

1 SENATE BILL NO. 333

2 AMENDMENT IN THE NATURE OF A SUBSTITUTE

3 (Proposed by the Senate Committee on Education and Health

4 on _____)

5 (Patron Prior to Substitute--Senator Salim)

6 A BILL to amend and reenact §§ 32.1-3, 32.1-325, and 38.2-4319 of the Code of Virginia and to amend
7 the Code of Virginia by adding a section numbered 38.2-3418.22, relating to state plan for medical
8 assistance services; fertility preservation treatments.

9 **Be it enacted by the General Assembly of Virginia:**

10 **1. That §§ 32.1-3, 32.1-325, and 38.2-4319 of the Code of Virginia are amended and reenacted and**
11 **that the Code of Virginia is amended by adding a section numbered 38.2-3418.22 as follows:**

12 **§ 32.1-3. Definitions.**

13 As used in this title unless the context requires otherwise or it is otherwise provided:

14 "Board" or "State Board" means the State Board of Health.

15 "Commissioner" means the State Health Commissioner.

16 "Department" means the State Department of Health.

17 "Iatrogenic infertility" means an impairment of fertility or reproductive functioning caused by
18 surgery, chemotherapy, radiation, or other medical treatment.

19 "Medical care facility" means any institution, place, building, or agency, whether or not licensed
20 or required to be licensed by the Board or the Department of Behavioral Health and Developmental
21 Services, whether operated for profit or nonprofit, and whether privately owned or privately operated or
22 owned or operated by a local governmental unit, (i) by or in which health services are furnished,
23 conducted, operated, or offered for the prevention, diagnosis, or treatment of human disease, pain, injury,
24 deformity, or physical condition, whether medical or surgical, of two or more nonrelated persons who are

25 injured or physically sick or have mental illness, or for the care of two or more nonrelated persons
26 requiring or receiving medical, surgical, nursing, acute, chronic, convalescent, or long-term care services,
27 or services for individuals with disabilities, or (ii) which is the recipient of reimbursements from third-
28 party health insurance programs or prepaid medical service plans.

29 The term "medical care facility" does not include any facility of (a) the Department of Behavioral
30 Health and Developmental Services; (b) any nonhospital substance abuse residential treatment program
31 operated by or contracted primarily for the use of a community services board under the Department of
32 Behavioral Health and Developmental Services' Comprehensive State Plan; (c) an intermediate care
33 facility for individuals with intellectual disability (ICF/IID) that has no more than 12 beds and is in an
34 area identified as in need of residential services for individuals with intellectual disability in any plan of
35 the Department of Behavioral Health and Developmental Services; (d) a physician's office, except that
36 portion of a physician's office described in subdivision A 6 of § 32.1-102.1:3; (e) the Wilson Workforce
37 and Rehabilitation Center of the Department for Aging and Rehabilitative Services; (f) the Department of
38 Corrections; or (g) the Department of Veterans Services.

39 "Person" means an individual, corporation, partnership, or association or any other legal entity.

40 **§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health**
41 **and Human Services pursuant to federal law; administration of plan; contracts with health care**
42 **providers.**

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

47 1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21,
48 placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing

49 agencies by the Department of Social Services or placed through state and local subsidized adoptions to
50 the extent permitted under federal statute;

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

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

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

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

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

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

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

95 9. A provision identifying entities approved by the Board to receive applications and to determine
96 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate
97 contact information, including the best available address and telephone number, from each applicant for
98 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant

99 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et
100 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance
101 directives and how the applicant may make an advance directive;

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

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

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

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

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

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

124 16. A provision for payment of medical assistance for low-dose screening mammograms for
125 determining the presence of occult breast cancer. Such coverage shall make available one screening
126 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
127 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
128 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
129 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
130 radiation exposure of less than one rad mid-breast, two views of each breast;

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

143 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
144 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
145 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
146 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
147 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
148 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant

149 center where the surgery is proposed to be performed have been used by the transplant team or program
150 to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed
151 and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an
152 irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range
153 of physical and social functioning in the activities of daily living;

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

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

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

167 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer
168 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer
169 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease
170 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under
171 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including
172 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under
173 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise

174 eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v)
175 have not attained age 65. This provision shall include an expedited eligibility determination for such
176 women;

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

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

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

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

198 health care provider who provides health care services through telemedicine services shall be required to
199 use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

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

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

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

211 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
212 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
213 Department shall not impose any utilization controls or other forms of medical management limiting the
214 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month
215 supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, dispense, or
216 furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude
217 coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice,
218 for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive"
219 means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications
220 containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by
221 the U.S. Food and Drug Administration for such purpose;

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

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

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

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

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

256 33. A provision for payment of medical assistance for standard fertility preservation for individuals
257 who have been diagnosed with a form of cancer by a physician and need treatment for that cancer that
258 may cause a substantial risk of sterility or iatrogenic infertility, including surgery, radiation, or
259 chemotherapy. Standard fertility preservation service includes fertility preservation procedures and
260 services that: (i) are not considered experimental or investigational by the American Society for
261 Reproductive Medicine or the American Society of Clinical Oncology and (ii) are consistent with
262 established medical practices or professional guidelines published by the American Society for
263 Reproductive Medicine or the American Society of Clinical Oncology, including (a) sperm banking, (b)
264 oocyte banking, (c) embryo banking, (d) banking of reproductive tissues, and (e) storage of reproductive
265 cells and tissues. Recipients of medical assistance pursuant to this subdivision shall be eligible to receive
266 payment for the preservation of their reproductive cells and tissues for one year. After one year, recipients
267 shall have the option to take over payment for preservation of their reproductive cells and tissues or have
268 such reproductive cells and tissues destroyed.

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

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

- 272 2. Initiate such cost containment or other measures as are set forth in the appropriation act.
- 273 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the
274 provisions of this chapter.
- 275 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations
276 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services.
277 For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with
278 local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include
279 the projected costs/savings to the local boards of social services to implement or comply with such
280 regulation and, where applicable, sources of potential funds to implement or comply with such regulation.
- 281 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in
282 accordance with 42 C.F.R. § 488.400 et seq., Enforcement of Compliance for Long-Term Care Facilities
283 With Deficiencies.
- 284 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card,
285 or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
286 recipient of medical assistance services, and shall upon any changes in the required data elements set forth
287 in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective
288 information as may be required to electronically process a prescription claim.
- 289 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement
290 for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
291 regardless of any other provision of this chapter, such amendments to the state plan for medical assistance
292 services as may be necessary to conform such plan with amendments to the United States Social Security
293 Act or other relevant federal law and their implementing regulations or constructions of these laws and
294 regulations by courts of competent jurisdiction or the United States Secretary of Health and Human
295 Services.

296 In the event conforming amendments to the state plan for medical assistance services are adopted,
297 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
298 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
299 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
300 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
301 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the
302 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
303 of the General Assembly unless enacted into law.

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

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

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

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

318 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
319 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
320 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-

321 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
322 program pursuant to 42 C.F.R. Part 1002.

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

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

326 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
327 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
328 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
329 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
330 the date of receipt of the notice.

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

337 F. When the services provided for by such plan are services which a marriage and family therapist,
338 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
339 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
340 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
341 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
342 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which
343 reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social
344 workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon
345 reasonable criteria, including the professional credentials required for licensure.

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

351 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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

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

390 **§ 38.2-3418.22. Coverage for standard fertility preservation.**

391 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or
392 group accident and sickness insurance policies providing hospital, medical and surgical, or major medical
393 coverage on an expense-incurred basis; each corporation providing individual or group accident and
394 sickness subscription contracts; and each health maintenance organization providing a health care plan for

395 health care services shall provide coverage for standard fertility preservation for individuals who have
396 been diagnosed with a form of cancer by a physician and need treatment for such cancer that may cause a
397 substantial risk of sterility or iatrogenic infertility, including surgery, radiation, or chemotherapy. The
398 provisions of this section shall apply only to policies, contracts, and health plans issued in the large group
399 market as defined in § 38.2-3431.

400 B. As used in this section:

401 "Iatrogenic infertility" means an impairment of fertility or reproductive functioning caused by
402 surgery, chemotherapy, radiation, or other medical treatment.

403 "Standard fertility preservation" includes fertility preservation procedures and services that (i) are
404 not considered experimental or investigational by the American Society for Reproductive Medicine or the
405 American Society of Clinical Oncology and (ii) are consistent with established medical practices or
406 professional guidelines published by the American Society for Reproductive Medicine or the American
407 Society of Clinical Oncology, including (a) sperm banking, (b) oocyte banking, (c) embryo banking, (d)
408 banking of reproductive tissues, and (e) storage of reproductive cells and tissues. The insurer shall be
409 responsible for coverage for the preservation of the insured's reproductive cells and tissues for one year
410 after the end of treatment. After one year, the insurer has the option to end coverage and give the insured
411 the option to take over payment for preservation of his reproductive cells and tissues or have such
412 reproductive cells and tissues destroyed.

413 C. An insurer shall not impose (i) any exclusions, limitations, or other restrictions on coverage of
414 fertility medications that are different from those imposed on any other prescription medication; (ii) any
415 exclusions, limitations, or other restrictions on coverage of any fertility services based on a covered
416 individual's participation in fertility services provided by or to a third party; or (iii) deductibles,
417 copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for
418 the diagnosis and treatment of infertility and standard fertility preservation procedures, except as provided
419 in this section, that are different from those imposed upon benefits for services not related to infertility.

420 D. The provisions of this section shall not apply to (i) short-term travel, accident-only, or limited
421 or specified disease policies; (ii) policies, contracts, or plans issued in the individual market or small group
422 markets; (iii) contracts designed for issuance to persons eligible for coverage under Title XVIII of the
423 Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental
424 plans; or (iv) short-term nonrenewable policies of not more than six months' duration.

425 **§ 38.2-4319. Statutory construction and relationship to other laws.**

426 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
427 chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218
428 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326,
429 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9
430 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-
431 1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-
432 1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§
433 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-
434 1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405,
435 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-
436 3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-
437 3418.19, 38.2-3418.21, 38.2-3418.22, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§
438 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503,
439 subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525,
440 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of
441 Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55
442 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66
443 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under
444 this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in

445 conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the
446 activities of its health maintenance organization.

447 B. For plans administered by the Department of Medical Assistance Services that provide benefits
448 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title
449 except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-
450 200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232,
451 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600
452 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-
453 1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-
454 1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of
455 Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter
456 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9,
457 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions E 1, 2, and 3 of § 38.2-3407.10, §§ 38.2-3407.10:1,
458 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1,
459 38.2-3418.2, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13
460 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-
461 3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§
462 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-
463 6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance
464 organization granted a license under this chapter. This chapter shall not apply to an insurer or health
465 services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200
466 et seq.) except with respect to the activities of its health maintenance organization.

467 C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives
468 shall not be construed to violate any provisions of law relating to solicitation or advertising by health
469 professionals.

470 D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful
471 practice of medicine. All health care providers associated with a health maintenance organization shall be
472 subject to all provisions of law.

473 E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health
474 maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to
475 offer coverage to or accept applications from an employee who does not reside within the health
476 maintenance organization's service area.

477 F. For purposes of applying this section, "insurer" when used in a section cited in subsections A
478 and B shall be construed to mean and include "health maintenance organizations" unless the section cited
479 clearly applies to health maintenance organizations without such construction.

480 **2. That the provisions of § 32.1-325 of the Code of Virginia, as amended by this act, shall not become**
481 **effective unless and until the amendment to the state plan for medical assistance services is approved**
482 **by the Centers for Medicare and Medicaid Services and federal financial participation is available.**

483 **3. That the provisions of § 38.2-3418.22 of the Code of Virginia, as created by this act, shall apply**
484 **to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery,**
485 **reissued, extended, or renewed in the Commonwealth in the large group market as defined in § 38.2-**
486 **3431 of the Code of Virginia on or after January 1, 2025, and to all such policies, contracts, or plans**
487 **to which a term is changed or any premium adjustment is made on or after such date.**

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