

SENATE BILL NO. 1538

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Education and Health

on _____)

(Patron Prior to Substitute--Senator Pillion)

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

Be it enacted by the General Assembly of Virginia:

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

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

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

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

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of

27 such policies has been excluded from countable resources and (ii) the amount of any other revocable or
28 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the
29 individual's or his spouse's burial expenses;

30 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
31 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
32 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used
33 as the principal residence and all contiguous property. For all other persons, a home shall mean the house
34 and lot used as the principal residence, as well as all contiguous property, as long as the value of the land,
35 exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of
36 home as provided here is more restrictive than that provided in the state plan for medical assistance
37 services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as
38 the principal residence and all contiguous property essential to the operation of the home regardless of
39 value;

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

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

45 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
46 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
47 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
48 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
49 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 children which are within the time periods recommended by the attending physicians in accordance with
52 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines

53 or Standards shall include any changes thereto within six months of the publication of such Guidelines or
54 Standards or any official amendment thereto;

55 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 family planning services shall begin with delivery and continue for a period of 24 months, if the woman
58 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the
59 purposes of this section, family planning services shall not cover payment for abortion services and no
60 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

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

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

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

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

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

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

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

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

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

102 17. A provision, when in compliance with federal law and regulation and approved by the Centers
103 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
104 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
105 program and may be provided by school divisions, regardless of whether the student receiving care has an

106 individualized education program or whether the health care service is included in a student's
107 individualized education program. Such services shall include those covered under the state plan for
108 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
109 benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for
110 payment of medical assistance for health care services provided through telemedicine services, as defined
111 in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall
112 be required to use proprietary technology or applications in order to be reimbursed for providing
113 telemedicine services;

114 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
115 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
116 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
117 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
118 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
119 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant
120 center where the surgery is proposed to be performed have been used by the transplant team or program
121 to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed
122 and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an
123 irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range
124 of physical and social functioning in the activities of daily living;

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

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

131 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
132 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United

133 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant
134 Hearing in its most current position statement addressing early hearing detection and intervention
135 programs. Such provision shall include payment for medical assistance for follow-up audiological
136 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and
137 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

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

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

153 24. A provision, when authorized by and in compliance with federal law, to establish a public-
154 private long-term care partnership program between the Commonwealth of Virginia and private insurance
155 companies that shall be established through the filing of an amendment to the state plan for medical
156 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
157 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
158 such services through encouraging the purchase of private long-term care insurance policies that have
159 been designated as qualified state long-term care insurance partnerships and may be used as the first source

160 of benefits for the participant's long-term care. Components of the program, including the treatment of
161 assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and
162 applicable federal guidelines;

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

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

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

175 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
176 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
177 Department shall not impose any utilization controls or other forms of medical management limiting the
178 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month
179 supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, dispense, or
180 furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude
181 coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice,
182 for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive"
183 means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications
184 containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by
185 the U.S. Food and Drug Administration for such purpose;

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

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

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

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

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

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

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

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

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

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

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

236 In the event conforming amendments to the state plan for medical assistance services are adopted,
237 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
238 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
239 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or

240 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
241 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the
242 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
243 of the General Assembly unless enacted into law.

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

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

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

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

258 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
259 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
260 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-
261 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
262 program pursuant to 42 C.F.R. Part 1002.

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

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

266 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
267 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
268 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
269 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
270 the date of receipt of the notice.

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

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

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

291 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

317 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
318 recipients with special needs. The Board shall promulgate regulations regarding these special needs

319 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
320 needs as defined by the Board.

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

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

331 **§ 32.1-325. (Effective pursuant to Va. Const., Art. IV, § 13) Board to submit plan for medical**
332 **assistance services to U.S. Secretary of Health and Human Services pursuant to federal law;**
333 **administration of plan; contracts with health care providers.**

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

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

342 2. A provision for determining eligibility for benefits for medically needy individuals which
343 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount
344 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses
345 of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life

346 insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of
347 such policies has been excluded from countable resources and (ii) the amount of any other revocable or
348 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the
349 individual's or his spouse's burial expenses;

350 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
351 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
352 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used
353 as the principal residence and all contiguous property. For all other persons, a home shall mean the house
354 and lot used as the principal residence, as well as all contiguous property, as long as the value of the land,
355 exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of
356 home as provided here is more restrictive than that provided in the state plan for medical assistance
357 services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as
358 the principal residence and all contiguous property essential to the operation of the home regardless of
359 value;

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

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

365 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
366 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
367 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
368 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
369 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
370 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
371 children which are within the time periods recommended by the attending physicians in accordance with
372 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines

373 or Standards shall include any changes thereto within six months of the publication of such Guidelines or
374 Standards or any official amendment thereto;

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

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

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

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

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

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

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

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

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

415 16. A provision for payment of medical assistance for low-dose screening mammograms for
416 determining the presence of occult breast cancer. Such coverage shall make available one screening
417 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
418 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
419 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
420 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
421 radiation exposure of less than one rad mid-breast, two views of each breast;

422 17. A provision, when in compliance with federal law and regulation and approved by the Centers
423 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
424 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
425 program and may be provided by school divisions, regardless of whether the student receiving care has an

426 individualized education program or whether the health care service is included in a student's
427 individualized education program. Such services shall include those covered under the state plan for
428 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
429 benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for
430 payment of medical assistance for health care services provided through telemedicine services, as defined
431 in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall
432 be required to use proprietary technology or applications in order to be reimbursed for providing
433 telemedicine services;

434 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
435 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
436 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
437 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
438 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
439 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant
440 center where the surgery is proposed to be performed have been used by the transplant team or program
441 to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed
442 and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an
443 irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range
444 of physical and social functioning in the activities of daily living;

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

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

451 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
452 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United

453 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant
454 Hearing in its most current position statement addressing early hearing detection and intervention
455 programs. Such provision shall include payment for medical assistance for follow-up audiological
456 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and
457 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

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

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

473 24. A provision, when authorized by and in compliance with federal law, to establish a public-
474 private long-term care partnership program between the Commonwealth of Virginia and private insurance
475 companies that shall be established through the filing of an amendment to the state plan for medical
476 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
477 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
478 such services through encouraging the purchase of private long-term care insurance policies that have
479 been designated as qualified state long-term care insurance partnerships and may be used as the first source

480 of benefits for the participant's long-term care. Components of the program, including the treatment of
481 assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and
482 applicable federal guidelines;

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

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

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

495 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
496 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
497 Department shall not impose any utilization controls or other forms of medical management limiting the
498 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month
499 supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, dispense, or
500 furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude
501 coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice,
502 for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive"
503 means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications
504 containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by
505 the U.S. Food and Drug Administration for such purpose;

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

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

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

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

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

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

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

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

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

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

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

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

558 In the event conforming amendments to the state plan for medical assistance services are adopted,
559 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
560 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
561 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
562 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
563 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the
564 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
565 of the General Assembly unless enacted into law.

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

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

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

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

580 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
581 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
582 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-
583 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
584 program pursuant to 42 C.F.R. Part 1002.

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

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

588 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
589 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
590 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
591 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
592 the date of receipt of the notice.

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

599 F. When the services provided for by such plan are services which a marriage and family therapist,
600 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
601 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
602 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
603 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
604 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which
605 reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social
606 workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon
607 reasonable criteria, including the professional credentials required for licensure.

608 G. The Board shall prepare and submit to the Secretary of the United States Department of Health
609 and Human Services such amendments to the state plan for medical assistance services as may be
610 permitted by federal law to establish a program of family assistance whereby children over the age of 18

611 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
612 providing medical assistance under the plan to their parents.

613 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

635 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits
636 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price

637 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly
638 pays the pharmacist or pharmacy for pharmacist services.

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

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

647 K. When the services provided for by such plan are services by a pharmacist, pharmacy technician,
648 or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300
649 and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related
650 to initiation of services and treatment with or dispensing or administration of a vaccination by a
651 pharmacist, pharmacy technician, or pharmacy intern in accordance with § 54.1-3303.1, the Department
652 shall provide reimbursement for such service.

653 #