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HOUSE BILL NO. 1567

House Amendments in [ ] — January 19, 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 Prior to Engrossment—Delegate 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 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, which shall include a requirement that such entities *(i)* obtain accurate
68 contact information, including the best available address and telephone number, from each applicant for
69 medical assistance, to the extent required by federal law and regulations*, and (ii) provide each applicant*
70 *for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et*
71 *seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance*
72 *directives and how the applicant may make an advance directive*;
73 10. A provision for breast reconstructive surgery following the medically necessary removal of a
74 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been
75 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;
76 11. A provision for payment of medical assistance for annual pap smears;
77 12. A provision for payment of medical assistance services for prostheses following the medically
78 necessary complete or partial removal of a breast for any medical reason;
79 13. A provision for payment of medical assistance which provides for payment for 48 hours of
80 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
81 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for
82 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring
83 the provision of inpatient coverage where the attending physician in consultation with the patient
84 determines that a shorter period of hospital stay is appropriate;
85 14. A requirement that certificates of medical necessity for durable medical equipment and any
86 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician
87 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60
88 days from the time the ordered durable medical equipment and supplies are first furnished by the
89 durable medical equipment provider;
90 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons
91 age 40 and over who are at high risk for prostate cancer, according to the most recent published
92 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal
93 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this
94 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate
95 specific antigen;
96 16. A provision for payment of medical assistance for low-dose screening mammograms for
97 determining the presence of occult breast cancer. Such coverage shall make available one screening
98 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
99 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
100 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
101 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
102 radiation exposure of less than one rad mid-breast, two views of each breast;
103 17. A provision, when in compliance with federal law and regulation and approved by the Centers
104 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
105 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
106 program and may be provided by school divisions;
107 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
108 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
109 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
110 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
111 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
112 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific
113 transplant center where the surgery is proposed to be performed have been used by the transplant team
114 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy
115 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is
116 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and
117 restore a range of physical and social functioning in the activities of daily living;
118 19. A provision for payment of medical assistance for colorectal cancer screening, specifically
119 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in
120 appropriate circumstances radiologic imaging, in accordance with the most recently published

121 recommendations established by the American College of Gastroenterology, in consultation with the
122 American Cancer Society, for the ages, family histories, and frequencies referenced in such
123 recommendations;
124 20. A provision for payment of medical assistance for custom ocular prostheses;
125 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
126 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the
127 United States Food and Drug Administration, and as recommended by the national Joint Committee on
128 Infant Hearing in its most current position statement addressing early hearing detection and intervention
129 programs. Such provision shall include payment for medical assistance for follow-up audiological
130 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and
131 performed by a licensed audiologist to confirm the existence or absence of hearing loss;
132 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer
133 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer
134 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease
135 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under
136 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including
137 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under
138 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise
139 eligible for medical assistance services under any mandatory categorically needy eligibility group; and
140 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such
141 women;
142 23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and
143 services delivery, of medical assistance services provided to medically indigent children pursuant to this
144 chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the
145 FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for
146 both programs;
147 24. A provision, when authorized by and in compliance with federal law, to establish a public-private
148 long-term care partnership program between the Commonwealth of Virginia and private insurance
149 companies that shall be established through the filing of an amendment to the state plan for medical
150 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
151 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
152 such services through encouraging the purchase of private long-term care insurance policies that have
153 been designated as qualified state long-term care insurance partnerships and may be used as the first
154 source of benefits for the participant's long-term care. Components of the program, including the
155 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with
156 federal law and applicable federal guidelines; and
157 25. A provision for the payment of medical assistance for otherwise eligible pregnant women during
158 the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health
159 Insurance Program Reauthorization Act of 2009 (P.L. 111-3).
160 B. In preparing the plan, the Board shall:
161 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided
162 and that the health, safety, security, rights and welfare of patients are ensured.
163 2. Initiate such cost containment or other measures as are set forth in the appropriation act.
164 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the
165 provisions of this chapter.
166 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations
167 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social
168 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact
169 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact
170 analysis shall include the projected costs/savings to the local boards of social services to implement or
171 comply with such regulation and, where applicable, sources of potential funds to implement or comply
172 with such regulation.
173 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in
174 accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities
175 With Deficiencies."
176 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or
177 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
178 recipient of medical assistance services, and shall upon any changes in the required data elements set
179 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective
180 information as may be required to electronically process a prescription claim.
181 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for

182 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
183 regardless of any other provision of this chapter, such amendments to the state plan for medical
184 assistance services as may be necessary to conform such plan with amendments to the United States
185 Social Security Act or other relevant federal law and their implementing regulations or constructions of
186 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health
187 and Human Services.
188 In the event conforming amendments to the state plan for medical assistance services are adopted, the
189 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
190 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
191 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
192 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
193 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with
194 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
195 session of the General Assembly unless enacted into law.
196 D. The Director of Medical Assistance Services is authorized to:
197 1. Administer such state plan and receive and expend federal funds therefor in accordance with
198 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to
199 the performance of the Department's duties and the execution of its powers as provided by law.
200 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
201 health care providers where necessary to carry out the provisions of such state plan. Any such agreement
202 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is
203 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
204 agreement or contract. Such provider may also apply to the Director for reconsideration of the
205 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.
206 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement
207 or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or
208 pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider
209 as required by 42 C.F.R. § 1002.212.
210 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement
211 or contract, with a provider who is or has been a principal in a professional or other corporation when
212 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315,
213 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
214 program pursuant to 42 C.F.R. Part 1002.
215 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection
216 E of § 32.1-162.13.
217 6. (Expires January 1, 2020) Provide payments or transfers pursuant to § 457 of the Internal Revenue
218 Code to the deferred compensation plan described in § 51.1-602 on behalf of an individual who is a
219 dentist or an oral and maxillofacial surgeon providing services as an independent contractor pursuant to
220 a Medicaid agreement or contract under this section. Notwithstanding the provisions of § 51.1-600, an
221 "employee" for purposes of Chapter 6 (§ 51.1-600 et seq.) of Title 51.1 shall include an independent
222 contractor as described in this subdivision.
223 For the purposes of this subsection, "provider" may refer to an individual or an entity.
224 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
225 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R.
226 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
227 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
228 the date of receipt of the notice.
229 The Director may consider aggravating and mitigating factors including the nature and extent of any
230 adverse impact the agreement or contract denial or termination may have on the medical care provided
231 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to
232 subsection D, the Director may determine the period of exclusion and may consider aggravating and
233 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant
234 to 42 C.F.R. § 1002.215.
235 F. When the services provided for by such plan are services which a marriage and family therapist,
236 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
237 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
238 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
239 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
240 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations
241 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical
242 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based
243 upon reasonable criteria, including the professional credentials required for licensure.

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

H. The Department of Medical Assistance Services shall:

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

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

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

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

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

§ 63.2-501. Application for assistance.

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

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

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

C. Local departments or the Commissioner shall provide each applicant for [~~public assistance~~ Medicaid] with information regarding advance directives pursuant to Article 8 (§ 54.1-2981 et 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.