

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act 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.

[H 2610]

Approved

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;

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

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

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

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

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

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

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

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

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

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

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

social functioning in the activities of daily living;

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

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

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

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

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

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

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

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

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

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

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

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

as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by the U.S. Food and Drug Administration for such purpose;

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

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

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

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

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

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

B. In preparing the plan, the Board shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

284 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of §
 285 32.1-162.13.

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

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

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

296 F. When the services provided for by such plan are services which a marriage and family therapist,
 297 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to
 298 render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly
 299 licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed
 300 clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for
 301 covered services as provided in the state plan. The Board shall promulgate regulations which reimburse
 302 licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers,
 303 licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria,
 304 including the professional credentials required for licensure.

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

H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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.

§ 32.1-325.5. State pharmacy benefits manager.

A. As used in this section:

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

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

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

B. By July 1, 2026, the Department shall select and contract with a single third-party administrator to serve as the state pharmacy benefits manager to administer all pharmacy benefits for Medicaid recipients, including those enrolled in a managed care organization by such date with whom the Department contracts for the delivery of Medicaid services. Each managed care contract entered into or renewed by the Department for the delivery of Medicaid services by a managed care organization shall require the managed care organization to contract with and utilize the state pharmacy benefits manager for the purpose of administering all pharmacy benefits for Medicaid recipients enrolled with the managed care organization. Notwithstanding the provisions of § 38.2-3470, the state pharmacy benefits manager shall adhere to subdivision A 5 of § 38.2-3467 unless otherwise prohibited by federal law.

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 negotiated 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 2. That the Department of Medical Assistance Services (the Department) shall engage an independent
375 consultant with direct experience (i) advising Medicaid fraud control units and (ii) working with states
376 that have established a single pharmacy benefits manager for their Medicaid program for the
377 implementation of a contract with a third-party pharmacy benefits manager for the administration of
378 pharmacy benefits for the Virginia Medicaid managed care and fee-for-services programs. The
379 consultant shall not be engaged by any Virginia Medicaid managed care organization or by any
380 pharmacy benefits manager contracted with a Virginia Medicaid managed care organization. The
381 evaluation shall not affect the implementation date of July 1, 2026.