23103522D **SENATE BILL NO. 1538** 1 2 Offered January 20, 2023 3 A BILL to amend and reenact § 32.1-325, as it is currently effective and as it shall become effective, of 4 the Code of Virginia, relating to state plan for medical assistance services; pharmacy services. 5 Patron—Pillion 6 7 Referred to Committee on Education and Health 8 9 Be it enacted by the General Assembly of Virginia: 1. That § 32.1-325, as it is currently effective and as it shall become effective, of the Code of 10 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 law; administration of plan; contracts with health care providers. 14 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 42 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per 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

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59 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 60 purposes of this section, family planning services shall not cover payment for abortion services and no 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 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 88 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 162 been designated as qualified state long-term care insurance partnerships and may be used as the first 163 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 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);

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;

179 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
180 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
181 Department shall not impose any utilization controls or other forms of medical management limiting the

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182 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 183 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, 184 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) 185 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 186 187 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, 188 including medications containing estrogen or progesterone, that is self-administered, requires a 189 prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

190 28. A provision for payment of medical assistance for remote patient monitoring services provided 191 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically via telemedicine, as defined in § 192 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 193 194 condition who have had two or more hospitalizations or emergency department visits related to such 195 health condition in the previous 12 months when there is evidence that the use of remote patient 196 monitoring is likely to prevent readmission of such patient to a hospital or emergency department. For 197 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 198 199 electronically transmit that information securely to health care providers in a different location for 200 analysis, interpretation, and recommendations, and management of the patient. "Remote patient 201 monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, 202 pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and 203 interactive videoconferencing with or without digital image upload;

204 29. A provision for the payment of medical assistance for provider-to-provider consultations that is 205 no more restrictive than, and is at least equal in amount, duration, and scope to, that available through 206 the fee-for-service program; and

207 30. A provision for payment of the originating site fee to emergency medical services agencies for 208 facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As 209 used in this subdivision, "originating site" means any location where the patient is located, including any 210 medical care facility or office of a health care provider, the home of the patient, the patient's place of 211 employment, or any public or private primary or secondary school or postsecondary institution of higher 212 education at which the person to whom telemedicine services are provided is located. 213

B. In preparing the plan, the Board shall:

214 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided 215 and that the health, safety, security, rights and welfare of patients are ensured.

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

217 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter. 218

219 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 220 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 221 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact 222 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact 223 analysis shall include the projected costs/savings to the local boards of social services to implement or 224 comply with such regulation and, where applicable, sources of potential funds to implement or comply 225 with such regulation.

226 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in 227 accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities 228 With Deficiencies.

229 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or 230 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each 231 recipient of medical assistance services, and shall upon any changes in the required data elements set 232 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective 233 information as may be required to electronically process a prescription claim.

234 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for 235 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, 236 regardless of any other provision of this chapter, such amendments to the state plan for medical 237 assistance services as may be necessary to conform such plan with amendments to the United States 238 Social Security Act or other relevant federal law and their implementing regulations or constructions of 239 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health 240 and Human Services.

241 In the event conforming amendments to the state plan for medical assistance services are adopted, the 242 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 243 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the

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244 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or 245 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the 246 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with 247 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular 248 session of the General Assembly unless enacted into law.

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

250 1. Administer such state plan and receive and expend federal funds therefor in accordance with 251 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to 252 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 253 254 health care providers where necessary to carry out the provisions of such state plan. Any such agreement 255 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is 256 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new 257 agreement or contract. Such provider may also apply to the Director for reconsideration of the 258 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

259 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 260 pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider 261 262 as required by 42 C.F.R. § 1002.212.

263 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 264 or contract, with a provider who is or has been a principal in a professional or other corporation when 265 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 266 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal 267 program pursuant to 42 C.F.R. Part 1002.

268 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection 269 E of § 32.1-162.13. 270

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

271 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider 272 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. 273 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative 274 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of 275 the date of receipt of the notice.

276 The Director may consider aggravating and mitigating factors including the nature and extent of any 277 adverse impact the agreement or contract denial or termination may have on the medical care provided 278 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to 279 subsection D, the Director may determine the period of exclusion and may consider aggravating and 280 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant 281 to 42 C.F.R. § 1002.215.

282 F. When the services provided for by such plan are services which a marriage and family therapist, 283 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed 284 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, 285 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or 286 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter 287 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations 288 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical 289 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based 290 upon reasonable criteria, including the professional credentials required for licensure.

291 G. The Board shall prepare and submit to the Secretary of the United States Department of Health 292 and Human Services such amendments to the state plan for medical assistance services as may be 293 permitted by federal law to establish a program of family assistance whereby children over the age of 18 294 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of 295 providing medical assistance under the plan to their parents.

296 H. The Department of Medical Assistance Services shall:

297 1. Include in its provider networks and all of its health maintenance organization contracts a 298 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have 299 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse 300 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 301 302 provider with comparable expertise, as determined by the Director.

303 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an 304 exception, with procedural requirements, to mandatory enrollment for certain children between birth and

305 age three certified by the Department of Behavioral Health and Developmental Services as eligible for 306 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

307 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to 308 contractors and enrolled providers for the provision of health care services under Medicaid and the 309 Family Access to Medical Insurance Security Plan established under § 32.1-351.

310 4. Require any managed care organization with which the Department enters into an agreement for 311 the provision of medical assistance services to include in any contract between the managed care 312 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or 313 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the 314 managed care organization's managed care plans. For the purposes of this subdivision:

"Pharmacy benefits management" means the administration or management of prescription drug 315 benefits provided by a managed care organization for the benefit of covered individuals. 316 317

"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 318 319 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price 320 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly 321 pays the pharmacist or pharmacy for pharmacist services.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible 322 323 recipients with special needs. The Board shall promulgate regulations regarding these special needs 324 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special 325 needs as defined by the Board.

326 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public 327 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by 328 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law 329 and regulation.

330 K. When the services provided for by such plan are services by a pharmacist, pharmacy technician, 331 or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in 332 § 54.1-3300, (ii) related to initiation of services and treatment with or dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern in accordance with § 54.1-3303.1, 333 334 or (iii) performed under the terms of the state plan or managed care contractor of the Department, the 335 Department shall provide reimbursement for such service.

336 § 32.1-325. (Effective pursuant to Va. Const., Art. IV, § 13) Board to submit plan for medical 337 assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; 338 administration of plan; contracts with health care providers.

339 A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to 340 time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance 341 services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. 342 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, 343 344 placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing 345 agencies by the Department of Social Services or placed through state and local subsidized adoptions to 346 the extent permitted under federal statute;

347 2. A provision for determining eligibility for benefits for medically needy individuals which 348 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount 349 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 350 351 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender 352 value of such policies has been excluded from countable resources and (ii) the amount of any other 353 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of 354 meeting the individual's or his spouse's burial expenses;

355 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically 356 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the 357 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used 358 as the principal residence and all contiguous property. For all other persons, a home shall mean the 359 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 360 definition of home as provided here is more restrictive than that provided in the state plan for medical 361 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and 362 363 lot used as the principal residence and all contiguous property essential to the operation of the home 364 regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who 365 366 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per

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367 admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the 368 369 maintenance of the individual's spouse at home;

370 6. A provision for payment of medical assistance on behalf of pregnant women which provides for 371 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most 372 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American 373 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards 374 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 375 376 children which are within the time periods recommended by the attending physicians in accordance with 377 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines 378 or Standards shall include any changes thereto within six months of the publication of such Guidelines 379 or Standards or any official amendment thereto;

380 7. A provision for the payment for family planning services on behalf of women who were 381 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 382 383 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the 384 purposes of this section, family planning services shall not cover payment for abortion services and no 385 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

386 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow 387 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast 388 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a 389 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. 390 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

391 9. A provision identifying entities approved by the Board to receive applications and to determine 392 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate 393 contact information, including the best available address and telephone number, from each applicant for 394 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant 395 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et 396 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance 397 directives and how the applicant may make an advance directive;

398 10. A provision for breast reconstructive surgery following the medically necessary removal of a 399 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been 400 obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic; 401

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

402 12. A provision for payment of medical assistance services for prostheses following the medically 403 necessary complete or partial removal of a breast for any medical reason;

404 13. A provision for payment of medical assistance which provides for payment for 48 hours of 405 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of 406 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for 407 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring 408 the provision of inpatient coverage where the attending physician in consultation with the patient 409 determines that a shorter period of hospital stay is appropriate;

410 14. A requirement that certificates of medical necessity for durable medical equipment and any 411 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician 412 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 413 days from the time the ordered durable medical equipment and supplies are first furnished by the 414 durable medical equipment provider;

415 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons 416 age 40 and over who are at high risk for prostate cancer, according to the most recent published 417 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal 418 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this 419 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate 420 specific antigen;

421 16. A provision for payment of medical assistance for low-dose screening mammograms for 422 determining the presence of occult breast cancer. Such coverage shall make available one screening 423 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 424 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an 425 X-ray examination of the breast using equipment dedicated specifically for mammography, including but 426 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average 427 radiation exposure of less than one rad mid-breast, two views of each breast;

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428 17. A provision, when in compliance with federal law and regulation and approved by the Centers 429 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to 430 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid 431 program and may be provided by school divisions, regardless of whether the student receiving care has 432 an individualized education program or whether the health care service is included in a student's 433 individualized education program. Such services shall include those covered under the state plan for 434 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 435 436 payment of medical assistance for health care services provided through telemedicine services, as 437 defined in § 38.2-3418.16. No health care provider who provides health care services through 438 telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for 439 providing telemedicine services;

440 18. A provision for payment of medical assistance services for liver, heart and lung transplantation 441 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or 442 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and 443 application of the procedure in treatment of the specific condition have been clearly demonstrated to be 444 medically effective and not experimental or investigational; (iii) prior authorization by the Department of 445 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific 446 transplant center where the surgery is proposed to be performed have been used by the transplant team 447 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy 448 has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is 449 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; 450

451 19. A provision for payment of medical assistance for colorectal cancer screening, specifically 452 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in 453 appropriate circumstances radiologic imaging, in accordance with the most recently published 454 recommendations established by the American College of Gastroenterology, in consultation with the 455 American Cancer Society, for the ages, family histories, and frequencies referenced in such 456 recommendations;

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

458 21. A provision for payment for medical assistance for infant hearing screenings and all necessary 459 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the 460 United States Food and Drug Administration, and as recommended by the national Joint Committee on 461 Infant Hearing in its most current position statement addressing early hearing detection and intervention 462 programs. Such provision shall include payment for medical assistance for follow-up audiological 463 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and 464 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

465 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 466 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease 467 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under 468 469 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including 470 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 471 472 eligible for medical assistance services under any mandatory categorically needy eligibility group; and 473 (v) have not attained age 65. This provision shall include an expedited eligibility determination for such 474 women:

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

480 24. A provision, when authorized by and in compliance with federal law, to establish a public-private 481 long-term care partnership program between the Commonwealth of Virginia and private insurance 482 companies that shall be established through the filing of an amendment to the state plan for medical 483 assistance services by the Department of Medical Assistance Services. The purpose of the program shall 484 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 485 486 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 487 488 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with 489 federal law and applicable federal guidelines;

490 25. A provision for the payment of medical assistance for otherwise eligible pregnant women during 491 the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health 492 Insurance Program Reauthorization Act of 2009 (P.L. 111-3);

493 26. A provision for the payment of medical assistance for medically necessary health care services 494 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or 495 whether the patient is accompanied by a health care provider at the time such services are provided. No 496 health care provider who provides health care services through telemedicine services shall be required to 497 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 498 499 located, including any medical care facility or office of a health care provider, the home of the patient, 500 the patient's place of employment, or any public or private primary or secondary school or 501 postsecondary institution of higher education at which the person to whom telemedicine services are 502 provided is located;

503 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 504 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the 505 Department shall not impose any utilization controls or other forms of medical management limiting the 506 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 507 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, 508 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) 509 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of 510 practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal 511 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 512 513 prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

514 28. A provision for payment of medical assistance for remote patient monitoring services provided 515 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically 516 complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up 517 to three months following the date of such surgery; and (v) patients with a chronic or acute health 518 condition who have had two or more hospitalizations or emergency department visits related to such 519 health condition in the previous 12 months when there is evidence that the use of remote patient 520 monitoring is likely to prevent readmission of such patient to a hospital or emergency department. For 521 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 522 523 electronically transmit that information securely to health care providers in a different location for 524 analysis, interpretation, and recommendations, and management of the patient. "Remote patient 525 monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, 526 pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and 527 interactive videoconferencing with or without digital image upload;

528 29. A provision for the payment of medical assistance for provider-to-provider consultations that is 529 no more restrictive than, and is at least equal in amount, duration, and scope to, that available through 530 the fee-for-service program;

531 30. A provision for payment of the originating site fee to emergency medical services agencies for 532 facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As 533 used in this subdivision, "originating site" means any location where the patient is located, including any 534 medical care facility or office of a health care provider, the home of the patient, the patient's place of 535 employment, or any public or private primary or secondary school or postsecondary institution of higher 536 education at which the person to whom telemedicine services are provided is located; and

537 31. A provision for the payment of medical assistance for targeted case management services for 538 individuals with severe traumatic brain injury. 539

B. In preparing the plan, the Board shall:

540 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured. 541

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

543 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the 544 provisions of this chapter.

545 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations 546 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social 547 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact 548 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact 549 analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply 550

551 with such regulation.

552 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in 553 accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities 554 With Deficiencies.

555 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or 556 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each 557 recipient of medical assistance services, and shall upon any changes in the required data elements set 558 forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective 559 information as may be required to electronically process a prescription claim.

560 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, 561 regardless of any other provision of this chapter, such amendments to the state plan for medical 562 assistance services as may be necessary to conform such plan with amendments to the United States 563 564 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 565 566 and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the 567 568 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter 569 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the 570 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or 571 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the 572 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with 573 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular 574 session of the General Assembly unless enacted into law.

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

576 1. Administer such state plan and receive and expend federal funds therefor in accordance with 577 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to 578 the performance of the Department's duties and the execution of its powers as provided by law.

579 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other 580 health care providers where necessary to carry out the provisions of such state plan. Any such agreement 581 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is 582 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new 583 agreement or contract. Such provider may also apply to the Director for reconsideration of the 584 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 585 or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or 586 587 pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider 588 as required by 42 C.F.R. § 1002.212.

589 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement 590 or contract, with a provider who is or has been a principal in a professional or other corporation when 591 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 592 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal

593 program pursuant to 42 C.F.R. Part 1002.

594 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection 595 E of § 32.1-162.13. 596

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

597 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider 598 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. 599 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative 600 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of 601 the date of receipt of the notice.

602 The Director may consider aggravating and mitigating factors including the nature and extent of any 603 adverse impact the agreement or contract denial or termination may have on the medical care provided **604** to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to 605 subsection D, the Director may determine the period of exclusion and may consider aggravating and 606 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant 607 to 42 C.F.R. § 1002.215.

608 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 609 610 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 611 612 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.

617 G. The Board shall prepare and submit to the Secretary of the United States Department of Health 618 and Human Services such amendments to the state plan for medical assistance services as may be 619 permitted by federal law to establish a program of family assistance whereby children over the age of 18 620 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of 621 providing medical assistance under the plan to their parents.

622 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.

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

633 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to
634 contractors and enrolled providers for the provision of health care services under Medicaid and the
635 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:

641 "Pharmacy benefits management" means the administration or management of prescription drug642 benefits provided by a managed care organization for the benefit of covered individuals.

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

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

648 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
649 recipients with special needs. The Board shall promulgate regulations regarding these special needs
650 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
651 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 by a pharmacist, pharmacy technician,
or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in
§ 54.1-3300, (ii) related to initiation of services and treatment with or dispensing or administration of a
vaccination by a pharmacist, pharmacy technician, or pharmacy intern in accordance with § 54.1-3303.1,
or (iii) performed under the terms of the state plan or managed care contractor of the Department, the
Department shall provide reimbursement for such service.

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