23102751D **SENATE BILL NO. 1418** 1 Offered January 11, 2023 2 3 Prefiled January 11, 2023 4 A BILL to amend and reenact § 32.1-325 of the Code of Virginia, relating to state plan for medical 5 assistance services; telemedicine; in-state presence. 6 Patrons—Pillion and Dunnavant 7 8 Referred to Committee on Education and Health 9 10 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: 11 § 32.1-325. (Effective until date pursuant to Va. Const., Art. IV, § 13) Board to submit plan for 12 13 medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal 14 law; administration of plan; contracts with health care providers. 15 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to 16 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. 17 18 The Board shall include in such plan: 19 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, 20 placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing 21 agencies by the Department of Social Services or placed through state and local subsidized adoptions to 22 the extent permitted under federal statute; 2. A provision for determining eligibility for benefits for medically needy individuals which 23 24 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount 25 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 26 27 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender 28 value of such policies has been excluded from countable resources and (ii) the amount of any other 29 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of 30 meeting the individual's or his spouse's burial expenses; 31 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 32 33 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used 34 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 35 36 37 definition of home as provided here is more restrictive than that provided in the state plan for medical 38 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and 39 lot used as the principal residence and all contiguous property essential to the operation of the home 40 regardless of value; 41 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 42 43 admission: 44 5. A provision for deducting from an institutionalized recipient's income an amount for the 45 maintenance of the individual's spouse at home; 46 6. A provision for payment of medical assistance on behalf of pregnant women which provides for 47 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 48 49 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 50 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the 51 52 children which are within the time periods recommended by the attending physicians in accordance with 53 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 54 55 or Standards or any official amendment thereto; 7. A provision for the payment for family planning services on behalf of women who were 56 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such 57 58 family planning services shall begin with delivery and continue for a period of 24 months, if the woman

2 of 11

59 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 60 purposes of this section, family planning services shall not cover payment for abortion services and no 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 63 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast 64 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a 65 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. 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 68 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate 69 contact information, including the best available address and telephone number, from each applicant for medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant 70 71 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et 72 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance 73 directives and how the applicant may make an advance directive;

74 10. A provision for breast reconstructive surgery following the medically necessary removal of a 75 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been 76 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic; 77

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

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

80 13. A provision for payment of medical assistance which provides for payment for 48 hours of 81 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of 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 84 the provision of inpatient coverage where the attending physician in consultation with the patient 85 determines that a shorter period of hospital stay is appropriate;

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

91 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons 92 age 40 and over who are at high risk for prostate cancer, according to the most recent published 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 96 specific antigen;

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

17. A provision, when in compliance with federal law and regulation and approved by the Centers 104 105 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 106 107 program and may be provided by school divisions, regardless of whether the student receiving care has 108 an individualized education program or whether the health care service is included in a student's 109 individualized education program. Such services shall include those covered under the state plan for 110 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) 111 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 112 113 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 114 115 providing telemedicine services;

116 18. A provision for payment of medical assistance services for liver, heart and lung transplantation 117 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or 118 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and 119 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 120

121 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific 122 transplant center where the surgery is proposed to be performed have been used by the transplant team 123 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy 124 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is 125 not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and 126 restore a range of physical and social functioning in the activities of daily living;

127 19. A provision for payment of medical assistance for colorectal cancer screening, specifically 128 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in 129 appropriate circumstances radiologic imaging, in accordance with the most recently published 130 recommendations established by the American College of Gastroenterology, in consultation with the 131 American Cancer Society, for the ages, family histories, and frequencies referenced in such 132 recommendations;

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

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

141 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer 142 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer 143 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease 144 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under 145 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including 146 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under 147 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise 148 eligible for medical assistance services under any mandatory categorically needy eligibility group; and 149 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such 150 women;

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

156 24. A provision, when authorized by and in compliance with federal law, to establish a public-private 157 long-term care partnership program between the Commonwealth of Virginia and private insurance 158 companies that shall be established through the filing of an amendment to the state plan for medical 159 assistance services by the Department of Medical Assistance Services. The purpose of the program shall 160 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for 161 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 162 source of benefits for the participant's long-term care. Components of the program, including the 163 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with 164 165 federal law and applicable federal guidelines;

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

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

For the purposes of this subdivision, a health care provider duly licensed by the Commonwealth who
provides health care services exclusively through telemedicine services shall not be required to maintain
a physical presence in the Commonwealth to be considered an eligible provider for enrollment as a
Medicaid provider.

178 For the purposes of this subdivision, a telemedicine services provider group with health care
179 providers duly licensed by the Commonwealth shall not be required to have an in-state service address
180 to be eligible to enroll as a Medicaid vendor or Medicaid provider group.

181 For the purposes of this subdivision, "originating site" means any location where the patient is

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182 located, including any medical care facility or office of a health care provider, the home of the patient, 183 the patient's place of employment, or any public or private primary or secondary school or 184 postsecondary institution of higher education at which the person to whom telemedicine services are 185 provided is located;

186 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 187 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the 188 Department shall not impose any utilization controls or other forms of medical management limiting the 189 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 190 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, 191 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) 192 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of 193 practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal 194 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, 195 including medications containing estrogen or progesterone, that is self-administered, requires a 196 prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

197 28. A provision for payment of medical assistance for remote patient monitoring services provided 198 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically 199 complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up 200 to three months following the date of such surgery; and (v) patients with a chronic or acute health 201 condition who have had two or more hospitalizations or emergency department visits related to such 202 health condition in the previous 12 months when there is evidence that the use of remote patient 203 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 204 205 206 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 207 208 monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, 209 pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and 210 interactive videoconferencing with or without digital image upload;

29. A provision for the payment of medical assistance for provider-to-provider consultations that is 211 212 no more restrictive than, and is at least equal in amount, duration, and scope to, that available through 213 the fee-for-service program; and

214 30. A provision for payment of the originating site fee to emergency medical services agencies for 215 facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As 216 used in this subdivision, "originating site" means any location where the patient is located, including any 217 medical care facility or office of a health care provider, the home of the patient, the patient's place of 218 employment, or any public or private primary or secondary school or postsecondary institution of higher 219 education at which the person to whom telemedicine services are provided is located.

B. In preparing the plan, the Board shall:

221 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided 222 and that the health, safety, security, rights and welfare of patients are ensured. 223

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

224 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the 225 provisions of this chapter.

226 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 227 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 228 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact 229 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact 230 analysis shall include the projected costs/savings to the local boards of social services to implement or 231 comply with such regulation and, where applicable, sources of potential funds to implement or comply 232 with such regulation.

233 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in 234 accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities 235 With Deficiencies.

236 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or 237 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each 238 recipient of medical assistance services, and shall upon any changes in the required data elements set 239 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective 240 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 241 242 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, 243 regardless of any other provision of this chapter, such amendments to the state plan for medical

SB1418

5 of 11

244 assistance services as may be necessary to conform such plan with amendments to the United States 245 Social Security Act or other relevant federal law and their implementing regulations or constructions of 246 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health 247 and Human Services.

248 In the event conforming amendments to the state plan for medical assistance services are adopted, the 249 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 250 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the 251 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or 252 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the 253 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with 254 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular 255 session of the General Assembly unless enacted into law.

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

257 1. Administer such state plan and receive and expend federal funds therefor in accordance with 258 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. 259

260 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other 261 health care providers where necessary to carry out the provisions of such state plan. Any such agreement 262 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is 263 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new 264 agreement or contract. Such provider may also apply to the Director for reconsideration of the 265 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

266 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 267 268 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. 269

270 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 271 or contract, with a provider who is or has been a principal in a professional or other corporation when 272 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 273 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal 274 program pursuant to 42 C.F.R. Part 1002.

275 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection 276 E of § 32.1-162.13. 277

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

278 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider 279 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. 280 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative 281 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of 282 the date of receipt of the notice.

The Director may consider aggravating and mitigating factors including the nature and extent of any 283 284 adverse impact the agreement or contract denial or termination may have on the medical care provided 285 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to 286 subsection D, the Director may determine the period of exclusion and may consider aggravating and 287 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant 288 to 42 C.F.R. § 1002.215.

289 F. When the services provided for by such plan are services which a marriage and family therapist, 290 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed 291 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, 292 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or 293 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter 294 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations 295 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical 296 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based 297 upon reasonable criteria, including the professional credentials required for licensure.

298 G. The Board shall prepare and submit to the Secretary of the United States Department of Health 299 and Human Services such amendments to the state plan for medical assistance services as may be 300 permitted by federal law to establish a program of family assistance whereby children over the age of 18 301 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of 302 providing medical assistance under the plan to their parents.

303 H. The Department of Medical Assistance Services shall:

304 1. Include in its provider networks and all of its health maintenance organization contracts a 305 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have 306 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse 307 and neglect, for medically necessary assessment and treatment services, when such services are delivered 308 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a 309 provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an 310 311 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 312 313 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

314 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to 315 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. 316

317 4. Require any managed care organization with which the Department enters into an agreement for 318 the provision of medical assistance services to include in any contract between the managed care 319 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or 320 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the 321 managed care organization's managed care plans. For the purposes of this subdivision:

322 "Pharmacy benefits management" means the administration or management of prescription drug 323 benefits provided by a managed care organization for the benefit of covered individuals. 324

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

325 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits 326 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price 327 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services. 328

329 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible 330 recipients with special needs. The Board shall promulgate regulations regarding these special needs 331 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special 332 needs as defined by the Board.

333 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public 334 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by 335 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law 336 and regulation.

337 K. When the services provided for by such plan are services related to initiation of treatment with or 338 dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern 339 in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.

§ 32.1-325. (Effective pursuant to Va. Const., Art. IV, § 13) Board to submit plan for medical 340 341 assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; 342 administration of plan; contracts with health care providers.

343 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to 344 time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance 345 services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. 346 The Board shall include in such plan:

347 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, 348 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 349 350 the extent permitted under federal statute;

351 2. A provision for determining eligibility for benefits for medically needy individuals which 352 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount 353 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial 354 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value 355 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender 356 value of such policies has been excluded from countable resources and (ii) the amount of any other 357 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of 358 meeting the individual's or his spouse's burial expenses;

359 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically 360 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 361 as the principal residence and all contiguous property. For all other persons, a home shall mean the 362 house and lot used as the principal residence, as well as all contiguous property, as long as the value of 363 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the 364 definition of home as provided here is more restrictive than that provided in the state plan for medical 365 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and 366

367 lot used as the principal residence and all contiguous property essential to the operation of the home 368 regardless of value;

369 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who 370 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per 371 admission;

372 5. A provision for deducting from an institutionalized recipient's income an amount for the 373 maintenance of the individual's spouse at home;

374 6. A provision for payment of medical assistance on behalf of pregnant women which provides for 375 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 376 377 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 378 379 380 children which are within the time periods recommended by the attending physicians in accordance with 381 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines 382 or Standards shall include any changes thereto within six months of the publication of such Guidelines 383 or Standards or any official amendment thereto;

384 7. A provision for the payment for family planning services on behalf of women who were 385 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such 386 family planning services shall begin with delivery and continue for a period of 24 months, if the woman 387 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 388 purposes of this section, family planning services shall not cover payment for abortion services and no 389 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

390 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow 391 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast 392 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a 393 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. 394 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

395 9. A provision identifying entities approved by the Board to receive applications and to determine 396 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate 397 contact information, including the best available address and telephone number, from each applicant for 398 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant 399 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et 400 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance 401 directives and how the applicant may make an advance directive;

402 10. A provision for breast reconstructive surgery following the medically necessary removal of a 403 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been 404 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic; 405

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

406 12. A provision for payment of medical assistance services for prostheses following the medically 407 necessary complete or partial removal of a breast for any medical reason;

408 13. A provision for payment of medical assistance which provides for payment for 48 hours of 409 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of 410 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for 411 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 412 413 determines that a shorter period of hospital stay is appropriate;

414 14. A requirement that certificates of medical necessity for durable medical equipment and any 415 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician 416 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 417 days from the time the ordered durable medical equipment and supplies are first furnished by the 418 durable medical equipment provider;

419 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons 420 age 40 and over who are at high risk for prostate cancer, according to the most recent published 421 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal 422 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this 423 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate 424 specific antigen:

425 16. A provision for payment of medical assistance for low-dose screening mammograms for 426 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 427

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428 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
429 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

431 radiation exposure of less than one rad mid-breast, two views of each breast;

432 17. A provision, when in compliance with federal law and regulation and approved by the Centers 433 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to 434 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid 435 program and may be provided by school divisions, regardless of whether the student receiving care has 436 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 437 438 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) 439 benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for 440 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 441 442 telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for 443 providing telemedicine services;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation 444 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or 445 446 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and 447 application of the procedure in treatment of the specific condition have been clearly demonstrated to be 448 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 449 450 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 451 452 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 453 454 restore a range of physical and social functioning in the activities of daily living;

455 19. A provision for payment of medical assistance for colorectal cancer screening, specifically 456 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in 457 appropriate circumstances radiologic imaging, in accordance with the most recently published 458 recommendations established by the American College of Gastroenterology, in consultation with the 459 American Cancer Society, for the ages, family histories, and frequencies referenced in such 460 recommendations;

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

462 21. A provision for payment for medical assistance for infant hearing screenings and all necessary 463 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the 464 United States Food and Drug Administration, and as recommended by the national Joint Committee on 465 Infant Hearing in its most current position statement addressing early hearing detection and intervention 466 programs. Such provision shall include payment for medical assistance for follow-up audiological 467 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and 468 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 469 470 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer 471 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease 472 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under 473 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including 474 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under 475 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise 476 eligible for medical assistance services under any mandatory categorically needy eligibility group; and 477 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such 478 women:

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

484 24. A provision, when authorized by and in compliance with federal law, to establish a public-private
485 long-term care partnership program between the Commonwealth of Virginia and private insurance
486 companies that shall be established through the filing of an amendment to the state plan for medical
487 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
488 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
489 such services through encouraging the purchase of private long-term care insurance policies that have

9 of 11

490 been designated as qualified state long-term care insurance partnerships and may be used as the first
491 source of benefits for the participant's long-term care. Components of the program, including the
492 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with
493 federal law and applicable federal guidelines;

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

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

502 For the purposes of this subdivision, a health care provider duly licensed by the Commonwealth who
503 provides health care services exclusively through telemedicine services shall not be required to maintain
504 a physical presence in the Commonwealth to be considered an eligible provider for enrollment as a
505 Medicaid provider.

506 For the purposes of this subdivision, a telemedicine services provider group with health care
507 providers duly licensed by the Commonwealth shall not be required to have an in-state service address
508 to be eligible to enroll as a Medicaid vendor or Medicaid provider group.

509 For the purposes of this subdivision, "originating site" means any location where the patient is 510 located, including any medical care facility or office of a health care provider, the home of the patient, 511 the patient's place of employment, or any public or private primary or secondary school or 512 postsecondary institution of higher education at which the person to whom telemedicine services are 513 provided is located;

514 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 515 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the 516 Department shall not impose any utilization controls or other forms of medical management limiting the 517 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 518 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, 519 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) 520 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of 521 practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal 522 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, 523 including medications containing estrogen or progesterone, that is self-administered, requires a 524 prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

525 28. A provision for payment of medical assistance for remote patient monitoring services provided 526 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically 527 complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up 528 to three months following the date of such surgery; and (v) patients with a chronic or acute health 529 condition who have had two or more hospitalizations or emergency department visits related to such 530 health condition in the previous 12 months when there is evidence that the use of remote patient 531 monitoring is likely to prevent readmission of such patient to a hospital or emergency department. For 532 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 533 534 electronically transmit that information securely to health care providers in a different location for 535 analysis, interpretation, and recommendations, and management of the patient. "Remote patient 536 monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, 537 pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and 538 interactive videoconferencing with or without digital image upload;

539 29. A provision for the payment of medical assistance for provider-to-provider consultations that is
540 no more restrictive than, and is at least equal in amount, duration, and scope to, that available through
541 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

548 31. A provision for the payment of medical assistance for targeted case management services for549 individuals with severe traumatic brain injury.

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

586

551 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided 552 and that the health, safety, security, rights and welfare of patients are ensured. 553

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

554 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the 555 provisions of this chapter.

556 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 557 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 558 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact 559 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or 560 comply with such regulation and, where applicable, sources of potential funds to implement or comply 561 with such regulation. 562

563 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities 564 With Deficiencies. 565

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or 566 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each 567 568 recipient of medical assistance services, and shall upon any changes in the required data elements set 569 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective 570 information as may be required to electronically process a prescription claim.

571 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for 572 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, 573 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 574 575 Social Security Act or other relevant federal law and their implementing regulations or constructions of 576 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health 577 and Human Services.

578 In the event conforming amendments to the state plan for medical assistance services are adopted, the 579 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 580 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the 581 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 582 583 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with **584** the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular 585 session of the General Assembly unless enacted into law.

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

587 1. Administer such state plan and receive and expend federal funds therefor in accordance with 588 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to 589 the performance of the Department's duties and the execution of its powers as provided by law.

590 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other 591 health care providers where necessary to carry out the provisions of such state plan. Any such agreement 592 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is 593 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 594 595 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

596 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 597 pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider **598** 599 as required by 42 C.F.R. § 1002.212.

600 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 601 or contract, with a provider who is or has been a principal in a professional or other corporation when 602 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 603 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal **604** program pursuant to 42 C.F.R. Part 1002.

605 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection 606 E of § 32.1-162.13. 607

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

608 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider 609 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 610 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of 611

612 the date of receipt of the notice.

11 of 11

613 The Director may consider aggravating and mitigating factors including the nature and extent of any 614 adverse impact the agreement or contract denial or termination may have on the medical care provided 615 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to 616 subsection D, the Director may determine the period of exclusion and may consider aggravating and 617 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant 618 to 42 C.F.R. § 1002.215.

619 F. When the services provided for by such plan are services which a marriage and family therapist, 620 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed 621 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, 622 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or 623 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter 624 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 625 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based 626 627 upon reasonable criteria, including the professional credentials required for licensure.

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

633 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.

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

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

647
648 4. Require any managed care organization with which the Department enters into an agreement for
648 the provision of medical assistance services to include in any contract between the managed care
649 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or
650 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the
651 managed care organization's managed care plans. For the purposes of this subdivision:

652 "Pharmacy benefits management" means the administration or management of prescription drug653 benefits provided by a managed care organization for the benefit of covered individuals.

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

⁶⁵⁵ "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits
⁶⁵⁶ manager charges a managed care plan a contracted price for prescription drugs, and the contracted price
⁶⁵⁷ for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly
⁶⁵⁸ pays the pharmacist or pharmacy for pharmacist services.

659 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
660 recipients with special needs. The Board shall promulgate regulations regarding these special needs
661 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
662 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.

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