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HOUSE BILL NO. 831

Offered January 11, 2006
Prefiled January 10, 2006

A BILL to amend and reenact § 32.1-325 of the Code of Virginia, relating to a three-part medical assistance program.

Patrons—Welch and Hamilton

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:

§ 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

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59 purposes of this section, family planning services shall not cover payment for abortion services and no
60 funds shall be used to perform, assist, encourage or make direct referrals for abortions;
61 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow
62 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast
63 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a
64 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.
65 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;
66 9. A provision identifying entities approved by the Board to receive applications and to determine
67 eligibility for medical assistance;
68 10. A provision for breast reconstructive surgery following the medically necessary removal of a
69 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been
70 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;
71 11. A provision for payment of medical assistance for annual pap smears;
72 12. A provision for payment of medical assistance services for prostheses following the medically
73 necessary complete or partial removal of a breast for any medical reason;
74 13. A provision for payment of medical assistance which provides for payment for 48 hours of
75 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
76 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for
77 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring
78 the provision of inpatient coverage where the attending physician in consultation with the patient
79 determines that a shorter period of hospital stay is appropriate;
80 14. A requirement that certificates of medical necessity for durable medical equipment and any
81 supporting verifiable documentation shall be signed, dated, and returned by the physician or nurse
82 practitioner and in the durable medical equipment provider's possession within 60 days from the time the
83 ordered durable medical equipment and supplies are first furnished by the durable medical equipment
84 provider;
85 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons
86 age 40 and over who are at high risk for prostate cancer, according to the most recent published
87 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal
88 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this
89 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate
90 specific antigen;
91 16. A provision for payment of medical assistance for low-dose screening mammograms for
92 determining the presence of occult breast cancer. Such coverage shall make available one screening
93 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
94 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
95 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
96 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
97 radiation exposure of less than one rad mid-breast, two views of each breast;
98 17. A provision, when in compliance with federal law and regulation and approved by the Centers
99 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
100 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
101 program and may be provided by school divisions;
102 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
103 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
104 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
105 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
106 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
107 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific
108 transplant center where the surgery is proposed to be performed have been used by the transplant team
109 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy
110 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is
111 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and
112 restore a range of physical and social functioning in the activities of daily living;
113 19. A provision for payment of medical assistance for colorectal cancer screening, specifically
114 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in
115 appropriate circumstances radiologic imaging, in accordance with the most recently published
116 recommendations established by the American College of Gastroenterology, in consultation with the
117 American Cancer Society, for the ages, family histories, and frequencies referenced in such
118 recommendations;
119 20. A provision for payment of medical assistance for custom ocular prostheses;
120 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, 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, consistent with federal law, to establish a long-term care partnership program that shall encourage the private purchase of long-term care insurance as the primary source of funding the participant's long-term care. Such program shall provide protection from estate recovery as authorized by federal law*; and*

25. A provision that revises the state plan for medical assistance in all ways necessary to implement a three-part medical assistance services program in the Commonwealth that is structured to include (i) the present Virginia Medical Assistance Program, revised to require all recipients to be enrolled in managed care; (ii) the present Family Access to Medical Insurance Security Plan (FAMIS), also revised to require all eligible individuals to be enrolled in managed care; and (iii), upon obtaining approval of the necessary waiver, the implementation of enhanced benefits accounts (health care savings accounts), using electronic funds transfer technology and electronic benefits cards, that provide incentives to recipients to manage their health care through access to funds that are deposited into their accounts for purchasing private health insurance or for the purchase of other health care items or services as set forth in the revised state plan for medical assistance.

B. In preparing the plan, the Board shall:

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

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

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

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

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

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

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

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182 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health
183 and Human Services.
184 In the event conforming amendments to the state plan for medical assistance services are adopted, the
185 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
186 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
187 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
188 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
189 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with
190 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
191 session of the General Assembly unless enacted into law.
192 D. The Director of Medical Assistance Services is authorized to:
193 1. Administer such state plan and receive and expend federal funds therefor in accordance with
194 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to
195 the performance of the Department's duties and the execution of its powers as provided by law.
196 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
197 health care providers where necessary to carry out the provisions of such state plan. Any such agreement
198 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is
199 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
200 agreement or contract. Such provider may also apply to the Director for reconsideration of the
201 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.
202 3. Refuse to enter into or renew an agreement or contract with any provider who has been convicted
203 of a felony.
204 4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a
205 principal in a professional or other corporation when such corporation has been convicted of a felony.
206 E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his
207 interest in a convicted professional or other corporation, the Director shall, upon request, conduct a
208 hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's
209 participation in the conduct resulting in the conviction.
210 The Director's decision upon reconsideration shall be consistent with federal and state laws. The
211 Director may consider the nature and extent of any adverse impact the agreement or contract denial or
212 termination may have on the medical care provided to Virginia Medicaid recipients.
213 F. When the services provided for by such plan are services which a marriage and family therapist,
214 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
215 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
216 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
217 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
218 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations
219 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical
220 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based
221 upon reasonable criteria, including the professional credentials required for licensure.
222 G. The Board shall prepare and submit to the Secretary of the United States Department of Health
223 and Human Services such amendments to the state plan for medical assistance services as may be
224 permitted by federal law to establish a program of family assistance whereby children over the age of 18
225 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
226 providing medical assistance under the plan to their parents.
227 H. The Department of Medical Assistance Services shall:
228 1. Include in its provider networks and all of its health maintenance organization contracts a
229 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have
230 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse
231 and neglect, for medically necessary assessment and treatment services, when such services are delivered
232 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a
233 provider with comparable expertise, as determined by the Director.
234 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an
235 exception, with procedural requirements, to mandatory enrollment for certain children between birth and
236 age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse
237 Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20
238 U.S.C. § 1471 et seq.).
239 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
240 recipients with special needs. The Board shall promulgate regulations regarding these special needs
241 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
242 needs as defined by the Board.
243 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.