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HOUSE BILL NO. 733

Offered January 13, 2010
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A BILL to amend and reenact §§ 32.1-312, 32.1-314 through 32.1-317, 32.1-321.3, 32.1-321.4, and 32.1-325 of the Code of Virginia, relating to Medicaid fraud.

Patrons—Albo, Athey, Bell, Robert B., Byron, Cole, Cox, J.A., Hugo, Lingamfelter and Rust

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-312, 32.1-314 through 32.1-317, 32.1-321.3, 32.1-321.4, and 32.1-325 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-312. Fraudulently obtaining excess or attempting to obtain excess benefits or payments; penalty.

A. No person, agency or institution, but not including an individual medical assistance recipient of health care, on behalf of himself or others, whether under a contract or otherwise, shall obtain or attempt to obtain benefits or payments where the Commonwealth directly or indirectly provides any portion of the benefits or payments pursuant to the Plan for Medical Assistance and any amendments thereto as provided for in § 32.1-325, hereafter referred to as "medical assistance" in a greater amount than that to which entitled by ~~means of~~:

1. ~~A willful~~ *Knowingly and willfully making, causing to be made, or aiding and abetting in the making of any* false statement *or false representation of material fact*;

2. ~~By willful misrepresentation, or by willful concealment~~ *Knowingly and willfully concealing, causing to be concealed, or aiding and abetting in the concealing* of any material facts; or

3. ~~By other~~ *Engaging in any* fraudulent scheme or device, including, but not limited to, ~~billing~~ *submitting a claim* for services, drugs, supplies or equipment that were ~~unfurnished or were of a lower quality, or a substitution or misrepresentation of items billed~~ *not actually furnished to the person filing the claim; filing a claim for services, drugs, supplies, or equipment in a quantity or of a quality that is different from the quantity or quality actually furnished; or any other misrepresentation or substitution of services, drugs, supplies, or equipment for which the claim is filed.*

B. Any person, agency or institution knowingly *and willfully* violating any of the provisions of subsection A ~~of this section~~ shall be *(i)* liable for repayment of any excess benefits or payments received, plus interest on the amount of the excess benefits or payments at the rate of ~~1 1/2~~ *1.5* percent each month for the period from the date upon which payment was made to the date upon which repayment is made to the Commonwealth~~. Such person, agency or institution,~~ *and (ii)* in addition to any other penalties provided by law, ~~shall be~~ subject to civil penalties. The state Attorney General may petition the circuit court in the jurisdiction of the alleged offense, to seek an order assessing civil penalties in an amount not to exceed three times the amount of such excess benefits or payments. Such civil penalties shall not apply to any acts or omissions occurring prior to the effective date of this law.

C. A criminal action need not be brought against a person for that person to be civilly liable under this section.

D. Civil penalties shall be deposited in the general fund of the state treasury upon their receipt.

E. A civil action under this section shall be brought (i) within six years of the date on which the violation was committed, or (ii) within three years of the date when an official of the Commonwealth charged with the responsibility to act in the circumstances discovered or reasonably should have discovered the facts material to the cause of action. However, in no event shall the limitations period extend more than 10 years from the date on which the violation was committed.

§ 32.1-314. False statement or representation in applications for payment or for use in determining rights to payment; concealment of facts; penalty.

A. Any person who engages in the following activities shall be guilty of a felony punishable by a term of imprisonment of not less than one nor more than ~~twenty~~ *20* years, or in the discretion of the jury or the court trying the case without a jury, confinement in jail for not more than ~~twelve~~ *12* months and, in addition to such imprisonment or confinement, may be fined an amount not to exceed $25,000:

1. Knowingly and willfully making ~~or~~, causing to be made, *or aiding and abetting in the making of* any false statement or representation of a material fact in any application for any payment under medical assistance; ~~or~~

2. At any time knowingly and willfully making ~~or~~, causing to be made, *or aiding and abetting in the making of* any false statement or representation of a material fact for use in determining rights to such

payment, or knowingly and willfully falsifying, concealing or covering up by any trick, scheme or device a material fact, *causing a material fact to be falsified, concealed, or covered up in such a manner, or aiding and abetting in the falsifying, concealing, or covering up of a material fact in such a manner,* in connection with such application or payment; or

3. When having knowledge of the occurrence of any event affecting (i) the initial or continued right to any payment~~,~~ or (ii) the initial or continued right to any such payment of any other individual in whose behalf he has applied for or is receiving such payments, willfully concealing or failing to disclose such event, *causing such concealment or failure to disclose, or aiding and abetting the concealing or failure to disclose such an event* with an intent fraudulently to secure such payment either in a greater amount or quantity than is due or when no such payment is authorized.

B. The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.

§ 32.1-315. Solicitation or receipt of remuneration for certain services; offer or payment of remuneration for inducement of such services; penalty.

A. A person shall be guilty of a Class 6 felony and, in addition, may be fined an amount not to exceed $25,000, if he knowingly and willfully solicits or receives any remuneration, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in-kind, *causes such remuneration to be solicited or received, or aids and abets in the solicitation and receipt of such remuneration*:

1. In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under medical assistance; or

2. In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part under medical assistance.

B. A person shall be guilty of a Class 6 felony and, in addition, may be fined an amount not to exceed $25,000, if he knowingly and willfully offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in-kind to any person to induce such person, *causes such remuneration to be offered or paid, or aids and abets in the offering or payment of such remuneration*:

1. To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under medical assistance; or

2. To purchase, lease, order, or arrange for or recommend purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part under medical assistance.

C. Subsections A and B ~~of this section~~ shall not apply to:

1. A discount or other reduction in price obtained by a provider of services or other person under medical assistance, if the reduction in price is properly disclosed and appropriately reflected in the cost claimed or charges made by the provider or other person under medical assistance;

2. Any reasonable compensation paid by an employer to an employee who has a bona fide employment relationship with such employer, for employment in the provision of covered items or services;

3. An agreement by health care providers for the group purchase of equipment, goods, services, or supplies which results in fees paid to an agent of the providers, when such agreement has been presented to and authorized by the Department of Medical Assistance Services on the basis that the agreement will reduce the costs of providers of institutional services; and

4. Any remuneration, payment, business arrangement or payment practice that is not prohibited by 42 U.S.C. § 1320a-7b(b) or by any regulations adopted pursuant thereto.

D. The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.

§ 32.1-316. False statement or representation as to conditions or operations of institution or facility; penalty.

Any person who knowingly, willfully, and fraudulently makes or causes to be made, or induces or seeks to induce the making of, *or aids or abets in the making of* any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify, either upon initial certification or upon recertification, as a hospital, skilled nursing facility, intermediate care facility, or home care organization shall be guilty of a Class 6 felony. In addition thereto, a fine may be imposed in an amount not to exceed $5,000. *The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.*

§ 32.1-317. Collecting excess payment for services; charging, soliciting, accepting or receiving certain consideration as precondition for admittance to facility or requirement for continued stay; penalty.

When the cost of services provided in a facility or by an individual to a patient is paid for, in whole or in part, under medical assistance, any person who ~~knowingly and willfully~~:

1. ~~Collects~~ *Knowingly and willfully collects, causes to be collected, or aids and abets in the collecting* from a patient for any service provided under medical assistance, money or other consideration at a rate in excess of entitlements established by the Department of Medical Assistance Services; or

2. ~~Charges~~ *Knowingly and willfully charges*, solicits, accepts or receives, ~~in addition to any amount otherwise required to be paid under medical assistance~~ *or causes to be charged, solicited, accepted, or received, or aids and abets in the charging, soliciting, accepting, or receiving of* any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient, *in addition to any amount otherwise required to be paid under medical assistance*:

a. As a precondition of admitting a patient to a hospital, skilled nursing facility or intermediate care facility; or

b. As a requirement for the patient's continued stay in such facility;

shall be guilty of a Class 6 felony. In addition thereto, a fine may be imposed in an amount not to exceed $25,000. *The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.*

§ 32.1-321.3. Fraudulently obtaining benefits; liability for fraudulently issued benefits; civil action to recover; penalty.

Any person who, on behalf of himself or another, issues, obtains or attempts to obtain medical assistance benefits by means of (i) ~~willful~~ *knowingly and willfully making, causing to be made, or aiding and abetting in the making of any* false statement~~,~~ *or false representation of material fact;* (ii) ~~willful misrepresentation or concealment~~ *knowingly and willfully concealing, causing to be concealed, or aiding and abetting in the concealing* of a material fact~~,~~*;* or (iii) *engaging in* any other fraudulent scheme or device shall be liable for repayment of the cost of all benefits issued as a result of such fraud, plus interest on the amount of the benefits issued at the rate of ~~one and one-half~~ *1.5* percent per month for the period from the date upon which payment was made for such benefits to the date on which repayment is made to the Commonwealth.

Such matters may be referred for criminal action to the attorney for the Commonwealth having jurisdiction over the case. The Attorney General may, independent of any referral to or decision of the attorney for the Commonwealth, petition the circuit court in the jurisdiction of the alleged offense to seek an order assessing civil penalties in the amount of the benefits issued, in addition to repayment and interest and any other penalties provided by law.

All civil penalties shall be deposited in the general fund of the state treasury upon receipt.

§ 32.1-321.4. False statement or representation in applications for eligibility or for use in determining rights to benefits; concealment of facts; criminal penalty.

A. Any person who engages in the following activities, on behalf of himself or another, shall be guilty of larceny and, in addition to the penalties provided in §§ 18.2-95 and 18.2-96 as applicable, may be fined an amount not to exceed $10,000:

1. Knowingly and willfully making ~~or~~, causing to be made, *or aiding and abetting in the making of* any false statement or misrepresentation of a material fact in an application for eligibility, benefits or payments under medical assistance;

2. Knowingly and willfully falsifying, concealing or covering up by any trick, scheme, or device a material fact, *causing a material fact to be falsified, concealed, or covered up in such a manner, or aiding and abetting in the falsifying, concealing, or covering up of a material fact in such a manner,* in connection with an application for eligibility, benefits or payments;

3. Knowingly and willfully concealing or failing to disclose any event affecting the initial or continued right of any individual to any benefits or payment, *causing such concealment or failure to disclose, or aiding and abetting the concealing or failure to disclose such an event* with an intent to secure fraudulently such benefits or payment in a greater amount or quantity than is authorized or when no such benefit or payment is authorized;

4. Knowingly and willfully converting, *causing to be converted, or aiding and abetting in the converting of* any benefits or payment received pursuant to an application for another person and receipt of benefits or payment on behalf of such other person to use other than for the health and welfare of the other person; or

5. Knowingly and willfully failing to notify, *causing another to fail to notify, or aiding and abetting another in failing to notify* the local department of social services, through whom medical assistance benefits were obtained, of changes in the circumstances of any recipient or applicant which could result in the reduction or termination of medical assistance services.

B. It shall be the duty of the Director of Medical Assistance Services or his designee to enforce the provisions of this section. A warrant or summons may be issued for violations of which the Director or his designee has knowledge. Trial for violation of this section shall be held in the county or city in

which the application for medical assistance was made or obtained.

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

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

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

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

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

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

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

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

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

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

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

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

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

12. A provision for payment of medical assistance services for prostheses following the medically

necessary complete or partial removal of a breast for any medical reason;

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

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

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

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

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

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

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

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

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

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

eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;

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

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

B. In preparing the plan, the Board shall:

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

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

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

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

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

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

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

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

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

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

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new

agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract, *or elect to terminate an existing agreement or contract,* with any provider who has been convicted of ~~a~~ *or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316, or 32.1-317, or any other* felony, *or pursuant to 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 C.F.R. § 1002.212* .

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

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

E. In any case in which a Medicaid agreement or contract is *terminated or* denied to a provider ~~on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a~~ *pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a post-determination or post-denial* hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) ~~regarding the provider's participation in the conduct resulting in the conviction~~.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider *aggravating and mitigating factors including* the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients. *In cases in which an agreement or contract is terminated pursuant to subsection D, the Director may determine the period of exclusion and may consider to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.*

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

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

H. The Department of Medical Assistance Services shall:

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

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

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

4. Develop and implement a comprehensive system that utilizes external records search technologies and analytics technologies to detect, prevent, and investigate fraud, waste, and abuse in the medical assistance services program, specifically in the areas of provider enrollment, claims processing, and audits and investigations.

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

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

2. That the Director of the Department of Medical Assistance Services shall investigate options for the collection and review of data collected by public and private sources, including (i) data used to confirm the identity and eligibility of medical assistance services benefit recipients, (ii) data related to provider eligibility including information about providers' criminal history or sanctions against providers' in other states, and (iii) data about prepayment and postpayment claims, to detect, prevent and investigate fraud, waste and abuse in Virginia's medical assistance services program.