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**HOUSE BILL NO. 2610****AMENDMENT IN THE NATURE OF A SUBSTITUTE**(Proposed by the House Committee on Health and Human Services  
on January 28, 2025)

(Patrons Prior to Substitute—Delegates Callsen and Kilgore [HB 2209])

A *BILL to amend and reenact § 32.1-325 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-325.5, relating to Department of Medical Assistance Services; state pharmacy benefits manager.*

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

**1. That § 32.1-325 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-325.5 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, 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

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

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

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

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

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

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

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

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

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

100 17. A provision, when in compliance with federal law and regulation and approved by the Centers for  
101 Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to  
102 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program  
103 and may be provided by school divisions, regardless of whether the student receiving care has an  
104 individualized education program or whether the health care service is included in a student's individualized  
105 education program. Such services shall include those covered under the state plan for medical assistance  
106 services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in §  
107 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for  
108 health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care  
109 provider who provides health care services through telemedicine shall be required to use proprietary  
110 technology or applications in order to be reimbursed for providing telemedicine services;

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

121 social functioning in the activities of daily living;

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

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

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

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

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

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

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

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

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

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

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

177 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month  
178 supply of hormonal contraceptives at one time. Absent clinical contraindications, the Department shall not  
179 impose any utilization controls or other forms of medical management limiting the supply of hormonal  
180 contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. Nothing in this  
181 subdivision shall be construed to (i) require a provider to prescribe, dispense, or furnish a 12-month supply of

182 self-administered hormonal contraceptives at one time or (ii) exclude coverage for hormonal contraceptives  
183 as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive  
184 purposes. As used in this subdivision, "hormonal contraceptive" means a medication taken to prevent  
185 pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone,  
186 that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration  
187 for such purpose;

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

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

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

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

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

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

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

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

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

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

239 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant  
240 to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services. For  
241 regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local  
242 boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the

243 projected costs/savings to the local boards of social services to implement or comply with such regulation  
244 and, where applicable, sources of potential funds to implement or comply with such regulation.

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

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

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

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

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

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

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

277 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or  
278 contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to  
279 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  
280 C.F.R. § 1002.212.

281 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or  
282 contract, with a provider who is or has been a principal in a professional or other corporation when such  
283 corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315, 32.1-316,  
284 or 32.1-317, or any other felony or has been excluded from participation in any federal program pursuant to  
285 42 C.F.R. Part 1002.

286 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of §  
287 32.1-162.13.

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

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

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

298 F. When the services provided for by such plan are services which a marriage and family therapist,  
299 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to  
300 render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly  
301 licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed  
302 clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for  
303 covered services as provided in the state plan. The Board shall promulgate regulations which reimburse

304 licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers,  
305 licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria,  
306 including the professional credentials required for licensure.

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

312 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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

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

350 **§ 32.1-325.5. State pharmacy benefits manager.**

351 A. As used in this section:

352 "Pharmacy benefits manager" means the same as that term is defined in § 38.2-3465.

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

357 "State pharmacy benefits manager" means the pharmacy benefits manager contracted by the Department  
358 pursuant to this section to administer pharmacy benefits for all Medicaid recipients in the Commonwealth.

359 B. By December 31, 2025, the Department shall select and contract with a single third-party  
360 administrator to serve as the state pharmacy benefits manager to administer all pharmacy benefits for  
361 Medicaid recipients, including those enrolled in a managed care organization with whom the Department  
362 contracts for the delivery of Medicaid services. Each managed care contract entered into or renewed by the  
363 Department for the delivery of Medicaid services by a managed care organization shall require the managed  
364 care organization to contract with and utilize the state pharmacy benefits manager for the purpose of

365 *administering all pharmacy benefits for Medicaid recipients enrolled with the managed care organization.*  
366 *C. The Department's contract with the state pharmacy benefits manager shall:*  
367 *1. Establish the state pharmacy benefits manager's fiduciary duty owed to the Department;*  
368 *2. Require the use of pass-through pricing;*  
369 *3. Require the state pharmacy benefits manager to use the common formulary, reimbursement*  
370 *methodologies, and dispensing fees established by the Department;*  
371 *4. Require transparency in drug costs, rebates collected and paid, dispensing fees paid, administrative*  
372 *fees, and all other charges, fees, costs, and holdbacks; and*  
373 *5. Prohibit the use of spread pricing.*  
374 *D. No entity contracted by the Department to act as the state pharmacy benefits manager shall have a*  
375 *business conflict of interest with any Medicaid provider or vendor.*