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SENATE BILL NO. 1314

Senate Amendments in [] - January 23, 2025

A BILL to amend and reenact §§ 2.2-2818, 32.1-325, 38.2-3406.1, and 38.2-3418.7 of the Code of Virginia, relating to health insurance; coverage for prostate cancer screening.

Patron Prior to Engrossment—Senator McPike

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 32.1-325, 38.2-3406.1, and 38.2-3418.7 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical, and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage 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 and may be limited to a benefit of \$50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean 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.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be 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. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

3. Include an appeals process for resolution of complaints that shall provide reasonable procedures for the resolution of such complaints and shall be published and disseminated to all covered state employees. The appeals process shall be compliant with federal rules and regulations governing nonfederal, self-insured governmental health plans. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within time frames established by federal law. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more independent

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59 review organizations to review such decisions. Independent review organizations are entities that conduct
60 independent external review of adverse benefit determinations. The Department shall adopt regulations to
61 assure that the independent review organization conducting the reviews has adequate standards, credentials
62 and experience for such review. The independent review organization shall examine the final denial of claims
63 to determine whether the decision is objective, clinically valid, and compatible with established principles of
64 health care. The decision of the independent review organization shall (i) be in writing, (ii) contain findings
65 of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if
66 consistent with law and policy.

67 Prior to assigning an appeal to an independent review organization, the Department shall verify that the
68 independent review organization conducting the review of a denial of claims has no relationship or
69 association with (i) the covered person or the covered person's authorized representative; (ii) the treating
70 health care provider, or any of its employees or affiliates; (iii) the medical care facility at which the covered
71 service would be provided, or any of its employees or affiliates; or (iv) the development or manufacture of
72 the drug, device, procedure, or other therapy that is the subject of the final denial of a claim. The independent
73 review organization shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association
74 of health plans, or a professional association of health care providers. There shall be no liability on the part of
75 and no cause of action shall arise against any officer or employee of an independent review organization for
76 any actions taken or not taken or statements made by such officer or employee in good faith in the
77 performance of his powers and duties.

78 4. Include coverage for early intervention services. For purposes of this section, "early intervention
79 services" means medically necessary speech and language therapy, occupational therapy, physical therapy
80 and assistive technology services and devices for dependents from birth to age three who are certified by the
81 Department of Behavioral Health and Developmental Services as eligible for services under Part H of the
82 Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention
83 services for the population certified by the Department of Behavioral Health and Developmental Services
84 shall mean those services designed to help an individual attain or retain the capability to function age-
85 appropriately within his environment, and shall include services that enhance functional ability without
86 effecting a cure.

87 For persons previously covered under the plan, there shall be no denial of coverage due to the existence of
88 a preexisting condition. The cost of early intervention services shall not be applied to any contractual
89 provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the
90 insured's lifetime.

91 5. Include coverage for prescription drugs and devices approved by the United States Food and Drug
92 Administration for use as contraceptives.

93 6. Not deny coverage for any drug approved by the United States Food and Drug Administration for use
94 in the treatment of cancer on the basis that the drug has not been approved by the United States Food and
95 Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if
96 the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the
97 standard reference compendia.

98 7. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been
99 approved by the United States Food and Drug Administration for at least one indication and the drug is
100 recognized for treatment of the covered indication in one of the standard reference compendia or in
101 substantially accepted peer-reviewed medical literature.

102 8. Include coverage for equipment, supplies, and outpatient self-management training and education,
103 including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes,
104 gestational diabetes, and noninsulin-using diabetes if prescribed by a health care professional legally
105 authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes
106 outpatient self-management training and education shall be provided by a certified, registered, or licensed
107 health care professional.

108 9. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast
109 surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for
110 breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the
111 two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to
112 preexisting conditions.

113 10. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual
114 testing performed by any FDA-approved gynecologic cytology screening technologies.

115 11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient
116 following a radical or modified radical mastectomy and 24 hours of inpatient care following a total
117 mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in
118 this subdivision shall be construed as requiring the provision of inpatient coverage where the attending
119 physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

120 12. Include coverage (i) to persons age 50 and over and (ii) to persons age 40 and over who are at high

121 risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society,
 122 for one PSA *prostate-specific antigen* test in a 12-month period and digital rectal examinations; ~~all in~~
 123 accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing"
 124 means the analysis of a blood sample to determine the level of prostate specific antigen.

125 13. Permit any individual covered under the plan direct access to the health care services of a participating
 126 specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The
 127 plan shall have a procedure by which an individual who has an ongoing special condition may, after
 128 consultation with the primary care physician, receive a referral to a specialist for such condition who shall be
 129 responsible for and capable of providing and coordinating the individual's primary and specialty care related
 130 to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by
 131 such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision,
 132 "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii)
 133 requires specialized medical care over a prolonged period of time. Within the treatment period authorized by
 134 the referral, such specialist shall be permitted to treat the individual without a further referral from the
 135 individual's primary care provider and may authorize such referrals, procedures, tests, and other medical
 136 services related to the initial referral as the individual's primary care provider would otherwise be permitted
 137 to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special
 138 condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the
 139 treatment of the special condition. If the primary care provider, in consultation with the plan and the
 140 specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a
 141 referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating
 142 specialist to provide written notification to the covered individual's primary care physician of any visit to
 143 such specialist. Such notification may include a description of the health care services rendered at the time of
 144 the visit.

145 14. Include provisions allowing employees to continue receiving health care services for a period of up to
 146 90 days from the date of the primary care physician's notice of termination from any of the plan's provider
 147 panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider,
 148 except when the provider is terminated for cause.

149 For a period of at least 90 days from the date of the notice of a provider's termination from any of the
 150 plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the
 151 plan to render health care services to any of the covered employees who (i) were in an active course of
 152 treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care
 153 services from the provider.

154 Notwithstanding the provisions of this subdivision, any provider shall be permitted by the plan to continue
 155 rendering health services to any covered employee who has entered the second trimester of pregnancy at the
 156 time of the provider's termination of participation, except when a provider is terminated for cause. Such
 157 treatment shall, at the covered employee's option, continue through the provision of postpartum care directly
 158 related to the delivery.

159 Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering
 160 health services to any covered employee who is determined to be terminally ill (as defined under §
 161 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except
 162 when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for
 163 the remainder of the employee's life for care directly related to the treatment of the terminal illness.

164 A provider who continues to render health care services pursuant to this subdivision shall be reimbursed
 165 in accordance with the carrier's agreement with such provider existing immediately before the provider's
 166 termination of participation.

167 15. Include coverage for patient costs incurred during participation in clinical trials for treatment studies
 168 on cancer, including ovarian cancer trials.

169 The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on
 170 cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical
 171 procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments, and
 172 coinsurance factors that are no less favorable than for physical illness generally.

173 For purposes of this subdivision:

174 "Cooperative group" means a formal network of facilities that collaborate on research projects and have
 175 an established NIH-approved peer review program operating within the group. "Cooperative group" includes
 176 (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute
 177 Community Clinical Oncology Program.

178 "FDA" means the Federal Food and Drug Administration.

179 "Multiple project assurance contract" means a contract between an institution and the federal Department
 180 of Health and Human Services that defines the relationship of the institution to the federal Department of
 181 Health and Human Services and sets out the responsibilities of the institution and the procedures that will be

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182 used by the institution to protect human subjects.

183 "NCI" means the National Cancer Institute.

184 "NIH" means the National Institutes of Health.

185 "Patient" means a person covered under the plan established pursuant to this section.

186 "Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the
187 treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the
188 cost of nonhealth care services that a patient may be required to receive as a result of the treatment being
189 provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the
190 clinical trial, or (iii) the cost of the investigational drug or device.

191 Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided
192 if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may,
193 however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

194 The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

195 a. The National Cancer Institute;

196 b. An NCI cooperative group or an NCI center;

197 c. The FDA in the form of an investigational new drug application;

198 d. The federal Department of Veterans Affairs; or

199 e. An institutional review board of an institution in the Commonwealth that has a multiple project
200 assurance contract approved by the Office of Protection from Research Risks of the NCI.

201 The facility and personnel providing the treatment shall be capable of doing so by virtue of their
202 experience, training, and expertise.

203 Coverage under this subdivision shall apply only if:

204 (1) There is no clearly superior, noninvestigational treatment alternative;

205 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at
206 least as effective as the noninvestigational alternative; and

207 (3) The patient and the physician or health care provider who provides services to the patient under the
208 plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures
209 established by the plan.

210 16. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a covered
211 employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered employee
212 following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines.
213 Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when
214 the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is
215 appropriate.

216 17. Include coverage for biologically based mental illness.

217 For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition
218 caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially
219 limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental
220 illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major
221 depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder,
222 autism, and drug and alcoholism addiction.

223 Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for
224 any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime
225 durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and
226 coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

227 Nothing shall preclude the undertaking of usual and customary procedures to determine the
228 appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this
229 option, provided that all such appropriateness and medical necessity determinations are made in the same
230 manner as those determinations made for the treatment of any other illness, condition, or disorder covered by
231 such policy or contract.

232 18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery
233 or such other methods as may be recognized by the National Institutes of Health as effective for the long-term
234 reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments,
235 and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for
236 morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National
237 Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100
238 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan
239 Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared
240 with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep
241 apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used
242 herein, "BMI" equals weight in kilograms divided by height in meters squared.

243 19. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult

244 blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in
 245 accordance with the most recently published recommendations established by the American College of
 246 Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and
 247 frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be
 248 more restrictive than or separate from coverage provided for any other illness, condition, or disorder for
 249 purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar
 250 limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum
 251 for deductibles and copayments and coinsurance factors.

252 20. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or
 253 other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee
 254 provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth
 255 in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such
 256 corrective information as may be required to electronically process a prescription claim.

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

264 22. Notwithstanding any provision of this section to the contrary, every plan established in accordance
 265 with this section shall comply with the provisions of § 2.2-2818.2.

266 C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such
 267 funds as shall be appropriated by law. Appropriations, premiums, and other payments shall be deposited in
 268 the employee health insurance fund, from which payments for claims, premiums, cost containment programs,
 269 and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund
 270 shall be deemed separate and independent trust funds, shall be segregated from all other funds of the
 271 Commonwealth, and shall be invested and administered solely in the interests of the employees and their
 272 beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or
 273 authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and
 274 administrative expenses, including but not limited to legislative oversight of the health insurance fund.

275 D. For the purposes of this section:

276 "Peer-reviewed medical literature" means a scientific study published only after having been critically
 277 reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has
 278 been determined by the International Committee of Medical Journal Editors to have met the Uniform
 279 Requirements for Manuscripts submitted to biomedical journals. "Peer-reviewed medical literature" does not
 280 include publications or supplements to publications that are sponsored to a significant extent by a
 281 pharmaceutical manufacturing company or health carrier.

282 "Standard reference compendia" means:

- 283 1. American Hospital Formulary Service — Drug Information;
- 284 2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
- 285 3. Elsevier Gold Standard's Clinical Pharmacology.

286 "State employee" means state employee as defined in § 51.1-124.3; employee as defined in § 51.1-201;
 287 the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301 and judges, clerks,
 288 and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and
 289 district courts of the Commonwealth; interns and residents employed by the School of Medicine and Hospital
 290 of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth
 291 University Health System Authority as provided in § 23.1-2415; and employees of the Virginia Alcoholic
 292 Beverage Control Authority as provided in § 4.1-101.05.

293 E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as
 294 an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all
 295 or any portion of the cost thereof.

296 F. Any self-insured group health insurance plan established by the Department of Human Resource
 297 Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis
 298 of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan
 299 criteria established by the Department.

300 G. The plan shall include, in each planning district, at least two health coverage options, each sponsored
 301 by unrelated entities. No later than July 1, 2006, one of the health coverage options to be available in each
 302 planning district shall be a high deductible health plan that would qualify for a health savings account
 303 pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

304 In each planning district that does not have an available health coverage alternative, the Department shall

305 voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide
306 coverage under the plan.

307 This subsection shall not apply to any state agency authorized by the Department to establish and
308 administer its own health insurance coverage plan separate from the plan established by the Department.

309 H. Any self-insured group health insurance plan established by the Department of Human Resource
310 Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to
311 the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually,
312 and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics
313 committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and
314 (iii) other health care providers.

315 If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to
316 obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a
317 specific, medically necessary nonformulary prescription drug if, after reasonable investigation and
318 consultation with the prescriber, the formulary drug is determined to be an inappropriate therapy for the
319 medical condition of the person. The plan shall act on such requests within one business day of receipt of the
320 request.

321 Any plan established in accordance with this section shall be authorized to provide for the selection of a
322 single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the
323 covered person's address by mail, common carrier, or delivery service. As used in this subsection, "mail order
324 pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary
325 business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or
326 device to a patient primarily by mail, common carrier, or delivery service.

327 I. Any plan established in accordance with this section requiring preauthorization prior to rendering
328 medical treatment shall have personnel available to provide authorization at all times when such
329 preauthorization is required.

330 J. Any plan established in accordance with this section shall provide to all covered employees written
331 notice of any benefit reductions during the contract period at least 30 days before such reductions become
332 effective.

333 K. No contract between a provider and any plan established in accordance with this section shall include
334 provisions that require a health care provider or health care provider group to deny covered services that such
335 provider or group knows to be medically necessary and appropriate that are provided with respect to a
336 covered employee with similar medical conditions.

337 L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect
338 the interests of covered employees under any state employee's health plan.

339 The Ombudsman shall:

340 1. Assist covered employees in understanding their rights and the processes available to them according to
341 their state health plan.

342 2. Answer inquiries from covered employees by telephone and electronic mail.

343 3. Provide to covered employees information concerning the state health plans.

344 4. Develop information on the types of health plans available, including benefits and complaint
345 procedures and appeals.

346 5. Make available, either separately or through an existing Internet web site utilized by the Department of
347 Human Resource Management, information as set forth in subdivision 4 and such additional information as
348 he deems appropriate.

349 6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the
350 disposition of each such matter.

351 7. Upon request, assist covered employees in using the procedures and processes available to them from
352 their health plan, including all appeal procedures. Such assistance may require the review of health care
353 records of a covered employee, which shall be done only in accordance with the federal Health Insurance
354 Portability and Accountability Act privacy rules. The confidentiality of any such medical records shall be
355 maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

356 8. Ensure that covered employees have access to the services provided by the Ombudsman and that the
357 covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

358 9. Report annually on his activities to the standing committees of the General Assembly having
359 jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each
360 year.

361 M. The plan established in accordance with this section shall not refuse to accept or make reimbursement
362 pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

363 For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage
364 reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until
365 the covered employee notifies the plan in writing of the assignment.

366 N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification

367 number, which shall be assigned to the covered employee and shall not be the same as the employee's social
368 security number.

369 O. Any group health insurance plan established by the Department of Human Resource Management that
370 contains a coordination of benefits provision shall provide written notification to any eligible employee as a
371 prominent part of its enrollment materials that if such eligible employee is covered under another group
372 accident and sickness insurance policy, group accident and sickness subscription contract, or group health
373 care plan for health care services, that insurance policy, subscription contract, or health care plan may have
374 primary responsibility for the covered expenses of other family members enrolled with the eligible employee.
375 Such written notification shall describe generally the conditions upon which the other coverage would be
376 primary for dependent children enrolled under the eligible employee's coverage and the method by which the
377 eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered
378 expenses of each family member.

379 P. Any plan established by the Department of Human Resource Management pursuant to this section shall
380 provide that coverage under such plan for family members enrolled under a participating state employee's
381 coverage shall continue for a period of at least 30 days following the death of such state employee.

382 Q. The plan established in accordance with this section that follows a policy of sending its payment to the
383 covered employee or covered family member for a claim for services received from a nonparticipating
384 physician or osteopath shall (i) include language in the member handbook that notifies the covered employee
385 of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include
386 this language with any such payment sent to the covered employee or covered family member, and (iii)
387 include the name and any last known address of the nonparticipating provider on the explanation of benefits
388 statement.

389 R. The plan established by the Department of Human Resource Management pursuant to this section shall
390 provide that coverage under such plan for an incapacitated child enrolled under a participating state
391 employee's coverage shall be valid without regard to whether such child lives with the covered employee as a
392 member of the employee's household so long as the child is dependent upon the employee for more than half
393 of the child's financial support and the child is receiving residential support services.

394 For purposes of this subsection, "incapacitated child" means an adult child who is incapacitated due to a
395 physical or mental health condition that existed prior to the termination of coverage due to such child
396 attaining the limiting age under the plan for eligible children dependents.

397 S. The Department of Human Resource Management shall report annually, by November 30 of each year,
398 on cost and utilization information for each of the mandated benefits set forth in subsection B, including any
399 mandated benefit made applicable, pursuant to subdivision B 22, to any plan established pursuant to this
400 section. The report shall be in the same detail and form as required of reports submitted pursuant to §
401 38.2-3419.1, with such additional information as is required to determine the financial impact, including the
402 costs and benefits, of the particular mandated benefit.

403 **§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and**
404 **Human Services pursuant to federal law; administration of plan; contracts with health care providers.**

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

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

413 2. A provision for determining eligibility for benefits for medically needy individuals which disregards
414 from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of
415 \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual
416 or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an
417 individual owned by the individual or his spouse if the cash surrender value of such policies has been
418 excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or
419 other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial
420 expenses;

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

428 Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal
429 residence and all contiguous property essential to the operation of the home regardless of value;

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

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

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

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

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

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

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

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

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

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

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

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

485 16. A provision for payment of medical assistance for low-dose screening mammograms for determining
486 the presence of occult breast cancer. Such coverage shall make available one screening mammogram to
487 persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such
488 mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of

489 the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray
 490 tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than
 491 one rad mid-breast, two views of each breast;

492 17. A provision, when in compliance with federal law and regulation and approved by the Centers for
 493 Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
 494 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program
 495 and may be provided by school divisions, regardless of whether the student receiving care has an
 496 individualized education program or whether the health care service is included in a student's individualized
 497 education program. Such services shall include those covered under the state plan for medical assistance
 498 services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in §
 499 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for
 500 health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care
 501 provider who provides health care services through telemedicine shall be required to use proprietary
 502 technology or applications in order to be reimbursed for providing telemedicine services;

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

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

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

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

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

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

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

550 25. A provision for the payment of medical assistance for otherwise eligible pregnant women during the

551 first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance
552 Program Reauthorization Act of 2009 (P.L. 111-3);

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

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

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

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

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

580 28. A provision for payment of medical assistance for remote patient monitoring services provided via
581 telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically complex infants
582 and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months
583 following the date of such surgery; and (v) patients with a chronic or acute health condition who have had
584 two or more hospitalizations or emergency department visits related to such health condition in the previous
585 12 months when there is evidence that the use of remote patient monitoring is likely to prevent readmission
586 of such patient to a hospital or emergency department. For the purposes of this subdivision, "remote patient
587 monitoring services" means the use of digital technologies to collect medical and other forms of health data
588 from patients in one location and electronically transmit that information securely to health care providers in
589 a different location for analysis, interpretation, and recommendations, and management of the patient.
590 "Remote patient monitoring services" includes monitoring of clinical patient data such as weight, blood
591 pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data, treatment adherence
592 monitoring, and interactive videoconferencing with or without digital image upload;

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

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

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

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

612 accessories; and

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

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

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

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

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

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

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

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

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

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

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

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

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

669 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or
 670 contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to
 671 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
 672 C.F.R. § 1002.212.

673 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or

674 contract, with a provider who is or has been a principal in a professional or other corporation when such
675 corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316,
676 or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to
677 42 C.F.R. Part 1002.

678 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of §
679 32.1-162.13.

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

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

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

690 F. When the services provided for by such plan are services which a marriage and family therapist,
691 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to
692 render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly
693 licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed
694 clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for
695 covered services as provided in the state plan. The Board shall promulgate regulations which reimburse
696 licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers,
697 licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria,
698 including the professional credentials required for licensure.

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

704 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

734 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public Procurement

Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

K. When the services provided for by such plan are services by a pharmacist, pharmacy technician, or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and 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.

§ 38.2-3406.1. Application of requirements that policies offered by small employers include state-mandated health benefits.

A. As used in this section:

"Eligible individual" means an individual who is employed by a small employer and has satisfied applicable waiting period requirements.

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a corporation that provides accident and sickness subscription contracts, or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

"Small employer" has the same meaning ascribed to the term in § 38.2-3431.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services that is offered, sold, or issued by a health insurer to a small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit, except for:

a. Coverage for mammograms pursuant to § 38.2-3418.1;

b. Coverage for pap smears pursuant to § 38.2-3418.1:2;

c. Coverage for ~~PSA testing~~ *prostate cancer screening* pursuant to § 38.2-3418.7; and

d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

2. May include any, or none, of the state-mandated health benefits not otherwise noted in subdivision B 1 as the health insurer and the small employer shall agree.

Notwithstanding any provision of this section to the contrary, if any plan authorized by this section includes and offers health care services covered by the plan that may be legally rendered by a health care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services when rendered by such provider. Unless otherwise provided in this section, this provision shall not require any benefit be provided as a covered service.

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy, contract, or evidence of coverage is not required to provide state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide, and shall clearly describe all eligibility requirements.

D. A policy form, subscription contract, or evidence of coverage issued under this section to a small

796 employer shall prominently disclose any and all state-mandated health benefits that the policy, subscription
 797 contract, or evidence of coverage does not provide. Such disclosure shall also be included in certificate forms
 798 or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms
 799 providing coverage under this section shall clearly disclose the intended purposes for such policies, contracts,
 800 or evidences of coverage when submitting the forms to the Commission for approval in accordance with §
 801 38.2-316.

802 E. The Commission shall adopt any regulations necessary to implement this section.

803 F. The provisions of this section shall not apply in any instance in which the provisions of this section are
 804 inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

805 **§ 38.2-3418.7. Coverage for prostate cancer screening.**

806 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group
 807 accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage
 808 on an expense-incurred basis; each corporation providing individual or group accident and sickness
 809 subscription contracts; and each health maintenance organization providing a health care plan for health care
 810 services shall provide coverage to (i) persons age ~~forty~~ 50 and over and (ii) persons age ~~forty~~ 40 and over who
 811 are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer
 812 Society, for ~~one PSA test in a twelve-month period and digital rectal examinations, all in accordance with~~
 813 ~~American Cancer Society guidelines~~ *prostate cancer screening* under any such policy, contract, or plan
 814 delivered, issued for delivery, or renewed in ~~this~~ the Commonwealth on and after [~~July 1, 1998~~ *January 1,*
 815 *2026* July 1, 1998].

816 B. For the purpose of this section, "~~PSA testing~~" means ~~the analysis of a blood sample to determine the~~
 817 ~~level of prostate specific antigen~~ *"prostate cancer screening" includes one prostate-specific antigen test in a*
 818 *12-month period and digital rectal examinations.*

819 C. *No insurer, corporation, or health maintenance organization shall impose on any person receiving*
 820 *benefits pursuant to this section any deductible, coinsurance, copayment, or other cost-sharing requirement,*
 821 *except to the extent that coverage without cost-sharing would disqualify a high-deductible health benefit plan*
 822 *from eligibility for a health savings account pursuant to 26 U.S.C. § 223.*

823 D. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified
 824 disease policies other than cancer policies, (ii) short-term nonrenewable policies of not more than six months'
 825 duration, or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII
 826 of the Social Security Act, known as Medicare, or any other similar coverage under state or federal
 827 governmental plans.

828 [**2. That the provisions of this act shall apply only to contracts, policies, or plans delivered, issued for**
 829 **delivery, or renewed in the Commonwealth on or after January 1, 2026.]**