## **2021 SESSION**

ENGROSSED

21101488D **SENATE BILL NO. 1227** 1 Senate Amendments in [] - January 28, 2021 2 3 A BILL to amend and reenact § 32.1-325 of the Code of Virginia, relating to state plan for medical 4 assistance; payment of medical assistance; 12-month supply of hormonal contraceptives. 5 Patrons Prior to Engrossment-Senators Boysko, Hashmi, Locke, Marsden and McClellan; Delegates: Adams, D.M., Aird, Ayala, Carr, Carter, Hope, Hudson, Keam, Kory, Mundon King, Plum, Price, Rasoul, Reid, Samirah, Sickles, Simon, Simonds, Subramanyam, Sullivan and Watts 6 7 Referred to Committee on Education and Health 8 9 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: 10 § 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and 11 Human Services pursuant to federal law; administration of plan; contracts with health care 12 13 providers. 14 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 15 services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. 16 17 The Board shall include in such plan: 18 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, 19 placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing 20 agencies by the Department of Social Services or placed through state and local subsidized adoptions to 21 the extent permitted under federal statute; 2. A provision for determining eligibility for benefits for medically needy individuals which 22 23 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount 24 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial 25 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value 26 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender 27 value of such policies has been excluded from countable resources and (ii) the amount of any other 28 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of 29 meeting the individual's or his spouse's burial expenses; 30 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically 31 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 32 33 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 34 35 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the 36 definition of home as provided here is more restrictive than that provided in the state plan for medical 37 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and 38 lot used as the principal residence and all contiguous property essential to the operation of the home 39 regardless of value: 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who 40 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per 41 42 admission: 43 5. A provision for deducting from an institutionalized recipient's income an amount for the 44 maintenance of the individual's spouse at home; 6. A provision for payment of medical assistance on behalf of pregnant women which provides for 45 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most 46 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American 47 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards **48** 49 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 50 51 children which are within the time periods recommended by the attending physicians in accordance with 52 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines 53 or Standards shall include any changes thereto within six months of the publication of such Guidelines 54 or Standards or any official amendment thereto; 7. A provision for the payment for family planning services on behalf of women who were 55 56 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such

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57 family planning services shall begin with delivery and continue for a period of 24 months, if the woman 58 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 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;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow 61 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 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. 64 65 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine 66 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate 67 contact information, including the best available address and telephone number, from each applicant for 68 69 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et 70 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 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been 74 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;

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 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring 82 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 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician 86 87 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the 88 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 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal 92 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate 93 94 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 X-ray examination of the breast using equipment dedicated specifically for mammography, including but 100 101 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast; 102

103 17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to 104 105 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 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or 108 109 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be 110 111 medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific 112 transplant center where the surgery is proposed to be performed have been used by the transplant team 113 114 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 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and 116 117 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 appropriate circumstances radiologic imaging, in accordance with the most recently published 120 121 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;

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); and

160 26. A provision for the payment of medical assistance for medically necessary health care services 161 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or 162 whether the patient is accompanied by a health care provider at the time such services are provided. No 163 health care provider who provides health care services through telemedicine services shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services. 164

For the purposes of this subdivision, "originating site" means any location where the patient is 165 located, including any medical care facility or office of a health care provider, the home of the patient, 166 the patient's place of employment, or any public or private primary or secondary school or 167 postsecondary institution of higher education at which the person to whom telemedicine services are 168 169 provided is located; and

170 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 171 12-month supply of hormonal contraceptives at one time [for Medicaid and FAMIS enrollees]. Absent 172 clinical contraindications, the Department shall not impose any utilization controls or other forms of 173 medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished 174 to an amount less than a 12-month supply. Nothing in this subdivision shall be construed to (i) require 175 a provider to prescribe, dispense, or furnish a 12-month supply of self-administered hormonal 176 contraceptives at one time or (ii) exclude coverage for hormonal contraceptives as prescribed by a 177 prescriber, acting within his scope of practice, for reasons other than contraceptive purposes. As used in 178 this subdivision, "hormonal contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is 179

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180 self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration 181 for such purpose.

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

183 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided 184 and that the health, safety, security, rights and welfare of patients are ensured.

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

186 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the 187 provisions of this chapter.

188 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 189 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 190 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 191 192 analysis shall include the projected costs/savings to the local boards of social services to implement or 193 comply with such regulation and, where applicable, sources of potential funds to implement or comply 194 with such regulation.

195 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in 196 accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities 197 With Deficiencies."

198 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or 199 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each 200 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 201 202 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 203 204 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, 205 regardless of any other provision of this chapter, such amendments to the state plan for medical 206 assistance services as may be necessary to conform such plan with amendments to the United States 207 Social Security Act or other relevant federal law and their implementing regulations or constructions of 208 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health 209 and Human Services.

210 In the event conforming amendments to the state plan for medical assistance services are adopted, the 211 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 212 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the 213 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or 214 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the 215 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with 216 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular 217 session of the General Assembly unless enacted into law.

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

219 1. Administer such state plan and receive and expend federal funds therefor in accordance with 220 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to 221 the performance of the Department's duties and the execution of its powers as provided by law.

222 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other 223 health care providers where necessary to carry out the provisions of such state plan. Any such agreement 224 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is 225 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new 226 agreement or contract. Such provider may also apply to the Director for reconsideration of the 227 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

228 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 229 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 230 231 as required by 42 C.F.R. § 1002.212.

232 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 233 or contract, with a provider who is or has been a principal in a professional or other corporation when 234 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 235 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal 236 program pursuant to 42 C.F.R. Part 1002.

237 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection 238 E of § 32.1-162.13. 239

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

240 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider 241 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R.

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242 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative 243 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of 244 the date of receipt of the notice.

245 The Director may consider aggravating and mitigating factors including the nature and extent of any 246 adverse impact the agreement or contract denial or termination may have on the medical care provided 247 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to 248 subsection D, the Director may determine the period of exclusion and may consider aggravating and 249 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant 250 to 42 C.F.R. § 1002.215.

251 F. When the services provided for by such plan are services which a marriage and family therapist, 252 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed 253 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, 254 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or 255 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations 256 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical 257 258 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based 259 upon reasonable criteria, including the professional credentials required for licensure.

260 G. The Board shall prepare and submit to the Secretary of the United States Department of Health 261 and Human Services such amendments to the state plan for medical assistance services as may be 262 permitted by federal law to establish a program of family assistance whereby children over the age of 18 263 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of 264 providing medical assistance under the plan to their parents. 265

H. The Department of Medical Assistance Services shall:

266 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 267 268 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse 269 and neglect, for medically necessary assessment and treatment services, when such services are delivered 270 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a 271 provider with comparable expertise, as determined by the Director.

272 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an 273 exception, with procedural requirements, to mandatory enrollment for certain children between birth and 274 age three certified by the Department of Behavioral Health and Developmental Services as eligible for 275 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). 276 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to

277 contractors and enrolled providers for the provision of health care services under Medicaid and the 278 Family Access to Medical Insurance Security Plan established under § 32.1-351. 279 4. Require any managed care organization with which the Department enters into an agreement for

280 the provision of medical assistance services to include in any contract between the managed care 281 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or 282 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the 283 managed care organization's managed care plans. For the purposes of this subdivision:

284 "Pharmacy benefits management" means the administration or management of prescription drug 285 benefits provided by a managed care organization for the benefit of covered individuals. 286

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

287 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits 288 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price 289 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly 290 pays the pharmacist or pharmacy for pharmacist services.

291 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible 292 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 293 294 needs as defined by the Board.

295 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public 296 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by 297 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law 298 and regulation.