INTRODUCED

HB2232

23104056D

HOUSE BILL NO. 2232

Offered January 11, 2023 Prefiled January 11, 2023

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it shall become effective, of the Code of Virginia, relating to state plan for medical assistance services; violence prevention services.

Patrons—Murphy, Bennett-Parker, Bourne, Clark, Delaney, Guzman, Kory, Krizek, Lopez, Maldonado, Plum, Price, Seibold, Shin, Simon, Simonds, Subramanyam and Sullivan

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Referred to Committee on Health, Welfare and Institutions

11 Be it enacted by the General Assembly of Virginia:

12 1. That § 32.1-325, as it is currently effective and as it shall become effective, of the Code of 13 Virginia is amended and reenacted as follows:

§ 32.1-325. (Effective until date pursuant to Va. Const., Art. IV, § 13) Board to submit plan for
 medical assistance services to U.S. 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 U.S. Secretary 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 25 26 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount 27 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial 28 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value 29 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender 30 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 31 32 meeting the individual's or his spouse's burial expenses;

33 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically 34 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the 35 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used 36 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 37 38 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the 39 definition of home as provided here is more restrictive than that provided in the state plan for medical 40 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 41 regardless of value; 42

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

46 5. A provision for deducting from an institutionalized recipient's income an amount for the47 maintenance of the individual's spouse at home;

48 6. A provision for payment of medical assistance on behalf of pregnant women which provides for 49 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 50 51 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 52 53 children which are within the time periods recommended by the attending physicians in accordance with 54 55 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 56 57 or Standards or any official amendment thereto;

58 7. A provision for the payment for family planning services on behalf of women who were 59 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such 60 family planning services shall begin with delivery and continue for a period of 24 months, if the woman 61 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 62 purposes of this section, family planning services shall not cover payment for abortion services and no 63 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

64 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 65 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a 66 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. 67 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process; 68

9. A provision identifying entities approved by the Board to receive applications and to determine 69 70 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate contact information, including the best available address and telephone number, from each applicant for 71 72 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant 73 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et 74 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance directives and how the applicant may make an advance directive; 75

76 10. A provision for breast reconstructive surgery following the medically necessary removal of a 77 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been 78 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic; 79

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

80 12. A provision for payment of medical assistance services for prostheses following the medically 81 necessary complete or partial removal of a breast for any medical reason;

82 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 83 84 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 85 86 the provision of inpatient coverage where the attending physician in consultation with the patient 87 determines that a shorter period of hospital stay is appropriate;

88 14. A requirement that certificates of medical necessity for durable medical equipment and any 89 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician 90 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 91 days from the time the ordered durable medical equipment and supplies are first furnished by the 92 durable medical equipment provider;

93 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons 94 age 40 and over who are at high risk for prostate cancer, according to the most recent published 95 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal 96 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this 97 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate 98 specific antigen;

99 16. A provision for payment of medical assistance for low-dose screening mammograms for 100 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 101 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an 102 X-ray examination of the breast using equipment dedicated specifically for mammography, including but 103 104 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average 105 radiation exposure of less than one rad mid-breast, two views of each breast;

106 17. A provision, when in compliance with federal law and regulation and approved by the Centers 107 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to 108 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid 109 program and may be provided by school divisions, regardless of whether the student receiving care has 110 an individualized education program or whether the health care service is included in a student's individualized education program. Such services shall include those covered under the state plan for 111 112 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for 113 payment of medical assistance for health care services provided through telemedicine services, as 114 defined in § 38.2-3418.16. No health care provider who provides health care services through 115 telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for 116 117 providing telemedicine services;

118 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 119

120 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and 121 application of the procedure in treatment of the specific condition have been clearly demonstrated to be 122 medically effective and not experimental or investigational; (iii) prior authorization by the Department of 123 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific 124 transplant center where the surgery is proposed to be performed have been used by the transplant team 125 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy 126 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is 127 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and 128 restore a range of physical and social functioning in the activities of daily living;

129 19. A provision for payment of medical assistance for colorectal cancer screening, specifically 130 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in 131 appropriate circumstances radiologic imaging, in accordance with the most recently published 132 recommendations established by the American College of Gastroenterology, in consultation with the 133 American Cancer Society, for the ages, family histories, and frequencies referenced in such 134 recommendations;

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

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

143 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer 144 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer 145 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease 146 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 147 148 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under 149 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise 150 eligible for medical assistance services under any mandatory categorically needy eligibility group; and 151 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such 152 women;

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

158 24. A provision, when authorized by and in compliance with federal law, to establish a public-private 159 long-term care partnership program between the Commonwealth of Virginia and private insurance 160 companies that shall be established through the filing of an amendment to the state plan for medical 161 assistance services by the Department of Medical Assistance Services. The purpose of the program shall 162 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for 163 such services through encouraging the purchase of private long-term care insurance policies that have 164 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 165 166 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with 167 federal law and applicable federal guidelines;

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

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

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

181 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 182 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the 183 Department shall not impose any utilization controls or other forms of medical management limiting the 184 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, 185 186 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) 187 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal 188 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, 189 190 including medications containing estrogen or progesterone, that is self-administered, requires a 191 prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

192 28. A provision for payment of medical assistance for remote patient monitoring services provided 193 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up 194 195 to three months following the date of such surgery; and (v) patients with a chronic or acute health 196 condition who have had two or more hospitalizations or emergency department visits related to such 197 health condition in the previous 12 months when there is evidence that the use of remote patient 198 monitoring is likely to prevent readmission of such patient to a hospital or emergency department. For 199 the purposes of this subdivision, "remote patient monitoring services" means the use of digital 200 technologies to collect medical and other forms of health data from patients in one location and 201 electronically transmit that information securely to health care providers in a different location for 202 analysis, interpretation, and recommendations, and management of the patient. "Remote patient monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, 203 204 pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and 205 interactive videoconferencing with or without digital image upload;

29. A provision for the payment of medical assistance for provider-to-provider consultations that is 206 207 no more restrictive than, and is at least equal in amount, duration, and scope to, that available through 208 the fee-for-service program; and

209 30. A provision for payment of the originating site fee to emergency medical services agencies for 210 facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As 211 used in this subdivision, "originating site" means any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of 212 213 employment, or any public or private primary or secondary school or postsecondary institution of higher 214 education at which the person to whom telemedicine services are provided is located; and

215 31. A provision for the payment of medical assistance for violence prevention services provided by a qualified violence prevention professional to an individual who receives medical treatment for an injury 216 217 sustained as a result of community violence who is determined by a health care provider to be at risk of 218 repeat injury or retaliation. The Department shall recognize violence prevention professionals, as 219 defined by the National Uniform Claim Committee provider code 405300000X, as eligible providers for 220 reimbursement for violence prevention services and shall approve at least one governmental or 221 nongovernmental accrediting body with expertise in violence prevention services for training and 222 certifying violence prevention professionals. 223

As used in this subdivision:

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224 "Community violence" means physical violence that happens between unrelated individuals, who may 225 or may not know each other, generally outside the home, including assaults or fights among groups and 226 shootings in public places, such as schools and on the streets.

227 "Violence prevention services" means evidence-based, trauma-informed, and culturally responsive 228 preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related 229 harms and promote trauma recovery, stabilization, and improved health outcomes. 230

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.

234 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the 235 provisions of this chapter.

236 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 237 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 238 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact 239 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact 240 analysis shall include the projected costs/savings to the local boards of social services to implement or 241 comply with such regulation and, where applicable, sources of potential funds to implement or comply 242 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.

258 In the event conforming amendments to the state plan for medical assistance services are adopted, the 259 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 260 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the 261 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or 262 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the 263 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 264 265 session of the General Assembly unless enacted into law.

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

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267 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.

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

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

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 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.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

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 aggravating and mitigating factors 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

304 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations 305 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical 306 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based 307 upon reasonable criteria, including the professional credentials required for licensure.

308 G. The Board shall prepare and submit to the Secretary of the United States Department of Health 309 and Human Services such amendments to the state plan for medical assistance services as may be 310 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 311 312 providing medical assistance under the plan to their parents. 313

H. The Department of Medical Assistance Services shall:

314 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 315 316 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 317 318 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a 319 provider with comparable expertise, as determined by the Director.

320 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an 321 exception, with procedural requirements, to mandatory enrollment for certain children between birth and 322 age three certified by the Department of Behavioral Health and Developmental Services as eligible for 323 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

324 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 325 Family Access to Medical Insurance Security Plan established under § 32.1-351. 326

327 4. Require any managed care organization with which the Department enters into an agreement for 328 the provision of medical assistance services to include in any contract between the managed care 329 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or 330 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the 331 managed care organization's managed care plans. For the purposes of this subdivision:

332 "Pharmacy benefits management" means the administration or management of prescription drug 333 benefits provided by a managed care organization for the benefit of covered individuals. 334

"Pharmacy benefits manager" means a person that performs pharmacy benefits management.

335 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits 336 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price 337 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly 338 pays the pharmacist or pharmacy for pharmacist services.

339 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible 340 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 341 342 needs as defined by the Board.

343 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public 344 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by 345 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law 346 and regulation.

347 K. When the services provided for by such plan are services related to initiation of treatment with or 348 dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern 349 in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.

§ 32.1-325. (Effective pursuant to Va. Const., Art. IV, § 13) Board to submit plan for medical 350 assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; 351 352 administration of plan; contracts with health care providers.

353 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to 354 time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance 355 services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. 356 The Board shall include in such plan:

357 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, 358 placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing 359 agencies by the Department of Social Services or placed through state and local subsidized adoptions to 360 the extent permitted under federal statute;

361 2. A provision for determining eligibility for benefits for medically needy individuals which 362 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount 363 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 364 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender 365

366 value of such policies has been excluded from countable resources and (ii) the amount of any other 367 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of 368 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 369 370 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the 371 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used 372 as the principal residence and all contiguous property. For all other persons, a home shall mean the 373 house and lot used as the principal residence, as well as all contiguous property, as long as the value of 374 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the 375 definition of home as provided here is more restrictive than that provided in the state plan for medical 376 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and 377 lot used as the principal residence and all contiguous property essential to the operation of the home 378 regardless of value;

379 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who 380 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per 381 admission;

382 5. A provision for deducting from an institutionalized recipient's income an amount for the 383 maintenance of the individual's spouse at home;

384 6. A provision for payment of medical assistance on behalf of pregnant women which provides for 385 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most 386 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American 387 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards 388 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 389 390 children which are within the time periods recommended by the attending physicians in accordance with 391 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines 392 or Standards shall include any changes thereto within six months of the publication of such Guidelines 393 or Standards or any official amendment thereto;

394 7. A provision for the payment for family planning services on behalf of women who were 395 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such 396 family planning services shall begin with delivery and continue for a period of 24 months, if the woman 397 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 398 purposes of this section, family planning services shall not cover payment for abortion services and no 399 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

400 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow 401 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast 402 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a 403 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. 404 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

405 9. A provision identifying entities approved by the Board to receive applications and to determine 406 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate 407 contact information, including the best available address and telephone number, from each applicant for 408 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant 409 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et 410 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance 411 directives and how the applicant may make an advance directive;

412 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 413 414 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic; 415

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

416 12. A provision for payment of medical assistance services for prostheses following the medically 417 necessary complete or partial removal of a breast for any medical reason;

418 13. A provision for payment of medical assistance which provides for payment for 48 hours of 419 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of 420 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for 421 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring 422 the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate; 423

424 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 425 426 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60

427 days from the time the ordered durable medical equipment and supplies are first furnished by the 428 durable medical equipment provider;

429 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons 430 age 40 and over who are at high risk for prostate cancer, according to the most recent published 431 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal 432 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this 433 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate 434 specific antigen;

435 16. A provision for payment of medical assistance for low-dose screening mammograms for 436 determining the presence of occult breast cancer. Such coverage shall make available one screening 437 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 438 439 X-ray examination of the breast using equipment dedicated specifically for mammography, including but 440 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average 441 radiation exposure of less than one rad mid-breast, two views of each breast;

442 17. A provision, when in compliance with federal law and regulation and approved by the Centers 443 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 444 445 program and may be provided by school divisions, regardless of whether the student receiving care has 446 an individualized education program or whether the health care service is included in a student's 447 individualized education program. Such services shall include those covered under the state plan for 448 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for 449 payment of medical assistance for health care services provided through telemedicine services, as 450 451 defined in § 38.2-3418.16. No health care provider who provides health care services through 452 telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for 453 providing telemedicine services;

454 18. A provision for payment of medical assistance services for liver, heart and lung transplantation 455 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or 456 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and 457 application of the procedure in treatment of the specific condition have been clearly demonstrated to be 458 medically effective and not experimental or investigational; (iii) prior authorization by the Department of 459 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific 460 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 461 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is 462 463 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and 464 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 465 466 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 467 recommendations established by the American College of Gastroenterology, in consultation with the 468 469 American Cancer Society, for the ages, family histories, and frequencies referenced in such 470 recommendations: 471

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

472 21. A provision for payment for medical assistance for infant hearing screenings and all necessary 473 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the 474 United States Food and Drug Administration, and as recommended by the national Joint Committee on 475 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 476 477 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and 478 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

479 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer 480 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer 481 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 482 483 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including **484** treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under 485 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise 486 eligible for medical assistance services under any mandatory categorically needy eligibility group; and 487 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such 488 women;

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

494 24. A provision, when authorized by and in compliance with federal law, to establish a public-private 495 long-term care partnership program between the Commonwealth of Virginia and private insurance 496 companies that shall be established through the filing of an amendment to the state plan for medical 497 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 498 499 such services through encouraging the purchase of private long-term care insurance policies that have 500 been designated as qualified state long-term care insurance partnerships and may be used as the first 501 source of benefits for the participant's long-term care. Components of the program, including the 502 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with 503 federal law and applicable federal guidelines;

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

507 26. A provision for the payment of medical assistance for medically necessary health care services 508 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or 509 whether the patient is accompanied by a health care provider at the time such services are provided. No 510 health care provider who provides health care services through telemedicine services shall be required to 511 use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

512 For the purposes of this subdivision, "originating site" means any location where the patient is 513 located, including any medical care facility or office of a health care provider, the home of the patient, 514 the patient's place of employment, or any public or private primary or secondary school or 515 postsecondary institution of higher education at which the person to whom telemedicine services are 516 provided is located;

517 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 518 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the 519 Department shall not impose any utilization controls or other forms of medical management limiting the 520 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 521 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, 522 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) 523 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of 524 practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal 525 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a 526 527 prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

528 28. A provision for payment of medical assistance for remote patient monitoring services provided 529 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically 530 complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up 531 to three months following the date of such surgery; and (v) patients with a chronic or acute health 532 condition who have had two or more hospitalizations or emergency department visits related to such 533 health condition in the previous 12 months when there is evidence that the use of remote patient 534 monitoring is likely to prevent readmission of such patient to a hospital or emergency department. For 535 the purposes of this subdivision, "remote patient monitoring services" means the use of digital 536 technologies to collect medical and other forms of health data from patients in one location and 537 electronically transmit that information securely to health care providers in a different location for analysis, interpretation, and recommendations, and management of the patient. "Remote patient 538 539 monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, 540 pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and 541 interactive videoconferencing with or without digital image upload;

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

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

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550 education at which the person to whom telemedicine services are provided is located; and

551 31. A provision for the payment of medical assistance for targeted case management services for 552 individuals with severe traumatic brain injury; and

553 32. A provision for the payment of medical assistance for violence prevention services provided by a 554 qualified violence prevention professional to an individual who receives medical treatment for an injury 555 sustained as a result of community violence who is determined by a health care provider to be at risk of 556 repeat injury or retaliation. The Department shall recognize violence prevention professionals, as 557 defined by the National Uniform Claim Committee provider code 405300000X as eligible providers for 558 reimbursement for violence prevention services, and shall approve at least one governmental or 559 nongovernmental accrediting body with expertise in violence prevention services for training and 560 certifying violence prevention professionals.

As used in this subdivision:

562 "Community violence" means physical violence that happens between unrelated individuals, who may 563 or may not know each other, generally outside the home, including assaults or fights among groups and 564 shootings in public places, such as schools and on the streets.

565 "Violence prevention services" means evidence-based, trauma-informed, and culturally responsive 566 preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related 567 harms and promote trauma recovery, stabilization, and improved health outcomes. 568

B. In preparing the plan, the Board shall:

569 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided 570 and that the health, safety, security, rights and welfare of patients are ensured. 571

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

572 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the 573 provisions of this chapter.

574 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 575 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 576 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact 577 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact 578 analysis shall include the projected costs/savings to the local boards of social services to implement or 579 comply with such regulation and, where applicable, sources of potential funds to implement or comply 580 with such regulation.

581 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in 582 accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities 583 With Deficiencies.

584 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or 585 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each 586 recipient of medical assistance services, and shall upon any changes in the required data elements set 587 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective 588 information as may be required to electronically process a prescription claim.

589 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for 590 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, 591 regardless of any other provision of this chapter, such amendments to the state plan for medical 592 assistance services as may be necessary to conform such plan with amendments to the United States 593 Social Security Act or other relevant federal law and their implementing regulations or constructions of 594 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health 595 and Human Services.

596 In the event conforming amendments to the state plan for medical assistance services are adopted, the 597 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 598 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the 599 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or 600 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the 601 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with 602 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular 603 session of the General Assembly unless enacted into law. 604

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

605 1. Administer such state plan and receive and expend federal funds therefor in accordance with 606 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to 607 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 **608** 609 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 610 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new 611

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612 agreement or contract. Such provider may also apply to the Director for reconsideration of the 613 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

614 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 or otherwise pled guilty to a felony, or 615 616 pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider 617 as required by 42 C.F.R. § 1002.212.

618 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 619 or contract, with a provider who is or has been a principal in a professional or other corporation when 620 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 621 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal 622 program pursuant to 42 C.F.R. Part 1002.

623 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection 624 E of § 32.1-162.13. 625

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 626 627 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. 628 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative 629 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of 630 the date of receipt of the notice.

631 The Director may consider aggravating and mitigating factors including the nature and extent of any 632 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 633 634 subsection D, the Director may determine the period of exclusion and may consider aggravating and 635 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215. 636

637 F. When the services provided for by such plan are services which a marriage and family therapist, 638 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed 639 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, **640** duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or 641 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter **642** shall pay for covered services as provided in the state plan. The Board shall promulgate regulations 643 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical 644 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based 645 upon reasonable criteria, including the professional credentials required for licensure.

646 G. The Board shall prepare and submit to the Secretary of the United States Department of Health 647 and Human Services such amendments to the state plan for medical assistance services as may be 648 permitted by federal law to establish a program of family assistance whereby children over the age of 18 649 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of 650 providing medical assistance under the plan to their parents. 651

H. The Department of Medical Assistance Services shall:

652 1. Include in its provider networks and all of its health maintenance organization contracts a 653 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have 654 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse 655 and neglect, for medically necessary assessment and treatment services, when such services are delivered 656 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. 657

658 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an 659 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 660 661 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

662 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to 663 contractors and enrolled providers for the provision of health care services under Medicaid and the 664 Family Access to Medical Insurance Security Plan established under § 32.1-351.

665 4. Require any managed care organization with which the Department enters into an agreement for 666 the provision of medical assistance services to include in any contract between the managed care 667 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or 668 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the 669 managed care organization's managed care plans. For the purposes of this subdivision:

"Pharmacy benefits management" means the administration or management of prescription drug 670 671 benefits provided by a managed care organization for the benefit of covered individuals.

"Pharmacy benefits manager" means a person that performs pharmacy benefits management. 672

673 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits
674 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price
675 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly
676 pays the pharmacist or pharmacy for pharmacist services.

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

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

685 K. When the services provided for by such plan are services related to initiation of treatment with or
686 dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern
687 in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.

688 2. That the Department of Health shall post on its website the date upon which violence
689 prevention services may be provided and billed pursuant to subdivision A 32 of § 32.1-325 of the
690 Code of Virginia, as amended by this act.

691 3. That the Department of Health shall convene a work group to design and implement the

692 violence prevention services benefit. Such work group shall include members from the Department 693 of Health, representatives from violence prevention programs, medical providers, survivors of

693 of Health, representatives from violence prevention programs, medical providers, survivors of 694 community violence, and other members as deemed appropriate by the Department of Health.