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## HOUSE BILL NO. 1332

## AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions  
on February 4, 2020)

(Patron Prior to Substitute—Delegate Kilgore)

A BILL to amend and reenact § 32.1-325 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-122.03:1, relating to Statewide Telehealth Plan.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-122.03:1 as follows:

§ 32.1-122.03:1. *Statewide Telehealth Plan.*

A. As used in this section:

"Remote patient monitoring services" has the same meaning as in § 38.2-3418.16.

"Telehealth services" means the use of telecommunications and information technology to provide access to health assessments, diagnosis, intervention, consultation, supervision, and information across distance. "Telehealth services" include the use of such technologies as telephones, facsimile machines, electronic mail systems, store-and-forward technologies, and remote patient monitoring devices that are used to collect and transmit patient data for monitoring and interpretation. Nothing in this definition shall be construed or interpreted to amend the appropriate establishment of a bona fide practitioner-patient relationship, as defined in § 54.1-3303.

"Telemedicine services" has the same meaning as in § 38.2-3418.16.

B. The Board shall develop and implement, by July 1, 2022, and thereafter maintain as a component of the State Health Plan a Statewide Telehealth Plan to promote an integrated approach to the introduction and use of telehealth services and telemedicine services. The Statewide Telehealth Plan shall promote (i) the use of remote patient monitoring services and store-and-forward technologies, including in cases involving patients with chronic illness; (ii) the leveraging of telehealth and telemedicine technologies to streamline general practice and nonemergency triage services; (iii) rapid patient access to emergency medicine providers through telehealth services and telemedicine services; and (iv) such other telehealth services and telemedicine services and technologies as the Board deems appropriate.

C. The Statewide Telehealth Plan shall include provisions for:

1. The promotion of the inclusion of telehealth services and telemedicine services in the operating procedures of hospitals, primary care facilities, public primary and secondary schools, state-funded post-secondary schools, emergency medical services agencies, and such other state agencies and practices deemed necessary by the Board;

2. A uniform and integrated set of proposed criteria for the use of telehealth technologies for prehospital and interhospital triage and transportation of patients initiating or in need of emergency medical services developed by the Board in consultation with the Department of Health Professions, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, the Virginia Chapter of the American College of Surgeons, the American Stroke Association, the American Telemedicine Association, and prehospital care providers. The Board may revise such criteria from time to time to incorporate accepted changes in medical practice and appropriate use of new and effective innovations in telehealth or telemedicine technologies, or to respond to needs indicated by analysis of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se;

3. A strategy for integration of the Statewide Telehealth Plan with the State Health Plan, the Statewide Emergency Medical Services Plan, the Statewide Trauma Triage Plan, and the Stroke Triage Plan to support the purposes of each plan;

4. A strategy for the maintenance of the Statewide Telehealth Plan through (i) the development of an innovative payment model for emergency medical services that covers the transportation of a patient to a destination providing services of appropriate patient acuity and facilitates in-place treatment of a patient at the scene of an emergency response or via telehealth services and telemedicine services, where appropriate; (ii) the development of collaborative and uniform operating procedures for establishing and recording informed patient consent for the use of telehealth services and telemedicine services that are easily accessible by those medical professionals engaging in telehealth services and telemedicine services; and (iii) appropriate liability protection for providers involved in such telehealth and telemedicine consultation and treatment; and

5. *Collection of data regarding the use of telehealth services and telemedicine services in the delivery of inpatient and outpatient services, treatment of chronic illnesses, remote patient monitoring, and emergency medical services to determine the effect of use of telehealth services and telemedicine services on the medical service system in the Commonwealth, including (i) the potential for reducing unnecessary inpatient hospital stays, particularly among patients with chronic illnesses or conditions; (ii) the impact of the use of telehealth services and telemedicine services on patient morbidity, mortality, and quality of life; (iii) the potential for reducing unnecessary prehospital and interhospital transfers; and (iv) the impact on annual expenditures for health care services for all payers, including expenditures by third-party payers and out-of-pocket expenditures by patients.*

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

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

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

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

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

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

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

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

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

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a

performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

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

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

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

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

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

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

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

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;

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;

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

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

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

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

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

218 26. A provision for the payment of medical assistance for medically necessary health care services  
219 provided through telemedicine services;

220 27. *A provision for payment of medical assistance for emergency medical services delivered through*  
221 *telehealth services or telemedicine services, as those terms are defined in § 32.1-122.03:1, provided*  
222 *pursuant to the Statewide Telehealth Plan. The originating site for such services may include (i) the*  
223 *home of the person to whom services are provided, (ii) any public or private primary or secondary*  
224 *school or postsecondary institution of higher education at which the person to whom services are*  
225 *provided is located, and (iii) in the case of emergency medical services delivered through telehealth*  
226 *services or telemedicine services, as those terms are defined in § 32.1-122.03:1, the location where the*  
227 *patient received prehospital, interhospital, or emergency medical services in conjunction with*  
228 *appropriate emergency medical, medical, or long-term care providers included as originating sites for*  
229 *such telehealth services or telemedicine services, as those terms are defined in § 32.1-122.03:1; and*

230 28. *A provision for the payment of medical assistance for medically necessary health care services*  
231 *provided through remote patient monitoring services, as defined in § 32.1-122.03:1, for priority*  
232 *populations as determined by the Director of Medical Assistance Services, with the home as an eligible*  
233 *originating site, as permitted by federal law.*

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

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

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

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

240 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations  
241 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social  
242 services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact  
243 analysis with local boards of social services prior to submission to the Registrar. The fiscal impact  
244 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.

6. [Expired.]

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.

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

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed

306 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,  
307 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or  
308 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter  
309 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations  
310 which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical  
311 social workers, licensed professional counselors and licensed clinical nurse specialists at rates based  
312 upon reasonable criteria, including the professional credentials required for licensure.

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

318 H. The Department of Medical Assistance Services shall:

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

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

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

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

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