferred compensation plan as defined by § 457 of the Internal Revenue Code, or any federal government retirement program, the contributions to which were deductible from the taxpayer's federal adjusted gross income, but only to the extent the contributions to such plan or program were subject to taxation under the income tax in another state.

20. For taxable years beginning on and after January 1, 1997, any income attributable to a distribution of benefits or a refund from a prepaid tuition contract or savings trust account with the Virginia College Savings Plan, created pursuant to Chapter 4.9 (§ 23-38.75 et seq.) of Title 23. The subtraction for any income attributable to a refund shall be limited to income attributable to a refund in the event of a beneficiary's death, disability, or receipt of a scholarship.

21. For taxable years beginning on or after January 1, 1998, all military pay and allowances, to the extent included in federal adjusted gross income and not otherwise subtracted, deducted, or exempted under this section, earned by military personnel while serving by order of the President of the United States with the consent of Congress in a combat zone or qualified hazardous duty area which is treated as a combat zone for federal tax purposes pursuant to § 112 of the Internal Revenue Code.

22. For taxable years beginning on or after January 1, 2000, the gain derived from the sale or exchange of real property or the sale or exchange of an easement to real property which results in the real property or the easement thereto being devoted to open-space use, as that term is defined in § 58.1-3230, for a period of time not less than 30 years. To the extent a subtraction is taken in accordance with this subdivision, no tax credit under this chapter for donating land for its preservation shall be allowed for three years following the year in which the subtraction is taken.

23. Effective for all taxable years beginning on or after January 1, 2000, $15,000 of military basic pay for military service personnel on extended active duty for periods in excess of 90 days; however, the subtraction amount shall be reduced dollar-for-dollar by the amount which the taxpayer's military basic pay exceeds $15,000 and shall be reduced to zero if such military basic pay amount is equal to or exceeds $30,000.

24. Effective for all taxable years beginning on and after January 1, 2000, the first $15,000 of salary for each federal and state employee whose total annual salary from all employment for the taxable year is $15,000 or less.

25. Unemployment benefits taxable pursuant to § 85 of the Internal Revenue Code.

26. For taxable years beginning on and after January 1, 2001, any amount received as military retirement income by an individual awarded the Congressional Medal of Honor.

27. Effective for all taxable years beginning on and after January 1, 1999, income received as a result of (i) the "Master Settlement Agreement," as defined in § 3.1-1106; (ii) the National Tobacco Grower Settlement Trust dated July 19, 1999; and (iii) the Tobacco Loss Assistance Program, pursuant to 7 C.F.R. Part 1464 (Subpart C, §§ 1464.201 through 1464.205), by (a) tobacco farmers; (b) any

person holding a tobacco marketing quota, or tobacco farm acreage allotment, under the Agricultural Adjustment Act of 1938; or (c) any person having the right to grow tobacco pursuant to such a quota or allotment, but only to the extent that such income has not been subtracted pursuant to subdivision C 18 of § 58.1-402.

28. For taxable years beginning on and after January 1, 2000, items of income attributable to, derived from or in any way related to (i) assets stolen from, hidden from, or otherwise lost by an individual who was a victim or target of Nazi persecution or (ii) damages, reparations, or other consideration received by a victim or target of Nazi persecution to compensate such individual for performing labor against his will under the threat of death, during World War II and its prelude and direct aftermath. This subtraction shall not apply to assets acquired with such items of income or with the proceeds from the sale of assets stolen from, hidden from, or otherwise lost to, during World War II and its prelude and direct aftermath, a victim or target of Nazi persecution. The provisions of this subdivision shall only apply to an individual who was the first recipient of such items of income and who was a victim or target of Nazi persecution, or a spouse, widow, widower, or child or stepchild of such victim.

"Victim or target of Nazi persecution" means any individual persecuted or targeted for persecution by the Nazi regime who had assets stolen from, hidden from, or otherwise lost as a result of any act or omission in any way relating to (i) the Holocaust; (ii) World War II and its prelude and direct aftermath; (iii) transactions with or actions of the Nazi regime; (iv) treatment of refugees fleeing Nazi persecution; or (v) the holding of such assets by entities or persons in the Swiss Confederation during World War II and its prelude and aftermath. A victim or target of Nazi persecution shall also include any individual forced into labor against his will, under the threat of death, during World War II and its prelude and direct aftermath. As used in this subdivision, "Nazi regime" means the country of Nazi Germany, areas occupied by Nazi Germany, those European countries allied with Nazi Germany, or any other neutral European country or area in Europe under the influence or threat of Nazi invasion.

29. For taxable years beginning on and after January 1, 2002, any gain recognized as a result of the Peanut Quota Buyout Program of the Farm Security and Rural Investment Act of 2002 pursuant to 7 C.F.R. Part 1412 (Subpart H, §§ 1412.801 through 1412.811) as follows:

a. If the payment is received in installment payments pursuant to 7 C.F.R. § 1412.807(a) (2), then the entire gain recognized may be subtracted.

b. If the payment is received in a single payment pursuant to 7 C.F.R. § 1412.807(a) (3), then 20 percent of the recognized gain may be subtracted. The taxpayer may then deduct an equal amount in each of the four succeeding taxable years.

30. Effective for all taxable years beginning on and after January 1, 2002, but before January 1, 2005, the indemnification payments received by contract poultry growers and table egg producers from the U.S. Department of Agriculture as a result of the depopulation of poultry flocks because of low pathogenic avian influenza in 2002. In no event shall indemnification payments made to owners of poultry who contract with poultry growers qualify for this subtraction.

31. Effective for all taxable years beginning on or after January 1, 2001, the military death gratuity payment made after September 11, 2001, to the survivor of deceased military personnel killed in the line of duty, pursuant to Chapter 75 of Title 10 of the United States Code; however, the subtraction amount shall be reduced dollar-for-dollar by the amount that the survivor may exclude from his federal gross income in accordance with § 134 of the Internal Revenue Code.

D. In computing Virginia taxable income there shall be deducted from Virginia adjusted gross income as defined in § 58.1-321:

1. a. The amount allowable for itemized deductions for federal income tax purposes where the taxpayer has elected for the taxable year to itemize deductions on his federal return, but reduced by the amount of income taxes imposed by the Commonwealth or any other taxing jurisdiction and deducted on such federal return and increased by an amount which, when added to the amount deducted under § 170 of the Internal Revenue Code for mileage, results in a mileage deduction at the state level for such purposes at a rate of 18 cents per mile; or

b. Three thousand dollars for single individuals for taxable years beginning on and after January 1, 1989; $5,000 for married persons (one-half of such amounts in the case of a married individual filing a separate return) for taxable years beginning on and after January 1, 1989, but before January 1, 2005; and $6,000 for married persons (one-half of such amounts in the case of a married individual filing a separate return) for taxable years beginning on and after January 1, 2005; provided that the taxpayer has not itemized deductions for the taxable year on his federal income tax return. For purposes of this section, any person who may be claimed as a dependent on another taxpayer's return for the taxable year may compute the deduction only with respect to earned income.

2. a. A deduction in the amount of $800 for taxable years beginning on and after January 1, 1988, but before January 1, 2005, and $900 for taxable years beginning on and after January 1, 2005, for each personal exemption allowable to the taxpayer for federal income tax purposes.

b. For taxable years beginning on and after January 1, 1987, each blind or aged taxpayer as defined under § 63 (f) of the Internal Revenue Code shall be entitled to an additional personal exemption in the

amount of $800.

The additional deduction for blind or aged taxpayers allowed under this subdivision shall be allowable regardless of whether the taxpayer itemizes deductions for the taxable year for federal income tax purposes.

3. A deduction equal to the amount of employment-related expenses upon which the federal credit is based under § 21 of the Internal Revenue Code for expenses for household and dependent care services necessary for gainful employment.

4. An additional $1,000 deduction for each child residing for the entire taxable year in a home under permanent foster care placement as defined in § 63.2-908, provided the taxpayer can also claim the child as a personal exemption under § 151 of the Internal Revenue Code.

5. a. Effective for all taxable years beginning on or after January 1, 1996, but before January 1, 2004, a deduction in the amount of $12,000 for taxpayers age 65 or older, or $6,000 for taxpayers age 62 through 64.

b. For taxable years beginning on and after January 1, 2004, a deduction in the amount of $12,000 for individuals born on or before January 1, 1939.

c. For taxable years beginning January 1, 2004, but before January 1, 2005, a deduction in the amount of $6,000 for individuals born on or between January 2, 1940, and January 1, 1942.

d. For taxable years beginning January 1, 2005, but before January 1, 2006, a deduction in the amount of $6,000 for individuals born on or between January 2, 1941, and January 1, 1942.

e. For taxable years beginning on and after January 1, 2004, a deduction in the amount of $12,000 for individuals born after January 1, 1939, who have attained the age of 65. This deduction shall be reduced by $1 for every $1 that the taxpayer's adjusted federal adjusted gross income exceeds $50,000 for single taxpayers or $75,000 for married taxpayers. For married taxpayers filing separately, the deduction will be reduced by $1 for every $1 the total combined adjusted federal adjusted gross income of both spouses exceeds $75,000.

f. For the purposes of this subdivision, "adjusted federal adjusted gross income" means federal adjusted gross income minus any benefits received under Title II of the Social Security Act and other benefits subject to federal income taxation solely pursuant to § 86 of the Internal Revenue Code, as amended.

6. For taxable years beginning on and after January 1, 1997, the amount an individual pays as a fee for an initial screening to become a possible bone marrow donor, if (i) the individual is not reimbursed for such fee or (ii) the individual has not claimed a deduction for the payment of such fee on his federal income tax return.

7. a. A deduction shall be allowed to the purchaser or contributor for the amount paid or contributed during the taxable year for a prepaid tuition contract or savings trust account entered into with the Virginia College Savings Plan, pursuant to Chapter 4.9 (§ 23-38.75 et seq.) of Title 23. Except as provided in subdivision 7 c, the amount deducted on any individual income tax return in any taxable year shall be limited to $2,000 per prepaid tuition contract or savings trust account. No deduction shall be allowed pursuant to this section if such payments or contributions are deducted on the purchaser's or contributor's federal income tax return. If the purchase price or annual contribution to a savings trust account exceeds $2,000, the remainder may be carried forward and subtracted in future taxable years until the purchase price or savings trust contribution has been fully deducted; however, except as provided in subdivision 7 c, in no event shall the amount deducted in any taxable year exceed $2,000 per contract or savings trust account. Notwithstanding the statute of limitations on assessments contained in § 58.1-312, any deduction taken hereunder shall be subject to recapture in the taxable year or years in which distributions or refunds are made for any reason other than (i) to pay qualified higher education expenses, as defined in § 529 of the Internal Revenue Code or (ii) the beneficiary's death, disability, or receipt of a scholarship. For the purposes of this subdivision, the term "purchaser" or "contributor" means the person shown as such on the records of the Virginia College Savings Plan as of December 31 of the taxable year. In the case of a transfer of ownership of a prepaid tuition contract or savings trust account, the transferee shall succeed to the transferor's tax attributes associated with a prepaid tuition contract or savings trust account, including, but not limited to, carryover and recapture of deductions.

b. The amount paid for a prepaid tuition contract during taxable years beginning on or after January 1, 1996, but before January 1, 1998, shall be deducted in taxable years beginning on or after January 1, 1998, and shall be subject to the limitations set out in subdivision 7 a.

c. A purchaser of a prepaid tuition contract or contributor to a savings trust account who has attained age 70 shall not be subject to the limitation that the amount of the deduction not exceed $2,000 per prepaid tuition contract or savings trust account in any taxable year. Such taxpayer shall be allowed a deduction for the full amount paid for the contract or contributed to a savings trust account, less any amounts previously deducted. If a prepaid tuition contract was purchased by such taxpayer during taxable years beginning on or after January 1, 1996, but before January 1, 1998, such taxpayer may take the deduction for the full amount paid during such years, less any amounts previously deducted with respect to such payments, in taxable year 1999 or by filing an amended return for taxable year 1998.

8. For taxable years beginning on and after January 1, 2000, the total amount an individual actually

contributed in funds to the Virginia Public School Construction Grants Program and Fund, established in Chapter 11.1 (§ 22.1-175.1 et seq.) of Title 22.1, provided the individual has not claimed a deduction for such amount on his federal income tax return.

9. For taxable years beginning on and after January 1, 1999, an amount equal to 20 percent of the tuition costs incurred by an individual employed as a primary or secondary school teacher licensed pursuant to Chapter 15 (§ 22.1-289.1 et seq.) of Title 22.1 to attend continuing teacher education courses that are required as a condition of employment; however, the deduction provided by this subsection shall be available only if (i) the individual is not reimbursed for such tuition costs and (ii) the individual has not claimed a deduction for the payment of such tuition costs on his federal income tax return.

10. For taxable years beginning on and after January 1, 2000, the amount an individual pays annually in premiums for long-term health care insurance, provided the individual has not claimed a deduction for federal income tax purposes, *or a credit under § 58.1-339.11.*

E. There shall be added to or subtracted from federal adjusted gross income, as the case may be, the individual's share, as beneficiary of an estate or trust, of the Virginia fiduciary adjustment determined under § 58.1-361.

F. There shall be added or subtracted, as the case may be, the amounts provided in § 58.1-315 as transitional modifications.

§ 58.1-339.11. Long-term care insurance tax credit.

A. For taxable years beginning on or after January 1, 2006, any individual shall be entitled to a credit against the tax levied pursuant to § 58.1-320 for certain long-term care insurance premiums paid by the individual during the taxable year pursuant to an insurance policy entered into on or after January 1, 2006. The amount of the credit for each taxable year shall equal 15% of the amount paid by the individual during the taxable year in long-term care insurance premiums for long-term care insurance coverage for himself, but in no event shall the total credits over the life of any policy exceed 15% of the amount of premiums paid for the first 12 months of coverage. For purposes of this section, "long-term care insurance premium" means the amount paid during a taxable year for any qualified long-term care insurance contract as defined in § 7702B(b) of the Internal Revenue Code, as amended, covering an individual.

B. If the amount of the credit as determined in subsection A exceeds the individual's income tax liability for the taxable year, the amount that exceeds such liability may be carried over for credit against the income taxes of such individual in the next five taxable years or until the full credit is used, whichever occurs first.

C. The credit described in this section shall not be claimed to the extent the individual has claimed a deduction for federal income tax purposes for long-term care insurance premiums for himself or a deduction under subdivision D 10 of § 58.1-322.

D. The Tax Commissioner shall establish guidelines regarding the information to include and the format for proof of payment. Such guidelines shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.).

INTRODUCED

063459136

HOUSE BILL NO. 787

Offered January 11, 2006

Prefiled January 10, 2006

A BILL to repeal the second enactment of Chapter 671 of the Acts of Assembly of 2001, as amended by Chapters 63 and 70 of the Acts of Assembly of 2003, relating to local health partnership authorities.

Patrons—Brink, Landes, Melvin and O'Bannon; Senator: Rerras

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That the second enactment of Chapter 671 of the Acts of Assembly of 2001, as amended by Chapters 63 and 70 of the Acts of Assembly of 2003, is repealed.

INTRODUCED

CHAPTER 113

An Act to amend and reenact § 30-170 of the Code of Virginia, relating to the Joint Commission on Health Care.

[H 788]

Approved March 23, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 30-170 of the Code of Virginia is amended and reenacted as follows:

§ 30-170. (Effective until July 1, 2007) Sunset.

The provisions of this chapter shall expire on July 1, ~~2007~~ *2010.*

CHAPTER 114

An Act to amend and reenact § 19.2-175 of the Code of Virginia, relating to the compensation of an expert witness in certain criminal cases.

[H 789]

Approved March 23, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 19.2-175 of the Code of Virginia is amended and reenacted as follows:

§ 19.2-175. Compensation of experts.

Each psychiatrist, clinical psychologist or other expert appointed by the court to render professional service pursuant to §§ 19.2-168.1, 19.2-169.1, 19.2-169.5, subsection A of § 19.2-176, §§ 19.2-182.8, 19.2-182.9, 19.2-264.3:1, 19.2-264.3:3 or § 19.2-301, who is not regularly employed by the Commonwealth of Virginia except by the University of Virginia School of Medicine and the Medical College of Virginia *Commonwealth University*, shall receive a reasonable fee for such service. *For any psychiatrist, clinical psychologist, or other expert appointed by the court to render such professional services who is regularly employed by the Commonwealth of Virginia, except by the University of Virginia School of Medicine or the Medical College of Virginia Commonwealth University, the fee shall be paid only for professional services provided during nonstate hours that have been approved by his employing agency as being beyond the scope of his state employment duties.* The fee shall be determined in each instance by the court that appointed the expert, in accordance with guidelines established by the Supreme Court after consultation with the Department of Mental Health, Mental Retardation and Substance Abuse Services. Except in capital murder cases the fee shall not exceed $400, but in addition if any such expert is required to appear as a witness in any hearing held pursuant to such sections, he shall receive mileage and a fee of $100 for each day during which he is required so to serve. An itemized account of expense, duly sworn to, must be presented to the court, and when allowed shall be certified to the Supreme Court for payment out of the state treasury, and be charged against the appropriations made to pay criminal charges. Allowance for the fee and for the per diem authorized shall also be made by order of the court, duly certified to the Supreme Court for payment out of the appropriation to pay criminal charges.

CHAPTER 199

An Act to amend and reenact § 19.2-182.10 of the Code of Virginia, relating to revocation of conditional release.

[H 790]

Approved March 24, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 19.2-182.10 of the Code of Virginia is amended and reenacted as follows:

§ 19.2-182.10. Release of person whose conditional release was revoked.

If an acquittee is returned to the custody of the Commissioner for inpatient treatment pursuant to revocation proceedings, and his condition improves to the degree that, within ~~thirty~~ *60* days of resumption of custody following the hearing, the acquittee, in the opinion of hospital staff treating the acquittee and the supervising community services board, is an appropriate candidate for conditional release, he may be, with the approval of the court, conditionally released as if revocation had not taken place. If treatment is required for longer than ~~thirty~~ *60* days, the acquittee shall be returned to the custody of the Commissioner for a period of hospitalization and treatment which is governed by the provisions of this chapter applicable to committed acquittees.

CHAPTER 343

An Act to amend and reenact §§ 19.2-182.8 and 19.2-182.9 of the Code of Virginia, relating to not guilty by reason of insanity; conditional release.

[H 791]

Approved March 30, 2006

Be it enacted by the General Assembly of Virginia:

1. That §§ 19.2-182.8 and 19.2-182.9 of the Code of Virginia are amended and reenacted as follows:

§ 19.2-182.8. Revocation of conditional release.

If at any time the court that released an acquittee pursuant to § 19.2-182.7 finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, it may order an evaluation of the acquittee by a psychiatrist or clinical psychologist, provided the psychiatrist or clinical psychologist is qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) is mentally ill or mentally retarded and requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner. *An acquittee's conditional release shall not be revoked solely because of his voluntary hospital admission.*

At any hearing pursuant to this section, the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The hearing is a civil proceeding.

§ 19.2-182.9. Emergency custody of conditionally released acquittee.

When exigent circumstances do not permit compliance with revocation procedures set forth in § 19.2-182.8, any district court judge or a special justice, as defined in § 37.2-100, or a magistrate may issue an emergency custody order, upon the sworn petition of any responsible person or upon his own motion based upon probable cause to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) requires inpatient hospitalization. The emergency custody order shall require the acquittee within his judicial district to be taken into custody and transported to a convenient location where a person designated by the community services board or behavioral health authority who is skilled in the diagnosis and treatment of mental illness shall evaluate such acquittee and assess his need for inpatient hospitalization. A law-enforcement officer who, based on his observation or the reliable reports of others, has probable cause to believe that any acquittee on conditional release has violated the conditions of his release and is no longer a proper subject for conditional release and requires emergency evaluation to assess the need for inpatient hospitalization, may take the acquittee into custody and transport him to an appropriate location to assess the need for hospitalization without prior judicial authorization. The evaluation shall be conducted immediately. The acquittee shall remain in custody until a temporary detention order is issued or until he is released, but in no event shall the period of custody exceed four hours. If it appears from all evidence readily available (i) that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) that he requires emergency evaluation to assess the need for inpatient hospitalization, the district court judge or a special justice, as defined in § 37.2-100, or magistrate, upon the advice of such person skilled in the diagnosis and treatment of mental illness, may issue a temporary detention order authorizing the executing officer to place the acquittee in an appropriate institution for a period not to exceed 48 hours prior to a hearing. If the 48-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the acquittee may be detained until the next day which is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.

The committing court or any district court judge or a special justice, as defined in § 37.2-100, shall have jurisdiction to hear the matter. Prior to the hearing, the acquittee shall be examined by a psychiatrist or licensed clinical psychologist, provided the psychiatrist or clinical psychologist is skilled in the diagnosis of mental illness, who shall certify whether the person is in need of hospitalization. At the hearing the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the

right to introduce evidence and cross-examine witnesses at the hearing. Following the hearing, if the court determines, based on a preponderance of the evidence presented at the hearing, that the acquittee (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) has mental illness or mental retardation and is in need of inpatient hospitalization, the court shall revoke the acquittee's conditional release and place him in the custody of the Commissioner. *An acquittee's conditional release shall not be revoked solely because of his voluntary hospital admission.*

When an acquittee on conditional release pursuant to this chapter is taken into emergency custody, detained, or hospitalized, such action shall be considered to have been taken pursuant to this section, notwithstanding the fact that his status as an insanity acquittee was not known at the time of custody, detention, or hospitalization. Detention or hospitalization of an acquittee pursuant to provisions of law other than those applicable to insanity acquittees pursuant to this chapter shall not render the detention or hospitalization invalid. If a person's status as an insanity acquittee on conditional release is not recognized at the time of emergency custody or detention, at the time his status as such is verified, the provisions applicable to such persons shall be applied and the court hearing the matter shall notify the committing court of the proceedings.

CHAPTER 225

An Act to amend and reenact § 19.2-182.10 of the Code of Virginia, relating to the duration of the custody period following the revocation of a person's conditional release but before he is subject to hospitalization and treatment.

[S 250]

Approved March 24, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 19.2-182.10 of the Code of Virginia is amended and reenacted as follows:

§ 19.2-182.10. Release of person whose conditional release was revoked.

If an acquittee is returned to the custody of the Commissioner for inpatient treatment pursuant to revocation proceedings, and his condition improves to the degree that, within ~~thirty~~ *60* days of resumption of custody following the hearing, the acquittee, in the opinion of hospital staff treating the acquittee and the supervising community services board, is an appropriate candidate for conditional release, he may be, with the approval of the court, conditionally released as if revocation had not taken place. If treatment is required for longer than ~~thirty~~ *60* days, the acquittee shall be returned to the custody of the Commissioner for a period of hospitalization and treatment which is governed by the provisions of this chapter applicable to committed acquittees.

CHAPTER 170

An Act to amend and reenact § 19.2-175 of the Code of Virginia, relating to the compensation of an expert witness in certain criminal cases.

[S 251]

Approved March 23, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 19.2-175 of the Code of Virginia is amended and reenacted as follows:

§ 19.2-175. Compensation of experts.

Each psychiatrist, clinical psychologist or other expert appointed by the court to render professional service pursuant to §§ 19.2-168.1, 19.2-169.1, 19.2-169.5, subsection A of § 19.2-176, §§ 19.2-182.8, 19.2-182.9, 19.2-264.3:1, 19.2-264.3:3 or § 19.2-301, who is not regularly employed by the Commonwealth of Virginia except by the University of Virginia School of Medicine and the Medical College of Virginia *Commonwealth University*, shall receive a reasonable fee for such service. *For any psychiatrist, clinical psychologist, or other expert appointed by the court to render such professional services who is regularly employed by the Commonwealth of Virginia, except by the University of Virginia School of Medicine or the Medical College of Virginia Commonwealth University, the fee shall be paid only for professional services provided during nonstate hours that have been approved by his employing agency as being beyond the scope of his state employment duties.* The fee shall be determined in each instance by the court that appointed the expert, in accordance with guidelines established by the Supreme Court after consultation with the Department of Mental Health, Mental Retardation and Substance Abuse Services. Except in capital murder cases the fee shall not exceed $400, but in addition if any such expert is required to appear as a witness in any hearing held pursuant to such sections, he shall receive mileage and a fee of $100 for each day during which he is required so to serve. An itemized account of expense, duly sworn to, must be presented to the court, and when allowed shall be certified to the Supreme Court for payment out of the state treasury, and be charged against the appropriations made to pay criminal charges. Allowance for the fee and for the per diem authorized shall also be made by order of the court, duly certified to the Supreme Court for payment out of the appropriation to pay criminal charges.

CHAPTER 368

An Act to repeal the second enactment of Chapter 671 of the Acts of Assembly of 2001, as amended by the second enactment of Chapters 63 and 70 of the Acts of Assembly of 2003, relating to local health partnership authorities.

[S 252]

Approved March 30, 2006

Be it enacted by the General Assembly of Virginia:

1. That the second enactment of Chapter 671 of the Acts of Assembly of 2001, as amended by the second enactment of Chapters 63 and 70 of the Acts of Assembly of 2003, is repealed.

CHAPTER 570

An Act to amend and reenact § 58.1-322 of the Code of Virginia and to amend the Code of Virginia by adding in Article 3 of Chapter 3 of Title 58.1 a section numbered 58.1-339.11, relating to individual income tax deductions and credits for the cost of long-term care insurance premiums.

[S 287]

Approved April 5, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 58.1-322 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 3 of Chapter 3 of Title 58.1 a section numbered 58.1-339.11 as follows:

§ 58.1-322. Virginia taxable income of residents.

A. The Virginia taxable income of a resident individual means his federal adjusted gross income for the taxable year, which excludes combat pay for certain members of the Armed Forces of the United States as provided in § 112 of the Internal Revenue Code, as amended, and with the modifications specified in this section.

B. To the extent excluded from federal adjusted gross income, there shall be added:

1. Interest, less related expenses to the extent not deducted in determining federal income, on obligations of any state other than Virginia, or of a political subdivision of any such other state unless created by compact or agreement to which Virginia is a party;

2. Interest or dividends, less related expenses to the extent not deducted in determining federal taxable income, on obligations or securities of any authority, commission, or instrumentality of the United States, which the laws of the United States exempt from federal income tax but not from state income taxes;

3. Unrelated business taxable income as defined by § 512 of the Internal Revenue Code;

4. The amount of a lump sum distribution from a qualified retirement plan, less the minimum distribution allowance and any amount excludable for federal income tax purposes that is excluded from federal adjusted gross income solely by virtue of an individual's election to use the averaging provisions under § 402 of the Internal Revenue Code; and

5. through 8. [Repealed.]

9. The amount required to be included in income for the purpose of computing the partial tax on an accumulation distribution pursuant to § 667 of the Internal Revenue Code.

C. To the extent included in federal adjusted gross income, there shall be subtracted:

1. Income derived from obligations, or on the sale or exchange of obligations, of the United States and on obligations or securities of any authority, commission, or instrumentality of the United States to the extent exempt from state income taxes under the laws of the United States including, but not limited to, stocks, bonds, treasury bills, and treasury notes, but not including interest on refunds of federal taxes, interest on equipment purchase contracts, or interest on other normal business transactions.

2. Income derived from obligations, or on the sale or exchange of obligations of this Commonwealth or of any political subdivision or instrumentality of the Commonwealth.

3. [Repealed.]

4. Benefits received under Title II of the Social Security Act and other benefits subject to federal income taxation solely pursuant to § 86 of the Internal Revenue Code.

4a. Through December 31, 2000, the same amount used in computing the federal credit allowed under § 22 of the Internal Revenue Code by a retiree under age 65 who qualified for such retirement on the basis of permanent and total disability and who is a qualified individual as defined in § 22 (b) (2) of the Internal Revenue Code; however, any person who claims a deduction under subdivision 5 of subsection D of this section may not also claim a subtraction under this subdivision.

4b. For taxable years beginning on or after January 1, 2001, up to $20,000 of disability income, as defined in § 22 (c) (2) (B) (iii) of the Internal Revenue Code; however, any person who claims a deduction under subdivision 5 of subsection D of this section may not also claim a subtraction under this subdivision.

5. The amount of any refund or credit for overpayment of income taxes imposed by the Commonwealth or any other taxing jurisdiction.

6. The amount of wages or salaries eligible for the federal Targeted Jobs Credit which was not deducted for federal purposes on account of the provisions of § 280C (a) of the Internal Revenue Code.

7., 8. [Repealed.]

9. [Expired.]

10. Any amount included therein less than $600 from a prize awarded by the State Lottery

Department.

11. The wages or salaries received by any person for active and inactive service in the National Guard of the Commonwealth of Virginia, not to exceed the amount of income derived from 39 calendar days of such service or $3,000, whichever amount is less; however, only those persons in the ranks of O3 and below shall be entitled to the deductions specified herein.

12. Amounts received by an individual, not to exceed $1,000 in any taxable year, as a reward for information provided to a law-enforcement official or agency, or to a nonprofit corporation created exclusively to assist such law-enforcement official or agency, in the apprehension and conviction of perpetrators of crimes. This provision shall not apply to the following: an individual who is an employee of, or under contract with, a law-enforcement agency, a victim or the perpetrator of the crime for which the reward was paid, or any person who is compensated for the investigation of crimes or accidents.

13. [Repealed.]

14. [Expired.]

15., 16. [Repealed.]

17. For taxable years beginning on and after January 1, 1995, the amount of "qualified research expenses" or "basic research expenses" eligible for deduction for federal purposes, but which were not deducted, on account of the provisions of § 280C (c) of the Internal Revenue Code and which shall be available to partners, shareholders of S corporations, and members of limited liability companies to the extent and in the same manner as other deductions may pass through to such partners, shareholders, and members.

18. For taxable years beginning on or after January 1, 1995, all military pay and allowances, not otherwise subtracted under this subsection, earned for any month during any part of which such member performed military service in any part of the former Yugoslavia, including the air space above such location or any waters subject to related naval operations, in support of Operation JOINT ENDEAVOR as part of the NATO Peace Keeping Force. Such subtraction shall be available until the taxpayer completes such service.

19. For taxable years beginning on and after January 1, 1996, any income received during the taxable year derived from a qualified pension, profit-sharing, or stock bonus plan as described by § 401 of the Internal Revenue Code, an individual retirement account or annuity established under § 408 of the Internal Revenue Code, a deferred compensation plan as defined by § 457 of the Internal Revenue Code, or any federal government retirement program, the contributions to which were deductible from the taxpayer's federal adjusted gross income, but only to the extent the contributions to such plan or program were subject to taxation under the income tax in another state.

20. For taxable years beginning on and after January 1, 1997, any income attributable to a distribution of benefits or a refund from a prepaid tuition contract or savings trust account with the Virginia College Savings Plan, created pursuant to Chapter 4.9 (§ 23-38.75 et seq.) of Title 23. The subtraction for any income attributable to a refund shall be limited to income attributable to a refund in the event of a beneficiary's death, disability, or receipt of a scholarship.

21. For taxable years beginning on or after January 1, 1998, all military pay and allowances, to the extent included in federal adjusted gross income and not otherwise subtracted, deducted, or exempted under this section, earned by military personnel while serving by order of the President of the United States with the consent of Congress in a combat zone or qualified hazardous duty area which is treated as a combat zone for federal tax purposes pursuant to § 112 of the Internal Revenue Code.

22. For taxable years beginning on or after January 1, 2000, the gain derived from the sale or exchange of real property or the sale or exchange of an easement to real property which results in the real property or the easement thereto being devoted to open-space use, as that term is defined in § 58.1-3230, for a period of time not less than 30 years. To the extent a subtraction is taken in accordance with this subdivision, no tax credit under this chapter for donating land for its preservation shall be allowed for three years following the year in which the subtraction is taken.

23. Effective for all taxable years beginning on or after January 1, 2000, $15,000 of military basic pay for military service personnel on extended active duty for periods in excess of 90 days; however, the subtraction amount shall be reduced dollar-for-dollar by the amount which the taxpayer's military basic pay exceeds $15,000 and shall be reduced to zero if such military basic pay amount is equal to or exceeds $30,000.

24. Effective for all taxable years beginning on and after January 1, 2000, the first $15,000 of salary for each federal and state employee whose total annual salary from all employment for the taxable year is $15,000 or less.

25. Unemployment benefits taxable pursuant to § 85 of the Internal Revenue Code.

26. For taxable years beginning on and after January 1, 2001, any amount received as military retirement income by an individual awarded the Congressional Medal of Honor.

27. Effective for all taxable years beginning on and after January 1, 1999, income received as a result of (i) the "Master Settlement Agreement," as defined in § 3.1-1106; (ii) the National Tobacco Grower Settlement Trust dated July 19, 1999; and (iii) the Tobacco Loss Assistance Program, pursuant to 7 C.F.R. Part 1464 (Subpart C, §§ 1464.201 through 1464.205), by (a) tobacco farmers; (b) any

person holding a tobacco marketing quota, or tobacco farm acreage allotment, under the Agricultural Adjustment Act of 1938; or (c) any person having the right to grow tobacco pursuant to such a quota or allotment, but only to the extent that such income has not been subtracted pursuant to subdivision C 18 of § 58.1-402.

28. For taxable years beginning on and after January 1, 2000, items of income attributable to, derived from or in any way related to (i) assets stolen from, hidden from, or otherwise lost by an individual who was a victim or target of Nazi persecution or (ii) damages, reparations, or other consideration received by a victim or target of Nazi persecution to compensate such individual for performing labor against his will under the threat of death, during World War II and its prelude and direct aftermath. This subtraction shall not apply to assets acquired with such items of income or with the proceeds from the sale of assets stolen from, hidden from, or otherwise lost to, during World War II and its prelude and direct aftermath, a victim or target of Nazi persecution. The provisions of this subdivision shall only apply to an individual who was the first recipient of such items of income and who was a victim or target of Nazi persecution, or a spouse, widow, widower, or child or stepchild of such victim.

"Victim or target of Nazi persecution" means any individual persecuted or targeted for persecution by the Nazi regime who had assets stolen from, hidden from, or otherwise lost as a result of any act or omission in any way relating to (i) the Holocaust; (ii) World War II and its prelude and direct aftermath; (iii) transactions with or actions of the Nazi regime; (iv) treatment of refugees fleeing Nazi persecution; or (v) the holding of such assets by entities or persons in the Swiss Confederation during World War II and its prelude and aftermath. A victim or target of Nazi persecution shall also include any individual forced into labor against his will, under the threat of death, during World War II and its prelude and direct aftermath. As used in this subdivision, "Nazi regime" means the country of Nazi Germany, areas occupied by Nazi Germany, those European countries allied with Nazi Germany, or any other neutral European country or area in Europe under the influence or threat of Nazi invasion.

29. For taxable years beginning on and after January 1, 2002, any gain recognized as a result of the Peanut Quota Buyout Program of the Farm Security and Rural Investment Act of 2002 pursuant to 7 C.F.R. Part 1412 (Subpart H, §§ 1412.801 through 1412.811) as follows:

a. If the payment is received in installment payments pursuant to 7 C.F.R. § 1412.807(a) (2), then the entire gain recognized may be subtracted.

b. If the payment is received in a single payment pursuant to 7 C.F.R. § 1412.807(a) (3), then 20 percent of the recognized gain may be subtracted. The taxpayer may then deduct an equal amount in each of the four succeeding taxable years.

30. Effective for all taxable years beginning on and after January 1, 2002, but before January 1, 2005, the indemnification payments received by contract poultry growers and table egg producers from the U.S. Department of Agriculture as a result of the depopulation of poultry flocks because of low pathogenic avian influenza in 2002. In no event shall indemnification payments made to owners of poultry who contract with poultry growers qualify for this subtraction.

31. Effective for all taxable years beginning on or after January 1, 2001, the military death gratuity payment made after September 11, 2001, to the survivor of deceased military personnel killed in the line of duty, pursuant to Chapter 75 of Title 10 of the United States Code; however, the subtraction amount shall be reduced dollar-for-dollar by the amount that the survivor may exclude from his federal gross income in accordance with § 134 of the Internal Revenue Code.

D. In computing Virginia taxable income there shall be deducted from Virginia adjusted gross income as defined in § 58.1-321:

1. a. The amount allowable for itemized deductions for federal income tax purposes where the taxpayer has elected for the taxable year to itemize deductions on his federal return, but reduced by the amount of income taxes imposed by the Commonwealth or any other taxing jurisdiction and deducted on such federal return and increased by an amount which, when added to the amount deducted under § 170 of the Internal Revenue Code for mileage, results in a mileage deduction at the state level for such purposes at a rate of 18 cents per mile; or

b. Three thousand dollars for single individuals for taxable years beginning on and after January 1, 1989; $5,000 for married persons (one-half of such amounts in the case of a married individual filing a separate return) for taxable years beginning on and after January 1, 1989, but before January 1, 2005; and $6,000 for married persons (one-half of such amounts in the case of a married individual filing a separate return) for taxable years beginning on and after January 1, 2005; provided that the taxpayer has not itemized deductions for the taxable year on his federal income tax return. For purposes of this section, any person who may be claimed as a dependent on another taxpayer's return for the taxable year may compute the deduction only with respect to earned income.

2. a. A deduction in the amount of $800 for taxable years beginning on and after January 1, 1988, but before January 1, 2005, and $900 for taxable years beginning on and after January 1, 2005, for each personal exemption allowable to the taxpayer for federal income tax purposes.

b. For taxable years beginning on and after January 1, 1987, each blind or aged taxpayer as defined under § 63 (f) of the Internal Revenue Code shall be entitled to an additional personal exemption in the

amount of $800.

The additional deduction for blind or aged taxpayers allowed under this subdivision shall be allowable regardless of whether the taxpayer itemizes deductions for the taxable year for federal income tax purposes.

3. A deduction equal to the amount of employment-related expenses upon which the federal credit is based under § 21 of the Internal Revenue Code for expenses for household and dependent care services necessary for gainful employment.

4. An additional $1,000 deduction for each child residing for the entire taxable year in a home under permanent foster care placement as defined in § 63.2-908, provided the taxpayer can also claim the child as a personal exemption under § 151 of the Internal Revenue Code.

5. a. Effective for all taxable years beginning on or after January 1, 1996, but before January 1, 2004, a deduction in the amount of $12,000 for taxpayers age 65 or older, or $6,000 for taxpayers age 62 through 64.

b. For taxable years beginning on and after January 1, 2004, a deduction in the amount of $12,000 for individuals born on or before January 1, 1939.

c. For taxable years beginning January 1, 2004, but before January 1, 2005, a deduction in the amount of $6,000 for individuals born on or between January 2, 1940, and January 1, 1942.

d. For taxable years beginning January 1, 2005, but before January 1, 2006, a deduction in the amount of $6,000 for individuals born on or between January 2, 1941, and January 1, 1942.

e. For taxable years beginning on and after January 1, 2004, a deduction in the amount of $12,000 for individuals born after January 1, 1939, who have attained the age of 65. This deduction shall be reduced by $1 for every $1 that the taxpayer's adjusted federal adjusted gross income exceeds $50,000 for single taxpayers or $75,000 for married taxpayers. For married taxpayers filing separately, the deduction will be reduced by $1 for every $1 the total combined adjusted federal adjusted gross income of both spouses exceeds $75,000.

f. For the purposes of this subdivision, "adjusted federal adjusted gross income" means federal adjusted gross income minus any benefits received under Title II of the Social Security Act and other benefits subject to federal income taxation solely pursuant to § 86 of the Internal Revenue Code, as amended.

6. For taxable years beginning on and after January 1, 1997, the amount an individual pays as a fee for an initial screening to become a possible bone marrow donor, if (i) the individual is not reimbursed for such fee or (ii) the individual has not claimed a deduction for the payment of such fee on his federal income tax return.

7. a. A deduction shall be allowed to the purchaser or contributor for the amount paid or contributed during the taxable year for a prepaid tuition contract or savings trust account entered into with the Virginia College Savings Plan, pursuant to Chapter 4.9 (§ 23-38.75 et seq.) of Title 23. Except as provided in subdivision 7 c, the amount deducted on any individual income tax return in any taxable year shall be limited to $2,000 per prepaid tuition contract or savings trust account. No deduction shall be allowed pursuant to this section if such payments or contributions are deducted on the purchaser's or contributor's federal income tax return. If the purchase price or annual contribution to a savings trust account exceeds $2,000, the remainder may be carried forward and subtracted in future taxable years until the purchase price or savings trust contribution has been fully deducted; however, except as provided in subdivision 7 c, in no event shall the amount deducted in any taxable year exceed $2,000 per contract or savings trust account. Notwithstanding the statute of limitations on assessments contained in § 58.1-312, any deduction taken hereunder shall be subject to recapture in the taxable year or years in which distributions or refunds are made for any reason other than (i) to pay qualified higher education expenses, as defined in § 529 of the Internal Revenue Code or (ii) the beneficiary's death, disability, or receipt of a scholarship. For the purposes of this subdivision, the term "purchaser" or "contributor" means the person shown as such on the records of the Virginia College Savings Plan as of December 31 of the taxable year. In the case of a transfer of ownership of a prepaid tuition contract or savings trust account, the transferee shall succeed to the transferor's tax attributes associated with a prepaid tuition contract or savings trust account, including, but not limited to, carryover and recapture of deductions.

b. The amount paid for a prepaid tuition contract during taxable years beginning on or after January 1, 1996, but before January 1, 1998, shall be deducted in taxable years beginning on or after January 1, 1998, and shall be subject to the limitations set out in subdivision 7 a.

c. A purchaser of a prepaid tuition contract or contributor to a savings trust account who has attained age 70 shall not be subject to the limitation that the amount of the deduction not exceed $2,000 per prepaid tuition contract or savings trust account in any taxable year. Such taxpayer shall be allowed a deduction for the full amount paid for the contract or contributed to a savings trust account, less any amounts previously deducted. If a prepaid tuition contract was purchased by such taxpayer during taxable years beginning on or after January 1, 1996, but before January 1, 1998, such taxpayer may take the deduction for the full amount paid during such years, less any amounts previously deducted with respect to such payments, in taxable year 1999 or by filing an amended return for taxable year 1998.

8. For taxable years beginning on and after January 1, 2000, the total amount an individual actually

contributed in funds to the Virginia Public School Construction Grants Program and Fund, established in Chapter 11.1 (§ 22.1-175.1 et seq.) of Title 22.1, provided the individual has not claimed a deduction for such amount on his federal income tax return.

9. For taxable years beginning on and after January 1, 1999, an amount equal to 20 percent of the tuition costs incurred by an individual employed as a primary or secondary school teacher licensed pursuant to Chapter 15 (§ 22.1-289.1 et seq.) of Title 22.1 to attend continuing teacher education courses that are required as a condition of employment; however, the deduction provided by this subsection shall be available only if (i) the individual is not reimbursed for such tuition costs and (ii) the individual has not claimed a deduction for the payment of such tuition costs on his federal income tax return.

10. For taxable years beginning on and after January 1, 2000, the amount an individual pays annually in premiums for long-term health care insurance, provided the individual has not claimed a deduction for federal income tax purposes, *or a credit under § 58.1-339.11.*

E. There shall be added to or subtracted from federal adjusted gross income, as the case may be, the individual's share, as beneficiary of an estate or trust, of the Virginia fiduciary adjustment determined under § 58.1-361.

F. There shall be added or subtracted, as the case may be, the amounts provided in § 58.1-315 as transitional modifications.

§ 58.1-339.11. Long-term care insurance tax credit.

A. For taxable years beginning on or after January 1, 2006, any individual shall be entitled to a credit against the tax levied pursuant to § 58.1-320 for certain long-term care insurance premiums paid by the individual during the taxable year pursuant to an insurance policy entered into on or after January 1, 2006. The amount of the credit for each taxable year shall equal 15% of the amount paid by the individual during the taxable year in long-term care insurance premiums for long-term care insurance coverage for himself, but in no event shall the total credits over the life of any policy exceed 15% of the amount of premiums paid for the first 12 months of coverage. For purposes of this section, "long-term care insurance premium" means the amount paid during a taxable year for any qualified long-term care insurance contract as defined in § 7702B(b) of the Internal Revenue Code, as amended, covering an individual.

B. If the amount of the credit as determined in subsection A exceeds the individual's income tax liability for the taxable year, the amount that exceeds such liability may be carried over for credit against the income taxes of such individual in the next five taxable years or until the full credit is used, whichever occurs first.

C. The credit described in this section shall not be claimed to the extent the individual has claimed a deduction for federal income tax purposes for long-term care insurance premiums for himself or a deduction under subdivision D 10 of § 58.1-322.

D. The Tax Commissioner shall establish guidelines regarding the information to include and the format for proof of payment. Such guidelines shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.).

CHAPTER 369

An Act to amend and reenact § 19.2-182.8 of the Code of Virginia, relating to revocation of conditional release; expedited hearing.

[S 288]

Approved March 30, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 19.2-182.8 of the Code of Virginia is amended and reenacted as follows:

§ 19.2-182.8. Revocation of conditional release.

If at any time the court that released an acquittee pursuant to § 19.2-182.7 finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, it may order an evaluation of the acquittee by a psychiatrist or clinical psychologist, provided the psychiatrist or clinical psychologist is qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) is mentally ill or mentally retarded and requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner.

At any hearing pursuant to this section, the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. *The hearing shall be scheduled on an expedited basis and shall be given priority over other civil matters before the court.* Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The hearing is a civil proceeding.

CHAPTER 370

An Act to amend and reenact §§ 19.2-182.8 and 19.2-182.9 of the Code of Virginia, relating to not guilty by reason of insanity; conditional release.

[S 289]

Approved March 30, 2006

Be it enacted by the General Assembly of Virginia:

1. That §§ 19.2-182.8 and 19.2-182.9 of the Code of Virginia are amended and reenacted as follows:

§ 19.2-182.8. Revocation of conditional release.

If at any time the court that released an acquittee pursuant to § 19.2-182.7 finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, it may order an evaluation of the acquittee by a psychiatrist or clinical psychologist, provided the psychiatrist or clinical psychologist is qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) is mentally ill or mentally retarded and requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner. *An acquittee's conditional release shall not be revoked solely because of his voluntary hospital admission.*

At any hearing pursuant to this section, the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The hearing is a civil proceeding.

§ 19.2-182.9. Emergency custody of conditionally released acquittee.

When exigent circumstances do not permit compliance with revocation procedures set forth in § 19.2-182.8, any district court judge or a special justice, as defined in § 37.2-100, or a magistrate may issue an emergency custody order, upon the sworn petition of any responsible person or upon his own motion based upon probable cause to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) requires inpatient hospitalization. The emergency custody order shall require the acquittee within his judicial district to be taken into custody and transported to a convenient location where a person designated by the community services board or behavioral health authority who is skilled in the diagnosis and treatment of mental illness shall evaluate such acquittee and assess his need for inpatient hospitalization. A law-enforcement officer who, based on his observation or the reliable reports of others, has probable cause to believe that any acquittee on conditional release has violated the conditions of his release and is no longer a proper subject for conditional release and requires emergency evaluation to assess the need for inpatient hospitalization, may take the acquittee into custody and transport him to an appropriate location to assess the need for hospitalization without prior judicial authorization. The evaluation shall be conducted immediately. The acquittee shall remain in custody until a temporary detention order is issued or until he is released, but in no event shall the period of custody exceed four hours. If it appears from all evidence readily available (i) that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) that he requires emergency evaluation to assess the need for inpatient hospitalization, the district court judge or a special justice, as defined in § 37.2-100, or magistrate, upon the advice of such person skilled in the diagnosis and treatment of mental illness, may issue a temporary detention order authorizing the executing officer to place the acquittee in an appropriate institution for a period not to exceed 48 hours prior to a hearing. If the 48-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the acquittee may be detained until the next day which is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.

The committing court or any district court judge or a special justice, as defined in § 37.2-100, shall have jurisdiction to hear the matter. Prior to the hearing, the acquittee shall be examined by a psychiatrist or licensed clinical psychologist, provided the psychiatrist or clinical psychologist is skilled in the diagnosis of mental illness, who shall certify whether the person is in need of hospitalization. At the hearing the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the

right to introduce evidence and cross-examine witnesses at the hearing. Following the hearing, if the court determines, based on a preponderance of the evidence presented at the hearing, that the acquittee (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) has mental illness or mental retardation and is in need of inpatient hospitalization, the court shall revoke the acquittee's conditional release and place him in the custody of the Commissioner. *An acquittee's conditional release shall not be revoked solely because of his voluntary hospital admission.*

When an acquittee on conditional release pursuant to this chapter is taken into emergency custody, detained, or hospitalized, such action shall be considered to have been taken pursuant to this section, notwithstanding the fact that his status as an insanity acquittee was not known at the time of custody, detention, or hospitalization. Detention or hospitalization of an acquittee pursuant to provisions of law other than those applicable to insanity acquittees pursuant to this chapter shall not render the detention or hospitalization invalid. If a person's status as an insanity acquittee on conditional release is not recognized at the time of emergency custody or detention, at the time his status as such is verified, the provisions applicable to such persons shall be applied and the court hearing the matter shall notify the committing court of the proceedings.

CHAPTER 178

An Act to amend and reenact § 30-170 of the Code of Virginia, relating to the Joint Commission on Health Care.

[S 438]

Approved March 23, 2006

Be it enacted by the General Assembly of Virginia:

1. That § 30-170 of the Code of Virginia is amended and reenacted as follows:

§ 30-170. (Effective until July 1, ~~2007~~ *2010*) Sunset.

The provisions of this chapter shall expire on July 1, ~~2007~~ *2010.*

062033136

HOUSE JOINT RESOLUTION NO. 96

Offered January 11, 2006

Prefiled January 10, 2006

Encouraging the Board and Department of Education and the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities to take certain actions to improve the education and treatment of individuals with autism spectrum disorders.

Patrons—Hamilton, Brink and Morgan

Referred to Committee on Rules

WHEREAS, autism spectrum disorders (ASDs), as characterized by the National Institute of Mental Health (NIMH), cause "varying degrees of impairment in communication skills, social interactions, and restricted, repetitive and stereotypical patterns of behavior"; and

WHEREAS, most often diagnosed in early childhood, ASDs range from severe (autistic disorder) "through pervasive development disorder not otherwise specified (PDD-NOS), to a much milder form, Asperger syndrome"; and

WHEREAS, as noted on the NIMH website, "[t]there is no single best treatment package for all children with ASD"; and

WHEREAS, while noting that autism was only added to special education in 1991, the Centers for Disease Control and Prevention (CDC) acknowledges that the number of children classified as having ASD for purposes of special education services has increased "six-fold" from 1994 to 2003 and also recognizes that "it is clear that more children than ever before are being classified as having an Autism Spectrum Disorder"; and

WHEREAS, the CDC prevalence rates for ASDs have been summarized as "between 1 in 500 (2/1,000) to 1 in 166 children (6/1,000)"; and

WHEREAS, a 2001 study entitled Services Available for Individuals with Autism and Pervasive Developmental Disorders found "[f]ew professionals indicated that they received adequate preparation to teach children with autism during their preservice training programs and many indicated limited satisfaction with both their access to inservice training and the usefulness of the training they received"; and

WHEREAS, the 2001 study also indicated that there is a teacher shortage in special education; therefore, since that time, the Department of Education has provided additional training opportunities to teachers serving students with disabilities such as autism spectrum disorders through Training and Technical Assistance Centers that are located in the eight superintendent's regions around the Commonwealth; and

WHEREAS, in recent years, some additional training opportunities for teachers of children with ASDs have become available, such as the Department of Education's Autism Priority Project Teams, George Mason University's online training program, and various courses offered by Virginia Commonwealth University, Regent University, and James Madison University as well as other Virginia institutions of higher education; and

WHEREAS, the Behavioral Health Care Subcommittee of the Joint Commission on Health Care has received presentations from school division representatives relating to the challenges of serving children with ASDs and did unanimously approve on November 10, 2005, the introduction of this resolution and the continuation of the study of autism in its 2006 workplan; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board and Department of Education and the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities be encouraged to take certain actions to improve the education and treatment of individuals with autism spectrum disorders. During the regulatory review and public comment periods for the proposed revisions to the Regulations Governing the Review and Approval of Education Programs in Virginia and the Virginia Licensure Regulations for School Personnel, the Board and Department of Education are urged to continue to implement initiatives designed to strengthen teacher qualifications, to include preservice and inservice professional development opportunities relating to the effective treatment of autism spectrum disorders, and to consider the treatment of autism spectrum disorders. Further, the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities are urged to continue to expand training opportunities that include approaches specifically addressing the needs of children with autism spectrum disorders; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit a copy of this resolution

to the President of the Board of Education and the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, requesting that they further disseminate copies of this resolution to their respective constituents so that they may be apprised of the sense of the General Assembly of Virginia in this matter.

HOUSE JOINT RESOLUTION NO. 97

Requesting the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services. Report.

Agreed to by the House of Delegates, February 10, 2006
Agreed to by the Senate, February 28, 2006

WHEREAS, House Bill No. 2601 (2005) was introduced to allow the Department of Medical Assistance Services to seek a waiver of the Social Security Act, 42 U.S.C. 1315, § 1115, to create more restrictive asset transfer limits than those currently allowed under federal law or regulations; and

WHEREAS, the introduction of HB No. 2601 raised a variety of issues related to individuals disposing of assets to gain access to Medicaid long-term care services; and

WHEREAS, the Joint Legislative Audit and Review Commission completed a study over a decade ago entitled Medicaid Asset Transfers and Estate Recovery Senate Document 10 (1993) that addressed the impact of Medicaid asset transfers in Virginia; and

WHEREAS, the federal Omnibus Budget Reconciliation Act of 1993 imposed additional restrictions on Medicaid asset transfers after the conclusion of the Joint Legislative Audit and Review Commission study; and

WHEREAS, the Joint Commission on Health Care, in response to Commission member requests, conducted a review of Medicaid asset transfer issues and found that other than anecdotal evidence, current data is not available on the extent of Medicaid asset transfer abuses in Virginia; and

WHEREAS, federal legislation has been proposed to reform Medicaid asset transfer rules; and

WHEREAS, states have primary responsibility for enforcement of Medicaid asset transfer limitations; and

WHEREAS, the Department of Medical Assistance Services is the state agency charged with the administration of Medicaid funds and determining eligibility; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission be requested to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services.

For the purpose of advising the General Assembly and the Governor, the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission shall monitor pending federal legislation concerning Medicaid asset transfers to (i) evaluate the potential impact of proposed changes in federal law and their correlation to Virginia law; (ii) ascertain reports and analyses prepared in connection with the proposed federal legislation; (iii) review the practice by which persons transfer, convert, give away, or otherwise shelter assets to become eligible for Medicaid long-term care services; (iv) recommend options available to limit the financial impact of sheltering assets for Medicaid qualification on the Commonwealth upon the passage of any such federal legislation; and (v) apprise the General Assembly concerning any changes in state law regarding asset sheltering that may be necessary.

Technical assistance shall be provided to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, to accomplish the objectives of this resolution, by the Departments of Social Services and Taxation. All agencies of the Commonwealth shall provide assistance to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, upon request.

The Commissioner of the Department of Medical Assistance Services and the Chairman of the Joint Legislative Audit and Review Commission shall jointly submit to the Division of Legislative Automated Systems an executive summary and report of their progress in meeting the requests of this resolution no later than the first day of 2007 Regular Session of the General Assembly. The executive summary and report shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

ENROLLED

SENATE JOINT RESOLUTION NO. 122

Requesting the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services. Report.

Agreed to by the Senate, March 8, 2006
Agreed to by the House of Delegates, March 6, 2006

WHEREAS, House Bill No. 2601 (2005) was introduced to allow the Department of Medical Assistance Services to seek a waiver of § 1115 of the Social Security Act, 42 U.S.C. 1315, to create more restrictive asset transfer limits than those currently allowed under federal law or regulations; and

WHEREAS, the introduction of House Bill No. 2601 raised a variety of issues related to individuals disposing of assets to gain access to Medicaid long-term care services; and

WHEREAS, the Joint Legislative Audit and Review Commission completed a study over a decade ago entitled *Medicaid Asset Transfers and Estate Recovery*, Senate Document 10 (1993), that addressed the impact of Medicaid asset transfers in Virginia; and

WHEREAS, the federal Omnibus Budget Reconciliation Act of 1993 imposed additional restrictions on Medicaid asset transfers after the conclusion of the Joint Legislative Audit and Review Commission study; and

WHEREAS, the Joint Commission on Health Care, in response to Commission member requests, conducted a review of Medicaid asset transfer issues and found that, other than anecdotal evidence, current data is not available on the extent of Medicaid asset transfer abuses in Virginia; and

WHEREAS, federal legislation has been proposed to reform Medicaid asset transfer rules; and

WHEREAS, states have primary responsibility for enforcement of Medicaid asset transfer limitations; and

WHEREAS, the Virginia Department of Medical Assistance Services is the state agency charged with the administration of Medicaid funds and determining eligibility; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission be requested to monitor changes in federal restrictions on sheltering assets to qualify for Medicaid long-term care services.

For the purpose of advising the General Assembly and the Governor, the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission shall monitor pending federal legislation concerning Medicaid asset transfers to (i) evaluate the potential impact of proposed changes in federal law and their correlation to Virginia law; (ii) ascertain reports and analyses prepared in connection with the proposed federal legislation; (iii) review the practice by which persons transfer, convert, give away, or otherwise shelter assets to become eligible for Medicaid long-term care services; (iv) recommend options available to limit the financial impact of sheltering assets for Medicaid qualification on the Commonwealth upon the passage of any such federal legislation; and (v) apprise the General Assembly concerning any changes in state law regarding asset sheltering that may be necessary.

Technical assistance shall be provided to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, to accomplish the objectives of this resolution, by the Departments of Social Services and Taxation. All agencies of the Commonwealth shall provide assistance to the Department of Medical Assistance Services and the Joint Legislative Audit and Review Commission, upon request.

The Commissioner of the Department of Medical Assistance Services and the Chairman of the Joint Legislative Audit and Review Commission shall jointly submit to the Division of Legislative Automated Systems an executive summary and report of their progress in meeting the requests of this resolution no later than the first day of the 2007 Regular Session of the General Assembly. The executive summary and report shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

SENATE JOINT RESOLUTION NO. 125

Encouraging the Board and Department of Education and the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities to take certain actions to improve the education and treatment of individuals with autism spectrum disorders.

Agreed to by the Senate, February 8, 2006
Agreed to by the House of Delegates, March 6, 2006

WHEREAS, autism spectrum disorders (ASDs), as characterized by the National Institute of Mental Health (NIMH), cause "varying degrees of impairment in communication skills, social interactions, and restricted, repetitive and stereotypical patterns of behavior"; and

WHEREAS, most often diagnosed in early childhood, ASDs range from severe (autistic disorder) "through pervasive development disorder not otherwise specified (PDD-NOS), to a much milder form, Asperger syndrome"; and

WHEREAS, as noted on the NIMH website, "[t]here is no single best treatment package for all children with ASD"; and

WHEREAS, while noting that autism was only added to special education in 1991, the Centers for Disease Control and Prevention (CDC) acknowledges that the number of children classified as having ASD for purposes of special education services has increased "six-fold" from 1994 to 2003 and also recognizes that "it is clear that more children than ever before are being classified as having an Autism Spectrum Disorder"; and

WHEREAS, the CDC prevalence rates for ASDs have been summarized as "between 1 in 500 (2/1,000) to 1 in 166 children (6/1,000)"; and

WHEREAS, a 2001 study entitled *Services Available for Individuals with Autism and Pervasive Developmental Disorders* found "[f]ew professionals indicated that they received adequate preparation to teach children with autism during their preservice training programs and many indicated limited satisfaction with both their access to inservice training and the usefulness of the training they received"; and

WHEREAS, the 2001 study also indicated that there is a teacher shortage in special education; therefore, since that time, the Department of Education has provided additional training opportunities to teachers serving students with disabilities, such as autism spectrum disorders, through Training and Technical Assistance Centers that are located in the eight superintendents' regions around the Commonwealth; and

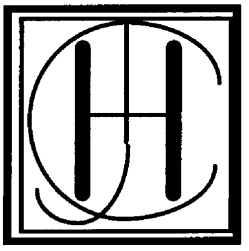
WHEREAS, in recent years, some additional training opportunities for teachers of children with ASDs have become available, such as the Department of Education's Autism Priority Project Teams, George Mason University's online training program, and various courses offered by Virginia Commonwealth University, Regent University, and James Madison University as well as other Virginia institutions of higher education; and

WHEREAS, the Behavioral Health Care Subcommittee of the Joint Commission on Health Care has received presentations from school division representatives relating to the challenges of serving children with ASDs and did unanimously approve on November 10, 2005, the introduction of this resolution and the continuation of the study of autism in its 2006 workplan; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Board and Department of Education and the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities be encouraged to take certain actions to improve the education and treatment of individuals with autism spectrum disorders. During the regulatory review and public comment periods for the proposed revisions to the Regulations Governing the Review and Approval of Education Programs in Virginia and the Virginia Licensure Regulations for School Personnel, the Board and Department of Education are urged to continue to implement initiatives designed to strengthen teacher qualifications, to include preservice and inservice professional development opportunities relating to the effective treatment of autism spectrum disorders, and to consider the treatment of autism spectrum disorders. Further, the Board and Department of Education are urged to examine appropriate educational placements considering the individualized educational plans of autistic students, the effects of mainstreaming, and the feasibility of alternative placements in public and private schools having qualified staff and adequate facilities. Finally, the Board and Department of Mental Health, Mental Retardation and Substance Abuse Services and other relevant entities are urged to continue to expand training opportunities that include approaches specifically addressing the needs of children with autism spectrum disorders; and, be it

RESOLVED FURTHER, That the Clerk of the Senate transmit a copy of this resolution to the

President of the Board of Education and the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, requesting that they further disseminate copies of this resolution to their respective constituents so that they may be apprised of the sense of the General Assembly of Virginia in this matter.



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