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HOUSE BILL NO. 494

Offered January 12, 2022

Prefiled January 11, 2022

A *BILL to amend and reenact §§ 32.1-325 and 38.2-4319, as it is currently effective and as it may become effective, of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 5 of Title 32.1 an article numbered 9, consisting of a section numbered 32.1-162.15:12, and by adding a section numbered 38.2-3418.21, relating to licensing of human donor milk bank licensing; payment of medical assistance and health insurance coverage.*

Patron—Rasoul

Committee Referral Pending

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325 and 38.2-4319, as it is currently effective and as it may become effective, of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 5 of Title 32.1 an article numbered 9, consisting of a section numbered 32.1-162.15:12, and by adding a section numbered 38.2-3418.21 as follows:

*Article 9.**Licensing of Human Donor Milk Banks.***§ 32.1-162.15:12. Human donor milk banks; license required; renewal; standards.**

A. No person shall establish or operate a human donor milk bank without first obtaining a license issued by the Commissioner.

B. The Commissioner shall establish criteria for the licensure of human donor milk banks, which shall include (i) a process for licensure and renewal of a license as a human donor milk bank; (ii) appropriate fees for licensure and renewal of a license as a human donor milk bank; (iii) standards and requirements for human donor milk banks to protect the health and safety of the public and ensure the quality of human donor milk and human donor milk derived products; (iv) provisions for inspections of human donor milk banks; and (v) provisions for revocation or denial of a license to operate a human donor milk bank.

C. Requirements for human donor milk banks developed pursuant to clause (iii) of subsection B shall (i) provide for the testing of all donated human donor milk and human donor milk-derived products for the presence of viruses, bacteria, and adulterants as determined by the Department, and (ii) prohibit the sale, distribution, processing, or donation of any human donor milk and human donor milk-derived products that contain such substances.

§ 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

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59 the land, exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the
60 definition of home as provided here is more restrictive than that provided in the state plan for medical
61 assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and
62 lot used as the principal residence and all contiguous property essential to the operation of the home
63 regardless of value;

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

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

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

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

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

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

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

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

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

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

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

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

120 16. A provision for payment of medical assistance for low-dose screening mammograms for

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

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

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

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

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

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

182 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
183 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
184 such services through encouraging the purchase of private long-term care insurance policies that have
185 been designated as qualified state long-term care insurance partnerships and may be used as the first
186 source of benefits for the participant's long-term care. Components of the program, including the
187 treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with
188 federal law and applicable federal guidelines;

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

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

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

202 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
203 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
204 Department shall not impose any utilization controls or other forms of medical management limiting the
205 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a
206 12-month supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe,
207 dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii)
208 exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of
209 practice, for reasons other than contraceptive purposes. As used in this subdivision, "hormonal
210 contraceptive" means a medication taken to prevent pregnancy by means of ingestion of hormones,
211 including medications containing estrogen or progesterone, that is self-administered, requires a
212 prescription, and is approved by the U.S. Food and Drug Administration for such purpose; ~~and~~

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

225 29. *A provision for the payment of medical assistance for pasteurized human donor milk and human*
226 *milk-derived products from a human donor milk bank licensed pursuant to § 32.1-162.15:12 in*
227 *accordance with a written order of a licensed health care provider, provided that: (i) the infant is under*
228 *the age of 12 months based on that child's correct gestational age; (ii) the infant is medically or*
229 *physically unable to receive maternal breastmilk or breastmilk of adequate caloric density; and (iii) the*
230 *infant exhibits one or more of the following: (a) an infant birth weight of below 1,800 grams; (b) an*
231 *infant gestational age equal to or less than 34 weeks; (c) infant hypoglycemia; (d) a high risk for*
232 *development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity; (e)*
233 *a congenital or acquired gastrointestinal condition with long-term feeding or malabsorption*
234 *complications; (f) congenital heart disease requiring surgery in the first year of life; (g) an organ or*
235 *bone marrow transplant; (h) sepsis; (i) congenital hypotonias associated with feeding difficulty or*
236 *malabsorption; (j) renal disease requiring dialysis in the first year of life; (k) craniofacial anomalies; (l)*
237 *an immunologic deficiency; (m) neonatal abstinence syndrome; or (n) any other serious congenital or*
238 *acquired condition for which the use of pasteurized human donor milk and human donor milk derived*
239 *products is medically necessary and supports the treatment and recovery of the child. Reimbursement for*
240 *pasteurized human donor milk or human milk-derived products shall be made separately from the*
241 *hospital payment for inpatient services.*

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

243 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided

and that the health, safety, security, rights and welfare of patients are ensured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

325 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

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

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

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

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

359 **§ 38.2-3418.21. Coverage for expenses incurred in the provision of human donor milk.**

360 A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or
361 group accident and sickness insurance policies providing hospital, medical and surgical, or major
362 medical coverage on an expense-incurred basis; each corporation providing individual or group
363 accident and sickness subscription contracts; and each health maintenance organization providing a
364 health care plan for health care services shall provide coverage for expenses incurred in the provision
365 of pasteurized human donor milk, which shall include human milk fortifiers if indicated in a medical
366 order provided by a licensed medical practitioner, provided that:

1. The covered person is an infant under the age of six months;
 2. The milk is obtained from a human milk bank that meets quality guidelines established by the Department of Health; and

3. A licensed medical practitioner has issued a written order for the provision of such human donor milk for an infant who: (i) is under the age of 12 months based on that child's correct gestational age; (ii) is medically or physically unable to receive maternal breastmilk or breastmilk of adequate caloric density; and (iii) exhibits one or more of the following: (a) a birth weight of below 1,800 grams; (b) an infant gestational age equal to or less than 34 weeks; (c) infant hypoglycemia; (d) a high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity; (e) a congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications; (f) congenital heart disease requiring surgery in the first year of life; (g) requires an organ or bone marrow transplant; (h) sepsis; (i) congenital hypotonias associated with feeding difficulty or malabsorption; (j) renal disease requiring dialysis in the first year of life; (k) craniofacial anomalies; (l) an immunologic deficiency; (m) neonatal abstinence syndrome; or (n) any other serious congenital or acquired condition for which the use of pasteurized human donor milk and human donor milk-derived products is medically necessary and supports the treatment and recovery of the child.

C. Nothing in this section shall preclude the insurer, corporation, or health maintenance organization from performing utilization review, including periodic review of the medical necessity of a particular service.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee, or condition that is not equally imposed upon all individuals in the same benefit category.

E. The provisions of this section shall apply to any policy, contract, or plan delivered, issued for delivery, or renewed in the Commonwealth on and after January 1, 2023.

F. The provisions of this section shall not apply to short-term travel, accident-only, or limited or specified disease policies; contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans; or short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. (Contingent expiration date) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.20, 38.2-3418.21, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and Chapter 65 (§ 38.2-6500 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, 2, and 3 of

§ 38.2-3407.10, §§ 38.2-3407.10:1, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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

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

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

§ 38.2-4319. (Contingent effective date) Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.20, 38.2-3418.21, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) and 9 (§ 38.2-3465 et seq.) of Chapter 34, § 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), Chapter 65 (§ 38.2-6500 et seq.), and Chapter 66 (§ 38.2-6600 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, 2, and 3 of § 38.2-3407.10, §§ 38.2-3407.10:1, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer

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