

## 1 VIRGINIA ACTS OF ASSEMBLY — CHAPTER

2 *An Act to amend and reenact § 32.1-325 of the Code of Virginia, relating to Department of Medical*  
 3 *Assistance Services; remote monitoring services through pregnancy and postpartum for high-risk*  
 4 *pregnant patients and patients with advanced maternal age; reimbursement.*

5 [H 425]

6 Approved

7 **Be it enacted by the General Assembly of Virginia:**8 **1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:**9 **§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and**  
 10 **Human Services pursuant to federal law; administration of plan; contracts with health care providers.**11 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time,  
 12 and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services  
 13 pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall  
 14 include in such plan:15 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in  
 16 foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the  
 17 Department of Social Services or placed through state and local subsidized adoptions to the extent permitted  
 18 under federal statute;19 2. A provision for determining eligibility for benefits for medically needy individuals which disregards  
 20 from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of  
 21 \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual  
 22 or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an  
 23 individual owned by the individual or his spouse if the cash surrender value of such policies has been  
 24 excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or  
 25 other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial  
 26 expenses;27 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy  
 28 persons whose eligibility for medical assistance is required by federal law to be dependent on the budget  
 29 methodology for Aid to Families with Dependent Children, a home means the house and lot used as the  
 30 principal residence and all contiguous property. For all other persons, a home shall mean the house and lot  
 31 used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive  
 32 of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of home as  
 33 provided here is more restrictive than that provided in the state plan for medical assistance services in  
 34 Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal  
 35 residence and all contiguous property essential to the operation of the home regardless of value;36 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are  
 37 Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;38 5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance  
 39 of the individual's spouse at home;40 6. A provision for payment of medical assistance on behalf of pregnant women which provides for  
 41 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most  
 42 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American  
 43 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for  
 44 Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.  
 45 Payment shall be made for any postpartum home visit or visits for the mothers and the children which are  
 46 within the time periods recommended by the attending physicians in accordance with and as indicated by  
 47 such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include  
 48 any changes thereto within six months of the publication of such Guidelines or Standards or any official  
 49 amendment thereto;50 7. A provision for the payment for family planning services on behalf of women who were Medicaid-  
 51 eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning  
 52 services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the  
 53 financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section,  
 54 family planning services shall not cover payment for abortion services and no funds shall be used to perform,  
 55 assist, encourage or make direct referrals for abortions;

56 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow

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

61 9. A provision identifying entities approved by the Board to receive applications and to determine  
62 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate  
63 contact information, including the best available address and telephone number, from each applicant for  
64 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant for  
65 medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et seq.) of  
66 Chapter 29 of Title 54.1, including information about the purpose and benefits of advance directives and how  
67 the applicant may make an advance directive;

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

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

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

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

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

85 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40  
86 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the  
87 American Cancer Society, for prostate cancer screening, which includes one prostate-specific antigen test in a  
88 12-month period and digital rectal examinations;

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

96 17. A provision, when in compliance with federal law and regulation and approved by the Centers for  
97 Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to  
98 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program  
99 and may be provided by school divisions, regardless of whether the student receiving care has an  
100 individualized education program or whether the health care service is included in a student's individualized  
101 education program. Such services shall include those covered under the state plan for medical assistance  
102 services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in §  
103 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for  
104 health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care  
105 provider who provides health care services through telemedicine shall be required to use proprietary  
106 technology or applications in order to be reimbursed for providing telemedicine services;

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

118 19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening

119 with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate  
120 circumstances radiologic imaging, in accordance with the most recently published recommendations  
121 established by the American College of Gastroenterology, in consultation with the American Cancer Society,  
122 for the ages, family histories, and frequencies referenced in such recommendations;

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

124 21. A provision for payment for medical assistance for infant hearing screenings and all necessary  
125 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United  
126 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant  
127 Hearing in its most current position statement addressing early hearing detection and intervention programs.  
128 Such provision shall include payment for medical assistance for follow-up audiological examinations as  
129 recommended by a physician, physician assistant, advanced practice registered nurse, or audiologist and  
130 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

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

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

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

154 25. A provision for the payment of medical assistance for otherwise eligible pregnant women during the  
155 first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance  
156 Program Reauthorization Act of 2009 (P.L. 111-3);

157 26. A provision for the payment of medical assistance for medically necessary health care services  
158 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or  
159 whether the patient is accompanied by a health care provider at the time such services are provided. No health  
160 care provider who provides health care services through telemedicine services shall be required to use  
161 proprietary technology or applications in order to be reimbursed for providing telemedicine services.

162 For the purposes of this subdivision, a health care provider duly licensed by the Commonwealth who  
163 provides health care services exclusively through telemedicine services shall not be required to maintain a  
164 physical presence in the Commonwealth to be considered an eligible provider for enrollment as a Medicaid  
165 provider.

166 For the purposes of this subdivision, a telemedicine services provider group with health care providers  
167 duly licensed by the Commonwealth shall not be required to have an in-state service address to be eligible to  
168 enroll as a Medicaid vendor or Medicaid provider group.

169 For the purposes of this subdivision, "originating site" means any location where the patient is located,  
170 including any medical care facility or office of a health care provider, the home of the patient, the patient's  
171 place of employment, or any public or private primary or secondary school or postsecondary institution of  
172 higher education at which the person to whom telemedicine services are provided is located;

173 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month  
174 supply of hormonal contraceptives at one time. Absent clinical contraindications, the Department shall not  
175 impose any utilization controls or other forms of medical management limiting the supply of hormonal  
176 contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. Nothing in this  
177 subdivision shall be construed to (i) require a provider to prescribe, dispense, or furnish a 12-month supply of  
178 self-administered hormonal contraceptives at one time or (ii) exclude coverage for hormonal contraceptives  
179 as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive  
180 purposes. As used in this subdivision, "hormonal contraceptive" means a medication taken to prevent

181 pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone,  
182 that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration  
183 for such purpose;

184 28. A provision for payment of medical assistance for remote patient monitoring services provided via  
185 telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons *through 12 months postpartum*;  
186 (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone  
187 surgery, for up to three months following the date of such surgery; and (v) patients with a chronic or acute  
188 health condition who have had two or more hospitalizations or emergency department visits related to such  
189 health condition in the previous 12 months when there is evidence that the use of remote patient monitoring is  
190 likely to prevent readmission of such patient to a hospital or emergency department. For the purposes of this  
191 subdivision, "remote patient monitoring services" means the use of digital technologies to collect medical and  
192 other forms of health data from patients in one location and electronically transmit that information securely  
193 to health care providers in a different location for analysis, interpretation, and recommendations, and  
194 management of the patient. "Remote patient monitoring services" includes monitoring of clinical patient data  
195 such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data,  
196 treatment adherence monitoring, and interactive videoconferencing with or without digital image upload;

197 29. A provision for the payment of medical assistance for provider-to-provider consultations that is no  
198 more restrictive than, and is at least equal in amount, duration, and scope to, that available through the fee-  
199 for-service program;

200 30. A provision for payment of the originating site fee to emergency medical services agencies for  
201 facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As used  
202 in this subdivision, "originating site" means any location where the patient is located, including any medical  
203 care facility or office of a health care provider, the home of the patient, the patient's place of employment, or  
204 any public or private primary or secondary school or postsecondary institution of higher education at which  
205 the person to whom telemedicine services are provided is located;

206 31. A provision for the payment of medical assistance for targeted case management services for  
207 individuals with severe traumatic brain injury;

208 32. A provision for payment of medical assistance for the initial purchase or replacement of complex  
209 rehabilitative technology manual and power wheelchair bases and related accessories, as defined by the  
210 Department's durable medical equipment program policy, for patients who reside in nursing facilities. Initial  
211 purchase or replacement may be contingent upon (i) determination of medical necessity; (ii) requirements in  
212 accordance with regulations established through the Department's durable medical equipment program  
213 policy; and (iii) exclusive use by the nursing facility resident. Recipients of medical assistance shall not be  
214 required to pay any deductible, coinsurance, copayment, or patient costs related to the initial purchase or  
215 replacement of complex rehabilitative technology manual and power wheelchair bases and related  
216 accessories;

217 33. A provision for payment of medical assistance for remote ultrasound procedures and remote fetal non-  
218 stress tests. Such provision shall utilize established CPT codes for these procedures and shall apply when the  
219 patient is in a residence or other off-site location from the patient's provider that provides the same standard  
220 of care. The provision shall provide for reimbursement only when a provider uses digital technology (i) to  
221 collect medical and other forms of health data from a patient and electronically transmit that information  
222 securely to a health care provider in a different location for interpretation and recommendation; (ii) that is  
223 compliant with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et  
224 seq.); and (iii) that is approved by the U.S. Food and Drug Administration. For fetal non-stress tests under  
225 CPT Code 59025, the provision shall provide for reimbursement only if such test (a) is conducted with a  
226 place of service modifier for at-home monitoring and (b) uses remote monitoring solutions that are approved  
227 by the U.S. Food and Drug Administration for on-label use to monitor fetal heart rate, maternal heart rate,  
228 and uterine activity;

229 34. A provision for payment of medical assistance for the prophylaxis, diagnosis, and treatment of  
230 pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-  
231 onset neuropsychiatric syndrome. Such provision shall include payment for treatment using antimicrobials,  
232 medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines,  
233 plasma exchange, and intravenous immunoglobulin therapy. For the purposes of this subdivision:

234 "Pediatric acute-onset neuropsychiatric syndrome" or "PANS" means a clinically defined disorder  
235 characterized by the sudden onset of obsessive-compulsive symptoms (OCD) or eating restrictions,  
236 concomitant with acute behavioral deterioration in at least two designated domains. Comorbid PANS  
237 symptoms may include anxiety, sensory amplification or motor abnormalities, behavioral regression,  
238 deterioration in school performance, mood disorder, urinary symptoms, or sleep disturbances. PANS does not  
239 require a known trigger, although it is believed to be triggered by one or more pathogens.

240 "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" or  
241 "PANDAS" means a subset of PANS that has five distinct criteria for diagnosis, including (i) abrupt  
242 "overnight" OCD or dramatic, disabling tics; (ii) a relapsing-remitting, episodic symptom course; (iii) young

243 age at onset; (iv) presence of neurologic abnormalities; and (v) temporal association between symptom onset  
 244 and Group A streptococcal infection. The five criteria of PANDAS are usually accompanied by similar  
 245 comorbid symptoms as found in PANS;

246 35. A provision for payment of medical assistance for rapid whole genome sequencing for children three  
 247 years of age or younger who are receiving inpatient hospital services in an intensive care unit. For the  
 248 purposes of this subdivision, "rapid whole genome sequencing" is defined as an investigation of the entire  
 249 human genome to identify disease-causing genetic changes that returns preliminary positive results within  
 250 seven days and final results within 15 days from the date of receipt of the sample by the lab performing the  
 251 test. "Rapid whole genome sequencing" includes patient-only whole genome sequencing and duo and trio  
 252 whole genome sequencing of the patient and biological parent or parents;

253 36. A provision for payment of medical assistance for comprehensive dental care services for pregnant  
 254 women. Such services shall include (i) preventive services, such as cleanings, oral exams, and x-rays; (ii)  
 255 diagnostic services, including periodontal assessments and consultations; (iii) restorative procedures,  
 256 including fillings, root canals, and crowns; (iv) emergency dental care to address acute pain and infection; (v)  
 257 periodontal treatment for gum disease, including deep cleanings; and (vi) any other dental services deemed  
 258 medically necessary by the Department in consultation with dentists, other dental professionals, and public  
 259 health experts. Such provision shall provide for at least four dental visits during pregnancy, with additional  
 260 visits permitted upon recommendation from a licensed dentist or obstetrician. The Department of Medical  
 261 Assistance Services shall report annually to the Governor and the General Assembly on the implementation  
 262 and outcomes of this act. The report shall include (i) the number of pregnant women who utilized expanded  
 263 dental services; (ii) analysis of the impact of the expanded dental services on maternal and infant health  
 264 outcomes; (iii) any barriers to access or service delivery; and (iv) recommendations for further improvement;  
 265 and

266 37. A provision for payment of medical assistance for postpartum doula care. Postpartum doula care  
 267 covered under such provision shall include (i) emotional and physical support for the birthing individual and  
 268 family during the postpartum period; (ii) assistance with infant care, breastfeeding, and safe sleeping  
 269 practices; (iii) education on postpartum mental health and referrals to mental health resources as needed; (iv)  
 270 guidance on physical recovery, nutrition, and self-care for the birthing individual; (v) connection to  
 271 community resources and social support systems; and (vi) culturally appropriate and individualized care  
 272 tailored to the birthing individual's needs. Such provision shall ensure that eligible individuals receive  
 273 payment of medical assistance services for up to 10 doula visits, with up to four doula visits during pregnancy  
 274 and up to six doula visits during the 12 months after the individual gives birth, with additional visits  
 275 permitted if such visits are deemed medically necessary. The Department of Medical Assistance Services  
 276 shall report annually to the Governor and the General Assembly on the implementation and outcomes of this  
 277 act. The report shall include (i) the number of postpartum individuals who utilized doula care services; (ii)  
 278 analysis of the impact of doula care services on maternal and infant health outcomes; (iii) feedback from  
 279 birthing individuals, families, and doula service providers; and (iv) recommendations for improvement or  
 280 expansion.

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

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

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

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

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

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

296 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other  
 297 technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each recipient of  
 298 medical assistance services, and shall upon any changes in the required data elements set forth in subsection  
 299 A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be  
 300 required to electronically process a prescription claim.

301 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for  
 302 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,  
 303 regardless of any other provision of this chapter, such amendments to the state plan for medical assistance  
 304 services as may be necessary to conform such plan with amendments to the United States Social Security Act

305 or other relevant federal law and their implementing regulations or constructions of these laws and  
306 regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

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

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

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

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

325 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or  
326 contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to  
327 Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42  
328 C.F.R. § 1002.212.

329 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or  
330 contract, with a provider who is or has been a principal in a professional or other corporation when such  
331 corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316,  
332 or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to  
333 42 C.F.R. Part 1002.

334 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of  
335 § 32.1-162.13.

336 For the purposes of this subsection, "provider" may refer to an individual or an entity.

337 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to  
338 subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a  
339 post-determination or post-denial hearing in accordance with the Administrative Process Act (§ 2.2-4000 et  
340 seq.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

341 The Director may consider aggravating and mitigating factors including the nature and extent of any  
342 adverse impact the agreement or contract denial or termination may have on the medical care provided to  
343 Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to subsection  
344 D, the Director may determine the period of exclusion and may consider aggravating and mitigating factors to  
345 lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.

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

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

360 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

381 K. When the services provided for by such plan are services by a pharmacist, pharmacy technician, or  
 382 pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and  
 383 consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to  
 384 services and treatment in accordance with § 54.1-3303.1, the Department shall provide reimbursement for  
 385 such service.

386 **2. That the Department of Medical Assistance Services (the Department) shall assess whether and to**  
 387 **what extent other states provide medical assistance services coverage for remote patient monitoring**  
 388 **services provided via telemedicine for pregnant persons 35 years of age or older at their estimated**  
 389 **delivery date through 12 months postpartum. The Department shall survey the type of medical**  
 390 **assistance services coverage provided for such persons in other states, costs associated with such**  
 391 **coverage, best practices in providing such coverage, and any other relevant information for the**  
 392 **General Assembly to consider regarding the expansion of medical assistance services coverage in the**  
 393 **Commonwealth to such populations, including whether age is a consideration in defining those eligible**  
 394 **for coverage. The Department shall submit a report on its findings to the Chairs of the Senate**  
 395 **Committees on Finance and Appropriations and Education and Health and the House Committees on**  
 396 **Appropriations and Health and Human Services no later than November 1, 2026.**