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HOUSE BILL NO. 1987

Offered January 13, 2021

Prefiled January 11, 2021

A BILL to amend and reenact §§ 32.1-325, 38.2-3418.16, and 54.1-3303 of the Code of Virginia, relating to telemedicine.

Patrons—Adams, D.M., Helmer, Ayala, Bell, Carter, Cole, M.L., Coyner, Davis, Filler-Corn, Fowler, Guzman, Head, Herring, Keam, Kilgore, Kory, LaRock, Levine, Lopez, Mugler, Mundon King, Murphy, Plum, Rasoul, Robinson, Roem, Samirah, Sickles, Simon, Simonds, Sullivan, Tran, Webert and Wyatt; Senators: Boysko, Marsden and McPike

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325, 38.2-3418.16, and 54.1-3303 of the Code of Virginia are amended and reenacted as follows:

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

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

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

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

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

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

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

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

56 or Standards or any official amendment thereto;

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

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

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

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

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

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

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

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

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

98 16. A provision for payment of medical assistance for low-dose screening mammograms for
99 determining the presence of occult breast cancer. Such coverage shall make available one screening
100 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
101 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
102 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
103 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
104 radiation exposure of less than one rad mid-breast, two views of each breast;

105 17. A provision, when in compliance with federal law and regulation and approved by the Centers
106 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
107 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
108 program and may be provided by school divisions;

109 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
110 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
111 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
112 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
113 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
114 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific
115 transplant center where the surgery is proposed to be performed have been used by the transplant team
116 or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy
117 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 telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. No health care provider who provides health care services through telemedicine services shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

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

27. A provision for payment of medical assistance for remote patient monitoring services provided via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic health condition who have had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months. For the purposes of this subdivision, "remote patient monitoring services" means the use of digital technologies to collect medical and other forms of health data from

179 patients in one location and electronically transmit that information securely to health care providers in
180 a different location for assessment and recommendations. "Remote patient monitoring services" include
181 monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose,
182 and other patient physiological data, treatment adherence monitoring, and interactive videoconferencing
183 with or without digital image upload.

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

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

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

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

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

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

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

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

212 In the event conforming amendments to the state plan for medical assistance services are adopted, the
213 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
214 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
215 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
216 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
217 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with
218 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
219 session of the General Assembly unless enacted into law.

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

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

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

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

234 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement
235 or contract, with a provider who is or has been a principal in a professional or other corporation when
236 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315,
237 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
238 program pursuant to 42 C.F.R. Part 1002.

239 5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection
240 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.

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.

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

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

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

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

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

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

§ 38.2-3418.16. Coverage for telemedicine services.

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

308 B. As used in this section:

309 "Originating site" means the location where the patient is located at the time services are provided by
310 a health care provider through telemedicine services.

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

316 "Telemedicine services" as it pertains to the delivery of health care services, means the use of
317 electronic technology or media, including interactive audio or video, for the purpose of diagnosing or
318 treating a patient, providing remote patient monitoring services, or consulting with other health care
319 providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the
320 patient is accompanied by a health care provider at the time such services are provided. "Telemedicine
321 services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or
322 online questionnaire. *Nothing in this section shall preclude coverage for a service that is not a*
323 *telemedicine service, including real-time audio-only telehealth services.*

324 C. An insurer, corporation, or health maintenance organization shall not exclude a service for
325 coverage solely because the service is provided through telemedicine services and is not provided
326 through face-to-face consultation or contact between a health care provider and a patient for services
327 appropriately provided through telemedicine services.

328 D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the
329 treating provider or the consulting provider for technical fees or costs for the provision of telemedicine
330 services; however, such insurer, corporation, or health maintenance organization shall reimburse the
331 treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured
332 delivered through telemedicine services on the same basis that the insurer, corporation, or health
333 maintenance organization is responsible for coverage for the provision of the same service through
334 face-to-face consultation or contact. No insurer, corporation, or health maintenance organization shall
335 require a provider to use proprietary technology or applications in order to be reimbursed for providing
336 telemedicine services.

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

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

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

354 H. The requirements of this section shall apply to all insurance policies, contracts, and plans
355 delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021,
356 or at any time thereafter when any term of the policy, contract, or plan is changed or any premium
357 adjustment is made.

358 I. This section shall not apply to short-term travel, accident-only, or limited or specified disease
359 policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage
360 under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under
361 federal governmental plans.

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

are available.

K. Prescribing of controlled substances via telemedicine shall comply with the requirements of § 54.1-3303 and all applicable federal law.

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient, *including by telemedicine*, provided that, ~~in cases in which the practitioner has performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically,~~ the prescribing of such Schedule II through V controlled substance is in compliance with federal requirements for the practice of telemedicine.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a A prescriber may establish a bona fide practitioner-patient relationship *for the purpose of prescribing a Schedule II through VI controlled substance, including by telemedicine*, by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a ~~Schedule VI~~ controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

For purposes of this section, a bona fide veterinarian-client-patient relationship is one in which a veterinarian, another veterinarian within the group in which he practices, or a veterinarian with whom he is consulting has assumed the responsibility for making medical judgments regarding the health of and providing medical treatment to an animal as defined in § 3.2-6500, other than an equine as defined in § 3.2-6200, a group of agricultural animals as defined in § 3.2-6500, or bees as defined in § 3.2-4400, and a client who is the owner or other caretaker of the animal, group of agricultural animals, or bees has consented to such treatment and agreed to follow the instructions of the veterinarian. Evidence that a

425 veterinarian has assumed responsibility for making medical judgments regarding the health of and
426 providing medical treatment to an animal, group of agricultural animals, or bees shall include evidence
427 that the veterinarian (A) has sufficient knowledge of the animal, group of agricultural animals, or bees
428 to provide a general or preliminary diagnosis of the medical condition of the animal, group of
429 agricultural animals, or bees; (B) has made an examination of the animal, group of agricultural animals,
430 or bees, either physically or by the use of instrumentation and diagnostic equipment through which
431 images and medical records may be transmitted electronically or has become familiar with the care and
432 keeping of that species of animal or bee on the premises of the client, including other premises within
433 the same operation or production system of the client, through medically appropriate and timely visits to
434 the premises at which the animal, group of agricultural animals, or bees are kept; and (C) is available to
435 provide follow-up care.

436 C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of
437 treatment or for authorized research. A prescription not issued in the usual course of treatment or for
438 authorized research is not a valid prescription. A practitioner who prescribes any controlled substance
439 with the knowledge that the controlled substance will be used otherwise than for medicinal or
440 therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of
441 the provisions of law relating to the distribution or possession of controlled substances.

442 D. No prescription shall be filled unless a bona fide practitioner-patient-pharmacist relationship exists.
443 A bona fide practitioner-patient-pharmacist relationship shall exist in cases in which a practitioner
444 prescribes, and a pharmacist dispenses, controlled substances in good faith to a patient for a medicinal
445 or therapeutic purpose within the course of his professional practice.

446 In cases in which it is not clear to a pharmacist that a bona fide practitioner-patient relationship
447 exists between a prescriber and a patient, a pharmacist shall contact the prescribing practitioner or his
448 agent and verify the identity of the patient and name and quantity of the drug prescribed.

449 Any person knowingly filling an invalid prescription shall be subject to the criminal penalties
450 provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or
451 possession of controlled substances.

452 E. Notwithstanding any provision of law to the contrary and consistent with recommendations of the
453 Centers for Disease Control and Prevention or the Department of Health, a practitioner may prescribe
454 Schedule VI antibiotics and antiviral agents to other persons in close contact with a diagnosed patient
455 when (i) the practitioner meets all requirements of a bona fide practitioner-patient relationship, as
456 defined in subsection B, with the diagnosed patient and (ii) in the practitioner's professional judgment,
457 the practitioner deems there is urgency to begin treatment to prevent the transmission of a communicable
458 disease. In cases in which the practitioner is an employee of or contracted by the Department of Health
459 or a local health department, the bona fide practitioner-patient relationship with the diagnosed patient, as
460 required by clause (i), shall not be required.

461 F. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state
462 practitioner of medicine, osteopathy, podiatry, dentistry, optometry, or veterinary medicine, a nurse
463 practitioner, or a physician assistant authorized to issue such prescription if the prescription complies
464 with the requirements of this chapter and the Drug Control Act (§ 54.1-3400 et seq.).

465 G. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to
466 § 54.1-2957.01 may issue prescriptions or provide manufacturers' professional samples for controlled
467 substances and devices as set forth in the Drug Control Act (§ 54.1-3400 et seq.) in good faith to his
468 patient for a medicinal or therapeutic purpose within the scope of his professional practice.

469 H. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to
470 § 54.1-2952.1 may issue prescriptions or provide manufacturers' professional samples for controlled
471 substances and devices as set forth in the Drug Control Act (§ 54.1-3400 et seq.) in good faith to his
472 patient for a medicinal or therapeutic purpose within the scope of his professional practice.

473 I. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to
474 Article 5 (§ 54.1-3222 et seq.) of Chapter 32 may issue prescriptions in good faith or provide
475 manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the
476 scope of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to
477 § 54.1-3223, which shall be limited to (i) analgesics included on Schedule II controlled substances as
478 defined in § 54.1-3448 of the Drug Control Act (§ 54.1-3400 et seq.) consisting of hydrocodone in
479 combination with acetaminophen; (ii) oral analgesics included in Schedules III through VI, as defined in
480 §§ 54.1-3450 and 54.1-3455 of the Drug Control Act (§ 54.1-3400 et seq.), which are appropriate to
481 relieve ocular pain; (iii) other oral Schedule VI controlled substances, as defined in § 54.1-3455 of the
482 Drug Control Act, appropriate to treat diseases and abnormal conditions of the human eye and its
483 adnexa; (iv) topically applied Schedule VI drugs, as defined in § 54.1-3455 of the Drug Control Act;
484 and (v) intramuscular administration of epinephrine for treatment of emergency cases of anaphylactic
485 shock.

486 J. The requirement for a bona fide practitioner-patient relationship shall be deemed to be satisfied by

487 a member or committee of a hospital's medical staff when approving a standing order or protocol for the
488 administration of influenza vaccinations and pneumococcal vaccinations in a hospital in compliance with
489 § 32.1-126.4.

490 K. Notwithstanding any other provision of law, a prescriber may authorize a registered nurse or
491 licensed practical nurse to approve additional refills of a prescribed drug for no more than 90
492 consecutive days, provided that (i) the drug is classified as a Schedule VI drug; (ii) there are no changes
493 in the prescribed drug, strength, or dosage; (iii) the prescriber has a current written protocol, accessible
494 by the nurse, that identifies the conditions under which the nurse may approve additional refills; and (iv)
495 the nurse documents in the patient's chart any refills authorized for a specific patient pursuant to the
496 protocol and the additional refills are transmitted to a pharmacist in accordance with the allowances for
497 an authorized agent to transmit a prescription orally or by facsimile pursuant to subsection C of §
498 54.1-3408.01 and regulations of the Board.

499 **2. That the Board of Medical Assistance Services shall adopt regulations for reimbursement for**
500 **telemedicine services delivered through audio-only telephone, which shall include regulations for (i)**
501 **services that may be delivered via audio-only telephone, (ii) reimbursement rates for services**
502 **delivered via audio-only telephone, and (iii) such other regulations as the Board of Medical**
503 **Assistance Services may deem necessary.**