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**HOUSE BILL NO. 1567**

Offered January 11, 2017

Prefiled January 2, 2017

A *BILL to amend and reenact §§ 32.1-325 and 63.2-501 of the Code of Virginia, relating to Medicaid applications; information about advance directives.*

Patron—Orrock

Referred to Committee on Health, Welfare and Institutions

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 32.1-325 and 63.2-501 of the Code of Virginia are amended and reenacted as follows:**

**§ 32.1-325. 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 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

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59 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the  
60 purposes of this section, family planning services shall not cover payment for abortion services and no  
61 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

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

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

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

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

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

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

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

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

97 16. A provision for payment of medical assistance for low-dose screening mammograms for  
98 determining the presence of occult breast cancer. Such coverage shall make available one screening  
99 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through  
100 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an  
101 X-ray examination of the breast using equipment dedicated specifically for mammography, including but  
102 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average  
103 radiation exposure of less than one rad mid-breast, two views of each breast;

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

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

119 19. A provision for payment of medical assistance for colorectal cancer screening, specifically  
120 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in

121 appropriate circumstances radiologic imaging, in accordance with the most recently published  
122 recommendations established by the American College of Gastroenterology, in consultation with the  
123 American Cancer Society, for the ages, family histories, and frequencies referenced in such  
124 recommendations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

189 In the event conforming amendments to the state plan for medical assistance services are adopted, the  
190 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter  
191 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the  
192 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or  
193 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the  
194 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with  
195 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular  
196 session of the General Assembly unless enacted into law.

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

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

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

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

211 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement  
212 or contract, with a provider who is or has been a principal in a professional or other corporation when  
213 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315,  
214 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal  
215 program pursuant to 42 C.F.R. Part 1002.

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

218 6. (Expires January 1, 2020) Provide payments or transfers pursuant to § 457 of the Internal Revenue  
219 Code to the deferred compensation plan described in § 51.1-602 on behalf of an individual who is a  
220 dentist or an oral and maxillofacial surgeon providing services as an independent contractor pursuant to  
221 a Medicaid agreement or contract under this section. Notwithstanding the provisions of § 51.1-600, an  
222 "employee" for purposes of Chapter 6 (§ 51.1-600 et seq.) of Title 51.1 shall include an independent  
223 contractor as described in this subdivision.

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

225 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider  
226 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R.  
227 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative  
228 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of  
229 the date of receipt of the notice.

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

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

244 upon reasonable criteria, including the professional credentials required for licensure.

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

250 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

272 **§ 63.2-501. Application for assistance.**

273 A. Except as provided for in the state plan for medical assistance services pursuant to § 32.1-325,  
274 application for public assistance shall be made to the local department and filed with the local director  
275 of the county or city in which the applicant resides; however, when necessary to overcome backlogs in  
276 the application and renewal process, the Commissioner may temporarily utilize other entities to receive  
277 and process applications, conduct periodic eligibility renewals, and perform other tasks associated with  
278 eligibility determinations. Such entities shall be subject to the confidentiality requirements set forth in  
279 § 63.2-501.1. Applications and renewals processed by other entities pursuant to this subsection shall be  
280 subject to appeals pursuant to § 63.2-517. Such application may be made either electronically or in  
281 writing on forms prescribed by the Commissioner and shall be signed by the applicant or otherwise  
282 attested to in a manner prescribed by the Commissioner under penalty of perjury in accordance with  
283 § 63.2-502.

284 If the condition of the applicant for public assistance precludes his signing or otherwise attesting to  
285 the accuracy of information contained in an application for public assistance, the application may be  
286 made on his behalf by his guardian or conservator. If no guardian or conservator has been appointed for  
287 the applicant, the application may be made by any competent adult person having sufficient knowledge  
288 of the applicant's circumstances to provide the necessary information, until such time as a guardian or  
289 conservator is appointed by a court.

290 B. Local departments or the Commissioner shall provide each applicant for public assistance with  
291 information regarding his rights and responsibilities related to eligibility for and continued receipt of  
292 public assistance. Such information shall be provided in an electronic or written format approved by the  
293 Board that is easily understandable and shall also be provided orally to the applicant by an employee of  
294 the local department, except in the case of energy assistance. The local department shall require each  
295 applicant to acknowledge, in a format approved by the Board, that the information required by this  
296 subsection has been provided and shall maintain such acknowledgment together with information  
297 regarding the application for public assistance.

298 C. Local departments or the Commissioner shall provide each applicant for public assistance with  
299 information regarding advance directives pursuant to Article 8 (§ 54.1-2981 et seq.) of Chapter 29 of  
300 Title 54.1, including information about the purpose and benefits of advance directives and how the  
301 applicant may make an advance directive.