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SENATE BILL NO. 954

Offered January 8, 2025

Prefiled January 6, 2025

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

Patron—Salim

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.22 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 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

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

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

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

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

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section,

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family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

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

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

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

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

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

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

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

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

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

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

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

determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

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

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

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

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

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

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

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

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

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

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

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

27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the Department shall not

181 impose any utilization controls or other forms of medical management limiting the supply of hormonal
182 contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. Nothing in this
183 subdivision shall be construed to (i) require a provider to prescribe, dispense, or furnish a 12-month supply of
184 self-administered hormonal contraceptives at one time or (ii) exclude coverage for hormonal contraceptives
185 as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive
186 purposes. As used in this subdivision, "hormonal contraceptive" means a medication taken to prevent
187 pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone,
188 that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration
189 for such purpose;

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

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

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

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

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

223 33. A provision for payment of medical assistance for remote ultrasound procedures and remote fetal non-
224 stress tests. Such provision shall utilize established CPT codes for these procedures and shall apply when the
225 patient is in a residence or other off-site location from the patient's provider that provides the same standard
226 of care. The provision shall provide for reimbursement only when a provider uses digital technology (i) to
227 collect medical and other forms of health data from a patient and electronically transmit that information
228 securely to a health care provider in a different location for interpretation and recommendation; (ii) that is
229 compliant with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et
230 seq.); and (iii) that is approved by the U.S. Food and Drug Administration. For fetal non-stress tests under
231 CPT Code 59025, the provision shall provide for reimbursement only if such test (a) is conducted with a
232 place of service modifier for at-home monitoring and (b) uses remote monitoring solutions that are approved
233 by the U.S. Food and Drug Administration for on-label use to monitor fetal heart rate, maternal heart rate,
234 and uterine activity; and

235 34. A provision for payment of medical assistance for standard fertility preservation for individuals who
236 have been diagnosed with a form of cancer by a physician and need treatment for that cancer that may cause
237 a substantial risk of sterility or iatrogenic infertility, including surgery, chemotherapy, or radiation. Standard
238 fertility preservation service includes fertility preservation procedures and services that: (i) are not
239 considered experimental or investigational by the American Society for Reproductive Medicine or the
240 American Society of Clinical Oncology and (ii) are consistent with established medical practices or
241 professional guidelines published by the American Society for Reproductive Medicine or the American

Society of Clinical Oncology, including (a) sperm banking, (b) oocyte banking, (c) banking of reproductive tissues, and (d) storage of reproductive cells and tissues. Recipients of medical assistance pursuant to this subdivision shall be eligible to receive payment for the preservation of their reproductive cells and tissues for one year. After one year, recipients shall have the option to take over payment for preservation of their reproductive cells and tissues or have such reproductive cells and tissues destroyed. As used in this subdivision, "iatrogenic infertility" means an impairment of fertility or reproductive functioning caused by surgery, chemotherapy, radiation, or other medical treatment.

B. In preparing the plan, the Board shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of §

303 32.1-162.13.

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

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

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

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

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

328 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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

361 K. When the services provided for by such plan are services by a pharmacist, pharmacy technician, or
362 pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and
363 consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to

services and treatment in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.

§ 38.2-3418.22. Coverage for standard fertility preservation.

A. Notwithstanding the provisions of § 38.2-3419 or subdivision A 1 of § 38.2-6506, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for standard fertility preservation for individuals who have been diagnosed with a form of cancer by a physician and need treatment for such cancer that may cause a substantial risk of sterility or iatrogenic infertility, including surgery, chemotherapy, or radiation. The insurer shall be responsible for coverage for the preservation of the insured's reproductive cells and tissues for one year after the end of treatment. After one year, the insurer has the option to end coverage and give the insured the option to take over payment for preservation of the insured's reproductive cells and tissues or have such reproductive cells and tissues destroyed. The provisions of this section shall apply only to policies, contracts, and health plans issued in the large group market as defined in § 38.2-3431.

B. As used in this section:

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

"Standard fertility preservation" includes fertility preservation procedures and services that (i) are not considered experimental or investigational by the American Society for Reproductive Medicine or the American Society of Clinical Oncology and (ii) are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, including (a) sperm banking, (b) oocyte banking, (c) banking of reproductive tissues, and (d) storage of reproductive cells and tissues.

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

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

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

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this 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 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-316.2, 38.2-322, 38.2-325, 38.2-326, 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 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 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, 38.2-3411, 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 38.2-3418.19, 38.2-3418.21, 38.2-3418.22, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this 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 through 38.2-225, 38.2-229, 38.2-232, 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 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 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 Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 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, 38.2-3407.9:01, and 38.2-3407.9:02, subsection E of § 38.2-3407.10, §§ 38.2-3407.10:1, 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, 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 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 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 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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

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

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

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

3. That the provisions of § 38.2-3418.22 of the Code of Virginia, as created by this act, shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, extended, or renewed in the Commonwealth in the large group market as defined in § 38.2-3431 of the Code of Virginia on or after January 1, 2026, and to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on or after such date.