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HOUSE BILL NO. 2287

Offered January 8, 2003

Prefiled January 8, 2003

A BILL to amend and reenact § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia, relating to children's health insurance.

Patrons—Devolites, Bryant, Hall, Hamilton, Jones, S.C. and Melvin; Senators: Rerras and Stolle

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325, as it is currently effective and as it may become effective, and § 32.1-351 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-325. (For effective date -/ See note) Board to submit plan for medical assistance services to 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 Secretary of the United States Department 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 twenty-one, 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 twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one 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 payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of twenty-one who have been diagnosed with

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

63 8. A provision identifying entities approved by the Board to receive applications and to determine
64 eligibility for medical assistance;

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

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

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

71 12. A provision for payment of medical assistance which provides for payment for forty-eight hours
72 of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four
73 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection
74 for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as
75 requiring the provision of inpatient coverage where the attending physician in consultation with the
76 patient determines that a shorter period of hospital stay is appropriate;

77 13. A requirement that certificates of medical necessity for durable medical equipment and any
78 supporting verifiable documentation shall be signed, dated, and returned by the physician and in the
79 durable medical equipment provider's possession within sixty days from the time the ordered durable
80 medical equipment and supplies are first furnished by the durable medical equipment provider;

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

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

95 16. A provision, when in compliance with federal law and regulation and approved by the Health
96 Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible
97 students when such services qualify for reimbursement by the Virginia Medicaid program and may be
98 provided by school divisions;

99 17. A provision for payment of medical assistance services for liver, heart and lung transplantation
100 procedures for individuals over the age of twenty-one years when (i) there is no effective alternative
101 medical or surgical therapy available with outcomes that are at least comparable to the transplant
102 procedure; (ii) the transplant procedure and application of the procedure in treatment of the specific
103 condition have been clearly demonstrated to be medically effective and not experimental or
104 investigational; (iii) prior authorization by the Department of Medical Assistance Services has been
105 obtained; (iv) the patient-selection criteria of the specific transplant center where the surgery is proposed
106 to be performed have been used by the transplant team or program to determine the appropriateness of
107 the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond
108 to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii)
109 the transplant is likely to prolong the patient's life and restore a range of physical and social functioning
110 in the activities of daily living;

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

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

118 20. A provision for payment for medical assistance for infant hearing screenings and all necessary
119 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the
120 United States Food and Drug Administration, and as recommended by the national Joint Committee on

121 Infant Hearing in its most current position statement addressing early hearing detection and intervention
 122 programs. Such provision shall include payment for medical assistance for follow-up audiological
 123 examinations as recommended by a physician or audiologist and performed by a licensed audiologist to
 124 confirm the existence or absence of hearing loss; and

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

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

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

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

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

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

146 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations
 147 pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services.
 148 For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis
 149 with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall
 150 include the projected costs/savings to the local boards of social services to implement or comply with
 151 such regulation and, where applicable, sources of potential funds to implement or comply with such
 152 regulation.

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

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

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

168 In the event conforming amendments to the state plan for medical assistance services are adopted, the
 169 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
 170 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
 171 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
 172 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
 173 regulations are necessitated by an emergency situation. Any such amendments which are in conflict with
 174 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
 175 session of the General Assembly unless enacted into law.

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

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

180 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
 181 health care providers where necessary to carry out the provisions of such state plan. Any such agreement

182 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is
183 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
184 agreement or contract. Such provider may also apply to the Director for reconsideration of the
185 agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

186 3. Refuse to enter into or renew an agreement or contract with any provider which has been
187 convicted of a felony.

188 4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a
189 principal in a professional or other corporation when such corporation has been convicted of a felony.

190 E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his
191 interest in a convicted professional or other corporation, the Director shall, upon request, conduct a
192 hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's
193 participation in the conduct resulting in the conviction.

194 The Director's decision upon reconsideration shall be consistent with federal and state laws. The
195 Director may consider the nature and extent of any adverse impact the agreement or contract denial or
196 termination may have on the medical care provided to Virginia Medicaid recipients.

197 F. When the services provided for by such plan are services which a clinical psychologist or a
198 clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render
199 in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical
200 social worker or licensed professional counselor or licensed clinical nurse specialist who makes
201 application to be a provider of such services, and thereafter shall pay for covered services as provided in
202 the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists,
203 licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at
204 rates based upon reasonable criteria, including the professional credentials required for licensure.

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

210 H. The Department of Medical Assistance Services shall:

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

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

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

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

230 § 32.1-325. (Delayed effective date /- See notes) Board to submit plan for medical assistance services
231 to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts
232 with health care providers

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

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

241 2. A provision for determining eligibility for benefits for medically needy individuals which
242 disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount
243 not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial

244 expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value
 245 of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender
 246 value of such policies has been excluded from countable resources and (ii) the amount of any other
 247 revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of
 248 meeting the individual's or his spouse's burial expenses;

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

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

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

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

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

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

286 9. A provision identifying entities approved by the Board to receive applications and to determine
 287 eligibility for medical assistance;

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

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

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

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

300 14. A requirement that certificates of medical necessity for durable medical equipment and any
 301 supporting verifiable documentation shall be signed, dated, and returned by the physician and in the
 302 durable medical equipment provider's possession within sixty days from the time the ordered durable
 303 medical equipment and supplies are first furnished by the durable medical equipment provider;

304 15. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons

305 age forty and over who are at high risk for prostate cancer, according to the most recent published
306 guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal
307 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this
308 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate
309 specific antigen;

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

318 17. A provision, when in compliance with federal law and regulation and approved by the Health
319 Care Financing Administration, for payment of medical assistance services delivered to Medicaid-eligible
320 students when such services qualify for reimbursement by the Virginia Medicaid program and may be
321 provided by school divisions;

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

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

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

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

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

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

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

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

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

366 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the

367 provisions of this chapter.

368 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations
 369 pursuant to § 2.2-4007, the potential fiscal impact of such regulation on local boards of social services.
 370 For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis
 371 with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall
 372 include the projected costs/savings to the local boards of social services to implement or comply with
 373 such regulation and, where applicable, sources of potential funds to implement or comply with such
 374 regulation.

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

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

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

390 In the event conforming amendments to the state plan for medical assistance services are adopted, the
 391 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
 392 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
 393 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
 394 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
 395 regulations are necessitated by an emergency situation. Any such amendments which are in conflict with
 396 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
 397 session of the General Assembly unless enacted into law.

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

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

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

408 3. Refuse to enter into or renew an agreement or contract with any provider which has been
 409 convicted of a felony.

410 4. Refuse to enter into or renew an agreement or contract with a provider who is or has been a
 411 principal in a professional or other corporation when such corporation has been convicted of a felony.

412 E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his
 413 interest in a convicted professional or other corporation, the Director shall, upon request, conduct a
 414 hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's
 415 participation in the conduct resulting in the conviction.

416 The Director's decision upon reconsideration shall be consistent with federal and state laws. The
 417 Director may consider the nature and extent of any adverse impact the agreement or contract denial or
 418 termination may have on the medical care provided to Virginia Medicaid recipients.

419 F. When the services provided for by such plan are services which a clinical psychologist or a
 420 clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render
 421 in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical
 422 social worker or licensed professional counselor or licensed clinical nurse specialist who makes
 423 application to be a provider of such services, and thereafter shall pay for covered services as provided in
 424 the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists,
 425 licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at
 426 rates based upon reasonable criteria, including the professional credentials required for licensure.

427 G. The Board shall prepare and submit to the Secretary of the United States Department of Health

428 and Human Services such amendments to the state plan for medical assistance services as may be
 429 permitted by federal law to establish a program of family assistance whereby children over the age of
 430 eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward
 431 the cost of providing medical assistance under the plan to their parents.

432 H. The Department of Medical Assistance Services shall:

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

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

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

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

452 § 32.1-351. Family Access to Medical Insurance Security Plan established.

453 A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical
 454 Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan.
 455 The Department of Medical Assistance Services shall provide coverage under the Family Access to
 456 Medical Insurance Security Plan for individuals, ~~up to the age of nineteen~~ *under the age of 19 including*
 457 *the period from conception to birth*, when such individuals (i) have family incomes at or below 200
 458 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's
 459 FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue
 460 to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii)
 461 are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as
 462 amended; (iii) are not covered under a group health plan or under health insurance coverage, as defined
 463 in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91(a) and (b) (1)); (iv) have been
 464 without health insurance for at least ~~six~~ 4 months or meet the exceptions as set forth in the Virginia
 465 Plan for Title XXI of the Social Security Act, as amended; and (v) meet both the requirements of Title
 466 XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan.

467 B. Family Access to Medical Insurance Security Plan participants ~~whose incomes are above 150~~
 468 ~~percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title~~
 469 ~~XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the~~
 470 ~~Social Security Act pay an annual enrollment fee of \$25 per family.~~ The annual aggregate cost-sharing
 471 for all eligible children in a family ~~at or above 150 percent of the federal poverty level shall not exceed~~
 472 ~~five percent of the family's gross income or as allowed by federal law and regulations.~~ ~~Cost-sharing~~ *The*
 473 *annual aggregate cost-sharing* for all eligible children in a family ~~between 100 percent and at or below~~
 474 ~~150 percent of the federal poverty level shall be limited to nominal copayments and the annual~~
 475 ~~aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income.~~ *The nominal*
 476 *copayments for all eligible children in a family shall not be less than those in effect on January 1,*
 477 *2003.* Cost-sharing shall not be required for well-child and preventive services including age-appropriate
 478 child immunizations.

479 C. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care
 480 benefits to program participants, including well-child and preventive services, to the extent required to
 481 comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include
 482 comprehensive medical, dental, vision, mental health, and substance abuse services, and physical
 483 therapy, occupational therapy, speech-language pathology, and skilled nursing services for special
 484 education students. *The mental health services required herein shall incorporate, in the same manner*
 485 *and with the same coverage and limitations, the services provided to covered persons under the State*
 486 *Plan for Medical Assistance Services and as set forth in the Board's regulations.*

487 D. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that
 488 participants in the Family Access to Medical Insurance Security Plan who have access to
 489 employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required

490 to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its
 491 designee shall make premium payments to such employer's plan on behalf of eligible participants if the
 492 Department of Medical Assistance Services or its designee determines that such enrollment is
 493 cost-effective, as defined in § 32.1-351.1. The Family Access to Medical Insurance Security Plan shall
 494 provide for benefits not included in the employer-sponsored health insurance benefit plan through
 495 supplemental insurance equivalent to the comprehensive health care benefits provided in subsection C.

496 E. The Family Access to Medical Insurance Security Plan shall ensure that coverage under this
 497 program does not substitute for private health insurance coverage.

498 F. The health care benefits provided under the Family Access to Medical Insurance Security Plan
 499 shall be through existing Department of Medical Assistance Services' contracts with health maintenance
 500 organizations and other providers, or through new contracts with health maintenance organizations,
 501 health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the
 502 Department of Medical Assistance Services, or through employer-sponsored health insurance.

503 G. The Department of Medical Assistance Services may establish a centralized processing site for the
 504 administration of the program to include responding to inquiries, distributing applications and program
 505 information, and receiving and processing applications. The Family Access to Medical Insurance
 506 Security Plan shall include a provision allowing a child's application to be filed by a parent, legal
 507 guardian, authorized representative or any other adult caretaker relative with whom the child lives. The
 508 Department of Medical Assistance Services may contract with third-party administrators to provide any
 509 additional administrative services. Duties of the third-party administrators may include, but shall not be
 510 limited to, enrollment, outreach, eligibility determination, data collection, premium payment and
 511 collection, financial oversight and reporting, and such other services necessary for the administration of
 512 the Family Access to Medical Insurance Security Plan. Any centralized processing site shall determine a
 513 child's eligibility for either Title XIX or Title XXI and shall enroll eligible children in Title XIX or Title
 514 XXI. *A single application form shall be used to determine eligibility for Title XIX or Title XXI of the*
 515 *Social Security Act, as amended, and outreach, enrollment, re-enrollment and services delivery shall be*
 516 *coordinated with the FAMIS Plus program pursuant to § 32.1-325.* In the event that an application is
 517 denied, the applicant shall be notified of any services available in his locality that can be accessed by
 518 contacting the local department of social services.

519 H. (Effective until July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as
 520 amended, shall include a provision that, in addition to any centralized processing site, local social
 521 services agencies shall provide and accept applications for the Family Access to Medical Insurance
 522 Security Plan and shall assist families in the completion of applications. Contracting health plans,
 523 providers, and others may also provide applications for the Family Access to Medical Insurance Security
 524 Plan and may assist families in completion of the applications.

525 The plan shall also include a provision to request the custodial parent's cooperation with the
 526 Commonwealth in securing medical and child support payments. However, such cooperation shall not be
 527 a condition of eligibility.

528 H. (Effective July 1, 2003) The Virginia Plan for Title XXI of the Social Security Act, as amended,
 529 shall include a provision that, in addition to any centralized processing site, local social services
 530 agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan
 531 and shall assist families in the completion of applications. Contracting health plans, providers, and others
 532 may also provide applications for the Family Access to Medical Insurance Security Plan and may assist
 533 families in completion of the applications.

534 I. The Department of Medical Assistance Services shall develop and submit to the federal Secretary
 535 of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance
 536 Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions
 537 shall comply with the requirements of federal law, this chapter, and any conditions set forth in the
 538 appropriation act. In addition, the plan shall provide for coordinated implementation of publicity,
 539 enrollment, and service delivery with existing local programs throughout the Commonwealth that
 540 provide health care services, educational services, and case management services to children. In
 541 developing and revising the plan, the Department of Medical Assistance Services shall advise and
 542 consult with the Joint Commission on Health Care and shall provide quarterly reports on enrollment,
 543 policies affecting enrollment, such as the exceptions that apply to the ~~six~~ 4 months' prior coverage
 544 limitation referenced in subsection A of this section, benefit levels, outreach efforts, including efforts to
 545 enroll uninsured children of former Temporary Assistance to Needy Families (TANF) recipients, and
 546 other topics.

547 J. Funding for the Family Access to Medical Insurance Security Plan shall be provided through state
 548 and federal appropriations and shall include appropriations of any funds that may be generated through
 549 the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

550 K. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt,

551 promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.)
552 as may be necessary for the implementation and administration of the Family Access to Medical
553 Insurance Security Plan.

554 L. Children enrolled in the Virginia Plan for Title XXI of the Social Security Act prior to
555 implementation of these amendments shall continue their eligibility under the Family Access to Medical
556 Insurance Security Plan and shall be given reasonable notice of any changes in their benefit packages.
557 Continuing eligibility in the Family Access to Medical Insurance Security Plan for children enrolled in
558 the Virginia Plan for Title XXI of the Social Security Act prior to implementation of these amendments
559 shall be determined in accordance with their regularly scheduled review dates or pursuant to changes in
560 income status. Families may select among the options available pursuant to subsections D and F of this
561 section.

562 M. The provisions of Chapter 9 (§ 32.1-310 et seq.) of this title relating to the regulation of medical
563 assistance shall apply, mutatis mutandis, to the Family Access to Medical Insurance Security Plan.

564 N. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does
565 not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the
566 Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of
567 application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to
568 include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title
569 XXI of the Social Security Act, upon approval of FAMIS by the federal Health Care Financing
570 Administration as Virginia's State Children's Health Insurance Program.