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HOUSE BILL NO. 1512

Offered January 11, 2023

Prefiled January 4, 2023

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

Patrons—Adams, D.M., Bennett-Parker, Carr, Clark, Guzman, Jenkins, Kory, Maldonado, Mundon King, Murphy, Rasoul, Shin and Simon; Senator: Barker

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

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

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

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

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

2. A provision for determining eligibility for benefits for medically needy individuals which 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;

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

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

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

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

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

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

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

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

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

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

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

118 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
119 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or

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 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 transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy 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 restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically 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 recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

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

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, physician assistant, 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;

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

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

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. No 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.

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

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

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

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

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

215 31. *A provision for payment of medical assistance for the initial purchase or replacement of complex*
216 *rehabilitative technology manual and power wheelchair bases and related accessories, as defined by the*
217 *Department's durable medical equipment program policy, for patients who reside in nursing facilities.*
218 *Initial purchase or replacement may be contingent upon (i) determination of medical necessity; (ii)*
219 *requirements in accordance with regulations established through the Department's durable medical*
220 *equipment program policy; and (iii) exclusive use by the nursing facility resident. Recipients of medical*
221 *assistance shall not be required to pay any deductible, coinsurance, copayment, or patient costs related*
222 *to the initial purchase or replacement of complex rehabilitative technology manual and power*
223 *wheelchair bases and related accessories.*

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

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

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

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

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

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

240 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or
241 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
242 recipient of medical assistance services, and shall upon any changes in the required data elements set

forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

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

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

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

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

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

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

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

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

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

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

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

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

304 permitted by federal law to establish a program of family assistance whereby children over the age of 18
305 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
306 providing medical assistance under the plan to their parents.

307 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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

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

344 **§ 32.1-325. (Effective pursuant to Va. Const., Art. IV, § 13) Board to submit plan for medical**
345 **assistance services to U.S. Secretary of Health and Human Services pursuant to federal law;**
346 **administration of plan; contracts with health care providers.**

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

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

355 2. A provision for determining eligibility for benefits for medically needy individuals which
356 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount
357 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial
358 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value
359 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender
360 value of such policies has been excluded from countable resources and (ii) the amount of any other
361 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of
362 meeting the individual's or his spouse's burial expenses;

363 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
364 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
365 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 purposes of this section, family planning services shall not cover payment for abortion services and no 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 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast 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. 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 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate contact information, including the best available address and telephone number, from each applicant for 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 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;

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 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

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 necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of 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 the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

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 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 durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons 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 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 specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 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 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;

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 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions, regardless of whether the student receiving care has an individualized education program or whether the health care service is included in a student's individualized education program. Such services shall include those covered under the state plan for medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services;

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 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 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 transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy 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 restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically 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 recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

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

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, physician assistant, 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;

24. A provision, when authorized by and in compliance with federal law, to establish a public-private

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

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

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. No 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.

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

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

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

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

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

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

32. *A provision for payment of medical assistance for the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories, as defined by the Department's durable medical equipment program policy, for patients who reside in nursing facilities.*

550 *Initial purchase or replacement may be contingent upon (i) determination of medical necessity; (ii)*
551 *requirements in accordance with regulations established through the Department's durable medical*
552 *equipment program policy; and (iii) exclusive use by the nursing facility resident. Recipients of medical*
553 *assistance shall not be required to pay any deductible, coinsurance, copayment, or patient costs related*
554 *to the initial purchase or replacement of complex rehabilitative technology manual and power*
555 *wheelchair bases and related accessories.*

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

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

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

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

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

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

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

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

584 In the event conforming amendments to the state plan for medical assistance services are adopted, the
585 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
586 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
587 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
588 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
589 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with
590 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
591 session of the General Assembly unless enacted into law.

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

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

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

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

606 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement
607 or contract, with a provider who is or has been a principal in a professional or other corporation when
608 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315,
609 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
610 program pursuant to 42 C.F.R. Part 1002.

611 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection

E of § 32.1-162.13.

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

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

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

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

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

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

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

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

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.

673 K. When the services provided for by such plan are services related to initiation of treatment with or
674 dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern
675 in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.
676 **2. That the Board of Medical Assistance Services shall promulgate regulations to implement the**
677 **provisions of this act to be effective within 280 days of its enactment.**