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HOUSE BILL NO. 1332

Offered January 8, 2020
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A BILL to amend and reenact §§ 32.1-111.3, 32.1-325, and 38.2-3418.16 of the Code of Virginia, relating to telehealth services.

Patrons—Kilgore and Tran

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-111.3, 32.1-325, and 38.2-3418.16 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-111.3. Statewide Emergency Medical Services Plan; Trauma Triage Plan; Stroke Triage Plan; Emergency Telehealth Plan.

A. The Board of Health shall develop a Statewide Emergency Medical Services Plan that shall provide for a comprehensive, coordinated, emergency medical services system in the Commonwealth and shall review, update, and publish the Plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency medical services system. The Plan shall incorporate the regional emergency medical services plans prepared by the regional emergency medical services councils pursuant to § 32.1-111.4:2. Publishing through electronic means and posting on the Department website shall satisfy the publication requirement. The objectives of such Plan and the emergency medical services system shall include the following:

1. Establishing a comprehensive statewide emergency medical services system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment;

3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia;

4. Promoting continuing improvement in system components including ground, water, and air transportation; communications; hospital emergency departments and other emergency medical care facilities; health care provider training and health care service delivery; and consumer health information and education;

5. Ensuring performance improvement of the emergency medical services system and emergency medical services and care delivered on scene, in transit, in hospital emergency departments, and within the hospital environment;

6. Working with professional medical organizations, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;

7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of emergency medical services personnel, including expanding the availability of paramedic and advanced life support training throughout the Commonwealth with particular emphasis on regions underserved by emergency medical services personnel having such skills and training;

8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs;

9. Establishing a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies;

10. Establishing and maintaining a process for designation of appropriate hospitals as trauma centers, certified stroke centers, and specialty care centers based on an applicable national evaluation system;

11. Maintaining a comprehensive emergency medical services patient care data collection and performance improvement system pursuant to Article 3.1 (§ 32.1-116.1 et seq.);

12. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.);

13. Establishing and maintaining a process for crisis intervention and peer support services for emergency medical services personnel and public safety personnel, including statewide availability and accreditation of critical incident stress management or peer support teams and personnel. Such accreditation standards shall include a requirement that a peer support team be headed by a Virginia-licensed clinical psychologist, Virginia-licensed psychiatrist, Virginia-licensed clinical social worker, or Virginia-licensed professional counselor, who has at least five years of experience as a mental health consultant working directly with emergency medical services personnel or public safety personnel;

14. Establishing a statewide program of emergency medical services for children to provide coordination and support for emergency pediatric care, availability of pediatric emergency medical care equipment, and pediatric training of health care providers;

15. Establishing and supporting a statewide system of health and medical emergency response teams, including emergency medical services disaster task forces, coordination teams, disaster medical assistance teams, and other support teams that shall assist local emergency medical services agencies at their request during mass casualty, disaster, or whenever local resources are overwhelmed;

16. Establishing and maintaining a program to improve dispatching of emergency medical services personnel and vehicles, including establishment of and support for emergency medical services dispatch training, accreditation of 911 dispatch centers, and public safety answering points;

17. Identifying and establishing best practices for managing and operating emergency medical services agencies, improving and managing emergency medical services response times, and disseminating such information to the appropriate persons and entities;

18. Ensuring that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted immediately to deploy assistance in the event there are victims as defined in § 19.2-11.01, and that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund become the lead coordinating agencies for those individuals determined to be victims; and

19. Maintaining current contact information for both the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund.

B. The Board of Health shall also develop and maintain as a component of the Emergency Medical Services Plan a statewide prehospital and interhospital Trauma Triage Plan designed to promote rapid access for pediatric and adult trauma patients to appropriate, organized trauma care through the publication and regular updating of information on resources for trauma care and generally accepted criteria for trauma triage and appropriate transfer. The Trauma Triage Plan shall include:

1. A strategy for maintaining the statewide Trauma Triage Plan through development of regional trauma triage plans that take into account the region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A and inclusion of such regional plans in the statewide Trauma Triage Plan. The regional trauma triage plans shall be reviewed triennially. Plans should ensure that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted immediately to deploy assistance in the event there are victims as defined in § 19.2-11.01, and that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund become the lead coordinating agencies for those individuals determined to be victims; and maintain current contact information for both the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of trauma patients developed by the Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses 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 performance improvement program for monitoring the quality of emergency medical services and trauma services, consistent with other components of the Emergency Medical Services Plan. The program shall provide for collection and analysis of data on emergency medical and trauma services from existing validated sources, including the emergency medical services patient care information system, pursuant to Article 3.1 (§ 32.1-116.1 et seq.), the Patient Level Data System, and mortality data. The Advisory Board shall review and analyze such data on a quarterly basis and report its findings to the Commissioner. The Advisory Board may execute these duties through a committee composed of persons having expertise in critical care issues and representatives of emergency medical services providers. The program for monitoring and reporting the results of emergency medical services and trauma services data analysis shall be the sole means of encouraging and promoting compliance with the

trauma triage criteria.

The Commissioner shall report aggregate findings of the analysis annually to each regional emergency medical services council. The report shall be available to the public and shall identify, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

The Advisory Board or its designee shall ensure that each hospital director or emergency medical services agency chief is informed of any incorrect interfacility transfer or triage, as defined in the statewide Trauma Triage Plan, specific to the hospital or agency and shall give the hospital or agency an opportunity to correct any facts on which such determination is based, if the hospital or agency asserts that such facts are inaccurate. The findings of the report shall be used to improve the Trauma Triage Plan, including triage, and transport and trauma center designation criteria.

The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the Advisory Board, any committee acting on behalf of the Advisory Board, any hospital or prehospital care provider, any regional emergency medical services council, emergency medical services agency that holds a valid license issued by the Commissioner, or group or committee established to monitor the quality of emergency medical services or trauma services pursuant to this subdivision, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

C. The Board shall also develop and maintain as a component of the Statewide Emergency Medical Services Plan a statewide prehospital and interhospital Stroke Triage Plan designed to promote rapid access for stroke patients to appropriate, organized stroke care through the publication and regular updating of information on resources for stroke care and generally accepted criteria for stroke triage and appropriate transfer. The Stroke Triage Plan shall include:

1. A strategy for maintaining the statewide Stroke Triage Plan through development of regional stroke triage plans that take into account the region's geographic variations and stroke care capabilities and resources, including hospitals designated as comprehensive stroke centers, primary stroke centers, primary stroke centers with supplementary levels of stroke care distinction, and acute stroke-ready hospitals through certification by the Joint Commission, DNV Healthcare, the American Heart Association, or a comparable process consistent with the recommendations of the Brain Attack Coalition, and inclusion of such regional plans in the statewide Stroke Triage Plan. The regional stroke triage plans shall be reviewed triennially.

2. A uniform set of proposed criteria for prehospital and interhospital triage and transport of stroke patients developed by the Advisory Board, in consultation with the American Stroke Association, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses 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.

D. *The Board shall also develop and maintain as a component of the Statewide Emergency Medical Services Plan a statewide prehospital and interhospital Emergency Telehealth Plan to promote rapid patient access to emergency medical physicians through telehealth and telemedicine services, as defined in § 38.2-3418.16. The Emergency Telehealth Plan shall include:*

1. The establishment of a statewide emergency telehealth program for the use of telehealth services, as defined in § 38.2-3418.16, and telemedicine services, as defined in § 38.2-3418.16, in the delivery of emergency medical services and a requirement for development of regional emergency telehealth plans to support maintenance of the Statewide Telehealth Plan;

2. The promotion of the inclusion of telehealth and telemedicine services and technologies in the operating procedures of emergency medical services agencies;

3. A uniform set of proposed criteria for the use of telehealth and telemedicine services for prehospital and interhospital triage and transportation of patients in need of emergency medical services developed by the Advisory Board in consultation with 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 Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice, appropriate use of new and effective innovations in telehealth or telemedicine services and technologies, or 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 uniform set of standards for telehealth and telemedicine technologies used in the delivery of emergency medical services;

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

5. Provisions for collection of data regarding the use of telehealth and telemedicine services and technologies in the delivery of emergency medical services to determine the effect of use of telehealth and telemedicine services on the emergency medical services system including (i) the potential for reducing unnecessary prehospital and interhospital transfers and (ii) the impact on annual expenditures for emergency medical services.

E. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle, or other form of conveyance.

§ 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;

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

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

26. A provision for the payment of medical assistance for medically necessary health care services provided through *telehealth services, as defined in § 38.2-3418.16, and* telemedicine services, *as defined in § 38.2-3418.16, with the (i) home of the person to whom services are provided, (ii) any public or private primary or secondary school, or postsecondary institution of higher education at which the person to whom services are provided is located, and (iii) in the case of emergency medical services delivered through telehealth services or telemedicine services, the location where the patient received prehospital, interhospital, or emergency medical services in conjunction with appropriate emergency medical, medical, or long-term care providers included as originating sites for such telehealth services or telemedicine services.*

B. In preparing the plan, the Board shall:

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

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

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

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

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

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

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

H. The Department of Medical Assistance Services shall:

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

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

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

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

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

§ 38.2-3418.16. Coverage for telehealth and telemedicine services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through *telehealth services or* telemedicine services, as provided in this section.

B. As used in this section:

"Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

"Telehealth services" means the delivery of health care services, including telemedicine services and other medical, emergency medical, and behavioral health services that are not equivalent to health care services provided through face-to-face consultation or contact between a health care provider and a patient, through the use of telecommunications and information technology that supports the delivery of remote or long-distance health care services.

"Telemedicine services" ~~as it pertains to~~ *means* the delivery of health care services~~, means~~ *that are equivalent to health care services provided through face-to-face consultation or contact between a health care provider and a patient through* the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, *providing store-and-forward data transmissions,* or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through *telehealth services or* telemedicine services and

is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through *telehealth services or* telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of *telehealth services or* telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis *of,* consultation *with,* ~~or~~ treatment of, *or other health care services provided to* the insured delivered through *telehealth or* telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact *if the service is one that is equivalent to a service provided through face-to-face consultation or contact*.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of *telehealth services or* telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent *telehealth services or* telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through *telehealth services or* telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for *telehealth services or* telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to *(i)* all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made, *or (ii) to policies or contracts designed for issuance to persons eligible for coverage under Title XIX of the Social Security Act, known as Medicaid, or any similar coverage under state or federal governmental plans issued for delivery, reissued, or extended in the Commonwealth on or after January 1, 2021, provided those amendments to the state plan providing for the payment of medical assistance for telehealth services or telemedicine services required pursuant to § 32.1-325 are approved by the U.S. Secretary of Health and Human Services*.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts~~, nor to policies or 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~~.

J. The coverage required by this section shall include the use of *telehealth and* telemedicine technologies as it pertains to medically necessary remote patient monitoring services to the full extent that these services are available.

2. That the Secretary of Health and Human Resources shall establish a workgroup to develop recommendations for (i) innovative payment models that support the use of telehealth services and telemedicine services in accordance with the Statewide Emergency Telehealth Plan including payment of the cost of transporting of a patient to a destination providing services appropriate to the patient's level of acuity and in-place treatment of a patient at the scene of an emergency response or vial telehealth services or telemedicine services where appropriate, and (ii) appropriate liability protections for health care providers providing services through telehealth services and telemedicine services. The workgroup shall report its recommendations to the Governor and the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Education and Health and Finance by November 1, 2020.