

HOUSE BILL NO. 278

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health and Human Services

on _____)

(Patron Prior to Substitute--Delegate Helmer)

A BILL to amend and reenact § 32.1-325 of the Code of Virginia, relating to state plan for medical assistance services; fertility preservation treatments.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

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

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

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

27 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the
28 individual's or his spouse's burial expenses;

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

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

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

44 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
45 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
46 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
47 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
48 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
49 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
50 children which are within the time periods recommended by the attending physicians in accordance with
51 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines
52 or Standards shall include any changes thereto within six months of the publication of such Guidelines or
53 Standards or any official amendment thereto;

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

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

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

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

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

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

78 13. A provision for payment of medical assistance which provides for payment for 48 hours of
79 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
80 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for

81 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring
82 the provision of inpatient coverage where the attending physician in consultation with the patient
83 determines that a shorter period of hospital stay is appropriate;

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

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

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

101 17. A provision, when in compliance with federal law and regulation and approved by the Centers
102 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
103 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
104 program and may be provided by school divisions, regardless of whether the student receiving care has an
105 individualized education program or whether the health care service is included in a student's
106 individualized education program. Such services shall include those covered under the state plan for
107 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

108 benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for
109 payment of medical assistance for health care services provided through telemedicine services, as defined
110 in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall
111 be required to use proprietary technology or applications in order to be reimbursed for providing
112 telemedicine services;

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

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

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

130 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
131 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United
132 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant
133 Hearing in its most current position statement addressing early hearing detection and intervention
134 programs. Such provision shall include payment for medical assistance for follow-up audiological

135 examinations as recommended by a physician, physician assistant, advanced practice registered nurse, or
136 audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

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

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

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

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

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

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

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

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

181 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
182 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
183 Department shall not impose any utilization controls or other forms of medical management limiting the
184 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month
185 supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, dispense, or
186 furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude
187 coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice,
188 for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive"

189 means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications
190 containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by
191 the U.S. Food and Drug Administration for such purpose;

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

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

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

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

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

226 33. A provision for payment of medical assistance for standard fertility preservation for individuals
227 who have been diagnosed with a form of cancer by a physician and need treatment for that cancer that
228 may cause a substantial risk of sterility or iatrogenic infertility, including surgery, radiation, or
229 chemotherapy. Standard fertility preservation service includes fertility preservation procedures and
230 services that (i) are not considered experimental or investigational by the American Society for
231 Reproductive Medicine or the American Society of Clinical Oncology and (ii) are consistent with
232 established medical practices or professional guidelines published by the American Society for
233 Reproductive Medicine or the American Society of Clinical Oncology, including (a) sperm banking, (b)
234 oocyte banking, (c) embryo banking, (d) banking of reproductive tissues, and (e) storage of reproductive
235 cells and tissues. Recipients of medical assistance pursuant to this subdivision shall be eligible to receive
236 payment for the preservation of their reproductive cells and tissues for one year. After one year, recipients
237 shall have the option to take over payment for preservation of their reproductive cells and tissues or have
238 such reproductive cells and tissues destroyed. For the purposes of this subdivision, "iatrogenic infertility"
239 means an impairment of fertility or reproductive functioning caused by surgery, chemotherapy, radiation,
240 or other medical treatment.

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

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

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

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

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

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

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

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

268 In the event conforming amendments to the state plan for medical assistance services are adopted,
269 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
270 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
271 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
272 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
273 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the
274 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
275 of the General Assembly unless enacted into law.

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

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

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

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

290 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
291 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
292 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-
293 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
294 program pursuant to 42 C.F.R. Part 1002.

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

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

298 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
299 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
300 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
301 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
302 the date of receipt of the notice.

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

309 F. When the services provided for by such plan are services which a marriage and family therapist,
310 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
311 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
312 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
313 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
314 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which
315 reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social
316 workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon
317 reasonable criteria, including the professional credentials required for licensure.

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

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

323 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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

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

357 K. When the services provided for by such plan are services by a pharmacist, pharmacy technician,
358 or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300
359 and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related
360 to services and treatment in accordance with § 54.1-3303.1, the Department shall provide reimbursement
361 for such service.

362 **2. That the provisions of this act shall not become effective unless and until the Department of**
363 **Medical Assistance Services obtains assurance from the Centers for Medicare and Medicaid**
364 **Services that the provision of medical assistance for fertility preservation services pursuant to this**
365 **act is medically necessary and eligible to receive federal funding.**

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